Understanding Practice Variations

* Dealing with Unwarranted Variations: Some policy options

Understanding Variations in Medicare Spending

- More than 2 fold variation, even after adjustment for differences in age structure, race and illness
- Regional Patterns > spending in South, Urban Northeast & Southern California
- Equity Issue #1: transfer payments from low to high spending regions
- Equity Issue #2: Policy for paying HMOs => extra benefits to residents of high cost regions

Reform Must Address Unwarranted Variations in Use of Health Care Among Fee-for-Service Health Care Organizations

- Underuse of Effective Care
- Misuse of Preference Sensitive Care
- Overuse of Supply Sensitive Care

Can Health Care Organizations Provide Remedy for Unwarranted Variations?

- The Data Gap
- The Implementation Gap
- The Incentive Gap

The data gap can be filled:

Medicare Data Provide the Basis for Monitoring Performance of Health Care Organizations

- Resource Inputs (workforce, beds, dollars)
- Performance Measures
  - effective care
  - preference sensitive care
  - supply sensitive care

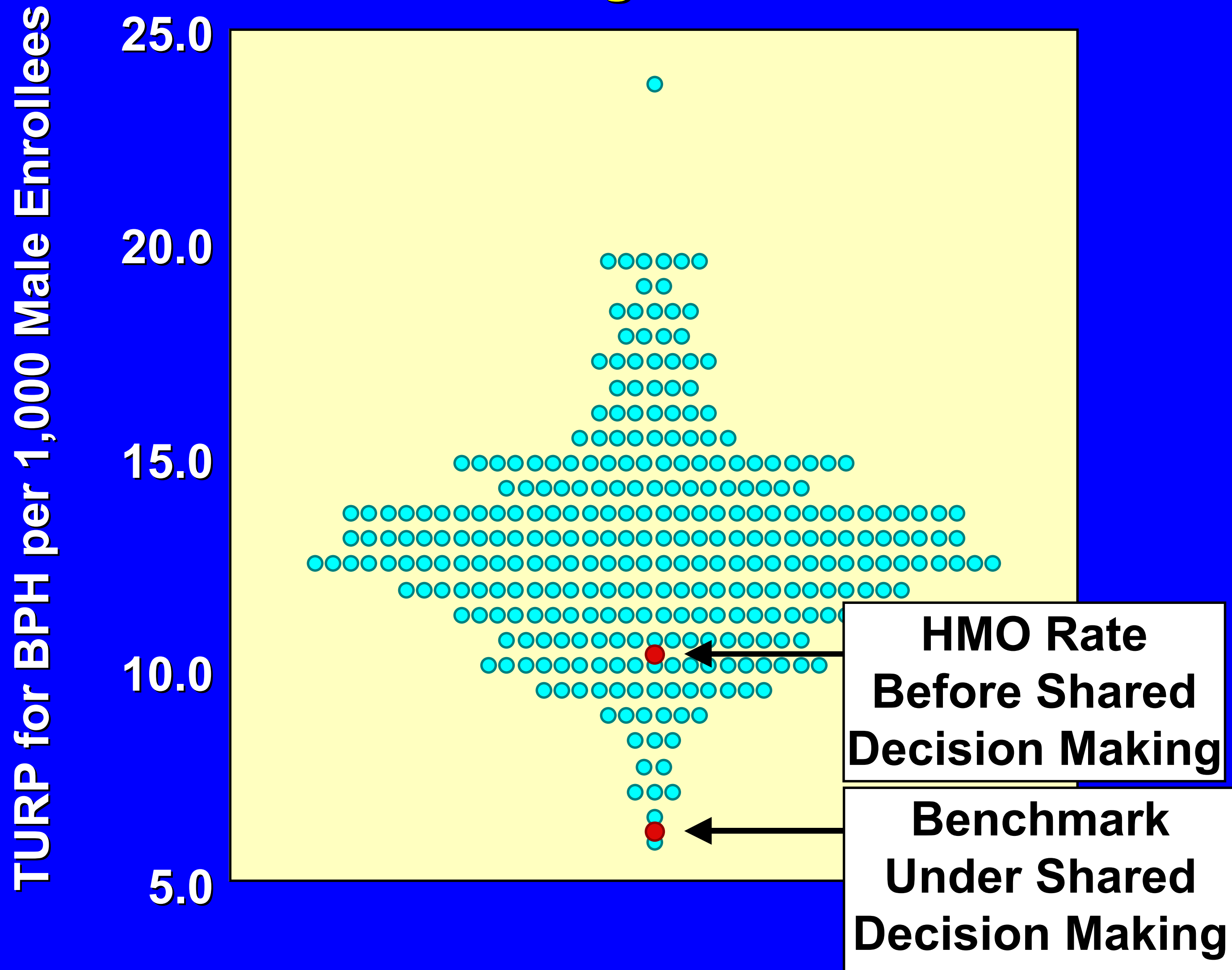
The implementation gap:

Remedies Exist But Have Not Been Widely Implemented

- Effective Care
- Preference Sensitive Care

Learning Which Rate is Right for Preference Sensitive Services

Shared Decision Making in 2 Staff Model HMOs



The implementation gap:

Remedies Exist But Have Not Been Widely Implemented

– Effective Care
– Preference Sensitive Care
– Supply Sensitive Care

Requirements for governing use of supply-sensitive services

- System level:
  - control of capacity
- Patient level:
  - chronic disease management

Staff Model Health Care Organizations can Govern Supply Sensitive Services because they:

- They know the size of the population they serve
- Their financial structure supports chronic disease management
- Incentives are to reduce overuse of supply-sensitive services

Can the Fee-for-Service Incentive Gap be Filled?

- **The incentive gap:**
  - **Reward efficiency and the reducing of unwarranted variations**
  - **Provide resources to cover infra-structure costs for achieving higher quality**

Our Working Hypothesis re Value Health Purchasing

- Efficient providers (those with lower frequency of use of supply sensitive care) can be identified
- Interventions can be designed to reward efficient health care organizations who agree to reduce unwarranted variations in each category of care
- Incentives can be created to cause the less efficient to emulate "best practice" benchmarks

Optimistic scenario for value health purchasing targeted to efficient health care organizations *

- Efficient Provider accepts “virtual capitation” for managing chronic illness based on its own historical actuarial costs
- Agrees to improve quality of care in 3 categories of unwarranted variation and including managing capacity
- incentives lead new patients to choose “preferred provider, decreasing further the per person costs
- and cause frequency of use of supply sensitive care and actuarial costs to rise higher among inefficient providers who loose market share
- leading inefficient providers to emulate benchmarks of efficient providers
- Resulting in an overall decline in per capita costs in the market

  – * provider with actuarial costs for managing chronic illness that are below market average.

Experimentation is best because the "system" is too complex to predict outcomes on the basis of theory

- CMS chronic disease management Initiatives
- CMS physician group practice demonstration project
- S-1756

Final Word

- What ever else we do, need to put resources into evaluating the common practices of medicine to improve the scientific basis of clinical decision making
- And use Medicare data to provide feedback on performance