

BPCI Advanced Model Overview Webcast Script

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Welcome to the overview webcast for the Bundled Payments for Care Improvement Advanced Model, also known as BPCI Advanced. BPCI Advanced is an Advanced Alternative Payment Model, or Advanced APM, designed to promote seamless, patient-centered care around a set of specific Clinical Episodes.

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In this webcast, we will provide an overview of BPCI Advanced, discuss who can participate, and outline criteria the Model must meet in order to qualify as an Advanced APM. We will continue by defining the Clinical Episodes and describing the payment and pricing methodology.

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We'll then move on to reviewing the quality measures, sharing the approach for monitoring and evaluation, and describing the Learning System. Finally, we will provide information about how to apply to participate in BPCI Advanced.

Let's get started.

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BPCI Advanced builds upon lessons learned from current and previous CMS models, demonstrations, and programs. On October 1, 2018, the first cohort of Participants started in BPCI Advanced. On April 24, 2019, CMS opened the application period for the second cohort of Applicants, who will start in Model Year 3, which coincides with Calendar Year 2020.

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BPCI Advanced is a voluntary bundled payment model and has a single payment and risk track structure with a 90-day episode period. Beginning January 1, 2020, BPCI Advanced will have multiple inpatient Clinical Episodes and a number of outpatient Clinical Episodes.

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Because BPCI Advanced is an Advanced APM, CMS ties payment under the Model to performance on a number of quality measures.

CMS will provide preliminary Target Prices in advance of the Performance Period of each Model Year and adjust these prices during the semi-annual reconciliation process to calculate a final Target Price that reflects realized patient case mix during the applicable Performance Period.

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BPCI Advanced seeks to improve the quality of care furnished to Medicare beneficiaries and to reduce expenditures by focusing on five key objectives:

- The first objective is Financial Accountability. BPCI Advanced tests a payment model that creates extended financial accountability for the outcomes of improved quality and reduced spending, in the context of acute and chronic episodes of care
- The second objective is Care Redesign. BPCI Advanced supports and encourages Participants, Participating Practitioners, and Episode Initiators (also referred to as “EIs”) who are reengineering the delivery of care in order to continuously improve quality
- The third objective focuses on Data Analysis and Feedback. BPCI Advanced leverages data to decrease the cost of a Clinical Episode by eliminating unnecessary or low-value care, increasing care coordination, and fostering quality improvement
- The fourth objective is Health Care Provider Engagement. BPCI Advanced seeks to create environments that stimulate the rapid development and incorporation of new evidence-based knowledge into clinical practice
- The last objective is Patient and Caregiver Engagement. BPCI Advanced focuses on educating patients, facilitating ongoing communication, and providing guidance throughout the Clinical Episode

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Let’s review the BPCI Advanced application timeline for Model Year 3, also known as “MY3.” It’s important to pay careful attention to the deadlines for each step of this process.

CMS posted the Request for Applications, or RFA, and opened the BPCI Advanced Application Portal on April 24, 2019. The RFA is available on the BPCI Advanced home page on CMS’s website, which appears at the end of this presentation. Applications submitted via the BPCI Advanced Application Portal, closed on June 24, 2019, at 11:59 p.m. EDT.

For detailed guidance on BPCI Advanced and how applications will be reviewed, we encourage you to download the RFA.

Between June and July 2019, CMS will review submitted applications. CMS plans to distribute preliminary Target Prices to applicants in September 2019. Also, in September 2019, CMS will distribute Participation Agreements, and Applicants will have several weeks to review both the agreements and preliminary Target Prices to decide whether they want to participate in BPCI Advanced. Applicants will need to sign agreements and return them to CMS in November 2019.

CMS will not execute Participation Agreements until applicants successfully pass a provider vetting by the CMS Center for Program Integrity and complete a law enforcement screening process.

Applicants must submit a “Participant Profile” that identifies their Clinical Episode selections in November. Several deliverables will be due in December, and CMS will provide more guidance and distribute templates in advance of the December due date. Newly selected and returning Participants will officially begin Model Year 3 on January 1, 2020.

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Now, we’ll turn to who can participate in BPCI Advanced.

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Let’s take a closer look at the two types of Participants: Convener Participants and Non-Convener Participants.

A Convener Participant may be a Medicare provider or supplier, or a non-Medicare entity. A Convener Participant brings together at least one Downstream Episode Initiator and facilitates coordination among Episode Initiators and bears and apportions financial risk. Downstream Episode Initiators must be either an Acute Care Hospital (known as an ACH) and/or a Physician Group Practice (also known as a PGP).

A Non-Convener Participant is either an ACH or PGP that bears financial risk only for itself and does not bear financial risk on behalf of Downstream Episode Initiators.

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The term Episode Initiator is used widely in BPCI Advanced.

A BPCI Advanced Episode Initiator (or “EI”) is a Medicare provider that can trigger Clinical Episodes by the submission of a claim for either an inpatient hospital stay (referred to as an Anchor Stay) or an outpatient procedure (called an Anchor Procedure). In BPCI Advanced, Episode Initiators include ACHs or PGPs.

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There are specific organizations that are not eligible to participate in BPCI Advanced.

Critical Access Hospitals (or CAHs) are not subject to the ACH Inpatient Prospective Payment System (IPPS) or Hospital Outpatient Prospective Payment System (OPPS), making it difficult to calculate Target Prices and leading to potential double payment by CMS. Therefore, CAHs are not eligible to participate in BPCI Advanced in any capacity.

Also, Prospective Payment System-Exempt Cancer Hospitals, inpatient psychiatric facilities, hospitals in Maryland, hospitals participating in the Rural Community Hospital Demonstration, and hospitals in the Pennsylvania Rural Health Model are unable to participate in BPCI Advanced because of their unique payment methodologies.

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Under BPCI Advanced, Clinical Episodes are attributed at the Episode Initiator level and can only be attributed to one Episode Initiator.

The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators is as follows, in descending order of precedence: first is the attending PGP; second is the operating PGP; and third is the ACH.

Note that BPCI Advanced will not use time-based precedence rules for attribution, therefore Participants that started in October 1, 2018 will not have precedence over those starting in the Model for the first time on January 1, 2020.

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BPCI Advanced must meet three criteria to be considered an Advanced APM. These include financial risk, Certified Electronic Health Record Technology (or “CEHRT”), and quality measures.

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First, let’s consider financial risk. Advanced APM participants must bear risk for monetary losses of more than a nominal amount.

In BPCI Advanced, Participants are financially at risk for up to 20 percent of the final Target Price for each Clinical Episode in which they have selected to participate.

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The second criteria for an Advanced APM requires the use of CEHRT.

In BPCI Advanced, CMS requires Participants to attest to their use of CEHRT prior to participation.

For non-hospital participants, at least 75 percent of eligible clinicians in the entity must use the CEHRT definition of certified health IT functions to participate in this initiative.

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Third, payments under the Model must link to quality measures comparable to Merit-Based Incentive Payment System quality measures.

In BPCI Advanced, CMS calculates a quality score for each quality measure at the Clinical Episode level. These scores are volume-weighted and scaled across all Clinical Episodes attributed to a given Episode Initiator to calculate an Episode Initiator-specific Composite Quality Score, or CQS.

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Because 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 eligible to receive the 5 percent APM Incentive Payment.

The first date for QP determination in Model Year 3 will be 03/31/2020.

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QP Determinations are an important aspect of BPCI Advanced, as they define an attribution-eligible beneficiary.

Participant type and type of Episode Initiators will establish how QP determinations are assessed. For Non-Convener Participants, QP determinations will be assessed individually for those that are hospitals and will be assessed as a group for those that are PGPs.

Similar QP determinations will be made for Convener Participants who only have one type of Episode Initiator under a single Participation Agreement. For Convener Participants with only hospital Episode Initiators, their eligible clinicians will be assessed individually, while Convener Participants with only PGP Episode Initiators, their eligible clinicians will be assessed as a group.

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A different scenario occurs for Convener Participants who will have ACHs and PGPs as Downstream Episode Initiators under a single Participation Agreement. In this case, eligible clinicians only participating through PGP Episode Initiators, will be assessed for QP determination as a group. Eligible clinicians associated with the ACH Episode Initiators will not be assessed for QP determinations.

In order for ACH eligible clinicians to be assessed for QP determinations, Convener Participants may choose to enter into separate Participation Agreements with CMS. If a Convener Participant chooses to do this, they must submit separate applications for each Participation Agreement they would like to have with CMS. Additional information will be available in the Participation Agreement and can be found on the QPP Website.

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Now let's discuss Clinical Episodes.

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In BPCI Advanced, an Anchor Stay is the inpatient stay at an ACH assigned to a qualifying MS-DRG for which an Episode Initiator submits a claim to Medicare fee-for-service.

The length of the Clinical Episode will depend on the site of service. For inpatient Clinical Episodes, the episode length is the Anchor Stay plus 90 days. The first day of the 90-day period begins on the day of discharge.

An Anchor Procedure is a hospital outpatient procedure identified by a qualifying code under the Healthcare Common Procedure Coding System (“HICPICS”) for which an Episode Initiator submits a claim to Medicare fee-for-service.

For the outpatient Clinical Episodes, the episode length is the Anchor Procedure plus 90 days. The first day of the 90-day period begins on the day of completion of the outpatient procedure.

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Here is a list of the 31 Inpatient Clinical Episodes.

CMS has grouped the Clinical Episodes into seven categories. Four appear on this slide. They are: Spine, Bone, and Joint Episodes; Kidney Episodes; Infectious Disease Episodes; and Neurological Episodes.

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The remaining three categories are: Cardiac Episodes; Pulmonary Episodes; and Gastrointestinal Episodes.

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BPCI Advanced currently includes four outpatient Clinical Episodes.

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Each Clinical Episode includes Medicare fee-for-service Part A and Part B non-excluded items and services furnished during the Anchor Stay or Anchor Procedure and performed during the 90-day period following the Anchor Stay or Anchor Procedure. This includes hospice services and related and unrelated admissions.

Additionally, Clinical Episodes triggered by an Anchor Stay include diagnostic testing and certain therapeutic services furnished by the admitting hospital up to three days prior to the Anchor Stay and charges incurred for transferring the BPCI Advanced Beneficiary from the Emergency Department at another facility either the day of or the day before the admission for the Anchor Stay.

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Here is a list of types of services included in a Clinical Episode (unless specifically excluded):

- Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- Other hospital outpatient services and inpatient hospital readmission services
- Inpatient rehabilitation facility
- Skilled nursing facility (or SNF)
- Home health agency
- Clinical laboratory
- Durable medical equipment

- Part B drugs*
- Hospice
- Long-term care hospital
- And, Physicians' services

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CMS excludes the following from a Clinical Episode:

- All Part A and Part B services furnished to a BPCI Advanced Beneficiary during certain specified ACH admissions and readmissions (for example., an admission assigned at discharge to MS-DRGs for organ transplants, major trauma, cancer-related care, or ventricular shunts)
- New technology add-on payments under the IPPS
- Payments for items and services with pass-through payment status under the OPPI
- And Payment for blood clotting factors to control bleeding for hemophilia patients

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In addition, CMS excludes Medicare beneficiaries:

- Who are covered under managed care plans
- Who are eligible on the basis of end-stage renal disease (ESRD)
- Whose primary payer is not Medicare
- Who die during the Anchor Stay or Anchor Procedure, or
- Who are not enrolled in Medicare Part A or Part B for the entire Clinical Episode

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Under BPCI Advanced, CMS excludes a number of readmissions. CMS manages a single list of excluded MS-DRGs, including Transplant and Tracheostomy, Trauma, Cancer (when an MS-DRG explicitly indicates cancer), and Ventricular Shunts.

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BPCI Advanced will treat transfers as one continuous hospitalization. The Clinical Episode will begin at admission of the first part of the transfer and will be assigned to the first provider.

The post-discharge 90-day period begins following discharge from the last part of the transfer and the MS-DRG is assigned from the last part of the hospital transfer.

If a patient is transferred to a BPCI Advanced-participating ACH from the Emergency Department at a different ACH, Part B payments associated with the Emergency Department visit from date of admission with a one-day look-back period will be rolled into the Clinical Episode.

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As mentioned earlier, Applicants must submit to CMS their selection of Clinical Episodes and Episode Initiators, as applicable, on the Participant Profile due approximately 60 days before the start of Model Year 3.

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In the following section, we will discuss the payment and pricing methodology for BPCI Advanced.

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The methodology for calculating the Benchmark Price in BPCI Advanced is different for an ACH Episode Initiator and a PGP Episode Initiator.

To determine the Episode Initiator-specific Benchmark Price for a hospital, CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode: patient case-mix, the hospital's characteristics, projected trends in spending among the hospital's peer group, and historical Medicare fee-for-service expenditures specific to the hospital's baseline period.

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To determine a PGP's Benchmark Price, CMS will use an alternative method.

BPCI Advanced will base the PGPs Benchmark Prices on the Benchmark Prices for the hospitals where its Anchor Stays or Anchor Procedures occur. CMS will adjust each hospital-specific Benchmark Price to calculate a PGP-hospital-specific Benchmark Price that accounts for the PGP's historical spending patterns and the PGP's patient case mix, each relative to the hospital.

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Now, we'll describe how CMS calculates the Target Price in BPCI Advanced. The Target Price equals the Benchmark Price multiplied by the difference of one minus the CMS discount. The CMS Discount is three percent for all Clinical Episodes.

CMS will provide preliminary Target Prices prospectively before each Applicant finalizes its Participation Agreement with CMS and prior to the selection of Clinical Episodes. Episode Initiators will receive a preliminary Target Price determined prospectively based upon their historic patient case mix.

CMS will set a final Target Price retrospectively at the time of reconciliation by replacing the historic patient case mix with the actual patient case mix in the Performance Period, which is transparent and specific to the Participant's beneficiaries.

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BPCI Advanced has one Risk Track. CMS limits risk to Participants by applying a cap to Clinical Episodes at the 1st and 99th percentile of total standardized allowed amounts within the Clinical

Episode during each baseline calendar year and of national Medicare fee-for-service spending on each MS-DRG and HCPCS code. CMS will apply the cap to Clinical Episodes in both the Performance Period and the Baseline Period.

CMS will provide further details regarding this methodology to Applicants prior to executing a Participation Agreement with CMS.

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Now that we have looked at the calculation of Target Prices, let's discuss how Reconciliation will occur in BPCI Advanced.

CMS conducts semi-annual Reconciliation of the Clinical Episode-specific preliminary Target Prices and final Target Prices. Final Target Prices are based on the Participant's actual case mix. CMS will provide a Reconciliation Report to Participants specifying the Reconciliation Amount, which can be either positive or negative.

If aggregate Medicare fee-for-service expenditures for items and services included in the Clinical Episode are less than the final Target Price for that Clinical Episode, there will be a Positive Reconciliation Amount.

If aggregate Medicare fee-for-service expenditures for items and services included in the Clinical Episode exceed the final Target Price, there will be a Negative Reconciliation Amount.

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CMS will then link payment to quality performance using a pay-for-performance methodology. CMS will net all Positive Reconciliation Amounts and Negative Reconciliation Amounts across all Clinical Episodes attributed to the Episode Initiator, resulting in the Adjusted Positive or Negative Total Reconciliation Amount.

For Non-Convener Participants, if this calculation results in an Adjusted Positive Total Reconciliation Amount, this is the Net Payment Reconciliation Amount (NPRA) that CMS pays to the Participant.

In Model Year 3, CMS will continue to apply the 10 percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount. However, the 10 percent cap is subject to change.

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If this calculation results in an Adjusted Positive Total Reconciliation Amount for Non-Convener Participants, this amount is the Repayment Amount that Participants pay to CMS.

For Convener Participants, CMS will net all Adjusted Positive Total Reconciliation Amounts against all Adjusted Negative Total Reconciliation Amounts for the Participant's Episode

Initiators to calculate either the NPRA, which CMS pays to the Participant, or the Repayment Amount, which Participants pay to CMS.

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Reconciliation will occur Semi-Annually with two “True-Ups” to allow for claims run-out.

CMS will reconcile Clinical Episodes based on the Performance Period in which the Clinical Episode ends.

The first Performance Period of a Model Year will cover Clinical Episodes that end during the period of January 1 – June 30. The second Performance Period of a Model Year will cover Clinical Episodes that end during the period of July 1 – December 31.

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NPRA payments and Repayment Amounts are subject to a 20 percent Stop-Gain/Stop-Loss provision at the Episode Initiator level.

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There are several useful waivers available to participants under BPCI Advanced.

Certain Fraud and Abuse laws are waived so that BPCI Advanced Participants and their NPRA Sharing Partners have the flexibility to negotiate and enter into certain Financial Arrangements or furnish beneficiary engagement incentives under the Model. Separate from any fraud and abuse waivers, CMS intends to offer conditional waivers for three Medicare payment rules, referred to as “Payment Policy Waivers,” to test whether flexibility and coverage of additional services will lower costs, improve quality, and/or facilitate the delivery of care in new settings, and to better engage beneficiaries in their care.

The 3-Day SNF Rule Payment Policy Waiver is a conditional waiver of the requirement that a Medicare beneficiary must have a prior inpatient hospital stay of not less than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF services.

The Telehealth Payment Policy Waiver is a conditional waiver of the geographic area and setting for Telehealth originating site requirements for Medicare coverage of Telehealth services.

The Post-Discharge Home Visits Payment Policy Waiver is a conditional waiver of the requirement that the services and supplies furnished incident to the service of a physician or other practitioner, also known as “incident to” services, be furnished under the direct supervision of the physician or other practitioner.

Please note that CMS will provide details of the exact conditions and applicable criteria for each payment policy waiver in the Appendices of the Participation Agreement and Fraud and Abuse requirements in a notice of waivers document.

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We will now provide an overview on the Quality Measures sets for Model Year 3 participation in BPCI Advanced.

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For quality measure reporting in Model Year 3, CMS may provide Participants with the flexibility to choose one of two quality measure sets, an Administrative Quality Measures Set or an Alternate Quality Measures Set.

The established CQS calculation methodology would apply to both.

The Administrative Quality Measures Set includes those measures used in Model Years 1 and 2 and includes only claims-based measures directly collected by CMS.

The Alternate Quality Measures Set may include a combination of claims-based and registry-based measures. The Alternate Quality Measures Set was developed after CMS gathered information from various established registries to identify a tailored set of quality measures that align with each of the specialty-specific Clinical Episodes in the Model

All Participants, whether they select the Administrative Quality Measures Set or the Alternate Quality Measures Set, will be accountable for no more than five measures per Clinical Episode.

CMS anticipates that the full list of quality measures associated with all Clinical Episodes in Model Year 3 will be available prior to the close of the application period. CMS may update the quality measures on an annual basis.

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CMS will measure and monitor care throughout BPCI Advanced to ensure that the Model objectives in redesigning care, achieving quality measure thresholds and patient experience-of-care standards, and demonstrating improved care coordination are met.

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CMS may monitor BPCI Advanced performance by:

- Tracking claims data and medical record reviews
- Conducting ad hoc reviews and analyzing financial and quality performance measurements
- Implementing site visits, surveys, and interviews with Participants, Episode Initiators, Participating Practitioners, beneficiaries, and other parties

CMS will conduct an independent evaluation to assess the changes in quality of care and spending under BPCI Advanced.

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Additionally, CMS will implement a 30-day Post-Episode Monitoring Period. CMS will measure the cost of care furnished during this period to ensure that the aggregate Medicare fee-for-service expenditures for BPCI Advanced Beneficiaries do not increase due to cost shifting or other reasons. CMS's review will include measuring Medicare fee-for-service expenditures for items and services furnished to BPCI Advanced Beneficiaries by healthcare providers that are not participating in BPCI Advanced.

CMS will compare all non-excluded Medicare fee-for-service expenditures for BPCI Advanced Beneficiaries during the Post-Episode Monitoring Period to the 99.5 percent confidence interval of predicted spending for post-discharge days 90-120 under the statistical model used for setting Target Prices. If Medicare FFS expenditures during the Post-Episode Monitoring Period exceed this risk threshold, then the Participant must pay Medicare the difference.

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To support achieving the goals of BPCI Advanced, the CMS Innovation Center Learning System serves three broad functions.

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First, the Learning System identifies and packages new knowledge and best practices. Second, it leverages data and Participant input to guide change and improvement. Third, it builds learning communities and networks to share and spread new knowledge and practice.

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The Learning System creates a three-way channel of engagement between CMS and Participants and is fully integrated into the design and operations of BPCI Advanced. The first channel flows from CMS to Participants and includes tools and information that help Participants take action to be successful in BPCI Advanced. The second channel flows from Participants to CMS and includes feedback and data that help CMS improve models and plan for expansions. The third channel flows between Participants and includes peer-to-peer learning that enables them to share lessons learned, collaborate on common goals, and generate new knowledge.

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Participants will have the ability to access several BPCI Advanced portals. The BPCI Advanced Application Portal is a web-based platform for Applicants to access previously submitted applications from the MY3 application period.

The BPCI Advanced Participant Portal is a web-based platform that current Participants use to submit legal documents and Model deliverables.

The Data Portal is a web-based platform used to obtain monthly claims files, Target Price data, and eventually reconciliation workbooks.

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We hope that you found this webcast informative. If you have questions about this presentation, or the application process, please contact the BPCI Advanced Team at BPCIAdvanced@cms.hhs.gov.

We encourage you to visit the CMS Innovation Center website for additional information and updates on the BPCI Advanced timeline.

Thank you for taking the time to learn more about BPCI Advanced.