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BPCI Advanced: Second Cohort 2020

The Centers for Medicare & Medicaid Services (CMS) announced on April 24, 2019 that it is accepting applications for a new, second cohort of participation in the Bundled Payments for Care Improvement - Advanced (BPCI Advanced) voluntary episode payment model which will include outpatient total knee arthroplasty (TKA) for the first time.

The first round of BPCI Advanced started on October 1, 2018. Participants selected for the second cohort will start Model Year 3 (MY3), beginning on January 1, 2020, and run through December 31, 2023. The application portal for participation in the second cohort opened on April 24, 2019 and will remain open through June 24, 2019. CMS anticipates no additional BPCI Advanced application periods in the future.

Current BPCI Advanced Participants who wish to add new episode initiating providers to their arrangement, or who wish to separate existing arrangements into multiple Participant agreements with CMS, may apply to do so under the same deadline.

Model Overview

BPCI Advanced is a retrospective bundled payment model that makes participating providers (Participants) fiscally responsible for the medical procedures associated with selected conditions and for nearly all of the care occurring in a 90-day period following the procedure (Clinical Episodes). During the application process, Participants select which Clinical Episodes they will be responsible for. Similar to earlier BPCI Models, CMS makes Medicare fee-for-service (FFS) payments during a Clinical Episode and the total expenditures for the Clinical Episode are later 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 are adjusted based on quality measures. If this adjusted difference is positive, CMS pays the Participant the amount. If the difference is negative the Participant is responsible for paying CMS the amount.

In addition to bearing risk for monetary losses and reporting performance through quality measures comparable to Merit Based Incentive Payment System (MIPS) quality measures, Participants must attest to their use Certified Electronic Health Record Technology (CEHRT). These three criteria enable BPCI Advanced to qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program. Eligible Providers participating in an Advanced APM are excluded from the requirement to independently report quality measures under MIPS.

Understanding Physician Participation

While physician group practices (PGPs) can participate in the BPCI Advanced though multiple avenues, they are 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 CMS 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 Convener Participant may be either an entity that is not enrolled in Medicare or a Medicare enrolled clinical entity other than an 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.

Defining a Clinical Episode

Clinical Episodes 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.

For MY3, BPCI Advanced will include 33 inpatient and 4 outpatient episodes, including:

- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Hip and femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major joint replacement of the upper extremity
- Major joint replacement of the lower extremity

The following are new procedure options for MY3:

- Outpatient TKA
- Bariatric Surgery
- Inflammatory Bowel Disease
- Seizures
- Transcatheter Aortic Valve Replacement

Payment Methodology

On a semi-annual basis, CMS conducts a reconciliation process comparing the aggregate Medicare expenditures included in a Clinical Episode against a Clinical Episode specific Target Price. CMS repeats 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 is adjusted based on the

Episode Initiator's quality performance. During the first 2 years of BPCI Advanced, the adjustment based on quality performance was capped at 10%, leaving the adjusted payment amount between 90-100% of the pre-quality performance adjusted amount. CMS will continue to apply the 10% cap in MY3.

Reconciliation Payment: For Non-Convener Participants, if the quality performance final adjusted amount is positive, a payment flows from CMS to the Non-Convener Participant. If the quality performance final adjusted amount is negative, the Non-Convener Participant is 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: For MY3, the reconciliation payments either to or from CMS remain 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 monitors FFS spending and if actual spending exceeds predicted spending, the Participant is 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 establishes 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.

- **Benchmark Price for PGPs:** To establish the Episode Initiator specific Benchmark Price for PGPs, CMS uses the Benchmark Price for *the ACH where the Anchor event occurs*; this price is 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:** In MY3, the discount rate to CMS will be 3%. However, CMS may elect to adjust this amount in future years.

Quality Measures

CMS has not finalized quality measure reporting in MY3. CMS states that it *may* provide Participants the flexibility to choose to report one of two separate quality measure sets as follows.

- *Administrative Quality Measures Set*: For each Clinical Episode, MY3 Participants will select five (down from seven) quality measures upon which to be measured. Participants choose from the same list of claims-based measures directly collected by CMS in Model Years 1 and 2, which includes

    - All-cause Hospital Readmission Measure
    - Advanced Care Plan
    - Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin
    - Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA
    - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery
    - Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
    - AHRQ Patient Safety Indicators

- *Alternate Quality Measures Set*: This set includes a combination of claims-based and registry-based measures. The Alternate Quality Measures Set was developed by CMS based on study of various established registries to identify a tailored set of quality measures that align with each of the specialty-specific Clinical Episodes.

CMS may determine whether to incorporate additional quality measures into either set in future Model Years. CMS may update the quality measures on an annual basis.

Restructuring Existing Participant Profiles

Current Participants have the opportunity to add Episode Initiators and/or separate their Downstream Episode Initiators into multiple agreements for MY3. In order to submit the requests, Participants must complete the EI Addition Template or the EI Restructure Template by June 24, 2019.

Important Dates

April 24, 2019	MY3 Request for Applications Released
April 24, 2019	Application Portal Opens
June 24, 2019	Application Due Date
September 2019	CMS distributes Price Targets to Applicants
September 2019	CMS offers Participation Agreements to Applicants
November 2019	Participation Agreements Due to CMS
November 2019	Clinical Episode Selections Due to CMS
January 1, 2020	Model Go Live Date

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