Bundled Payments for Care Improvement Advanced (BPCI Advanced) Quality Methodology Webcast Transcript

Dr. Steven Farmer: Welcome to our next webcast in the BPCI Advanced Series titled Quality Methodology.

During today's webcast we will first do a quick overview of the BPCI Advanced Model. We will then shift to a discussion of quality measurement within the model. After a discussion of how quality measures will be applied in BPCI Advanced, we will walk through an example before summarizing.

To begin, let's do a quick overview of BPCI Advanced to reorient you to the model.

Bundled Clinical Episodes represent a shift in how we typically think about care. Care is designed around the patient's overall need, instead of being viewed from the vantage point of where services are delivered. In the new model, Episode Initiators will deliver patient care during the anchor hospitalization or procedure and will take leadership and accountability for the patients care over the next 90 days. Clinical Episodes are assessed based on both the quality and cost of care.

Clinical Episodes are intended to promote a patient centered approach to care, and the episode concept better reflects the way that patients experience their care. For Episode Initiators, Clinical Episodes are also clinically intuitive, concrete, and actionable. In the model, Episode Initiators are leading and coordinating care for a defined patient, with a specific condition, over a defined time period. We have developed BPCI Advanced based on important insights gleaned from the original BPCI model. The new model is intended to provide an Advanced Alternative Payment Model, and Merit Based Incentive Payment System, or MIPS, APM opportunity for specialty physicians.

BPCI Advanced has a streamlined design. There is one model and all episodes include a 90-day post anchor period. There is a single risk track, and payment is tied to performance on quality measures. Responsive to stakeholder feedback, target prices are largely set in advance. Target prices are modified after the fact, only to account for the complexity of patients actually treated during the period of performance. We recognize that physicians are crucial to success in the model, and the model emphasizes physician engagement and learning. Lastly, BPCI Advanced is designed as an Advanced APM under the Quality Payment Program.

In a prior webcast, we reviewed how target prices are set within the model. Now, let's discuss how quality is applied to the model.

Remember that the CMS Innovation Center models are intended to reduce expenditures while preserving or enhancing quality. There are three scenarios for success. First, we improve quality with no impact on expenditures. Second, we have no impact on quality but successfully decrease expenditures. The third scenario is the best case, in which our model both increases quality and decreases expenditures. If any of these three scenarios are met, the Secretary of Health and Human Services may expand the model to the broader Medicare population.

Alternative payment models are intended to better align payment with the value of care delivered. The concept of value incorporates both quality and expenditure elements. To align payment with value, BPCI Advanced Positive or Negative Total Reconciliation Amounts are adjusted for performance on quality measures. In the first model year, this quality adjustment will be limited to a maximum of 10%.

Over the past several years, CMS has worked to improve the quality measures aligned with the Quality Payment Program, or QPP. These changes benefit both clinicians and patients in several ways. For clinicians, these changes intend to streamline reporting, standardize measures, eliminate duplicative reporting, align measures across payers wherever possible, and incorporate incentives for improved care quality. For patients, these changes are intended to increase access to high quality care, improve care coordination, and improve outcomes of care.

For years one and two, the model includes three measures that apply to all Clinical Episodes, both inpatient and outpatient. These are the hospital wide, all-cause, unplanned, readmission measure, or NQF 1789, the care plan, NQF 0326, and the CMS patient safety indicator measure NQF 0531. Note that the care plan measure has been modified from the NQF endorsed version to better align it with the model. Instead of assessing performance at the physician level, in the model, we will assess performance at the Episode Initiator level. The remaining four measures apply more narrowly to specific clinical circumstances. Several apply only to selected surgical admissions, including the hospital level risk standardized complication rate following primary total hip arthroplasty, and/or total knee arthroplasty, measure NQF 1550. And the hospital 30-day all-cause, risk standardized mortality rate following coronary artery bypass surgery, or NQF 2558. One applies only to acute myocardial infarction, specifically, the excess days in acute care after hospitalization for acute myocardial infarction, or NQF 2881.

The selection of prophylactic antibiotic, first or second-generation cephalosporin, or NQF 0268 measure, applies to surgical episodes, as defined on this slide. Note that while implantable cardiac defibrillator, and pacemaker implantation's, both involve surgery, the measure has not historically been applied and the data are not readily available.

As I previously mentioned, all of these measures are tracked through administrative claims. Five are repurposed from the Inpatient Quality Reporting System, the Perioperative Care measure will be pulled from the MIPS QCDR or a G Code. It is important to know that the Advance Care Plan Measure will be calculated based on submitted claims, and many participants may not yet be submitting the associated CPT, or Category Two CPT Code. Also, note that we will count the measure if a claim is submitted either during the Clinical Episode, or during the prior nine months by any physician or Advanced Practice Provider, regardless of whether they are participating in BPCI Advanced. The point of the measure is to assure that patients in the model have a documented advanced directive.

The use of administrative claims to assess quality within the model has important implications for the timing of quality assessment and of payment adjustment. Administrative claims are finalized only after a considerable lag, and so quality adjustment for the 2019 performance year will not be applied until the true up in the fall of 2020. 2017 and 2018 data will be provided to participants for benchmarking purposes, but actual measure performance will be assessed by calendar year beginning in 2019.

The current administration has championed patients over paperwork and burden reduction for clinicians. Consequently, all quality measures in the model will be derived from administrative claims through 2020. Additionally, the measure set must meet specific requirements to qualify as an Advanced APM, including the use of at least one outcome measure. Even so, the CMS Innovation Center aims to improve on our quality strategy for the 2020 model year and beyond. We may add additional measures in the future, potentially with differing reporting mechanisms.

The Innovation Center is working with clinicians to refine the quality measures aligned with the model. In this discussion, we have set several aspirational goals, notably, measures should be evidence based and have a clear relationship to quality. Measure sets should be timely, actionable, and should reflect care delivered within the model. Measures selection should minimize participant burden. And finally, data must be readily available for incorporation into the model.

In this next section, I will turn the presentation over to my colleague to illustrate how the measures are actually applied to the model.

Elizabeth Currier: BPCI Advanced includes 29 inpatient and 3 out-patient Clinical Episodes. There's a real diversity of patients and conditions, and not all quality measures apply to all Clinical Episodes. Consequently, performance on individual quality measures is only compared within the same Clinical Episode.

Measure performance within Clinical Episodes is compared against Episode Initiator peers. Relative performance is assessed by converting raw performance scores into a scaled score that is grouped by decile.

After raw performance for individual quality measures is converted to a scaled score, individual quality measure scaled scores are combined into a quality score for each Clinical Episode. For example, for a COPD Clinical Episode, the hospital wide, all-cause, unplanned, readmission measure, the care plan, and the CMS PSI 90 measures apply. Scores on each of these three measures are rolled up into a quality score for the COPD Clinical Episode. But, many Episode Initiators will participate in multiple Clinical Episodes. The Episode Initiator on this slide is participating in COPD, heart failure, total knee arthroplasty, and sepsis Clinical Episodes.

Quality scores for each of these Clinical Episodes are rolled up into a Composite Quality Score, or CQS, at the Episode Initiator level. In this example, for simplicity, we've assumed equal episode volumes for each of the four Clinical Episodes. But, if you have variable volume across Clinical Episodes, the Composite Quality Score will reflect a weighted average of quality score performance from the individual Clinical Episodes.

In the final step, Composite Quality Score performance, again, CQS, at the Episode Initiator level, is compared against CQS scores attained by Episode Initiator peers. Relative CQS performance is converted through a scaler function to an adjustment percentage that will be applied to either Positive or Negative Net Total Reconciliation amounts.

Now let's review a concrete example to illustrate how this all works. I'll walk through each of the steps in-turn.

In the first step, we convert raw quality measure data into a scaled score by decile. The scaled score compares performance scores against Episode Initiator peers. This conversion allows valid comparisons across measures that have very different values and ranges.

In the second step, scaled scores for individual quality measures are rolled up into a Quality Score. The Quality Score reflects the mean of individual quality measure scaled scores and a Quality Score will be calculated for each Clinical Episode. Within each Clinical Episode, all included measures are weighed equally.

In the third step, quality scores for individual Clinical Episodes are rolled up into a composite quality score at the Episode Initiator level. Quality scores for individual Clinical Episodes are weighted by volume.

In the fourth step, the CQS score is assigned an adjustment amount.

In the fifth step, the total positive or negative reconciliation amount is multiplied by the CQS adjustment amount to reach either the Net Payment Reconciliation amount, or Repayment Amount. This step, again, occurs at the Episode Initiator level.

The sixth step applies only to Convener Participants. Here, the Net Payment Reconciliation amounts, or Repayment Amounts, for multiple Episode Initiators are combined.

In the final step, each participant, whether a Non-Convener Participant, or a Convener Participant, will receive a Net Payment Reconciliation amount, or owe back a Repayment Amount.

Let's go through a concrete example, beginning with the first step.

Each Clinical Episode has three or more aligned quality measures. In this example, the Coronary Artery Bypass Grafting, or CABG, Clinical Episode, has five individual measures. We will calculate the actual scores for each of these measures and then convert them to a scaled score, by decile, relative to a national cohort.

In the second step, we roll the scaled scores up into a quality score for the Clinical Episode. Each of the included measures is weighted equally, and the Quality Score is the mean of the individual Quality Scores. Remember that many Episode Initiators will participate in multiple Clinical Episodes. In this example, an Acute Care Hospital is the Episode Initiator and is participating in both a CABG Clinical Episode and a heart failure Clinical Episode. Note that heart failure Clinical Episode has three aligned quality measures, while the CABG Clinical Episode has five.

In the third step, the quality scores for the heart failure Clinical Episode and the CABG Clinical Episode are combined into a Composite Quality Score at the Episode Initiator level. Also, note that while an Episode Initiator may participate in multiple Clinical Episodes, the volumes for each of those Clinical Episodes may vary. In this example, the Episode Initiator led 30 heart failure Clinical Episodes and 20 CABG Clinical Episodes. The quality scores for each of the Clinical Episodes are weighted by volume when they are combined into a composite quality score for the Episode Initiator.

Let's use a Physician Group Practice Episode Initiator as a second example. Like the previously described Acute Care Hospital Episode Initiator, the PGP Episode Initiator is also participating in

both the heart failure and CABG Clinical Episodes. But while an Acute Care Hospital Episode Initiator can only initiate episodes from their own facility, a Physician Group Practice may initiate episodes from multiple Acute Care Hospitals. Thus, the calculation is different for PGP's that practice at multiple hospitals. Here, a Quality Score is calculated for each Clinical Episode, at each Acute Care Hospital, where the Physician Group Practice initiates Clinical Episodes.

A PGP level quality score for each Clinical Episode is calculated based on a weighted average of scores, drawn from each of the hospitals where Clinical Episodes were initiated. In this example, the PGP initiated more heart failure Clinical Episodes at hospitals two and three then at hospital one. And so, hospitals two and three carry more weight in the Clinical Episode Quality Score than hospital one. Then, as we did in our Acute Care Hospital example, the Quality Scores for both the heart failure and CABG Clinical Episodes are combined into a Composite Quality Score for the PGP.

To reach a composite Quality Score, Clinical Episodes are weighted by the overall volumes of each Clinical Episode. In this example, there were 50 heart failure and 70 CABG Clinical Episodes.

In step four, the CQS is assigned a payment adjustment percentage. In this first example, both Episode Initiators successfully saved money, relative to their respective target prices. The Net Positive Reconciliation amounts for both of them will be adjusted for performance on their respective Composite Quality Scores.

Participant A did very well on their CQS and will receive 98% of their net positive reconciliation amount. Participant B attained a more average CQS score and will receive 95.7% of their Net Positive Reconciliation amount. Remember that for model years one and two, the quality adjustment is limited to 10%.

Let's also look at two examples where the Episode Initiators led Clinical Episodes that cost more than their respective target prices. Both participants have a Net Negative Reconciliation amount. In this example, participant A did very well on their CQS, and as a result, they will only owe 92% of their Net Negative Reconciliation amount back to CMS. Participant B attained a more average CQS score and will owe back more of their Net Negative Reconciliation amount, or 94.3%. In effect, if you cost more than your target price, you get credit for the quality of the care provided within the episodes.

Putting this all together, let's look at two Episode Initiator examples where both achieved average Composite Quality Scores, and were assigned a 5% adjustment percentage. Both Episode Initiators participated in four Clinical Episodes, but the first Episode Initiator led episodes that, together, cost less money than their target prices. By contrast, the second Episode Initiator led episodes that, together, cost more money than their target prices.

Example one has a Net Positive Total Reconciliation amount, which is multiplied by the assigned adjustment percentage, to reach an adjusted positive total reconciliation amount. The first participant will receive a payment for 95% of the difference between their realized cost, and the target cost. They will receive a Net Payment Reconciliation amount as an additional payment from CMS.

Example two has a Net Negative Total Reconciliation amount, which is also multiplied by the adjustment percentage, to reach an Adjusted Negative Total Reconciliation amount. In other words, the second participant led episodes that cost more than the target prices for their Clinical Episodes. Since they had average quality performance, their obligation to CMS is reduced. After adjusting for quality, they will owe 95% of the difference between their realized costs and the target price for their Clinical Episodes. They will owe a Repayment Amount back to CMS.

In the previous examples, Episode Initiators, whether they were Acute Care Hospitals or Physician Group Practices, were participating on their own. But many Episode Initiators will choose to work with a Convener. All of the same steps for Non-Convener participants also apply to Convener participants, but there is one last step. For Convener participants, the Adjusted Positive Total Reconciliation amounts, and Adjusted Negative Total Reconciliation amounts from each Episode Initiator that works with them are combined into a single Net Payment Reconciliation amount, or, Repayment Amount, at the Convener level. In this example, aggregation of all Episode Initiator amounts results in a Positive Net Payment Reconciliation amount.

In this webcast we reviewed the details of how quality is assessed within Clinical Episodes and how quality effects payment. Now let's summarize.

This quality methodology webcast highlights core concepts in the model and is intended for clinicians and administrators. BPCI Advanced establishes responsibility and leadership for Clinical Episodes and we hope it will lead to a more seamless patient experience that both saves money and improves outcomes. BPCI Advanced is a new, voluntary, Advanced APM, and a MIPS APM. As such, payments are linked to both quality and cost performance in the model. Successful participants may receive additional payments beyond their standard fee for service billings, if things go well, but they may owe money back if they don't.

Thank you for joining us for today's webinar. Please visit the Innovation Center website for more learning and information around BPCI Advanced.