House Budget Committee Hearing:

Center for Medicare and Medicaid Innovation: Scoring Assumptions and Real-World Implications

September 7, 2016

Testimony of Mark Madden M.D., Orthopedic Surgeon with OrthoVirginia

Introduction:

Thank you, Chairman Price, Ranking Member Van Hollen, and distinguished Members of the Committee for inviting me to testify this morning. My name is Mark Madden and I am an orthopedic surgeon from Fairfax, Virginia. I am with OrthoVirginia, an independent physician practice that is a participant in one of the new Medicare payment models developed by the Center for Medicare & Medicaid Innovation (CMMI).

This particular payment model is known as the Bundled Payments for Care Improvement (BPCI) initiative. Specifically, it is BPCI Model 2, under which providers take responsibility for managing the quality and cost for a Medicare patient during a particular episode of care. The episode includes the patient's inpatient stay in an acute care hospital, plus the post-acute care in an inpatient or outpatient setting and all related services during the episode of care, which ends up to 90 days after the patient's discharge from the hospital. The goal of the initiative is to transition from Medicare fee-for-service payments to a payment model that rewards quality care provided during a patient's episode. Participating in BPCI Model 2 involves the risk of financial penalties as well as the possibility of bonus payments. There can be an administrative entity that deals directly with CMMI to reach an agreement for implementing the Model, and that entity in turn convenes a group of providers to participate in the Model in accordance with the agreement with CMMI. This administrative entity is known as an Awardee Convener and is directly responsible to the Centers for Medicare & Medicaid Services (CMS) in terms of bearing financial risk for all the episodes of care that are initiated by its participating providers, which are known as Episode Initiators.

Episode Initiators will receive bonus payments if the total cost of care for the episode is below a target price set by CMS. This target price is established using a baseline price which is calculated from the historical costs for all Part A and Part B services associated with the respective Episode Initiator involved in the episode. The baseline price is then adjusted to the present time period utilizing a three step methodology incorporating the National Trend Factor, the Wage Adjustment Factor, and a CMS 2% discount rate. This methodology, which I will further discuss in a few moments, creates a moving target that threatens the sustainability of BPCI and all episode payment models. If the total episode cost is above the target price, the difference must be paid to CMS.

BPCI Model 2:

I will now discuss the specific BPCI Model 2 in which I participate. My practice, OrthoVirginia, is an Episode Initiator working with Signature Medical Group, which is our Awardee Convener. We are a group of orthopedic physicians and Signature is a group of physicians. While there appears to be a movement in the United States toward hospital-led approaches to care, such as CJR, we believe that we have demonstrated physician-led models can be very successful. It is the physician who has the highest degree of one-on-one interaction with the patient and is the best prepared to evaluate the pre-operative and post-operative needs of the patient if the surgery and overall care is to be successful. We strongly believe the data from OrthoVirginia and other Episode Initiators working with Signature will bear this out.

OrthoVirginia participates in BPCI Model 2 for total joint replacement. Our engagement with Signature comprises the single largest clinically integrated orthopedic bundled payment program in the United States. It includes over 2,000 physicians in 56 practices across 26 states. Collectively, the physicians in Signature's model are managing 50,000 joint replacements every year. The results have been dramatic with reductions in adverse outcomes from 25% to 80% and significantly improved patient satisfaction, frequently over 95%.

I should point out that BPCI Model 2 is different than the new Comprehensive Care for Joint Replacement (CJR) model. All BPCI initiatives are voluntary, and they can be led by physician groups, hospitals, and other providers. CJR models, however, can only be led by hospitals, and participation is mandatory for all hospitals in a geographic area chosen by CMS, except for hospitals currently participating in BPCI. The significant problems that we have experienced in BPCI will be even more difficult in a larger, mandatory program like CJR unless they are corrected early on.

Our participating practices believe that moving away from a fee-for-service reimbursement model and toward reimbursement based on quality care is the future of medicine. That is why we decided to volunteer to get ahead of the curve by joining BPCI. We have learned a great deal and have enjoyed the new responsibility that goes along with greater decision making. Surgery is not an isolated event but a continuum of care before, during, and after surgery. If we fail to manage costs and quality effectively, we accept the financial consequences.

The success of our Model's physicians is evident from the following improvements in the rate of clinical problems that can occur after a joint replacement:

- Readmission to the hospital within 30 days after discharge: Reduction of 14%

- Infection of the surgical site: Reduction of 43%
- Joint infection within 30 days after surgery: Reduction of 25%
- Acute Myocardial Infarction within 7 days: Reduction of 23%
- Urinary Tract Infection: Reduction of 23%
- Pulmonary Embolism: Reduction of 27%

These statistics demonstrate that Medicare, the taxpayer, and most important, our patients are realizing substantial benefits from our BPCI initiative. Unfortunately, the story does not end there. Certain issues in the structure and design of the Model, if not corrected, will create a significant disincentive for physicians or hospitals to participate in BPCI or related programs such as the CJR, or any subsequent mandatory Medicare program that contains these design flaws. Without changes, the savings to the taxpayer and the benefits to the patients will be lost because the program will have become unsustainable for physicians or hospitals.

Before I discuss these flaws, I want to be clear that I am not implying that CMMI has been unwilling to engage in dialogue or make changes. To the contrary, we have had numerous discussions with them, and on a series of issues they have been open to change and made them either in our initiative or for other models such as CJR or for both.

Structural Concerns With BPCI Model 2:

The first and most significant issue of concern is the National Trend Factor, which continuously updates the target prices set by CMS and which the BPCI participants are expected to meet. The second issue of concern is the methodology through which CMS attributes particular items, services, and costs to particular providers. The third issue of concern is the need to coordinate the end of the BPCI initiative with the end of the CJR initiative.

I will focus my remaining time on discussing the National Trend Factor and will discuss the second and third issues in an attachment to my written statement, which I request be made part of the hearing record.

The National Trend Factor:

The National Trend Factor (NTF) plays a significant part in an Episode Initiator's success or failure in the BPCI initiative. Yet, how the NTF is calculated is ambiguous at best. CMMI provides very little visibility to BPCI participants on the data sources, even though the impact of its application on a BPCI participant's financial performance results can be quite significant. To date, we have seen the application

of the NTF produce unanticipated negative financial consequences to many of our practices despite clear care improvements derived from reducing overutilization of services while maintaining or improving quality and tremendous improvement over historical price trends. So, despite achieving CMMI's goals for the BPCI initiative on cost and quality, physician practices are being penalized financially—actually losing money on each episode-- because the care redesign efforts are outpaced by the downward spiraling NTF. No one in our convening group understands the methodology or data used to calculate these prices and most of us question their accuracy. In any event, without greater transparency, we cannot adequately plan nor compete. Without assured accuracy, we cannot participate. And if doctors and hospitals cannot participate, the taxpayer will not get savings and the patient will not get care.

Signature Medical Group prepared a presentation on the NTF and provided it to CMMI in December 2015. The presentation outlines the concerns and also offers a menu of possible solutions. I request that this presentation be made part of the hearing record. Unless issues with the calculation and application of the NTF are addressed in a prompt and comprehensive manner by CMMI/CMS, we believe CMS-designed bundled programs, including CJR or any subsequent mandatory program, will not be financially viable for their participants. While physicians and hospitals improve care and reduce costs to CMS the design flaws of the BPCI and CJR models rapidly erode the financial viability of the providers. That is not a winning strategy and providers will have little choice but to abandon engagement with CMMI. That, of course, is a problem far greater than a budgetary scoring issue. Happily, we believe there are reasonable solutions, but they must be resolved before these set of programs can succeed.

Thank you for your time and for your interest in this important issue. I am happy to respond to your questions as best as I am able.

Attachment: Additional Statement of Mark Madden M.D., Orthopedic Surgeon with OrthoVirginia

Two additional structural issues with BPCI Model 2:

<u>Issue #1: Attribution Methodology</u>

The methodology used by CMS/CMMI for patient attribution, based solely upon the National Provider Identification Number (NPI) reassignment of provider benefits to Episode Initiators (EIs), is flawed and could seriously compromise potential success of the BPCI initiative. A continuation of this faulty methodology may result in a mass exodus of providers from participation in BPCI and poses the potential for providers to completely disengage from participation in Medicare innovation projects. The adverse

impacts, both financial and programmatic, upon providers due to this erroneous methodology can be very significant and revolve around the following two areas:

- NPI assignment: EIs, both physician group practices (PGPs) and Hospitals, can be impacted from the inaccuracies of physician NPI assignment based on the PECOS system maintained by the Center for Program Integrity (CPI). Physicians with multiple reassignment of benefits (reassignments to two or more Tax Identification Numbers participating in BPCI) and aberrant assignments (physicians not accurately reassigned to a proper TIN) are impacted because the inaccurate reassignments will negate a physician's participation in BPCI and subsequently beneficiaries will not be accurately attributed to the appropriate EI.
- Anchor event determination: The attribution methodology of linking an episode to a DRG and either the CMS Certification Number (CCN) or TIN of an EI requires accurate documentation on the UB-04. Unfortunately, a hospital is reimbursed for the billed UB-04 whether or not the attending, operating and other NPI fields are accurately completed. We have found some hospitals that have incorrectly recorded provider NPIs on the UB-04 form 100% of the time, meaning the actual EI responsible for the episode of care for their patient, may have attributed to the wrong provider. The result is confusion on which provider is managing the care redesign process for the patient and ultimately beneficiary confusion about their personal care plan and care navigation.

Issue #2: BPCI and CJR End Dates

The BPCI initiative seeks to achieve the same goals as the CJR. Unlike the CJR program, however, the BPCI initiative includes physician group practices (PGPs) as conveners and participants and enables PGPs to take on full risk. This model design has empowered our physicians to drive new care designs across the entire continuum of patient care, and, as a consequence, enabled our practices to achieve the kinds of successes we have noted above. Originally, the BPCI initiative had a staggered three-year termination date, depending on when participants entered the initiative at full risk. CMMI made a policy change earlier this year to extend the program for all participants until September 2018. However, this is still two years prior to the end date for CJR. This time frame mismatch will force some former BPCI PGP patients into a CJR hospital when a second procedure is warranted for those patients. These patients are very likely to be admitted into a CJR hospital and into hospital care protocols that may be vastly different from those that PGPs successfully established under BPCI. These situations will undoubtedly lead to confusion on the part of a beneficiary who may have been a patient of the BPCI physician for many months or years.

The most effective solution to avoid this confusion is to extend the BPCI end date for all active BPCI participants to match that of CJR. This will help ensure that the patient-physician relationship—a bond that is forged and built on trust and intimidate knowledge of that patient over many months and years—is not disrupted by the hospital-centric design of the CJR model. A coterminous date will also allow for comparative data sets between the two programs—a physician-led BPIC Model 2 and CJR, a hospital led model. Hence, a more accurate determination can be made relative to which program produced the most optimal outcomes, which can in turn drive appropriate policy decisions regarding future alternative payment models.