

Medicare spending, utilization and quality vary widely across states according to recent CMS data

CMS data released earlier this month, showed how Medicare spending, utilization and quality vary across states; however, CMS noted these fluctuations by geography do not appear to reflect beneficiaries' health. The latest update on the [Geographic Public Use File](#), which includes data from 2007 to 2015 across seven categories at the state level, revealed for example that non-adjusted, non-standardized costs per user of Part B drugs in 2015 ranged from \$381.20 in Vermont to \$978.75 in Florida; the proportion of beneficiaries using Part B drugs ranged from a low of 33.52 percent in Maine to a high of 60.78 percent in Tennessee. Hawaii spent \$6,608 per traditional Medicare beneficiary, compared to \$10,700 in Mississippi.

Utilization was measured across 16 major Medicare-covered service categories and then organized into units of measurement used for each service, e.g. number of episodes and visits under home health. These calculations then generated three different types of utilization measures per geographic region.

Like spending, quality data also demonstrated a significant range across states as measured by 30-day inpatient hospital readmissions with the lowest rate reported out of Utah at 12.74 percent and the highest in Washington, D.C. at 21.39 percent.

Why the update and why now? Experts and policymakers “have long recognized the amount and quality of healthcare services that Medicare beneficiaries receive vary substantially across [regions]” and released the data with the intent to make healthcare spending and utilization analysis easier¹; however, there is not a clear consensus as to what causes the variation and how to address it, especially when it comes to payment reform.

¹ https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/Downloads/Geo_Var_PUF_Methods_Paper.pdf

PTAC recommends two payment model innovations for limited-scale testing while HHS Secretary Tom Price presses doctors to submit ideas for more payment alternatives

Speaking at the first voting meeting of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on April 11, Health and Human Services Secretary Tom Price said physicians should recommend more payment alternatives to fee-for-service Medicare, and that innovative payment models serve to avoid physicians feeling “[burned out](#)”. During

the two-day public meeting, the panel rejected one of the models that was submitted, [The COPD and Asthma Monitoring Project \(CAMP\)](#), and recommended limited-scale testing for two others: [Project Sonar](#), a care management program designed to improve chronic disease medical management and the other, [The ACS-Brandeis Advanced APM](#) from the American College of Surgeons which uses episodes of care to measure savings and losses and adjusts payment based on quality of care. For a more in-depth overview of each model from Essential Insights, click [here](#).

PTAC will draft its report to Secretary Price with recommendations and rationales and the Secretary will post his response to PTAC's recommendations on the CMS website. Also this week, PTAC announced a recent submission, [Oncology Bundled Payment Program Using CNA-Guided Care](#) from Hackensack Health and Cota Inc. This proposal is available for public comment until this Thursday, April 27, 2017.

A transcript of PTAC's April meeting will be made available on [the PTAC website](#) and a video recording of the meeting will be added to the [HHS YouTube Channel](#) shortly. PTAC's will hold its next public meeting on June 5, 2017.

RAND study estimates MACRA will decrease hospitals' Medicare revenue by \$250 billion by 2030

Published recently on [Health Affairs](#), a study titled "The Medicare Access And CHIP Reauthorization Act: Effects On Medicare Payment Policy And Spending," estimated the effect of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) on Medicare spending and utilization and also examined its effects under four different scenarios — a counterfactual "pre-MACRA baseline" and three MACRA scenarios categorized by how much risk physicians choose to take under Advanced Payment Models (APMs) — low, medium and high.

Due to the uncertainty of physician participation under MACRA, these three scenarios assume the percentage of physicians qualifying for the APM track over the 2015 to 2030 projection period by extrapolating historical ACO participation rates. They also assume that Medicare payments will shift over time as APM prevalence increases. The scenarios explore existing payment models - the Medicare Shared Savings Program (MSSP) Track 2 model, the Next Generation ACO model and a generic patient-centered medical home model - to provide estimates of the *prospectiveness*, or "the potential financial losses (or gains) that providers face if they increase (or decrease) the quantity and intensity of services provided," of the APMs under MACRA.

The study, using the RAND Corporation's Health Care Payment and Delivery Simulation Model (PADSIM), revealed how Medicare spending would change under each scenario for the 2015 to 2030 time period:

Pre-MACRA baseline scenario: In this scenario, physician payment rates will increase by 13 percent by 2030 and projected physician revenue from Medicare will increase from \$81 billion in 2014 (pre-MACRA) to \$109 billion in 2030. The study suggests that hospital revenue is expected to grow from \$223 billion to \$413 billion during the same time frame.

The low-prospectiveness scenario: This scenario assumes that all APMs resemble patient-centered medical homes and providers are not required to take on any downside financial risk. Physician Medicare revenue will be \$35 billion lower than the Pre-MACRA baseline scenario but hospital Medicare revenue will increase by \$32 billion. The study suggests this offset is the result of fewer physicians in the MIPS track and the value-based payment adjustment based on the total cost of care which will drive incentives to decrease hospital use.

The medium-prospectiveness scenario: This scenario assumes that APMs would resemble a mix of MSSP Track 2, Next Generation ACO, and patient-centered medical home models — with the remaining physicians in the MIPS track. The study considers payment rate structures and lump sum bonuses throughout the 2015 to 2030 time period and suggests that MACRA will reduce physician Medicare revenue by \$47 billion in this scenario. It also projects a \$22 billion decrease in hospital Medicare revenue.

The high-prospectiveness scenario: This scenario assumes that all APMs resemble Next Generation ACOs. Physician Medicare revenue is \$106 billion lower than the Pre-MACRA baseline scenario. Perhaps the most jarring, hospital revenue from Medicare will decrease by \$250 billion over the 2015-2030 time period. The study finds that this drop is the result of physicians' responding to payment model incentives that reduce hospital care use such as avoiding or reducing readmissions and so on.

The findings suggest that under the three MACRA scenarios presented in the study, physicians' Medicare payments will be lower under MACRA as "the result of low rates of annual increases in physician payment rates and the changes that physicians are expected to make in the provision of care under APMs". Their estimate reveals that the largest budgetary impact under MACRA derives from the reduced volume of hospital services.

The study concludes that while MACRA poses many substantial changes and challenges for providers, the new Medicare physician payment system can fare well if it meets two

conditions:

1. Organized medicine and individual physicians must be responsible stewards of society's resources and redesign their business model around value.
2. APMs must be well designed and implemented in order to avoid unintended consequences for patients.

[Health Affairs](#); [Becker's Hospital Review](#)