Bundled Payments for Care Improvement Advanced | BPCI Advanced

Center for Medicare and Medicaid Services

Pricing Methodology Open Forum Webinar

June 28, 2018 1:00 pm – 2:00 pm ET

Transcript

>> Leslie Vasquez:

I would like to welcome everyone to join us today on behalf of the CMS Innovation Center. Today's open form is entitled, "Bundled Payments for Care Improvement Advanced Pricing Methodology Open Forum". As she said, my name is Leslie Vasquez and we are pleased you joined us today. I'm joined by several members of the BPCI Advanced team to address your questions submitted in advance. During the event, feel free to submit additional questions using the chat feature, and members of the team will be standing by to review them. We plan to create a new Frequently Asked Question, or FAQ document, to incorporate the questions presented today plus additional questions when submitted through the chat feature. You can expect a recording of today's event to be available later on today. In order to access the recording, use the registration link that you receive when you registered. In about a week, we will also have a transcript and audio recording available on the BPCI website.

As we move forward with the work of launching the new model, we have a variety of resources available on the website. Most recently released was the reconciliation specification and a revised version of the Quality Measures that help identify which measures apply to which episode. Very soon, we will post templates for the 4 deliverables that Participants must submit to CMS prior to starting participation, along with training aids that will provide guidance on how to complete the documents. We encourage you to keep visiting the website often because we keep adding new resources on a regular basis. Before we get started with questions, we would like to send a few policy updates out. Introducing the policy updates first will be a member of the team, Joyce Olabisi. Joyce, over to you.

>> Joyce Olabisi

Thank you, Leslie. First, we want to start off discussing merger policy for Applicants. When reviewing a BPCI Advanced application, CMS will only consider the Tax Identifcation Number, or TIN, for the Physician Group Practive, PGP, or the CMS certification number, CCN, for the Acute Care Hospital, ACH, that was submitted by the Applicant, non-convener, or convener Participant or its Episode Initiators at the time of application deadline, March 12, 2018. If the TIN or CCN as listed for the

Applicant in the application is no longer valid prior to the execution of the BPCI-A participation agreement, then the Applicant and all the Episode Initiators are ineligible to participate in the model effective 10/01/18. If the EI is one with a TIN that is no longer valid, than only the EI is ineligible to participate.

Merger Policy for Participants: If an organization participating in BPCI Advanced merges after the model start date, and begins using a new TIN or CCN for billing purposes, their participation in the model will be terminated effective the date prior to the merger. If the TIN or CCN listed for an Applicant or Episode Initiator in the application is no longer valid after 10/1/18, then the Participant will be responsible for Clinical Episodes attributed to it, and its downstream Episode Initiators that were discharged prior to the date of termination. Any organization with circumstances previously described will be able to apply again for the second cohort of the model scheduled to begin in January 1, 2020. The applications period for the second cohort will occur in the spring of 2019.

CMS Policy Update Number Two, Academic Medical Center, or AMC status: CMS uses the Joint Commission's three-part criteria to determine if an acute care hospital participating in BPCI Advanced qualifies as an Academic Medical Center, for the purposes of determining Peer Group Characteristics when calculating Target Prices. One: the Applicant hospital is organizationally or administratively integrated with the medical school. Two: The Applicant hospital is the principal site for the education of both medical students, undergraduates, and postgraduate medical specialty trainees: For example, residents or interns from the medical school noted in criterion one. Three: At the time of application, the Applicant hospital is conducting academic and/or commercial human subjects research, under multiple approved protocols, involving patients of the hospital.

Applicants identified many potential Episode Initiators as academic medical centers in the participating organizations attachment, but some did not meet CMS criteria. To locate your AMC status, please refer to the table on the Peer Group Characteristics tab in the Target Price workbook under column D named “Academic Medical Centers.” Note that the self-designated AMC status may have changed following CMS verification.

>>Sacha Wolf:

Hi, this is Sacha Wolf. I just want to give you an update on the pricing for Total Knee Arthroplasty for Clinical Episodes in BPCI Advanced. We also want to provide an update on the BPCI-A approach pricing inpatient Total Knee Arthroplasty. This procedure is no longer on the inpatient-only list as of January 1st, 2018.

First, the model will not change existing CMS Fee-for-Service policies that guide the choice of appropriate setting, including the “two midnight rule.” Second, with regard to Clinical Episode pricing, please note target prices in BPCI Advanced are not determined using historical or regional averages, which are the methodology previously used by the BPCI initiative and bundled payment models. The Advanced Model Pricing Methodology creates Target Prices for clinical episodes, based on severity and historical spending relative to peer groups.

CMS will add three additional variables to the standard set that are unique to the Inpatient Major Joint Replacement of the Lower Extremity Clinical Episode (MJRLE), in order to address concerns regarding the inpatient Total Knee Arthroplastic (TKA) procedure no longer being on the CMS inpatient-

only list as of January 1, 2018. Additional variables: Indicator for the presence of a fracture, indicator for a Total Knee Arthoplasty (TKA) procedure, and an indicator that both a fracture and a TKA procedure exist for an individual clinical episode.

This clinical Severity Based Pricing will allow more uniform and precisely titrated inpatient Total Knee Arthroplasty pricing that is responsive Patient Case Mix of our time through robust set of variables that will assess clinical severity for major joint Clinical Episodes. This methodology will mitigate the possibility of a price distorting effect due to historical averages, which could be an issue in the event that a provider's case mix changes over time. Using this new approach, CMS does not believe there will be a risk of systematically underpricing inpatient Clinical Episodes, which will continue to be priced based on historical averages even as more Total Knee Arthroplasty procedures move to the outpatient setting. CMS will monitor spending and adjust our approach to pricing in future years of the model, as necessary.

>>Leslie Vasquez:

To provide a quick overview of the topics that we are going to discuss today, so for the most part we will cover questions based on pricing methodology and Quality Measures. As time permits, we will answer questions submitted via the chat.

To make the event a little bit easier to follow, we have grouped the questions into categories. We will start with questions around pricing, and then next we will go to questions around the Composite Quality Score.

Sacha, I've got the first question up for you to address. The question is: Is the Physician Group Practice, or PGP offset, comparing the PGP's efficiency at one hospital, or the PGP's efficiency at all hospitals?

>>Sacha Wolf:

The PGP offset is the ratio of PGP efficiency to hospital efficiency. PGP offset measures the PGP's efficiency relative to a specific hospital, at which it initiates its Clinical Episodes; thus, there's a separate PGP offset for every hospital at which he PGP's Clinical Episodes are initiated. Efficiency is defined as the ratio of Clinical Episode Spending relative to all other Episode Initiators after accounting for patient and Peer Group Characteristics to render the amounts comparable.

>>Leslie Vasquez:

Thanks. Our next question is: How can the Peer-Adjusted Trend Factor be trended to Quarter Three of 2019 if that time period has not happened?

>>Sacha Wolf:

In the Stage Two regression used to derive the Peer-Adjusted factor, or PA factors, the literal trending cost is estimated that uses calendar quarters as the unit of time. Once the coefficients of the time trend are estimated, any future time period can be substituted to provide a forward-looking projection of what the trends in Clinical Episode cost will be during the specified quarter. In this case, since Quarter One of 2013 is denoted using a value of one, Quarter Two of 2013 with the value of 2, et

cetera. Inserting a value of 27 for the calendar year quarter represents Quarter Three of 2019 and allows for cost to be projected to this quarter.

>>Leslie Vasquez:

Thanks. Our next question is: In calculating Target Prices, are standardizaed baseline spending, (SBS), Patient Case Mix Adjustment (PCMA), Peer-Adjusted Trend (PAT), and PGP offset factors constant across all Clinical Episodes for provider or do they vary by Clinical Episode?

>>Sacha Wolf:

That's a good question. All of these very at the level at which Target Prices are calculated. That is they vary at the Clinical Episode category at the hospital level. Since hospitals only initiate Clinical Episodes at the single hospital they receive a single Target Price within a Clinical Episode category. However, since PGP's can initiate Clinical Episodes at multiple hospitals within a single category, they will receive a separate Target Price for each hospital. The Standardized Baseline Spending, Patient Case Mix Adjustment, Peer-Adjusted Trend Factor, and the Denominator of the PGP offset all vary at the hospital level, and therefore, will be different for each hospital of an Applicant's Target Prices.

>>Leslie Vasquez:

Thank you. And our last question for you right now is, does the Target Price step three include Peer Group Characteristics in the Clinical Episode Spending from the Risk Adjustment Model?

>>Sacha Wolf:

No. The calculation of Patient Case Mix Adjustment, or PCMA, does not include Peer Group Characteristics from Stage One Regression. Peer Group Characteristics in Quarter Year indicators are included in the Stage One Regression Model to obtain robust estimates of the patient level characteristics, but only the Patient-level coefficients are retained. Trends used to construct Peer-Adjusted Trend Factor are then estimated in the Stage II Regression.

>>Leslie Vasquez:

Thank you. All right, for our next set of questions we will move over to Elen to address these. First question, can a hospital Peer Group Characteristic, such as hospital size, change quarter over quarter, due to an addition to hospital beds in a given year after capital investment? Or does CMS evaluate the Peer Group Characteristics at a specific point in time such as Q4 2016 and then trend that to Q3 of 2019? Elen, thoughts?

>>Elen Shrestha:

Most of the Peer Group Characteristics are constructed using the latest available data as of the processing date for the cut off that was used to construct Target Prices. However, the safety net characteristics is an exception, and this covariate is constructed for each calendar year and thus may vary across quarters in the baseline period.

>>Leslie Vasquez:

Our next question for you: Can you please help us understand this statement from the Target Price specifications? At the ACH quarter level, calculate the average ratio of observed Clinical Episode Spending to predicted Clinical Episode Spending and regress the average.

>>Elen Shrestha:

First, when we say at the ACH quarter level, calculate the average ratio of observed Clinical Episode Spending, we are building the portion of Clinical Episode Spending that is not explained by Patient Case Mix. Taking the average of this ratio across a hospital's baseline period Clinical Episodes in a quarter represents the Dependent Variable for the Stage II Regression. To build this, for each Clinical Episode, we calculate a ratio of observed spending to Patient Case Mix adjusted spending from Stage One Regression. As previously stated, this accounts for the portion of spending for this Clinical Episode that is not explained by Patient Case Mix Severity. We then calculate the average of this ratio at the hospital and quarter level. Once the average is built, we run the Stage II Regression and project the trends in the Clinical Episode Spending to the Performance Period of interest. In other words, we estimate an ordinary least squares regression of this average ratio and Peer Group Characteristics interacted with a time trend to identify what portion of the Clinical Episode Spending is explained by Peer Group Characteristics and time.

>>Leslie Vasquez:

Our last question for you at this time is: Given that the Target Prices are calculated at the Clinical Episode category level, can you explain in simple terms, how do we calculate the correct spending at the individual Clinical Episode level in order to compare the Target Price?

>>Elen Shrestha:

Yes, to determine what to include in the Performance Period Clinical Episodes, follow the steps in the episode creation specifications document, to determine the sum of spending for Clinical Episodes initiated at the same hospital for which the Target Price is applicable. See Section6 and 9, in particular. After the Clinical Episodes are built, the step-by-step details to aggregate the performance period spending are provided in Section 4 of the Reconciliation Specifications. Both these documents are available on the innovation center's BPCI Advanced website.

>>Leslie Vasquez:

For the next set of questions we will transition over to Mike McCormick from the team. Mike, the first question for you is: How does the Target Price incentivize historically low-cost providers? The hospital Efficiency Adjustment seems to effectively cancel out the Peer Adjustment. In other words, it seems that a hospital with low-cost relative to peers would have an Efficiency Adjustment that effectively cancels out any increase in target that may have been given from the Peer Adjustment.

>>Mike McCormick:

Thank you. The Efficiency Measure ensures that a Participant's Target Price is adjusted off of their historical spending. Therefore, after accounting for patient Therefore, after accounting for Patient Case Mix, and group levels, and trends the Participant that historically efficient Clinical Episode Spending

will have a lower Efficiency Measure relative to a Participant that has high-episode spending. This in itself provides us efficiency for the model ince Participants can achieve savings by lowering costs below their historical spending beyond the CMS discount factor.

This incentive is even greater for historically efficient PGP Episode Initiators, since PGPs who were historically efficient relative to the hospital, which they practice PGP offset is less than one, will have their offset increased by half its distance from one. For more information, see Step 14 B of the Target Price Specifications, available on the BPCI Advanced website. Thus, the Target Prices for these PGP's are increased above what is expected given their historical spending levels. Through this methodology, any Participant is capable of benefiting from participation, if they are able to lower costs from their own historical levels after adjusting for factors out of their control.

>>Leslie Vasquez:

Our next question for you is: For Performance Period hospital benchmark price, or HBP, will only the case mix adjustment, or PCMA, may change. Thus, will the standard line baseline spending and the PAT factor be the same as what will be in the baseline prices?

>>Mike McCormick:

Yes, only the Patient Case Mix Adjustment and the standardized ratio will be updated for the Performance Period hospital benchmark price. Final piece PCMA is constructed using the Clinical Episodes and the applicable model year. Additionally, final target process is updated for real dollars using the standardized ratio. We note, however, that standardized baseline spending and the Peer-Adjusted Trend Factor will be adjusted at the beginning of each fiscal and calendar year to account for payment setting price from the finalized rules.

>>Leslie Vasquez:

Thanks. And our next question for you is: Is the first and ninety-ninth percent Winsorization applied to all Clinical Episode Spending prior, during, or after the calculation?

>>Mike McCormick:

Clinical Episode Spending amounts input to the Risk Adjustment Model are winsorized to the 1st and 99th percentile for each Medicare severity diagnosis-related group or comprehensive ambulatory payment classification pools for each calendar year. No further Winsorization is applied to Target Prices after Risk Adjustment. This method ensures baseline and Performance Period Clinical Episodes are comparably truncated to remove extreme outliers.

>>Leslie Vasquez:

Thank you. For our next set of questions we will transition over to Julia Byram. The first question that we have is: Why would a PGP Participant receive a preliminary Target Price, but not receive raw baseline claims data?

>>Julia Byram:

PGPs, Participants, and Episode Initiators do not receive raw claims if they did not initiate any Clinical Episodes in the baseline period. However, they are still eligible to receive preliminary Target Prices based on the hospital prices for the CCNs listed in their practitioners list.

>>Leslie Vasquez:

Thank you. All right, the next question we have for you is: Why do we convert to real dollars if the performance information, conveyed in the hospital baseline and the monthly files, is expressed as standardized dollars? Shouldn't the actual targets be on the same basis, that is to say, standardized?

>>Julia Byram:

Sure, so CMS constructs Clinical Episode using standardized allowed amounts which reflect the cost of services after removing variation in spending arising from geographical adjustment of reimbursement and CMS payments systems, such as Hospital Wage Index and Geographic Practice Cost Index, and from policy driven adjustment such as indirect medical education and disproportionate share hospital. The complete description of the official CMS Standardization Methodology by setting can be found on the QualityNet.Org website. Real dollars represent the true amount the providers are reimbursed for their provision of Medicare covered care. Since reconciliations amounts are calculated in real dollars, Target Prices are converted into real dollars to allow comparison of Target Prices and actual spending, in a consistent manner.

>>Leslie Vasquez:

Thank you. And our last question for you at this time is: Is there a floor for the Efficiency Measure?

>>Julia Byram:

No, there is not a formal floor for the Efficiency Measure. However, since the PGP offsets less than one will be adjusted, such as the distance to one is reduced by 50 percent, in practice, no PGP offset will be less than 0.5.

>>Leslie Vasquez:

Thank you. Okay, this next question is for Sacha. Can you clarify when, in the overall process of setting Target Prices, the Patient Case Mix coefficients will be re- estimated? Having coefficients for the Patient Case Mix factors that are different from those of the original Patient Case Mix model, can impact final Target Prices.

>>Sacha Wolf:

Thanks. The Risk Adjustment Co-efficients will not be re-estimated in the Performance Period. Rather, the Risk Adjustment parameters will be re-applied to the realized case mix that occurs in the performance period. However, twice annually when Medicare sets new payment rates for payment systems on the fiscal year in calendar years, new siding specific update factors will be applied to the baseline period Clinical Episodes to make their spending comparable to the new prices. At these times, Risk Adjustment will be rerun and coefficients may change. Please note these changes will only reflect

in Medicare pressing updates and because prices increase on average it is expected that these changes will on average lead to increases in Target Prices.

>>Leslie Vasquez:

Thank you. Our next question for you is: Realty Target Price summary workbook be provided for each new Target Price period?

>>Sacha Wolf:

The same methods for determining Target Prices will be used for Model Years One and Two. However, twice annually when Medicare sets new payment rates for payment systems on the fiscal year and calendar years, these preliminary target process will be updated and revised workbooks will be provided. Specifically, the update in September of 2018 for fiscal year 2019 payment rates, the update December 2018 for calendar year 2019 payment rates, and the update in September 2019 for fiscal year 2020 payment rates. All of the Target Prices will be updated to reflect relies Performance Period beneficiary data during reconciliation cycles.

>>Leslie Vasquez:

Thank you very much. Our next question for you is: Are the Risk Adjustment parameters included in the baseline data for each beneficiary or episode?

>>Sacha Wolf:

Good question. Yes, patient characteristics are included in the baseline data. Referred to the claims files lay out workbook on the BPCI Advanced website. Also note that characteristics are provided in the preliminary Target Price summary workbooks.

>>Leslie Vasquez:

Thank you. All right, Mike, back over to you. First question: What is the duration of the Anchor Procedure for outpatient episodes? Furthermore, if the Anchor Procedure overlaps with an Anchor Stay, how are they Clinical Episodes treated?

>>Mike McCormick

I want to note that we have received some comments that the audio cut out a little bit when Sacha was explaining the TKA policy, and during my first question, and if we have time at the end, we will repeat those questions, and if not they will be on the FAQ document.

Okay, so the duration of the Anchor Procedures the duration of the outpatient claim line with the triggering Healthcare Common Procedure Coding System, or HCPCS code. If an Anchor Procedure overlaps with an admission that is eligible to start a Clinical Episode, the Clinical Episodes are attributed differently, depending on whether they occur in the baseline period and the Performance Period. In the baseline period, both will trigger and will follow normal attribution rules. However, in the Performance Period if the Anchor Procedure and Anchor Stay occur on the same day, only the inpatient Clinical Episode is attributed. Please refer to Tables 12 and 13 in the Creation Specification document available on the website, for more details on the Clinical Episode selection logic.

>>Leslie Vasquez:

Thanks. First, there is a comment: These specifications defined acute-to-acute transfers as consecutive inpatient stays at short-term hospitals. The question is: How do you define short-term hospitals and which claim types or facilities would be included?

>>Mike McCormick:

So the following hospitals are considered short-term hospitals, and would fall under the definition of acute-to-acute transfers in the specifications:

- Short term hospitals can be identified by a CCN with the last four digits between 0001-0879,
- Critical access hospitals, whose CCNs end between 1300-1399,
- Emergency hospitals whose CCNs have either an E or F as the sixth digit, and
- Veterans hospitals whose CCNs have a V as the fifth digit.

However, if such combined stays involved Critical Access Hospitals in any leg of the transfer, this does not trigger a Clinical Episode, as they are excluded from BPCI Advanced. In addition, you can reference the Research Data Assistant Center (or RESDAC) website for the provider number table to provide more information.

>>Leslie Vasquez:

If a PGP is included in the application, for example, three hospitals in which the PGP practiced during the 2013-16 time frame, is that PGP allowed to select one or all of the three hospitals for their respective Clinical Episodes during the performance years? The second part is must the PGP be responsible for all Clinical Episodes it selects, no matter which hospitals those Clinical Episodes are performed at during the performance years?

>>Julia Byram:

So that PGPs will be held responsible for all selected Clinical Episodes built under that PGP's TIN at any eligible hospital. This applies to all hospitals at which the PGP initiates Clinical Episodes in the Performance Period, even if the PGP did not receive preliminary Target Price for that specific hospital.

>>Leslie Vasquez:

Thanks. Next question for you is: The BPCI Advanced Aggregate Baseline file includes a tab entitled “Clinical Episode Spending.” Column L lists the mean Clinical Episode Spending, specifically. The question is, are dollar amounts in column L expressed in 2016 or have they been trended to model year dollars, such as 2018?

>>Julia Byram:

Payments for each Clinical Episode in the baseline period are updated to model year dollars using setting specific update factors. As such, the dollar amounts provided in the Clinical Episode Spending tab are also model year dollars. Table four in the baseline summary table workbook contains the factors that are applied to non-initiating payments.

>>Leslie Vasquez:

Thank you very much. This is for Elen. I see that every parameter/Clinical Episode type/clinical category combination has two Node estimates. Can you differentiate between Node One and Node Two?

>>Elen Shrestha:

Sure. The expected cost of a Clinical Episode is the weighted average of the expected costs in the two nodes with the weights given by the estimated probability that a case is an Node One and that a case is in Node Two. Allowing for two nodes provides the more flexible statistical specifications than simple linear or log linear regression models. Slide 80 and 81 of the pricing methodology technical review webinar posted on the BPCI Advanced website provides more technical details, including the log likelihood function used in statistical estimation, and the equation for calculating Patient Case Mix adjusted spending, respectively.

>>Leslie Vasquez:

Thank you. And the next question for you is: Can you please clarify how Applicants should calculate savings? Specifically, which spend and which target amounts are most appropriate to compare in order to calculate savings? Please clarify final spend and Target Price numbers or the fields and/or factors that we need to calculate savings, so that we can align with CMS savings calculations.

>>Elen Shrestha:

To calculate savings, preliminary Target Prices in 2018 will be updated to final Target Prices, based on real-life case mix information in the Performance Period. These amounts will be updated to account for the most recent Medicare payment rate updates. Performance Period spending will be winsorized at the 1st and 99th percentile, and expressed in real dollars. Assuming the Clinical Episode file provided is for the Performance Period, the spending variable in column SF in the episode level will be input to the Performance Period spending. This is standardized allowed amount with adjustment from setting winsorized factors at the 1st and 99th percentile. This spending will need to be multiplied by standardized ratio provided in the Target Price workbook. For detailed specifications, please review the Reconciliation Specifications document available on the BPCI Advanced website.

>>Leslie Vasquez:

Our next question, Sacha, back over to you. It's a question and a comment. We have noted that some postacute charges are appearing in the Anchor Stay in the summary data. Will CMS define what Part B charges will appear in the Anchor versus Post-anchor summaries and would CMS share the rules for allocating changes to the Anchor and Post-anchor?

>>Sacha Wolf:

First,we note the rules for assigning the standardized allowed amount to Anchor versus Post-anchor period by claim setting do not affect Clinical Episode costs which are used and Target Price and reconciliation calculations. That being said, cost for skilled nursing facilities and home health agencies and hospice claims that do not require proration that occurred during the anchor stay/ Anchor Procedure excluding the last day of the anchor state are in the anchor spending. The remaining skilled

nursing facility, Home health agency, and hospice claims that do not require proration, are in the Post-anchor spending. All three types of claims that overlapped the anchors the order Post-anchor period and post- episode period are prorated, and the relevant proportion of costs are assigned to each period. For exact proration methodology for all settings, refer to the Clinical Episode specification document on the BPCI Advanced website.

>>Leslie Vasquez:

Our next question is: When looking at the Preliminary Target Pricing Workbooks, the final preliminary Target Prices after step 18 are given in 2018 real dollars. In the TP components tab, we can see the preliminary Target Prices in Step 17 are still in standardized dollars. Therefore, in order to compare baseline mean costs-to-target, should we use the preliminary Target Price of step 17?

>>Sacha Wolf:

The baseline mean cost povided in the summary workbook are in standardized dollars. To compare these cost to the preliminary Target Price use the preliminary Target Price in step 17 in the TP components tab. Real dollars represent the true amount that providers are reimbursed for provision of Medicare covered care. Since reconciliation amounts are calculated real dollars Target Prices are converted into real dollars to make target and actual spending comparable.

>>Leslie Vasquez:

Okay, Mike back over to you for the next question. The question is: How will CMS attribute PGP episodes during the Performance Period?

>>Mike McCormick:

To create the PGP National Provider Identifier, or NPI combinations, used for PGP attribution, CMS first identifies the Part B claim billed for that beneficiary during and one day prior to the anchor stay Anchor Procedure. If found, they check if the TIN on the claim is a PGP Participant, and if so we check for a link between the attending or operating physicians on the hospital claim and the NPI on the Part B claim. If this occurs, the PGP and NPI mapping is considered valid, and you can refer to steps 24 and 29 on the episode construction specifications on the BPCI Advanced site for more details.

>>Leslie Vasquez:

Thanks so much. They next question we have for you is: Could CMMI please confirm if the SIGMA1 and SIGMA2 values in the Risk Adjustment parameters are a standard deviation?

>>Mike McCormick:

Yes, the values and the Risk Adjustment parameters tabs are the standard deviations of Node One and Node Two respectively. However, please note the values must be squared to convert them into variances.

>>Leslie Vasquez:

And our next question is: What we have observed different peer group constructions across our Target Price file than the CMS provider specific file regions in the grid provided. For example, BPCI

Advanced Census division three is labeled East North Central, but on the Census website, and in the file it's labeled as South Atlantic. Could you please clarify?

>>Mike McCormick:

Yes, so we have noticed that census division 3-6 are labeled incorrectly in the definitions tab of the preliminary Target Price summary workbooks. However, please note that the mistake was limited to the definitions tab, and the preliminary Target Prices were calculated correctly. Providers were assigned the census divisions as reported in the CMS provider specific file (PSF) and we will be providing the updated tables soon.

>>Leslie Vasquez:

Thank you. All right, our next question is for Julia. The aggregate data file states that it contains all Clinical Episodes with Anchor Stay discharge date, or Anchor Procedure and date between January 1, 2013, and December 31st, 2016. However, the minimum anchor end-date field for the Clinical Episode raw data file shows that the earliest date we are getting is January 1 of 2014, with a max Anchor end date of December 31st, 2016. Can you explain the difference?

>>Julia Byram:

The raw files are provided for three years only 2014-16 because it was determined that meets the minimum necessary requirement under HIPAA regulations to carry out healthcare operations as described in the BPCI Advanced Data Request and Attestation form.

>>Leslie Vasquez:

The next question is for Elen. The question is: How does the PAT factor constructed using the coefficients from stage two regression?

>>Elen Shrestha:

To calculate the Peer-Adjusted Trend Factor, or PAT factor, we can use the following steps : First, update the quarter year indicator to the middle of model year 2 that will be the third quarter of 2019. Assuming that first quarter of 2013 which is the first quarter in the baseline period is one. The new quarter value will be 27. Update the quarter trend by peer group interactions to reflect this new quarter value. And lastly, apply these stage II coefficients from the OLS regression to get the PAT factor for each hospital in quarter three of 2019.

>>Leslie Vasquez:

Thank you. And our next question is for you, Mike. The question is: How do the precedence rules or selection of Clinical Episodes differ in the baseline and Performance Period?

>>Mike McCormick:

Thanks. So to maximize the number of baseline period Clinical Episodes to create robust Target Prices, Clinical Episodes in the baseline period are allowed to overlap. This means that if a beneficiary is admitted to a hospital during an ongoing BPCI Advanced period Clinical Episode for a BPCI Advanced MS-DRG, or Healthcare Common Procedure Coding System (HCPCS) trigger code, a new Clinical Episode would be initiated. Also, to address the concerns that Clinical Episodes that overlap may have a

different cost better from those that do not a recent resource use Risk Adjustment flag captures cases in the data file. However, in the Performance Period, only one Clinical Episode can occur at a given time for beneficiary.

>>Leslie Vasquez:

Thank you, Mike. Elen, the next question for you. Why are preliminary PGP and ACH Target Prices constructed from few baseline periods clinical episodes subject to few significant changes from final targets?

>>Elen Shrestha:

Thanks. Some of the PGPs that received PGP specific prices, for example, not simply the hospital benchmark price, will have low baseline period Clinical Episode comes at a certain hospital, which can lead to high volatility of the preliminary relative case mix term since it is calculated from a few Clinical Episodes. These relative case mix terms should be viewed as placeholders, because they may not be representative of a PGP average case mix, as they may be heavily influenced by a few patients. These relative case mix terms and associated Target Prices should be interpreted with caution, as they may change substantially when they are updated to reflect realized performance case mix information. See an example in the next slide. [1]

TIN	ACH CCN Associated with Initiating Claim	Clinical Episode Category	PGP-ACH Baseline Clinical Episodes	Preliminary Price				Final Price			
				Preliminary HBP	PGP Offset	Preliminary Relative Case Mix	Preliminary PGP-ACH Benchmark Price	Final HBP	PGP Offset	Final Relative Case Mix	Final PGP-ACH Benchmark Price
0001	0002	Stroke	3	$28,000	1	3.2	$89,600	$28,500	1	0.9	**$25,650**
0001	0002	Urinary Tract Infection	5	$23,000	1	2.5	$57,500	$22,500	1	1.01	**$22,725**

This table shows an example for PGP Participants 001 that participate in two Clinical Episode categories at a hospital 0002. Specifically we can look at one Clinical Episode category to show it's the same idea. You will know that the preliminary and final hospital benchmark prices are similar, in that the final hospital benchmark price differs from the preliminary hospital benchmark price by only 1.8 percent. This will often be the case when a hospital has a large number of Clinical Episodes in the baseline and Performance Period. However, contrary to the table hospital benchmark price, you will see that the preliminary and final benchmark price differs from one another by a significant margin.

The PGP which has few Clinical Episodes has the highest preliminary case mix. In other words, the case mix of the patients in the baseline period is associated with much higher spending overall case mix of the hospital. Since the Performance Period relative case mix in this example is similar to that of the hospital, the final benchmark is closer to the hospital benchmark price. This example is intended to convey that PCMAs built on Clinical Episodes may not be representative of the same or similar case mix

[1] Please note that this table has been updated since the open forum to correct the numbers in the final column. However, the audio that goes with this slide is still accurate.

treated in the Performance Period. Preliminary PCMAs and relative case mix our estimates of the final version and should be interpreted with caution especially in the values are based on small episode counts. Please note that not all PGP's with a low volume of Clinical Episodes in the baseline period would see a significant change from final benchmark prices. Having a small number of Clinical Episodes in the baseline period only makes the scenario more likely.

>>Leslie Vasquez:

The question is: What will be included in the monthly data files that Participants receive when the model starts?

>>Mike McCormick:

We are still working to finalize the variables and the format for monthly data files that will be available to Applicants that end up signing a BPCI Advanced Participation agreement and a new Participant Data Request and attestation form. We've received some inquiries and requests regarding what will be included in these files and will give careful consideration to those requests as we work with our payment contractor. CMS will provide a new claims file layout that will give details on the data elements Participants will receive prior to the distribution of the first monthly data feeds, which are currently targeted to be sent out in late October.

>>Leslie Vasquez:

Now we are going to transition over to Quality Measures, and specifically how the Composite Quality Score can impact reconciliation results. The first question in this section is for Julia. The first question is: What is the submission process for Quality Measures?

>>Julia Byram:

There are seven Quality Measures in BPCI Advanced. Five measures will be pulled by CMMI from CMS data. Those are:

1. First, All-Cause Hospital Readmissions,
2. Second, Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty.
3. Third, Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction.
4. Fourth, 30-day All-Cause Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery, and
5. Fifth, CMS Patient Safety indicators.

The Perioperative Care measure will be pulled from MIPS submission. The Advanced Care Plan will be calculated based on claims from any PGP regardless of participation for the episode time period in one year prior. For more details about the Quality Measures and how they correlate to the Clinical Episodes, refer to the Quality Measures table posted in the BPCI Advanced website.

>>Leslie Vasquez:

Thank you. Okay, the next question is when will the Composite Quality Score, or CQS, be calculated for reconciliation purposes?

>>Julia Byram:

The first Composite Quality Score, CQS, will not be calculated until the reconciliation that occurs in the fall of 2020 reconciliation for episodes that end between 10/1/2018 through 6/30/2019. The initial reconciliation for those episodes will occur in the fall of 2019, but that reconciliation and the first true-up in the spring of 2020, will contain a placeholder for CQS in an effort to prevent the recoupment of previously distributed funds. Please refer to payment timeline included in the Reconciliation Specifications recently posted on the BPCI Advanced website.

>>Leslie Vasquez:

Our next set of questions are going to go over to Sacha. First, we have: Why is CMMI using the CMS Patient Safety Measure and not the AHRQ Patient Safety Measure?

>>Sacha Wolf:

The CMS Patient Safety Indicators 90 measure, is tailored to the Medicare population. Beginning with version 5.0, Patient Safety Indicators were recalibrated for use in CMS programs based on Medicare fee-for-service data. The CMS recalibration increases the accuracy of Patient Safety indicator Risk and Reliability Adjustment in the CMS population.

>>Leslie Vasquez:

Thanks. Next question is: What period of performance will serve as a basis for Quality Score performance calculations?

>>Sacha Wolf:

The initial calculations for the company -- quality composite score will be based on calendar year 2019 data and revised annually.

>>Leslie Vasquez:

Next question is: Why is CMMI applying the Care Plan Measure at the beneficiary level instead of the NQF specification at the NPI level?

>>Sacha Wolf:

This correctly points out the Endorsed Care Plan Measure is endorsed at the physician level. CMMI has instead applied the measure at the beneficiary level. Only beneficiaries who have Clinical Episodes attributed to Episode Initiators will be included in the Denominator of the measure. We believe specifically applying this measure to Clinical Episodes triggered under the model allows the Episode Initiator to influence measurable improvement. It also allows for a straightforward interpretation of performance by Episode Initiators.

>>Leslie Vasquez:

Thank you. Okay, Mike the next question is for you. Will Clinical Episodes have their own Quality Score? Will volumes affect the impact of performance on the overall Quality Score?

>>Mike McCormick:

Thanks. So yes, a Quality Score will be calculated for each individual Clinical Episode. For Episode Initiators that participate in multiple episodes, these Quality Scores for individual episodes will be combined into a Composite Quality Score at the initiator level. Also, to reach the composite qualities for individual Quality Scores will be weighted by the respective Clinical Episode volumes. This is converted into a percentage and applied to the net positive or net negative Total Reconciliation Amount to produce the Adjusted Total Positive or Negative reconciliation amount.

>>Leslie Vasquez:

Thanks. And our last question at this time: How does the Composite Quality Score accrual work?

>>Mike McCormick:

The Quality Measures that will be applied to Model Years One and Two are all derived from administrative claims which requires significant time to finalize. Quality measure data from 2017 and 2018 reflect performance outside the model, but will be provided for benchmarking purposes. Therefore, data from 2019 will be used to calculate the first CQS applied to payment but the CQS will not be available until the fall of 2020, as stated in a previous answer. Again, episodes in 2019 will be applied to the first or second true-up, depending on the end date and not to the original reconciliation.

>>Leslie Vasquez:

Thank you. Okay, because that was such a great answer to those questions we will address the last couple to you as well. All right, next up we have: Are preferred networks for skilled nursing facility and home health providers encouraged as long as patients are informed that they have any -- a choice of any provider?

>>Mike McCormick:

Thank you. Participants can create and/or recommend preferred postacute care networks. However, a beneficiary's freedom of choice cannot be suppressed. Therefore, Participants must notify beneficiaries of their participation in the model and require their Episode Initiators and participating practitioners to do the same.

>>Leslie Vasquez:

Okay. And the next question we have is: How can we identify Inpatient Rehab Facility spending on the summarized spending spreadsheet and the raw claim files?

>> Mike McCormick:

The claims related to inpatient rehabilitation facilities can be identified on the raw claims using the last four digits of the CCN. CCNs that end between 3025-3099 indicate rehabilitation hospitals.

>>Leslie Vasquez:

All right, thanks, Mike. So now I believe we can get back to slide 53 just for a wrap up. I want to thank everyone so much for joining today. Just share a final few housekeeping details. If we could go back to slide 53, please.

So in terms of housekeeping details, the recording of slides from today's event will be available in about three hours. Use the registration link you received to access the file. And then in about a week, we will have the transcript of the audio recording, available on the BPCI Advanced website. We are going to post a new edition of our FAQs based on today's event in the upcoming weeks. This document will incorporate other questions we presented today, plus the selection of the additional questions you submitted through the chat window.

We would like to remind everyone to please keep visiting the BPCI Advanced website because we are continually loading more and more resources for you all. If you have any questions about today's event or the model, please e-mail the team directly at BPCIAdvanced@cms.hhs.gov. And without further ado, we will go ahead and close the event. We would really appreciate if you took a couple of minutes and filled out the brief survey that's going to pop up at the end of the session. Natalie, over to you.

>>Natalie:

Thanks to all our Participants for joining us today. We hope you found this open forum informative. We would appreciate you giving us your feedback on this event by answering a few questions. You will receive a link at the end of the session. You may now disconnect. Have a great day.