Executive Summary: CMMI Bundled Payment for Care Improvement Advanced Model – Request for Applications Released

The Center for Medicare and Medicaid Innovation (CMMI) released the long-awaited request for applications (RFAs) for the Bundled Payment for Care Improvement Advanced payment model (BPCI Advanced or the Model) on January 9, 2018. Building on lessons learned in the Bundled Payment for Care Improvement (BPCI), BPCIA represents the next iteration of CMMI's efforts to advance episodic payment models on a voluntary basis, and provide payment models that will allow physicians – particularly specialists – to qualify for the Quality Payment Program's (QPP's) 5 percent Advanced Alternative Payment Model (AAPM) bonus.

Below are key facts healthcare finance executives need to know about the program. The BPCIA website provides additional resources and is available here.

1) *Participants*: Only physician group practices (PGPs) and Medicare certified sub-section (d) acute care hospitals (ACHs)[1] may initiate episodes. However, CMMI defines two categories of organizations that may apply to participate – non-convener participants, and convener participants.

   A non-convener participant can only be a PGP or an ACH, and only bears episode risk for itself (it is the episode initiator).

   A convener participant is a type of participant that brings together multiple downstream entities referred to as "Episode Initiators" to participate in BPCI Advanced, facilitates coordination among them, and bears and apportions financial risks. Conveners may be PGPs, ACHs, other Medicare enrolled suppliers (e.g. skilled nursing facility), or entities not enrolled in Medicare.

2) *Episode Definition*: BPCI Advanced will initially include 32 retrospectively reconciled episodes (29 inpatient and 3 outpatient). Each episode includes all non-excluded Part A and B spending for services provided during a period that begins with the anchor stay (including services in the three-day window) or anchor procedure and ends 90 days post-discharge. Additionally, CMMI will monitor claims experience 30 days post-episode (during days 90 – 120). It will hold providers accountable in instances where spending during the post-episode period is higher than expected based on CMMI pricing models.

   The 29 inpatient episodes are comprised of 105 Medicare Severity Diagnosis Related Groups (MS-DRGs), and account for approximately 53 percent of inpatient discharges in federal fiscal year 2015. The three outpatient episodes (percutaneous coronary intervention, cardiac defibrillator, and back or neck except spinal fusion) map back to 29 Healthcare Common Procedure Coding System (HCPCS) codes. Appendix I provides the list of inpatient episodes and their volume. A mapping of MS-DRGs and HCPCS codes to individual episodes is available here.

   Participants selected to participate in BPCIA beginning on October 1, 2018, may not add new Clinical Episodes until January 1, 2020. Participants that begin participating in the Model

[1] PPS-Exempt Cancer Hospitals, inpatient psychiatric facilities, CAHs, hospitals and Maryland, hospitals participating in the Rural Community Hospital demonstration, and Participant Rural Hospitals in the Pennsylvania Rural Health Model, are excluded from the definition of an ACH for purposes of BPCI Advanced.

beginning on October 1, 2018, will not be allowed to drop Clinical Episodes, except upon request by CMS, until January 1, 2020.

3) *Pricing and Risk Mitigation*: Episode target prices will be set prospectively based on the historical benchmark price[2] and a CMS discount. The benchmark price is calculated based on a combination of historical Medicare fee for service (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 that will occur at reconciliation. CMS will then reduce the benchmark price by 3 percent to lock in savings from the program. The RFA states that CMMI may make "slight" adjustments to the discount factor in subsequent years.

   BPCIA has several risk mitigation methods built into it. First, during reconciliation, the benchmark price will be updated to reflect the actual mix of cases that occurred during the performance period. This is an improvement over BPCI, as the benchmark was not updated to reflect changes in the mix of MS-DRGs within the episode during the performance period. Therefore, a participant who provided higher acuity services within an episode compared to the benchmark period faced a form of adverse selection.

   Second, BPCI Advanced will limit risk to participants through a risk track that applies Winsorization at the 1st/99th percentile of total standardized allowed amounts within the Clinical Episode during each baseline calendar year, and of national Medicare FFS spending on each MS-DRG and HCPCS code to account for random variation.

   Finally, the model includes a 20 percent stop-loss/stop-gain at the Episode Initiator level.

4) *Episode Attribution*: Clinical Episodes will be attributed at the Episode Initiator level. Based on the materials provided, it does not appear that BPCI participants will have "precedence" over those entities that bear risk for Medicare FFS episodes for the first time in BPCIA.

   The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators in BPCI Advanced is as follows, in descending order of precedence:

   - The Physician Group Practice (PGP) that has the attending physician's National Provider Identifier (NPI) listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) billed under the participating PGP's Tax Identification Number (TIN);
   - The PGP that has the operating physician's NPI listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) during the anchor stay or procedure billed under the participating PGP's TIN; and
   - The ACH where services during the anchor stay or anchor procedure were furnished.

   Episode Initiators who begin participating in BPCIA on 10/1/18 will not have precedence over participants with subsequent start dates (1/1/20).

[2] Each ACH episode initiator's target price will be based off its historical spending for a given baseline period. However, PGP target prices will be based on the benchmark target price for the ACH where the anchor stay or procedure occurs.

5) *Reconciliation*: Unlike in BPCI and Comprehensive Care for Joint Replacement (CJR), which provided a "risk free" period, BPCIA participants will bear downside risk from the outset of the program. Reconciliation will occur twice a year.

   Like BPCI, CMS will net the results for all the episodes an Episode Initiator participates in to calculate either a Positive Total Reconciliation Amount or a Negative Total Reconciliation Amount. As a simple example that does not account for quality (discussed below), if an Episode Initiator participated in the lower extremity joint replacement (LEJR) and acute myocardial infarction (AMI) episodes, and came in $100,000 below the volume adjusted LEJR target price and $200,000 above the volume adjusted AMI target price, the Episode Initiator would owe CMMI $100,000.

   The reconciliation amounts will be adjusted by the Composite Quality Score (CQS) based on the quality measures listed in Appendix II. The adjustment is based on the Episode Initiator's scores on the applicable set of quality measures. For the first two years, there will be a 10% cap on Net Payment Reconciliation Amount (NPRA) based on CQS. The total positive or negative adjusted reconciliation amount across all episodes for an Episode Initiator will be 90 to 100 percent of the reconciliation amount. Therefore, the quality adjustment does not provide a bonus, but serves as an "earn back" mechanism. This policy is subject to change in subsequent years.

6) *Data Availability*: CMS will offer applicants the opportunity to request certain data to support informed clinical episode selection, ongoing self-evaluation, and quality and process improvement. It will provide up to three years of both detailed line-level claims data and/or summarized data for beneficiaries who would have been attributed to the applicant. Participants, as described in a data request form on the BPCI Advanced website, must specify required data elements and the time-period desired. Participants will need to resubmit an application for the same information to request similar data for the participation period.

7) *Waivers*: Participants will have the opportunity to choose to furnish services to BPCI Advanced beneficiaries pursuant to one or more Medicare Payment Policy Waivers, which involve conditional waivers of certain payment rules; these waivers relate to the 3-Day skilled nursing facility rule, telehealth services, and post-discharge home visits services.

8) *Interactions with Other CMS and CMMI Programs*: Entities may concurrently participate in BPCI Advanced and the Medicare Shared Savings Program, the Innovation Center's Next Generation ACO Model, other shared savings initiatives, and medical home models. While entities involved in various CMS and CMMI APMs may participate in BPCI Advanced, certain payment models interact with BPCI Advanced as follows:

   a. QPP: BPCIA qualifies as an AAPM. Physicians who participate and meet volume or revenue criteria will qualify for the 5 percent AAPM bonus.
   b. CJR: CJR hospitals can participate in the BPCI Advanced program, but not for LEJR episodes. Further, LEJR episodes triggered under the CJR model will take precedence over clinical episodes in BPCI Advanced.

c. Oncology Care Model (OCM): Current participants in the OCM will be allowed to participate in BPCI Advanced, which will run concurrently with OCM. Instead of giving one model precedence over another, CMS will adjust OCM performance-based payments for BPCI Advanced NPRA payments based on the proportion of the BPCI Advanced Clinical Episode that overlaps with the OCM episode.
d. Next Gen Accountable Care Organizations (ACOs) and Track 3 Medicare Shared Savings Programs: Beneficiaries attributed to these models will be excluded from Clinical Episodes in BPCI Advanced.
e. Participants in the Vermont Medicare ACO Initiative: Beneficiaries attributed to these models will be excluded from Clinical Episodes in BPCI Advanced.
f. Comprehensive End-Stage Renal Disease Seamless Care Organizations with Downside Risk: Beneficiaries attributed to these models will be excluded from Clinical Episodes in BPCI Advanced.

9) *BPCI Advanced Duration*: The model will run from October 1, 2018, to December 31, 2023. There will be an initial start date of October 1, 2018, with a subsequent opportunity to for hospitals and physician group practices or conveners to enroll for participation starting January 1, 2020.

10) *Application Process*: Applications for the October 1, 2018, start date are due no later than 11:59 on March 12, 2018. The deadline for the January 1, 2020, start date will be posted later. A detailed summary of the BPCI Advanced application timeline is available here.

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Appendix I:

BPCI-A Inpatient Episodes and Their Volume Based on 2015 Medicare Discharges

BPCI-A Episode Name	2015 Medicare FFS Discharges	% of Medicare 2015 Total Discharges
Acute myocardial infarction	136,182	1.40%
Back and neck except spinal fusion	39,544	0.41%
Cardiac arrhythmia	247,879	2.54%
Cardiac defibrillator	20,412	0.21%
Cardiac Valve	74,000	0.76%
Cellulitis	150,838	1.55%
Cervical spinal fusion	46,871	0.48%
Chronic obstructive pulmonary disease, bronchitis/asthma	375,860	3.86%
Combined anterior posterior spinal fusion	11,966	0.12%
Congestive heart failure	479,321	4.92%
Coronary artery bypass graft surgery	61,874	0.64%
Disorders of liver except malignancy, cirrhosis or alcoholic hepatitis	46,105	0.47%
Double joint replacement of the lower extremity	9,620	0.10%
Fractures femur and hip/pelvis	39,172	0.40%
Gastrointestinal hemorrhage	229,332	2.35%
Gastrointestinal obstruction	106,550	1.09%
Hip and femur procedures except major joint	134,757	1.38%
Lower extremity and humerus procedure except hip, foot, femur	42,550	0.44%
Major bowel procedure	110,202	1.13%
Major joint replacement of the lower extremity	491,949	5.05%
Major joint replacement of upper extremity	47,757	0.49%
Pacemaker	63,585	0.65%
Percutaneous coronary intervention	176,469	1.81%
Renal failure	296,393	3.04%
Sepsis	711,561	7.30%
Simple pneumonia and respiratory infections	477,749	4.90%
Spinal fusion (non-Cervical)	82,073	0.84%
Stroke	248,256	2.55%
Urinary tract infection	234,229	2.40%
Grand Total	5,193,056	53.30%

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Appendix II – Quality Measures CMS may incorporate new quality measures, re-evaluate and improve existing quality measures, and adjust the quality measure set and/or composite quality score calculation methodology (used to adjust reconciliation amounts) on an annual basis during the performance period of the model.

The measures in Table A are claims-based measures for which reporting is required (a.k.a. the "Required Measures List") for participants (and their downstream Episode Initiators) whose participation begins on October 1, 2018, for the first two model years (2018 and 2019). These claims-based measures will be collected by CMS directly. The first two measures will be required for all episodes. The remaining five will be applied as appropriate to the episode.

Table A – 2018 and 2019 BPCIA Required Measures List

Measure Number	Description
NQF #1789	All-cause Hospital Readmission Measure
NQF #0326	Advanced Care Plan
NQF #0268	Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin
NQF #1550	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
NQF #2558	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery
NQF #2881	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
PSI 90	AHRQ Patient Safety Indicators

The measures in Table B are additional measures that may be included in the Required Quality Measures List for Model Year 3 (2020).

Table B – Potential Measures for Model Year 3 (2020) and After

Measure Number	Description
NQF #0005	CAHPS for Clinicians
NQF #0006	CAHPS for Hospitals
NQF #0166	CAHPS Home Health Care
CMS #373	Hypertension: Improvement in Blood Pressure
CMS #2849	Drug Regimen Review with Follow-up
NQF #0299	Surgical Site Infection (SSI)
CMS #1966	Unplanned Reoperation within the 30 Day Postoperative Period

Beginning on January 1, 2020, participants will be held accountable for, and must report on all applicable measures on the required quality measures list. Each participant, either on behalf of itself or its downstream providers and suppliers, will be required to report on all applicable non-claims based quality measures no later than February 20th of the year immediately following the model year in which

the quality measures were applicable. For example, by February 20, 2021, participants must report on all applicable quality measures for all of 2020.