

Bundled Payments for Care Improvement Advanced (BPCI Advanced) - Operationalizing BPCI Advanced Webcast Transcript

Hello and welcome to today's webcast. I'm Steve Farmer and I'm a practicing cardiologist who also works for the CMS Innovation Center, also called CMMI. I'm here with my colleague Elizabeth Currier, a Specialty Physician Practice Administrator and Senior Improvement Advisor here at CMMI. This presentation is the second in a series of clinician focused webcasts on our newest payment model, Bundled Payments for Care Improvement Advanced, or BPCI Advanced for short. The materials build on the conceptual overview that we broadcast in March and can be found on the BPCI Advanced website under the header Physician Focused Materials.

This webcast will last approximately 30 minutes. I will begin with a brief recap of the model's core features and walk through some practical implications for attribution of clinical episodes. I will then briefly touch on the application process and considerations for participation. Elizabeth will then describe challenges experienced by participants in the original Bundled Payments for Care Improvement model and some of the strategies they used to succeed in the model. She will also highlight how the CMS Innovation Center works with participants to help them succeed. Lastly, I will walk through the reconciliation process and describe how participants may leave the model. After a summary, I will direct viewers to additional resources.

Okay, let's get started. The CMS Innovation Center tests new service and delivery models that are designed to maintain or reduce costs while preserving or enhancing quality. Since its establishment, the Innovation Center has been a powerful driver of change within CMS while also providing crucial national leadership in the transition away from fee for service and towards value-based payment. Our models are animated by several guiding principles. Most important among them is the promotion of patient-centered care, but they also include the preservation of provider choice and incentives, the fostering of patient choice and market competition, the facilitation of peer to peer learning, and the administration of transparent model designs and evaluations. A bit more on the transparency principle: the Innovation Center scrutinizes all of our models in detailed multidisciplinary assessments that are publicly posted on the CMS Innovation Center website.

CMS Innovation Center models experiment with new ways of paying for and delivering healthcare and they are evaluated against one of three criteria for success. Our models are successful if they increase quality without an effect on cost, if they have no effect on quality but decrease cost, or ideally, if the both increase quality and decrease cost. If any of these three outcomes are demonstrated, the Secretary of Health and Human Services may expand models to the broader Medicare population.

In the conceptual overview webcast I presented the clinical and conceptual grounding of BPCI Advanced but let's recap the core design features of the model. BPCI Advanced tests a different approach to paying for healthcare. The new model re-conceives care as bundled clinical episodes that link physician, hospital, and post-acute care payments. These clinical episodes are assessed for the quality and cost of care provided and participants may earn additional payments above and beyond fee for service if things go well but may owe money back if they don't.

The new model is different than the existing BPCI model in important ways. BPCI Advanced has a single track with a streamlined design. All episodes are 90 days and all episode costs are kept at the 99th

percentile. We are focused on a smaller number of clinical episodes in the initial year and we have added outpatient episodes. Preliminary target prices will be provided in advance with adjustment after the fact only for the complexity of patients actually treated. Lastly, in keeping with the Advanced APM criteria, payments will now be tied to performance on quality measures. We recognize that clinical leadership is crucial to success of the model. Clinicians are on the front lines of patient care and are best positioned to innovate, to find opportunities to improve efficiencies, and to deliver patient-centered care. BPCI Advanced includes a greater emphasis on physician engagement and learning. That emphasis is evident in the new attribution rules for clinical episodes. Finally, the model is designed as an Advanced APM under the Quality Payment Program.

Clinical episodes may be led by either Physician Group Practices or by Acute Care Hospitals in collaboration with clinicians. Participating physician practices in Acute Care Hospitals are identified as episode initiators in the model. BPCI Advanced is designed so that physician group practices and acute care hospitals, again, episode initiators, can participate on their own. However, they also may choose to work with a convener participant. Convener participants are a third party that brings together episode initiators and they offer several advantages. For example, convener participants may facilitate participation by smaller physician group practices in acute care hospitals. They may assist with analytic feedback and with operational and logistical support. Perhaps more importantly, they bear financial risk to CMS under the model, though they may apportion some of that risk to practices and hospitals.

The current administration has championed patients over paperwork and burden reduction for clinicians. Consequently, all quality measures in the model will be derived from administrative claims through 2020. That said, we are particularly interested in feedback from clinicians on what measures should be included. Additional measures may be added in the future, potentially with varying reporting mechanisms.

These measures will apply to the 2018 and 2019 model years. They include two crosscutting measures that apply to all clinical episodes. These are the All-cause Hospital Readmission Measure and Documentation of an Advanced Directive. The remaining measures apply to varying degrees to specific clinical episodes. Of note, quality measure performance is compared only within the same clinical episode. There is a mechanism to roll up performance across clinical episodes into a composite quality score for each episode initiator.

Recall that benchmark prices for acute care hospital and physician group practice prices are set differently. The hospital's benchmark price is intended to compare apples to apples and accounts for patient characteristics, hospital costs, and cost trends at similar facilities. Physician group practices benchmark prices are set differently. The model anchors PGP benchmark prices on the hospitals where episodes are initiated but adjust the hospital price based on the PGP historical costs. This approach is intended to allow PGPs to refine practices over time and we hope it will allow more physician groups to participate in the model. One more comment. The benchmark price represents the expected cost of treating clinical episodes after accounting for patient characteristics, practice context, and cost trends among peers. The target price against which actual performance is compared is set at a 3% discount to the benchmark price.

All clinical episodes triggered by acute care hospitals that are participating in BPCI Advanced will receive the acute care hospital target price for the episode but physician group practices often practice at multiple hospitals. Consequently, physician group practices will receive target prices for each clinical episode at each hospital where they practice. In this example, the physician group practice's historical

costs were consistently higher than the historical cost for the hospitals where they initiated clinical episodes. For a limited time, the PGPs target prices are therefore higher than the hospital's target prices.

Unlike BPCI, BPCI Advanced will not use time-based precedence rules. What this means is that participants starting in the model in October of 2018 will not have precedence over participants that start in January 2020. Instead, in BPCI Advanced clinical episodes will be attributed at the episode initiator level. The hierarchy for attribution of a clinical episode among different types of episode initiators is as follows: in descending order of precedence, the attending physician group practice, the operating physician group practice, and the hospital.

So how does clinical episode attribution work in practice? Let's walk through an example using only a single clinical episode like pneumonia. In this case, the hospital itself is not participating in the model but two of three hospitalist groups that practice at the hospital are. Let's say that the hospitalist groups admit patients on an alternating schedule. If PGP one is participating and includes the attending of record for a pneumonia patient they are attributed the clinical episode. If PGP two is not participating and admits a pneumonia patient we would check to see if the hospital is participating next as there is no applicable operating physician and the hospital falls next on the hierarchy. Since the hospital is not participating a clinical episode is not initiated and the patient receives care outside the model. If PGP three is participating and admits a pneumonia patient they are attributed the clinical episode. One more point on the attending of record. The attending of record is determined by the hospital's UB-04 claim combined with the PGP submitted Part B claim for evaluation and management.

Let's walk through a second example, again using the pneumonia clinical episode. In this case, the hospital is participating in the model along with two of three hospitalist groups that practice at the hospital. Let's again say that the hospitalist groups alternate admissions. If PGP one is participating and includes the attending of record for a pneumonia patient they are attributed the clinical episode ahead of the hospital. If PGP two is not participating and admits a pneumonia patient, since the hospital is participating, we would attribute a clinical episode to the hospital instead. If PGP three is participating and includes the attending of record for a pneumonia patient they are attributed the clinical episode.

It is also important to note that multiple episode initiators may practice at the same hospital but be participating in different clinical episodes. For example, PGP one might be a cardiology group participating in the heart failure bundle. They will lead all clinical episodes where they are the attending of record as previously defined. The hospital may be participating instead in one or more of the orthopedic bundles and would lead those episodes assuming there were no orthopedic PGPs that were BPCI Advanced participants and were the admitting or operating attending of record. PGP three might be a neurology practice that participates in the stroke bundle. There are many potential scenarios but, as this example demonstrates, participants need not be competing with each other for attribution. In fact, they may collaborate on infrastructural investments and process changes that benefit them all.

Now, let's shift gears and talk a bit about the application process. Applicants that submitted applications and requested data in March will receive their data approximately in May. Depending on what you requested on your applicant data request and attestation form you will receive either summary data for all of your potential clinical episodes or beneficiary line level data or both. The detailed data allows applicants to do customized analyses of the data and to identify opportunities for improvement.

Applicants will receive participation agreements in June and will need to commit to participation and to specific clinical episodes by August 1st. Participants commit to joining clinical episodes through the next

agreement term which begins January 1st, 2020. It is important to note that many applicants applied on their own as well as through one or more conveners this March but they may only appear on one participant profile at the deadline in August.

After they receive their data, applicants will want to think through a number of issues before finalizing their participation agreements. Among them: Are the hospital and/or other physician group practices thinking of joining in the same clinical episode or episodes? Are there clear opportunities for improvement within one or more clinical episodes? Can operational investments be spread across multiple clinical episodes or shared with other participants? Can you safely assume financial risk? Does it make sense to go it alone or work with a convener? Would your physicians reach the qualification threshold for incentive payments as qualified providers within the Quality Payment Program? At this point, I'm going to turn the presentation over to my colleague Elizabeth Currier.

Hello. I am a Specialty Practice Administrator and Senior Advisor in the Learning and Diffusion Group at the Innovation Center. I have been working with participants in the original BPCI model and would like to review some of the challenges they faced, as well as some of the strategies they used to succeed within the model.

As a disclosure, the CMS Innovation Center does not endorse any particular vendor or tool. The following slides reflect feedback from our BPCI awardees on the strategies they found most useful. As a core strategy, many participants leverage clinical and administrative data to identify gaps in care and opportunities for improved efficiency and outcomes. Many commented that some form of data dashboard was a crucial tool. While some participants created one of their own, others used off the shelf software packages to bridge gaps between EMRs and to efficiently analyze data.

A subset of patients have highly specific needs and drive an outside proportion of avoidable costs. Many BPCI awardees used risk assessment tools to match the most intensive interventions with the patients who are most likely to benefit from them. Several examples are listed here that identify patients at high risk of readmission or death, manage care pathways, or assist with discharge planning.

Numerous studies of American healthcare demonstrate large variations in the manner and intensity of care delivery for patient populations matched on observable characteristics. This large practice variation suggests that there are real opportunities to improve efficiency and care outcomes. Defined care pathways may reduce unwarranted practice variation while improved predictability for patients and clinicians. Some BPCI participants reinforced these pathways through simplified patient forms and checklists and by establishing a hotline to guide patients to the optimal care level when problems arose.

Efficient execution of practice changes in BPCI often involved creating new staffing rules. In addition to new clinical rules, some participants created logistical roles to coordinate across sites of care. These roles may in some instances be filled by existing staff but some participants may need to hire new staff. Example roles include: inpatient and post-acute care coordinators, care navigators, and non-clinical data analysts.

Patient, family, and caregiver engagement is crucial. To achieve improved engagement, BPCI awardees created education tools and programs. For example, some participants developed pre-operative classes to help patients prepare for surgery and to set appropriate expectations in advance. One participant matched prospective patients with experienced patients who could offer coaching, mentorship, and guidance. Another actively engaged family members in post-operative therapy sessions. Of course,

clinician engagement is also critical. A respected physician champion can go a long way in bringing others along. All members of the team should understand the basics of the model and the rationale behind the strategies pursued.

BPCI awardees also identified important opportunities to decrease costs and improve outcomes during the post-acute care period. Some developed a network of preferred post-acute providers that agreed to coordinate care and meet quality standards. In some cases, post-acute providers implemented care protocols. In others, SNFists periodically checked in on patients while they were still in the SNF to assure that they were receiving appropriate care and to prevent readmissions.

BPCI includes waivers that help participants change conventional care delivery models. For example, a number of participants take advantage of our telehealth waiver to incorporate innovative technologies like smartphone apps or patient education through virtual town halls. Other participants use a remote care management platform to monitor patients' vital statistics, provide patient education, and conduct virtual patient visits. Some also use software which allows patients to review PAC options at the bedside on an iPad.

Most awardees began with some great ideas about how they would improve outcomes and decrease costs within clinical episodes but our best performers did not set it and forget it, instead they engaged in continuous quality improvement. These participants implemented various elements of the strategies we just discussed, assessed their impact, and identified new opportunities for improvement in a continuous cycle.

The health system is complex and improvement requires us working together. The Innovation Center works closely with model participants to help you succeed. We look forward to partnering and supporting you in these efforts. Care delivery and payment reforms are complicated. We can only succeed if we work together. Participants care for patients on the frontline, conceive and implement innovations, and engage in continuous quality improvement. The CMS Innovation Center, in turn, provides cost and quality transparency for participants, establishes payment mechanisms that support investment in care transformation, and awards participants that deliver in improved value.

The CMS Innovation Center also offers a learning and improvement system that identifies and packages new knowledge and best practices and facilitates peer to peer learning between participants. Through this system participants can help each other troubleshoot problems and identify promising solutions. The Innovation Center also learns from your experiences and builds your insights and successes into our models.

So, as this figure illustrates, both the CMS Innovation Center and model participants play important roles in payment model development and health system transformation. Participants learn from the CMS Innovation Center, participants learn from each other, and the CMS Innovation Center learns from participants and what works or doesn't work in this model test.

I hope I've given you a flavor of how BPCI awardees have succeeded within BPCI. I expect that similar strategies will be useful in BPCI Advanced as well. At this point, I'm going to turn the presentation back to Doctor Farmer to walk you through the reconciliation process and conclude the webcast. Steve?

Thanks, Elizabeth. I hope at this point you have a good idea how the model works and you can imagine implementing some of the strategies that Elizabeth highlighted. In the last section, I want to briefly

describe how we will assess your performance in the model. Your costs will be reconciled against your target price twice yearly. Because it can take a long time to finalize claims, each performance period is followed by two further adjustments or True-Ups that capture any claims that were missed in the initial reconciliation. In most cases these True-Ups will have limited impact. Clinical episodes will be reconciled based on the performance period in which the episode ends, either between January 1st and June 30th or between July 1st and December 31st.

After the CMS Innovation Center has completed the reconciliation for each performance period we will send participants a workbook that outlines their finalized target price for each clinical episode, the actual costs for their clinical episodes, and the difference between those two numbers. This difference is called the Net Payment Reconciliation Amount of NPRA is positive or the repayment amount if negative. The workbook will also include a summary of the participants aggregate quality measure performance.

Let's explore the NPRA and repayment amount concepts a bit more. At the end of each performance period all non-excluded Medicare fee for service expenditures are assigned to each clinical episode. Recall that participants receive a preliminary target price in advance which account for their historical patient case mix. At reconciliation the historical patient case mix is replaced with the actual patient case mix treated during the performance period to reach a final target price. In practice, if your case mix is stable over time your preliminary and final target prices should be very similar. The difference between your clinical episode costs and the final target price is the positive or negative reconciliation amount. Remember that many participants will sign up for multiple clinical episodes. For example, a cardiology group might sign up for acute myocardial infarction, heart failure, and PCI. For each episode initiator all positive and negative reconciliation amounts will be netted across all clinical episodes resulting in a positive or negative total reconciliation amount.

As an advanced alternative payment model, we take quality into consideration for payment. That is, payments are adjusted based on quality performance. In the final step, the total reconciliation amount whether positive or negative is adjusted for the participants' Composite Quality Score, also known as the CQS. The result is an adjusted positive or negative total reconciliation amount. For non-convener participants, if this amount is positive this is the NPRA, the amount CMS will pay to the participant. If negative, this is the repayment amount, the amount that the participant must pay to CMS. For convener participants, all of their episode initiators' adjusted positive and negative total reconciliation amounts are netted against one another to get the convener participants' NPRA or repayment amount. Two more points. There is a stop loss of 20% and a stop gain of 20% relative to your target price. So your NPRA or repayment amount cannot vary more than 20% in either direction. Also, for 2018 and 2019 the CQS adjustment is also limited. The quality adjustment cannot exceed 10% of the positive or negative total reconciliation amount.

After participants receive their workbooks they may contest any calculation or omission errors within 30 days and the CMS Innovation Center must respond to any contested numbers within 30 days upon receipt of a timely submission. Following the appeal window, the NPRA or repayment amount will be finalized and after processing participants will receive either a payment or a demand letter.

BPCI Advanced is a voluntary model and participants may wholly terminate their participation in the model at any time in accordance with the participation agreement. For physician practices and hospitals working with a convener, they may leave at any time though note that the convener participant remains responsible for the clinical episodes until the next enrollment or agreement period or until they wholly

terminate their participation in the model. For participants not working with a convener participant, they may terminate from the model at any time in accordance with the participation agreement.

We hope this webcast has given you a good sense of what it's like to participate in BPCI Advanced. To summarize, BPCI Advanced is a new, specialty-focused, voluntary, advanced alternative payment model that builds on prior models and is responsive to feedback from BPCI awardees. The model establishes accountability for clinical episodes and aims to catalyze health system transformation. Successful participants may receive additional payments beyond fee for service payments if they achieve savings and improve outcomes, but they may owe money back if they miss the mark. Participants that meet patient or expenditure thresholds through participation in BPCI Advanced may become qualified participants in the Advanced Alternative Payment Model Pathway of the Quality Payment Program. This status may exempt participants from MIPS reporting requirements and may entitle them to receive a 5% incentive payment.

One final note, like our model participants, the CMS Innovation Center also engages in continuous quality improvement and as a model test, future revisions to BPCI Advanced are likely. Some features may work well while others may need refinement. For example, the Innovation Center may revise design features in future years or add new clinical episodes or performance measure options. Your engagement is essential in this process so please keep an eye out for opportunities to work with us. We hope you will consider joining the model and partnering with us for the good of the patients we serve.

In closing, this webcast is the second in a series of presentations on BPCI Advanced. For those who are interested, there are many more resources available online. There are webcasts, print resources, and frequently asked questions, as well as technical specifications. New materials are added from time to time as well.