

Model Overview



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

January 2018

Webcast Outline



Model Overview



Timeline



Who Can Participate



Advanced Alternative Payment Model Criteria



Defining the Clinical Episode



Payment and Pricing Methodology



How to Apply

BPCI Advanced Model Overview

- Voluntary bundled payment model
- Single payment and risk track with a 90-day episode period
- 29 Inpatient Clinical Episodes
- 3 Outpatient Clinical Episodes
- Qualifies as Advanced Alternative Payment Model (Advanced APM)
- Payment is tied to performance on quality measures
- Preliminary Target Prices provided prospectively



Objectives of the Initiative

1

Care Redesign



2

Data Analysis and Feedback



3

Financial Accountability



4

Health Care Provider Engagement

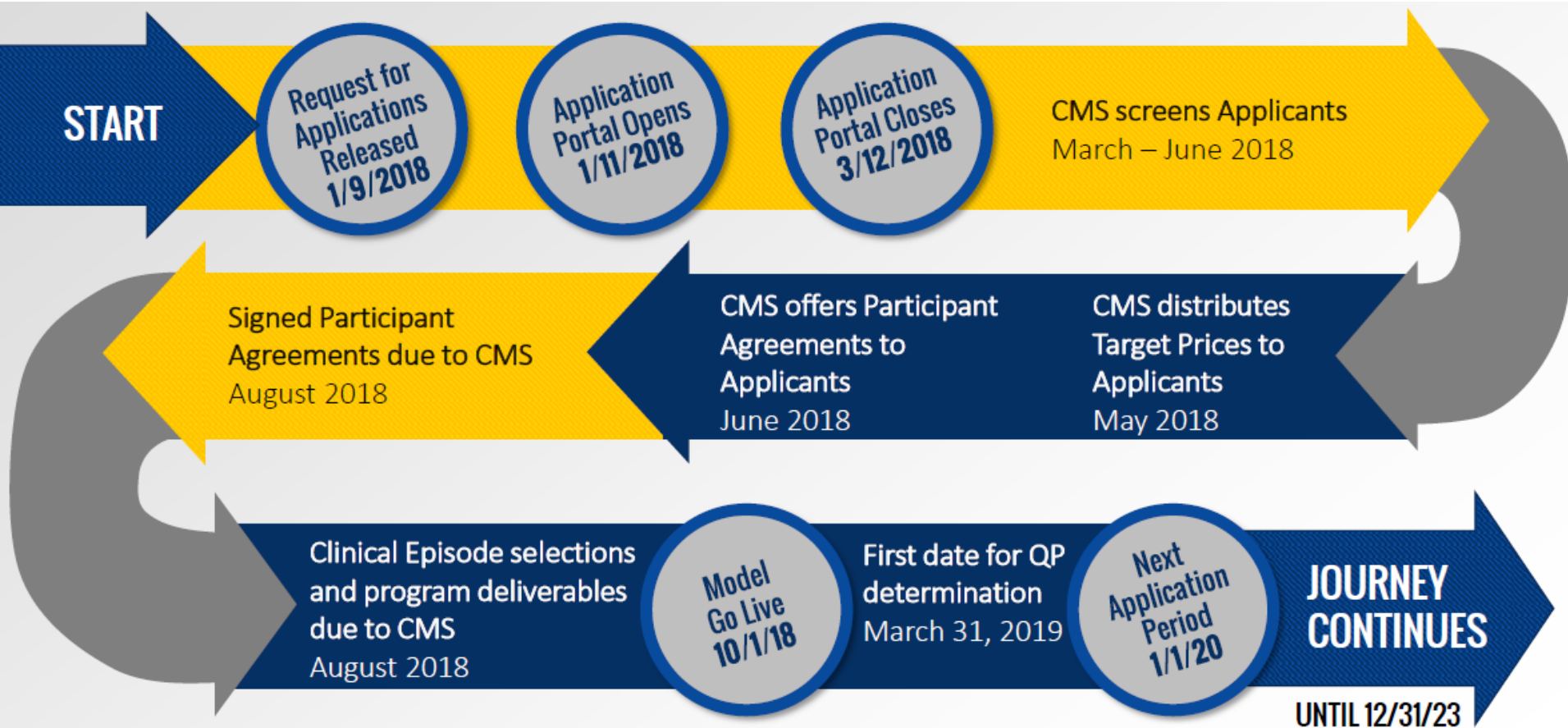


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Patient and Caregiver Engagement



BPCI Advanced Timeline



BPCI Advanced Model

**Who can participate
in BPCI Advanced?**



Two Categories of Participants

Convener Participant



- Brings together downstream Episode Initiators (EIs)
- Facilitates coordination
- Bears and apportions financial risks

Non-Convener Participant



- Is the Episode Initiator (EI)
- Bears financial risk only for itself, and
- Does not bear risk on behalf of downstream EIs

Who can Participate as a Non-Convener Participant?

**Physician Group
Practices (PGPs)**



**Acute Care Hospitals
(ACHs)**



Who can participate as a Convener Participant?

Entities that are either
Medicare-enrolled or not
Medicare-enrolled providers
or suppliers



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



Who can be an Episode Initiator (EI)?

**Physician Group
Practices (PGPs)**



**Acute Care Hospitals
(ACHs)**



Who can be an EI?, Continued

- A Participant's EIs cannot be changed until the next application opportunity in Model Year 3 in 2020
- Clinical Episode selections cannot be changed until 2020

Precedence Rules for EIs

1



Attending PGP

2



Operating PGP

3



ACHs

BPCI Advanced will not use time-based precedence rules.

BPCI Advanced Model

Advanced Alternative Payment Model (Advanced APM) Criteria



Advanced Alternative Payment Model (Advanced APM) Criteria

BPCI Advanced will be an Advanced APM as of the first day of the Model Performance Period: October 1, 2018

Financial Risk

- Participants will be financially at risk for up to 20% of the final Target Price



Certified Electronic Health Record Technology (CEHRT)

- Participants must be able to attest to the use of Certified Electronic Health Record Technology (CEHRT), prior to participating in the Model.
- For non-hospital participants, at least 50% of eligible clinicians in an entity must use the CEHRT definition of certified health IT functions to participate in this Model.



Quality Measures

- Payment will be linked to quality using a pay-for-performance methodology
- A quality score will be calculated for each quality measure at the Clinical Episode level, as applicable
- These scores will be volume-weighted and scaled across all Clinical Episodes attributed to a given EI, to calculate an EI-specific Composite Quality Score (CQS)
- A CQS Adjustment amount will be applied to Positive or Negative Total Reconciliation Amounts



Quality Measures, Continued



For the first two Model Years, the amount by which any **Positive** Total Reconciliation Amount or **Negative** Total Reconciliation Amount may be adjusted by the CQS Adjustment Amount is capped at 10 percent.

Model Years 1 & 2 will include **claims-based measures**.



Additional measures with varying reporting mechanisms may be added in Model Year 3 and beyond.



Quality Measures, Continued

Quality measures for:	
All Clinical Episodes	All-cause Hospital Readmission Measure (National Quality Forum [NQF] #1789)
	Care Plan (NQF #0326)
Specific Clinical Episodes	Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
	AHRQ Patient Safety Indicators (PSI 90)

Participating Practitioners – 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% APM Incentive Payment.
- **The first date for QP determination will be March 31, 2019.**

Participating Practitioners – Qualified APM Participants (QPs), Continued

- For **ACH Participants**, eligible clinicians will be assessed individually for purposes of QP determinations.
- For **PGP Participants**, eligible clinicians will be assessed as a group for purposes of QP determinations.
- For **Convener Participants** who will have ACHs and PGPs as Episode Initiators, the QP determinations for eligible clinicians will happen as a group.

Participating Practitioners – Qualified APM Participants (QPs), Continued

- In order to avoid this action for ACH physicians, **Convener Participants** may choose to enter into separate agreements with CMS for ACHs EIs and PGPs EIs.
- If a Convener Participant chooses to do this, they must submit separate applications.

BPCI Advanced Model

Defining the Clinical Episode in BPCI Advanced



29 Inpatient (IP) Clinical Episodes

Spine, Bone, and Joint Episodes

- Back & neck except spinal fusion
- Spinal fusion (non-cervical)
- Cervical spinal fusion
- Combined anterior posterior spinal fusion
- Fractures of the femur and hip or pelvis
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity



Kidney

- Renal failure



Infectious Diseases

- Cellulitis
- Sepsis
- Urinary tract infection



Neurology

- Stroke



29 Inpatient (IP) Clinical Episodes, Continued

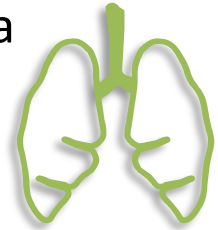
Cardiac Episodes

- Acute myocardial infarction
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft
- Congestive heart failure



Pulmonary Episodes

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



Gastrointestinal Episodes

- Major bowel procedure
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- **Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis (New Episode for BPCI Advanced)**



3 Outpatient (OP) Clinical Episodes

- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck Except Spinal Fusion



Clinical Episode Definition



Anchor Stay – inpatient stay at an Acute Care Hospital with a qualifying MS-DRG billed to Medicare FFS by an EI
– *105 MS-DRGs across 29 Clinical Episodes*



Anchor Procedure – outpatient procedure (identified by a Healthcare Common Procedure Coding System (HCPCS) code)) on an associated Hospital Outpatient (HOPD) facility claim billed to Medicare FFS by an EI
– *29 HCPCS codes* across 3 Clinical Episodes;
Ambulatory Payment Classification (APC) adjusts payment*

** Based on 2018 OPPS final rule*

Exclusion Criteria for Beneficiaries in a Clinical Episode

- Beneficiaries covered under United Mine Workers or managed care plans (e.g. Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations)
- Beneficiaries for whom Medicare is not the primary payer
- Beneficiaries eligible for Medicare on the basis of end-stage renal disease (ESRD)
- Beneficiaries who die during the Anchor Stay or Anchor Procedure
- Beneficiaries not enrolled in Medicare A/B for the entire Clinical Episode

Clinical Episode Length

IP Clinical Episode:

Anchor Stay

+ 90 days beginning the day of discharge



OP Clinical Episode:

Anchor Procedure

+ 90 days beginning on the day of completion of the outpatient procedure



Services Included in the Clinical Episode

- IP or OP hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Physicians' services
- Other hospital OP services
- IP hospital readmission services
- Long-term care hospital (LTCH) services
- Hospice 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

Service-level Exclusions from the Clinical Episode

Blanket exclusions:

- Blood clotting factors to control bleeding for hemophilia patients
- New technology add-on payments under the IPPS
- Payments for items and services with pass-through payment status under the OPPS

Part B services:

- Excluded only if incurred during a specified IP admissions and readmissions to an ACH that is excluded based on its MS-DRG

Readmission Exclusions from the Clinical Episode

Single list of excluded MS-DRGs apply to Clinical Episodes, which will include 122 MS-DRGs:

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

Transfer Rule

BPCI Advanced will treat transfers as one continuous hospitalization:

- Clinical Episode begins at admission of the first part of the transfer
- Clinical Episode assigned to the provider of the first part of the transfer
- Post-discharge 90-day period begins following discharge from the last part of the transfer
- MS-DRG assigned from the last part of the ACH transfer
- If patient is transferred to a BPCI Advanced-participating ACH from the Emergency Department at a different ACH, Part B payments associated with the ED visit from date of admit with a 1-day look-back period will be rolled into Clinical Episode

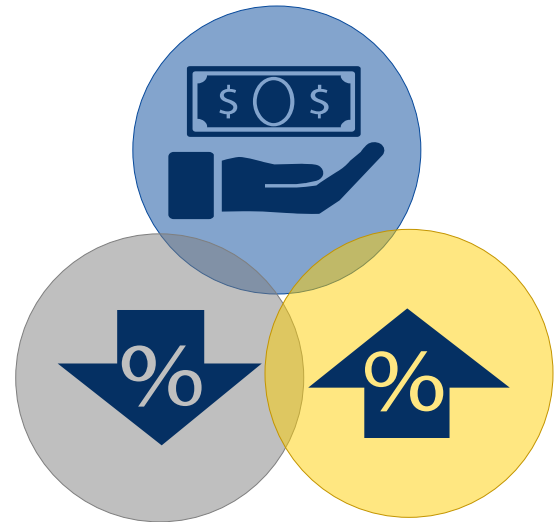
Selection of Clinical Episodes

“Participant Profile”

- Applicants’ selection of Clinical Episodes must be submitted to CMS 60 days before the start date of the Model.
- Those selections, as well as the Episode Initiators, cannot be changed until the start of Model Year 3 in 2020

BPCI Advanced Model

Payment and Pricing Methodology for BPCI Advanced



ACH's Benchmark Price

To determine the Episode Initiator 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. Patterns of spending relative to the ACHs peer group over time



3. Historic Medicare FFS expenditures efficiency in resource use specific to the ACHs Baseline Period

Physician Group Practice's (PGP's) Benchmark Price

- CMS will use an alternative method to determine the **PGP's Benchmark Price**
- The PGP's Benchmark Price will be based on the Benchmark Price for the ACH where the Anchor Stay or Anchor Procedure occurs
- CMS will then adjust the ACH-specific Benchmark Price to calculate a PGP-specific Benchmark Price that accounts for the PGP's level of efficiency in the past and the PGP's patient case mix, each relative to the hospital's.

Target Price Calculations

**Target
Price (TP)**

=

**Benchmark
Price (BP)**

×

**(1- CMS
Discount)**

- CMS Discount = 3% 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 Adjustment with the realized value in the Performance Period

Risk Track

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

Frequency of Reconciliation

- Semi-Annually with two (2) “True-Ups” to allow for claims run-out
- Clinical Episodes will be reconciled **based on the Performance Period in which the Clinical Episode is attributed**, which is determined by the start of the Anchor Stay or the Anchor Procedure
- There are two Performance Periods per calendar year

Reconciliation

- Retrospective reconciliation based on comparing actual Medicare FFS expenditures to the final Target Price
- All non-excluded Medicare FFS expenditures for a Clinical Episode will be compared against the final Target Price, resulting in a Positive or Negative Reconciliation Amount
- All Positive and Negative Reconciliation Amounts will be netted across all Clinical Episodes attributed to an EI, resulting in a Positive or Negative Total 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 an EI that is also a Non-Convener Participant, the Adjusted Positive Total Reconciliation Amount is the **Net Payment Reconciliation Amount (NPRA)**, which CMS will pay to the Participant

Reconciliation, Continued

- If instead this calculation results in an Adjusted Negative Total Reconciliation Amount for Non-Convener Participants, this amount is the **Repayment Amount**, which must be paid by the Participant to CMS
- For Convener Participants, all Adjusted Positive Total Reconciliation Amounts are netted against all the Adjusted Negative Total Reconciliation Amounts for the Participant's EIs to calculate either the NPRA or a Repayment Amount

Stop-Loss/Stop-Gain Limits

Stop-loss/stop-gain limits:

- Reconciliation payments, both to Participants from CMS, and from Participants to CMS, are capped at +/- 20% of the volume-weighted sum of final Target Prices across all Clinical Episodes netted to the EI level within the Performance Period
- Applied following the CQS adjustment

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% confidence interval (CI) around expected spending, estimated using historical data
- **Recourse:** Participant must repay CMS the total amount identified as excess spending
- **Frequency:** Once a year

Waivers

- **Fraud and Abuse Waivers**: For purposes of this Model and consistent with the standards set forth in section 1115A of the Act, the Secretary may consider exercising such waiver authority with respect to the fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. Any such waivers will apply solely to BPCI Advanced and will be set forth in separately issued documentation
- **Payment Policy Waivers**:
 - 3-Day SNF Rule
 - Telehealth
 - Post-Discharge Home Visit

Key Differences: BPCI vs. BPCI Advanced

BPCI	BPCI Advanced
48 Inpatient (IP) Clinical Episodes	29 IP and 3 OP Clinical Episodes
Not an Advanced APM since lacking CEHRT requirement and quality not tied to payment	Model is an Advanced APM
No quality measures required for payment purposes	Quality measures are reportable and performance on these measures will be tied to payment
Excludes cost of care associated with services according to 13 unique exclusion listings of “unrelated” care	Limited exclusions; Excludes the Part A & B costs associated with ACH readmissions qualifying based on a limited set of MS-DRGs
Model 3 includes PAC providers triggering episodes in the post-discharge period	No equivalent for Model 3; design is similar to Model 2 with PGPs and ACHs as EIs; PAC Providers, and other Medicare-enrolled, as well as non-Medicare-enrolled entities can participate as Convener Participants
Risk corridor of 20% of spending above the upper limit of the selected risk track	One risk track Risk is capped at +/-20%
Target Prices provided at reconciliation	Preliminary Target Prices provided prospectively, before the start of each Model Year

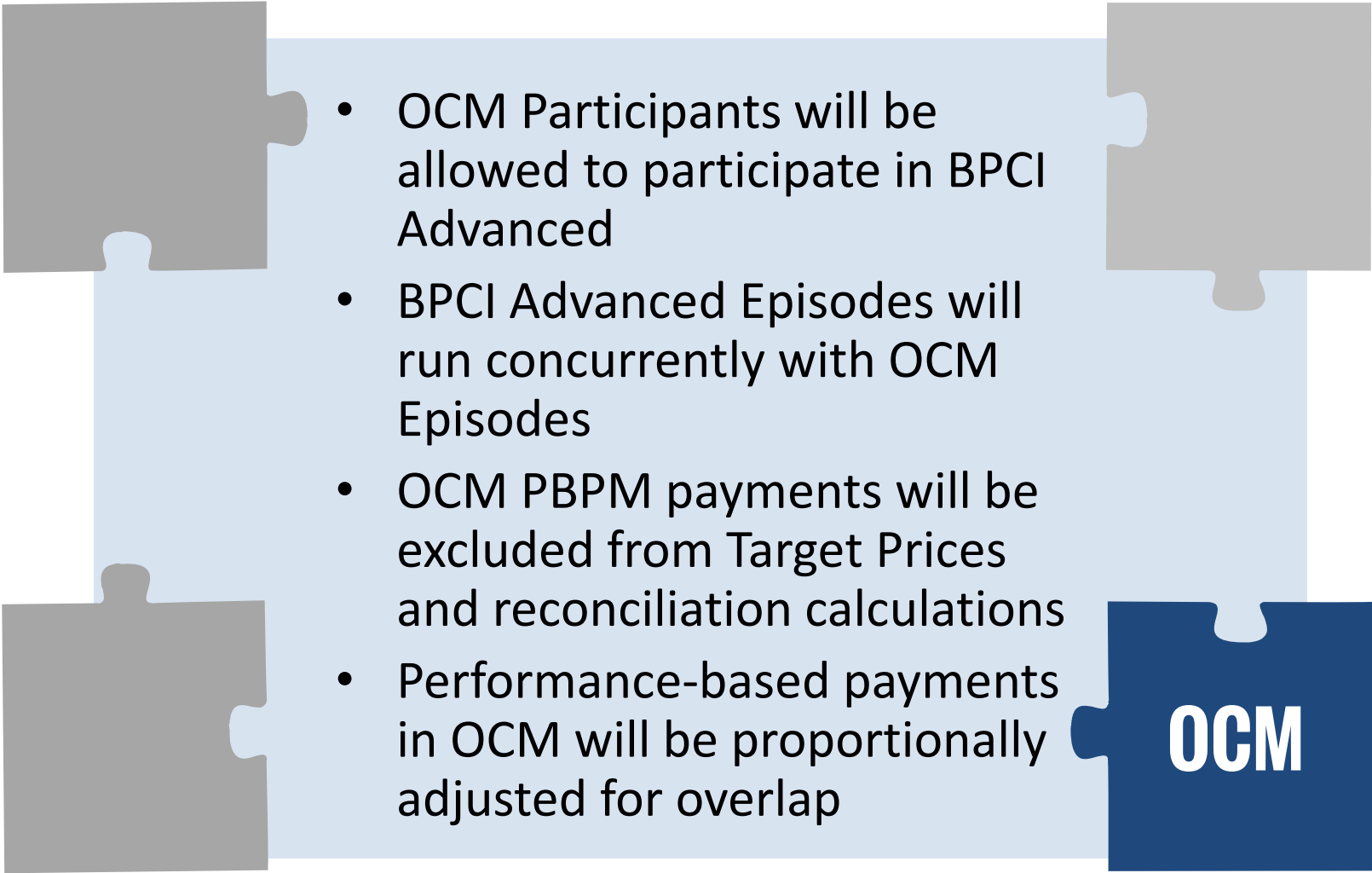
Overlap with other CMS Models – Comprehensive Care for Joint Replacement (CJR)



CJR

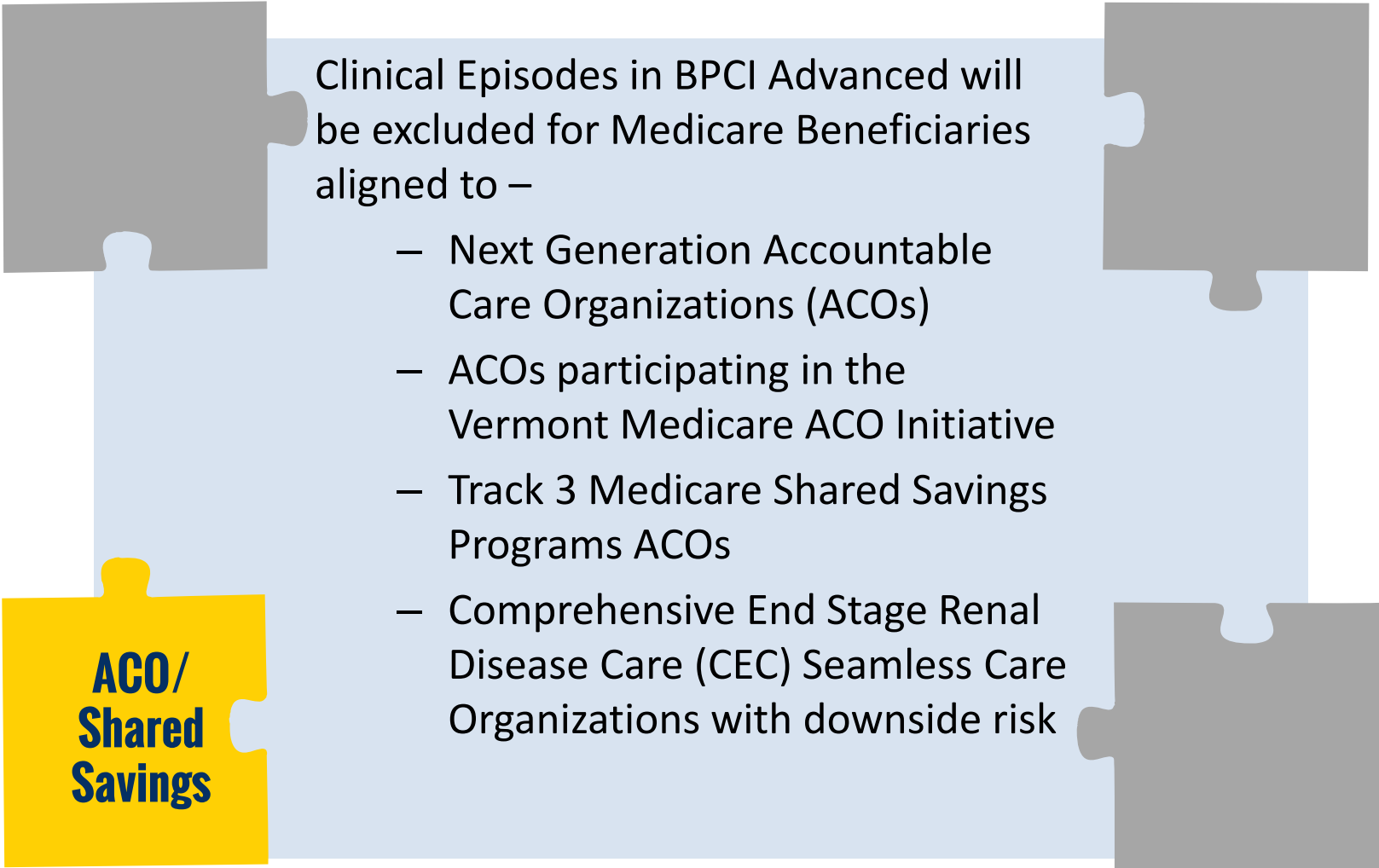
- CJR episodes will take precedence over BPCI Advanced Clinical Episodes
- Organizations in CJR will not be permitted to participate in BPCI Advanced for the Clinical Episodes included in CJR.

Overlap with other CMS Models – Oncology Care Model (OCM)

- 
- OCM Participants will be allowed to participate in BPCI Advanced
 - BPCI Advanced Episodes will run concurrently with OCM Episodes
 - OCM PBPM payments will be excluded from Target Prices and reconciliation calculations
 - Performance-based payments in OCM will be proportionally adjusted for overlap

OCM

Overlap with other CMS Models – Accountable Care Organizations (ACOs)/Shared Savings Model

A diagram consisting of four interlocking puzzle pieces arranged in a square. The top-left and top-right pieces are grey. The bottom-right piece is grey. The bottom-left piece is yellow and contains the text 'ACO/ Shared Savings'. The central area, formed by the negative space of the puzzle pieces, is light blue and contains the main text of the slide.

Clinical Episodes in BPCI Advanced will be excluded for Medicare Beneficiaries aligned to –

- Next Generation Accountable Care Organizations (ACOs)
- ACOs participating in the Vermont Medicare ACO Initiative
- Track 3 Medicare Shared Savings Programs ACOs
- Comprehensive End Stage Renal Disease Care (CEC) Seamless Care Organizations with downside risk

**ACO/
Shared
Savings**

Overlap with other CMS Models, Continued

- For additional details on how the overlap of the various CMS Models will be addressed, please refer to the BPCI Advanced Request for Applications (RFA)
- For a comparison table of the various CMS Bundled Payment Models, please visit the CMS Innovation Center website:



<https://innovation.cms.gov/initiatives/bpci-advanced>

BPCI Advanced Model

**CMS Innovation
Center
Learning Systems**



The Goal of the CMS Innovation Center Learning Systems is to Accelerate the Implementation and Success of New Models

Model Participants deliver higher quality care at lower cost.



Hospitals



Practices

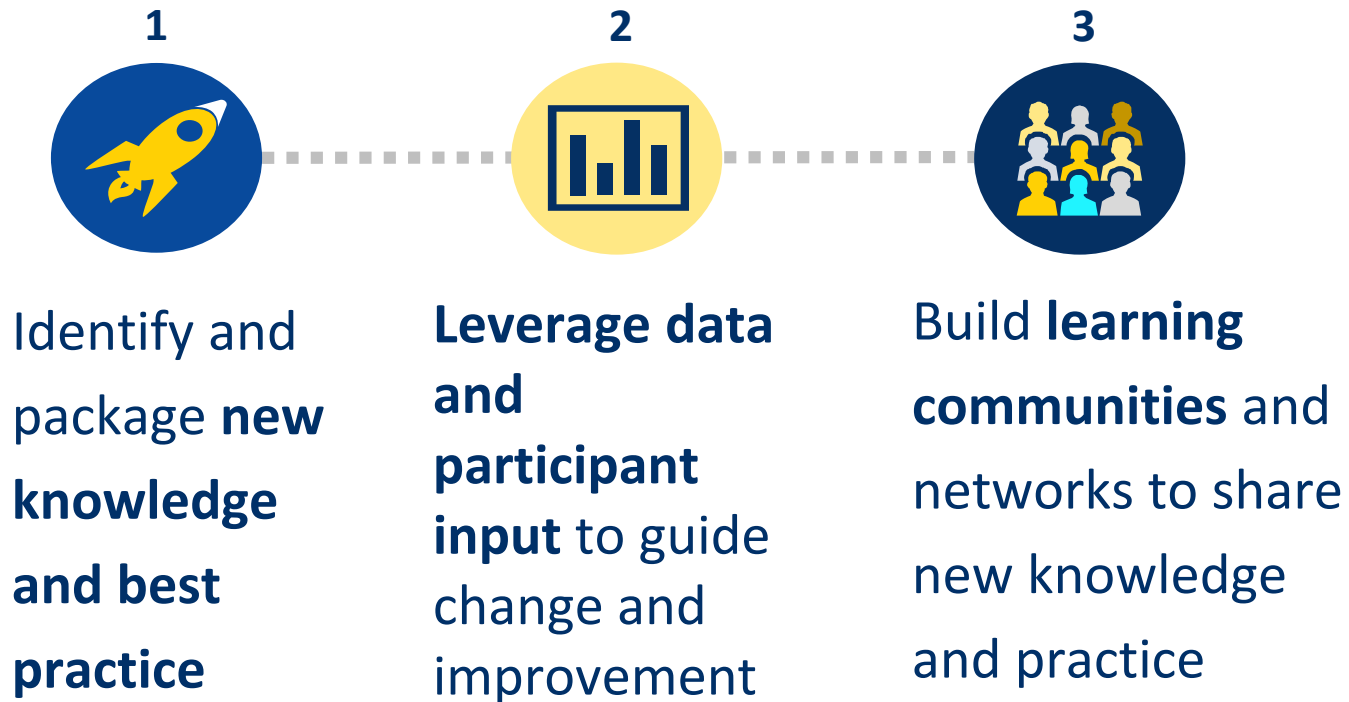


Clinicians are engaged in the model

CMS Innovation Center Facilitates Continuous Improvement

CMS develops and implements new payment and service delivery models that drive higher quality care at lower cost.

To Achieve this Goal, CMS Innovation Center Learning Systems Serves Three Broad Functions



Model Learning Systems Provide a 3-way Channel of Engagement to Drive Success



BPCI Advanced Model

**How to Apply to
Participate
in BPCI Advanced**



**Deadline for Submission of Applications
March 12, 2018 @11:59 pm EST**

Request For Applications (RFA)

- The RFA outlines the different elements of the Model in detail and explains how the applications will be reviewed
- The RFA can be downloaded from the CMS Innovation Center website:
 - <https://innovation.cms.gov/initiatives/bpci-advanced>



Application Template and Application Portal

- The application template and all required attachments are available for download here:



<https://innovation.cms.gov/initiatives/bpci-advanced>

- However, the actual submission of the application **MUST** be made via the BPCI Advanced Application Portal here:

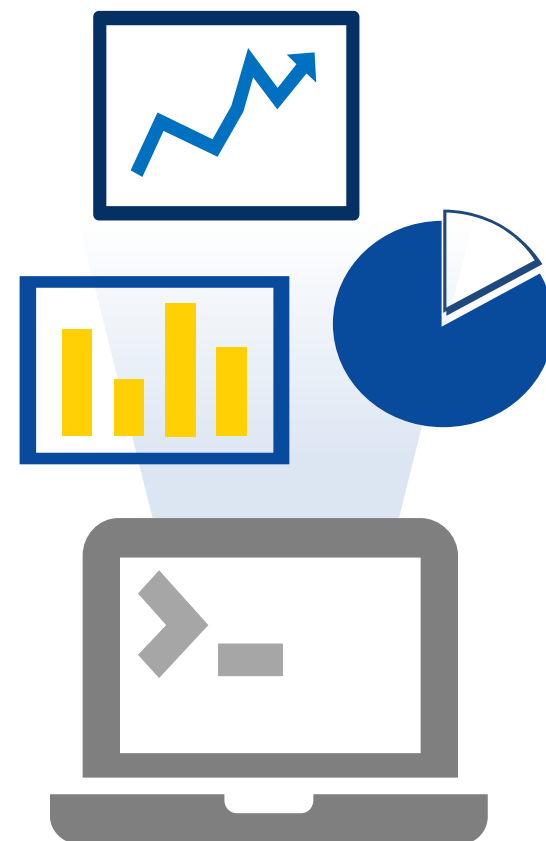


<https://app1.innovation.cms.gov/bpciadvancedapp>

- ***Paper applications submitted via email will not be accepted***

Data Request and Attestation (DRA) Form

- Applicants must submit a Data Request and Attestation (DRA) form along with their completed application in order to receive data and preliminary Target Prices
- The DRA template and further instructions can be downloaded from the CMS Innovation Center website
- CMS expects to distribute Target Prices to Applicants in May 2018



Organization Information: Required Documents

- Convener Applicants must download and populate the “**Participating Organizations**” attachment to provide information on all of their EIs
- PGPs Applicants and Convener Applicants that have Physician Group Practices as Participating Organizations must download and populate the “**PGP Practitioners List**” attachment to provide information on all physicians who were in the practice at any time during Calendar Years 2013, 2014, 2015, 2016, as well as in which Hospitals you expect to trigger Clinical Episodes



Attachments can be downloaded from either the CMS Innovation Center website or from the BPCI Advanced Application Portal.

Additional Resources

- “Application Process” webcast
- Application Process Handout
- General Fact Sheet
- General FAQs
- Physician-Focused Fact Sheet
- Physician-Focused FAQs
- Comparison Table of Bundled Payment Models
- Roadmap - Model Timeline

These resources, as well as other materials to be developed, can be found on the CMS Innovation Center website.

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>
- **Your opinion is important:** Please complete this short survey to provide feedback on this webcast:

<https://www.surveymonkey.com/r/BPCIWebcast301>

