Early Returns for Groups Participating in Medicare’s BPCI Advanced Program

A review of refinements to the BPCI-A program, insights gained from enrolled groups, and attributes of high-performing participants, with a specific focus on the PCI bundles.

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Early in 2018, the Centers for Medicare & Medicaid Services (CMS) announced a voluntary reboot of the Bundled Payment for Care Improvement (BPCI) initiative, called BPCI Advanced (BPCI-A). Nonbinding applications were due March 12, 2018, just a couple months after the announcement of the program, but applying would allow providers to see their data and begin analyzing whether or not participation would make sense. A final decision on participation was due August 8, 2018, for a start date of October 1, 2018, and 66 cardiovascular participants went forward. Figure 1 displays the volume and type of episode initiators who went forward in each of the cardiology bundles. Providing some level of safety net, CMS allowed an early exit without any liability on March 1, 2019, for groups that entered. Approximately 15% of cardiology groups exited at this opportunity.

CMS opened a new enrollment window on April 24, 2019, so groups that were either on the fence or waiting for additional data to be released now had a second chance to enter the program. The window will close on June 24, 2019. This article describes some important refinements that CMS made to the BPCI-A program for this next enrollment, along with some valuable insights gained from groups that entered the program last fall. A specific focus will be given to the two percutaneous coronary intervention (PCI) bundles (one inpatient and one outpatient).

REVIEW OF THE PROGRAM

BPCI-A sets a total target price for a 90-day episode of care, which includes a specific procedure or admission, and then reconciles a participant’s actual costs against this target. The target price includes a 3% discount, which guarantees 3% savings to CMS. Participants in the program can be physician groups (physician group practices) or hospitals (acute care hospitals). If a participant’s costs are lower than the target, the participant keeps all of the savings. Conversely, if actual costs are higher than the target, the participant is required to repay the overage. The target price is calculated using a very complicated methodology and also blends regional costs with the participant’s historical actual costs. The regional breakdown used to adjust target prices is shown in Figure 2. Participants’ earnings or losses are adjusted in part by their performance in a set of quality metrics.

The original BPCI program, now often referred to as BPCI Classic, did not risk adjust target prices for patient-specific characteristics. However, BPCI-A does adjust for these characteristics, so at the patient level, it provides another level of sophistication and more accuracy in comparing “like” patients. In addition, CMS now uses the claims-based quality metrics, which greatly lessens the administrative burden on participating providers.

CMS replaced the retrospective and unpredictable national trend factor with prospective peer-adjusted trend factors, as these provide much more stability in performance, a key complaint of many providers with BPCI Classic. CMS now also provides very robust claims data that include details on patient comorbidities and other risk factors, allowing more accurate performance calculations for providers and conveners.

One of the key advantages of participation in BPCI-A is the opportunity for groups to qualify as advanced alternative payment model (A-APM) participants, therefore avoiding the merit-based incentive payment system (MIPS). Certain volume thresholds must be satisfied for qualification, but programs that qualify as A-APM participants receive a 5% bonus on the Medicare Physician Fee Schedule. Because the thresholds to qualify for A-APMs are very high, many providers will have to include volumes from other Medicare A-APMs or commercial risk programs to qualify. Providers that do not have enough volume to meet the A-APM threshold can still benefit from favorable scoring under MIPS.
PCI BUNDLES

One of the new outpatient bundles added to the program is PCI. This bundle is triggered by elective PCI procedures performed in the hospital outpatient department setting. The spending associated with this bundle includes the anchor outpatient PCI procedure and all services that occur in the 90-day postprocedure period, including readmissions, emergency department visits, postacute care services, office visits, and all of the associated professional services revenue. There are a few exceptions for spending counted in the bundle, namely spending associated with inpatient cancer- and trauma-related services. Drugs paid for under Medicare Part D, such as antiplatelet medications, are also excluded.

Although not new, there is also an inpatient PCI bundle, which is triggered by the inpatient PCI procedure associated with the diagnosis-related groups (DRGs) 246–251, as well as other intracardiac procedures associated with DRGs 273–274. As with the outpatient PCI bundles, the total costs include all services in the 90-day period after discharge.

One common barrier—and a bit of a surprise—to achieving overall savings in the outpatient PCI bundle was a small number of very expensive staged transcatheter aortic valve replacements (TAVRs), which are counted as readmissions in the BPCI-A program. Among providers who went live with Archway Health in outpatient PCI but decided to drop that bundle on March 1, 2019, the average estimated losses were $2,100 per episode, driven by a small percentage of cases that had planned TAVRs that were clinically appropriate (Figure 3).

Looking deep into the PCI data, there was less variability found in groups with an established formal policy around staging of procedures than those without. This would lead the authors to consider this a best practice. However, even within this cohort with a formal policy, variability in costs was noted. Additionally, there will be clinical situations in which a PCI prior to TAVR is the best course of treatment for the patient. Because of this, it is hoped that CMS will reconsider the treatment of TAVR as a readmission within the PCI bundle as it refines the program.

ATTRIBUTES OF HIGH-PERFORMING PARTICIPANTS

Perhaps the single most important trait of groups that have been successful in BPCI-A thus far is the belief in and commitment to value-based health care. Programs that have value-based health care as part of their strategic plan and have committed resources to the value transition—not just from a revenue generation perspective, but also for patient care improvement—were more likely to show success.

The commitment of resources, both financial and human, is also critical to success. Higher-performing groups tended to have an executive sponsor, a knowledgeable BPCI program lead, dedicated coordinator(s), and solid physician engagement. Beyond just the leadership team, higher-performing groups have attained buy-in from stakeholders throughout the organization, from the bedside to the registration desk.

Data and expert analytics are critical with any risk program, and BPCI-A is no exception. Successful groups have been able to wrangle the vast and varied data inputs into meaningful and action-oriented outputs, either using internal resources or partnering with expert conveners and external data managers. These data create useful

"We were pleasantly surprised with how the risk adjustment in BPCI-A favorably impacted our target price. The only exception would be those very sick patients who happened to have no claims in the 90 days prior to the bundle, so they had no upward adjustment on risk."

—Ed Coyne, MD, President of Cardiovascular Medicine, PC, Davenport, Iowa
dashboards for tracking critical performance indicators, provide clinical inputs for individual patient care plan development, and, critically, quickly and easily identify patients who will be included in the participating bundle.

In addition, higher-performing groups have an infrastructure in place to manage process improvement initiatives, such as staging policies, care plan redesign, and general standardization of processes. This same infrastructure will allow for the development of preferred provider networks (with skilled nursing, home health, and other bundle players) and to ensure accountability both within the participating provider organization and those that impact total bundle performance.

It is important to note that participation in BPCI Classic was not seen as a predictor of early success in BPCI-A; in other words, programs entirely new to bundled payments were as likely to be seeing positive early performance as those with experience. Thus, for groups that have yet to participate in either BPCI Classic or BPCI-A, this should not be seen as a deterrent to entering at the next open enrollment window.

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REASONS YOU MAY WANT TO PARTICIPATE

As previously noted, CMS has opened a new enrollment window that closes on June 24, 2019, and this will be the last opportunity to join BPCI-A. Similar to the original opening, providers can sign up without committing to participation and receive their full claims data around each bundle they select. These data are invaluable for assessing how an organization is performing against its peers, both regionally and nationally, and provide a wealth of intelligence beyond the bundles themselves.

Participation in bundles is also a way for organizations to learn how to take risks within a relatively low-threat, protected environment. Armed with deep historical data, participation can be limited to just those bundles where success is very likely, thereby mitigating further risk. For groups that have a very low tolerance for any potential losses, there are third-party conveners willing to shelter exposure in exchange for greater upside participation.

Because CMS has made clear its intentions to move further into bundled models, the next generation is likely to be mandatory and gaining experience when providers can pick and choose their bundles seems like a wise course. Additionally, self-funded employers have shown a deep affinity to bundled payment models as have some commercial insurance plans. Particularly in the case of employers, these entities have no restrictions of Stark law, Anti-Kickback Statute, and Fraud and Abuse law. As one larger employer executive succinctly stated recently, “We will disrupt health care.”

Although far from an easy hurdle to clear, one major opportunity with BPCI-A participation is the 5% bonus potential under the Medicare Access and CHIP Reauthorization Act A-APM track. For many groups, this payment alone can be worth hundreds of thousands of dollars per year and has motivated several groups to jump in.

CONCLUSION

The BPCI-A program is not uncomplicated, but at its very core, it is a model that most providers fundamentally understand: If I can maintain high quality and drive down cost, I will be rewarded. At present, the program is voluntary allowing providers to pick and choose, based on historical performance data, only those bundles where they are likely to succeed. In addition, there are third-party resources that can help with the data, care delivery redesign and infrastructure development, or even share any downside risk. Given this and the likelihood that mandatory risk programs are forthcoming, either from CMS or from nonfederal payment parties, participation at some level with BPCI-A may make good sense for your organization.

“Staging of procedures has been very common for years...With bundles, we’ve gone back and taken a hard look at this practice and, when clinically appropriate, are doing all interventions in the same procedure. We keep a close eye on it, but our physicians feel comfortable, in most cases, performing TAVR without a prior revascularization or sometimes within the same procedure.”

–Ed Coyne, MD

“Overall, the BPCI-A program has us tracking and monitoring patients more closely in real time, using simple tools provided to us by our convener. This is allowing us to provide better care at a lower cost. That’s exactly the point of the program and aligns very nicely with our organizational goals.”

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