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5 Things You Need to Know About Medicare's New Voluntary Bundled Payment Model

January 2018

On January 9, 2018, the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) announced a new voluntary episode payment model, Bundled Payments for Care Improvement Advanced (BPCI Advanced). Building upon the original BPCI Initiative that was launched in 2013, BPCI Advanced will test bundled payments for 32 clinical episodes. In its announcement, CMS indicated that evaluations of the previous BPCI model helped to inform this new iteration, which is also aimed at generating savings and improving quality and will link payments across all health care providers during an episode of care. The model includes incentives to encourage care coordination, eliminate unnecessary care and reduce readmissions.

Helpful Resources

- Model Overview is available here.
- Press Release is available here.
- General Frequently Asked Questions is available here.
- Registration for Open Door Forum on the BPCI Advanced Model (January 30, 2018) is available here.

For more information on the CMS Quality Payment Program visit the **McDermottPlus MACRA Resource Center** or contact Sheila Madhani, Piper Su, or Eric Zimmerman.

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BPCI Advanced is a voluntary model, and its Model Performance Period starts on October 1, 2018, and runs through December 31, 2023. Participants may apply to the program by submitting the application and all required materials via the BPCI Advanced Application Portal. The Portal opened on January 11, 2018, and will close on March 12, 2018, at 11:59 pm EST. Questions regarding the BPCI Advanced Model can be directed to BPCIAdvanced@cms.hhs.gov.

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Model Timeline

Application Process	**January – March 2018**
	• January 9, 2018: Requests for Application released • January 11, 2018: Application portal opens • March 12, 2018: Application portal closes
CMS Screens Applicants	**March – June 2018**
Agreement Process	**May – August 2018**
	• May 2018: CMS distributes target prices to applicants • June 2018: CMS offers participant agreements to applicants • August 2018: Signed participant agreements due to CMS; clinical episode selections and program deliverables also due to CMS
Model Implementation	**August 2018 – December 2023**
	• October 1, 2018: Model goes live • March 31, 2019: First date for Advanced Alternative Payment Model (APM) Qualified Participant determination • January 1, 2020: Next application period • December 31, 2023: End of first cycle

1. **Medicare-certified acute care hospitals (ACHs) and physician group practices (PGPs) may participate in BPCI Advanced as either Convener Participants or Non-Convener Participants.**

   CMS defines a Participant in the model as an entity that enters into a BPCI Advanced Model Participation Agreement with CMS.

   - A **Convener Participant** is a type of Participant that brings together multiple downstream entities, referred to as "Episode Initiators"—which must be either ACHs or PGPs—to participate in BPCI Advanced, facilitates coordination among them, and bears and apportions financial risks.
   - A **Non-Convener Participant** is any Participant that is not a Convener Participant because it bears financial risk only for itself and does not bear financial risk on behalf of multiple downstream Episode Initiators.

   Medicare-enrolled providers or suppliers—other than ACHs and PGPs—may participate in BPCI Advanced as Convener Participants, but not as Non-Convener Participants.

   Both Convener Participants and Non-Convener Participants may enter into arrangements with downstream practitioners, referred to as **Participating Practitioners**, who furnish care under this initiative and participate in BPCI Advanced Activities (*i.e.*, care redesign, quality measure reporting and use of Certified EHR Technology). A Participating Practitioner may be any physician or non-physician practitioner (*e.g.*, nurse practitioner, physician assistant, physical therapist) paid separately by Medicare for his or her professional services.

2. **BPCI Advanced will require all Participants to take on downside financial risk from the outset of the Performance Period of the Model.**

   The unit of service of this model is a clinical episode. A clinical episode is triggered by the submission of a claim for either an inpatient hospital stay (anchor stay) or an outpatient procedure (anchor procedure). BPCI Advanced will operate under a retrospective, total-cost-of-care financial construct where the standard fee-for-service (FFS) payments are made and then the total FFS payment for the clinical episode is retrospectively reconciled against a predetermined target price. All items and services furnished to a BPCI Advanced Beneficiary during the clinical episode, including outlier payments, will be part of the clinical episode expenditures for purposes of the target price and reconciliation calculations, unless specifically excluded.

   The target price will be calculated by applying a discount, referred to as the CMS Discount, to the benchmark price. During the initial years of the Model, the CMS Discount is 3 percent. However, CMS may make slight adjustments to this amount in future Model years. The benchmark price is, in turn, calculated based on the historical Medicare FFS expenditures for most items and services furnished during the clinical episode. Based on actual Medicare spending relative to the target price, Participants may either have the opportunity to earn a Net Payment Reconciliation Amount (NPRA) to be paid by CMS, or may owe CMS a Repayment Amount.

CMS is establishing a 20 percent stop-loss and stop-gain limit at the episode initiator level that is applied to the reconciliation amount.

3. **The BPCI Advanced Model includes 29 inpatient clinical episode categories and three outpatient categories.**

When signing participation agreements, Participants must select the clinical episodes for which they will be held accountable. CMS may elect to add or remove episodes on an annual basis beginning in 2020. Participants joining the Model for the Performance Period beginning on October 1, 2018, will not be allowed to drop clinical episodes until 2020, except upon request by CMS. Most of the eligible inpatient episodes mirror those used in the original BPCI model with one exception: the addition of an episode related to liver disorders. The new model also adds three outpatient episode options as CMS moves forward with its desire to expand the availability of bundled payment in multiple care settings.

Eligible Inpatient Clinical Episodes

- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis*
  *(New episode added to BPCI Advanced)
- Acute myocardial infarction
- Back and neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- COPD, bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

Eligible Outpatient Clinical Episodes

- Percutaneous coronary intervention
- Cardiac defibrillator
- Back and neck except spinal fusion

4. <u>The BPCI Advanced Model will qualify as an Advanced APM and a MIPS APM under the Quality Payment Program (QPP) beginning with the 2019 Performance Period.</u>

Notably, BPCI Advanced will meet the criteria to qualify as an Advanced APM beginning on the first Performance Period's effective date, October 1, 2018. Beginning on January 1, 2019, participation in the model will be considered for the purposes of Qualifying APM Participant (QP) determination and the 5 percent APM incentive payment.

The model will also be considered a MIPS APM beginning January 1, 2019, and may benefit those participants who are not QPs and thus will be subject to the MIPS APM scoring standard under QPP. The MIPS APM scoring standard accounts for the quality, cost and electronic health record reporting required by the APM, resulting in a reduced MIPS reporting burden.

5. <u>Final positive or negative payment adjustments will be affected by performance on quality measures.</u>

BPCI Advanced participants must report on all applicable quality measures set forth by CMS, and their performance on those measures could result in a positive or negative payment adjustment for an episode. CMS will utilize the reported quality data measures to calculate a composite Quality Score (CQS), which will then be applied to make an upward or downward adjustment to the total reconciliation amount for an episode. For the first two model years, CMS establishes a 10 percent cap on the amount of the CQS adjustment in order to allow participants to acclimate to the program without excessive exposure to financial risk based upon quality reporting.

CMS identifies the following quality measures in the model announcement and notes that it may add new measures or remove existing measures on an annual basis.

- Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
- All-cause Hospital Readmission Measure (NQF #1789)
- Advanced Care Plan (NQF #0326)
- 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)

CMS also indicates that it may include the following measures for Model Year 3 (2020).

- CAHPS for Clinicians (NQF #0005)
- CAHPS for Hospitals (NQF #0006)
- CAHPS Home Health Care (NQF #0166)

- Hypertension: Improvement in Blood Pressure (CMS #373)
- Drug Regimen Review with Follow-up (CMS #2849)
- Surgical Site Infection (SSI) (NQF #0299)
- Unplanned Reoperation within the 30 Day Postoperative Period (CMS #1966)

BPCI Advanced represents the first large-scale Innovation Center model announced under the Trump Administration, as well as the first view of how bundled payments may evolve under the new CMS leadership. Following public statements by former US Department of Health and Human Services (HHS) Secretary Tom Price and CMS Administrator Seema Verma indicating a strong preference for voluntary rather than mandatory bundled payment models, the provider community has been awaiting the announcement of this new voluntary model opportunity. However, comments made by HHS Secretary nominee Alex Azar during his recent Senate confirmation hearings indicate that mandatory models may still be considered as an option by this Administration. During the committee questioning, Mr. Azar noted that he supports testing new payment models for providers on a mandatory as well voluntary basis, a viewpoint that is sure to shape the direction taken by CMS and the Innovation Center on future alternative payment models.

For more information on the CMS Quality Payment Program visit the **McDermottPlus MACRA Resource Center** or contact Sheila Madhani at (202) 204-1459, Piper Su at (202) 204-1462, or Eric Zimmerman at (202) 204-1457.