MILLIMAN WHITE PAPER

BPCI Advanced Model Year 4 pricing methodology changes: What does this mean for participants?

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The Centers for Medicare and Medicaid Services (CMS) has announced important changes to the Bundled Payment for Care Improvement (BPCI) Advanced model for Model Year 4 (MY4). These changes are designed to improve target price accuracy and help bolster the long-term sustainability of the model.

The BPCI Advanced model began its first performance period on October 1, 2018 as an evolution of CMS's original voluntary episode payment model, BPCI. The BPCI Advanced model is aimed at furthering the goals of the original model by incentivizing greater care coordination and expenditure reductions while improving the quality of care provided to patients.[1]

MY4 (starting on January 1, 2021) will incorporate five significant programmatic changes intended to improve the target price development methodology and ensure financial solvency for the model. Each of these changes has the potential to impact the net savings/losses that any individual participant can expect to receive within the model. This paper discusses each of the five methodological changes for MY4 and explores the impact each change might have on participants.

MY4 methodology changes

1. Realized trend adjustment

In June 2020, CMS released a study by Acumen that found the BPCI Advanced prospective peer group trends (PGTs) in MYs 1 & 2 were overestimated compared to actual trends. This difference in observed trend resulted in a net reconciliation (all participants) over both years that was approximately $680 million dollars greater than it would have been if CMS had used a retrospective trend to set target prices and measure performance.[2]

In order to minimize the impact of inaccurate prospective trends beginning in MY4, CMS will restate target prices (initially calculated using a prospective trend) using a retrospective PGT at reconciliation. CMS will limit the change in PGT from the preliminary (prospective) trend to the final (retrospective) trend at plus-or-minus 10%. For example, if the preliminary prospective trend for a peer group was 5% (PGT factor of 1.05) but the realized retrospective trend was 20% (PGT factor of 1.20), CMS would restate the target price using a PGT of 1.155 (equal to 1.05 * 1.1).

Up through MY3, target prices have been set using a prospective PGT, providing participants with a target price that is known from the start of the MY. In MY4, preliminary target prices will be adjusted using a retrospective trend during reconciliation (after the MY ends) that could increase or decrease target prices by up to 10%. This change will make it very difficult for participants to accurately estimate their Net Payment Reconciliation Amount (NPRA) and set internal budgets/expectations.

2. Clinical Episode Service Line Groups

Currently, participants have the option to choose to participate in (and be held accountable for) individual Clinical Episodes (CEs) based on their assessment of the potential clinical and financial opportunity within these CEs. For example, a participant could select to participate in one Orthopedics-focused episode but not another. Starting in MY4, participants will need to select (and be held accountable for) entire Clinical Episode Service Line Groups (CESLGs) rather than selecting individual CEs (see Figure 1 for MY4 episode groupings). The participant will only be allowed to exclude a CE within the CESLG if their baseline volume for that CE falls below a minimum volume threshold (40 episodes or fewer). This change may be concerning for participants who are implementing clinical interventions that are specific to a selected CE, and who may not be able to implement additional clinical

[1] https://innovation.cms.gov/innovation-models/bpci-advanced

[2] https://www.hfma.org/topics/news/2020/07/after-big-payouts--medicare-may-throttle-back-bundled-payment-pr.html

interventions to address the other CEs within the CESLG due to resource limitations or other challenges. While CEs are grouped into CESLGs based on shared characteristics, participants may need to expand or re-structure their current interventions in order to feel comfortable taking risk for additional CEs.

3. Modified Clinical Episode overlap methodology

In MY4, CMS will not allow CEs to overlap in either the baseline or performance periods. In both periods, every episode will be attributed to a single entity without regard to participation status.

This is a change from the current methodology where clinical episodes are allowed to overlap in the baseline period (but not the performance period) and they are attributed to both participants and non-participants—thus maximizing the number of acute care hospitals (ACHs) eligible to participate in BPCI Advanced for any given CE. In the performance period, episodes are preferentially attributed to participants, which maximizes the number of CEs those participants accrue in the model.

According to CMS,[3] this change is meant to "…create consistency in the way that Clinical Episodes are constructed in both the baseline and Performance Periods…" This consistency could improve target price accuracy. However, this update will limit the number of ACHs eligible for CEs (due to fewer baseline episodes being attributed) and will reduce the number of CEs in BPCI Advanced Performance Periods beginning in MY4.

Given the MY4 expansion of participation to include all CEs within a CESLG, it is possible that this change will limit the number of additional unwanted CEs that a given ACH may be held accountable for (as well as the volume of those CEs).

FIGURE 1: MY4 EPISODE GROUPINGS

MY4 CESLGs

Cardiac Care

- Acute Myocardial Infarction (AMI)
- Cardiac Arrhythmia
- Congestive Heart Failure

Cardiac Procedures

- Cardiac Defibrillator (IP)
- Cardiac Defibrillator (OP)
- Cardiac Valve
- Coronary Artery Bypass Graft (CABG)
- Endovascular Cardiac Valve Replacement
- Pacemaker
- Percutaneous Coronary Intervention (PCI – IP)
- Percutaneous Coronary Intervention (PCI – OP)

Gastrointestinal Care

- Disorders of the Liver Except Malignancy, Cirrhosis, or Alcoholic Hepatitis
- Gastrointestinal Hemorrhage
- Gastrointestinal Obstruction
- Inflammatory Bowel Disease

Gastrointestinal Surgery

- Bariatric Surgery
- Major Bowel Procedure

Medical & Critical Care

- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Asthma
- Renal Failure
- Sepsis
- Simple Pneumonia & Respiratory Infections
- Urinary Tract Infection

Neurological Care

- Seizures
- Stroke

Orthopedics

- 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 Lower Extremity (IP and OP)
- Major Joint Replacement of the Upper Extremity

Spinal Procedures

- Back and Neck Except Spinal Fusion (IP)
- Back and Neck Except Spinal Fusion (OP)
- Spinal Fusion

[3] https://innovation.cms.gov/media/document/bcpi-model-overview-fact-sheet-my4

4. MJRLE risk adjustment

CMS will be adding five new procedural flags to the risk adjustment model for major joint replacement of the lower extremity (MJRLE) episodes in MY4:

- Partial Knee Arthroplasty
- Total Knee Arthroplasty
- Partial Hip Arthroplasty
- Total Hip Arthroplasty and Hip Resurfacing
- Ankle and Reattachments and/or Others

Currently, the risk adjustment model underestimates participant spending on hip procedures and overestimates spending on knee procedures.[4] In order to help rectify this issue, CMS is updating the risk adjustment methodology to improve the model's ability to predict costs and therefore set more equitable target prices. This change will decrease target prices for the knee episodes and increase target prices for the hip episodes. The impact of this change on a specific participant will be highly dependent on the participant's mix of services within the MJRLE CE.

5. Removal of the Physician Group Practice offset

The Physical Group Practice (PGP) Offset is a factor in the BPCI Advanced target price setting methodology, which measures a PGP's efficiency relative to the hospital where the PGP initiates CEs. It is applied to target prices for PGPs only, and modifies their target prices to reflect their relative efficiency so that the target for the PGP could be either higher or lower than the average at the hospitals in which they practice. CMS will be eliminating the PGP Offset for MY4 in order to simplify the target pricing methodology. Note that this change has no impact on non-PGP participants.

With the exception of the impact of Patient Case Mix Adjustment (PCMA) risk adjustment, target prices for episodes within a given ACH will be the same (within a CE) regardless of the PGP that triggered the episode. This complicates measurement of PGP performance since these physicians are being compared against a bar that is created not by them, but rather by the historical experience of all the physicians within the hospitals where they practice without adjustment for their relative efficiency. More efficient PGPs will appear to be consistently better performing than less efficient PGPs regardless of their historical efficiency or any efficiency improvements.

This change may lead to reduced PGP participation in BPCI Advanced if PGPs do not feel that their performance is being fairly measured.

Conclusion

BPCI Advanced is adopting a number of methodological changes for MY4 that are, according to CMS, meant to "…ensure that Reconciliation payments reflect actual decreases in spending due to Care Redesign in response to BPCI Advanced and to make BPCI Advanced less susceptible to unpredictable changes in policy, coding, and clinical practice…"[5] These modifications represent a significant change for many participants that may impact their future participation status. It will be important for individual participants to evaluate how the changes to the BPCI Advanced model could impact their performance as they move forward toward MY4.

[4] https://innovation.cms.gov/media/document/bpci-advanced-pricing-methodology-memo-my4

[5] https://innovation.cms.gov/innovation-models/bpci-advanced

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