Quality Measures Fact Sheet

Advance Care Plan (NQF #0326)

National Quality Strategy Domain: Communication and Coordination

BPCI Advanced and Quality

The Center for Medicare & Medicaid Innovation's (the CMS Innovation Center's) BPCI Advanced Model rewards health care providers for delivering services more efficiently, supports enhanced care coordination, and recognizes high quality care. Hospitals and clinicians should work collaboratively to achieve these goals, which have the potential to improve the BPCI Advanced Beneficiary experience and align to the CMS Quality Strategy goals of promoting effective communication and care coordination, highlighting best practices, and making care safer and more affordable. A goal of the BPCI Advanced Model is to promote seamless, patient-centered care throughout each Clinical Episode, regardless of who is responsible for a specific element of that care.

Background on Advance Care Planning

For the Medicare beneficiary population, consideration of care goals is central to delivering patient-centered care. An Advance Care Plan (ACP) typically documents patient preferences for their care, including use of life-sustaining treatment options. An ACP is based on an individual's personal values, preferences, and discussions with their loved ones. ACPs empower patients to direct the care they want to receive, particularly should they become unable to speak for themselves.

CMS Innovation Center Rationale for Including the ACP Measure in BPCI Advanced

At the heart of a patient-centered episode of care lies a patient's values, meaningful conversation, and planning. Inclusion of the ACP measure is especially important in the BPCI Advanced Model because many beneficiaries that trigger an episode are hospitalized for life threatening conditions and/or undergoing major medical procedures. These triggering events, as challenging as they may be, represent opportunities for hospitals and clinicians to collaborate with each other and the patient to ensure care reflects the patient's will.[1] The CMS Innovation Center has added a revised version of the National Quality Forum (NQF)-endorsed ACP measure to the BPCI Advanced Model. This measure will encourage the documentation of these important discussions, and/or the existence of an ACP in an efficient manner through Medicare claims. Even though the CMS Innovation Center has revised the measure specifically for the BPCI Advanced Model, it is still based upon the ACP measure that CMS has

[1] National Quality Forum (2007). NQF #0326 Advance Care Plan measure submission and evaluation worksheet 5.0. Retrieved from: www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=69984.

used or is currently using in the following Federal programs: the Home Health Value Based Purchasing Model (HHVBP), Medicare Physician Quality Reporting System (PQRS), Physician Quality and Resource Use Reports (QRUR), the Merit-based Incentive Payment System (MIPS), and the Physician Value-Based Payment Modifier.

Applicable Clinical Episodes

The ACP measure is in both the Administrative and Alternate Quality Measures Sets and applies to all inpatient and outpatient Clinical Episodes included in the BPCI Advanced Model.

Measure Specifications

The ACP measure selected for BPCI Advanced follows NCQA's provider level measure, "Advance Care Plan," (ACP) specifications endorsed by NQF (#0326) and appears in the Quality Payment Program (QPP) as measure #47. The CMS Innovation Center will calculate the measure at the Episode Initiator level, limited to BPCI Advanced Beneficiaries treated during an attributed Clinical Episode during the calendar year. The term "BPCI Advanced Beneficiary" refers to a Medicare beneficiary eligible for the Model[2] who receives care from a clinician in an acute care hospital (ACH) or physician group practice (PGP) that participates in BPCI Advanced, and who triggers a Clinical Episode as specified in the "Applicable Clinical Episodes" section above. In Model Year 3, measure-eligible Clinical Episodes are those with anchor and end dates from January 1, 2020 to December 31, 2020. An Episode Initiator must have a minimum of 10 attributed Clinical Episodes that fit the criteria for the denominator and end during the calendar year to generate a score.

Any Medicare health care provider, including physicians, advance practice nurses, and physician assistants, can submit the qualifying Current Procedural Terminology (CPT) codes (CPT or CPT II codes) for this measure regardless of the health care provider's participation in the Model. Any health care setting, including hospitals and outpatient clinics, can use these ACP codes in any health care setting, except the emergency department. If an ACP discussion occurs outside of a BPCI Advanced Beneficiary's annual preventive visit, that patient may incur an associated copay if the billing department applies the qualifying CPT codes to the bill. To avoid this, health care providers can either utilize the applicable qualifying CPT II tracking codes provided below that do not generate a charge, or health care providers should inform the BPCI Advanced Beneficiary of the cost sharing prior to having the discussion.

Denominator

The denominator of the ACP measure includes all BPCI Advanced Beneficiaries, aged 65 years and older, who trigger one of the Clinical Episodes listed in the "Clinical Episodes" section, that CMS attributes to a BPCI Advanced Episode Initiator. CMS attributes Clinical Episodes to Episode Initiators based upon their

[2] Medicare beneficiaries entitled to benefits under Part A and enrolled under Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for an Anchor Stay or Anchor Procedure. The term BPCI Advanced Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of an end-stage renal disease (ESRD) diagnosis; (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure. A BPCI Advanced Beneficiary must meet this definition for the full duration of the Clinical Episode. (2018 Participation Agreement)

CMS Certification Number if they are an ACH, or by their Taxpayer Identification Number if they are a PGP. For the purposes of quality measure calculation, the anchor end date of the Clinical Episode (the last date of the Anchor Stay or the date of the Anchor Procedure) will determine the calendar year to which the Clinical Episode belongs. The revised BPCI Advanced ACP measure specifications apply to all relevant BPCI Advanced Beneficiaries in the BPCI Advanced Clinical Episode cohort, whereas the NQF-endorsed ACP measure specifications apply to all relevant patients.

Numerator

The numerator includes individuals in the previously defined denominator who have a Medicare claim with a qualifying CPT or CPT II code for ACP during the 12 months prior to the BPCI Advanced episode end date. The qualifying codes for this measure are CPT codes 99497 and 99498 and/or CPT II codes 1123F and 1124F. The ACP CPT codes are billing codes which may result in additional Medicare Beneficiary charges outside of annual preventive visits, as opposed to the ACP CPT II codes which are tracking codes that do not result in charges.

CPT Billing Code	Description
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure).

CPT II Tracking Code	Description
1123F	Advance care planning discussed and documented – advance care plan or surrogate decision-maker was documented in the medical record.
1124F	Advance care planning discussed and documented in the medical record – Beneficiary/patient did not wish to or was unable to provide an advance care plan or name a surrogate decision-maker. If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, submit this CPT II code.

Measure Submission

The CMS Innovation Center will calculate this measure using Medicare claims data. Model Participants only need to make sure they are reporting the relevant codes listed above on their claims. For Model Years 1 and 2, CMS will calculate the measure for measure-eligible Clinical Episodes with anchor end dates from July 1, 2019 to December 31, 2019. Beginning in Model Year 3, CMS will calculate the measure for measure-eligible Clinical Episodes with anchor end dates within the Calendar Year (January 1, 2020 to December 31, 2020). For example, if a Clinical Episode has an anchor end date on December 15, 2019, and a Clinical Episode end date on March 14, 2020, then the Clinical Episode will be used in the measure calculation for Model Years 1 and 2.

Revisions from the Published Specifications

The measure calculations occur at the Episode Initiator level, for only BPCI Advanced Beneficiaries, as opposed to all Medicare beneficiaries, at the National Provider Identifier (NPI) level. This revised version also removes the data completion requirement in NCQA's provider level ACP measure endorsed by NQF (#0326) and distinguishes between a failure to adhere to the guidelines and failure to bill the CPT or CPT II codes, regardless of whether a qualifying health care provider discussed an advance care plan. As a result, the BPCI Advanced version does not exclude BPCI Advanced Beneficiaries with missing CPT or CPT II codes from the denominator.

With Medicare claims for BPCI Advanced Beneficiaries where the health care team did not report the appropriate codes (99497, 99498, 1123F, or 1124F), the CMS Innovation Center will continue to count beneficiaries in the denominator but not in the numerator. In other words, unlike the NCQA's provider level ACP measure, endorsed by NQF (#0326), the CMS Innovation Center will treat failure to code equivalently to failing to provide appropriate advance care planning services, without regard to the 8P modifier code: advance care planning not documented, reason not otherwise specified.

Composite Quality Score

The ACP measure is one component of the BPCI Advanced Composite Quality Score (CQS) calculation. The CMS Innovation Center uses the CQS to adjust a portion of any Positive Total Reconciliation Amount and any Negative Total Reconciliation Amount. The CQS adjustment will not adjust the Positive Total Reconciliation Amount down by more than 10 percent, nor will it adjust the Negative Total Reconciliation Amount up by more than 10 percent. More information is available at the BPCI Advanced website provided below.

Other Resources

Organization/Resource	Website Address
CMS/Medicare Learning Network ACP fact sheet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
CMS ACP Frequently Asked Questions	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
National Hospice and Palliative Care Organization	http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289
BPCI Advanced	https://innovation.cms.gov/initiatives/bpci-advanced