Bundled Payments for Care Improvement (BPCI) Advanced Model Overview Webcast

Welcome to the first Bundled Payments for Care Improvement Advanced webcast. Our goal is to provide an overview of a new bundled payment model that the CMS Innovation Center has developed to better support health care providers who invest in practice innovation, care redesign, and enhanced care coordination.

BPCI Advanced builds on the earlier success of bundled payment models and is an important step in the move away from fee-for-service and towards paying for value. The model will align incentives for reducing costs with those for improving coordination and quality of care to Medicare beneficiaries.

In this webcast, our goal is to provide an overview of the new model and present the timeline for implementation, discuss who can participate, and to outline the criteria the model must meet in order to qualify as an advanced alternative payment model. Also, we will define the characteristics of the clinical episodes, describe the model payment and pricing methodology, and provide information on how to apply to participate in BPCI Advanced.

Let's get started. BPCI Advanced is a new voluntary bundled payment model and has a single payment and risk track structure with a 90-day episode period. In addition to 29 inpatient clinical episodes, there are, for the first time, three outpatient clinical episodes as well.

Because BPCI Advanced is an Advanced APM, payment under the model will be tied to performance on a number of quality measures. CMS will provide preliminary target prices in advance of the performance period of each model year, subject to adjustment for actual patient case mix - a key change from BCPI.

BPCI Advanced seeks to improve the quality of care furnished to Medicare beneficiaries and reduce costs by focusing on five areas.

Care redesign by supporting and encouraging participants, participating practitioners and episode initiators who are interested in continuous quality improvement.

Data analysis and feedback, to decrease the cost of each clinical episode by eliminating unnecessary or low-valued care, increasing care coordination and fostering quality improvement.

Financial accountability, by developing and testing a payment model that creates extended financial accountability for the outcomes of improved quality and reduced spending in the context of acute and chronic clinical episodes.

Health care provider engagement will create an environment that stimulates the rapid development of new evidence-based knowledge.

Patient and caregiver engagement increase the likelihood of better health at lower costs through patient education and ongoing communication throughout the clinical episode.

Let's review the BPCI Advanced timeline. There are a number of steps that are required for participants to begin participation in the model. The selected participants will start on October 1st, 2018. You will want to pay careful attention to the deadlines for each step of this process.

The request for applications, or RFA, is available now on the CMS Innovation Center website. You'll find the website address at the end of this presentation. Applications must be submitted via a web-based portal. The BPCI Advanced Application Portal opened on January 11th and will close on March 12th, 2018. For detailed guidance on the application process, we encourage you to download the RFA.

Between March and June 2018, CMS will review submitted application. CMS plans to distribute target prices to applicants in May. In June 2018, CMS will distribute participation agreements for applicants to review and sign. Prior to the go-live date, CMS will execute participation agreements for those applicants that successfully completed the program integrity and law enforcement screenings.

Applicants will have several weeks to review the agreements and target prices, decide on whether they want to participate, and return the signed agreement to CMS by August. Applicants will have to submit a participant profile that identifies their clinical episode selections in August. A variety of required deliverables will have to be submitted by applicants 60 days before the start of the model, also due in August. We'll provide more guidance on this topic and distribute the templates for the various deliverables well in advance.

The selected participants will officially kick off on October 1st, 2018. CMS will provide an additional application opportunity for model year 2020. The model is scheduled to run until December 31st, 2023.

I'm sure you want to know who can participate in BPCI Advanced. Let's take a closer look at the two types of participants: convener participants and non-convener participants.

Both participant types bear financial risk under the model. A convener participant is a type of participant that brings together multiple downstream entities referred to as episode initiators. Convener participants facilitate coordination among its episode initiators and bears and apportions financial risk under the model. A non-convener participant is a participant that must, itself, be an episode initiator and, therefore, bear financial risk only for itself rather than on behalf of multiple downstream episode initiators.

One key difference between BPCI Advanced and BPCI is that there will be no facilitator conveners in the new model. All conveners will be required to sign participation agreements with CMS.

Now that you know the difference between a convener participant and a non-convener participant, let's take a more in-depth look at who can participate in each category. The following eligible entities may participate in BPCI Advanced as a non-convener participant: physician group practices and acute care hospitals.

Who can participate in BPCI Advanced as a convener participant? Eligible entities that are either Medicare-enrolled or not Medicare-enrolled providers or suppliers. Therefore, post-acute care providers may participate in BPCI Advanced as convener participants. Convener participants must enter into agreements with downstream episode initiators, which may be acute care hospitals and/or physician group practices.

Let's identify those specific organizations that are not eligible to participate in BPCI Advanced. Critical access hospitals are not subject to the inpatient prospective payment system or outpatient prospective payment system, making it difficult to calculate target prices and leading to potential double payment by CMS.

Also, PPS-exempt cancer hospitals, inpatient psychiatric facilities, hospitals in Maryland, and hospitals participating in the Rural Community Hospital Demonstration, and the hospitals in the Pennsylvania Rural Health Model are all excluded from the definition of an acute care hospital for purposes of BPCI Advanced. This is because of their unique payment methodologies, and thus, they may not participate in the model in any capacity.

You might be wondering what an episode initiator is and how it relates to BPCI Advanced. An episode initiator is a Medicare provider that can trigger a clinical episode under BPCI Advanced. In this model, episode initiators are limited to physician group practices and acute care hospitals, including those where outpatient procedures included in the clinical episodes list are performed in hospital outpatient departments.

A participant's episode initiators cannot be changed until the next application opportunity in model year three in 2020. That means that episode initiators cannot be added or withdrawn during the model year two, 2019. In addition, clinical episode selections cannot be changed, either, until 2020.

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: One, the attending physician group practice; two, the operating physician group practice; and three, the hospital.

BPCI Advanced will not use time-based precedence rules. What this means is that participants starting in the model on October 2018 will not have precedence over those that might start in future years. This is a difference from BPCI. BPCI Advanced will be an Advanced APM as of the first day of the model performance period October 1st, 2018.

There are three criteria that the BPCI Advanced Model must satisfy in order to qualify as an Advanced Alternative Payment Model. The first criterion is the model must require participants to bear risk for monetary losses of more than a nominal amount under the model. In BPCI Advanced, participants will be financially at risk for up to 20% of the final target price for each clinical episode in which they have selected to participate, which exceeds the minimum requirement of three percent for the benchmark base standard under the quality payment program.

The second criterion is that participants are required to use CEHRT. In BPCI Advanced, participants will be required to attest to their use of Certified Electronic Health Record Technology prior to participating in the model. For non-hospital participants, at least 50% of eligible clinicians in the entity must use the CEHRT definition of certified health IT functions to participate in this initiative.

The third criterion is that payments under the model must be linked to quality measures comparable to MIPS quality measures. In BPCI Advanced, a quality score will be calculated for each quality measure at the clinical episode level. These scores will be volume-weighted and scaled across to all clinical episodes attributed to a given episode initiator to calculate an episode initiator-specific composite quality score, or CQS. A CQS adjustment amount will be applied to positive or negative total reconciliation amounts.

For the first two model years, the amount by which any positive total reconciliation amount or negative total reconciliation amount may be adjusted by the CQS adjustment amount is capped at 10%. This percentage may change in future model years. Model years one and two will include claims-based

measures. Additional measures may be added in model year three and beyond. These measures may have different reporting mechanisms, the reporting of which will be the responsibility of the participant.

In the first two model years, participants will be responsible for seven claims-based quality measures as applicable. Two of the measures -- the All-cause Hospital Readmission Measure and the Care Plan Measure -- will be applicable to all clinical episodes. The other quality measures are Clinical Episode-Specific Measures. For example, the Acute Myocardial Infarction 30-day Mortality Measure only applies to the acute myocardial infarction clinical episode.

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 five percent APM incentive payment. The first date for QP determination will be March 31st, 2019.

For hospital participants, eligible clinicians who are employed by the hospital and NPRA sharing partners and are included on the financial arrangement screening list, which will be considered as the affiliated practitioner's list for quality payment program purposes. Therefore, these eligible clinicians will be assessed individually for QP determinations.

For PGP participants, eligible clinicians who have reassigned his or her rights to receive Medicare payment to a PGP participant and are included on the PGP list, which will be considered as the participation list for quality payment program purposes. Therefore, these eligible clinicians will be assessed as a group for QP determinations.

For convener participants, who will have hospitals and PGPs as episode initiators, the QP determinations for eligible clinicians will happen as a group.

In order to avoid this action for hospital physicians, convener participants may choose to enter in to separate agreements with CMS for hospital episode initiators, EIs, and PGPs episode initiators. If a convener participant chooses to do this, they must submit separate applications to CMS.

Now, let's discuss how clinical episodes are defined. The following inpatient and outpatient clinical episodes will be tested in the new model. BPCI Advanced includes 29 inpatient clinical episodes. We have reduced the number of clinical episodes offered based on our experience with BPCI and in order to refine the test. However, for those of you familiar with BPCI, you will note that we have added a new clinical episode to BPCI Advanced: disorders of the liver, excluding malignancy, cirrhosis, and alcoholic hepatitis.

BPCI Advanced will test three outpatient clinical episodes: percutaneous coronary intervention, cardiac defibrillator, and back and neck, except spinal fusion. Additional clinical episodes may be included in future model years.

In BPCI Advanced, a clinical episode is the defined period of time triggered by the submission of a claim for an anchor stay for inpatient clinical episodes or anchor procedure for outpatient clinical episodes by an episode initiator, during which all Medicare fee-for-services expenditures for all non-excluded items and services furnished to a BPCI Advanced beneficiary are bundled together for reconciliation purposes.

An anchor stay is the inpatient stay at an acute care hospital assigned to a qualifying MS-DRG for which an episode initiator submits a claim to Medicare fee-for-services, which in turn triggers a clinical episode. There are 105 selected MS-DRGs across 29 inpatient clinical episodes.

An anchor procedure is a hospital outpatient procedure, identified by a qualifying Healthcare Common Procedure Coding System -- HCPCS code -- for which an episode initiator submits a claim to Medicare fee-for-service, which in turn triggers a clinical episode. There are 29 selected HCPCS codes across three outpatient procedures.

There are five reasons why a Medicare beneficiary would be excluded from triggering a clinical episode. First, when the beneficiary is covered under United Mine Workers or managed care plans such as Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations. Second, if Medicare is not a primary payer. Third, if the beneficiary is eligible for Medicare on the basis of end-stage renal disease. Fourth, if the beneficiary dies during the anchor stay or the anchor procedure. And fifth, if the beneficiary is not enrolled in Medicare Part A or B for the entire clinical episode.

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 beginning the day of discharge. For the outpatient clinical episodes, the episode length is the anchor procedure plus 90 days beginning on the day of completion of the outpatient procedure. Day one of the 90-day period for inpatient and outpatient clinical episodes is the day of discharge from the anchor stay and the day of completion of the anchor procedure, respectively.

BPCI Advanced will operate under a total cost of care concept. That means that the total Medicare fee-for-services, spending in all items and services furnished to a beneficiary are included in the clinical episode unless specifically excluded. Outlier payments will also be included in the expenditures for purposes of the target price and reconciliation calculations.

Let's outline the service-level exclusions from the clinical episode. They are first claims related to blood clotting factors to control bleeding for hemophilia patients. Second, new technology add-on payments under the IPPS. And third, payments for items and services with pass-through payment status under the OPPS.

Most Part B costs incurred during the clinical episode will be included in the episode. However, Part A and Part B services furnished to a Medicare beneficiary during certain specified hospital admissions and readmissions based on MS-DRG will be excluded for the purpose of target price calculations and reconciliation results. BPCI Advanced will not follow the clinically-related criteria guiding Part B exclusions used in BPCI.

Readmissions will be excluded from the clinical episode only when they are related to one of the 122 MS-DRGs. For example, readmissions due to transplants, tracheostomy, trauma, cancer, and ventricular shunts.

BPCI Advanced will treat transfers as one continuous hospitalization. Clinical episode will begin at admission of the first part of the transfer and will be assigned to the first provider. Post-discharge 90 day period begins following discharge from the last part of the transfer. The MS-DRG is assigned from the last part of the hospital transfer.

Applicants' selection of clinical episodes must be submitted to CMS 60 days before the start date of the model. Those selections cannot be changed until the start of model year three in 2020. Those selections, as well as the episode initiators, cannot be changed -- additions or deletions -- until the start of model year three in 2020.

Now that we have defined the clinical episode in detail, let's look at how target prices will be calculated and how reconciliation will be performed in BPCI Advanced.

The methodology for calculating the benchmark price in BPCI Advanced will be different for a hospital episode initiator than the physician group practice initiator. To determine the hospital's benchmark price, CMS will use risk-adjustment models to account for the following contributors to variation in the episode standard spending amounts.

One, patient case mix. Two, patterns of spending relative to the hospital's peer group over time. And three, historic Medicare fee-for-service expenditures efficiency in resource use specific to the hospital's baseline period.

CMS will use an alternative method to determine the PGP's benchmark price. Specifically, since a physician affiliation to a PGP changes over time, discrepancies often occur between the pool of clinical episodes in the baseline period and the pool of clinical episodes in the performance period. Consequently, BPCI Advanced will base the PGP's benchmark price on the benchmark price for the hospital where the anchor stay or anchor procedure occurs. CMS will then adjust this hospital-specific benchmark price to calculate a PGP-specific benchmark price that accounts for the PGP's level of efficiency in the past and the PGP's patient case mix, each relative to the hospitals.

The target price equals the benchmark price times one minus the CMS discount. The CMS discount is three percent for all clinical episodes. Preliminary target prices will be provided prospectively before an applicant signs its participation agreement with CMS. Once the model goes live, participants will receive preliminary target prices prior to selection of clinical episodes for each model year.

Episode initiators will receive a preliminary target price determined prospectively based upon its historical patient case mix. The final target price will be set retrospectively at the time of reconciliation by replacing the historic patient case mix adjustment with the realized value in the performance period. It will be specific and transparent to the participant's beneficiaries.

BPCI Advanced will only have one risk track. Individual clinical episodes will have spending capped at the first and 99th percentile of total standardized allowed amounts within the clinical episode during each baseline calendar year and of national episode spending by MS-DRG or HCPCS. This is in contrast to BPCI, which currently offers three risk tracks and has a 20% financial responsibility beyond the upper threshold. The risk cap is applied to clinical episodes in both the performance period and the baseline period.

Reconciliation will occur semi-annually with two "True-Ups" to allow for claims run-out. Clinical episodes will be reconciled based on the performance period in which the clinical episode is attributed, which is determined by the start of the anchor stay or the anchor procedure. There are two performance periods per calendar year: January through June and July through December.

Once benchmark prices and target prices have been calculated for each six-month performance period, CMS will do a retrospective reconciliation comparing the total of actual Medicare fee-for-services expenditures to the final target price.

All non-excluded Medicare fee-for-services expenditures for a clinical episode for which the participant has committed to be held accountable for will be compared against the final target price, resulting in a positive or negative reconciliation amount. All positive and negative reconciliation amounts will be netted across all clinical episodes attributed to an episode initiator, resulting in a positive or negative total reconciliation amount.

The positive or negative reconciliation amount for an episode initiator is then adjusted based on quality performance, resulting in the adjusted positive or negative total reconciliation amount. For an episode initiator that is also a non-convener participant, the adjusted positive total reconciliation amount is the net payment reconciliation amount -- or NPRA -- which CMS will pay to the participant. If, instead, this calculation results in an adjusted negative total reconciliation amount for non-convener participants, this amount is the repayment amount which must be paid by the participant to CMS.

For convener participants, all adjusted positive total reconciliation amounts are netted against all the adjusted negative total reconciliation amounts for the participant's episode initiators. This calculates either the NPRA, which is when CMS will pay the participant, or a repayment amount, which is when the participant must repay CMS for the expenditures above the target price.

CMS recognizes the financial risks associated with participation in the new model and has instituted stop-loss/stop-gain limits. Reconciliation payments, both to participants from CMS and from participants to CMS, are capped at plus or minus 20% of the volume-weighted sum of final target prices across all clinical episodes netted to the EI level within the performance period, which is a key difference from BPCI, where the stop-loss/stop-gain cap is applied at the awardee level.

There will be a post-episode monitoring period for 30 days following the episode end date. CMS will calculate the total expenditures for all Part A and Part B services during that period and, if there is determination of spending outside the norm, participant must repay CMS the total amount identified as excess spending. These calculations will occur once per model year.

CMS will request fraud and abuse waivers specific to BPCI Advanced. More information regarding these waivers will be provided at a later time. Participants in BPCI Advanced will have the opportunity to use several Medicare payment policy waivers which involve conditional waivers of certain payment rules. These waivers related to the three-day skilled nursing facility, or SNF, rule, telehealth services, and post-discharge home visit services.

The BPCI initiative has been in place since 2013 and is scheduled to end on September 30th, 2018, and BPCI Advanced is scheduled to start on October 1st, 2018. We recognize there is a need for current BPCI awardees to clearly understand the differences between the two models.

Some key characteristics of BPCI Advanced that are different from BPCI are first, there will be a reduced number of clinical episodes offered in BPCI Advanced, but it will also include three outpatient clinical episodes. Second, BPCI Advanced will be an advanced APM. Third, payments in BPCI Advanced will be tied to performance on quality measures. Fourth, BPCI Advanced has a much more limited list of exclusions for the expenditures, which will be included in the bundle.

Fifth, the design of BPCI Advanced is similar to the BPCI model two. Previously, in BPCI model three, PAC providers could act as episode initiators. However, in BPCI Advanced, PAC providers can only participate as convener participants. Other Medicare-enrolled providers as well as non-Medicare enrolled entities can also participate as convener participants.

Sixth, in BPCI Advanced, the risk to participants is capped at plus or minus 20% of the target price. Lastly, BPCI Advanced participants will receive preliminary target prices prior to the start of each model year.

Overlap is bound to occur among Medicare beneficiaries in receipt of items and services being furnished by health care providers participating in different CMS models and programs. In the next few slides, we will address the interaction between BPCI Advanced and the Comprehensive Care for Joint Replacement Model, the Oncology Care Model, Accountable Care Organization Models, and the Medicare Shared Savings Programs.

Clinical episodes triggered under the Comprehensive Care for Joint Replacement Model will take precedence over clinical episodes in BPCI Advanced. Organizations in CJR will not be permitted to participate in BPCI Advanced for the clinical episodes in CJR.

Current participants in the Oncology Care Model will be allowed to participate in BPCI Advanced, and those episodes will run concurrently with OCM episodes. OCM per beneficiary-per month payments will be excluded from target prices and reconciliation calculations. In addition, performance-based payments in OCM will be proportionally adjusted for overlap.

CMS is interested in expanding participation in BPCI Advanced to Accountable Care Organizations, which include the ability for ACOs to participate in NPRA sharing. However, clinical episodes in BPCI Advanced will be excluded for Medicare beneficiaries aligned to: next-generation Accountable Care Organizations, or ACOs; ACOs participating in the Vermont Medicare ACO Initiative; Track 3 Medicare Shared Savings Programs ACOs; comprehensive end-stage renal disease care -- CEC -- Seamless Care Organizations with downside risk.

For more details on the overlap of the various CMS models mentioned before, we encourage you to review the RFA and visit the CMS Innovation Center website where you will also find a comparison table of CMS bundled payment models.

The goal of the CMS Innovation Center Learning Systems is to accelerate the implementation and success of our models. The Learning System increases the odds of both you and the model being successful. The Learning System connects you with one another, informs you, and keeps CMS tuned in to what you're discovering. Finally, the Learning System enables the model to learn and improve. The model learns from what's happening and becomes a better, more effective model.

To achieve this goal, the CMS Innovation Center Learning Systems serves three broad functions: Identify and package new knowledge and practice; leverage data and participant input to guide change and improvement; build learning communities and networks to share and spread new knowledge and practice. By integrating what CMS is learning from participants, what the participants are learning from CMS and what the participants are learning from each other, the Learning Systems provides a three-way channel of engagement to drive success in implementing new models.

After learning about this new voluntary bundled payment model, are you interested in applying to participate in BPCI Advanced? Then make a note in your calendar that the deadline for submission of the application is March 12th, 2018.

In preparing for the process of completing your BPCI Advanced application, you might find it helpful to have the request for applications as a reference. The RFA provides more details on the different elements of the model than what we have covered in this presentation. The application template and all required attachments are available for download at the CMS Innovation Center website.

Since the actual submission of the application must be made via the BPCI Advanced Application Portal, we encourage you to work on the different sections of the application offline. At the beginning of the application process, you will receive an application ID number. You will need to use that number whenever you communicate with CMS regarding your application. Paper applications submitted via US mail or e-mail will not be accepted.

CMS will provide preliminary target prices to applicants prior to the distribution of the participation agreements. In addition, CMS will provide the opportunity to request certain summary beneficiary claims data and line-level beneficiary claims data to be described in greater detail on the DRA form. In order to receive this data from CMS, applicants must submit a Data Request and Attestation -- or DRA -- form along with their completed application. The DRA template and further instructions can be downloaded from the CMS Innovation Center website.

CMS expects to distribute preliminary target prices to applicants in May 2018. Applicants selected to participate in the model will need to complete another DRA form in order to continue to receive data as a participant.

There are two attachments that some applicants must complete. Convener applicants must download and populate the "Participating Organizations" attachment to provide information on all of their episode initiators. As a reminder, if selected to participate in BPCI Advanced, the episode initiators included on this attachment cannot be changed -- additions or deletions -- until model year three in 2020.

Applicants who are PGPs and convener applicants that have PGPs as participating organizations must download and populate the "PGP Practitioners List" attachment. You must provide information on all physicians who are in the practice at any time during calendar years 2013, 2014, 2015, 2016, as well as in which hospitals you expect to trigger clinical episodes.

All attachments are available for download from the CMS Innovation Center website or from the application portal. If you download the template from the website and enter the required information, the completed document can be uploaded in to the application portal. There is no requirement to use the template available within the application portal since they are identical.

CMS has prepared additional resources to help the public better understand how the new model works. These resources, as well as other materials to be developed, can be found on the CMS Innovation Center website.

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

encourage you to visit the CMS Innovation Center website for additional information and updates on the model's timeline.

Thank you for taking the time to learn more about this new model. We would appreciate your feedback on this webcast and ask that you please complete a short survey. Click on the link to be taken directly to the survey.

Have a great day.