

**Geographic Variation in Medicare Payments**

**Testimony**

*Presented To*

**The Committee on Finance  
United States Senate**

*Presented At*

**Iowa Historical Society  
Des Moines, Iowa**

**By**

**Gail R. Wilensky, Ph.D.  
Senior Fellow, Project HOPE**

**On**

**Monday, April 14, 2003**

Mr. Chairman: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation and I am also Co-chair of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. I have served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) during the first Bush Administration and also chaired the Medicare Payment Advisory Commission from 1997 to 2001. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences at HCFA and MedPAC. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses geographic variations in Medicare payments per senior and variations in Medicare payments to physicians and institutional providers, the reason these variations occur and some reforms to Medicare payments that should be considered. I also discuss the implications of Medicare payment variations for seniors and for the business community and include some final observations on what other reforms might be of interest to states like Iowa.

#### *Geographic Variations in Spending by Medicare*

There are two types of geographic variations in Medicare payments that are frequently discussed: variations in Medicare payments per senior and variations in Medicare payments to physician and institutional providers. Although these two types of variation are related to each other, i.e.,

one is a subset of the other; they are fundamentally separate phenomena and are therefore best considered separately.

### *Medicare Spending Per Beneficiary*

The first measure, variations in Medicare spending per beneficiary, has received a lot of attention in Iowa although the precise measure that has received most of the attention is not the right measure to use. The measure that has received most of the attention in Iowa is cash receipts to providers in Iowa divided by the number of Iowa beneficiaries. This measure purports to show what Medicare is spending on behalf of Iowans but it does not do so for two reasons. The most important reason is that it doesn't account for services provided to beneficiaries outside the state. Since there is a significant net use of services outside the state, probably a combination of the relative proximity of major health centers such as the Mayo Clinic and the use of health care services by Iowans in the South during the winter, the use of provider cash receipts per beneficiary understates the Medicare services received by Iowa residents. Second, cash receipts are generally regarded as a less appropriate measure for analysis than accrued claims because cash receipts can reflect timing issues in the actual payment for services and may cause some years to look artificially high or low if payments get bunched.

If Medicare spending in the traditional fee for service program per Iowa beneficiary is considered rather than provider cash receipts per Iowa beneficiary, Iowa is 35<sup>th</sup> in terms of Medicare spending rather than 50<sup>th</sup>. In other words, Iowa is in the lower half of Medicare spending per beneficiary by state but certainly not the lowest.

There are two main reasons that explain why states differ in their per capita Medicare expenditures. The first is differences in the cost of providing services as reflected in the prices that Medicare pays for services. Service costs reflect differences in local input prices and differences in the mix of providers used to provide the service. MedPAC has estimated that a little less than half (46%) of Iowa's deviation from the average spending per beneficiary is attributable to differences in the cost of providing services and a little more than half (54%) is attributable to differences in the quantity of services used. About a third of this service-use difference can be attributed to Iowa's beneficiaries being healthier than average and the rest reflects a more conservative practice style by physicians and other providers and perhaps by Iowans seeking less care.

#### *Medicare Payments for Physicians and Institutional Providers*

As indicated above, slightly less than half of the difference in Iowa's Medicare spending per beneficiary relative to the national average is attributable to Medicare's calculation of the costs of providing services in Iowa and the mix of providers used, particularly the use of hospitals that receive extra payments for teaching or that treat large numbers of Medicaid patients.

There has been a lot of debate about whether Medicare properly measures differences in the costs of local inputs and whether Medicare properly distinguishes between the inputs that are

purchased in national markets (which shouldn't have local adjustments) from those that are purchased in local markets.

Let me make a few observations. The adoption of the resource-based relative value scale in 1992 as the reimbursement mechanism for physicians was designed to produce an increase in payments to physicians in rural areas relative to physicians in urban areas and to increase payments to physicians in primary care specialties relative to those in procedure-based specialties. Both of these changes would have helped Iowa in general. MedPAC tracked the relative increases from 1991-1997, the transition period for the implementation of the new fee schedule, and reported substantially greater increases in rural counties relative to metropolitan areas during that period. The most significant current debate with regard to physician payments is the use of a spending limit that is tied to the economic growth of the economy—a strategy that has been hitting all physicians rather than rural physicians disproportionately, although the apparent use of a conservative practice style by the physicians of Iowa does exacerbate the problem for Iowa.

With respect to hospital payments, there have been a variety of special provisions that have been put in place to help rural hospitals over the years but there are several more reforms that MedPAC has proposed, some of which have been proposed now for at least several years. These include the use of a low volume adjustment to the inpatient rate, the re-evaluation of the labor component, the elimination of differential base rates between large urban hospitals and other hospitals and an increase in the cap for disproportionate payments to rural hospitals. I support all of these changes and I hope that the Congress will pass legislation supporting these reforms.

## **What Does Medicare's per beneficiary Spending Rate Mean for Iowa's Seniors?**

There is no indication that Iowa's lower Medicare spending per beneficiary is disadvantaging its beneficiary population, and there are some reasons to believe the lower spending rates provide certain advantages. Some of the advantages are obvious. Lower spending rates mean lower cost sharing for Iowa's beneficiaries. Not surprisingly, lower Medicare spending rates are also associated with lower Medigap rates. Iowans also pay less into the HI trust fund because their wages tend to be lower.

There is also no indication that lower spending rates are associated with lower rates of quality of care. In a recent set of articles reported in the *Annals of Internal Medicine*, Elliot Fisher and his colleagues at Dartmouth provided the results of detailed studies on three medical conditions. They found that areas with greater expenditures received more discretionary services but not greater improvements in health outcomes. This finding was upheld for measures that encompassed quality of life (such as patient satisfaction and functional status) as well measures of quantity of life (such as mortality rates). In a more direct measure of quality of care to Medicare beneficiaries on a state-by-state basis, Iowans also fared well. In a study reported earlier this year in *JAMA*, Steve Jencks et al. looked at how states performed according to 22 quality improvement indicators for a variety of disease states. Iowa had an average state rank of 8<sup>th</sup> in 1998-99 and 6<sup>th</sup> in 2000-2001.

## **What Does Medicare's per beneficiary Spending Rate Mean for Business?**

Since more than half of the reason that Iowa's Medicare spending rate per beneficiary is lower than average is attributable to the lower quantity of services used, Iowa's business community stands to gain. The more conservative practice style that physicians use in treating their Medicare patients should also be occurring for their employer-sponsored patients. Earlier studies that examined the effects of DRG's in Medicare indicated that the length of stay changes that resulted from DRG's were found in the private sector as well as in Medicare and that physicians who changed their admitting behavior did so for all patients and not just their Medicare patients. Also, to the extent that some of the lowered use reflects a healthier population in Iowa, this is undoubtedly true for the employed population as well.

Whether or not the level of Medicare payments impacts pricing in the private sector is the subject of some dispute. In some very competitive areas, Medicare is among the higher payers, especially for physicians. In other areas or sectors, where Medicare is a lower payer, it is unclear whether the lower payments result in any cost shifting. In part, it depends on the relative power of the provider and payer communities and in part on the competitiveness of each sector.

## **Conclusions**

Medicare spending per beneficiary is lower in Iowa than the national average but the Iowa's ranking is 35<sup>th</sup>, not 50<sup>th</sup> as is sometimes claimed when an inappropriate measure of spending is

used. Iowa's lower than average spending occurs because both the cost of providing services is lower in Iowa than the national average and because the quantity of services provided is lower.

The lower spending per beneficiary has advantages for seniors in terms of lower cost-sharing for Medicare services and lower Medigap premiums. Iowans also pay less into the HI trust fund because of lower wages. The lower spending also does not appear to negatively affect quality. Based on 22 quality improvement indicators, Iowa scores high on quality and independent studies on geographic variations in spending do not show improved health outcomes in areas with higher expenditures.

There is also no indication that the lower Medicare spending per beneficiary negatively affects the business community. More than half of the lower spending is attributable to a lower use of services, because of better health status, a conservative practice style and maybe less care demanded by Iowans. All of these will be true for the under-65 population as well. The evidence regarding cost shifting as a phenomenon is at best mixed and would require a compliant payer community and a very noncompetitive environment.

Some of the providers, especially small, low-occupancy hospitals continue to complain about under-payments. MedPAC has recommended several payment reforms that would help rural hospitals, including a low volume adjustment and an increase in the cap on disproportionate share payments to rural hospitals. I support the four recommendations in MedPAC's most recent report.



However, there are some problems that Medicare cannot fix. A small hospital with low occupancy isn't likely to be made solvent no matter what Medicare pays. Iowa has an extensive network of critical access hospitals and to the extent that this has resulted in some hospitals that are too small to be solvent, even with the extra payment, reconsideration may need to be given to the viability of some of them. Also, some of the problems that rural states have in recruiting physicians may be beyond Medicare's ability to fix.

Iowa has a record of high quality health care according to the measures currently available. Medicare does not currently reward physicians or institutional providers who provide higher quality with higher payments. In fact most of the efforts of the last two decades have focused on formulating the "right" or "just" price, without an allowance for quality differentials. This is not uncommon in an administered-pricing system where government sets reimbursement rather than reimbursement being set by the market, but it is a deficiency that is starting to be noticed by CMS and MedPAC. Because Iowa historically has had an unusually good and extensive data collection system, perhaps it would be possible for Iowa to serve as a demonstration site for strategies that would reward physicians and hospitals that provide high quality.