BPCI Advanced Program Overview

Start Date
OCTOBER 1, 2018

Timeframe
6 PERFORMANCE YEARS

Savings
CONTINGENT ON COST & QUALITY

Downside Risk
IMMEDIATE

EPISODES
29 Inpatient Episodes
3 Outpatient Episodes

EPISODE INITIATORS
Acute Care Hospitals
Physician Group Practices

MEETS ADVANCED APM CRITERIA
A convener bears risk on behalf of multiple EIs.

A non-convener bears risk only on behalf of itself.
Model Years

There will be an additional opt-in period in January 2020.
Eligible Beneficiaries

**INCLUDES**
- Medicare FFS Enrollees with both Parts A and B
- Medicare must be the primary payer

**EXCLUDES**
- Medicare FFS Enrollees *without* both Parts A and B
- Beneficiaries who do not have Medicare as the primary payer
- Beneficiaries who die during the anchor stay or anchor procedure
- Medicare ESRD enrollees
- Beneficiaries covered under managed care plans (Medicare Advantage), or under United Mine Workers
Inpatient Episodes

29 Clinical Episodes (including 105 MS-DRGs)

Anchor Admission

+ 90 days

• 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
• Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis (NEW)
• Double joint replacement of the lower extremity
• Fractures of the femur and hip or pelvis

• Gastrointestinal hemorrhage
• Gastrointestinal obstruction
• Hip and femur procedures except major joint
• Lower extremity/humerus procedure except hip, foot, femur
• Major bowel procedure
• Major joint replacement of 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
Outpatient Episodes

Anchor Procedure

+ 90 days

Percutaneous Coronary Intervention

HCPCS Trigger Codes: 92920, C9600, C9604, 92924, 92937, 92928, 92943, C9606, 92933, C9602, C9607

Cardiac Defibrillator

HCPCS Trigger Codes: 33262-33264, 33249, 33270

Back or Neck except Spinal Fusion

HCPCS Trigger Codes: 62287, 63005, 63011, 63012, 63017, 63030, 63040, 63042, 63045-63047, 63056, 63075
Episode Payments Included

Includes non-excluded Parts A and B payments

Anchor Stay/Procedure

+ 90 days

- Physicians’ services
- Skilled Nursing Facility
- Clinical Lab services
- IP/OP services for anchor stay/procedure
- Long-Term Care Hospital
- Part B drugs
- Other hospital OP
- Home Health
- Durable Medical Equipment
- IP readmissions (subject to CMS exclusions)
- Inpatient Rehabilitation
- Hospice

医保 FFS Payments

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# Payment Exclusions

CMS applies the **same exclusions to ALL BPCIA episodes**

<table>
<thead>
<tr>
<th>Excluded</th>
<th>Parts A and B services furnished during ACH admissions and readmissions for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✗ organ transplants</td>
</tr>
<tr>
<td></td>
<td>✗ major trauma</td>
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<tr>
<td></td>
<td>✗ cancer-related care</td>
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<tr>
<td></td>
<td>✗ ventricular shunts</td>
</tr>
</tbody>
</table>
Special Medicare Payments

EXCLUDED

<table>
<thead>
<tr>
<th>OPPS pass-through payments</th>
<th>New technology add-ons under IPPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemophilia clotting factors</td>
<td>IME/DSH/Capital from inpatient claims</td>
</tr>
</tbody>
</table>
Payment Methodology
Hospital Baseline Episode Cost (July 2009 - June 2012) \[ \times \] National Trend Factor \[ \times \] Hospital Wage Factor Ratio = Benchmark Price

Benchmark Price \[ \times \] (1-Discount Factor) (2-3%) = Target Price

CMS Savings Amount for Each Episode
BPCI ADVANCED TARGETS

Hospital Peer Group Characteristics

Hospital Historical Performance

Patient Characteristics during Episodes

EPISODE TARGET
**BPCI ADVANCED TARGETS: ACH**

- **Hospital Baseline Episode Cost (Jan 1, 2013 – Dec 31, 2016)**
- **Peer Adjusted Trend Factor**
- **Benchmark Price**
- **Target Price**
- **CMS Savings Amount for Each Episode**

Benchmark Price x (1-Discount Factor) (3%) = Target Price

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BPCI Advanced Targets

CMS accounts for each component using regression models for each clinical episode category.

\[ y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3 \ldots + \beta_n x_n + \varepsilon \]

- \( y \) = baseline episode expenditures
- \( x_1, x_2, x_3 \) = covariates (age, sex, # of HCCs, DRG or APC, etc.)

Risk Adjustment for Patient Characteristics

- Demographics
- Comorbidities: # of HCCs
- Severity: DRG or APC
CMS will not stratify target prices by fracture status.

The baseline price includes the proportion of fracture vs. non-fracture cases. A change in the proportion of fracture cases from the baseline to performance period will adjust the target price.
BPCI ADVANCED TARGETS: PGP

Hospital Benchmark \times \text{Adjust for PGP patient characteristics} \times \text{Adjust for PGP's efficiency in FFS expenditures during baseline compared to hospital} = \text{PGP Benchmark Price}

\text{PGP Benchmark Price} \times (1 - \text{Discount Factor}) (3\%) = \text{PGP Target Price}

If the PGP doesn't have enough volume for CMS to calculate the adjustment, the PGP will have the hospital target.
Quality Measurement
## QUALITY MEASURES – Model Years 1 and 2

<table>
<thead>
<tr>
<th>All Clinical Episodes</th>
<th>Select Clinical Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All-Cause Hospital Readmission Measure</td>
<td>• Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin</td>
</tr>
<tr>
<td>• Advanced Care Plan</td>
<td>• Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA</td>
</tr>
<tr>
<td></td>
<td>• Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery</td>
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<tr>
<td></td>
<td>• Excess Days in Acute Care after Hospitalization for AMI</td>
</tr>
<tr>
<td></td>
<td>• AHRQ Patient Safety Indicators [PSI 90]</td>
</tr>
</tbody>
</table>
MEASUREMENT METHODOLOGY

1. A quality score will be calculated for each quality measure at the Episode-level.

2. The scores then will be scaled across all Episodes attributed to the EI, weighted by Episode volume.

3. Scaled/weighted scores from Step 2 will be summed to calculate an EI-specific **Composite Quality Score (CQS)**.

4. The CQS Adjustment will be applied to the Reconciliation Amount (+/- 10%) resulting in the Adjusted Positive/Negative Total Reconciliation Amount.
What We Know and Don’t Know Today

**Known**
- Quality measures for Model Years 1 and 2
- Overall concept for pay-for-reporting methodology (CQS)

**Information Forthcoming from CMS**
- *Which measures apply* for each Clinical Episode
- *Weighting scheme for multiple measures* – only know that outcome measures will be weighted more than process measures
- *What is the methodology for CQS* – how CMS will calculate benchmarks for measures and against which peer groups
- *Additional quality measures* for Model Years 3-6
AAMC Resource: Hospital Compare Reports

Frequency of Report: Quarterly

Review trends and compare your decile rank relative to COTH institutions, as well as state and national peers

Includes the following measures:

- READM-30-HOSP-WIDE (All-Cause Hospital Readmission Measure)
- COMP-HIP-KNEE (Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA)
- MORT-30-CABG (Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery)
- EDAC-30-AMI (Excess Days in Acute Care After Hospitalization for AMI)
- PSI-90-SAFETY (AHRQ Patient Safety Indicators)

For questions about AAMC’s Hospital Compare Reports please email COTH@aamc.org
Reconciliation

Aggregate FFS Payments \( < \) Target = Positive Reconciliation Amount

Aggregate FFS Payments \( > \) Target = Negative Reconciliation Amount
Caps on Risk
Caps on Risk: Aggregate Level

Gains & losses capped at +/- 20% of the sum of the target prices across all episodes

Sum of volume-weighted targets
Caps on Risk

1 risk track: caps spending at the 99th percentile

99th Percentile: $88,404

MJR Target Price: $27,187
Precedence Rules and Model Overlap
Model Precedence

CJR Episodes > BPCI Advanced MJR Episodes

OR
BPCI Advanced Hierarchy of Attribution

1st
Attending PGP

2nd
Operating PGP

3rd
Acute Care Hospital

There are NO time based precedence rules
MODEL OVERLAP

Exclude patients prospectively aligned to:

- Next Gen ACO
- Vermont All Payer ACO
- ESRD Seamless Care Organization (ESCO)
- MSSP Track 3 ACO

Benefits aligned to MSSP ACOs in Tracks 1, 1+, or 2 are included.

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Waivers and Gainsharing
Medicare Payment Waivers

- Telehealth
- 3 day stay SNF
- Home Health Visits
Gainsharing

Payments of NPRA
- Positive
- Negative

Internal Cost Savings
- Allowed

Limit on Gainsharing Payments
Payments cannot exceed 50% of the total Medicare FFS expenditures included in clinical episodes attributed to the Participant.
Gainsharing

Participant

Shared Repayment Amount
NPRA Sharing Partner

NPRA Shared Payment
NPRA Sharing Partner
MACRA

Advanced APM

- 2019: first BPCI Advanced model year relevant for Qualified APM Participant (QP) status
- First snapshot date: March 31, 2019

MIPS APM

- Qualifies beginning in 2019
- Option only available to PGP conveners
Data

- Must request through Data Request and Attestation form
- 3 years (2014-2016)
  - Aggregate Historical Claims Data
  - Raw Historical Claims Data
Application Support:

If your institution intends to apply for BPCI Advanced, please notify us by 2/15/18 by emailing aamcbundledpayments@aamc.org

Send completed applications to aamcbundledpayments@aamc.org by 2/20/18

Applications reviewed on a rolling basis