ROPES & GRAY

ALERT

Health Care

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# CMS's New Advanced APM: Bundled Payments for Care Improvement Advanced

On January 9, 2018, the Centers for Medicare & Medicaid Services ("CMS") Center for Medicare and Medicaid Innovation ("CMMI") announced a new voluntary bundled payment model called "Bundled Payments for Care Improvement Advanced" ("BPCI Advanced"). CMS is accepting applicants through March 12, 2018, and the new model will begin on October 1, 2018, when the current Bundled Payments for Care Improvement ("BPCI") Initiative expires. CMS anticipates that the model will run through December 31, 2023.

## Key Features and Program Logistics

- *Overview.* As with the original BPCI and other bundled payment reimbursement models, the goal of BPCI Advanced is to incentivize financial accountability, care redesign, data analysis and feedback, provider engagement, and patient engagement through the use of bundled payments, care redesign activities, and accountability for performance on quality measures. BPCI Advanced will use a retrospective bundled payment approach, in which usual fee-for-service ("FFS") payments are made to participating, Medicare-enrolled providers and suppliers, and the total FFS payments for each clinical episode are then retrospectively reconciled against a predetermined target price, as described more fully below.

- *Comparison to BPCI.* Unlike the original BPCI, which was comprised of four broadly defined models with different payment models and risk tracks, BPCI Advanced consists of a single payment model and risk track for all clinical episodes, which begin on the first day of the triggering inpatient stay or outpatient procedure and extend through the 90-day period starting on the day of discharge from the inpatient stay or the completion of the outpatient procedure, as applicable. Other key differences include simplified precedence rules and risk adjustment at both the provider and beneficiary level, as noted below. Aside from these differences, BPCI Advanced is in many respects a continuation of the original BPCI. There are many similarities between the models, and CMS has promised to help current BPCI participants seamlessly transition into the new payment model.

- *Participants.* For purposes of BPCI Advanced, a "Participant" is an entity that enters into a BPCI Advanced Model Participation Agreement with CMS to participate in the model. There are two categories of Participants under BPCI Advanced: "Convener Participants" and "Non-Convener Participants." Convener Participants bring together and coordinate multiple downstream "Episode Initiators," which must be either physician group practices ("PGPs") or acute care hospitals ("ACHs"). In addition to serving this coordinating function, Convener Participants bear and apportion financial risk on behalf of and among their Episode Initiators. Non-Convener Participants are Episode Initiators (*i.e.*, PGPs and ACHs) that bear only their own financial risk, and do not bear risk on behalf of any downstream Episode Initiators. Both Convener Participants and Non-Convener Participants may enter into agreements with individual downstream physicians and non-physician practitioners ("Participating Practitioners") who furnish care during clinical episodes.

- *Clinical Episodes.* Initially, BPCI Advanced will include 105 Medicare Severity-Diagnosis Related Groups (MS-DRGs), grouped into 29 inpatient clinical episode categories, as well as three outpatient clinical episode categories—namely, Percutaneous Coronary Intervention, Cardiac Defribillator, and Back & Neck (except Spinal Fusion)—each identified by 30 Healthcare Common Procedure Coding System codes (collectively,

"Clinical Episodes"). Participants may elect to be held accountable for any of the 29 inpatient and three outpatient Clinical Episodes included in the model, but will not be allowed to add or drop Clinical Episodes except as expressly permitted by CMS.

- *Reconciliation and Gainsharing.* CMS will conduct semi-annual reconciliation against prospectively determined Clinical Episode-specific target prices, adjusted by CMS based on the Participant's actual patient case mix, to calculate the final target price (the "Target Price"). If, during the semi-annual reconciliation process, all non-excluded Medicare FFS expenditures for a Clinical Episode for which the Participant has opted in are less than the final Target Price for that Clinical Episode, a positive reconciliation amount results. (By contrast, if all non-excluded Medicare FFS expenditures for a Clinical Episode are greater than the final Target Price, this results in a negative reconciliation amount.) CMS nets reconciliation amounts across all Clinical Episodes attributed to each Episode Initiator to calculate a total reconciliation amount, which CMS then adjusts according to certain pre-defined quality criteria (as described below). For Convener Participants, CMS nets the quality-adjusted reconciliation amounts across all of the Participant's Episode Initiators to calculate either the "Net Payment Reconciliation Amount" ("NPRA") (if positive) or a "Repayment Amount" (if negative). These reconciliation payments, both to Participants from CMS, and from Participants to CMS, are capped at +/-20% of the volume-weighted sum of the final Target Prices across all Clinical Episodes netted for each Episode Initiator within the Performance Period. Participants may also enter into financial arrangements with "NPRA Sharing Partners" (such as Participating Practitioners, PGPs, ACHs, and Accountable Care Organizations) to share NPRAs or to apportion the responsibility for Repayment amounts, subject to a cap set at 50% of the total Medicare FFS expenditures included in Clinical Episodes attributed to the Participant for which the NPRA or Repayment Amount was calculated. This limitation on financial arrangements with NPRA Sharing Partners (which we describe using the CMS language from the Request for Applications) has prompted questions in the industry and will be an area for further analysis and clarification.

- *Quality Measures and MACRA.* As noted above, CMS will adjust the total reconciliation amounts to reflect an Episode Initiator-specific "Composite Quality Score" ("CQS"), which CMS will calculate based on the Episode Initiator's scores on the applicable set of quality measures. While CMS may adjust the specific set of quality measures on an annual basis, the measures will include both process (*e.g.*, advance care plan) and outcome (*e.g.*, all-cause hospital readmissions) measures. For the first two model years, the amount by which a reconciliation amount may be adjusted based on the CQS is capped at 10 percent. In light of this quality-adjusted payment methodology and other features of BPCI Advanced (including more than nominal risk-sharing by Participants and required use of Certified Electronic Health Record Technology), CMS anticipates that BPCI Advanced will qualify as an Advanced Alternative Payment Model under the Medicare Access and Chip Reauthorization Act of 2015 ("MACRA").

- *Fraud and Abuse Waivers.* As with BPCI, CMS anticipates that fraud and abuse waivers will be issued pursuant to the Secretary's authority under Section 1115A of the Social Security Act, 42 U.S.C. § 1315a. As of this writing, however, no such waivers have been issued.

## Additional Details and Frequently Asked Questions

On January 30, 2018, CMS held an "Open Door Forum" to answer questions about the BPCI Advanced program and the application process. CMS solicited questions in advance of the event and received more than 600 submissions. According to CMS, the six most frequently asked questions were as follows:

1. ***Question:*** Regarding the overlap with CJR, who gets "precedence"—a CJR participant hospital or a PGP participating in BPCI Advanced?

   ***Context:*** The Comprehensive Care for Joint Replacement ("CJR") model tests bundled payments and quality measurement for episodes of care associated with lower extremity joint replacements ("LEJRs")

(*i.e.*, hip and knee replacements). Under BPCI Advanced, Clinical Episodes will be attributed at the Episode Initiator ("EI") level. The hierarchy for attribution of a Clinical Episode among different types of EIs in BPCI Advanced is as follows, in descending order of precedence: (1) the PGP that submits a claim that includes the National Provider Identifier (NPI) for the attending physician; (2) the PGP that submits a claim that includes the NPI of the operating physician; and (3) the ACH where the services that triggered the Clinical Episode were furnished. There are no time-based precedence rules under BPCI Advanced (*i.e.*, a PGP that becomes a Participant on October 1, 2018, when the model begins, will not automatically have precedence over a PGP that becomes a Participant at a later date).

***Answer:*** Notwithstanding the hierarchy of attribution described above, with respect to an LEJR Episode of Care, a CJR participant hospital in one of the 34 mandatory Metropolitan Statistical Area ("MSAs"), or a hospital in one of the 33 voluntary MSAs that "opts in" by the deadline of January 31, 2018 in accordance with the applicable CJR rules, will have precedence over a PGP participating in BPCI Advanced. (For all other 31 Clinical Episodes, a PGP will have precedence over a CJR participant hospital that is also participating in BPCI Advanced for those Clinical Episodes.) Between now and September 30, 2018, when the original BPCI is scheduled to end, clinical episodes in the original BPCI will continue to have precedence over CJR clinical episodes. Hospitals currently participating in original BPCI that are located in a mandatory MSA will become CJR participant hospitals as of October 1, once BPCI ends. Those hospitals still have the option of applying to participate in BPCI Advanced for the other 31 Clinical Episodes.

2. ***Question:*** When will the BPCI Advanced pricing methodology be available?

   ***Answer:*** CMS is planning to release the Target Price specifications "in the next few weeks."

3. ***Question:*** If I submit an application, am I obligated to participate in BPCI Advanced?

   ***Answer:*** No. Application submission does not obligate an organization to participate in BPCI Advanced. Likewise, submission of an application does not guarantee that applicants will be selected for participation. A signed and executed BPCI Advanced Model Participation Agreement with CMS is required to participate in the model. CMS will not execute an agreement until applications have been reviewed and applicants have passed multiple levels of program integrity and law enforcement screening.

4. ***Question:*** Why isn't there a "Model 3" (*i.e.*, involving episodes of care triggered by post-acute care services) under BPCI Advanced?

   ***Answer:*** According to CMS, the BPCI Advanced model was developed using lessons learned and successes of original BPCI. CMS wanted to provide prospective Target Prices, add a risk-adjustment component, and make the model an Advanced APM by tying payments to quality. CMS also wanted model pricing to recognize, and not penalize, the efficiency achievements of current BPCI awardees. Incorporating all of these features into a pricing approach that included post-acute care providers as Episode Initiators proved too challenging.

5. ***Question:*** Can you please clarify . . . about Gainsharing/NPRA Shared Payments?

   ***Answer:*** CMS is currently limited in its ability to respond to the many questions it received around gainsharing. CMS has requested fraud and abuse waivers for BPCI Advanced; if issued, CMS expects

for the waivers to be effective for the start of the model performance period on October 1, 2018. The waivers will be available for review prior to execution of the BPCI Advanced Model Participation Agreement.

6. ***Question:*** Can an Episode Initiator apply to participate through multiple Convenor Participants and/or as a Non-Convenor Participant?

   ***Answer:*** Yes. An Episode Initiator can be listed in applications submitted by multiple Convenor Participants, and can also submit an application as a Non-Convenor Participant. However, an Episode Initiator that is listed in multiple applications must ensure that, by the time of submission of the "Participant Profile" in August 2018 by a given Convenor Participant or a Non-Convenor Participant, such Episode Initiator appears in only one Participant Profile. Otherwise, the Episode Initiator will not be eligible to participate in BPCI Advanced effective October 1, 2018. The organization can apply again during the next application opportunity for Model Year 3 in January 2020.

## Takeaways and Implications for Value-Based Healthcare

CMS drew attention in late 2017 when the agency cancelled the Episode Payment Models and Cardiac Rehabilitative Incentive Payment Model initiatives and substantially reduced the scope of the Comprehensive Care for Joint Replacement Model. CMS Administrator Seema Verma noted at the time that she believed in the value of bundled payment models to reduce health care costs and deliver superior care, but objected to the mandatory nature of those three initiatives. Her position was in line with that of former Secretary of the Department of Health and Human Services ("HHS") Tom Price, who frequently criticized mandatory value-based payment initiatives as too burdensome for providers. Ms. Verma pledged last year to introduce more voluntary bundled payment initiatives, and the announcement of BPCI Advanced is the first step toward making good on that promise. The announcement suggests that CMS will remain a player in testing and facilitating value-based payment reform, which has continued apace in the commercial sector notwithstanding CMS's position with respect to mandatory payment models and the concern voiced by some industry observers following the agency's actions last year.