

Model Overview



***Center for Medicare &
Medicaid Innovation
(CMS Innovation Center)***

September 2019

Webcast Outline



Model Overview



Who Can Participate



Advanced Alternative Payment Model Criteria



Defining the Clinical Episodes



Payment and Pricing Methodology

Webcast Outline



Quality Measures



Monitoring and Evaluation



CMS Innovation Center Learning System



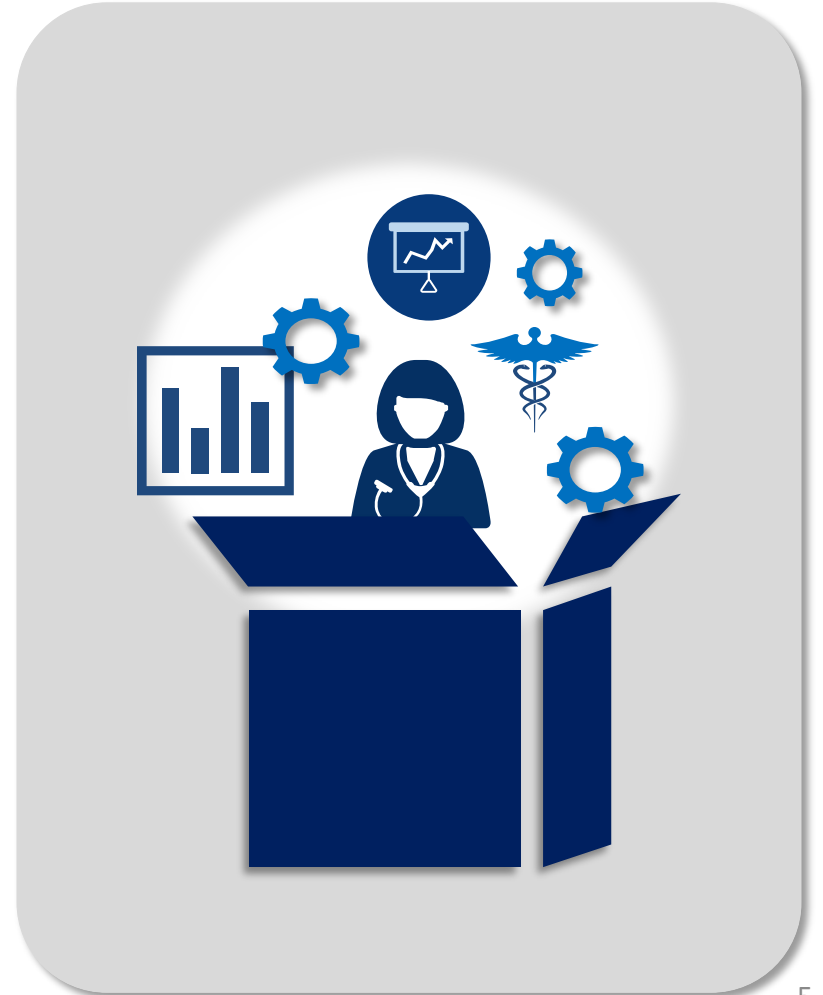
How to Apply

BPCI Advanced Model Overview



BPCI Advanced Model Overview

- Voluntary bundled payment model
- Single payment and risk track with a 90-day episode period
- 31 Inpatient Clinical Episodes
- 4 Outpatient Clinical Episodes



BPCI Advanced Model Overview

(Continued)

- Qualifies as Advanced Alternative Payment Model (Advanced APM)
- Payment tied to performance on quality measures
- Preliminary Target Prices provided prospectively
- Final Target Prices reflect realized patient case mix



Objectives of BPCI Advanced

1

Financial Accountability



2

Care Redesign



3

Data Analysis and Feedback



4

Health Care Provider Engagement

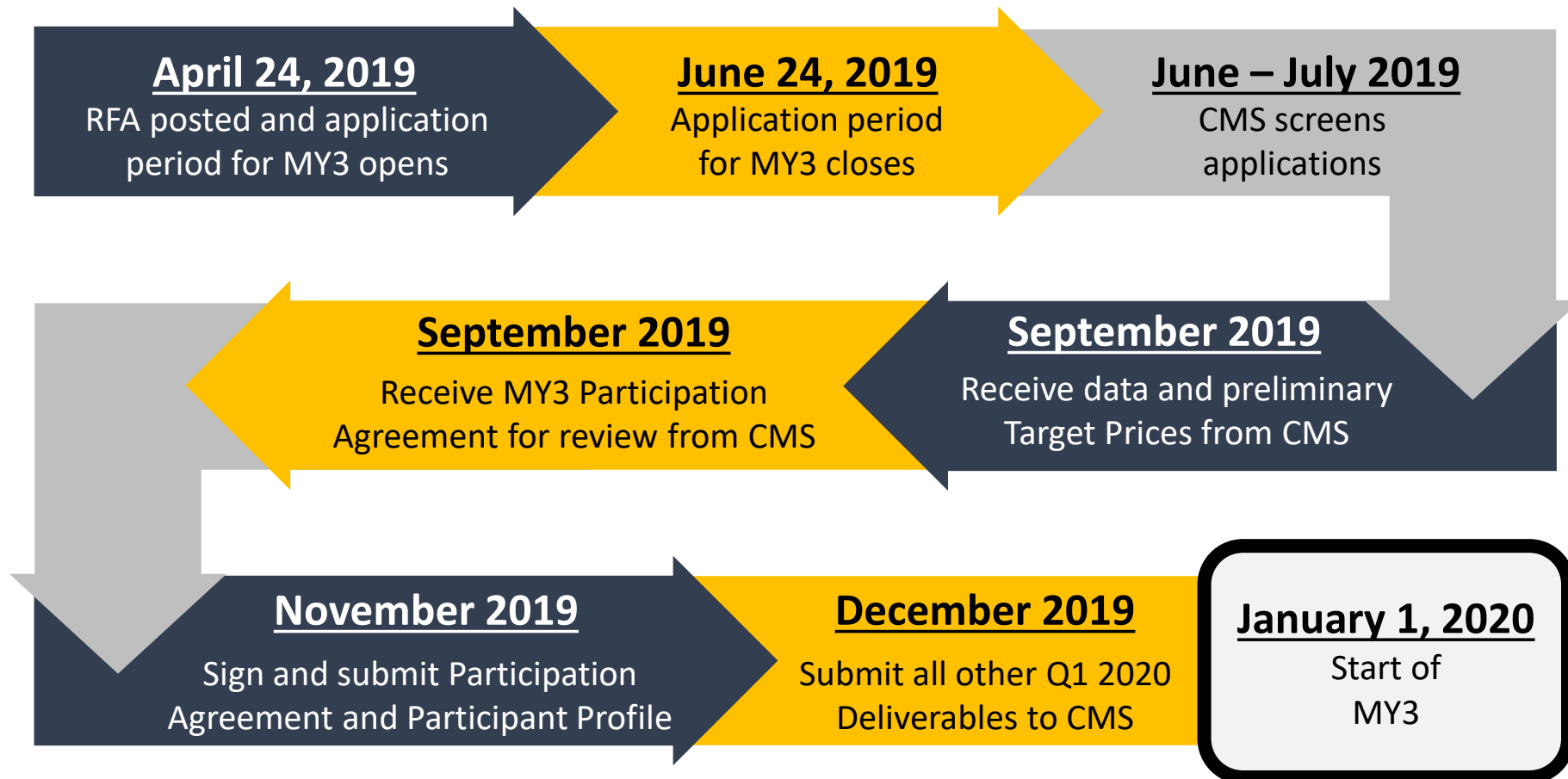


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Patient and Caregiver Engagement



Application Roadmap – Model Year 3 (MY3)



Who can participate in BPCI Advanced?



Two Types of Participants

Convener Participant



- Brings together Downstream Episode Initiators (EIs)
- Facilitates coordination
- Bears and apportions financial risk

Non-Convener Participant



- Is the EI
- Bears financial risk only for itself
- Does not bear risk on behalf of Downstream EIs

Episode Initiators (EIs)

An EI is a Medicare provider that can trigger Clinical Episodes by the submission of a claim for either an inpatient hospital stay (Anchor Stay) or an outpatient procedure (Anchor Procedure).

**Acute Care Hospitals
(ACHs)**



**Physician Group
Practices (PGPs)**



Who cannot participate in BPCI Advanced?

- Critical Access Hospitals (CAHs)
- Prospective Payment System (PPS)-exempt Cancer Hospitals
- Inpatient Psychiatric facilities
- Hospitals in Maryland
- Hospitals in the Rural Community Hospital Demonstration
- Hospitals in the Pennsylvania Rural Health Model



Episode Attribution

1



Attending PGP

2



Operating PGP

3



ACHs

BPCI Advanced will not use time-based precedence rules

Advanced Alternative Payment Model (Advanced APM) Criteria



Financial Risk

- **Advanced APM:** bear risk for monetary losses of more than a nominal amount
 - **BPCI Advanced:** financially at risk for up to 20 percent of the final Target Price for each Clinical Episode



Certified Electronic Health Record Technology (CEHRT)

- **Advanced APM: use CEHRT**
 - **BPCI Advanced:** attest to using CEHRT prior to participation
 - **Non-hospital participants:** at least 75 percent of eligible clinicians in an entity must use certified health IT functions



Quality Measures

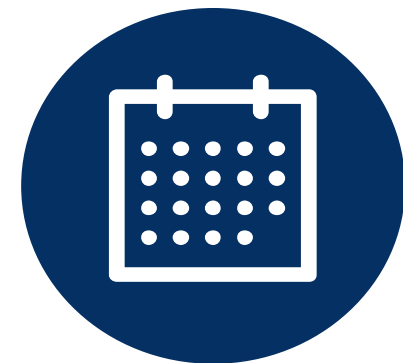
- **Advanced APM:** linked to quality measures comparable to Merit-Based Incentive Payment System measures
 - **BPCI Advanced:** CMS calculates a quality score for each quality measure at the Clinical Episode level
 - **Composite Quality Score (CQS):** these scores are volume-weighted and scaled across all Clinical Episodes attributed to a given EI



Qualified APM Participants (QPs)

Since BPCI Advanced is an Advanced APM, eligible clinicians who meet the patient count or payment thresholds under the Model may become Qualified APM Participants (QPs) and be eligible to receive the 5 percent APM Incentive Payment.

**The first date for QP determination
will be 03/31/2020**



QP Determinations

Participant Type	QP Determination
Non-Convener Participants that are ACHs	Eligible clinicians listed on the QPP Affiliated Practitioner List will be assessed individually for purposes of QP determinations
Non-Convener Participants that are PGPs	Eligible clinicians listed on the QPP Participation List will be assessed as a group for purposes of QP determinations
Convener Participants that have only ACHs as Episode Initiators	Eligible clinicians listed on the QPP Affiliated Practitioner List will be assessed individually for purposes of QP determinations
Convener Participants that have only PGPs as Episode Initiators	Eligible clinicians listed on the QPP Participation List will be assessed as a group for purposes of QP determinations

QP Determinations

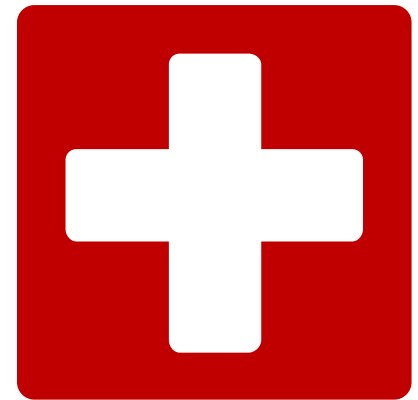
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Participant Type	QP Determination
Convener Participants that have ACHs and PGPs as Episode Initiators	Eligible clinicians listed on the QPP Participation List will be assessed as a group for purposes of QP determinations. Eligible clinicians listed on the QPP Affiliated Practitioners List <u>will not</u> be assessed for QP determinations.

In order for ACH eligible clinicians to be assessed for QP determinations, Convener Participants may choose to enter into separate Participation Agreements with CMS. If a Convener Participant chooses to do this, they must submit separate applications for each Participation Agreement they would like to have with CMS.

Additional information about QP determinations can be found on the CMS QPP website: <https://qpp.cms.gov/>

Defining the Clinical Episodes in BPCI Advanced



Definition of Clinical Episodes



Anchor Stay: inpatient stay at an ACH with a qualifying MS-DRG billed to Medicare FFS by an EI

- *Clinical Episode length: Anchor Stay + 90 days, with 90 days starting on the day of discharge*



Anchor Procedure : outpatient procedure (identified by a Healthcare Common Procedure Coding System (HCPCS) code) on an associated Hospital Outpatient facility claim billed to Medicare FFS by an EI

- *Clinical Episode length: Anchor Procedure + 90 days beginning on the day of completion of the outpatient procedure*

31 Inpatient Clinical Episodes

Spine, Bone, and Joint

- Back and neck except spinal fusion
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Hip and femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- **Major joint replacement of the lower extremity (MJRLE)****
- Major joint replacement of the upper extremity
- **Spinal fusion***

Kidney

- Renal failure

Infectious Disease

- Cellulitis
- Sepsis
- Urinary tract infection

Neurological

- **Seizures***
- Stroke

*New Clinical Episode in MY3

**This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.

31 Inpatient Clinical Episodes

(Continued)

Cardiac

- Acute myocardial infarction
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Congestive heart failure
- Coronary artery bypass graft
- Pacemaker
- Percutaneous coronary intervention
- **Transcatheter Aortic Valve Replacement***

Pulmonary

- COPD, bronchitis, asthma
- Simple pneumonia and respiratory infections

Gastrointestinal

- **Bariatric Surgery***
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- **Inflammatory Bowel Disease***
- Major bowel procedure

4 Outpatient Clinical Episodes

- Back and Neck, except Spinal Fusion
- Cardiac Defibrillator
- **Major joint replacement of the lower extremity (MJRLE)****
- Percutaneous Coronary Intervention



**This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.

Items and Services Included in a Clinical Episode



Part A and Part B non-excluded items and services furnished:

- during the Anchor Stay or Anchor Procedure
- 90-day period following the Anchor Stay or Anchor Procedure, including hospice services and related and unrelated readmissions



Clinical Episodes triggered by an Anchor Stay:

- hospital diagnostic testing and certain therapeutic services up to three days prior to Anchor Stay
- charges from that Emergency Department (ED) visit and if transferred from another facility's ED

Types of Items and Services Included in a Clinical Episode*

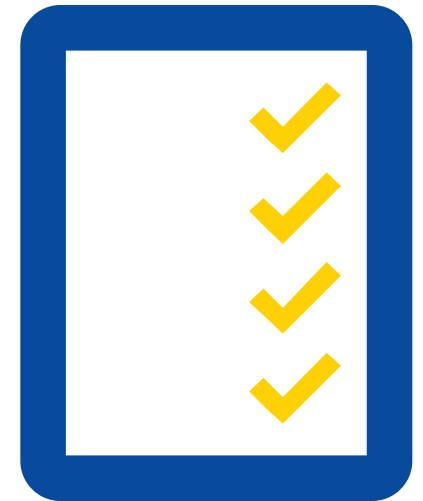
- Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Other hospital outpatient services, inpatient hospital readmission services
- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Clinical laboratory services
- Durable medical equipment (DME)
- Part B drugs*
- Hospice services
- Long-term care hospital (LTCH) services
- Physicians' services

*Unless specifically excluded



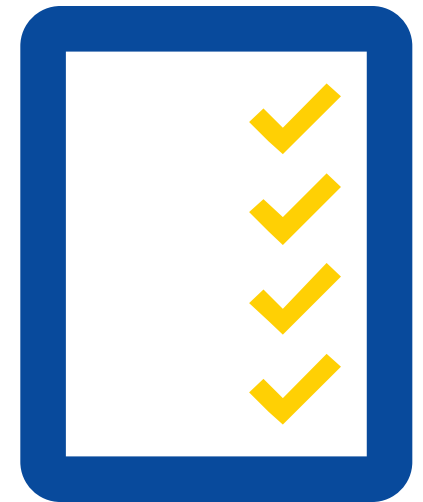
Items and Services Excluded from a Clinical Episode

- Part A and Part B services furnished during certain specified ACH admissions and readmissions (i.e., an admission assigned at discharge to MS-DRGs for organ transplants, major trauma, cancer-related care, ventricular shunts)
- New technology add-on payments under the Hospital Inpatient Prospective Payment System
- Payments for items and services with pass-through payment status under the Outpatient Prospective Payment System
- Payment for blood clotting factors to control bleeding for hemophilia patients



Beneficiary Level Exclusions from a Clinical Episode

- Services furnished to Medicare beneficiaries:
 - Covered under managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations)
 - Eligible on the basis of end-stage renal disease (ESRD)
 - Whose primary payer is not Medicare
 - Who die during the Anchor Stay or Anchor Procedure, or
 - Not enrolled in Medicare Part A or Part B for the entire Clinical Episode



Readmission Exclusions from a Clinical Episode

Single List of MS-DRGs, including:

- Transplant and Tracheostomy
- Trauma
- Cancer (when explicitly indicated by MS-DRG)
- Ventricular Shunts

Transfer Rule

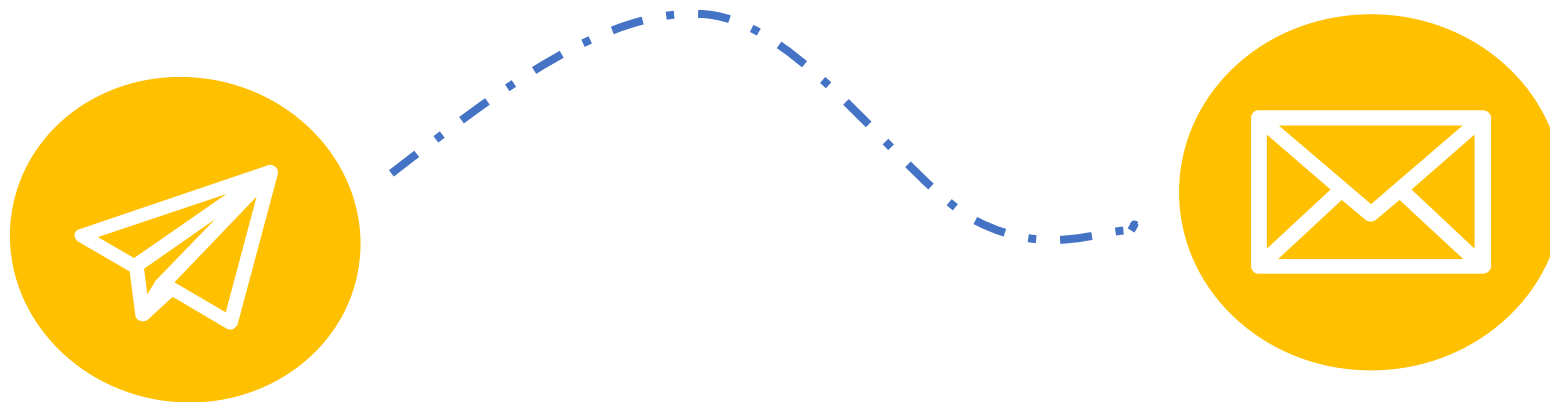
One continuous hospitalization:

1. Admission to the first hospital
 - Clinical Episode begins
 - Clinical Episode is assigned to the provider of the first part of the transfer
2. Hospital transfer occurs
3. Discharge from the second hospital
 - Post-discharge 90-day period begins
 - MS-DRG assigned from the last part of the ACH transfer

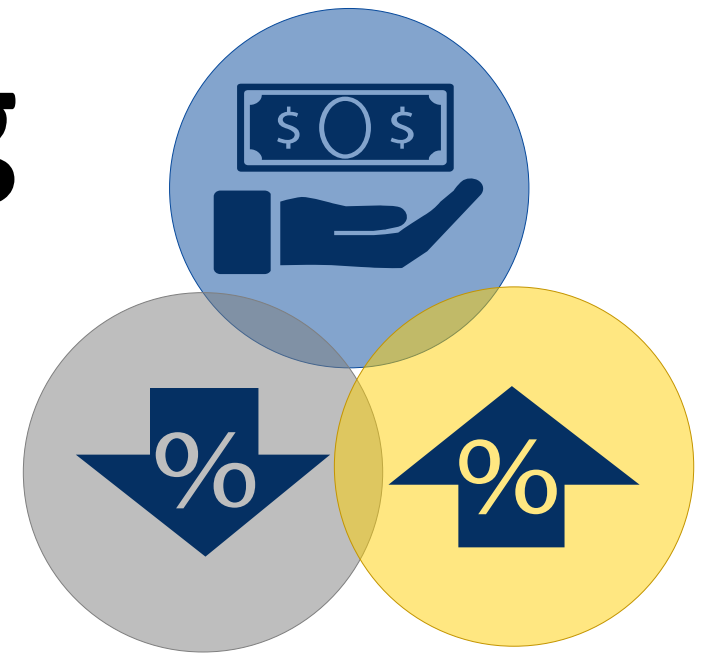


Selection of Clinical Episodes “Participant Profile”

Applicants' selections of Clinical Episodes and Episode Initiators, as applicable, will be identified on the Participant Profile, due approximately 60 days before the start of MY3.



Payment and Pricing Methodology for BPCI Advanced



ACH's Benchmark Price

To determine the EI-specific Benchmark Price for an ACH, CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode:



1. Patient case-mix



2. ACH's characteristics



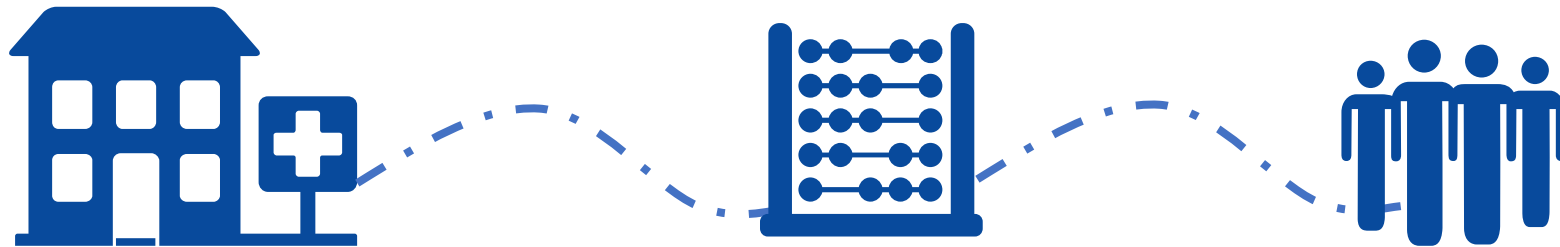
3. Projected trends in spending among ACH's peer group



4. Historical Medicare FFS expenditures specific to the ACHs Baseline Period

PGP's Benchmark Price

BPCI Advanced will base the PGP's Benchmark Prices on the Benchmark Prices for the ACHs where its Anchor Stays or Anchor Procedures occur. CMS will adjust each ACH-specific Benchmark Price to calculate a PGP-ACH-specific Benchmark Price that accounts for the PGP's historical spending patterns and the PGP's patient case mix, each relative to the ACH.



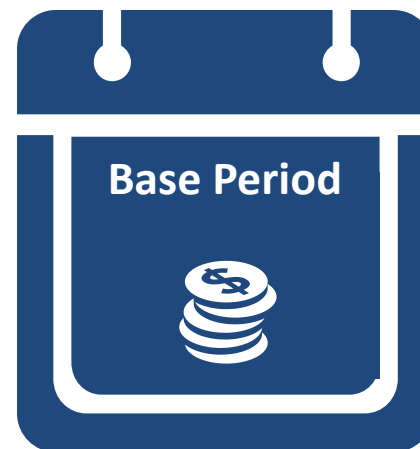
Target Price Calculations

$$\text{Target Price} = \text{Benchmark Price} \times (1 - \text{CMS Discount})$$

- CMS Discount = 3 percent for all Clinical Episodes
- Preliminary Target Prices will be provided prospectively
- Final Target Price will be set retrospectively at the time of Reconciliation by replacing the historic patient case mix with the actual patient case mix in the Performance Period

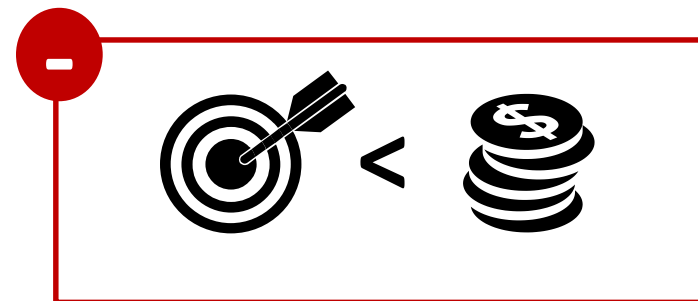
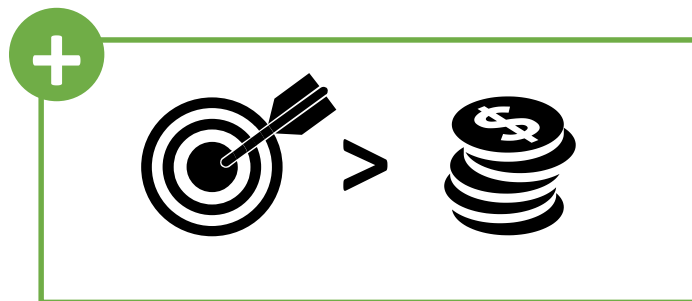
Risk Track

- The cap will apply to Clinical Episodes at the 1st and 99th percentile of spending
- The cap will apply to Clinical Episodes in both the Performance Period and the Baseline Period



Reconciliation

- Reconciliation is based on comparing actual Medicare FFS expenditures to the final Target Price
- If all non-excluded Medicare FFS expenditures for a Clinical Episode for which the Participant is held accountable are less than the final Target Price for that Clinical Episode, there will be a Positive Reconciliation Amount
- If all non-excluded Medicare FFS expenditures for the Clinical Episode are greater than the final Target Price, there will be a Negative Reconciliation Amount



Reconciliation

(Continued)

- The Positive or Negative Total Reconciliation Amount for an EI is then adjusted based on quality performance, resulting in the Adjusted Positive or Negative Total Reconciliation Amount
- For Non-Convener Participants, the Adjusted Positive Total Reconciliation Amount is the Net Payment Reconciliation Amount (NPRA) that CMS pays to the Participant
- In Model Year 3, CMS will continue to apply the 10 percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount. However, the 10 percent cap is subject to change



Reconciliation

(Continued)

- If this calculation instead results in an Adjusted Negative Total Reconciliation Amount for Non-Convener Participants, this amount is the Repayment Amount that Participants pay to CMS
- For Convener Participants, CMS will net all Adjusted Positive Total Reconciliation Amounts against all Adjusted Negative Total Reconciliation Amounts for the Participant's EIs to calculate either the NPRA or Repayment Amount



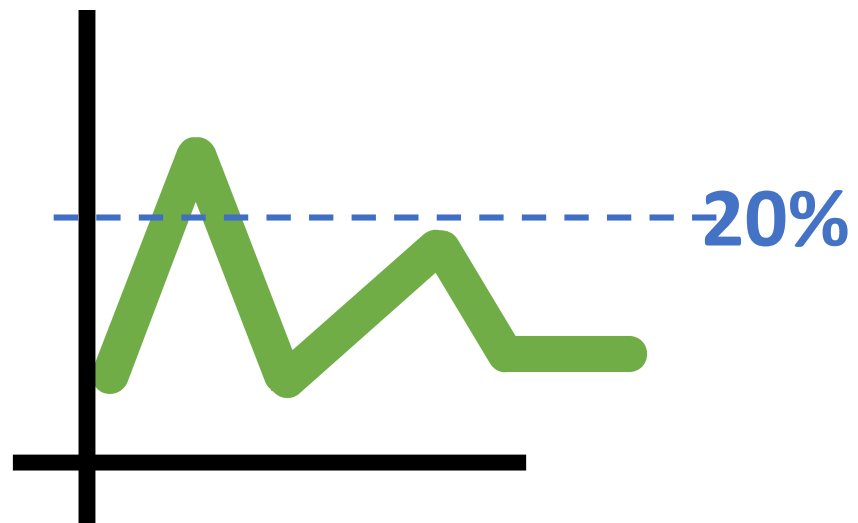
Frequency of Reconciliation

- Semi-Annually with two “True-Ups” to allow for claims run-out
- Clinical Episodes will be reconciled based on the Performance Period in which the Clinical Episode ends
- **First Performance Period of a Model Year:** Clinical Episodes that end during the period of January 1 – June 30
- **Second Performance Period of a Model Year:** Clinical Episodes that end during the period of July 1 – December 31



Stop-Loss/Stop-Gain Limits

NPRA payments and Repayment Amounts are subject to a 20 percent Stop-Gain/Stop-Loss provision at the EI level.



Waivers

- **Fraud and Abuse Waivers**: Certain Fraud and Abuse laws are waived so that Participants and their partners have the flexibility to negotiate and enter into certain Financial Arrangements or furnish beneficiary engagement incentives under BPCI Advanced
- **Payment Policy Waivers**:
 - 3-Day SNF Rule
 - Telehealth
 - Post-Discharge Home Visit



Quality Measures



Quality Measures

Administrative Quality Measures Set

- Used in Model Years 1 and 2, and continued in MY3
- Includes only claims-based measures directly collected by CMS

Alternate Quality Measures Set

- CMS is considering for MY3
- Includes a combination of claims-based and registry-based measures

All Participants, regardless of the measure set they select, will be accountable for no more than five quality measures per Clinical Episode.

Monitoring and Evaluation

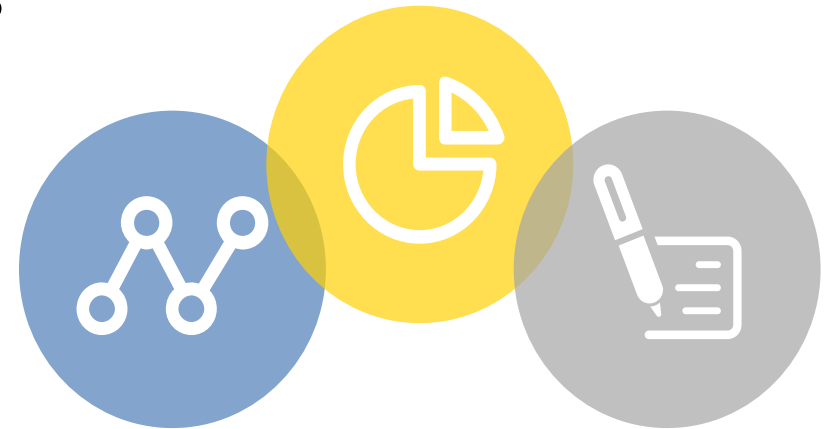


Monitoring and Evaluation

CMS may monitor Model performance by:

- Tracking claims data and medical reviews
- Ad hoc reviews and analysis of financial and quality performance measurements
- Site visits, surveys and interviews with Participants, EIs, Participating Practitioners, Beneficiaries, and other parties

CMS will conduct an independent evaluation to assess the changes in quality of care and spending under BPCI Advanced.



Post-Episode Monitoring Period

- **Time period:** 30 days following the Clinical Episode end date
- **Services included:** All Part A and Part B services
- **Trigger threshold:** 99.5 percent confidence interval around expected spending, estimated using historical data
- **Recourse:** Participant must repay CMS the total amount identified as excess spending



CMS Innovation Center Learning System



Learning System Functions

1



Identify and package
new knowledge and
best practices

2



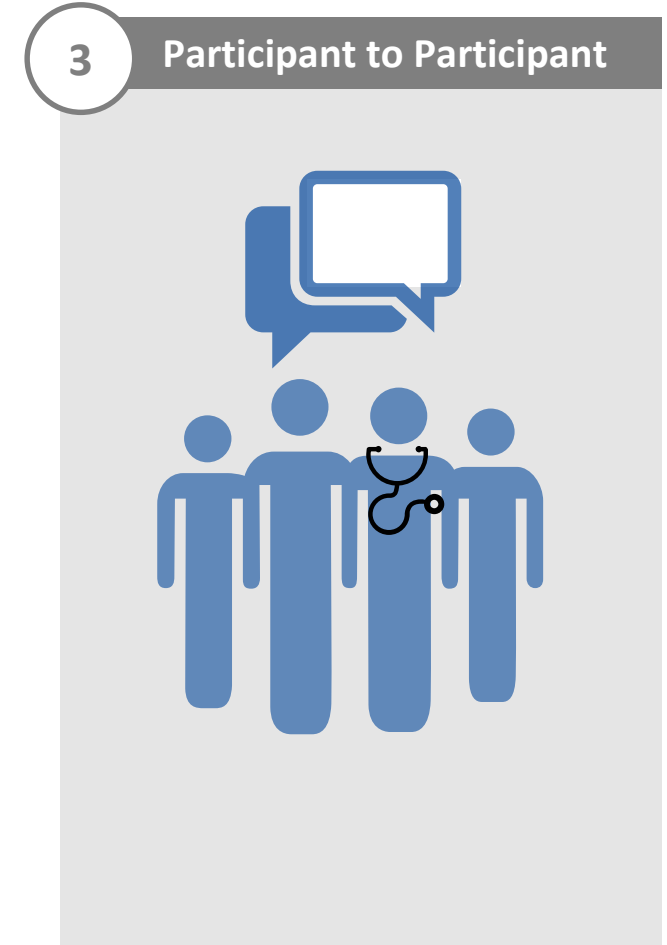
Leverage data
and participant
input to guide
change and
improvement

3



Build learning
communities and
networks to share new
knowledge and practice

Three-way Channel of Engagement to Drive Success



Portals

- **BPCI Advanced Application Portal:** This is the web-based platform for Applicants to complete and submit applications. Opened April 24, 2019 and closed June 24, 2019



<https://app1.innovation.cms.gov/bpciadvancedapp>

- **BPCI Advanced Participant Portal:** This is a web-based platform current Participants use to submit legal documents and Model deliverables



<https://app1.innovation.cms.gov/bpciadv>

- **Data Portal:** This is the web-based platform used to obtain monthly claims files, Target Price data, and eventually reconciliation workbooks



<https://portal.cms.gov>

Questions and Feedback

- If you have questions about this presentation, or the application process, please contact the BPCI Advanced Model Team at BPCIAdvanced@cms.hhs.gov
- Additional information can be found at the CMS Innovation Center website: <https://innovation.cms.gov/initiatives/bpci-advanced>

