STATEMENT

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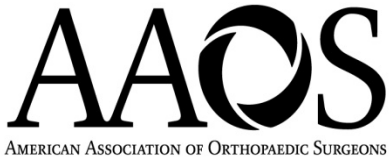

on the

Independent Payment Advisory Board

Committee on Ways and Means

Subcommittee on Health

US House of Representatives

March 6, 2012

On behalf of over 18,000 orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) commends you for convening a hearing on the Independent Payment Advisory Board (IPAB) and its impact on Medicare. Founded in 1933, AAOS is the pre-eminent provider of musculoskeletal education to orthopaedic surgeons and others in the world. We continue to be a committed partner in providing high quality health care that focuses on patient safety and cultural competency.

AAOS strongly supports HR 452 "The Medicare Decisions Accountability Act" introduced by Congressman Phil Roe (TN-01). HR 452 currently has 228 bipartisan cosponsors and is an important step in preserving Congress' historically central and appropriate role in managing Medicare payment policy. We strongly feel that the IPAB, created by the Patient Protection and Affordable Care Act (PPACA), threatens the ability of the people's elected representatives in Congress to ensure access for Medicare and Medicaid beneficiaries to the health care they need, when they need it. Leaving payment policy decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will have a deleterious effect on the availability of quality, efficient health care to the millions of Medicare beneficiaries in the United States. From the beginning of Medicare, Members of Congress have always played an essential role in shaping policies to ensure the health care system is equipped to care for diverse populations across the country. Creation of the IPAB severely limits Congressional authority, eliminates the transparency of hearings, severely limits needed debate and stakeholder input, and will result in the reduced availability of quality, efficient health care to Medicare beneficiaries.

By current law, fewer than half of the IPAB members can be health care providers, and no member can be a practicing physician or otherwise employed. This makes no sense. No other federal authority is mandated to *not* include the professionals it regulates and for good reason- because all professional activities, especially the activity of medicine requires tremendously specific expertise, expertise attained through specific education and experience. Instead, the current legislation leaves decisions about patient's medical care in the hands of individuals who would not fully understand the day-to-day reality of delivering care. Physicians have the best knowledge and the most direct interest in their patient care and are the best judges of the potential effects of any physician payment model on the quality of care delivered to patients. If IPAB were allowed to come into existence as it is envisioned in current legislation, Congress and the public would lose the ability to have any say in payment decisions.

In addition to this flaw, there are other significant flaws with IPAB if it is left as is. Under current law, the IPAB will be required to recommend cuts based on unrealistic spending targets starting in 2014. Its recommendations are then to be "fast tracked" and automatically go into effect starting in fiscal year 2015 unless blocked or amended by Congress. Providers representing roughly 37 percent of all Medicare payments, including hospitals and hospice care, are exempt from IPAB cuts until 2020. However, IPAB members must still take their costs into consideration when recommending cuts. Thus, IPAB directed cuts will disproportionately fall on all other providers and suppliers, including orthopaedic surgeons. Furthermore, without a permanent solution to the Sustainable Growth Rate (SGR) formula, physicians already facing cuts in excess of 40 percent over the next decade are essentially subject to "double jeopardy" with cuts from both SGR and IPAB.

Even if Congress is unable to find qualified "experts" to sit on the IPAB panel, the law still calls for cuts to curb Medicare spending, directing the Secretary of the Department of Health and Human Services to enforce budget reductions unilaterally.

Finally, because IPAB will only be making recommendations based on a yearly target, more thoughtful, longer-term solutions are off the table. Repeal of the IPAB will allow policymakers and providers to work together to advance innovative payment methods that will achieve cost savings by incentivizing efficient, high quality care for all Americans.

AAOS recognizes the importance of lowering health care costs and is committed to providing high quality care that is also cost effective. Arbitrarily slashing reimbursement rates for Medicare providers is not likely to actually lower health care costs and most certainly will do nothing to promote or preserve quality care. Instead, AAOS recommends a series of initiatives that are already in place or can be easily implemented. The AAOS initiated and is a partner in the American Joint Replacement Registry (AJRR), is engaged in developing clinical practice guidelines, and has published a primer to help educate orthopaedic surgeons on issues related to Accountable Care Organizations.

AAOS also recommends meaningful and varied payment reform as a better way to lower Medicare costs and increase the overall health quality for Medicare beneficiaries. AAOS believes that payment reform must create a system consisting of financial incentives that reward higher quality care based on appropriate patient-centric measures of health outcomes. These measures must be risk adjusted so as to account for the medical, social, and personal co-morbidities that are beyond a provider's control. These include factors such as obesity, diminished mobility, chronic disease states, noncompliance with treatment recommendations, poor nutrition, tobacco and alcohol use and many other conditions which are beyond the control of health care providers.

Payment systems should reward physicians for developing medically innovative treatments that increase quality and reduce costs. This will keep patients healthier and out of hospitals, thereby increasing their productivity and Gross Domestic Product. Orthopaedics has long been a driver of medical innovation such as arthroscopic treatments for conditions which formerly required

open surgery and inpatient hospital stays. These types of innovative technological advances have saved employers, patients, Medicare, and other payers billions of dollars a year in reduced costs, principally though reductions in hospital stays and post operative days of patient morbidity. By tying payment to quality and to savings generated by medical innovation, Medicare can reduce overall costs and drive innovation.

AAOS believes that a tiered payment system can be built upon evidence-based guidelines, appropriate use criteria, risk-adjusted performance measures, and mandatory participation in national registries. In the last ten years, many registries have been created and disseminated by specialty societies and these deserve legislative, payor, purchaser, hospital, and health care provider support. We now have a foundation of quality measures and evolving evidence in virtually every area of medical practice. These are the best resources for a quality-focused payment system. We also have a sufficient foundation of outcomes research to begin to determine what constitutes a high quality outcome compared to a low quality outcome. These types of quality measures should be the foundation of a new delivery system that replaces our current fee-for-service system with one that increases quality of care while reducing healthcare costs.

Again, we thank you for your leadership on this issue and look forward to working with you. We stand ready to assist Members of Congress so that we can better enhance patient care.

Cc: House Ways and Means Committee