TheOrthoForum

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Urge CMS to Preserve Patient Access to Independent Physician Group Practices as Medicare Transitions to Value-Based Care

The OrthoForum fully supports the goal of moving the Medicare program away from the traditional fee-for-service, procedure-by-procedure payment system to a system that makes payment on the basis of providing value-based care. As this transition moves forward, however, the Centers for Medicare & Medicaid Services *(CMS)* is making decisions that favor the dominance of large hospital-based systems, which in turn threatens the ability of patients to choose to receive care from independent physician group practices *(PGPs)*.

With 96 orthopedic physician practices in 37 States, the OrthoForum is a national physician specialty organization whose membership includes many of the largest independently-owned orthopedic practices in the United States. Our central goal is to preserve the ability of orthopedic physician group practices to remain independent and to grow, notwithstanding the consolidation of healthcare entities in the United States and the ongoing purchase of PGPs by large hospital-led health systems.

One of the most successful new innovative alternative payment models *(APMs)* that CMS has developed is the Bundled Payments for Care Improvement *(BPCI)* initiative. For hip and knee replacements, PGP-led BPCI projects have been very successful in providing quality care at lower costs, thereby producing substantial savings for the Medicare program. Yet, as the BPCI program moves to the next stage *(BPCI "Advanced")*, CMS is taking actions that will cause many independent PGPs to decline to participate in the program, including PGPs that were very successful in the original BPCI program. Meanwhile, hospital-led projects will become more and more dominant.

Although in this document the OrthoForum is focused on the BPCI program, it is just one example of programs and policies of concern. Independent PGPs are concerned that various Medicare-related decisions by CMS over the next few years will ultimately lead to a healthcare world in which it will be very difficult for any PGPs to be independent from hospital-led healthcare systems.

[Note: The final section below summarizes the changes in the BPCI Advanced program sought by the OrthoForum.]

Background on BPCI Program

- In the original BPCI program *(now known as BPCI "Classic")*, many orthopedic PGPs participated in Model 2 for hip and knee replacements, known as lower extremity join replacements *(LEJR)*. The surgeon, the hospital, and other providers cooperated to manage the surgery and the follow-up services after discharge as a 90-day episode of care under Medicare. The BPCI Model 2 program allowed PGP-led projects, in addition to hospital-led projects. A key feature of the BPCI program was that it was voluntary. In other words, it was not a "mandatory" program in which CMS forced hospitals or PGPs to participate in order to continue receiving Medicare payments.
- To achieve savings and receive gainsharing payments in a Model 2 project, the participants had to beat their historical price for the episode, known as the "*target price*." If the episode's cost was above the target price, the participants had to pay the difference to CMS. The overall objective was to lower Medicare's costs for an episode of care while maintaining or improving quality.
- To create a Model 2 project, an entity could "*convene*" multiple PGPs to participate in the project. The convener organization dealt directly with CMS, rather than the PGPs doing so. Many of the conveners were hospitals, but some Model 2 projects had PGPs as conveners. Any PGP could also participate by working directly with CMS, rather than working with a convener.
- The BPCI Classic program ended on September 30, 2018, and the BPCI Advanced program began the next day, October 1. The Advanced program does not have various models. The single model used in Advanced generally follows the approach of Classic Model 2, including being a voluntary program, but there are important differences, as discussed below.

March 1, 2019, Exit-Option Deadline for BPCI Advanced Should be Extended

- This deadline affects all participants in BPCI Advanced. CMS launched the Advanced program very quickly in January 2018, with March 12, 2018, as the deadline to submit applications and August 8, 2018, as the deadline to submit binding participation agreements. Recognizing the difficulties participants faced with this rapid process, including errors in data that had been supplied by CMS, the agency announced on July 6, 2018, that it is giving participants until March 1, 2019 to submit an irrevocable exit option to the agency. If used, this option can take one of two forms. A participant can stay in the program but withdraw patient episodes that began before that date, or the participant can choose to exit the program entirely.
- This deadline does not allow participants to receive sufficient feedback on their performance in the program. As of the March 1 deadline, they will not know whether they will receive gainsharing payments or will owe CMS money. The only relatively complete claims data a participant will have at that point is from the first "performance period," October-December 2018. The second performance period will be January-June 2019. CMS should extend the exit deadline to no earlier than July 1, 2019, when participants will have enough claims data to predict whether they will be successful in the program. Participants, however, will not definitely know their status until Fall 2019, when CMS will release the results of its analysis of the first two performance periods; therefore, it would be best if the deadline is a date after participants learn their results.

Certain CMS Decisions on BPCI Advanced Disadvantage Physician Group Practices

- ***Change on Use of Gainsharing Amount is Detrimental to PGPs in Many Situations:***
  - In both the BPCI Classic and Advanced programs, a physician cannot receive a gainsharing payment in an amount exceeding 50 percent of the amount traditional Medicare pays for the type of clinical episode involved. BPCI Classic applied that gainsharing cap to each physician in a PGP, but allowed the remainder of the PGP's gainsharing amount to be used by the PGP itself (the business entity that employs the individual physicians). The PGP was able to use these remainder funds to offset direct and indirect costs related to participation in BPCI, as well as to offset general overhead of the PGP.
  - In BPCI Advanced, however, some PGPs will be able to use these gainsharing remainder funds, and some will not. CMS clarified late on August 6—less than 2 days before the deadline to join the program—that a PGP cannot use the remainder funds if it works with a convener organization (and PGPs not working with a convener can use those funds). This places an unfair substantial burden on some PGPs, but not others. This restriction also is not as burdensome for hospitals, as they are paid almost 8 times as much for a surgery as a PGP. Moreover, this CMS gainsharing policy seems to indicate the agency has a negative attitude toward convener organizations and the PGPs that use them. This is perplexing, given that orthopedic BPCI projects carried out through convener organizations have been very successful, providing quality care at reduced costs. The restriction on the use of gainsharing remainder funds by PGPs that work with conveners should be removed immediately, which will help the affected PGPs decide whether to use the March 1, 2019 exit option (discussed above).

- ***"Precedence" Policy Favors CJR Hospitals Over BPCI Physician Group Practices:***
  - The Comprehensive Care for Joint Replacement *(CJR)* program that CMS has created is similar to the BPCI program, except that the only clinical episode involved in CJR is LEJR, the program is mandatory for hospitals, and only hospitals can lead CJR projects (i.e., a PGP cannot lead a CJR project). Since BPCI and CJR both involve LEJR episodes, CMS issued a regulation in 2015 to govern the situation in which a BPCI physician performs an LEJR surgery at a CJR hospital. This regulation gave BPCI "*precedence*" over CJR, meaning that the surgery and the post-acute care were attributed to the BPCI project, not the CJR project.
  - With BPCI Advanced, however, CMS has reversed the precedence policy; therefore, an orthopedic surgeon participating in BPCI Advanced who performs an LEJR surgery in a CJR hospital will not get BPCI credit for his or her PGP. In other words, the surgery will be attributed to the CJR hospital, not the surgeon's BPCI PGP. This has a profound effect on patients and on orthopedic PGPs, since there are 34 metropolitan statistical areas *(MSAs)* in the country in which all hospitals are required to participate in CJR, and there are 33 additional MSAs in which hospitals had the option of participating. In a CJR situation, when a patient chooses a surgeon in a BPCI-participating PGP to perform LEJR, the patient will

lose that surgeon and the PGP after the surgery, since the hospital will take over and handle all the post-surgery care of the patient.
    - CMS should change its precedence policy so that an LEJR episode is attributed to a BPCI PGP or a CJR hospital on the basis of which of the two programs the operating surgeon is participating in. This would give patients more control over their healthcare, since patients usually choose their surgeons carefully and do not want to lose them after the surgery. This attribution approach would also help prevent the anticompetitive use of precedence policies to "capture" patients and restrict their access to other providers.

- ***Counterproductive Methodology for Evaluating Performance of Physician Group Practices:*** In BPCI Advanced, the problem is the methodology used by CMS to set the target price for a PGP. The target price, which must be beat to achieve savings, is essentially the historical price for the clinical episode involved, with certain adjustments based on more recent data. These adjustments operate so that a PGP's record of efficiency in providing quality care at a lower cost actually works against the PGP, since that record ends up setting the target price at a level that makes it more difficult to achieve savings. This is particularly true for PGPs that were successful in BPCI Classic. Their past efficient performance now results in a more difficult target price in the Advanced Program. CMS should make changes in the target price methodology so that PGPs are not penalized for being efficient.

- ***The Security Deposit Requirement for PGPs to Participate in BPCI Advanced is Unfairly Applied in Some Situations:*** If a PGP does not work with a convener organization, a security deposit is required to ensure that CMS receives its money if the PGP fails to meet its target price. But a security deposit is not required for a hospital that does not work with a convener organization. CMS believes it can recoup its money from a hospital by reducing payments on future Medicare claims by the hospital. The agency should take a claims payment-reduction approach for PGPs that do not work with convener organizations, and should remove the security deposit requirement for such PGPs.

Take Action to Preserve Patient Access to Independent Physician Group Practices

- It appears very unlikely that CMS will change any of the BPCI policies described above unless it receives external pressure. In fact, the agency has been candid with some stakeholders that the agency will hold firm unless Congress directly or indirectly takes action. The OrthoForum therefore urges House and Senate offices to contact CMS and advocate for changes to these policies. In addition, the appropriate committees in Congress should hold hearings on these issues. *With respect to the BPCI Advanced program, the OrthoForum believes that CMS should—*
    - *extend the March 1, 2019 exit-option deadline to a date that is after participants have sufficient data to gauge their performance (no earlier than July 1, 2019);*
    - *immediately remove the restriction on the use of gainsharing remainder funds by PGPs that work through convener organizations, which will help affected PGPs decide whether to use the March 1 exit option;*
    - *change its CJR-BPCI precedence policy so that an LEJR episode is attributed on the basis of which of the two programs the operating surgeon is participating in;*
    - *change the target-price methodology so that it does not penalize PGPs for being efficient; and*
    - *remove the requirement that PGPs without convener organizations give CMS a security deposit, and instead recoup money owed the agency by reducing payments to the PGPs for future Medicare claims, as is done for hospitals without convener organizations.*

- We also urge individual PGPs and physicians, as well as other interested parties, to contact the local offices of their Senators and Representatives about these BPCI issues. Congress takes notice when there are grassroots concerns about positions taken by federal agencies.

- Beyond the BPCI Advanced program, please take whatever actions are appropriate to ensure that patients do not lose access to independent physician group practices. Specifically, we need to ensure that Medicare-related decisions by CMS over the next few years do not ultimately lead to a healthcare world in which it will be very difficult for any PGPs to be independent from hospital-led healthcare systems.

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