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The Road to BPCI Advanced

Overview of BPCI Advanced

Expert Panel: What Providers Need to Know
Two Steps Back and One Step Forward

After Cancelling EPMs and Scaling Back CJR, Bundles are Back

Timeline of Recent Bundled Payment Programs

- **April 2013**: BPCI\(^1\), a voluntary bundled payment program, begins
- **April 2016**: CJR begins in 67 markets across the country
- **December 20, 2016**: CMS finalizes rule for three new EPM\(^3\) bundles for hip and cardiac episodes
- **January 9, 2018**: CMS announces BPCI Advanced, a new voluntary program
- **July 2015**: CMS announces CJR\(^2\), a mandatory orthopedic bundle
- **July 25, 2016**: CMS proposes three new EPM\(^3\) bundles for hip and cardiac episodes
- **August 15, 2017**: CMS proposes to cancel the EPMs and scale back CJR; finalizes cancellation in November

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1) Bundled Payment for Care Improvement initiative.
2) Comprehensive Care for Joint Replacement.
3) Episode Payment Model.
# Mandatory Bundle Programs Out of Favor (for Now)

BPCI Advanced Set to Expand on Trend Towards Voluntary Participation

## Cardiac EPMs Cancelled

- **Mandatory** bundling for CABG and AMI\(^1\), originally slated to go into effect July 2017
- CMS cancelled programs in November 2017 after delaying the program’s start date

## CJR Scaled Back

- **Mandatory** bundling for hip and knee replacements, originally in 67 markets
- Changed to voluntary participation for 33 markets, cancel planned expansion to SHFFT\(^2\)

## BPCI Advanced

- **Voluntary** bundling program; providers may opt into any of 32 different episodes
- Post-acute providers unable to directly bear risk, may participate in other ways

### GOP Historically Opposed to CMS’s Mandatory Models

“**CMMI has overstepped its authority** and there are real-life implications—both medical and constitutional. That’s why we’re demanding CMMI cease all current and future mandatory models.”

*Letter from GOP Lawmakers to CMS, September 2016*

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1) Coronary artery bypass graft and acute myocardial infarction; MS-DRGs: 280-282; 246-251; 231-236  
2) Surgical hip/femur fracture treatment; MS-DRGs: 480-482.
MACRA: Executive Summary

Legislation in Brief

• Medicare Access and CHIP Reauthorization Act (MACRA) passed in April 2015
• Repeals the Sustainable Growth Rate (SGR)
• Locks Medicare Physician Fee Schedule reimbursement rates at near-zero growth:
  o 2016-2019: 0.5% annual increase
  o 2020-2025: 0% annual increase
  o 2026 and on: 0.25% annual increase or 0.75% increase, depending on payment track
• Stipulates development of the Quality Payment Program, which is two new Medicare Part B payment tracks: Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)

The Quality Payment Program: Two New Medicare Part B Payment Tracks Created by MACRA

1 Merit-Based Incentive Payment System (MIPS)
   • Rolls existing Medicare Physician Fee Schedule payment programs into one budget-neutral pay-for-performance program
   • Clinicians will be scored on quality, advancing care information, improvement activities, and cost—and assigned a positive, neutral, or negative payment adjustment accordingly

2 Advanced Alternative Payment Models (APM)
   • Requires significant share of patients and/or revenue in payment contracts with two-sided risk, quality measurement, and EHR requirements
   • APM track participants will be exempt from MIPS payment adjustments and qualify for a 5 percent incentive payment in 2019-2024

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Advisory Board interviews and analysis.

1) Meaningful Use, Value-Based Payment Modifier, and Physician Quality Reporting System.
2) Electronic Health Record.
MACRA Dealing Physicians in on Risk

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>MIPS Bonuses/Penalties</th>
<th>APM Bonuses/Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015–2019:</td>
<td>+/-4%</td>
<td>Annual lump-sum bonus from 2019-2024 (plus any bonuses/penalties from Advanced Payment Models themselves)</td>
</tr>
<tr>
<td>2020–2025:</td>
<td>+/-9%</td>
<td>5%</td>
</tr>
<tr>
<td>2026 onward:</td>
<td>$500M</td>
<td>0.25% annual update (MIPS track) 0.75% annual update (Advanced APM track)</td>
</tr>
</tbody>
</table>

Baseline payment updates¹:

2015 – 2019: 0.5% annual update (both tracks)

2020 – 2025: Payment rates frozen (both tracks)

2026 onward: 0.25% annual update (MIPS track) 0.75% annual update (Advanced APM track)

Macra Reauthorizations Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.

1) Relative to 2015 payment.
BPCI Advanced Provides an Entry to APM Track

Unlike BPCI 1.0, New Program Mandates Certain APM Features

How BPCI 1.0 Stacked Up Against Advanced APM Criteria

- Threshold to trigger losses no greater than 4%
- Loss sharing at least 30%
- Maximum possible loss at least 4% of spending target
- Quality requirements comparable to MIPS
- Certified EHR use

Three Key Features of BPCI Advanced that Qualify it as an Advanced APM

1. All participants must use certified EHR
2. Participants bear more than a nominal risk – up to 20% of the Target Price for each episode
3. Payment is tied to quality measures, including all-cause readmission and advanced care plan

March 31, 2019
First snapshot date for QP determination for eligible clinicians

Widespread Interest in New Bundles

Familiar Reasons and Objectives Cited for BPCI Advanced Participation

If CMS Announced a New Voluntary Bundled Payment Program for 2018, How Likely Is it That Your Organization Would Elect to Participate in the Program? Hospitals and PGPs

Top Reasons to Participate
Ranked by Sum of ‘Very High’ and ‘Moderate’ Importance Responses

<table>
<thead>
<tr>
<th>Rank</th>
<th>Reason Cited</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Continuing to prepare for future payment reform</td>
<td>98%</td>
</tr>
<tr>
<td>2</td>
<td>To improve overall patient care delivery</td>
<td>96%</td>
</tr>
<tr>
<td>3</td>
<td>To better coordinate with other providers</td>
<td>94%</td>
</tr>
<tr>
<td>4</td>
<td>To receive financial benefits</td>
<td>92%</td>
</tr>
<tr>
<td>5</td>
<td>To qualify physicians for the APM track under MACRA</td>
<td>83%</td>
</tr>
</tbody>
</table>

1) Physician Group Practices.
2) Responses to the survey question: How important are the following reasons for your organization's participation in a voluntary bundle payment program?

Source: Post-Acute Care Collaborative 2017 Survey on Bundled Payments; Post-Acute Care Collaborative interviews and analysis.
Unclear Outlook for Participation in BPCI Advanced

Participation in BPCI 1.0 Declined when Risk was Required

BPCI’s Two-Phase Implementation Timeline

Number of BPCI Participants Over Time

April 2013
BPCI Model 2, 3 and 4 enrollment begins

Q2 2014
Q3 2014
Q2 2015
Q3 2015
Q2 2017

2,603
6,652
6,293
2,093
1,239

66% decline in enrollment during Phase II

July 2015
Providers required to transition at least one episodic bundle to Phase II


1) Participants here are measured as unique organizations enrolled in at least one of the 48 episodes of care covered under BPCI Models 2, 3 or 4. Participant organizations are comprised of all eligible providers such as acute care hospitals, physician groups, or skilled nursing facilities.
## Assessing Bundles’ Success To Date

### A Mixed Bag of Results for CMS and Providers

#### Arguments For

<table>
<thead>
<tr>
<th>CMS’s Perspective</th>
<th>Provider’s Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reducing system cost:</strong></td>
<td><strong>Opportunity for financial wins:</strong></td>
</tr>
<tr>
<td>• CMS costs for MJRLE(^1) decreased 4.5% in BPCI</td>
<td>• Reconciliation payments averaged $98K in CJR</td>
</tr>
<tr>
<td><strong>Motivating behavior change:</strong></td>
<td><strong>Impact on care quality:</strong></td>
</tr>
<tr>
<td>• 48% of CJR hospitals met minimum bonus requirements</td>
<td>• 2.7% point reduction in MJRLE readmissions for BPCI Model 3 SNF EIs(^3)</td>
</tr>
</tbody>
</table>

#### Arguments Against

<table>
<thead>
<tr>
<th>CMS’s Perspective</th>
<th>Provider’s Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SNFs and HHAs increased rates of unplanned readmissions in BPCI Model 3(^2)</td>
<td>• Only 35 BPCI participants distributed money in financial gainsharing arrangements</td>
</tr>
<tr>
<td></td>
<td>• Statistically insignificant change in 90-day readmissions for MJRLE under BPCI Model 2(^4)</td>
</tr>
</tbody>
</table>

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1) Major Joint Replacement of the Lower Extremity; the highest volume clinical episode for BPCI Model 3.
2) For nonsurgical cardiovascular episodes.
3) Episode Initiators.
4) MJRLE is the highest volume clinical episode for BPCI Model 2.

The Road to BPCI Advanced

Overview of BPCI Advanced

Expert Panel: What Providers Need to Know
Overview of BPCI Advanced

1. Program and Application Timeline
2. Included Episodes and Services
3. Eligible Clinicians
4. Payment Mechanics and Quality Measures
5. Gainsharing and Waivers

Source: CMS; Advisory Board analysis.
Introducing BPCI Advanced

Providers Will Get Another Opportunity to Join in 2020

Key Dates for BPCI Advanced Program

Model Year 1
- October 2018

Model Year 2
- First date for QP determination
- January 2019
- March 2019

Model Year 3
- Model Year 4
- January 2020
- January 2021

Model Year 5
- Model Year 6
- January 2022
- January 2023

December 2023
BPCI Advanced program ends

For participants joining in 2018, 2020 is the first opportunity to change clinical episode selections

Source: CMS; Advisory Board analysis.
Providers Must Act Quickly to Apply

Episode Selection and Participation Decisions Occur in Summer 2018

BPCI Advanced Application Timeline

January 11, 2018
Application portal opens

March 12, 2018
Application portal closes

May 2018
CMS provides target prices to applicants

June 2018
CMS offers Participation Agreements to applicants

August 2018
Signed Participation Agreements due to CMS; participants choose clinical episodes

BPCI Advanced starts 10/1/18

Providers should make sure to complete a data request and attestation form with their application in order to receive the data used to calculate Target Prices

Source: CMS; Advisory Board analysis.
A New Format for Episodic Cost Management

BPCI Advanced Introduces Outpatient Clinical Episodes for the First Time

- **Inpatient Clinical Episodes**
  - 29 Clinical Episodes tied to 105 MS-DRGs
  - Clinical episode starts with an inpatient admission, known as the anchor stay, and continues 90 days post discharge

- **Outpatient Clinical Episodes**
  - 3 Clinical Episodes tied to 29 HCPCS codes
  - Clinical episode starts with the outpatient procedure, known as the anchor procedure, and continues 90 days post procedure

Source: CMS, Advisory Board analysis.
## Inpatient and Outpatient Clinical Episodes

### Inpatient Clinical Episodes

<table>
<thead>
<tr>
<th>Joint and Spine</th>
<th>Cardiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Double joint replacement of the lower extremity</td>
<td>11. Cardiac arrhythmia</td>
</tr>
<tr>
<td>2. Major joint replacement of the lower extremity</td>
<td>12. Cardiac defibrillator</td>
</tr>
<tr>
<td>3. Major joint replacement of the upper extremity</td>
<td>13. Cardiac valve</td>
</tr>
<tr>
<td>4. Fractures of the femur and hip or pelvis</td>
<td>14. Pacemaker</td>
</tr>
<tr>
<td>5. Hip &amp; femur procedures except major joint</td>
<td>15. Percutaneous coronary intervention</td>
</tr>
<tr>
<td>7. Spinal fusion (non-cervical)</td>
<td>17. Congestive heart failure</td>
</tr>
<tr>
<td>8. Cervical spinal fusion</td>
<td>18. Acute myocardial infarction</td>
</tr>
<tr>
<td>9. Combined anterior posterior spinal fusion</td>
<td></td>
</tr>
<tr>
<td>10. Back &amp; neck except spinal fusion</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmonary Services</th>
<th>Nephrology</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. COPD, bronchitis, asthma</td>
<td>22. Urinary tract infection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastroenterology</th>
<th>Other Clinical Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Gastrointestinal hemorrhage</td>
<td>27. Cellulitis</td>
</tr>
<tr>
<td>24. Gastrointestinal obstruction</td>
<td>28. Sepsis</td>
</tr>
<tr>
<td>25. Major bowel procedure</td>
<td>29. Stroke</td>
</tr>
<tr>
<td>26. <em>Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis [Not Included in Original BPCI]</em></td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Clinical Episodes

1. Cardiac Defibrillator
2. Percutaneous coronary intervention
3. Back & neck except spinal fusion
A Wide Scope of Included Services

**INCLUDED IN BUNDLE**

All related services/items paid under Part A or B including acute admission or outpatient procedure through 90-days post-discharge or post-procedure

- Inpatient hospital services (paid under IPPS)
- Outlier payments
- Physicians’ services
- **Related and unrelated readmissions**
- Post-acute care (LTCH\(^1\), IRF\(^2\), SNF\(^3\), HHA\(^4\))
- Hospice
- Other hospital outpatient services
- Clinical lab services
- Durable medical equipment
- Part B drugs
- Medicare services provided to patients that die during the Anchor Stay or Procedure are excluded

**EXCLUDED FROM BUNDLE**

- Hospital readmissions for MS-DRGs in the following categories:
  - Oncology
  - Trauma
  - Transplants
  - Ventricular shunts
- Part B payments, only if incurred during a specified IP admissions and/or readmissions to an ACH\(^5\) that is excluded based on its MS-DRG
- Payments for items, services with pass-through payment status under the OPPS.
- IPPS new technology add-on payments
- Blood clotting factors used to control bleeding for hemophilia patients

1) Long-term acute care hospital.
2) Inpatient rehab facility.
3) Skilled nursing facility.
4) Home health agency.
5) Acute-care hospital.

Source: CMS; Advisory Board analysis.
Outpatient Shift’s Impact on Joint Episodes

TKA¹ Exited IPO List on January 1, 2018

Finalized Changes for TKA

1. Covered in HOPD Effective CY 2018, With Lower Reimbursement
   - HOPD reimbursement: $10,122.22
   - APC 5115
   - Inpatient reimbursement: $12,384.78
   - MS-DRG 470¹

2. Two-Year RAC² Prohibition Will Postpone 2 Midnight-Based Denials

   CMS is easing the outpatient TKA transition by prohibiting RAC patient status review for any inpatient TKA procedures for CY 2018 and CY 2019.

   However, TKA cases may still be audited for other reasons (e.g., to determine medical necessity).

CMS Doesn’t Anticipate Rapid TKA Outpatient Migration

We do not expect a significant volume of TKA cases currently being performed in the hospital inpatient setting to shift to the hospital outpatient setting… as providers’ knowledge and experience in the delivery of hospital outpatient TKA treatment develops, there may be a greater migration of cases to the hospital outpatient setting.”

CY 2018 Final HOPPS Rule

¹) Total knee arthroplasty.
²) Recovery audit contractor.

Source: CMS; Advisory Board analysis.
Hospitals, Physicians Set to be Primary Participants

Post-Acute Care Providers Unable to be Bear Risk on Their Own

Different Types of Participants in BPCI Advanced

<table>
<thead>
<tr>
<th>Episode Initiator</th>
<th>Non-Convener Participant</th>
<th>Convener Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basics of Participation</td>
<td>A participant who triggers the clinical episode; all target price and reconciliation calculations happen at the episode initiator level</td>
<td>Any participant that bears financial risk only on their own behalf</td>
</tr>
</tbody>
</table>

Eligible Providers

- Hospitals, PGPs, and individual physicians if they are registered as a single physician PGP
- Hospitals and PGPs
- Medicare-enrolled and non-Medicare enrolled providers and suppliers, including post-acute care providers

Excluded Providers

- Critical Access Hospitals
- PPS-exempt cancer hospitals
- Inpatient psychiatric facilities
- Hospitals in Maryland
- Hospitals in the Rural Community Hospital Demonstration
- Hospitals in the Pennsylvania Rural Health model

Source: CMS; Advisory Board analysis.
Eligibility for Advanced APM, MIPS APM

APM Determination in MACRA’s Quality Payment Program (QPP)

PGP Non-Convener Participants and Conveners with PGP EIs

Eligible clinicians who have reassigned his/her rights to receive Medicare payment to a PGP participant and who are included on the PGP list

APM Participant

May qualify for QP¹ status in the APM track if sufficient volume threshold met

MIPS APM Scoring

Special MIPS APM scoring standard applies to clinicians who do not become QPs

ACH Non-Convener Participants and Conveners without PGP EIs

Eligible clinicians who are NPRA² Sharing Partners included on the Financial Arrangements Screening List

APM Affiliated Practitioner

May qualify for QP status in the APM track if sufficient volume threshold met

Not MIPS APM

NPRA Sharing Partners who do not become QPs are subject to “regular” MIPS scoring as special MIPS APM scoring does not apply³

1) Qualifying APM Participant, a clinician in the APM track under the QPP.
2) Net Payment Reconciliation Amount.
3) MIPS APM scoring standard applies only for MIPS APMs to the extent that APM entities include at least one MIPS eligible clinician on a Participation List.

Source: CMS; Advisory Board analysis.
Precedence Within and Outside of BPCI Advanced

Navigating Participation in Multiple Payment Programs at Once

**Precedence within BPCI Advanced**

1. Attending PGP

2. Operating PGP

3. Acute-Care Hospital

**Precedence with Other CMMI Programs**

- CJR episodes take precedence over BPCI Advanced episodes

- OCM episodes run concurrently with BPCI Advanced episodes

- Certain downside-risk ACO beneficiaries are excluded from BPCI Advanced episodes

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1) CJR participants cannot participate in BPCI Advanced for clinical episodes included in CJR.

2) Oncology Care Model. OCM participants can participate in BPCI Advanced. PBPM payments will be excluded from target price and reconciliation calculations. Performance-based payments in OCM will be proportionally adjusted for overlap.

3) For Next-Gen ACOs, ACOs in the Vermont Medicare ACO Initiative, Track 3 Medicare Shared Savings Program (MSSP) and Comprehensive End Stage Renal Disease Seamless Care Organizations with downside risk. Beneficiaries attributed to MSSP Track 1, Track 1+ and Track 2 are NOT excluded.

Source: CMS; Advisory Board analysis.
Breaking Down Retrospective Bundling Mechanics

CMS Using Retrospective Reconciliation to Adjust Participant Payments

Payment Process Under BPCI Advanced

1. **Fee-for-Service Billing**
   - Providers (e.g., acute hospital, physicians, PACs) receive FFS\(^1\) payment as usual; CMS tracks claims.

2. **Comparison to Target**
   - Total costs compared to target price based on historic claims two times a year.

3. **Payment Reconciliation**
   - If over target, provider repays CMS; if under, receives reconciliation.

**Hospital Target Price Based on Historic Claims Data**
- Target price based on 3-4\(^2\) years of participant’s historic claims data, with a 3% discount applied.
- CMS will adjust prices for patient characteristics, regional spending trends.

**PGP Target Price Based on Hospital Benchmark**
- Target price based on the benchmark price for the hospital where the Anchor Stay/Procedure takes place.
- Price then adjusted to calculate a PGP-specific price, based on the PGP’s efficiency and case-mix index.

- Pricing includes a risk cap applied at the 1\(^{st}\) and 99\(^{th}\) percentile of spending.
- Participants will receive target prices at the beginning of each year.

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1) Fee-for-service.
2) CMS has offered conflicting guidance to-date regarding the lookback period.
The Reconciliation Process

CMS Will Get Their Cut No Matter What

Reconciliation or Repayment Calculated Based on Actual Cost Compared to Target Price

Episodic Spending in BPCI Advanced

Target Price

Episode 1

Negative Reconciliation Amount

Episode 2

Positive Reconciliation Amount

Positive Reconciliation Amount
Amount by which all expenditures are less than the Target Price for an Episode

Negative Reconciliation Amount
Amount by which all expenditures exceed the Target Price for an Episode

No More Phased-In Financial Risk
Unlike earlier bundles, participants will take on total financial risk from the outset of the program

Source: CMS; Advisory Board analysis.
The Reconciliation Process, Cont.

Performance Adjusted for Quality and Stop/Gains Losses

Adjusting Reconciliation (or Repayment) for Quality
Example of Reconciliation Process Leading to Reconciliation Payment

Sum of Target Prices Across All Episodes | Positive Reconciliation Amount (All Episodes) | Negative Reconciliation Amount (All Episodes) | Total Positive Reconciliation Amount

$500K | $200K | ($75K) | $125K

For the first two model years, the CQS adjustment is capped at 10%

Total reconciliation amount adjusted by an EI-specific Composite Quality Score (CQS)

CQS Adjustment: -$12,500

$112,500

Adjusted Positive Total Reconciliation Amount

$100,000

Reconciliation Payment from CMS

20% stop gain applied, based on the sum of target prices across all episodes

1) For non-convener participants, this amount is the net payment reconciliation amount (NPRA). For convener participants it is netted against all Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts across the Convener Participant’s downstream Episode Initiators, resulting in either the Repayment Amount or NPRA, as applicable.

Source: CMS; Advisory Board analysis.
Incorporating Quality Measures in BPCI Advanced

First Two Years of CQS Adjustments to be Claims-Based Calculations

<table>
<thead>
<tr>
<th>BPCI Advanced Quality Measures</th>
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<tbody>
<tr>
<td><strong>All Clinical Episodes</strong></td>
<td></td>
</tr>
<tr>
<td>All-cause Hospital Readmission Measure (National Quality Forum (NQF) #1789)</td>
<td></td>
</tr>
<tr>
<td>Care Plan (NQF #0326)</td>
<td></td>
</tr>
<tr>
<td><strong>Specific Clinical Episodes</strong></td>
<td></td>
</tr>
<tr>
<td>Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)</td>
<td></td>
</tr>
<tr>
<td>Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)</td>
<td></td>
</tr>
<tr>
<td>Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)</td>
<td></td>
</tr>
<tr>
<td>Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)</td>
<td></td>
</tr>
<tr>
<td>AHRQ Patient Safety Indicators (PSI 90)</td>
<td></td>
</tr>
</tbody>
</table>

CQS Calculation Information

- Model Years 1 and 2 (2018, 2019) will be **claims-based measures**
- Subsequent years may see **additional reporting mechanisms**
- Payment will be linked to CQS measures using a **pay-for-performance methodology**
- CQS will be **volume-weighted and scaled** across all Clinical Episodes

Source: CMS, Advisory Board analysis.
A Premium on Cross-Continuum Cost Savings

Providers Cannot Share Internal Cost Savings in BPCI Advanced

NPRA\(^1\) Sharing Partners

- Participants may enter into financial arrangements with NPRA Sharing Partners, including individual physicians, PGPs, ACOs, hospitals, and post-acute providers
- Gains must come from actual savings under the bundle
- **Gains cannot be shared from internal cost savings**

Risk Sharing Restrictions

- 50% Percent of total spending in an EI’s Clinical Episodes that can be apportioned as risk

Gain Sharing Restrictions

- 50% Percent of total spending in an EI’s Clinical Episodes that can be shared as gain
- 50% Percent of the amount normally paid to sharing partner for clinical episodes that can be paid as gains

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1) Net Payment Reconciliation Amount.

Source: CMS; Advisory Board analysis.
Key BPCI Advanced Program Waivers

Skilled Nursing Facility Three-Day Rule
• Under waiver, patients can receive Medicare coverage of SNF care even if discharged <3 days
• SNF must have at least a three star quality rating in 7 of last 12 months (on Nursing Home Compare)
• Not available for patients in the three outpatient clinical episodes

Telehealth Services Geographic and Location Restrictions
• CMS will waive the geographic site requirement for telehealth
• Allows BPCI Advanced patients to receive telehealth services no matter where they are located, even if they are not considered rural status

“Incident to” Direct Supervision Requirements for Home Visits
• Non-physician staff permitted to provide home visits under general supervision (physician doesn’t have to be present) for related discharges
• Exact parameters of waiver, including permitted number of visits, to be made clear in the Participation Agreements distributed to applicants

Source: CMS; Advisory Board analysis.
Beneficiary Engagement Incentives

Participants May Provide Services to Improve Cost and Quality

**Beneficiary Engagement Opportunities**

- Must be during the 90-day episode
- Paid for by participant, not reimbursed by CMS
- Only the participant can provide these
- Must be related to the episode:
  - Adherence to drug regime
  - Adherence to care plan
  - Reduction of related readmissions
- *Example: transportation, equipment*

**Beneficiary Incentives Cannot:**

- Be more than reasonably necessary (e.g., a smartphone)
- Steer patients to one provider
- Encourage more services than necessary
- Be advertised broadly
- Shift costs to another federal health care program

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1) Based on previous CMS guidance related to beneficiary engagement incentives. CMS has not provided detailed guidance on incentive waivers and will provide additional information in the Participation Agreements.

Source: CMS; Advisory Board analysis.
Five Key Takeaways from BPCI Advanced

1. Providers Must Act Quickly to Apply
   • Applications close March 12th, but providers will have time to select episodes for participation over the summer

2. Bundling Goes Outpatient
   • The addition of outpatient procedures provides new avenues for taking on episodic risk

3. PAC Providers Unable to Initiate Episodes
   • While PAC providers anticipated joining BPCI Advanced, program participation is limited to being a Convener

4. Expect Risk from Day One
   • Unlike previous bundled payment programs, participants will not phase in their downside risk exposure

5. New Gainsharing Rule Exclude Internal Cost Savings, Only NPRA¹ is Fair Game
   • Providers will need to achieve savings primarily from readmissions reductions and post-acute spend in order to generate gainsharing funds

Source: CMS; Advisory Board analysis.
The Road to BPCI Advanced

Overview of BPCI Advanced

Expert Panel: What Providers Need to Know
The Future Outlook for Payment Reform

### Five Implications of BPCI Advanced for the Future Direction of Payment Reform

1. After a relatively quiet 2017, payment reform is off to a rapid start in 2018 the arrival of BPCI Advanced and announcement of new ACOs in both the Medicare Shared Savings Program and Next Generation ACO Model.

2. While leaders may have interpreted the rollback of mandatory bundles as a sign of CMS slowing the pace of payment transformation, recent events reinforce CMS’s continued focus on payment reform.

3. Although alternative payment models are likely to remain voluntary in the near term, providers face several pressures—most notably erosion of fee-for-service economics and MACRA—that encourage participation.

4. Providers must develop and execute an intentional Medicare risk strategy; with MACRA in full effect and the universe of payment programs expanding, leaders need purposeful and effective plan.

5. As they evaluate alternative payment models, hospital leaders may find bundles most advantageous; episodic bundles build on existing competencies and skill sets—and provide a new avenue for partnering with specialists.
The Service Line Leader’s Perspective

Considerations for Service Line Leaders
Evaluating BPCI Advanced

1. Cancellation of the mandatory cardiac bundles disappointed many providers who engaged in care redesign efforts; voluntary bundles provide an opportunity to leverage the time and resource investments they’ve already made.

2. Episodic cost scrutiny for CV will continue to increase, regardless: P4P programs (e.g., Value-Based Purchasing), and private payers are increasingly focusing on episodic cost measures.

3. CV leaders will need to carefully consider the appeal of joining outpatient bundles; as CV procedures continue to shift outpatient, these may be an attractive proposition to create financial success, yet this has not been a focus of past P4P metrics and therefore many may be starting from scratch.

4. While providing an opportunity for CV physicians to qualify for the APM track in MACRA may be appealing, providers will need to ensure that they have an adequate volume of cases flowing through BPCI Advanced to meet the payment/patient thresholds for an APM.
Lessons from Implementing Previous Bundles

Considerations for Succeeding under Episodic Cost Management

1. Organizations that have already made significant strides in reducing care variation, aligning with post-acute care providers, and pursuing other population health initiatives are ideal candidates for BPCI Advanced.

2. Downside risk will begin on day 1 of this program which means that providers should carefully review preliminary Target Prices for each clinical episode (available in May after applying) and determine if they think they can be successful at improving performance in a condensed time period.

3. Hospitalists and surgeons will be able to participate in BPCI Advanced in addition to Track 1 of the Medicare Shared Savings Program (74% of Medicare ACOs). That flexibility will allow these hospital-based physicians a separate qualification route for the APM bonus as well as additional upside potential for their efforts at reducing cost and improving quality.

4. While many physicians and post-acute providers may want to partner with you, be careful not to dilute rewards or drag down overall performance by including too many partners.
Key Considerations for Post-Acute Providers

Three Key Questions for Post-Acute Providers

1. Should I pursue participation as a Convener Participant?

2. How will this program impact me if I don’t participate as a Convener Participant?

3. Will CMS give post-acute providers an opportunity to participate in bundles as an Episode Initiator again?
How Can We Help You Prepare?

Key Advisory Board Resources

Executive Education
Stay tuned for future webinars, publications, and best practice guides on BPCI Advanced

Data and Analytics
Request a tailored discussion with our team, where we can use our analytics to identify opportunities

Consulting Services
We can partner with you to manage costs in the post-acute / inpatient settings and align BPCI Advanced with your overall MACRA strategy

Technologies
Our Dedicated Advisors will help you harness and optimize the value of your current technologies

To set up time with our experts or for more information, please complete the survey question at the end of this section or email postacute@advisory.com

Source: Advisory Board analysis.
Analytical Resources Available

The Hospital Benchmark Generator
- Organization-specific data relative to national benchmarks for orthopedic and cardiac complications, readmissions and HCAHPS

SNF, HH Benchmark Generators
- Benchmark information on post-acute outcomes and costs
- Includes benchmarks for LOS, cost-per-case, and readmissions

Care Coordination Episode Profiler
- View episodic spending allocation at specific locations and time intervals following anchor discharge
- Modify view in intervals of 5 days (up to 90) following anchor hospitalization

Source: Advisory Board analysis.
Introducing the Post-Acute Pathways Explorer

Market-Level Insights At Your Fingertips

Key Use Cases

1. Size your Medicare Market
2. Identify Provider Relationships
3. Assess Care Quality and Efficiency