PUBLICATION

BPCI Advanced – CMS Offers a Familiar Program with a New Twist

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The Centers for Medicare & Medicaid Services (CMS) is launching BPCI Advanced – the successor program to the Bundled Payments for Care Improvement Initiative. Providers that like the current BPCI program, or simply missed the opportunity to join BPCI when it launched in 2013, should consider applying for BPCI Advanced before the March 12, 2018 application deadline.

CMS created the concept of bundled payments as a way to link payments across all health care providers during a single episode of care, with the aim of improving care and removing waste from the health care delivery system. BPCI Advanced builds on the work of CMS's Center for Medicare and Medicaid Innovation (CMMI) and the foundation of the first BPCI initiative, which started in April 2013 and will end on September 30, 2018. The BPCI Advanced performance period will begin on October 1, 2018 and run through December 31, 2023.

The intent behind holding health care providers accountable for resource management and costs with bundled payments is to motivate providers to better coordinate medical decisions across the various stages of care, keeping in mind the financial implications of their treatment decisions. BPCI Advanced requires all participants to accept financial risk at the outset of the program. Success requires participants to continually evaluate how they are delivering care and redesign and improve that delivery system. CMMI anticipates that BPCI Advanced will continue to improve efficiency and quality through better management during episodes of care, eliminating unnecessary care, and reducing post-discharge emergency department visits and readmissions. As with previous CMMI initiatives, CMS will monitor performance under BPCI Advanced through data analysis, audits and evaluations of performance measures, site visits, and surveys.

CMMI has established BPCI Advanced to satisfy the requirements for Advanced Alternative Payment Model (APM) classification. This enables clinicians participating in BPCI Advanced to participate in the Quality Payment Program as an Advanced APM and become eligible for an incentive bonus.

Bundled Payment Approach

BPCI Advanced will adopt a retrospective approach to bundled payments. Under this approach, fee-for-service (FFS) payments are made, and the total FFS payment for the Clinical Episode (discussed below) is then retrospectively reconciled against a predetermined Target Price. CMS will reconcile all non-excluded Medicare FFS expenditures for a Clinical Episode against a Target Price for that Clinical Episode. The Target Price is calculated by applying a discount, referred to as the CMS Discount, to the Benchmark Price. The Benchmark Price is calculated based on a combination of historical Medicare FFS spending, adjusted to reflect the Episode Initiator's efficiency relative to its peers over time, along with adjustments for patient characteristics and regional spending trends. The CMS Discount is the set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price. BPCI Advanced is different from the initial BPCI program in that BPCI Advanced introduces prospective pricing, risk adjustment at both the provider and beneficiary level, and annual re-basing of Target Prices that will generate more accurate pricing.

Application Process and Timelines

The application period for participation in BPCI Advanced began January 11, 2018 and applications will be accepted and processed via the BPCI Advanced Application Portal on a rolling basis until March 12, 2018.

Importantly, applications submitted outside of the Application Portal or that are incomplete will not be accepted. CMS will distribute Target Prices to BPCI Advanced applicants in May 2018 and applicants will have until August 2018 to sign their BPCI Advanced Participation Agreements. The BPCI Advanced performance period will then begin on October 1, 2018 and run until December 31, 2023. Target Prices are calculated and distributed to participants prior to the first performance period of each model year.

CMS encourages all providers to thoroughly review the Request for Applications and application template before starting their application. Prior to signing the BPCI Advanced Participation Agreement, applicants will have the opportunity to request a summary of beneficiary claims data and line-level beneficiary claims to review, which will be distributed in late May 2018. Reviewing this information may provide potential applicants with an indication of how they might perform under the program. Applicants interested in viewing this information must complete a Data Request and Attestation (DRA) form during the application process and provide the time period for the data requested and the legal basis for disclosure under the Health Insurance Portability and Accountability Act (HIPAA) upon which the request is made.

Those considering participation may want to apply in order to gain access to this CMS data. It will provide valuable insight to a provider's cost and care delivery processes. If a provider determines the program is not a good fit, a written request can be submitted to withdraw the application prior to entering into a BPCI Advanced Participation agreement with CMS.

Providers unable to apply at this time can take advantage of the one additional application opportunity to participate in the program that will occur in January 2020. The date coincides with the currently proposed termination date for the Comprehensive Care Joint Replacement Program (CJR).

Participants and Applicant Partners

Former and current BPCI initiative participants and participants in other episode payment models are encouraged to apply for BPCI Advanced, though CMS notes that former or current BPCI initiative participants will not receive special consideration in the application process. Participation is open to all states (except Maryland), territories, and the District of Columbia, although certain regions may be less viable because of the program overlap restrictions discussed below.

BPCI Advanced has two categories of Participants: Convener Participants and Non-Convener Participants.

Convener Participants

The Convener Participants can be any type of entity and do not have to be enrolled in Medicare. Convener Participants take on risk both on their own behalf and on behalf of one or more Episode Initiators. Episode Initiators can only be either an acute care hospital (ACH) or a physician group practice (PGP). The Convener Participants facilitate coordination among Episode Initiators and bear the financial risk for the model. Acute care hospitals and physician practice groups can be both Convener Participants and Non-Convener Participants. For those Convener Participants that are not enrolled in Medicare, an irrevocable line of credit or similar mechanism is required as a means to ensure they are financially able to make any Repayment Amounts to CMS if the Convener Participant's expenditures exceed the bundled payment target price.

Non-Convener Participant

A Non-Convener Participant only bears financial risk for itself. The only types of entities that can participate as Non-Convener Participants are acute care hospitals and physician group practice.

Certain providers are excluded from BPCI Advanced because of their unique payment methodologies, including Prospective Payment System (PPS) Exempt Cancer Hospitals, inpatient psychiatric facilities, Critical Access Hospitals (CAH), hospitals in the Rural Community Hospital Demonstration program, and certain hospitals in Maryland and Pennsylvania. To participate in BPCI Advanced, providers must pass the pre-screening process, be accountable for one or more Clinical Episodes, and sign a Participation Agreement with CMS. Non-Convener Participants are not required to provide a line of credit because CMS may use future claims as a source of funds for any future repayment Amount.

Applicant Partners

Participants (either Convener Participants or Non-Convener Participants) can partner with the following in their care redesign efforts:

- Participating Practitioners – physicians, nurse practitioners, physician assistants, and physical therapists
- Episode Initiators – acute care hospital or physician group practice that can trigger a Clinical Episode

Clinical Episodes

BPCI Advanced is a voluntary program that will initially include a total of 32 Clinical Episodes:

- Twenty-nine inpatient Clinical Episodes: including, for example, major joint replacement of the lower extremity, percutaneous coronary intervention, stroke, sepsis, and disorders of the liver (excluding malignancy, cirrhosis, alcoholic hepatitis) (not previously included in BPCI).
- Three outpatient Clinical Episodes: percutaneous coronary intervention, cardiac defibrillator, and back and neck episodes, except spinal fusion.

CMS reduced the number of Clinical Episodes from the 48 BPCI Clinical Episodes in order to focus on Clinical Episodes with significant volume and clarity.

A Clinical Episode is triggered under BPCI Advanced by an acute care hospital's submission of an inpatient or outpatient claim that contains a qualifying MS-DRG or HCPCS code respectively. Once triggered, the inpatient Clinical Episodes run for 90 days post discharge from the acute care hospital and the outpatient Clinical Episodes run for 90 days post completion of the qualifying outpatient procedure.

MACRA/QPP Determinations

Advanced APM

BPCI Advanced has been developed to meet the criteria of an Advanced Alternative Payment Model (Advanced APM) upon commencement. As an approved Advanced APM, eligible clinicians can become a Qualifying APM Participant (QP) with sufficient participation in the Model. If a clinician achieves QP status under BPCI Advanced, the clinician is not subject to the reporting requirements under the Merit-based Incentive Payment System (MIPS) and will be eligible to earn a five percent APM incentive payment under the Quality Payment Program. The first year a clinician can potentially qualify as a QP under BPCI Advanced begins with the January 1, 2019 Performance Period. The first date for QP determination is expected to be March 31, 2019. CMS has outlined those Model Participants who are eligible for QP determination, which differs for Non-Convener and Convener Participants.

MIPS APM

CMS also provides insight on how an eligible clinician participating in BPCI Advanced will be scored if the clinician does not achieve QP status for the year. As this Model is expected to be considered a MIPS APM as of January 1, 2019, eligible clinicians who are physicians and reassigned their rights to receive Medicare payment to a PGP Participant (or a Convener Participant with at least one downstream Episode Initiator that is a PGP) and are included on the PGP list (the Participation List) but do not achieve QP status for the year will have the APM scoring standard applied to them rather than MIPS reporting requirement obligations.

Reconciliation

Similar to BPCI, the total Medicare fee-for-service expenditure for Medicare Parts A and B for a BPCI Advanced Clinical Episode will be compared to a Clinical Episode-specific Target Price. During the initial phases of BPCI Advanced, the Target Price will be set at a three percent discount to the Benchmark Price used for the Clinical Episode. The expenditures will begin with the Anchor Stay (for inpatient procedures) or the Anchor Procedure (for outpatient procedures) and continue through the 90-day period following that anchor event. CMS will semi-annually reconcile the total spending to the Target Price as well as risk adjust the total spend based on each Participant's actual case mix.

For all Clinical Episodes, the total spend will include hospice services and any related or unrelated readmissions. The total spend for Clinical Episodes that begin with an Anchor Stay will include all non-excluded hospital diagnostic testing and certain therapeutic services provided by the admitting hospital (or a wholly owned affiliate) in the three days prior to the Anchor Stay (consistent with the three-day payment window rules). In that situation, the total spend will also include any charges from an emergency department visit if the patient was transferred from another facility's emergency department on either the day of or the day before the Anchor Stay.

CMS will also exclude the following payments from its total spend calculations:

1. All Part A and Part B services furnished to a BPCI Advanced Beneficiary during certain specified ACH admissions and readmissions (i.e., an admission assigned at discharge to MS-DRGs for organ transplants, major trauma, cancer-related care, ventricular shunts);
2. New technology add-on payments under the IPPS;
3. Payments for items and services with pass-through payment status under the OPPS;
4. Payment for blood clotting factors to control bleeding for hemophilia patients;
5. Medicare FFS expenditures on items and services furnished to:

Medicare beneficiaries covered under managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations);

Medicare beneficiaries eligible on the basis of end-stage renal disease (ESRD);

Medicare beneficiaries for whom Medicare is not the primary payer; and

Medicare beneficiaries who died during the Clinical Episode.

After determining whether the expenditure was less than the Target Price, which would result in a Positive Reconciliation Amount, or whether the expenditure was greater than the Target Price, resulting in a Negative Reconciliation Amount, CMS will determine the net reconciliation amounts on a per-Episode Initiator basis. Using the Clinical Episodes attributed to each Episode Initiator, CMS will determine whether there is a Positive, or Negative, Total Reconciliation Amount. CMS will next apply the Composite Quality Score (CQS) adjustment, discussed below, to the Positive or Negative Total Reconciliation. The CQS adjustment will be determined on a Clinical Episode-by-Clinical Episode basis using the BPCI Advanced Quality Metrics. If there is a positive

amount after the CQS adjustment, then this amount is the Net Payment Reconciliation Amount, or NPRA, to be paid by CMS. If there is a negative amount, then this amount is the Repayment Amount to be paid to CMS.

A number of payment restrictions are implemented during the initial phases of BPCI Advanced. During the first two Model Years of BPCI Advanced, CQS will be limited in its effect on the Repayment Amount and the NPRA. CQS can only increase or decrease the final amount by no more than ten percent. Additionally, there will be a 20 percent stop-gain (if there is NPRA) or a 20 percent stop-loss (if there is a Repayment Amount) that will be applied to the amount paid or attributed to the Episode Initiator.

Quality Metrics

Performance on Quality Measures to determine the CQS is a key element in the reconciliation of the total expenditure to the Target Price. While CMS is interested in reducing costs associated with care, it is careful to ensure that reduction in spending does not have a negative impact on the quality of care beneficiaries receive. An Episode Initiator's score on the quality measures will impact both a Positive Total Reconciliation Amount or Negative Total Reconciliation Amount.

The Quality Measure List for BPCI Advanced includes both process and outcome quality measures. For participants entering the Model on October 1, 2018, CMS has established seven quality measures referred to as the "Required Quality Measure List" for Model Years in 2018 and 2019. Of these measures, two are required for all Clinical Episodes. These include:

- All-cause Hospital Readmission Measure (National Quality Forum (NQF) #1789); and
- Advance Care Plan (NQF #0326).

The other five measures apply as appropriate based on episode. These include:

- Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268);
- Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550);
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558);
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF#2881); and
- AHRQ Patient Safety Indicators (PSI 90). CMS has included additional measures that may be required in future Model years.

For measures required by CMS, Participants must report all non-claims-based quality measures no later than February 20 of the year immediately following the Model Year in which the quality measures were tracked. Claims-based measures do not require reporting by Participants, as CMS will collect that data directly. CMS noted that Participants may be able to report on additional measures in future Model Years on a voluntary basis. New measures may also be included in the future for benchmarking purposes to assist CMS in determining if those quality measures should become part of the Required Measure List for future Model Years. It is likely that CMS will adjust the Quality Measures as the Model develops.

Fraud and Abuse and Payment Policy Waivers

At this time, no fraud and abuse waivers have been issued for this Model, although under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive certain statutory requirements for the purpose of testing a model such as BPCI Advanced. Individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver or waivers issued specifically for BPCI Advanced pursuant to Section 1115A(d)(1) if and when they are available.

The Model does include some Medicare Payment Policy Waivers that will assist Participants in testing whether flexibility and coverage of additional services will lower costs, improve quality, facilitate the delivery of care in new settings, and better engage beneficiaries in their care. These waivers include:

- Waiver of the SNF Three-Day Rule will waive the requirement for a prior hospital stay of three consecutive days for a beneficiary to be eligible for SNF services. Such waiver requires discharge to a Qualified SNF, includes certain DRGs and is used only for BPCI Advanced Beneficiaries. If the conditions are not met, the Participant may be held responsible for the cost of the SNF stay.
- Telehealth Services Waiver is a conditional waiver of geographic requirements for telehealth services when provided to BPCI Advanced Beneficiaries during a Clinical Episode.
- Post-Discharge Home Visits Services Waiver will allow post-discharge "incident to" services provided in a Beneficiary's home to be furnished by auxiliary personnel under general supervision of the physician rather than direct supervision.

Program Overlap with Other Innovative Payment Models

BPCI Advanced will have program overlap rules that will be similar to the ones used in other innovative payment models. Similar to BPCI, Clinical Episodes initiated under the Comprehensive Care Joint Replacement (CJR) program will have precedence over BPCI Advanced Clinical Episodes. Hospitals and other participants in CJR will not be allowed to participate in BPCI Advanced for the Clinical Episodes included in CJR. Unfortunately, the timing of the release of the RFA and the opt-in changes to CJR, which take effect January 31, 2018, leave CJR participants little time to evaluate the merits and differences between the two programs. Additionally, Clinical Episodes in BPCI Advanced will be excluded for Medicare beneficiaries attributed to Next Generation ACOs, ACOs participating in the Vermont Medicare ACO Initiative, Track 3 Medicare Shared Savings Program ACOs, and Comprehensive End Stage Renal Disease Care Seamless Care Organizations.

Beneficiary Protections

Ensuring that beneficiaries' rights are protected has been a key element of the models developed by CMMI, and BPCI Advanced is no exception. Under this Model, beneficiaries must receive notice from Participants and downstream Episode Initiators and Participating Practitioners about their participation in the Model. This must be done via a template notification letter provided by CMS for BPCI Advanced Beneficiaries. Such letter template should be provided to beneficiaries prior to, or as soon as possible following, the submission of a claim for the Anchor Stay or the Anchor Procedure that triggers a Clinical Episode. Although beneficiaries cannot opt out of participation in the payment methodology, their freedom to choose their health care provider will not be limited. Participants, downstream Episode Initiators and Participating Practitioners are not permitted to restrict a beneficiary's choice of provider or supplier.

Additionally, a beneficiary's Medicare benefits are unchanged by participation in the Model. One exception to this that may benefit the beneficiary is if a Participant meets the conditions for and selects to furnish services under one or more the Payment Policy Waivers and the beneficiary receives access to additional benefits. Otherwise, the out-of-pocket costs for the beneficiary will not be impacted by the Model.

Takeaways

Providers wishing to apply to the BPCI Advance initiative will need to move quickly to review and assess the application process and how the BPCI Advance initiative will fit within their current or planned care redesign efforts, and then define their application strategy. Some points for consideration:

- Be mindful of the application deadlines.

- Be mindful of the January 31, 2018 deadline for opting in to the CJR program. Hospitals in voluntary CJR MSAs and rural and low-volume hospitals in mandatory CJR MSAs need to consider BPCI Advanced before making their opt-in decision.
- Evaluate overlap with other bundled payment/shared savings/quality initiatives within your organization and market that could impact success under BPCI Advanced.
- Evaluate current provider relationships and opportunity for alignment strategies.
- Evaluate the required infrastructure for success in BPCI Advanced. Those currently participating in BPCI should evaluate how your current BPCI infrastructure can be modified/altered to support BPCI Advanced.
- BPCI Advanced qualifies as an Advanced APM under the Quality Payment Program. Participants who are able to achieve QP status under the program will be eligible for a five percent incentive bonus above any incentives achieved under the program. If QP status is not achieved, certain clinicians may have to report under MIPS for that Performance Period.