



**Association of
American Medical Colleges**
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0460 F 202 862 6161
www.aamc.org

Darrell G. Kirch, M.D.
President and Chief Executive Officer

July 21, 2009

The Honorable Nancy Pelosi
Speaker of the House
United States House of Representatives
Washington, DC 20515

Dear Madame Speaker:

We applaud the Tri-Committee bill's efforts to expand coverage, reduce costs, and improve the health of the nation. **We are pleased to see that Section 1159 calls on the IOM to examine the reasons for variations in spending on medical care.**

The Association of American Medical Colleges is a not-for-profit association representing all 131 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

While some have suggested that the nation should move quickly to reallocate resources among health care providers and communities to reduce variations in Medicare spending, multiple studies have demonstrated that Medicare spending is poorly correlated with other health spending at the geographic level and the overall investment in health is often hidden when examining Medicare spending alone. In addition, while it is clear that over-utilization (and under-utilization) contribute to variations, so too do patient needs and preferences. These findings raise more questions than they answer, and we look forward to working with the IOM to expand the knowledge base from which Congress and providers can make better decisions about our nation's investment in health and health care.

The wide variations of spending on end-of-life care are often cited as a prime example of where some communities and facilities 'waste' precious resources. While these differences are real, they too reflect the wide variation in services offered and patients treated even among U.S. teaching hospitals. According to the Dartmouth Atlas, Medicare spent an average of \$25,860 during the last two years of life on inpatient care (2001—2005), but this amount varies several fold between hospitals. Individual hospitals in Boston, Detroit, Kansas City, San Francisco, and Rochester, Minnesota spend, on average, 50% more on Medicare beneficiaries during the last two years of life. These hospitals often care for patients who are sicker, sometimes through chance and sometimes because of their inability to access appropriate health care for decades before becoming eligible for Medicare (and we deeply appreciate that your efforts on health care reform will help with the latter). Hospitals have higher average costs for a variety of reasons, including their willingness to often serve patients that no one else can—or will.

And while it is true that Medicare spends, on average, less during the last two years of life for patients treated at some hospitals in La Crosse, Casper, and Grand Forks, this is also true of individual hospitals in Raleigh, Houston, and Austin. Health care is local, complex and depends upon a variety of factors which may or may not legitimately lead to higher costs. Many of the services that major teaching hospitals offer are, indeed, costly—such as transplants, trauma care and care of advanced breast or cervical cancer left undiagnosed for years because of inadequate screening.

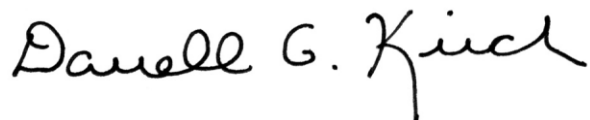
As we work to better understand these variations, we urge you to continue to seek these answers through careful study so that Congress and providers can further improve delivery and treatment—and to reject calls to bluntly alter payment distribution with good intent but potentially catastrophic, unintended consequences.

Similarly, any implementation of Section 1158 must continue to ‘hold harmless’ those providers in geographic areas of the country with higher geographic payment adjustments until all of the contributing factors are better understood. Failure to do so may unintentionally endanger the vulnerable patients health care reform legislation ought to protect.

The nation’s teaching hospitals and physicians will continue to innovate and improve care and the health of communities as we move forward to reform the U.S. health care system, but we must not destabilize the institutions that American communities rely on during this transition.

We applaud your leadership and look forward to working with you to ensure that meaningful health care reform legislation is passed this year.

Sincerely,

A handwritten signature in black ink that reads "Darrell G. Kirch". The signature is written in a cursive, slightly slanted style.

Darrell G. Kirch, M.D.