



**American Hospital
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Transmitted electronically via e-mail

October 1, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

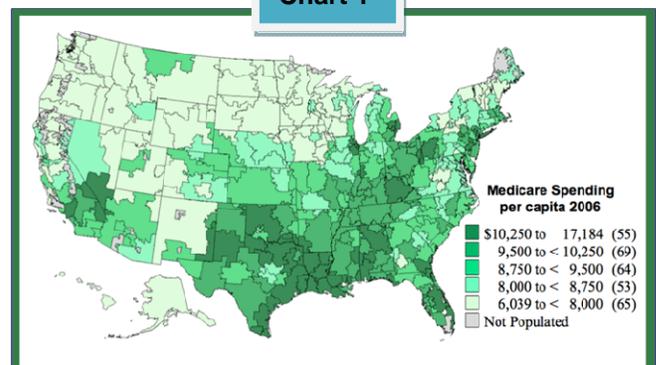
RE: National Summit on Health Care Quality and Value

Dear Secretary Sebelius:

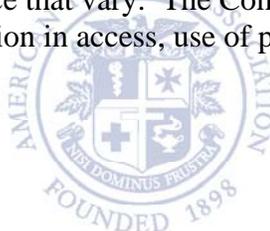
On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 40,000 individual members, the American Hospital Association (AHA) welcomes your decision to convene a summit to look at the critical issue of health care quality and value. Last year, the AHA convened a task force to specifically examine the issue of variation in health care spending and develop recommendations to address it. Under the leadership of its chair, Scott Malaney, president and CEO of Blanchard Valley Health Care System in Findlay, OH, the task force studied the research, talked to many experts, and sought the input of our hospital members through the AHA governance process. The work of the task force is still ongoing, but I wanted to share with you some of the key lessons we have learned through this process.

Variation exists at all levels of the health care system. Over its nearly 30 years of research, the Dartmouth Institute has uncovered variation in Medicare spending per capita across and within states, as illustrated in Chart 1. Their work also has shown significant variation within communities and across similar organizations such as academic medical centers. Additionally, nearly any health care professional would say that variation in care practices occurs even within single organizations. The implications of these findings is that care must be taken to ensure that measures of performance don't penalize good performers in poor performing areas and *vice versa*.

Chart 1



Variation exists across multiple performance dimensions. Spending is just one of the many dimensions of health system performance that vary. The Commonwealth Fund's *State Report Card* documents the high level of variation in access, use of prevention and treatment, cost,

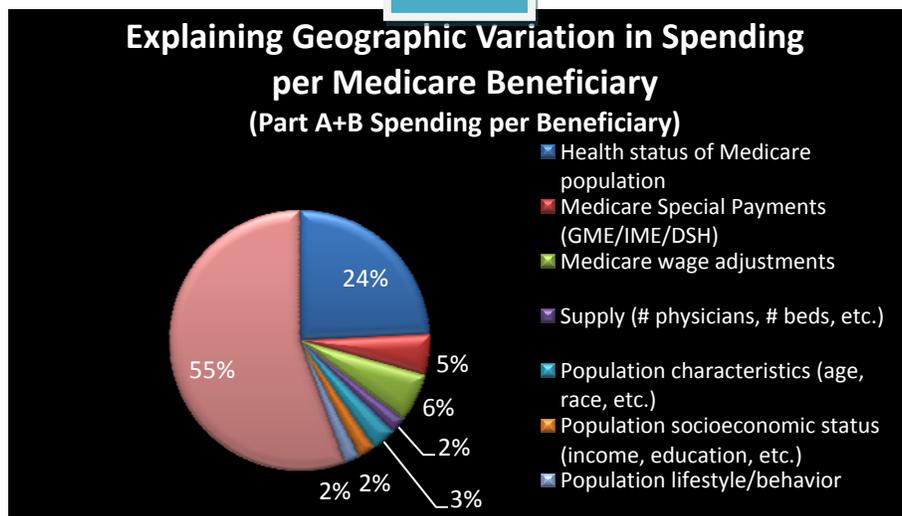


equity, and health behavior. Additionally, measures of health status and behavior vary dramatically from region to region. For example, southern states tend to have higher rates of obesity, heart disease and diabetes. The link between spending and these other performance dimensions is unclear raising the possibility of unintended consequences if too much focus is placed on spending. These findings also illustrate the importance of multi-stakeholder involvement, including the public health community, employers, schools, payers and others, in addressing variation.

Hospitals are not the only source of variation in spending. The AHA commissioned a study to examine variation across service types and care settings. High spending in an area did not necessarily imply high spending on hospital care. Often, levels of variation were higher in other settings or services, such as home health, ambulatory surgery centers (ASC) or durable medical equipment (DME). However, because hospitals represent the setting where the greatest percentage of care dollars are spent – including physician and other professional fees – reducing variation in hospital care will be critical to reducing variation overall. But this can only be achieved in collaboration with physicians, who direct much of the care provided in hospitals.

Many factors influence health care spending, some of which are beyond a provider’s control. A regression analysis of Medicare spending per beneficiary commissioned by the AHA found that the largest contributor to variation in spending is health status, but other factors are significant as well. The picture is further complicated by interactions among the factors. For example, health behaviors and socioeconomic factors were found to be associated with health status. Once quantifiable factors are accounted for, about 55 percent of the variation remains unexplained. This portion of variation is likely due to differences in practice patterns, patient preferences, and other local factors. However, data to measure these differences are incomplete and imperfect. Sorting out the factors within and beyond a provider’s control in order to make appropriate risk adjustments makes the development of performance measures based on spending levels challenging. This finding also illustrates the importance of multi-stakeholder involvement. Chart 2 displays the results of the regression analysis.

Chart 2



Some degree of variation in medical practice will, and should, exist. Protocols do not exist for every diagnosis. Patients tend to have multiple diagnoses that require tailoring those protocols that do exist. Innovation in care depends on testing new ways of caring for patients. As policies to reduce variation are implemented, outcomes must be carefully tracked to guard against unintended consequences.

Regional variation in service use is not the same as regional variation in spending. Last December, the Medicare Payment Advisory Commission (MedPAC) released an analysis of how the factors Medicare uses to adjust payment to account for wage differences and other special circumstances contribute to variation in Medicare spending. MedPAC adjusted spending data for these factors to arrive at a measure that reflects service use. While this adjustment reduces the level of variation, significant variation remains, as shown in Chart 3.

Regions that have high levels of spending are not always the regions with high spending growth. Areas in the bottom quartile for spending can be in the top quartile for spending growth. Both are important to consider in addressing spending for the long term, especially in efforts to bend the cost curve.

Financial incentives matter. Changing financial incentives can influence provider behavior. On the one hand, physicians order more services when they have an ownership interest in an entity that is going to provide those services. On the other hand, capitation can result in the withholding of care. Experiences with payment models on either extreme illustrate the challenges of constructing incentive systems that result in the right amount of care.

Providers respond to data even without the use of financial incentives. A collaborative effort between providers and Blue Cross Blue Shield of Michigan illustrates the power of data in changing physician behavior (Chart 4). This program involves consortia of providers using comparative performance reports to identify processes of care which are associated with optimal outcomes and using this information to guide improvement. Many other individual provider organizations and collaboratives have successfully taken this approach – a number of which are participating in the summit.

Chart 3

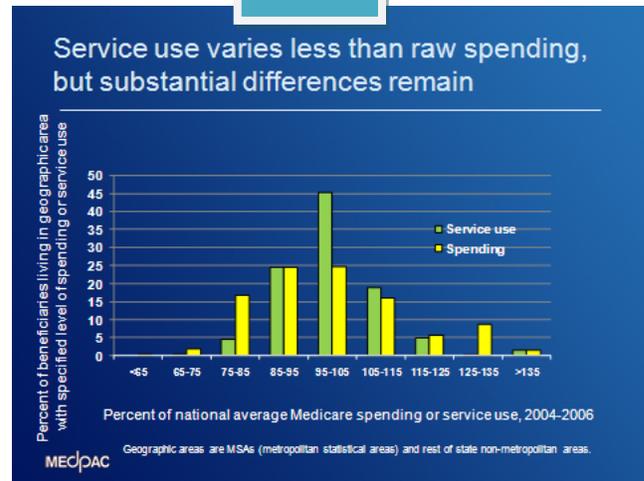
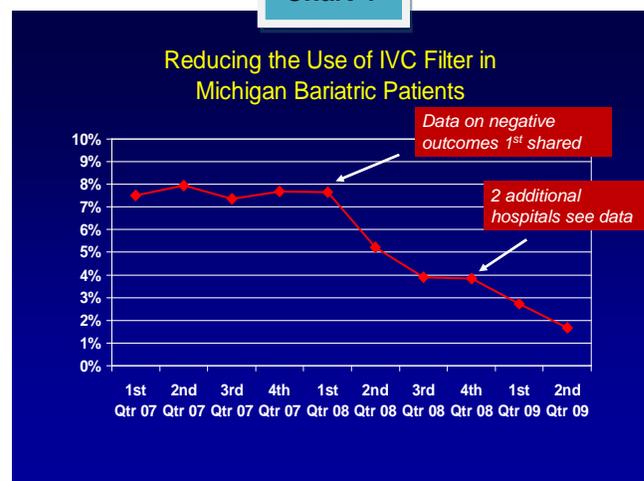


Chart 4



Honorable Kathleen Sebelius

October 1, 2010

Page 4 of 4

The link between quality and spending is disputed. One area of continued controversy is the link between quality of care and spending. The Agency for Healthcare Research and Quality (AHRQ) has compiled data that show that state spending levels and performance on AHRQ quality measures appear to have no relationship. On the other hand, a recent study by researchers at a consortium of California teaching hospitals, delving more deeply into the Dartmouth end-of-life research, found that when patients with similar characteristics were followed forward, the organization with the highest level of spending had the lowest level of mortality.

These are just some of the lessons learned during the educational phase of the AHA task force process. We are eager to share with you the full task force report once it has been approved by our Board of Trustees. We also look forward to working with you to shape the regulations that will implement the *Patient Protection and Affordable Care Act (ACA)*. Many aspects of the ACA hold the promise of providing the incentives, data and tools needed to support providers in efforts to reduce inappropriate variation.

If you have questions any questions, feel free to contact me at (202) 626-2363 or rumbdenstock@aha.org.

Sincerely,

Richard J. Umbdenstock
President & CEO