American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Testimony
of the
American Hospital Association
before the
Committee on Geographic Variation in Health Care Spending
of the
Institute of Medicine

January 17, 2011

Good morning, Mr. Chairman. I am Scott Malaney, president and CEO of Blanchard Valley Health System in Findlay, OH, and a member of the Board of Trustees of the American Hospital Association (AHA). On behalf of the AHA's more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 40,000 individual members, I thank you for the opportunity to speak here today about the factors influencing variation in health care spending and utilization across the nation.

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. I have been honored to chair this task force, which studied the research, talked to many experts and sought the input of our hospital members through the AHA governance process. I am pleased today to share with you some of the key findings and recommendations from this process.

KEY FINDINGS

Variation exists at all levels of the health care system. Variation in health care spending and utilization not only occurs across geographic regions, it also occurs within regions, within states and even across health care professionals within a single organization. The implication 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.* In short, geographic regions do not provide care; providers do. To be fair and effective, performance incentives and measures must be provider, not geographically, based.

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, as illustrated in Chart 1 in Appendix A. 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). The Medicare Payment Advisory Commission's (MedPAC) January 2011 report to Congress, *Regional Variation in Medicare Service Use*, confirmed this finding. 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. However, unexplained does not equate to inappropriate. Unexplained variation is the portion that cannot be *statistically* explained using quantifiable factors. What portion of unexplained variation is appropriate or inappropriate is unknown. Unexplained variation may be 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 again illustrates the importance of multi-stakeholder involvement. Chart 2 in Appendix A displays the results of the regression analysis.

Some degree of variation in medical practice will, and should, exist. Not all variation is inappropriate. Protocols do not exist for every diagnosis. And 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. In December 2009, MedPAC released an analysis of how the factors Medicare uses to adjust

payment to account for wage differences, teaching intensity, care for low-income populations, and other special circumstances contribute to variation in Medicare spending. Adjusting spending data for these factors results in a measure that reflects service use and reduces the level of variation, as shown in Chart 3 in Appendix A. While these policy adjustments deserve consideration in their own right, they should be evaluated separately from variation in service use.

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 the level and growth in spending are important to consider in addressing variation 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 3). 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. More money must be invested to develop and disseminate the data, tools and strategies that providers need to successfully address variation.

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 that delves 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. More research must be done to better understand this relationship.

FRAMEWORK

The Task Force developed a framework to capture the complexity surrounding variation (see Appendix B). Each category suggests a different approach for action. This framework recognizes that not all variation relates to the health care system and that even within the health care system, some variation is appropriate. Variation is inappropriate when care practices fail to conform to established medical practice. Providers should be held accountable for this type of variation. Other types will require multi-stakeholder engagement or will need to be accounted for in performance assessments.

RECOMMENDATIONS

The strong conclusion of the task force process was that the time for provider action is now. The lack of definitive data and unanswered questions on many aspects of this issue is not an excuse for inaction. In fact tremendous progress already is being made, particularly in the area of quality improvement. The AHA is committed to encouraging its members to take on this issue and is beginning to develop resources to support them in their efforts through its *Hospitals in Pursuit of Excellence* (HPOE) program.

Hospitals must accept accountability for what is within their control but other stakeholders – particularly physicians – must step up to the plate. Partnerships among providers, schools, employers, the public health community and local leaders will be necessary to influence underlying drivers of variation such as health behavior, environmental factors and local culture.

The AHA encourages the IOM to consider a number of the task force's recommendations in its own deliberations:

Invest federal dollars to make timely and comprehensive data readily available to providers and researchers. Better data will be essential in illuminating the nature, reasons for, and extent of variation and in tracking what types of interventions are effective in achieving predictable, superior results. The lack of data on care processes across the care continuum is a significant and ongoing barrier to addressing variation. Unfortunately, most providers only have a window into their part of the patient's episode of care.

Invest federal dollars in developing and disseminating practice standards, guidelines and comparative effectiveness research (including cost) to help providers identify and eliminate overuse and underuse. While variation in practice patterns has long been documented, limited information has been available to help providers determine the right course of care for a given patient. Without this information, incentives that potentially encourage less care could have unintended consequences. This investment should include the development of methods to quickly and effectively translate standards and guidelines and changes as they emerge into the decision support tools embedded in the electronic health record (EHR).

Structure measures and payment incentives to encourage action on variation, ensure accountability for these actions, and reward success. Performance measures must be: refined enough to ensure good performers in high-spending areas are not penalized and *vice versa;* adjusted to account for demographic factors, health status, costs of doing business, mission related costs (e.g., teaching and care for low income populations) and rural/urban location, among other factors; able to differentiate across providers or provider systems and zero in on the underlying sources of variation in terms of service and provider types; and refined enough to ensure good performers in high-spending areas are not penalized and that poor performers in low-spending areas are not rewarded.

Payment approaches must establish accountabilities for all providers. Physicians and other clinicians, hospitals, post-acute care providers and others must be held accountable for the quality and outcomes of the care provided, the coordination of care across different settings, and the efficiency with which that care is delivered.

Policies should recognize and reward high-performing providers. Many provider organizations have made efforts to reduce variation. Performance benchmarks should be set to differentiate those that already have achieved significant reductions in variation from those that are just beginning the process.

Eliminate the legal and regulatory barriers to clinical integration and coordination of care across the continuum. Hospitals seeking greater clinical integration first need to overcome the legal hurdles presented by the antitrust, Stark, Civil Monetary Penalty and anti-kickback laws and the Internal Revenue Service Code.

Thank you for the opportunity to present today. Please find attached a copy of the Task Force's report. We hope that the IOM will take these findings into consideration in its deliberations.

The hospital field looks forward to working with the Committee to better understand and address this issue.

Appendix A

Chart 1:

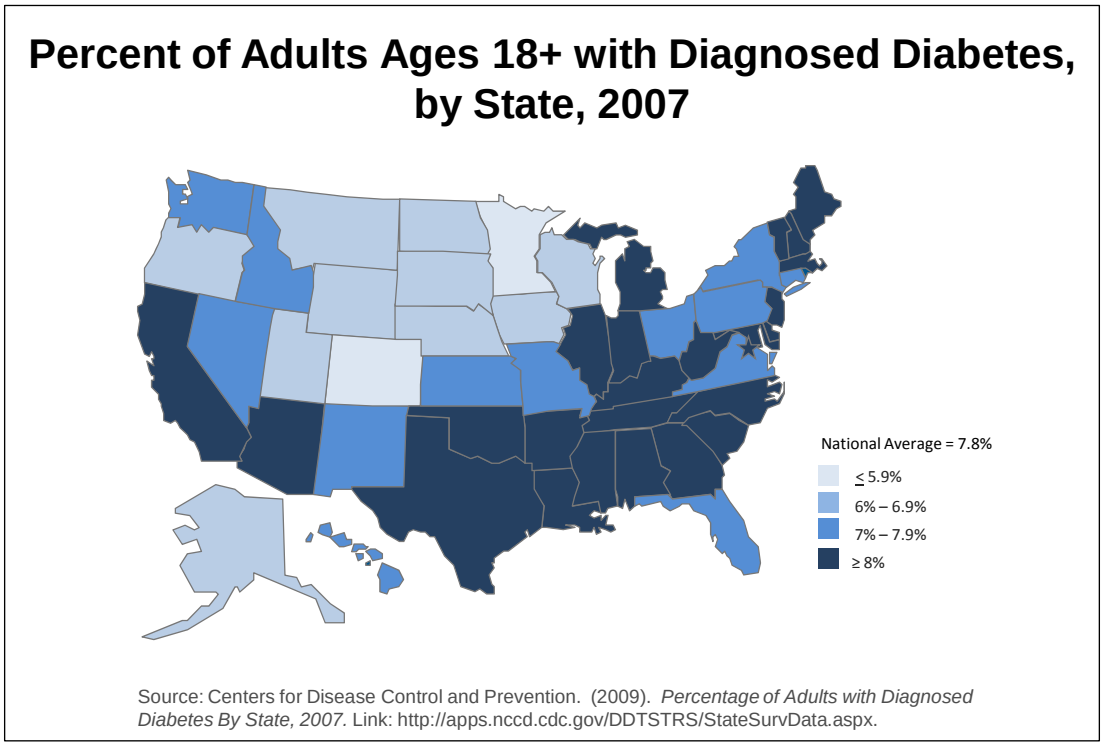


Chart 2:

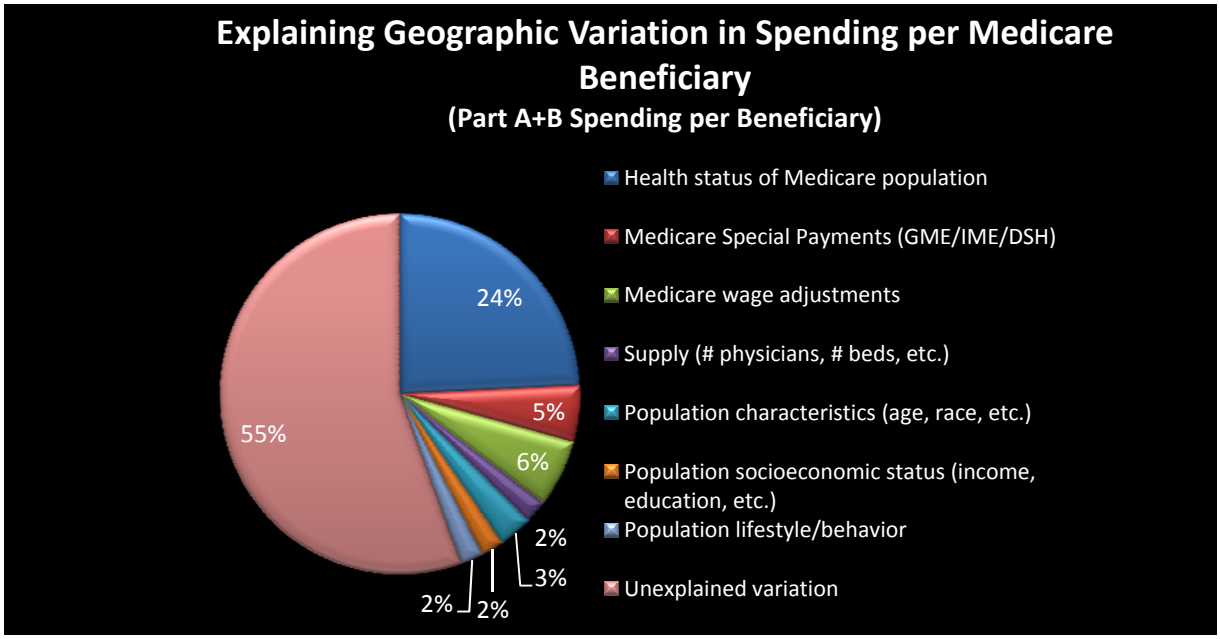


Chart 3:

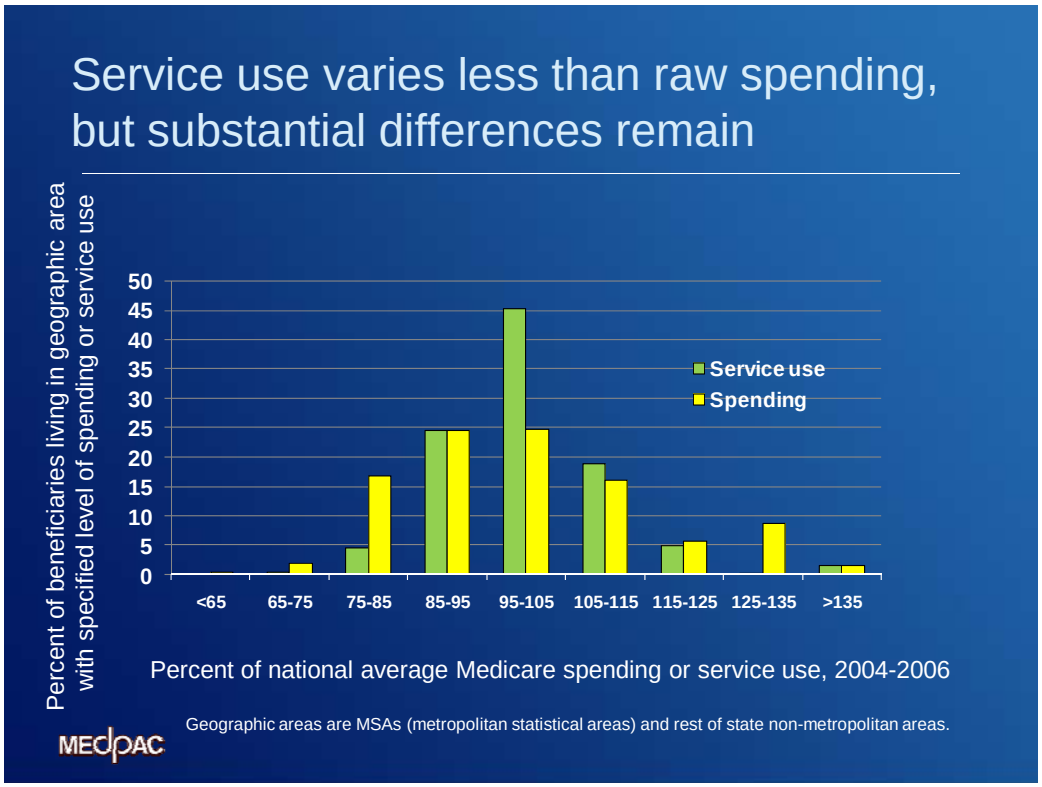
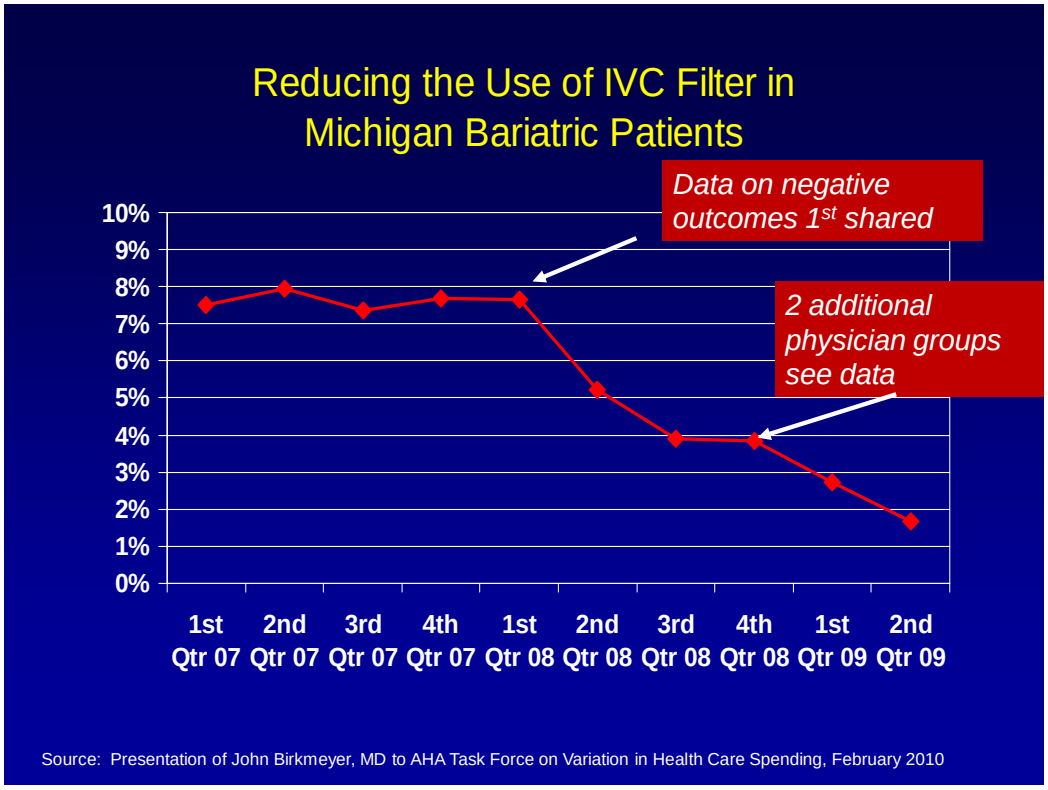


Chart 4:



Appendix B

Framework