BPCI Advanced
Quality Methodology Webcast Script

Slide	Speaker	Topic	Script
1	Mark	Title Slide	Hello. My name is Dr. Mark Reardon, a physician on the CMS Innovation Center's Medical Officer Team, driving innovation in quality for Bundled Payments for Care Improvement Advanced, known as BPCI Advanced, and across the Innovation Center. My colleagues Justin Bondietti, an analyst on the BPCI Advanced Team, and Dr. Beth Chalick-Kaplan, a Nurse Practitioner and analyst on the team, welcome you to the BPCI Advanced Quality Methodology webcast and hope you find it informative.
2	Mark	Quality Measurement Goals	BPCI Advanced promotes the larger goals of the Department of Health and Human Services' National Quality Strategy, which are centered around better care, healthier people and communities, and smarter spending. Quality Measures enable providers, institutions, and CMS to track health care processes and resulting outcomes, gain insight into the patient and family experience, and identify opportunities for quality improvement.
3	Mark	Advanced Alternative Payment Model (APM)	BPCI Advanced also qualifies as an Advanced Alternative Payment Model, or APM, under Medicare's Quality Payment Program. To qualify as an Advanced APM a Model must meet three requirements: • The first is the use of Certified Electronic Health Record Technology, or CEHRT • Next, Model Participants must assume risk for monetary losses of more than a nominal amount • Finally, payments under the model must be linked to Quality Measures comparable to Merit-Based Incentive Payment System Quality Measures, called MIPS measures.
4	Mark	BPCI Advanced as an Advanced APM	As an Advanced APM, BPCI Advanced ties quality to payment through a series of steps. First, by calculating a quality score for each Quality Measure at the Clinical Episode level. Then these scores are volume-weighted, and scaled across all Clinical Episodes attributed to a given Episode Initiator to calculate an Episode

			Initiator-specific Composite Quality Score, or CQS. Finally, the CQS becomes part of a calculation to determine a financial adjustment to Positive or Negative Total Reconciliation Amounts.
5	**Mark**	**Promoting Quality in BPCI Advanced**	The use of Quality Measures within the model's design promotes improvements in care redesign, peer-to-peer collaboration, care coordination, and patient outcomes. The Model monitors quality through a select set of Clinical Episode-specific Quality Measures.
6	**Mark**	**BPCI Advanced Quality Measures Evaluation**	For BPCI Advanced, there are three important components within Model Quality. The first is the Quality Methodology, which is the relationship between the Model's Clinical Episodes and Quality Measures, the application of precedence rules for assigning Clinical Episodes, and the sources for Quality Measure data. The second is the CQS, which involves understanding how CMS calculates the CQS for Acute Care Hospitals, or ACHs, and for Physician Group Practices, or PGPs, as well as how CMS aggregates Quality Measure data and incorporates Clinical Episode volumes. The third is the Reconciliation process, which involves understanding how Quality Measures and the CQS impact Reconciliation in Fall 2020. This webcast covers the first topic, Quality Methodology. The other two topics are covered in other webcasts, available on the BPCI Advanced Participant Portal, in the Announcements Section. Now I'd like to hand it over to Justin to begin our Quality Methodology discussion in detail.
7	**Justin**	**Clinical Episode Overview**	Thanks Mark. Quality in BPCI Advanced begins with Clinical Episodes and how they're structured and triggered. To begin, I'd like to call your attention to new Clinical Episodes in the Model.
8	**Justin**	**New Features in Model Year 3**	CMS has added four new inpatient and one outpatient Clinical Episodes to the Model, bringing the total number of Clinical Episodes from 31 in Model Years 1 and 2 to 35 in Model Year 3. The new inpatient Clinical Episodes are: • Bariatric Surgery • Inflammatory Bowel Disease

			• Seizures, and • Transcatheter Aortic Valve Replacement The new outpatient Clinical Episode is major joint replacement of the lower extremity, or MJRLE, which is a multi-setting Clinical Episode triggered in both inpatient and outpatient settings. Additionally, starting in Model Year 3 there will be only one Spinal Fusion Clinical Episode, which is an update from Model Years 1 and 2.
9	**Justin**	**BPCI Advanced Model Year 3 Clinical Episodes**	The thirty-one inpatient Clinical Episodes cover a wide range of specialties and procedures that have been grouped into the following specialties: • Cardiac • Gastrointestinal • Infectious Disease • Kidney • Neurological • Pulmonary, and • Orthopedic The remaining four Clinical Episodes listed below initiate in the outpatient setting: • MJRLE • Percutaneous coronary intervention • Cardiac defibrillator, and • Back and neck surgery, except spinal fusion Again, MJRLE is a multi-setting Clinical Episode category. Total Knee Arthroplasty, or TKA, procedures can trigger Clinical Episodes in both inpatient and outpatient settings.
10	**Justin**	**Defining a Clinical Episode in BPCI Advanced**	The Model has separate definitions for Clinical Episodes in inpatient and outpatient settings. Inpatient Clinical Episodes begin with an Anchor Stay. Episode Initiators trigger inpatient Clinical Episodes when they file a claim for an inpatient stay that includes a qualifying Medicare Severity Diagnosis Related Group, or MS-DRG, code billed to Medicare Fee-for-Service, or FFS.

			The length of the Clinical Episode includes the Anchor Stay plus the 90 days post-discharge. The date of discharge is day one of this 90-day period. Similarly, outpatient Clinical Episodes begin with an Anchor Procedure. Episode Initiators trigger outpatient Clinical Episodes when they file a claim for an outpatient visit that includes a qualifying Healthcare Common Procedure Coding System, or HCPCS, code billed to Medicare FFS. The length of the Clinical Episode includes the Anchor Procedure, plus the following 90 days. The date that the Anchor Procedure is completed is day one of the 90-day period.
11	**Justin**	**Clinical Episode Attribution Process**	Many Participants have asked how they will know if a Clinical Episode belongs to them, since many different healthcare practitioners are involved in a patient's care. CMS uses a hierarchy that includes precedence rules to assign potential Clinical Episodes to Episode Initiators. We say "potential Clinical Episodes" because it's important to note that Clinical Episodes are not actually attributed to specific Episode Initiators until Reconciliation. First, prior to attribution, CMS identifies a potential Clinical Episode in claims data based on an Anchor Stay, or Anchor Procedure triggers which are DRGs or HCPCS codes. The Clinical Episode is created, and specifications are applied. Then, CMS applies Clinical Episode-level exclusions. At this time, CMS also analyzes patient level characteristics and eliminates some potential Clinical Episodes based on characteristics of the Beneficiary. For example, Clinical Episodes triggered by a Beneficiary with exclusionary characteristics are removed from the Model. Some examples of exclusionary characteristics are: Beneficiaries who were not continuously enrolled in Medicare Part A and Part B during the Clinical Episode period or the 90-day lookback period, or Beneficiaries who died during the Anchor Stay or Anchor Procedure. Additional exceptions are detailed within the BPCI Advanced Quality Measure Fact Sheets on the BPCI Advanced website.

			Clinical Episodes are then assigned at the Episode Initiator level. They are first assigned to participating PGPs based on the precedence rules; then, to any operating PGPs, and then to participating ACHs. Now, let's look at the precedence rules in more detail.
12	**Justin**	**Precedence Rules for Episode Initiators**	In BPCI Advanced, Episode Initiators are either participating PGPs or participating ACHs. Here you see a visual decision tree that shows the precedence rules once a Participant has triggered a Clinical Episode. In descending order of precedence, CMS checks: • Whether the National Provider Identifier, or NPI, for the **attending** physician belongs to a BPCI Advanced PGP; • Whether the NPI of the **operating** physician belongs to a BPCI Advanced PGP; and • Whether the ACH that furnished the services that triggered the Clinical Episode belongs to BPCI Advanced. CMS will not include the potential Clinical Episode in BPCI Advanced unless it meets one of the above requirements.
13	**Justin**	**Example: Elective Total Knee Arthroplasty (TKA)**	Meet William who is about to undergo an elective TKA. To help demonstrate the precedence rule hierarchy process, we'll use his surgery as an example. We'll continue to use William as an example throughout the presentation. William had his elective TKA, on July 15. TKA falls into the MJRLE Clinical Episode.
14	**Justin**	**Example: Defining a Clinical Episode**	Let's see how BPCI Advanced treats William's surgery as a Clinical Episode. As we see on the left side of the screen, if William's procedure occurred in an inpatient setting, then the Medicare bill will have a MS-DRG code of 470. CMS uses this MS-DRG code to detect that the Participant has triggered a Clinical Episode. The Anchor Stay starts when William is admitted to the hospital on July 15 and ends three days later when he is discharged on July 18.

			The Clinical Episode continues for an additional 90 days, with day one of that 90 day period being the date that William was discharged, which was July 18th. William's total Clinical Episode length is his anchor stay, plus the 90 days, with his discharge date counting as day one of the additional 90 day period. Therefore, the total length of this Clinical Episode is July 15 to October 15. As we see on the right side of the screen, if William received the TKA in an outpatient setting, the Medicare bill will include the HCPCS code 27447. CMS uses this code to detect that the Participant has triggered a Clinical Episode. His Anchor Procedure starts and ends on July 15. The Clinical Episode continues for an additional 90 days, with day one of that 90 day period being the date that William's anchor procedure was completed, which was July 15th. Therefore, the total length of this Clinical Episode is July 15 to October 12. Note that the discharge date for inpatient Clinical Episodes and the procedure completion date for outpatient Clinical Episodes are considered 'day one' of the 90-day period.
15	**Justin**	**Example: Precedence Rules (Part 1)**	Now let's walk through some scenarios that demonstrate the precedence rules for William's TKA, using the inpatient example. In this case, the claim that the Participant filed for William contains MS-DRG 470, so BPCI Advanced will identify it as an MJRLE Clinical Episode. Now we proceed to the precedence rules.
16	**Justin**	**Example: Precedence Rules (Part 2)**	The first step in the process is to see if William's attending physician has an NPI that is associated with a PGP participating in BPCI Advanced and the MJRLE Clinical Episode.
17	**Justin**	**Example: Precedence Rules (Part 3)**	Let's say that William's attending physician was a match.
18	**Justin**	**Example: Precedence Rules (Part 4)**	Therefore, William's TKA triggers the MJRLE Clinical Episode and BPCI Advanced will assign this Clinical Episode to the PGP.
19	**Justin**	**Example:**	Now, let's walk through another example.

		Precedence Rules (Part 5)	
20	**Justin**	**Example: Precedence Rules (Part 6)**	Let's say that William's attending physician was not a match. Then, we would move to the next step in the precedence rules.
21	**Justin**	**Example: Precedence Rules (Part 7)**	Next, we check to see whether William's operating physician has an NPI that is associated with a PGP participating in BPCI Advanced and the MJRLE Clinical Episode.
22	**Justin**	**Example: Precedence Rules (Part 8)**	Again, let's say there's no match. Now we move to the last step.
23	**Justin**	**Example: Precedence Rules (Part 9)**	We check to see whether William's TKA occurred at an ACH participating in BPCI Advanced and the MJRLE Clinical Episode.
24	**Justin**	**Example: Precedence Rules (Part 10)**	Here we see that yes, the ACH where William received care is a BPCI Advanced Episode Initiator and participant in the MJRLE Clinical Episode.
25	**Justin**	**Example: Precedence Rules (Part 11)**	Therefore, William's TKA triggers the MJRLE Clinical Episode and BPCI Advanced will assign this Clinical Episode to the ACH.
26	**Justin**	**Example: Precedence Rules (Part 12)**	Alternatively, let's say that William's TKA did *not* occur at an ACH participating in BPCI Advanced and the MJRLE Clinical Episode.
27	**Justin**	**Example: Precedence Rules (Part 13)**	In this case, no BPCI Advanced Clinical Episode would be triggered and the Clinical Episode would not be attributed at Reconciliation.
28	**Justin/Beth**	**Administrative Quality Measures Set for Model Years 1, 2, & 3**	We just finished talking about how BPCI Advanced constructs Clinical Episodes. I'm handing it over to Beth to describe how Quality Measures relate to the Clinical Episodes, by reviewing the Administrative Quality Measures Set in BPCI Advanced. Thanks Justin. Participants who joined in Model Year 1 are familiar with the Administrative Quality Measures Set, which is exclusively claims-based and consists of data collected directly by CMS. For Model Year 3, BPCI Advanced continues to use those seven Administrative Quality Measures. For Quality Measure reporting in Model Year 4, which starts in January 2021, CMS intends to provide Participants the flexibility to choose either the Administrative Quality Measures Set or a clinically aligned Alternate Quality

			Measures Set. Additional information regarding Model Year 4 Quality Measures will be provided in the future.
29	**Beth**	**Administrative Quality Measures Set**	The Administrative Quality Measures Set includes three Quality Measures that apply to every Clinical Episode: • Advance Care Plan • Hospital-Wide All-Cause Unplanned Readmission and • CMS Patient Safety Indicators 90 or CMS PSI 90 The Administrative Quality Measures Set also includes up to two additional Clinical Episode-specific Quality Measures for select Clinical Episodes. Participants are accountable for all Quality Measures within the Administrative Quality Measures Set that apply to their chosen Clinical Episodes. Thus, Participants will be accountable for all three cross-cutting Quality Measures, along with up to two Clinical Episode-specific Quality Measures.
30	**Beth**	**Quality Measures Correlation to Clinical Episodes Model Years 1, 2, & 3 (Part 1)**	This table, which continues onto the next slide, provides the correlation of Quality Measures to Clinical Episodes for Model Years 1, 2, and 3.
31	**Beth**	**Quality Measures Correlation to Clinical Episodes Model Years 1, 2, & 3 (Part 2)**	Here you see the seventh Quality Measure to complete the table shown on the previous slide. More detailed information can also be found on the BPCI Advanced website.
32	**Beth**	**MJRLE Example: Administrative Quality Measures Set**	Continuing with William's surgery as an MJRLE example, let's review which Quality Measures within the Administrative Quality Measures Set are applicable to the MJRLE Clinical Episode. On the slide, we have listed the five Quality Measures associated with the MJRLE Clinical Episode. Now, let's look at these Quality Measures in more detail to see how they cover the patient's total care experience in the Clinical Episode.
33	**Beth**	**MJRLE Example: Clinical Episode Life Cycle**	CMS selected the Quality Measures in the Administrative Quality Measures Set to reflect the patient experience before, during, and after the triggering event.

			In the time leading up to a triggering event, shown on the slide as "pre-event," the Advance Care Plan Quality Measure reviews whether care teams supported patient empowerment by discussing their long-term health plans. During the triggering event, the Quality Measures review whether physicians are following clinical best practices. CMS measures adherence to clinical best practices using the CMS PSI 90 and the Perioperative Cephalosporin Quality Measures. After the triggering event, shown as "post-event" on the slide, the Quality Measures assess Participants' ability to avoid preventable adverse outcomes. The All-Cause Readmission Measure is a cross-cutting measure that appears in all Clinical Episodes. In this MJRLE example, the Administrative Quality Measures Set also adds a second outcome measure: Hospital-Level Risk-Standardized Complication Rate, or RSCR, Following Elective Primary Total Hip Arthroplasty (THA) or TKA.
34	**Beth**	**Data Sources for Quality Measures**	Now we will discuss the different data sources that CMS uses to calculate Quality Measures.
35	**Beth**	**Administrative Quality Measures Data Sources**	You can see there are two data sources that cover the seven measures in the Administrative Quality Measures Set. Our first data source is the Inpatient Quality Reporting Program, known as the IQR Program, shown in gray, which contains five of the seven measures. The last two measures are captured by Medicare claims and are shown in light blue.
36	**Beth**	**Inpatient Quality Reporting Program (IQR) Program Data**	Under the Hospital IQR Program, CMS collects quality data from hospitals paid under the Inpatient Prospective Payment System, with the goal of driving quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care. ACHs already submit data to the IQR Program for Quality Measures. BPCI Advanced will obtain the Quality Measure results from the IQR Program for the Model. No action is required beyond IQR Program responsibilities.

37	**Beth**	**MJRLE Example: IQR Program Data**	Continuing to look at William's MJRLE example, you can see how these IQR Program Quality Measures fit into his total care experience. Here we can see that CMS PSI 90, All-Cause Readmission, and RSCR Following Elective Primary THA/TKA are all collected through the IQR.
38	**Beth**	**Medicare Claims Data**	Now we will discuss the second data source, Medicare claims data. Participants submit the data for two Quality Measures through the Medicare claims process. CMS will calculate these Quality Measures using payable Common Procedure Terminology, or CPT, codes and non-payable Quality Data Codes, or QDCs. For more information about submitting CPT, QDC, and HCPCS codes for these measures, please reference the Quality Measure Fact Sheets on the BPCI Advanced website under the subheading 'Quality Measures'. Participants need to make sure they are reporting the relevant codes on their CMS-1500 claim forms. We'll walk through an example on the next slide. Before we move on, here are a few helpful tips based on Participants' questions on claims reporting: • Participants must submit CPT codes on the claim with the denominator billing code • Medicare Administrative Contractors, or MACs, will typically not allow Participants to append these non-payable QDCs to claims after original claim submission. Therefore, you should make sure that the codes are on the CMS-1500 claim form before submission.
39	**Beth**	**Example: CMS-1500 Claim Form**	Here is an example of a completed CMS-1500 form, also known as the claim form, with associated codes for an MJRLE. As you can see in row one, the first code located in column D is a CPT/HCPCS code 27447. This is the trigger for an MJRLE Clinical Episode from the outpatient setting. The next code located in column D is G9197, which is the QDC for the Perioperative Cephalosporin Quality Measure. Note that the QDC has a charge of $0.00 because it is a non-payable code. In some systems, the charge may be $0.01

			depending on the system requirements. You may need to work with your Electronic Medical Record, or EMR, vendor or your MAC to ensure you are properly submitting QDCs.
40	**Beth**	**MJRLE Example: Claims Data**	Here, you can see how these claims-based Quality Measures fit into William's total care experience for MJRLE and that Advance Care Plan and Perioperative Cephalosporin are both collected through the Medicare claims process.
41	**Beth**	**Quality Data Timeline**	The Quality Data Timeline shown here illustrates the alignment of quality data collection with the Model's Timeline and reconciliation process. For Model Year 2 (2019), CMS will collect quality data for the 5 IQR measures for the entire 12 month period. The data collection period for the two claims based measures will cover a six month period from July through December of 2019. This was done to provide BPCI Advanced Participants, including clinicians and hospitals, extra time to work together to implement workflows to accurately code and submit claims for those two measures which historically had not been widely reported. You can see under the Model Year 3 section of the graphic, that the Model Year 3 data collection period for both the 5 IQR measures and the two claims based measures will cover a 12 month period. Calendar Year 2018 quality measures baseline data was provided to Participants for benchmarking purposes. Actual Quality Measure performance, calculated using the CQS, will be assessed once per Calendar Year, beginning in 2019. CMS will provide CY2019 Quality Measure performance data in Summer 2020, and for the first time this data will be used to calculate the CQS which will be incorporated in the Reconciliation Results that Participants will receive in Fall 2020. Administrative claims are finalized only after a considerable lag; therefore, to be more specific, the CQS for quality measures during the Performance Period 1 (October 2018 – June 2019) & Performance Period 2 (July 2019-December 2019) will not be applied until the "true ups" in the fall of 2020. It's important to note that the initial Reconciliation Results for Performance Periods 1 & 2 will reflect that 10% of the NPRA has

			been retained by CMS, as an accrual to cover the potential impact of the quality adjustments resulting from the CQS score.
42	**Beth**	**Additional Information**	In this webcast, we started by defining Clinical Episodes and the precedence rules for attribution of Clinical Episodes to Episode Initiators, explained how each Clinical Episode incorporates different Quality Measures, identified the two data sources that Participants must use to submit data to CMS for the CQS based on Quality Measures, and then provided a timeline for quality data and performance evaluation reporting. We hope this information has been useful in understanding how Quality Measures function in the BPCI Advanced Model and thank you for viewing the BPCI Advanced Quality Methodology Webcast. We also want to encourage you to review additional resources previously made available to Participants: BPCI Advanced Quality Measures - Understanding the Composite Quality Score (CQS) Webcast and the BPCI Advanced Model Years 1 & 2 Performance Period 1 Reconciliation Webcast. If you have additional questions or your question was not addressed in this presentation, we encourage you to first visit the BPCI Advanced website. As mentioned before, we have posted several helpful resources and will continue to post new and updated materials, such as Frequently Asked Question documents. If you need additional assistance, you can email the BPCI Advanced team at BPCIAdvanced@cms.hhs.gov. Please, be sure to include your Bundled Payment Identification number, or BPID. Finally, please take a moment to complete a short survey that appears at the end of the presentation which can be accessed by clicking on the link in the third bullet on this slide. This survey helps the BPCI Advanced Learning System Team to improve events and identify topics important to you. This concludes the BPCI Advanced Quality Methodology Webcast. We hope you found it informative.