March 7, 2018

CMS Announces New Voluntary Bundled Payment Program

BPCI Advanced Offers Path to Advanced APM Status

Highlights

- **Medicare is continuing with episode-based payment reform, but participation is not mandatory.** The scaling back of CJR and the cancellation of EPMs called into question the future of Medicare payment bundling. Bundled Payments for Care Improvement (BPCI) Advanced will encourage providers to systematize episodic cost containment and signals that voluntary models may be CMS's preferred vehicle for aligning provider incentives.
- **Providers' MACRA strategy should factor heavily in the decision to participate.** The new model meets Advanced Alternative Payment Model criteria, thus providing a vehicle for many specialists to avoid the Merit-based Incentive Payment System (MIPS) and access bonus payments under MACRA.
- **The application period closes on March 12, so interested providers should request data now.** Applicants should submit a Data Request and Attestation with their completed application to access the claims data on which Target Prices will be based. Applicants will learn their Target Prices prior to signing a Participant Agreement.

Background

On January 11, CMS opened up the application period for Bundled Payments for Care Improvement (BPCI) Advanced, the first new payment model to be proposed since the change in administration. BPCI Advanced represents CMS's fourth recent foray into payment bundling, illustrating the agency's continuing interest in episode-oriented payment reform. After an accelerated application and selection process, the performance period for BPCI Advanced will begin on October 1, 2018. The model will close at the end of 2023. Interested providers should visit CMS's BPCI Advanced website for application materials, bundle definitions and other information. For Advisory Board's own analysis of the program, please view our on-demand web conference BPCI Advanced: Everything You Need to Know.

Key Insights

New bundled payment model a blend of familiar elements from past models.

BPCI Advanced will apply to 29 inpatient episodes and 3 outpatient procedures. Eligible participants will include acute care hospitals and physician groups. The program design—including the 90-day timeframe and retrospective reconciliation—represents continuity with CMS's previous bundled payment models.

CMS tosses risk-free introductory period.

Participants will be financially accountable for episodic costs in selected episodes beginning October 1, 2018. Prior to January 2020, participants may drop episodes only with CMS's consent. The lack of a transition period is likely to suppress interest from providers with little experience managing bundles.

Reducing post-discharge utilization—not inpatient cost savings—will be key to financial success.

Care redesign and cost minimization for the inpatient stay will not by themselves lower total Medicare spending per episode. Reducing readmissions and controlling post-acute care use—particularly skilled nursing facility (SNF) stays—remain the primary levers for inflecting total spend and generating bonuses.

New Voluntary Bundled Payments Proof of Continued Interest in Episodic Cost Containment

The cancellation of the Episode Payment Models (EPMs) and the partial rollback of the Comprehensive Care for Joint Replacement (CJR) model, both mandatory programs, cast into doubt CMS's commitment to payment reform focused on reducing episodic costs. The announcement of BPCI Advanced—the long-awaited follow-up to the initial BPCI program—shows that the new administration believes that aligning financial incentives across the continuum of care, particularly on a *voluntary* basis, can be a path for reducing costs and improving quality in fee-for-service Medicare.

In many ways, BPCI Advanced is a straightforward extension of the previous program. The now-familiar 90-day retrospective bundle platform covers 29 of the highest volume inpatient services from the initial program. But the new program has also broadened its scope to include three outpatient procedures. CMS has also introduced refinements—such as including costs from unrelated readmissions within the bundle and scrapping the risk-free introductory period, to name only two. The net result of the changes may be that providers find financial success in the new model even harder to achieve than before.

As the timeline below illustrates, providers will need to act quickly if they want to participate. But since providers will have a chance to review their Target Prices before deciding to sign a binding Participation Agreement, interested providers can initiate the application process—and request critical episodic spending data—without risk.

Clinical Episodes Targeted by BPCI Advanced

Inpatient Services

Joint and Spine
- Double joint replacement of the lower extremity
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Fractures of the femur and hip or pelvis
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Spinal fusion (non-cervical)
- Cervical spinal fusion
- Combined anterior posterior spinal fusion
- Back & neck except spinal fusion

Cardiology
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft
- Congestive heart failure
- Acute myocardial infarction

Pulmonary Services
- Simple pneumonia and respiratory infections
- COPD, bronchitis, asthma

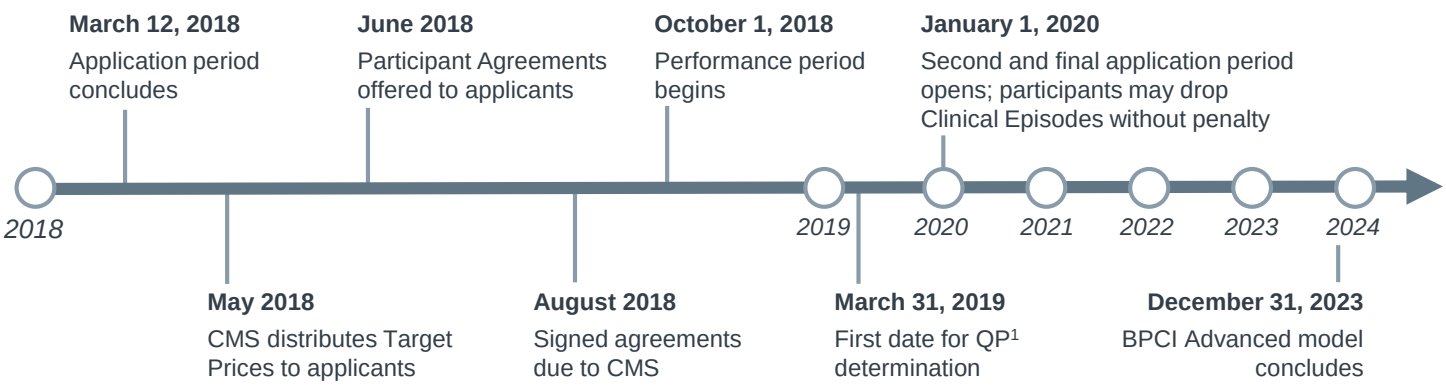
Nephrology
- Renal failure
- Urinary tract infection

Gastroenterology
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Major bowel procedure

Other
- Cellulitis
- Sepsis
- Stroke
- Disorders of the liver excluding malignancy, cirrhosis, and alcoholic hepatitis

Outpatient Services
- Cardiac defibrillator
- Percutaneous coronary intervention
- Back & neck except spinal fusion

Bundled Payment for Care Improvement (BPCI) Advanced Model Timeline



1) Qualifying APM Participant, an eligible clinician entitled to receive bonus payments and higher Medicare payment increases by virtue of participation in an Advanced Alternative Payment Model under MACRA.

Key Features of BPCI Advanced

Participants: Both Acute Care Hospitals (ACHs) and physician group practices (PGPs) can be an Episode Initiator (EI), that is, a participant triggering the clinical episode. Such participants may either be (1) **conveners** who bring together downstream EIs, coordinate participation, and bear and apportion risk, or (2) **non-conveners**, who bear financial risk only on their own behalf. Convener participants are not limited to hospitals and PGPs, and can include post-acute care providers.

Included in Episode: All items or services paid under Part A or Part B including acute-care admission or outpatient procedures through 90-days post discharge. Outlier payments, both related and unrelated readmissions—except for those specifically excluded—and post-acute care are all included in the bundle.

Excluded from Episode: Part A and B services provided for a BPCI Advanced Beneficiary during a hospital stay assigned a DRG related to **oncology, major trauma, transplants, and ventricular shunts**. Also excluded from bundles are payments with pass-through status, technology add-on payments, and payments for blood clotting factors.

Target Price Determination: Target Price determination differs for ACHs versus PGP participants. The *Hospital Target Price* is based on participants' historic claims data over 4 years, less a discount for CMS of 3% (in the first year). For PGPs, the target price is based on the benchmark for the hospital where the Anchor Stay/Procedure occurs, adjusted for the PGP's own efficiency and case mix index, less the CMS discount. Interested providers should read CMS's Target Price Specifications: Model Years 1 and 2.

Reconciliation Process: All providers will receive FFS payments as usual for services provided in an episode. Twice yearly, CMS will compare actual Medicare spending within episodes with the episode Target Price and net the differences across all episodes selected. If under target, participants will receive a reconciliation payment. If over target, they must repay CMS.

Quality Adjustment: According to CMS's Request for Applications: "A quality score will be calculated for each quality measure at the Clinical Episode Level, if applicable. These scores will be scaled across all Clinical Episodes attributed to a given Episode Initiator, weighted based on Clinical Episode volume, and summed to calculate an Episode Initiator-specific Composite Quality Score (CQS)."

BPCI Advanced Quality Measures	
All Clinical Episodes	All-cause Hospital Readmission Measure (National Quality Forum (NQF) #1789)
	Care Plan (NQF #0326)
Specific Clinical Episodes	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)
	AHRQ Patient Safety Indicators (PSI 90)

Quality adjustment based on the CQS can result in up to a 10% decrease in a positive reconciliation amount (i.e. the provider gets *less* money back). CMS has clarified, however, that the CQS adjustment cannot make a negative total reconciliation amount more negative.

Stop Loss and Stop Gain: Reconciliation amount or repayment cannot exceed 20% of Target Price.

Waivers: Participants may elect to share bundle savings—with certain restrictions—with physicians or other partners. Other common bundled-payment waivers—3-day SNF waiver, telehealth geographic restriction waiver, beneficiary engagement waiver, etc.—apply.

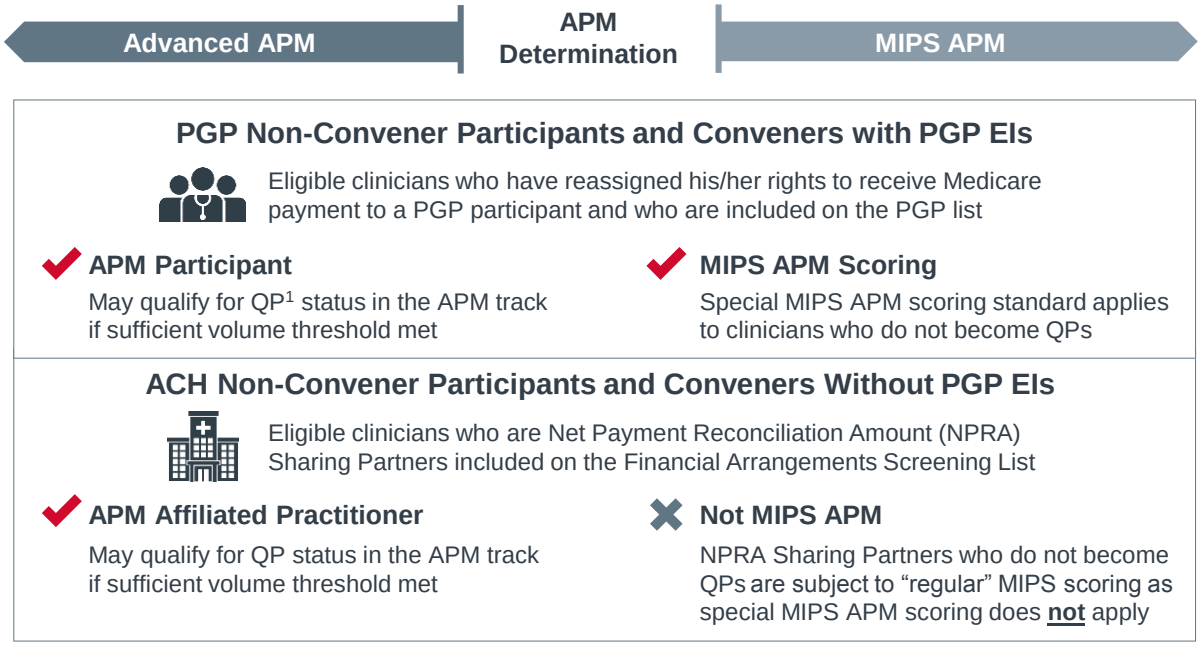
New Model a Vehicle for Specialists to Gain Bonus Payments and Escape MIPS

Unlike the voluntary program that preceded it, BPCI Advanced qualifies as an Advanced Alternative Payment Model under MACRA. As such, the new model will be attractive to specialists wishing to avoid some of the complexities of MIPS and who are eager to gain a 5% bonus payment and higher rates of future Medicare payment increases.

Three Key Features of BPCI Advanced That Qualify It as an Advanced APM

1. All participants must use **certified Electronic Health Record Technology (CEHRT)**
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**

Clinicians who fail to qualify for the Advanced APM track due to insufficient volume may still qualify for MIPS APM scoring, which uses a significantly differently scoring standard from 'regular' MIPS. Determining whether Advanced APM or MIPS APM applies depends on whether clinicians are part of a PGP participant or an Acute Care Hospital (ACH) participant.



March 31, 2019 will be the first date at which eligible clinicians will have their payment and volume thresholds assessed to determine if they are Qualifying APM Participants (QPs).

The information in this note is accurate as of its publishing date but is subject to change. If a change should occur, an updated note will be published.

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Related Resources

To explore these topics in more depth, access the following related resources:

BPCI Advanced: Everything You Need to Know
https://www.advisory.com/research/post-acute-care-collaborative/members/events/webconferences/2018/bpci-advanced-everything-you-need-to-know/ondemand

Your BPCI Advanced Questions—Answered
https://www.advisory.com/consulting/value/expert-insights/your-bpci-questions-answered

Care Coordination Episode Profiler
https://dag.advisory.com/2015_B_DAG_Episodic_Path/