



AMERICAN OSTEOPATHIC ASSOCIATION

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March 5, 2012

The Honorable Wally Herger
Chairman, Ways & Means Subcommittee on Health
U.S. House of Representatives
1101 Longworth House Office Building
Washington, D.C. 20515

The Honorable Pete Stark
Ranking Member, Ways & Means Subcommittee on Health
U.S. House of Representatives
1139E Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Herger and Ranking Member Stark:

As your Subcommittee prepares for its hearing on the Independent Payment Advisory Board (IPAB), I want to share the position of the American Osteopathic Association (AOA) for your consideration.

Without question, one of the most contested policies established by the “Patient Protection and Affordable Care Act” (PPACA) is the creation of the IPAB. PPACA authorized the creation of a 15 member panel with broad authority to make recommendations on reducing the overall growth of Medicare spending. Many Members of Congress and advocacy groups representing consumers, physicians, and hospitals have raised concerns regarding the IPAB and its proposed scope of work – including the AOA.

We recognize that the President, some Members of Congress, and several academic experts have signaled their strong support for the IPAB and have suggested why it is important to our nation’s long-term fiscal health. The AOA does not disagree that we should pursue aggressive policies that “bend the cost curve” with respect to the Medicare program. In fact, we strongly support policies that would reduce the escalating costs of health care, both in public and private programs. However, we do have concerns with the IPAB approach.

Our concerns are based in our belief that fundamental delivery system and infrastructure reforms are better approaches that have the potential to make substantive and long-term changes in the Medicare program. As a point of clarification, the AOA supported the passage and enactment of PPACA, so this is not an attempt to undermine the law. Instead, it is a defense of those policies in the law that stand to promote a delivery system that we believe is essential to meeting our shared goal of improved quality and more efficient care.

Our health care delivery system suffers from fragmentation, a lack of coordination, and a population that demands more, not less, health care services. The combination of these factors results in the delivery of duplicative services, uncoordinated care, and all too often care that actually may harm patients. Fragmentation in care delivery results in excessive spending both in the short and long term. While we did not arrive in our current state intentionally, it is a fact that our fragmented, uncoordinated, and over-utilized delivery system does not always foster high quality, efficient care.

The United States Congress and the Administration recognized this and took historic steps to create and implement a better delivery system through the enactment of two transformational laws – PPACA and the HITECH Act. We are convinced that reforms included in PPACA, specifically those that are being initiated by the Center for Medicare and Medicaid Innovation (CMMI), and the HITECH Act will result in better care for patients and decreased costs for payers. Let me explain.

PPACA invested billions of dollars in delivery system reforms, such as the patient-centered medical home, accountable care organizations, care transition programs, medication management, health innovation zones, and other programs that have the ability to improve the quality and safety of care while slowing the overall cost of health care in years to come. Additionally, PPACA made a historic investment in primary care. When you couple the provisions of PPACA with those included in the HITECH Act, which creates and implements a nationwide interoperable health information infrastructure, you have the foundation for fundamental long-term reforms that will slow spending on health care by investing in infrastructure and process changes versus a one-time across the board reduction in spending.

Already, we are seeing the true benefits – both in quality and efficiency – of integrated patient-centered delivery models. Across the country physicians are transforming their practices into medical homes, implementing electronic health records, and coordinating with local hospitals to create delivery models that promote high quality and highly coordinated care. And I would be remiss if I didn't mention that they are seeing dramatic reductions in per capita spending as a result.

By comparison, the IPAB would operate under a requirement of creating savings through reductions in Medicare spending, independent of fundamental reforms that would advance long-term improvements in quality, safety, and efficiency. By prohibiting IPAB from altering coverage and benefits for beneficiaries, IPAB is largely limited to cuts in payments as a means of achieving its statutory goals. Finally, IPAB contributes to the concept of fragmentation by ignoring the growing trend of care being delivered in ambulatory versus inpatient settings. By limiting the application of IPAB's recommendations to only part of overall Medicare spending (IPAB can only recommend changes impacting Parts B, C, and D, which represent less than 50 percent of overall Medicare spending), IPAB views the Medicare program as 4 individual parts versus a comprehensive health care system. This approach, in our opinion, actually undermines the positive provisions and programs included in PPACA and the HITECH Act by creating a financial disincentive for those that would otherwise invest in systemic reforms. It is difficult to persuade physicians, hospitals, and other providers to make the necessary investments in electronic health records, practice transformation, and care coordination when they face arbitrary reductions in payments. Again, we are concerned with IPAB because we think it is the wrong approach – not the wrong goal.

Finally, it is important that we move beyond the deliberate distortion of certain policies by labeling them as “rationing.” We are at a point in both science and policy development where we are able to have a meaningful debate regarding the appropriateness of various diagnostic and treatment modalities. Just because the FDA approved it or the physician fee schedule pays for it, we should not be so inflexible in our stance that it is appropriate for every patient. We should use the data and quality outcome measures

available to ensure that we are providing the appropriate care to each patient at the appropriate time. I would suggest that many patients are undertreated, but we cannot make such determinations if we remain resistant to comparative analysis of diagnosis and treatment modalities.

Congress and the Administration created the foundation for a better health care delivery system through the enactment of PPACA and the HITECH Act. These two laws included numerous provisions that strike at the heart of the nation's fragmented and uncoordinated delivery system and began the necessary process of establishing a more coordinated, patient-centric health care system that stands to improve health care for individuals, improve health for at-risk, high-need populations, and lower per capita spending. The AOA wants to see these initiatives have every opportunity to succeed and are concerned that policies, such as the IPAB, serve as a deterrent to realizing their true potential.

Sincerely,

A handwritten signature in black ink, appearing to read "Martin S. Levine, DO". The signature is fluid and cursive, with a prominent initial "M" and a long, sweeping underline.

Martin S. Levine, DO
President

C: Members, Ways & Means Subcommittee on Health