Bundled Payments for Care Improvement Advanced | BPCI Advanced

Model Year 4 Pricing Methodology Changes

September 2020

What's Changing?

CMS is making five important changes to its pricing methodology in Model Year 4 (MY4). This document provides an overview of what they mean for BPCI Advanced Participants.

The changes are:

1. Realized Trend Adjustment to the Peer Group Trend Factor

2. Modified Clinical Episode Overlap Methodology

3. Clinical Episode Service Line Groups (CESLGs)

4. Removal of the Physician Group Practice (PGP) Offset

5. Changes to MJRLE Risk Adjustment

Why are changes being made?

The BPCI Advanced Model is improving the way that Target Prices are calculated in Model Year 4 to ensure that BPCI Advanced Reconciliation payments reflect actual decreases in spending due to Care Redesign. The changes described in this document will help make BPCI Advanced less susceptible to unpredictable changes in policy, coding, and clinical practice in future Model Years.

1 Realized Trend Adjustment to the Peer Group Trend (PGT) Factor (10% cap)

BPCI Advanced Target Prices use peer groups to benchmark providers against other providers with similar hospital-level characteristics. Peer groups are determined by hospital characteristics, such as safety net hospital status, major teaching hospital status, geographic region, urban versus rural location, and size by bed count. The current Target Price component called the Peer Group Trend (PGT) factor relies on a prospective trend calculated from baseline period data and projected forward.

What does this change mean? In MY4, CMS will adjust final Target Prices at Reconciliation for peer group trends realized in Performance Period Clinical Episode spending. CMS will cap the difference between the realized PGT factor from the preliminary PGT factor at 10 percent of the preliminary trend. Capping the deviation from the preliminary PGT factor, as compared to applying the full realized PGT factor, creates some predictability and stability in Target Prices.

The realized trend adjustment will be applied to the PGT factor while the Peer Group Historical Adjustment (PGHA) will account for level differences in the average patient case-mix adjusted spending between peer groups in the baseline period. This approach will help to ensure that Participants are rewarded for improvements outside of peer group trends and not penalized for peer group trends that lead to greater spending over time.

You can find an example of how CMS will apply the 10% Cap on the Realized Trend Adjustment on page 3.

Model Year 4 Pricing Methodology Changes, Continued

2 Modified Clinical Episode Overlap Methodology

Currently, Clinical Episodes in the baseline period are allowed to overlap and are attributed to both non-Participants and Participants. Such overlap is not permitted during the Performance Period; instead, Clinical Episodes are preferentially attributed to Participants. This overlap methodology maximizes the number of ACHs eligible for the Model and also maximizes the number of Clinical Episodes attributed to Participants in the Performance Period.

What does this change mean? In MY4, Clinical Episodes will not overlap in either the baseline or Performance Period and will be attributed without regard to participation status in both periods. This change will create consistency in the way that Clinical Episodes are constructed in both the baseline and Performance Periods and has the potential to improve Target Price accuracy. However, this change may reduce the number of eligible ACHs and the number of Clinical Episodes attributed to Participants in the Performance Periods.

3 Clinical Episode Service Line Groups (CESLGs)

Currently, Participants choose to participate in and are held accountable for any number of Clinical Episode categories that are indicated in their Participant Profiles.

What does this change mean? In MY4, Participants will be required to select Clinical Episode Service Line Groups (CESLGs), instead of one or more Clinical Episode categories. Participants will not be conditionally required to participate in Clinical Episodes categories, within any CESLG, that do not meet the minimum volume threshold during the baseline period. To be accountable for a Clinical Episode Category within a CESLG, the Episode Initiators (EIs) who are acute care hospitals must trigger at least one Clinical Episode in the Performance Period and meet the minimum volume requirement in the baseline period. The EIs who are PGPs must trigger at least one Clinical Episode in the Performance Period at an acute care hospital that meets the minimum volume requirement in the baseline period.

The eight CESLGs are shown below.

Cardiac Care

- Acute Myocardial Infarction (AMI)
- Cardiac Arrhythmia
- Congestive Heart Failure

Cardiac Procedures

- Cardiac Defibrillator (Inpatient)
- Cardiac Defibrillator (Outpatient)
- Cardiac Valve
- Coronary Artery Bypass Graft (CABG)
- Endovascular Cardiac Valve Replacement
- Pacemaker
- Percutaneous Coronary Intervention (PCI - Inpatient)
- Percutaneous Coronary Intervention (PCI - Outpatient)

Spinal Procedures

- Back and Neck Except Spinal Fusion (Inpatient)
- Back and Neck Except Spinal Fusion (Outpatient)
- Spinal Fusion

Orthopedics

- 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 (Inpatient and Outpatient)
- Major Joint Replacement of the Upper Extremity

Gastrointestinal Surgery

- Bariatric Surgery
- Major Bowel Procedure

Gastrointestinal Care

- Disorders of the Liver Except Malignancy, Cirrhosis, or Alcoholic Hepatitis
- Gastrointestinal Hemorrhage
- Gastrointestinal Obstruction
- Inflammatory Bowel Disease

Neurological Care

- Seizures
- Stroke

Medical & Critical Care

- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Asthma
- Renal Failure
- Sepsis
- Simple Pneumonia and Respiratory Infections
- Urinary Tract Infection

Model Year 4 Pricing Methodology Changes, Continued

4 Removal of the Physician Group Practice (PGP) Offset

The PGP Offset is a component of the Target Price, and measures a PGP's efficiency relative to a specific hospital where the PGP initiates Clinical Episodes. This means that there's a separate PGP Offset for every hospital at which a PGP's Clinical Episodes are initiated. The PGP's efficiency is calculated as the mean of the ratio of observed to expected spending across all of the EI's baseline Clinical Episodes in the Clinical Episode category. For example, a less-efficient PGP will have a larger PGP Offset and thus a higher Target Price.

What does this change mean? CMS will remove the PGP Offset used in PGP Target Price construction. As a result, each Clinical Episode category at each eligible ACH will have a single Target Price that does not vary irrespective of the individual PGP who triggered the Clinical Episode. With the exception of the Patient Case Mix Adjustment (PCMA) for the average case mix specific to their subset of patients, the PGP's Target Prices (preliminary and final) will be the same as the ACH's Target Price. Removal of the PGP Offset simplifies the pricing methodology.

5 Changes to Major Joint Replacement of the Lower Extremities (MJRLE) Risk Adjustment

The current risk adjustment model that sets the MJRLE Target Prices systematically overpredicts spending on knee procedures and underpredicts spending on hip procedures.

What does this change mean? In order to improve the accuracy of payment for MJRLE Clinical Episodes, CMS will add the following procedure flags to the Model Year 4 risk adjustment model for the MJRLE: (i) Partial Knee Arthroplasty, (ii) Total Knee Arthroplasty, (iii) Partial Hip Arthroplasty, (iv) Total Hip Arthroplasty and Hip Resurfacing, and (v) Ankle and Reattachments and Others. CMS will also use combinations of flags, where applicable. These flags will help improve accuracy at the level of the procedure type and will improve the ability for the model to predict Target Prices as each procedure moves to the outpatient setting at different rates.

Example: How the 10% Cap for the Realized Trend Adjustment is to be Calculated

The realized trend adjustment caps the relative difference between the preliminary and realized peer group trend (PGT) factors at 10%. For example, if the preliminary Target Price has a preliminary PGT factor of 1.02, and the realized trend adjustment was 1.176 (without a cap), the uncapped PGT factor would be 1.20. However, since the realized trend adjustment will be capped at 1.10, the realized PGT factor will be calculated as follows:

$$\boldsymbol{Realized\ PGT\ factor} = \boldsymbol{Preliminary\ PGT\ factor} \times \boldsymbol{Realized\ Trend\ Adjustment}\ (\boldsymbol{Capped\ at}\ \mathbf{10}\%)$$

$$= 1.02 \times 1.10 = 1.122$$

In this example, the 10% cap applied to the realized trend adjustment limits the realized PGT factor to 1.122, down from 1.176, without a cap.