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Drill deeper to uncover variation across geographic areas

Provider communities lack local best practices

BY MARI EDLIN



SOMETIMES SUPPLY drives demand. That's one of the often cited conclusions reached by the Dartmouth Atlas Project focusing on supply-sensitive care.

The supply of a specific health service or resource has a major influence on utilization rates among Medicare beneficiaries with severe chronic illnesses during the last two years of their lives, according to ongoing Dartmouth research. Removing differences in the price of healthcare services, severity of illness and overall quality from the equation, results show relative Medicare spending in a specific region is influenced by the availability of medical resources—higher hospital admissions correlated with a higher number of hospital beds.

A study of 1.6 million Medicare beneficiaries released last month by the Center for Studying Health System Change, however, indicates that patient health is the driver of spending variation, not supply. When patient-level data was considered, market factors were insignificant or weakly related to cost.

Dartmouth uses a population-based analysis tool to study the experiences of Medicare populations. Data reveal that Medicare spending per capita varies almost three times between the lowest and highest spending regions in the country.

“Most variations in per capita spending for the Medicare population are due to the volume of services in different regions,” says Elliott Fisher, MD, director, Population Health and Policy, the Dartmouth Institute of Health Policy and Clinical Practice. “While Medicare spending is affected by different prices for the same service and by differences in the severity of patients’ morbidities, the Dartmouth Atlas shows that the utilization of supply-sensitive services for chronically ill patients varies tremendously across regions and is responsible for much of Medicare’s spending. Two major components of spending are unit cost and volume, which can be managed by eliminating unnecessary care.”

MORE OR LESS

Dr. Fisher emphasizes the need for more information, performance measurements, innovative payment systems and provider accountability. Regions with higher practice patterns do not necessarily produce better results, and it's a

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longstanding truth that more care and more expensive care is not necessarily better care.

A Dartmouth Atlas finding further attributes geographic variations to physician reimbursement and how care is organized. In interviewing physicians, Dr. Fisher found that most schedule office visits for minor patient concerns because only office visits are reimbursed. Other communication choices might be more efficient and less costly.

“National health plans should be able to reduce unwarranted variations from region to region through payment or incentives,” says Jeffrey Rideout, MD, senior vice president, cost and care management and chief medical officer for TriZetto. “Part of the challenge, however, is frequently a lack of evidence-based standards of care. More typically, providers practice according to the standards established in their local communities.”

The result of these variations is estimated at \$600 billion to \$800 billion of wasteful spending a year, according to TriZetto.

SERVICE INTENSITY ON THE RISE

Nathan Gunn, MD, chief operating officer, Verisk Health, a healthcare data analytics firm based in Waltham, Mass., adds that the intensity of services, such as using a CT scan when an X-ray would have sufficed, can cause significant variation in the cost of care.

While Dr. Gunn says that unit cost is often influenced by the market share of an insurer in an area or by the size of a provider group, who may wield more clout in contracting, utilization is more difficult to control.

“It’s hard to manage utilization when it is based on provider judgment about what is ordered,” he says.

He suggests that providers assume more risk as an incentive to improve performance. Observers hold out promise for accountable care organizations and the patient-centered medical home.

“We need to understand how financing

impacts behavior to better align incentives,” Dr. Gunn says.

One of his suggestions is to capitate primary care physicians at higher income levels and incent them for better quality, while basing reimbursement for hospitals and specialists on fee-for-service. In this way, he expects that a primary care physician will make better choices.

Ernest Moy, MD, medical officer, Center for Quality Improvement and Patient

MHE EXECUTIVE VIEW

■ **Variation results in as much as \$800 billion in wasteful spending annually.**

■ **ACOs could realign provider incentives.**

■ **Measure and report variation in practice patterns.**

Safety, Agency for Healthcare Research and Quality (AHRQ), says the key to uncovering variations in care is drilling deeper into under- and overutilization, inappropriate use of services and a sicker population.

“We must consider a patient’s needs before assessing quality of care,” Dr. Moy says. “Does a community consume more hospital care because there is a scarcity of primary care physicians, for example? It is important to target services and determine whether they are needed and if they are being delivered. What may seem to be overutilization in one community actually matches the needs of another community.”

He says measuring and reporting performance are critical in ensuring quality, enabling providers to compare their performance against others and against national benchmarks. Dr. Moy believes that appropriate reimbursement and incentives, or even disincentives, can help reduce variations in care.

Geographic variations are intertwined with ethnic differences in populations and cannot be overlooked when studying disparities in quality of care, he says.

Twelve different teams from six hospitals across Washington State will participate in a national initiative, Aligning Forces for Quality (AF4Q), funded by the Robert Wood Johnson Foundation to help reduce disparities in care. The region—encompassing four major cities and a 150-mile swath from north to south—will join 16 other communities across the country, who will share results over an 18-month period. The work with the hospitals is just one part of the AF4Q initiative.

Mary McWilliams, executive director, Puget Sound Health Alliance, which has been part of the AF4Q community since 2006, says that goal of AF4Q is to measure and publicly report providers’ performance and help consumers understand their role in recognizing and asking for high-quality care.

The alliance also is collecting data and publicly reporting on 21 measures related to prevention, appropriate use of services, management of chronic disease and the use of generics instead of branded drugs. McWilliams says that the participants will follow national standards endorsed by the National Committee on Quality Assurance and the National Quality Forum.

For example, she anticipates increasing generic use for proton pump inhibitors to 95%, reducing use of the emergency room by 30%, and decreasing avoidable hospitalizations by 10%.

“Even within our region, we know that the quality of care can vary significantly,” says McWilliams. “By measuring and publicly reporting the performance of medical groups and clinics, we can identify where those variations exist and develop strategies to address them. We believe that if you can measure it, you can fix it.” **MHE**