Model Overview Fact Sheet – Model Year 3 (MY3)

Introduction

Background and Overview

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is a voluntary Advanced Alternative Payment Model (Advanced APM) designed to promote seamless, patient-centered care around a set of specific clinical episodes. BPCI Advanced is a single-bundled payment and risk track that aims to align incentives among participating health care providers for reducing expenditures and improving quality of care for Medicare beneficiaries.

BPCI Advanced builds upon the framework from current and previous CMS episode payment models, demonstrations, and programs. Episode payment models provide a single bundled payment to healthcare providers for items and services furnished during an episode of care, while holding these healthcare providers accountable for the cost, quality, and patient outcomes during that episode. This approach spurs healthcare providers to better coordinate care, improve quality of care, and consider the financial implications of their treatment decisions, in pursuit of improved quality and reduced spending.

On October 1, 2018, the first cohort of Participants began participation in BPCI Advanced. The application period for Model Year 3 (MY3) opened on April 24, 2019 and closed on June 24, 2019. The second cohort of Participants will start on January 1, 2020, which begins MY3. BPCI Advanced runs through December 31, 2023.

Objective

With BPCI Advanced, CMS seeks to improve the quality of care furnished to Medicare beneficiaries and to reduce expenditures by:

- **Financial Accountability:** Testing a payment model that creates extended financial accountability for the outcomes of improved quality and reduced spending, in the context of acute and chronic episodes of care
- **Care Redesign:** Supporting and encouraging Participants, Participating Practitioners, and Episode Initiators (EIs) who are reengineering the delivery of care in order to continuously improve quality

- **Data Analysis and Feedback:** Leveraging data to decrease the cost of a Clinical Episode by eliminating unnecessary or low-value care, increasing care coordination, and fostering quality improvement
- **Health Care Provider Engagement:** Creating environments that stimulate the rapid development and incorporation of new evidence-based knowledge into clinical practice
- **Patient and Caregiver Engagement:** Educating patients, facilitating ongoing communication, and providing guidance throughout the Clinical Episode

Milestones/Dates

- Request for Applications (RFA) Released and Application Portal Opened: April 24, 2019
- Application Portal Closed: June 24, 2019 at 11:59 p.m. EDT
- Model Year 3 Begins: January 1, 2020

Who Can Participate

Participants

CMS defines a Participant as an entity that enters into a BPCI Advanced Participation Agreement with CMS. There are two Participant types:

- A **Convener Participant** brings together at least one downstream Acute Care Hospital (ACH) and/or Physician Group Practice (PGP), referred to as Downstream Episode Initiator (EI). The Convener Participant facilitates coordination among EIs and bears and apportions financial risk.
- A **Non-Convener Participant** is either an ACH or PGP that bears financial risk only for itself and does not bear financial risk on behalf of Downstream EIs

Beneficiaries

A Medicare beneficiary included in BPCI Advanced is an individual entitled to benefits under Part A and enrolled under Part B for which an EI submits a claim to Medicare fee-for-service (FFS) for an Anchor Stay or Anchor Procedure associated with the Clinical Episode for which a Participant is accountable.

BPCI Advanced specifically excludes Medicare beneficiaries:

- Covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations)
- Eligible for Medicare on the basis of end-stage renal disease (ESRD)
- Whose primary payer is not Medicare
- Who die during the Anchor Stay or Anchor Procedure
- Not enrolled in Medicare Part A or Part B for the entire Clinical Episode

Criteria

BPCI Advanced must meet three criteria to be considered an Advanced APM. The three criteria are:

1. *Participants must bear risk for monetary losses of more than a nominal amount under the model*. In BPCI Advanced, Participants are financially at risk for up to 20 percent of the final Target Price for each Clinical Episode in which they have selected to participate.
2. *Participants must use Certified Electronic Health Record Technology (CEHRT).* In BPCI Advanced, CMS requires Participants to attest to their use of CEHRT prior to participation. For non-hospital participants, at least 75 percent of eligible clinicians in the entity must use the CEHRT definition of certified health IT functions to participate in this initiative.
3. *Payments under the model must be linked to quality measures comparable to Merit-Based Incentive Payment System quality measures.* In BPCI Advanced, CMS calculates a quality score for each quality measure at the Clinical Episode level. These scores are volume-weighted and scaled across all Clinical Episodes attributed to a given EI to calculate an EI-specific Composite Quality Score.

Clinical Episodes

Inpatient Clinical Episode Triggers and Length

The submission of a claim to Medicare FFS by an EI for the inpatient Anchor Stay triggers an inpatient Clinical Episode, as identified by a Medicare Severity-Diagnosis Related Group (MS-DRG). An inpatient Clinical Episode ends 90 days following discharge from the Anchor Stay.

Outpatient Clinical Episode Triggers and Length

The submission of a claim to Medicare FFS by an EI for the outpatient Anchor Procedure triggers an outpatient Clinical Episode, as identified by a Healthcare Common Procedure Coding System code. An outpatient Clinical Episode ends 90 days following completion of the Anchor Procedure.

Inpatient Clinical Episodes

BPCI Advanced includes 31 inpatient Clinical Episodes for MY3 (see below).

- Acute myocardial infarction
- Back and neck surgery, excluding spinal fusion
- Bariatric Surgery*
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD), bronchitis, asthma
- Congestive heart failure
- Coronary artery bypass graft
- Disorders of the liver, excluding malignancy, cirrhosis, alcoholic hepatitis
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Inflammatory Bowel Disease*
- Hip and femur procedures except major joint

- Lower extremity/humerus procedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity (MJRLE)**
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Seizures*
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion*
- Stroke
- Transcatheter Aortic Valve Replacement*
- Urinary tract infection

*Indicates new Clinical Episode for MY3.
**This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.

Outpatient Clinical Episodes

BPCI Advanced includes four outpatient Clinical Episodes for MY3 (see below).

- Back and neck except spinal fusion
- Cardiac Defibrillator
- Major joint replacement of the lower extremity (MJRLE)**
- Percutaneous Coronary Intervention

**This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.

Items and Services Included in a Clinical Episode

Each Clinical Episode includes Medicare FFS expenditures for:

- Part A and Part B non-excluded items and services furnished during the Anchor Stay or Anchor Procedure
- 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
- With respect to those Clinical Episodes triggered by an Anchor Stay:
    - 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 days prior to the Anchor Stay (in accordance with the three-day payment window rule); and
    - If the BPCI Advanced Beneficiary transferred from the Emergency Department at another facility either the day of or the day before admission for the Anchor Stay, charges from that Emergency Department visit

Types of Items and Services Included in a Clinical Episode

Unless specifically excluded, Clinical Episodes include the services below:

- Physicians' services
- Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure, respectively
- Other hospital outpatient services
- Inpatient hospital readmission services
- LTCH services
- IRF services
- SNF services
- HHA services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs and hospice services

Items and Services Excluded from a Clinical Episode

CMS excludes from a Clinical Episode those Medicare FFS expenditures for:

- 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, or ventricular shunts)
- New technology add-on payments under the Inpatient Prospective Payment System (IPPS)
- Payments for items and services with pass-through payment status under the Outpatient Prospective Payment System (OPPS)
- Payment for blood clotting factors to control bleeding for hemophilia patients

Payment and Pricing Methodology

The BPCI Advanced Model uses a retrospective bundled payment approach. Specifically, under BPCI Advanced, CMS may make payments to Participants or Participants may owe a Repayment Amount to CMS after CMS reconciles all non-excluded Medicare FFS expenditures for a Clinical Episode against a Target Price for that Clinical Episode. The Target Price calculations, Reconciliation calculations, and attribution of Clinical Episodes to Participants will each occur at the EI level.

Benchmark Price

To determine the Episode Initiator-specific Benchmark Price for a hospital, CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode:

1. Patient case-mix
2. Hospital's characteristics
3. Projected trends in spending among the hospital's peer group
4. Historical Medicare FFS expenditures specific to the hospital's Baseline Period

BPCI Advanced will base the PGP's Benchmark Prices on the Benchmark Prices for the hospitals where its Anchor Stays or Anchor Procedures occur. CMS will adjust each hospital-specific

Benchmark Price to calculate a PGP-hospital-specific Benchmark Price that accounts for the PGP's historical spending patterns and the PGP's patient case mix, each relative to the hospital.

CMS Discount

The CMS Discount is a set percentage by which CMS reduces the Benchmark Price to calculate the Target Price. The CMS Discount for Model Year 3 will be three percent, a continuation from Model Years 1 and 2. However, CMS may make slight adjustments to this amount in future Model Years.

Target Price

The Target Price equals the Benchmark Price multiplied by the difference of one minus the CMS Discount (Target Price=Benchmark Price*(1 – CMS Discount)). CMS will provide preliminary Target Prices prospectively before each Applicant finalizes its Participation Agreement with CMS and before the selection of Clinical Episodes. Applicants will receive a preliminary Target Price for themselves and/or their EIs, determined prospectively based upon their historical patient case mix. CMS will set a final Target Price retrospectively at the time of reconciliation by replacing the historic patient case mix adjustment with the realized value in the Performance Period, which is transparent and specific to the Participant's beneficiaries.

Reconciliation

CMS conducts semi-annual Reconciliation of the Clinical Episode-specific preliminary Target Prices and final Target Prices. CMS bases final Target Prices on the Participant's actual case mix. CMS will provide Participants with a Reconciliation Report specifying the Reconciliation Amount, which can be either positive or negative:

- **Positive Reconciliation Amount:** If aggregate Medicare FFS expenditures for items and services included in the Clinical Episode (other than those specifically excluded) are less than the final Target Price for that Clinical Episode (with the Target Price updated to account for actual patient case mix), there will be a Positive Reconciliation Amount
- **Negative Reconciliation Amount:** If aggregate Medicare FFS payments for items and services included in the Clinical Episode exceed the final Target Price, there will be a Negative Reconciliation Amount

Composite Quality Score

CMS will link payment to quality using a pay-for-performance methodology. CMS will calculate a quality score for each quality measure at the Clinical Episode level, if applicable. CMS will scale these scores across all Clinical Episodes attributed to a given EI, weighted based on Clinical Episode volume, and summed to calculate an EI-specific Composite Quality Score (CQS).

CMS will apply a CQS Adjustment Amount to the Positive Total Reconciliation Amount, if any, resulting in the Adjusted Positive Total Reconciliation Amount, which becomes a Convener Participant's or Non-Convener Participant's Net Payment Reconciliation Amount. Similarly,

CMS will apply a CQS Adjustment Amount to the Negative Total Reconciliation Amount, if any, resulting in the Adjusted Negative Total Reconciliation Amount, which becomes a Convener Participant's or Non-Convener Participant's Repayment Amount.

In MY3, CMS will continue to apply the 10 percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount. However, the 10 percent cap is subject to change.

Stop-Loss/Stop-Gain Limits

CMS caps Reconciliation payments, both to and from Participants, at 20 percent at the level of the EI.

Quality Measures

For quality measure reporting in MY3, CMS may be providing Participants with the flexibility to choose one of two quality measure sets. The established CQS calculation methodology will apply to both.

- **Administrative Quality Measures Set:** This set, used in Model Years 1 and 2, includes only claims-based measures directly collected by CMS
- **Alternate Quality Measures Set:** This set includes a combination of claims-based and registry-based measures. The Alternate Quality Measures Set was developed after CMS gathered information on various established registries to identify a tailored set of quality measures that align with each of the specialty-specific Clinical Episodes in the Model.

All Participants, whether they select the Administrative Quality Measures Set or the Alternate Quality Measures Set, will be accountable for no more than five measures per Clinical Episode.

CMS anticipates that new Clinical Episodes in MY3 will be available prior to the close of the application period, along with the full list of quality measures associated with all Clinical Episodes. CMS may determine whether to incorporate additional quality measures into the Administrative Quality Measures Set or the Alternate Quality Measures Set in future Model Years, and CMS may update the quality measures on an annual basis.

Waivers

Fraud and Abuse Waivers

Certain Fraud and Abuse laws are waived so that BPCI Advanced Participants and their NPRA Sharing Partners have the flexibility to negotiate and enter into certain Financial Arrangements or furnish beneficiary engagement incentives under the Model. Additional details on the fraud and abuse waivers will be made available prior to Applicants signing a Participation Agreement.

Payment Policy Waivers

Separate from fraud and abuse waivers, CMS will offer conditional waivers of certain Medicare payment rules, or "Payment Policy Waivers," to test whether flexibility and coverage of additional services will lower costs, improve quality, and/or facilitate the delivery of care in new settings, and to better engage beneficiaries in their care. Participants may choose to furnish services to BPCI Advanced Beneficiaries pursuant to the 3-Day SNF Rule, Telehealth, and Post-Discharge Home Visit Payment Policy Waivers.

Monitoring

CMS will measure and monitor care throughout BPCI Advanced to ensure that Model objectives in redesigning care, achieving quality measure thresholds and patient experience-of-care standards, and demonstrating improved care coordination are met.

CMS may monitor BPCI Advanced performance by:

- Tracking claims data and medical record reviews
- Conducting ad hoc reviews and analyzing financial and quality performance measurements
- Implementing site visits, surveys and interviews with Participants, EIs, Participating Practitioners, Beneficiaries and other parties

CMS will conduct an independent evaluation to assess the changes in quality of care and spending under BPCI Advanced.

Post-Episode Spending Monitoring Period

CMS will measure the cost of care furnished during the 30-day Post-Episode Monitoring Period to ensure that aggregate Medicare FFS expenditures for BPCI Advanced Beneficiaries do not increase due to cost shifting or other reasons. CMS's review will include measuring Medicare FFS expenditures for items and services furnished to BPCI Advanced Beneficiaries by health care providers that are not participating in BPCI Advanced.

Have Questions or Need More Information?

Email the BPCI Advanced Team at BPCIAdvanced@cms.hhs.gov
Visit the website at https://innovation.cms.gov/initiatives/bpci-advanced