Part B Insider (Multispecialty) Coding Alert

STUDIES & SURVEYS: Less Is More, Says MedPAC

Some regions of the country are spending 60 percent more per patient on health care than others. But those regions aren't delivering better care, say researchers.

If anything, those regions produce the same outcomes as their more frugal counterparts, or even slightly worse ones, according to researchers led by **Dartmouth Medical School's Elliot Fisher**, MD. Survival rates for patients in high-spending regions were worse, according to a study Fisher and company published in the Annals of Internal Medicine.

Now the **Medicare Payment Advisory Commission** plans to pick up these data for its June report. At a March 20 hearing, staffers showed how they'd tallied the services per beneficiary for each state, adjusted to account for the costs of services. Then they plotted this against the states' rankings in a quality-of-care study published in the Jan. 17 Journal of the American Medical Association. The result showed the penny-pinching states with relatively high quality.

Once you adjust the figures for the providers' costs and the beneficiaries' health status, the differences in Medicare spending per beneficiary aren't quite as dramatic as the yawning gulf the Dartmouth researchers found, MedPAC staff claimed. But "expenditures still vary significantly by region," noted MedPAC Chair **Glenn Hackbarth**.

Former Sen. **David Durenberger** (R-MN), who spearheaded a campaign to equalize payments across geographic regions, said the dollar differences were less important than the question of how Medicare's payment system is contributing to this problem.

More frequent inpatient physician visits contributed massively to the higher spending in the Dartmouth survey. So did greater use of specialists and subspecialists and more frequent tests, radiology services and minor procedures.

"This study is consistent with evidence that the more hospital beds, physicians, laboratories, and subspecialists that are available in a region, the more they will be used," said former **Institute of Medicine** President **Kenneth Shin**e, MD, in a commentary published with the Annals report.

None of the Medicare reforms of the past decade has addressed the issue of geographic disparities. But with MedPAC taking the issue up, some see the possibility for a reform that targets wasteful spending in the fat regions and leaves the lean ones untouched.

Fisher's team published a proposal for a Medicare demonstration project to address geographic disparities in Health Affairs a year ago, Fisher tells PBI.

Fisher proposes gathering academic medical centers to develop a payment system that rewards quality as well as quantity. This could remain a fee-for-service system, he argues. "We're now talking with folks on the Hill," he adds. His reform proposal didn't make it into the last piece of omnibus legislation, but "we're starting over."

"The principle has to be able to figure out how we're going to pay not for specific services but to manage the overall health of the population and improve it," Fisher adds.

Existing reform proposals haven't focused on high-cost "supply-sensitive services" like frequency of physician visits or hospital stays. "Until our payment system catches up with our current understanding of what variations in practice and variations in spending are, we're not going to be able to fix them."

Medicare has tried to equalize regional spending, notes researcher **Jonathan Skinner**, who also worked on the Dartmouth study. For example, Medicare released Medicare+Choice plans from having to pay attention to local fee-for-

service costs and tried to "attenuate regional differences in M+C expenses, but that was a disaster."

Since the main tool available to policymakers is reimbursement rates, it's difficult to address regional disparities. If Medicare slashed payments to a high-spending area like Miami, it would punish conservative doctors in that area, while aggressive doctors would just provide more services to make up for lower rates.

Skinner says Medicare should keep track of "gray area" medical procedures and look for underuse of procedures that actually help patients.

That could lead to a "selective contracting," quality-based model for Medicare, which Skinner admits would be political dynamite.