Bundled Payments for Care Improvement Advanced | BPCI Advanced

Quality Payment PROGRAM

OPERATIONALIZING BPCI ADVANCED

MAY 2018

Introductions

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Webcast Outline

- The CMS Innovation Center
- Review of BPCI Advanced Features
- Application to the Model
- Participation in the Model
  - Common Challenges
  - Strategies for Success
- CMS Innovation Center Partnership
- Reconciliation Process
- Summary and Conclusions

INTRODUCTION

The CMS Innovation Center and BPCI Advanced

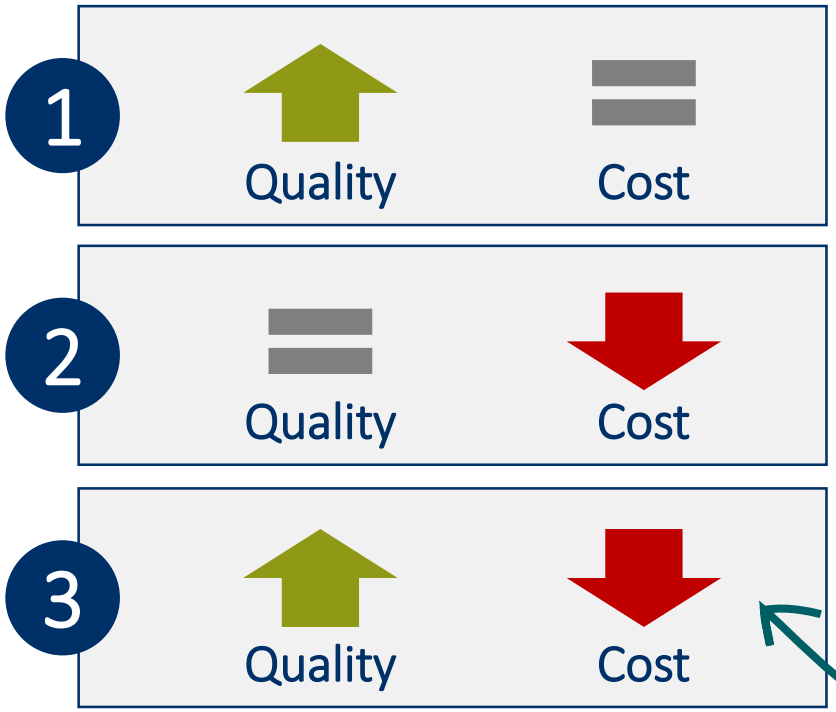
The CMS Innovation Center

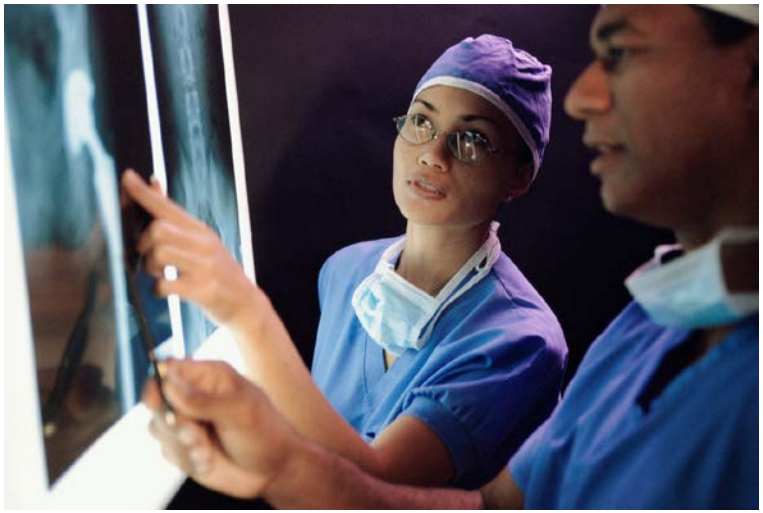
- As part of the Centers for Medicare & Medicaid Services (CMS), the CMS Innovation Center provides national leadership in the transition from volume to value

- The center tests innovative payment and service delivery models that reduce costs while preserving or enhancing quality

- Guiding principles
  - Patient centered care
  - Provider choice and incentives
  - Choice and competition in the market
  - Transparent model design and evaluation
  - Benefit design and price transparency
  - Small scale testing

Model Scenarios for Success

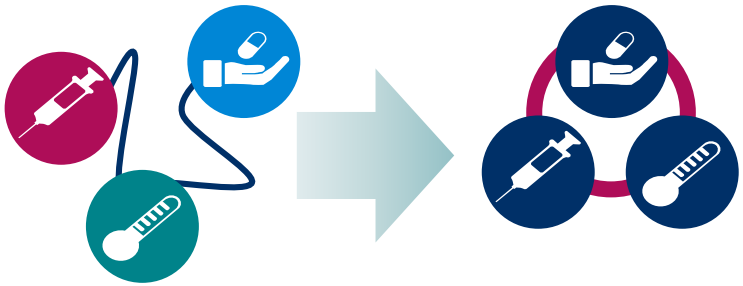




REVIEW

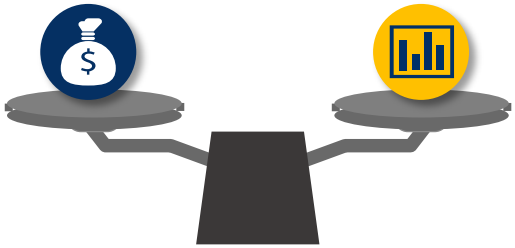
Bundled Payments for Care Improvement Advanced

BPCI Advanced Tests a Different Payment Approach



Shifts emphasis from **individual services** towards a coordinated **clinical episode**

Establishes an "**accountable party**"



Clinical episodes are assessed on the **quality and cost** of care

BPCI Advanced is Different Than BPCI

Streamlined design

- One model, 90-day episode period
- Single risk track
- Inpatient and Outpatient episodes
- Preliminary target prices provided in advance
- Payment tied to performance on quality measures

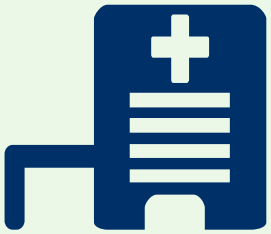
Greater focus on **physician engagement and learning**

Designed as an **Advanced APM** under the Quality Payment Program

Who Leads Clinical Episodes?

Physician Group Practices (PGPs)

Acute Care Hospitals (ACHs)



Participants May Work with a Convener

A Convener is a Medicare-enrolled provider or supplier or an entity that is not enrolled in Medicare.

Conveners may:

- Facilitate participation by smaller PGPs or ACHs
- Provide data and analytic feedback
- Offer logistical and operational support
- Bear financial risk to CMS under the Model

Quality Measures

Will include **claims-based measures through 2020**

Additional measures with varying reporting mechanisms may be added in the future

Initial Quality Measures

Quality measures for:	
All Clinical Episodes	All-cause Hospital Readmission Measure (National Quality Forum [NQF] #1789)
	Care Plan (NQF #0326)
Specific Clinical Episodes	Perioperative Care—Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
	AHRQ Patient Safety Indicators (PSI 90)

Setting Benchmark Prices

Hospital's Benchmark Price:

Patient case-mix

Peer group trends

Historic efficiency

Physician Group Practice (PGP) Benchmark Price:

Anchored on hospital

Accounts for PGP–specific historical practice pattern

PGP Pricing

Urban

ACH: $20,000
PGP: $22,000

Rural

ACH: $18,000
PGP: $20,000

Academic Medical Center (AMC)

ACH: $25,000
PGP: $27,000

PGP

KEY POINTS

1. PGPs may practice at multiple hospitals
2. Hospital pricing varies
3. Limited time PGP adjustment, anchored on hospital price

BPCI Advanced Precedence Rules

1.  Attending PGP
2.  Operating PGP
3.  ACHs

Patient Attribution: Multiple PGPs, Both Participating in Pneumonia Clinical Episode

Clinical Episode | Attribution

Non-Participating ACH

Participating PGP 1

Clinical Episode: ✓ | Attribution: PGP1

Non-Participating PGP 2

Clinical Episode: ✗

Participating PGP 3

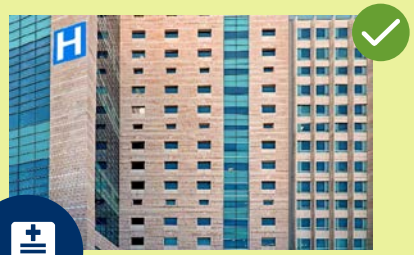
Clinical Episode: ✓ | Attribution: PGP3

KEY POINTS

1. Multiple PGPs may exist at an ACH
2. All PGPs need not participate
3. Attending identified through UB-04 and Part B Claim

Patient Attribution: ACH and Multiple PGPs, Participating in Pneumonia Clinical Episode

Participating ACH



	Clinical Episode	Attribution
Participating PGP 1 	✓	PGP1
Non-Participating PGP 2 	✓	ACH
Participating PGP 3 	✓	PGP3

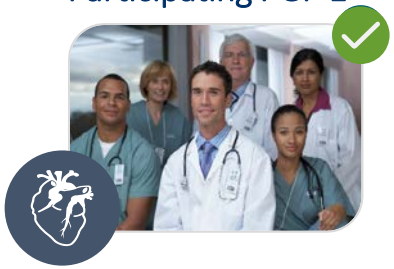
KEY POINTS

1. ACHs and PGPs may participate
2. If ACH participates, all clinical episodes are in the model

Patient Attribution: ACH and Multiple PGPs, Different Clinical Episodes

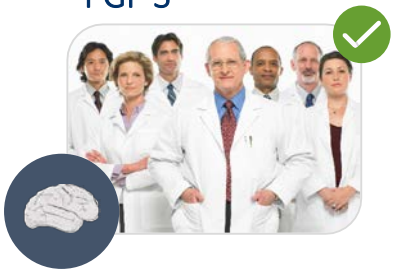
Participating ACH

Participating PGP 1



Non-Participating PGP 2

Participating PGP 3



Clinical Episode	Attribution
✓	PGP1
✓	ACH
✓	PGP3

KEY POINTS

1. PGPs and ACH may participate in different episode categories
2. Exclusive participant would get all episodes, subject to trigger rules

APPLICATION TO THE MODEL

Applicants Will Receive Data in Advance

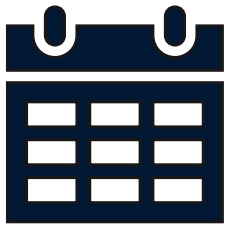
- CMS will provide preliminary target prices to applicants in May 2018

- Applicants who submit a Data Request and Attestation form
  - Three years of aggregate (summary) and/or raw (beneficiary line-level) Historical Claims data for the Medicare beneficiaries who would have been included in a Clinical Episode and attributed to the applicant

- **Convener applicants** receive target prices for all of their episode initiators (EIs)
- **Non-convener applicants** receive their own target prices

Clinical Episode Selection

- Participants will enter into an agreement with CMS
  - May be renewed annually
  - Commits to selected Clinical Episodes until the start of the following Agreement Term



- Episode selections must be submitted to CMS by **August 1, 2018**

Considerations for Participation

- Are there other potential Participants for the same Clinical Episode at the same ACH?
- Are there clear opportunities for improvement within the model?
- Can operational investments be spread across multiple clinical episodes?
- Can Participants safely assume financial risk?
- Does it make sense to work with a Convener?
- Would Participants qualify for incentive payments as a Qualifying APM Participant in the Quality Payment Program?

PARTICIPATION IN THE MODEL

Example Strategy: Data Transparency

- Utilize care management software to share data between hospital and PAC providers; include physician, hospital, and regional-level data.
- Create patient dashboards with real-time data that physicians and partners can easily access.
- Utilize a data analytic tool to help staff identify patients needing additional care during their SNF stay.

Example Strategy: Utilize a Risk Assessment Tool

- Incorporate a readmission prediction tool into your electronic health record (EHR) for both high and middle risk patients.
  - Use a tool, which includes a section for identifying patient risk for readmission, in tandem with "At-Risk" meetings.
  - Use a tool, which includes care pathways and “change in condition” tools, to manage care and prevent readmissions.
  - Use an index scoring tool for risk assessment of death and readmission.
- Use an analysis platform, which assists with risk assessment and discharge planning decisions.

Example Strategy: Redesign Care Pathways

- Update and simplify patient forms/checklists to ease pre-screening and post-acute care transfer. Support consistent use by all providers.
- Provide telephone number/toll-free hotline for patients to call with questions or concerns post-discharge to reduce readmissions.
- Modify clinical pathways to incorporate therapy interventions.

Example Strategy: Create or Hire Key Staffing Positions

- Create or hire positions:
  - Inpatient care coordinator (ICC) to help determine the next site of care.
  - Skilled inpatient care coordinator (SICC) to focus on reducing SNF length of stay and readmissions.
  - Create or hire “SNFist” position for PCPs working entirely within SNFs specializing in PAC and/or geriatrics.
  - Use regional care nurse navigators or transitional care managers to engage patients throughout the episode and to build relationships with community partners.
- Create or hire a non-clinical data analyst for BPCI.

Example Strategy: Increase Patient and Provider Education

- Designate a physician champion, either for a particular clinical episode or for all BPCI patients.
- Initiate a pilot program to determine which patients qualify for a home health aide (HHA). Offer the patients targeted information to support their acceptance of an HHA referral.
- Invite family members or caregivers to participate in therapy sessions.

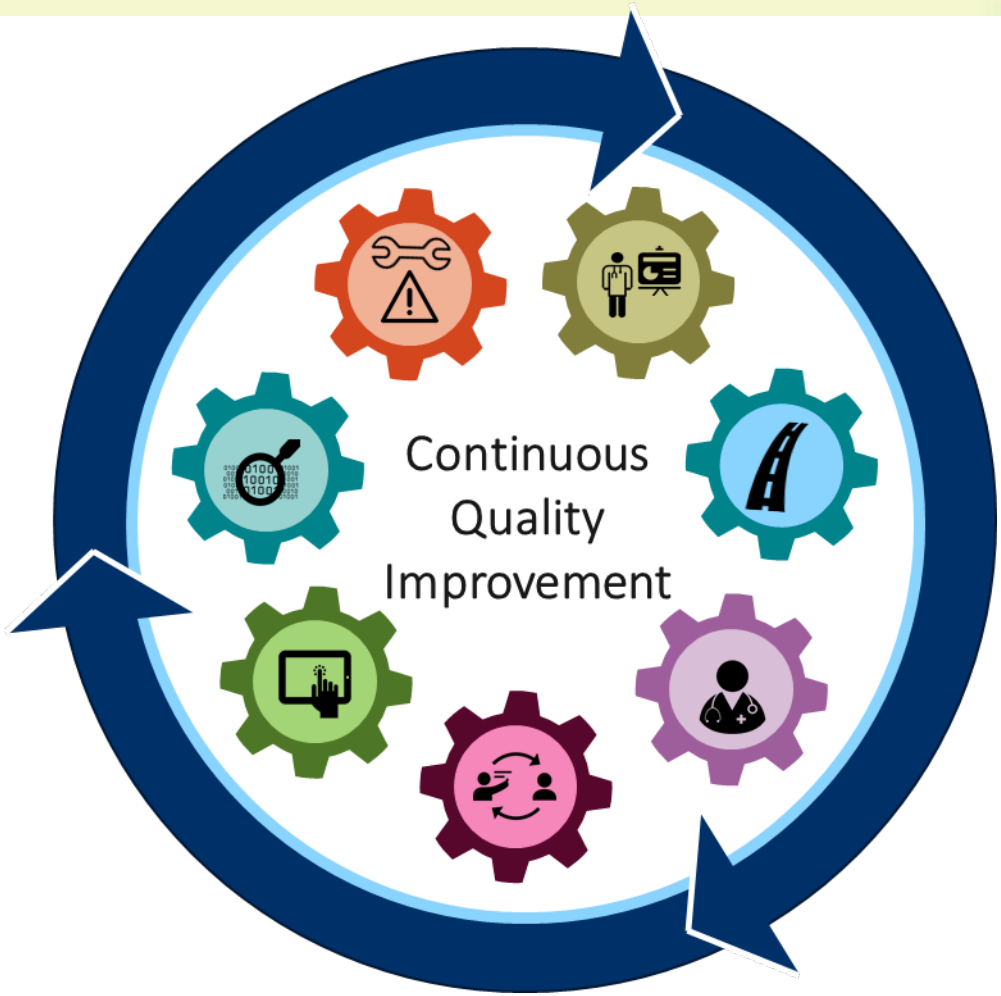
Example Strategy: Improve Coordination with PAC Providers

- Develop preferred provider networks.
- Meet weekly with SNF/HHA staff.
- Use care management software/data platform that promotes information transfer and helps coordinate care between hospital and PAC providers.

Example Strategy: Innovative Use of Technology

- Provide a telemonitoring device post discharge to high-risk patients for education and communication.
- Provide access to a smartphone app for physicians to view patient and quality data.
- Create a video library for patients and families, with a computer available in the facility for families to do research.

Participants Engage in Continuous Quality Improvement



CMS INNOVATION CENTER PARTNERSHIP

BPCI Advanced is a Partnership

- Clinicians
  - Care for patients on the front line
  - Engage in continuous quality improvement
- CMS Innovation Center
  - Provides greater transparency on cost and quality of services provided
  - Establishes payment mechanisms that support improved care processes
  - Rewards providers that deliver greater value

CMS Innovation Center Learning Systems Have Three Broad Functions

1

Identify and package **new knowledge and best practices**

2

Leverage data and participant input to guide change and improvement

3

Build **learning communities** and networks to disseminate successful strategies

Three Channels For Care Transformation

CMS learns from participants

Participants learn from CMS

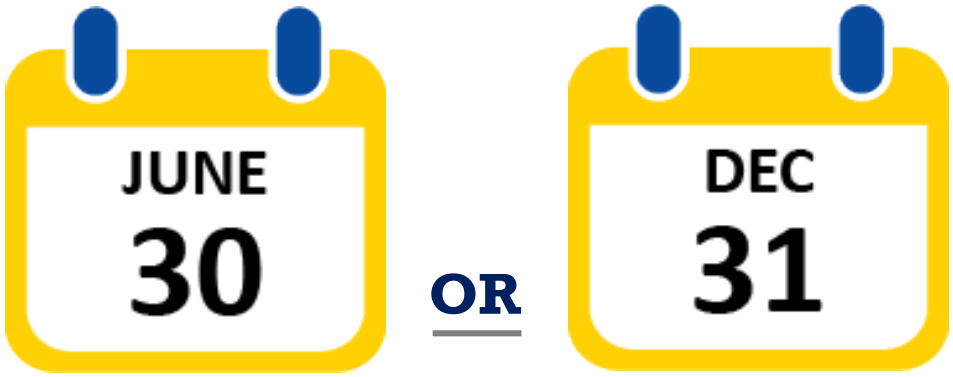
Participants learn from each other

RECONCILIATION PROCESS

Performance Will be Assessed Semi-Annually

- Semi-annual Reconciliation will include two (2) “True-Ups” to allow for claims run-out

- Clinical Episodes will be reconciled based on the Performance Period **in which the episode ends**:



Participants Will Receive a Workbook at the End of Each Performance Period

- Final target price for each clinical episode
  - Preliminary target price revised for realized case mix
- Actual costs for clinical episodes
- Net Payment Reconciliation Amounts (NPRA), by clinical episode
- Aggregate quality measure performance

Reconciliation Process

- All non-excluded Medicare FFS expenditures will be compared against the final Target Price, resulting in a **Positive or Negative Reconciliation Amount** for each Clinical Episode

- All Positive and Negative Reconciliation Amounts will be netted across all Clinical Episodes attributed to a Participant, resulting in a **Positive or Negative Total Reconciliation Amount**

Reconciliation Process, Continued

- The Positive or Negative Total Reconciliation Amount is then adjusted based on quality performance, resulting in the **Adjusted Positive or Negative Total Reconciliation Amount**

- This final number may result in either:
  - A payment from CMS
  - A repayment to CMS

Settling Up

- After numbers reviewed
  - Within 30 calendar days, may contest any calculation or omission errors
  - CMS must respond to appeals within 30 days

OR

- BPCI Advanced Payments
  - Following 30-day appeal window
  - Participants will receive either payment or a demand letter

Exiting the Model

Physician group practices and hospitals working with a convener may terminate from the model at any time, but the convener remains responsible for the clinical episodes until the next agreement period, or until they wholly terminate their participation in the model

Participants not working with a convener may terminate from the model at any time in accordance with the participation agreement.

SUMMARY AND CONCLUSIONS

Summary

- **BPCI Advanced is a new voluntary Advanced APM**
  - Builds on prior experience
  - Responsive to stakeholders

- **Establishes responsibility for clinical episodes**
  - Aims to catalyze health system transformation
  - Successful participants (quality, cost) may receive additional payments

- **Will be an Advanced APM in the Quality Payment Program**

As a Model Test, Future Revisions Are Likely

- As an entirely new model, some features may work well, while others may need improvements

- Evaluation results and stakeholder feedback is critical

- In the future, the Innovation Center may:
  - Revise design features
  - Add Clinical Episodes
  - Add performance measure options

Learning Resources

Webcasts

More details of the model can be found in two presentations:

- Model Overview
- Application Process

Available at the CMS Innovation Center website: https://innovation.cms.gov/initiatives/bpci-advanced

Print Resources

You can find a variety of resources, including a Model Timeline, Fact Sheet, FAQs (General and Physician-focused), Episode Definitions, and an Application Process Handout on the CMS Innovation Center website.

Questions

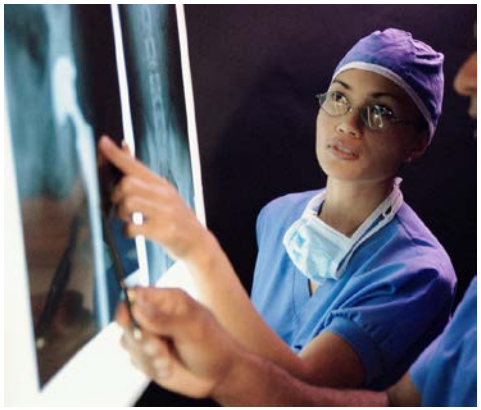
If you have questions, contact the BPCI Advanced Model team at: BPCIAdvanced@cms.hhs.gov

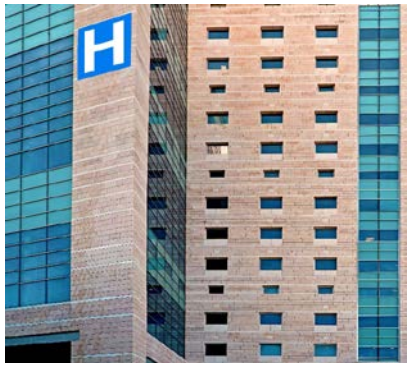
APPENDIX

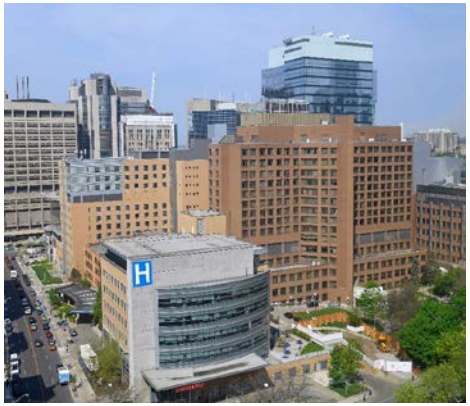
Key Differences: BPCI vs. BPCI Advanced

BPCI	BPCI Advanced
48 Inpatient (IP) clinical episodes	29 IP and 3 OP clinical episodes
Not an Advanced APM since lacking CEHRT requirement and quality not tied to payment	Model is an Advanced APM
No quality measures required for payment purposes	Quality measures are reportable and performance on these measures will be tied to payment
Excludes cost of care associated with services according to 13 unique exclusion listings of "unrelated" care	Limited exclusions; Excludes the Part A & B costs associated with ACH readmissions qualifying based on a limited set of MS-DRGs
Model 3 includes PAC providers triggering episodes in the post-discharge period	No equivalent for Model 3; design is similar to Model 2 with PGPs and ACHs as EIs; PAC Providers, and other Medicare-enrolled, as well as non-Medicare-enrolled entities can participate as Convener Participants
Risk corridor of 20% of spending above the upper limit of the selected risk track	One risk track Risk is capped at +/-20%
Target Prices provided at reconciliation	Preliminary Target Price provided prospectively, before the start of each Model Year

Questions?





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