



AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

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The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Members of the Committee:

Thank you very much for the opportunity to provide our comments and view points to the House Energy and Commerce Committee on the Sustainable Growth Rate (SGR) formula. I am writing to you as President of the American Academy of Orthopaedic Surgeons, which represents over 18,000 board-certified Orthopaedic Surgeons. We appreciate the committee's willingness to pursue a permanent fix and replacement of the SGR formula. As you have noted, the SGR formula, which was promulgated into law by the Balanced Budget Act (BBA) of 1997, has failed to curb the growth of Medicare expenditures for the past decade. As a result, Congress annually devotes significant portions of every Congressional session to passing short-term "fixes" which avoid imposing severe payment cuts to health care providers mandated under the SGR formula. This approach is a legislative nightmare and a major impediment to meaningful payment reform. We applaud your commitment to finding solutions for the budgetary hole of \$300 billion and a physician fee schedule that is fair and rewards quality rather than quantity.

The AAOS has long been committed to the replacement of the SGR formula and has created numerous position statements addressing Medicare programs and payment reform. In December of 2010 the AAOS adopted a "Principles of Payment Reform" which outlines the AAOS' recommendations for a reformed payment system.

Our recommendations to your committee are grouped into different categories: Payment Models, Cost Reduction, Market-based Innovations, Transparency, and Regulatory Reform. These areas of emphasis provide a roadmap for how our country could restructure the current system so as to emphasize higher quality, lower costs, and encourage innovation by providers by incorporating meaningful and fair cost controls, promoting coordination of care, and encouraging consumer and patient education and direct involvement in cost and quality.

Payment Reform Models

- **Congress should make “quality of care” the primary focus of payment reform**

Our current payment system offers few financial incentives to providers to provide higher quality care to patients. Instead, it pays the same amount for a given treatment intervention regardless of the quality of care delivered and the outcome of the intervention. This does not serve our patients or our healthcare system well and is contrary to a market-driven approach to payment. A market-driven approach would provide incentives for higher quality (rather than higher quantity) care, and would thus encourage providers to improve the quality and value of the care they provide.

The AAOS believes payment reform must provide financial incentives that reward higher quality care based on appropriately risk-adjusted, patient-centric measures of health outcome. This system must be risk adjusted so as to account for the medical, social, and personal co-morbidities that are beyond a provider’s control. These would include factors such as obesity, diminished mobility, chronic disease states, noncompliance with treatment recommendations, poor nutrition, tobacco and alcohol use and many other factors which are beyond the control of health care providers.

We believe 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 physician payment model that does not rely on the current fee-for-service payment mechanisms.

- **Congress should continue to explore payment reforms such as bundled payments under the leadership of physicians**

Physicians have the best knowledge and the most direct interest in their patient care. In collaboration with other stakeholders, physicians should be responsible for determining rates at which bundled and shared savings programs are reimbursed. Specialty societies should be at the forefront of developing measurements for quality and payment models that will provide the best incentives for particular groups of providers.

- **Congress should avoid relying on a one-size-fits-all approach to payment reform**

Within orthopaedics, all of the following types of payment systems could work for different types of orthopaedic care: capitation with warranties and floors, episode-of-care, and traditional fee-for-service. Capitation with warranties, for instance, might work well for treatment of chronic musculoskeletal conditions, while episode-of-care models might work well for joint-replacement care, and fee-for-service might work for non-patternable multi-system trauma services where episode-of-care and other approaches might not be applicable due to its high variability. A new payment model should create incentives both by offering higher reimbursement for quality and shared savings, but it should also create incentives by shifting some burden of financial risk to providers as well. The current system has zero financial risk for providers and by providing both positive and negative financial incentives for higher quality, a new model could move care in a new direction of better patient care with greater physician involvement in decision making.

- **Congress should continue to explore the creation and facilitation of Accountable Care Organizations (ACOs)**

ACOs represent an attractive alternative payment model. In recent years, several initiatives have been introduced to either control costs or improve quality: pay-for-performance, gainsharing, value-based purchasing. In theory, ACOs could combine all of the above. However, ACOs have not initiated operations within the Medicare system and therefore they will need to be adapted and altered based on direct experience and input from participating stakeholders. The AAOS believes ACOs cannot be relied upon as the sole alternative delivery model, but must be blended with other approaches, particularly in the early stages of ACO development and maturation.

Regulatory Reform

- **Congress should eliminate the Independent Payment Advisory Board (IPAB) and create a mechanism for review of Medicare payment rules and regulations that will focus on all aspects of health care payment, not just on physician payment rates**

Any such review body must be accountable to Congress and should not be an independent body with statutory powers. The majority of members of such an advisory council must be physicians and non-physician medical providers like nurses or nurse practitioners. Physicians and medical providers are the best judges of the potential impacts of any physician payment model on the quality of care delivered to patients.

- **Congress should ensure fiscal solvency of federal programs**

The current approach to physician payment has many drawbacks. It stifles payment, discourages innovation, and still manages to threaten the fiscal solvency

of the federal government. Any physician payment reform needs to balance equitable payment with a commitment to the long-term solvency of federal health care programs.

- **Congress should consider basing any new payment model on the prospective payment systems such as the one used for Part A Medicare services that include annual market basket updates to payment rates**

This approach is far more rational than the current SGR system used for Part B Medicare Services which bases updates on target expenditure rates rather than market basket updates. A prospective payment system must also recognize costs under the control of the provider and not include items beyond a provider's control. Until 2010, Medicare Part B included the costs of drugs provided in physician offices even though physicians had no control over these costs. CMS eventually changed this, but not before it had contributed significantly to the SGR "hole". A new model must ensure no such misattributions occur from the beginning.

- **Congress should look for savings from other Medicare programs besides Part B**

Part B expenditures are only a small percentage of total Medicare expenditures and any Congressional efforts toward cost savings in Medicare should look at Part A-hospital payments, Part C-Medicare advantage and Part D-drug payments in addition to Part B. Congress could achieve dramatic and immediate savings in parts C & D in particular.

Market-based Innovations

- **Congress should encourage medical innovation not stifle it**

Payment systems should reward physicians for developing medically innovative treatments that are better for our patients by increasing quality and by reducing health care costs. This will keep patients healthier and out of hospitals, thereby increasing their productivity and GDP. 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 through reductions in hospital stays and post operative days of patient morbidity. Yet, our current system, with its perverse incentives, pays more for procedures with longer procedure times and more hospital patient visits. This is economically irrational and must be corrected in future payment reform. By tying payment to quality and to savings generated by medical innovation, Medicare can reduce overall costs and drive innovation.

- **Congress should encourage and facilitate reinsurance for providers**
Reinsurance is a common method for corporations to insure themselves for catastrophic or unusual outcomes that are not typically covered in standard insurance contracts. These types of reinsurance provide corporations with stability in the face of outlier episodes. Physicians should also have the ability to carry reinsurance and payment reform should specifically include access to reinsurance for Medicare providers which would allow them to take on greater risk when warranted.
- **Congress should adopt multiple approaches to payment reform since not all physician services will fit one model**
Our current healthcare system is diverse, with organizational models ranging from solo practitioners to comprehensive, fully-integrated systems of care. What works well in one practice setting may not work for all patient disorders, for all physicians or in other practice environments. Yet our current payment system operates on the assumption that all physician practices are the same. More flexibility will reduce inefficiency and properly price physician services provided in the multiple settings that exist today. Payment reform must acknowledge this diversity and accommodate the need for flexibility.
- **Congress should encourage public and private sector collaboration**
New payment models should be transferrable to and usable for commercial and 3rd party health provider reimbursement and new payment models need to align with private sector approaches. The public and private sectors should be brought together to collaborate and share approaches that reward outcomes and value and reduce administrative demands.
- **Congress should stimulate private contracting between patients and providers**
The ban on the ability of providers to enter into private contracts with Medicare patients has further impacted the ability of providers to cover the widening gap between inadequate Medicare payments and the cost of providing services. Federal rules capping private contracting between patients and providers should be repealed in the absence of a reasonable long-term solution to inadequate payments to providers by CMS. Also, insurers should be forbidden from including such provisions in physician-insurer contracts. The AAOS believes this action will help providers close the gap between inadequate Medicare payments and the cost of providing services to seniors and other members of society.
- **Congress should enable Medicare beneficiaries to assume greater responsibility by cost-sharing for the Medicare program, with protections for low income beneficiaries, in order to preserve their access to quality care**
There are a broad range of options that policy makers could consider for enhancing beneficiary cost-sharing, among them are:

- Indexing Part B premiums to gradually raise the overall beneficiary cost-share of Part B increases above 25%.
 - Further reducing the subsidy for Medicare Part B premiums for high-income beneficiaries so that they assume a greater share of program costs.
 - Increasing Part B deductibles and indexing them to better reflect the cost growth in the program.
 - Replacing the complex set of cost-sharing arrangements with a single standardized coinsurance rate.
 - Restructuring Part A financing, including a Part A premium.
 - Establishing a co-payment for home health, clinical laboratory, pathology and skilled nursing facility services.
 - Raising the eligibility age for Medicare beneficiaries to be consistent with the Social Security program.
 - Eliminating the costs generated by the increased utilization of services due to Medigap first dollar coverage.
 - Enacting liability reform to lower the costs of liability insurance and the practice of defensive medicine.
 - Establishing a basic benefit package for every Medicare patient, the projected cost of which is within the budget, that would be expected to cover all basic health care needs. The program should then allow supplemental insurance by private companies to enhance an individual's coverage if he or she chooses.
- **Payment reform should account not just for costs but also benefits provided by specific procedures and types of care**
Care that reduces business and government cost by returning and keeping employees at work (as opposed to on worker's compensation, unemployment insurance, or simply not working at all) should be recognized as more valuable than care that contributes little to societal well-being. For instance, patient quality of life, typically captured by QALYs (Quality Adjusted Life Years) and DALYs (Disability Adjusted Life Years) should be accounted for in the form of greater payment for procedures and providers that increase QALY and DALY scores for patients.

Cost Reduction and Fraud Prevention

- **Congress should pass federal medical malpractice liability reform**
The current combination of increased risk of malpractice litigation and a fee-for-service system with no mechanism for annual updates has created incentives for potential over-utilization of medical services because physicians fear litigation. Payment reform must consider mechanisms for limiting real over-utilization, rather than focusing solely on cutting reimbursement of so-called over utilized procedures. This could be done through two positive incentives-- paying for quality outcomes which will encourage greater utilization of services that provide true quality, and by reducing or offsetting the risk of medical malpractice lawsuits which will free providers from defensively ordering extra tests and services. Reducing payment rates for discrete services probably will not curb the utilization problems, and, in fact, would likely create incentives for higher utilization; in contrast, meaningful medical malpractice liability reform will likely lead to lower utilization rates which will benefit patients and reduce costs.
- **Congress should work toward eliminating real Medicare fraud where it exists**
It is impossible to accurately account for the percentage of total Federal spending on physician services paid for fraudulent services, but it is reasonable to assume it is a significant and could be reduced through fair and thorough auditing. Any efforts to eliminate Medicare fraud must focus on true Medicare fraud and not become a mechanism for charges against honest providers of services. Congress should encourage the Centers for Medicare and Medicaid Services to work closely with specialty societies to identify Medicare utilization patterns that run counter to specialty society guidelines, appropriate use criteria and on best coding and billing practices. This collaborative effort could generate millions of dollars of savings without punishing honest physicians who constitute the vast majority of physicians in the United States.

Transparency

- **Congress should adopt and facilitate physician feedback**
Our current system makes meaningful interaction between physicians and policy makers difficult and rare. This is a disservice to our patients, our regulators and to taxpayers. Feedback mechanisms must be developed that will accurately assess how physicians are responding to new models and incentives. Local and federal “innovation zones” are one strategy to speed learning and dissemination of best practices in varied circumstances.

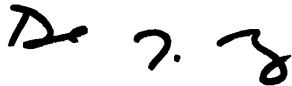
- **Payment reform should provide meaningful incentives for adoption of Electronic Medical Record (EMR) systems, meaningful use of EMR systems, and participation in registries**

In order for quality to become the lynchpin of any new payment models, it is essential that physicians report outcomes, performance measures and information in a secure environment. Physicians should be rewarded for contributing their data to large data repositories and Congress should allocate funds toward supporting the development of registries and depositories.

Any payment system is, by its nature, going to be complex and as the past 14 years of experience under the SGR formula has taught practitioners and legislatures alike, payment systems are fraught with unintended consequences and perverse incentives. That is why it is so important to create a payment system that rewards quality practitioners, and encourages constant improvement in the care of Medicare patients. The AAOS is committed to working with your committee and all of Congress to achieve this goal.

Thank you again for the opportunity to provide comments and ideas. We look forward to continuing to work further with all of you over the coming months.

Sincerely,



Daniel J. Berry, MD
AAOS President

cc: Karen L. Hackett, FACHE, CAE, AAOS Chief Executive Officer
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