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BPCI Advanced Voluntary Episode Payment Model

The Centers for Medicare & Medicaid Services ("CMS") announced Bundled Payments for Care Improvement Advanced ("BPCI Advanced"), a new voluntary episode payment model that will test a new iteration of bundled payments for 32 Clinical Episodes (29 inpatient and 3 outpatient), including major joint replacement of the lower extremity. CMS has indicated that **BPCI Advanced will qualify as an Advanced Alternative Payment Model ("APM") under the Quality Payment Program.** The BPCI Advanced performance period begins on October 1, 2018 and runs through December 31, 2023.[1] The application portal for participation in the Model opened on January 11, 2018**,** and applications for participation must be submitted by March 12, 2018. CMS is hosting a Q&A Forum on January 30, 2018 from 12 pm-1pm EST which is open to the public.

Model Overview

Designed as a retrospective bundled payment model, BPCI Advanced will make participants fiscally responsible for the medical procedures associated with selected conditions and for all of the non-excluded care occurring in a 90-day period following the procedure ("Clinical Episodes"). BPCI Advanced will permit participants to select which Clinical Episodes they will be responsible for during the application process. Similar to the BPCI Models 2 and 3, under BPCI Advanced CMS will continue to make fee-for-service ("FFS") payments during a Clinical Episode and the total expenditures for the Clinical Episode will later be reconciled against an episode-specific target price on a semi-annual basis. The difference between actual Medicare expenditures and the target prices across the Clinical Episodes experienced by a participant will be adjusted based on quality measures, if this adjusted amount is positive CMS will pay the participant the amount, if the amount is negative the participant will be responsible for paying CMS the amount.

Understanding Physician Participation

While physician group practices ("PGPs") can participate in the BPCI Advanced though multiple avenues, they will be considered **Episode Initiators** regardless of which method of participation they select. Episode Initiators must be either PGPs or acute care hospitals ("ACHs") and serve as the base entities to which Clinical Episodes are assigned, FFS spending is tracked, quality measures are evaluated, and reconciliation calculations are made.

As an Episode Initiator, a PGP may participate in BPCI Advanced as a Convener Participant, a Non-Convener Participant, or under a Convener Participant's agreement with the Innovation Center.

- **Convener Participants** facilitate coordination across multiple Episode Initiators and bear and allocate all the financial risk for the performance of those Episode Initiators. A

[1] Because the BPCI Advanced 2018 performance year will be less than one year, participation will not make a provider eligible to the Qualified Participant 5% Advanced APM bonus in 2018.

Convener Participants may be either an entity that is not enrolled in Medicare or a Medicare enrolled clinical entity other than a ACH or PGP (such as a post-acute care provider).

- **Non-Convener Participants** do not bear risk on behalf of other Episode Imitators. Therefore, in order to qualify as a Non-Convener Participant, an entity must be an Episode Initiator.

Medicare-enrolled providers or suppliers – other than ACHs and PGPs – and entities not themselves enrolled in Medicare may participate in BPCI Advanced as a Convener Participant, but not as a Non-Convener Participant.

Regardless of how a PGP elects to participate, beginning on October 1, 2018, participants selected to participate in BPCI Advanced must commit to be held accountable for one or more Clinical Episodes. Participants will be "locked in" to this selection, and cannot add or drop a Clinical Episode until January 1, 2020.

Defining a Clinical Episode

Initially, BPCI Advanced will include 29 inpatient Clinical Episodes and 3 outpatient Clinical Episodes. This initial set of Clinical Episodes *includes both major joint replacement of the lower extremity and hip & femur procedures except major joint. The initial set excludes the newly authorized outpatient TKA procedures.* Beginning on January 1, 2020, CMS may elect to revise which Clinical Episodes are included in the model. Clinical Episodes will begin either at the start of a qualifying inpatient admission to an ACH ("Anchor Stay") or at the start of a qualifying outpatient procedure ("Anchor Procedure"). Each Clinical Episode will include any non-excluded Medicare spending associated with the Anchor event and any non-excluded Medicare spending which occurs within 90 days of the conclusion of the Anchor event.

Medicare FFS Expenditures Included in the Clinical Episode	Medicare FFS Expenditures Excluded in the Clinical Episode
Part A and Part B non-excluded items and services that are furnished during the Anchor Stay or Anchor Procedure	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)
Part A and Part B non-excluded items and services furnished in the 90-day period following the Anchor Stay or Anchor Procedure, including hospice services and both related and unrelated readmissions	New technology add-on payments under the IPPS
With respect to those Clinical Episodes triggered by an Anchor Stay: (i) All non-excluded hospital diagnostic testing and certain therapeutic services furnished by the admitting hospital or an entity wholly owned or wholly operated by the admitting hospital in the three	Payments for items and services with pass-through payment status under the OPPS

Medicare FFS Expenditures Included in the Clinical Episode	Medicare FFS Expenditures Excluded in the Clinical Episode
days prior to the Anchor Stay (in accordance with the 3-day payment window rule); and (ii) if the beneficiary was transferred from the ED at another facility either the day of or the day before admission for the Anchor Stay, charges from that ED visit	
	Payment for blood clotting factors to control bleeding for hemophilia patients

Assigning Clinical Episodes

Each Clinical Episode will be attributed at the individual Episode Initiator level. When multiple Episode Initiators are involved in a Clinical Episode, the Clinical Episode is assigned based on the following order of precedence: (1) the PGP that submits a claim that includes the National Provider Identifier ("NPI") for the attending physician; (2) the PGP that submits a claim that includes the NPI of the operating physician; and (3) the ACH where the services that triggered the Clinical Episode were furnished.

Due to the way BPCI Advanced assigns responsibility for Clinical Episodes, it will be important for surgical practices considering participation in BPCI Advanced to understand if and how their partners in care plan on participating.

Payment Methodology

Under BPCI Advanced, CMS will continue to make FFS payments for the services provided during a Clinical Episode. On a semi-annual basis, CMS will conduct a reconciliation process comparing the aggregate Medicare expenditures included in a Clinical Episode against a Clinical Episode specific Target Price. CMS will repeat this process across all of the Clinical Episodes for which an Episode Initiator is responsible in order to calculate the Episode Initiator's financial performance.

Quality Adjustment: An Episode Initiator's financial performance will then be adjusted based on the Episode Initiator's quality performance. During the first 2 years of BPCI Advanced, the adjustment based on quality performance will be capped at 10%, leaving the adjusted payment amount between 90-100% of the pre-quality performance adjusted amount.

Reconciliation Payment: For Non-Convener Participants, if the quality performance final adjusted amount is positive, a payment will flow from CMS to the Non-Convener Participant. If the quality performance final adjusted amount is negative, the Non-Convener Participant will be responsible for paying CMS that amount. For Convener Participants, the quality performance adjusted amounts are netted across the Episode Initiators for which the Convener Participant is responsible for in order to calculate the amount owed to either the Convener Participant or CMS.

Stop-Loss and Stop Gain Provision: The reconciliation payments either to or from CMS are capped at 20% of the volume-weighted sum of the final target prices across all Clinical Episodes

netted to the level of the Episode Initiator.

Post-Episode Spending Monitoring Period: In an attempt to avoid cost shifting, BPCI Advanced features a 30-day post-episode monitoring period (day 91-120 following the conclusion of the Anchor event). During this period CMS will monitor FFS spending and if actual spending exceeds predicted spending, the Participant will be responsible for paying the excess amount back to CMS.

Establishing a Target Price

The Clinical Episode Target Price, against which actual spending is compared, is established by taking the CMS established Benchmark Price and adjusting it for the CMS established discount rate.

- **Benchmark Price for ACHs**: CMS will establish an Episode Initiator-specific Benchmark Price for ACHs using the standardized spending amounts for the procedure, risk adjusted for the following factors: patient case-mix, spending patterns relative to ACH's peer group, , and historical Medicare FFS expenditure efficiency in the ACH's baseline period.[2]
- **Benchmark Price for PGPs:** To establish the Episode Initiator specific Benchmark Price for PGPs, CMS will use the Benchmark Price for *the ACH where the Anchor event occurs*; this price will be adjusted to calculate a PGP-specific Benchmark Price to account for a PGP's past efficiency and patient case mix, relative to the ACH.
- **Discount Rate:** During the initial performance period for BPCI Advanced, the discount rate to CMS will be 3%. However, CMS may elect to adjust this amount in future model years.

Do to the method CMS has elected for Benchmark Price calculation, PGPs applying for participation in BPCI Advanced should consider not only their own performance but the performance of the facilities where they provide services which trigger Clinical Episodes.

Quality Measures

For the initial years of BPCI Advanced, CMS will collect seven quality measures. Two of the measures, the All-cause Hospital Readmission Measure and the Advanced Care Plan Measure, will be required for all Clinical Episodes. The other five quality measures will only be collected for those Clinical Episodes for which they are deemed applicable. Beginning in January, 2020, CMS may elect to collect additional quality measures. The initial list of quality measures includes:

- All-cause Hospital Readmission Measure (NQF #1789)
- Advanced Care Plan (NQF #0326)
- 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)

[2] At this point it is not clear what the "baseline period" will be, or how CMS defines "peer group "or" expenditure efficiency

- 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)
- AHRQ Patient Safety Indicators (PSI 90)

Overlap With Other Models

Applicants participating in any Innovation Center model implemented via regulation, such as the Comprehensive Care for Joint Replacement ("CJR"), *will not be permitted to participate in BPCI Advanced for the episodes included in those models*. CMS has specified in the BPCI Advanced Request for Applications that "while a hospital participating in CJR would generally be able to participate in the BPCI Advanced initiative, this hospital would not be able to select Clinical Episodes for the orthopedic bundle or Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episodes for purposes of BPCI Advanced."

However, participants in BPCI Advanced may simultaneously participate in the Medicare Shared Savings Program, the Innovation Center's Next Generation ACO Model, medical home initiatives, the Oncology Care Model, and other shared savings initiatives. BPCI Advanced payment methodologies will exclude Clinical Episodes for beneficiaries aligned to a Next Generation ACO; the Vermont All-payer ACO; an ESRD Seamless Care Organization; or a Shared Savings Program ACO participating under Track 3. BPCI Advanced payment methodologies will include Clinical Episodes for beneficiaries aligned to a Shared Savings Program ACO participating under Tracks 1, 1+, and 2.

Important Dates

January 9, 2018	CMS Request for Applications Released
January 11, 2018	Application Portal Opens
March 12, 2018	Application Due Date
May 2018	CMS distributes Price Targets to Applicants
June, 2018	CMS offers Participation Agreements to Applicants
August, 2018	Participation Agreements Due to CMS
August, 2018	Clinical Episode Selections Due to CMS
October 1, 2018	Model Go Live Date
March 31, 2019	First date for Advanced APM QP determination
January 1, 2020	Next Application Period