Bundled Payments for Care Improvement Advanced | BPCI Advanced

Introduction to Pricing Methodology

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Welcome, BPCI Advanced Applicants. This webcast is an introduction to BPCI Advanced pricing methodology intended for Model Applicants. The information shared in this webcast can also be a refresher for current Model Participants.

Webcast Facilitators

David Bowen
Health Insurance Specialist

Aaron Broun
Social Science Research Analyst

BPCI Advanced Model Team / Division of Payment Models (DPM)
Patient Care Models Group (PCMG)
Center for Medicare and Medicaid Innovation (CMMI)

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My name is David Bowen, and I'm an analyst on the BPCI Advanced Model Team. I'm joined here today by my colleague Aaron Broun, and we are excited to share more information on the pricing methodology within BPCI Advanced.

Webcast Outline

- **Pricing Overview and Updates**
- **Clinical Episode Categories and Service Line Group Selection**
- **Pricing Methodology**
- **Reconciliation Process**
- **Key Takeaways**

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This webcast will cover an overview of the pricing methodology and updates, Clinical Episode Service Line Group selection, and the pricing methodology process, and the Reconciliation process and finally with a summary.

Learning Objectives

At the conclusion of this webcast, Participants will be able to understand:

- What Clinical Episode Service Line Groups (CESLGs) are
- How BPCI Advanced calculates Target Prices
- The Reconciliation process and the Composite Quality Score (CQS)

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At the conclusion of this webcast, you should understand what Clinical Episode Service Line Groups (CESLGs) are and how BPCI Advanced calculates Target Prices, conducts Reconciliation and adjusts payments based on the Composite Quality Score, or CQS.

List of Common Acronyms Used in BPCI Advanced

Pricing Methodology Acronyms	
ACH – Acute Care Hospital	**MJRUE** – Major Joint Replacement of the Upper Extremity
AMI – Acute Myocardial Infarction	**MS-DRG** – Medicare Severity Diagnosis Related Groups
APC – Ambulatory Procedure Codes	**NPRA** – Net Payment Reconciliation Amount
CECs – Clinical Episode Categories	**OP** – Outpatient
CESLGs – Clinical Episode Service Line Groups	**PCMA** – Patient Case Mix Adjustment
CQS – Composite Quality Score	**PGHA** – Peer Group Historical Adjustment
HCPCS – Healthcare Common Procedure Coding System	**PGP** – Physician Group Practice
HCC – Hierarchical Condition Category	**PGT** – Peer Group Trend
HBP – Hospital Benchmark Price	**PGTFA** – Peer Group Trend Factor Adjustment
IP – Inpatient	**PP** – Performance Periods
MJRLE – Major Joint Replacement of the Lower Extremity	**SBS** – Standardized Baseline Spending

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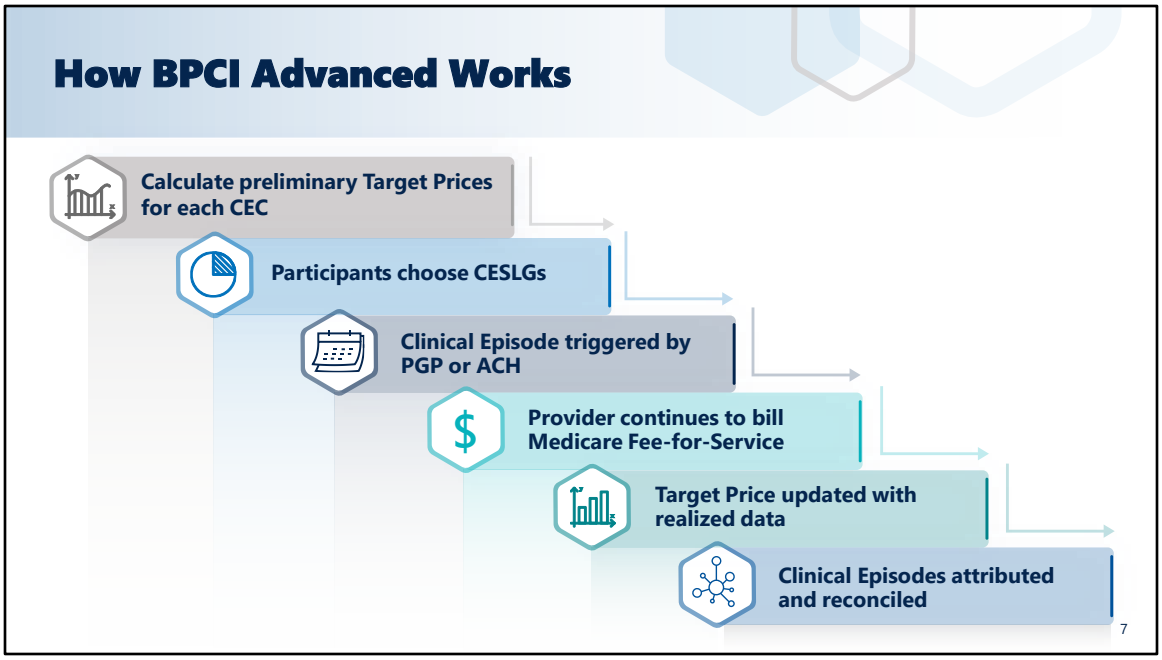
The terms listed on the slide will be used throughout the presentation. Each term will be defined at its first use and abbreviated at later uses.

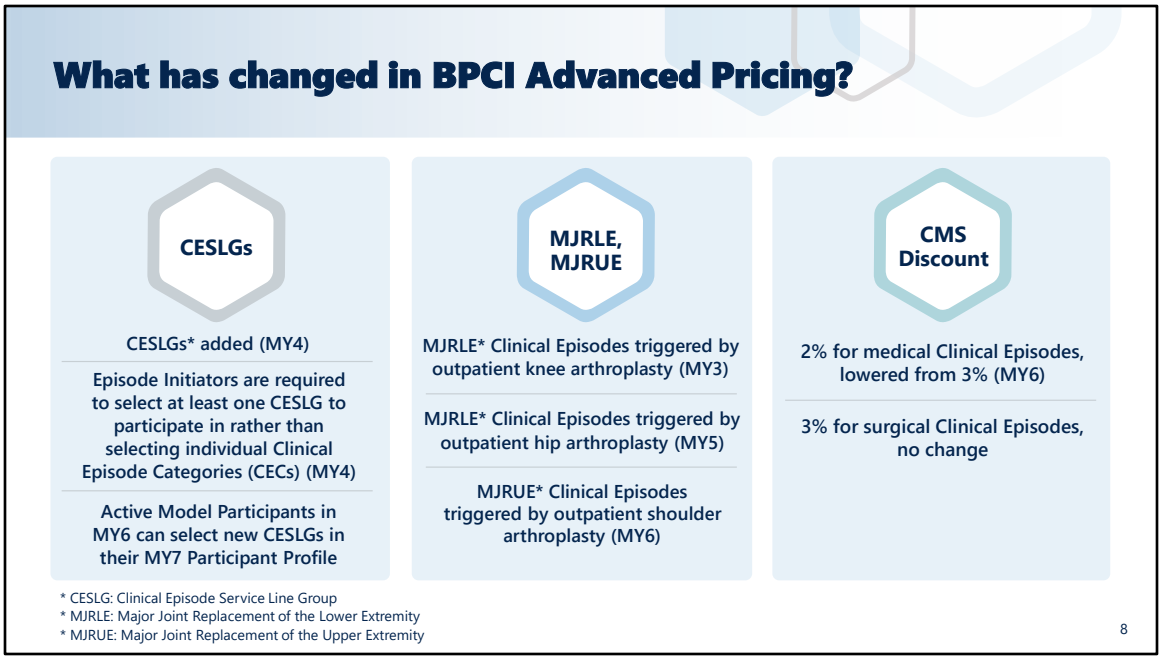
On to the first section, the basics of BPCI Advanced pricing methodology and the historical updates that have been made throughout the past Model Years.



The pricing methodology process for BPCI Advanced is as follows:

- CMS uses baseline data to calculate preliminary Target Prices for each Clinical Episode Category.
- Participants then choose the Service Line Groups for which they will be held accountable.
- A patient then triggers a Clinical Episode through an inpatient hospital stay or an outpatient procedure.
- The provider continues to bill Medicare under the standard Fee-for-Service system.
- And at the end of each Performance Period, CMS updates the Target Price with realized trends.
- In the final step of the pricing flow, Clinical Episodes are attributed to Participants, and CMS conducts Reconciliation to compare the final Target Prices against Fee-for-Service billing from Medicare claims.

Please note that CMS does not expect to make significant changes to the pricing methodology for Model Year 7.



To begin, we will cover the changes the Model has implemented over the years in response to feedback from Model Participants.

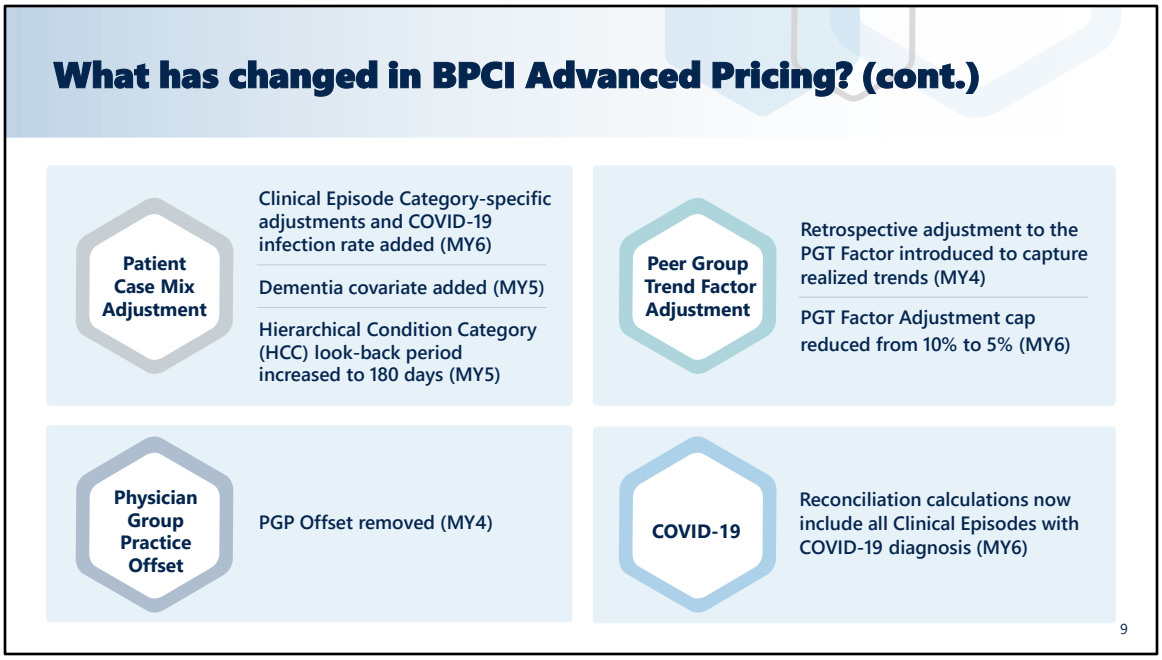
Since Model Year 4, Participants choose Service Line Groups instead of individual Clinical Episode Categories. Service Line Groups are made up of Clinical Episode Categories, and an Applicant who selects a Service Line Group participates in all Clinical Episode Categories within this group.

For Model Year 7, both Applicants and current Participants can make new Service Line Group selections in their Participant Profiles.

The joint-related Clinical Episodes now cover more procedures. Currently, Major Joint Replacement of the Lower Extremity, or MJRLE, includes outpatient knee arthroplasty and outpatient hip arthroplasty.

Meanwhile, Major Joint Replacement of the Upper Extremity, or MJRUE, now includes outpatient shoulder arthroplasty.

Additionally, the CMS discount factor was lowered from 3% to 2% for medical Clinical Episodes. The discount remains at 3% for surgical Clinical Episodes.

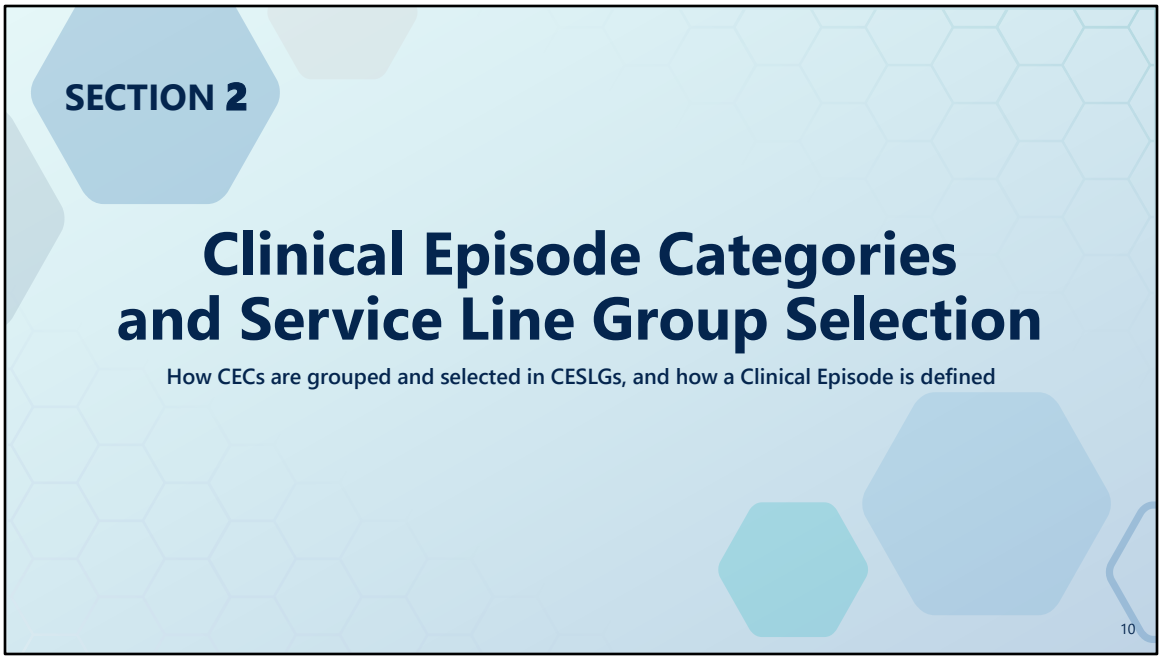


The Patient Case Mix Adjustment, or the PCMA, has several new factors added including dementia, Clinical Episode-specific adjustments and COVID-19 infection rate. The Hierarchical Condition Category, or HCC, look-back period also increased to 180 days.

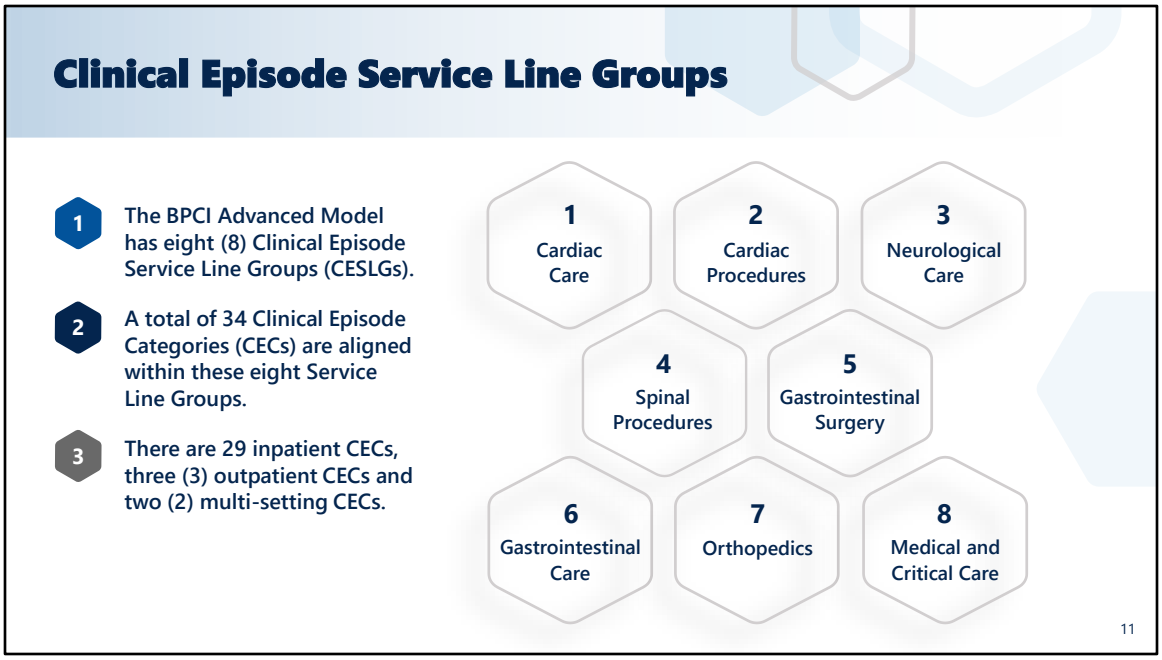
In Model Year 4, retrospective adjustment to the Peer Group Trend, or PGT, Factor was introduced to capture realized trends. In Model Year 6, the PGT Factor Adjustment cap was reduced from 10% to 5%.

For physician group practices, or PGPs, the PGP Offset was removed in Model Year 4.

And lastly, in line with Participant feedback, we adjusted our COVID-19 methodology from MY5 to MY6 so that Participants could be accountable for COVID-19 Clinical Episodes during Reconciliation.



Now that we covered an overview of the pricing process, we review how Clinical Episode Categories are grouped and selected in Service Line Groups.



The Model has 34 Clinical Episode Categories grouped into eight Service Line Groups, which you see here. In total, there are 29 Inpatient Clinical Episode Categories, and three Outpatient Clinical Episode Categories and two multi-setting Clinical Episode Categories.

Service Line Group selections for Model Year 7 will be made in the Participant Profile and are expected to be binding through Model Year 8.

CESLGs and Clinical Episode Categories

Cardiac Care	Neurological Care	Spinal Procedures	Gastrointestinal Surgery	Gastrointestinal Care	Orthopedics	Cardiac Procedures	Medical and Critical Care
☐ Acute Myocardia Infarction ☐ Cardiac Arrhythmia ☐ Congestive Heart Failure	☐ Seizures ☐ Stroke	☐ Back and Neck Except Spinal Fusion (Inpatient) ☐ Back and Neck Except Spinal Fusion (Outpatient) ☐ Spinal Fusion	☐ Bariatric Surgery ☐ Major Bowel Procedure	☐ Gastrointestinal Hemorrhage ☐ Gastrointestinal Obstruction ☐ Inflammatory Bowel Disease ☐ Disorders of The Liver Except Malignancy, Cirrhosis, or Alcoholic Hepatitis	☐ 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 (MJRLE) (Multi-setting Inpatient/Outpatient) ☐ Major Joint Replacement of the Upper Extremity (MJRUE) (Multi-setting Inpatient/Outpatient)	☐ Cardiac Defibrillator (Inpatient) ☐ Cardiac Defibrillator (Outpatient) ☐ Cardiac Valve ☐ Coronary Artery Bypass Graft ☐ Endovascular Cardiac Valve Replacement ☐ Pacemaker ☐ Percutaneous Coronary Intervention (PCI) (Inpatient) ☐ Percutaneous Coronary Intervention (PCI) (Outpatient)	☐ Sepsis ☐ Cellulitis ☐ Renal Failure ☐ Urinary Tract Infection ☐ Simple Pneumonia and Respiratory Infections ☐ Chronic Obstructive Pulmonary Disease, Bronchitis, Asthma

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The slide shows the specific Clinical Episode Categories under each Service Line Group.

Defining a Clinical Episode

1. An inpatient episode (IP) begins with a hospitalization – called the Anchor Stay – and lasts for an additional 90 days, beginning on the day of discharge.
2. An outpatient episode (OP) begins with an outpatient procedure – called an Anchor Procedure – and lasts for 90 days beginning on the day of completion of the procedure.
3. CMS will use Medicare Severity Diagnosis-Related Group (MS-DRG) codes to identify the inpatient stay and Healthcare Common Procedure Coding System (HCPCS) codes to identify the outpatient procedure.

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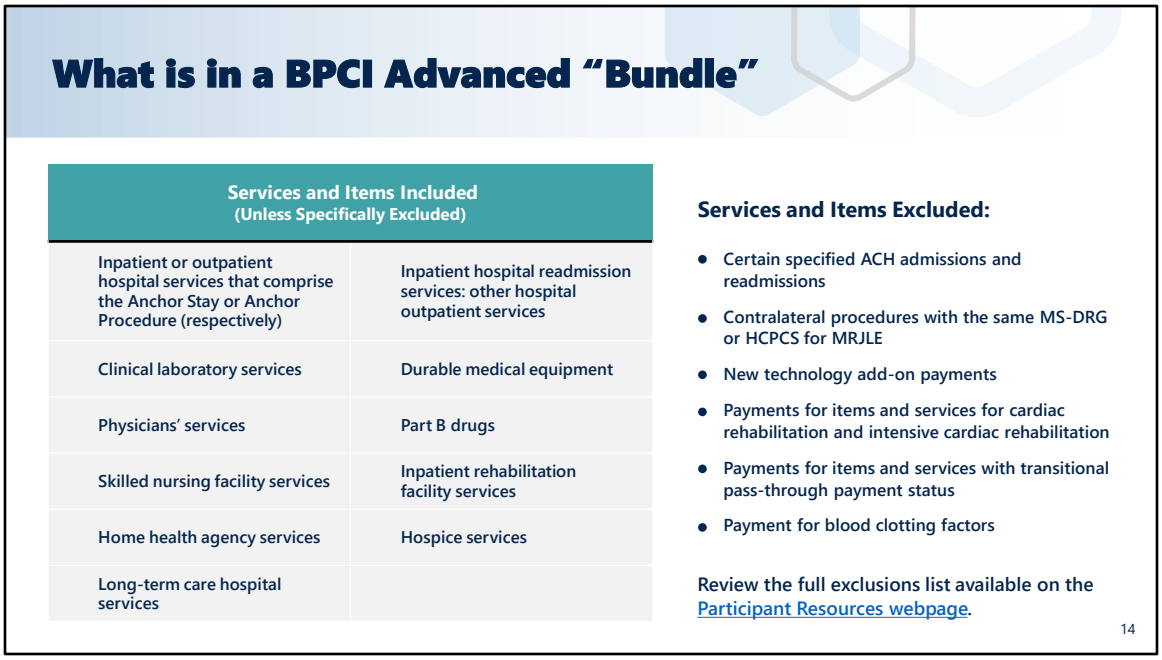
Clinical Episodes are inpatient stays or outpatient visits that a patient triggers by having certain Medicare Severity Diagnosis Related Group or MS-DRG or Healthcare Common Procedure Coding System or otherwise known as HCPCS codes on the Medicare claim. This trigger is referred to as the anchor stay or anchor procedure respectively. A Clinical Episode covers the initial trigger and the 90 days beginning on the date of the discharge or procedure completion.

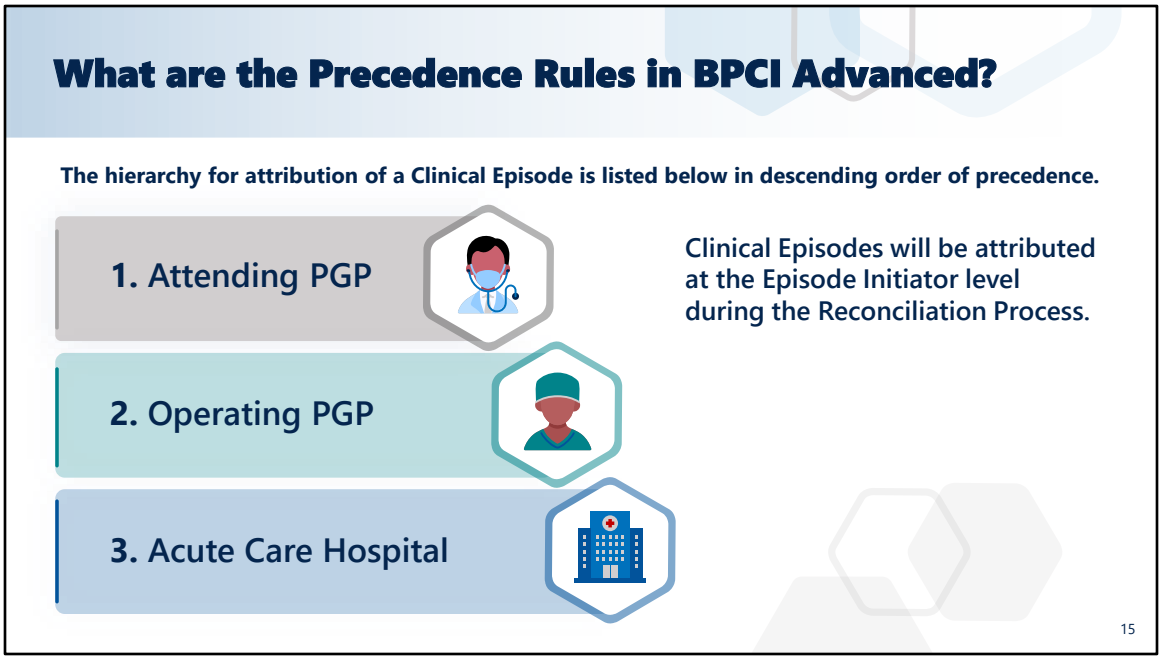


Unless specifically excluded, a BPCI Advanced Clinical Episode includes the following services:

- Inpatient or outpatient hospital services that comprise the anchor stay or anchor procedure;
- Clinical laboratory services;
- Physicians' services;
- Skilled nursing facility services;
- Home health agency services;
- Long-term care hospital services;
- Inpatient hospital readmission services and other hospital outpatient services;
- Durable medical equipment;
- Part B drugs;
- Inpatient rehabilitation facility services; and
- Hospice services.

Certain services and items are excluded from each Clinical Episode, such as: certain specific Acute Care Hospital (ACH) admissions and readmissions; contralateral procedures with the same MS-DRG or HCPCS for MJRLE; new technology add-on payments; payments for items and services for cardiac rehabilitation and intensive cardiac rehabilitation; payments for items and services with transitional pass-through payment status; and payment for blood clotting factors.

For the full exclusion list, please refer to the Participant Resources webpage.



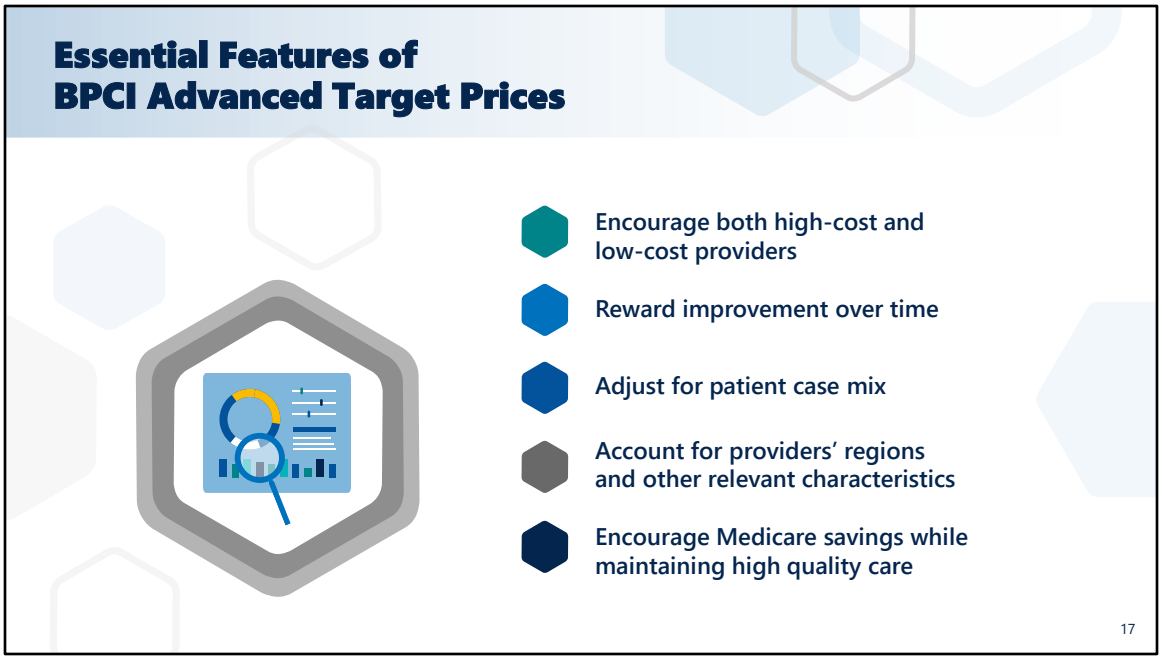
A BPCI Advanced Clinical Episode is attributed based on the following precedence rules:

First, attribute the Clinical Episode to the attending Physician Group Practice (PGP). If there is no attending PGP, the Clinical Episode is attributed to the operating PGP and then the Acute Care Hospital (ACH).

Clinical Episodes will be attributed at the Episode Initiator, or EI, level during the Reconciliation process.

Now I'll hand it over to my colleague Aaron Broun to tell us some more about the pricing methodology.

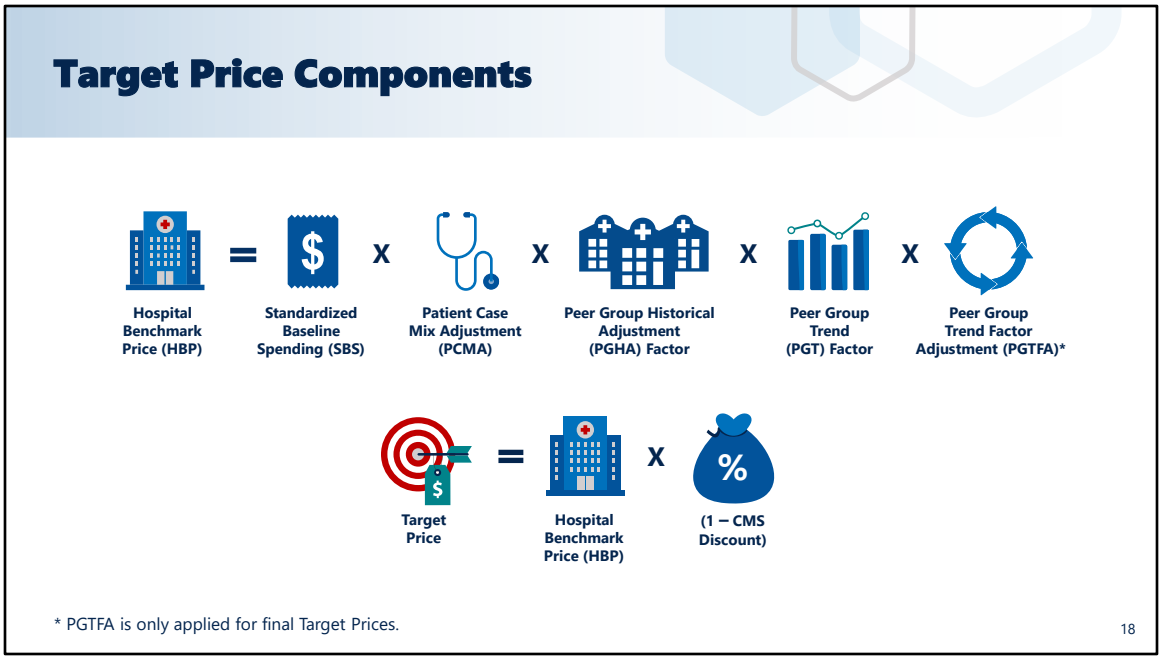
We have covered the Clinical Episode Service Line Group selection process and now we will go through the Model's pricing methodology.



The BPCI Advanced Target Prices are constructed to satisfy the following essential features:

- Encourage both high- and low-cost providers to participate;
- Reward Participants' improvement over time;
- Adjust for variation in patient case mix;
- Account for levels and trends of Clinical Episode spending that are distinct according to providers' regions and other relevant provider characteristics; and
- Encourage Medicare savings while maintaining high-quality care.

Based on these guidelines, the Model understands that Participants have specific circumstances and will balance Target Prices with peer group and patient mix adjustments.



The slide shows the two main formulas used for calculating pricing for hospitals.

The Hospital Benchmark Price or HBP is comprised of five factors: Standardized Baseline Spending or SBS, Patient Case Mix Adjustment or PCMA, Peer Group Historical Adjustment or PGHA, Peer Group Trend or PGT Factor, and, for final Target Prices, PGT Factor Adjustment or PGTFA.

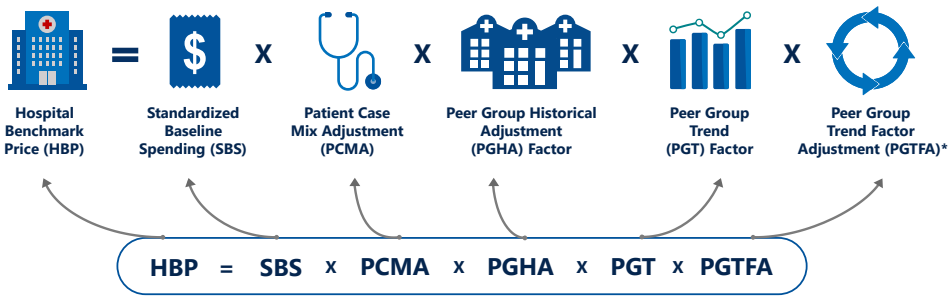
The Target Price calculation is comprised of the HBP and the CMS discount.

The HBP provides the basic dollar value of the Target Price for each hospital and each Clinical Episode Category.

In the next formula, we see that the Model calculated the Target Price by taking the HBP and applying the CMS discount. As a reminder, the CMS discount is 2% for medical Clinical Episode Categories and 3% for surgical Clinical Episode Categories.

The calculated Target Prices blend Participants' historical performance with trends and levels in each Clinical Episode Category's spending for each peer group, which we will elaborate on next.

Target Price Components Explained



* PGTFA is only applied for final Target Prices.

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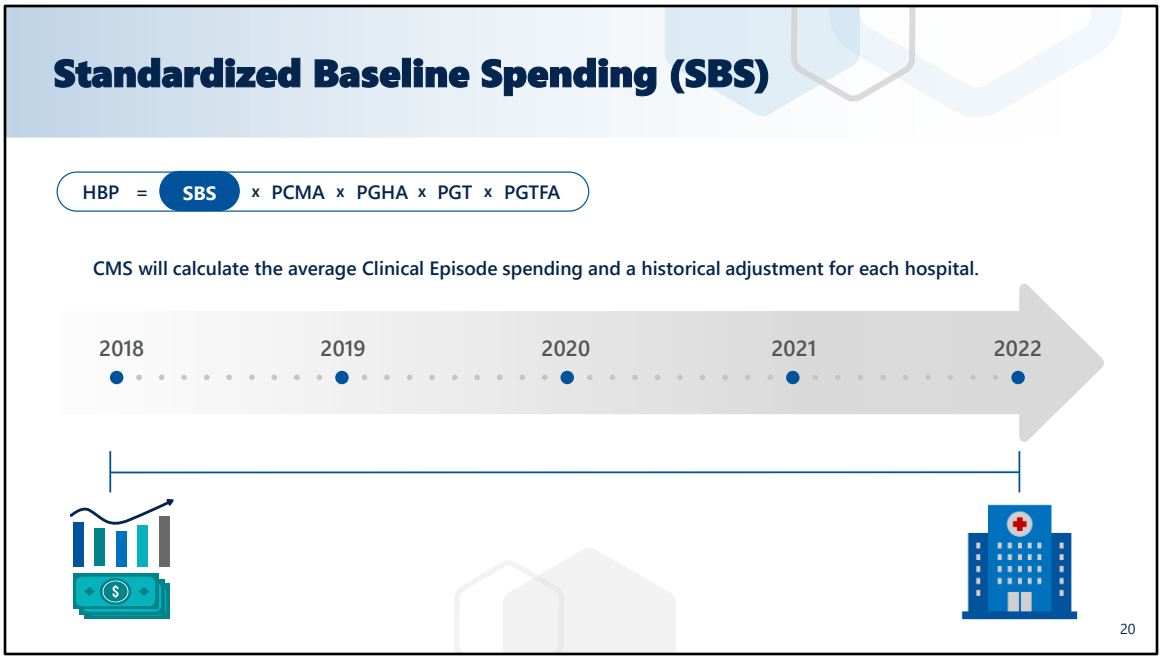
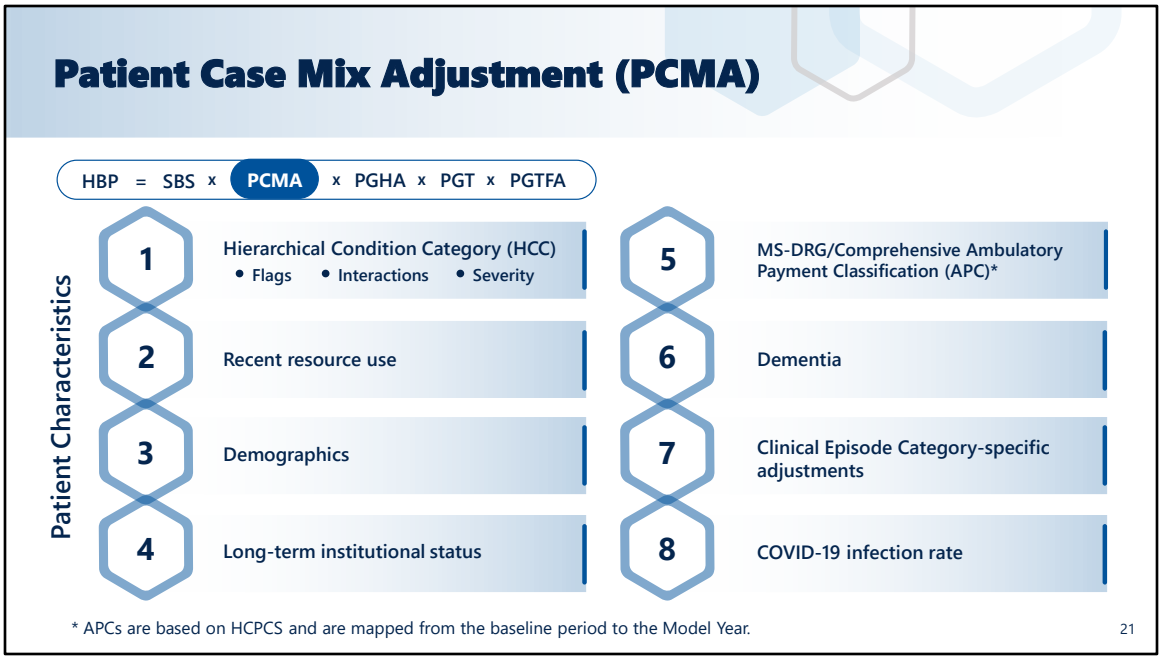
As we explore the components of the HBP in the following sections, we will keep this abbreviated formula as a visual aid, so you can see how they fit together.



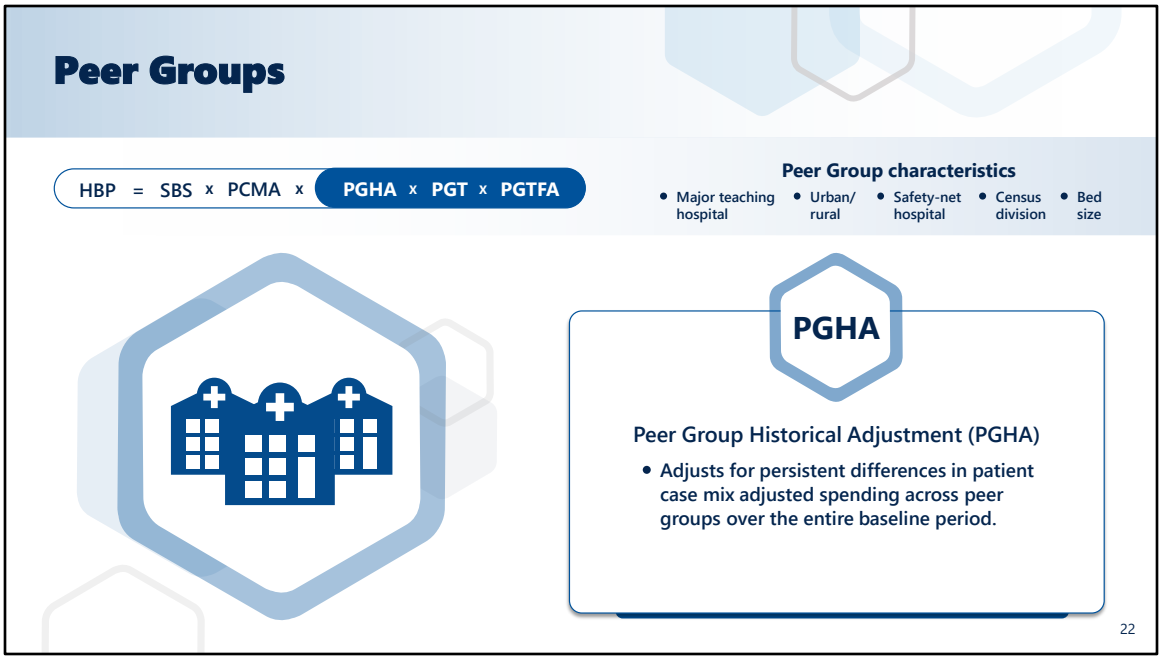
The first component of the Hospital Benchmark Price calculation is the SBS. The SBS accounts for the historical spending adjustment of acute care hospitals, or ACHs, in the baseline period by calculating risk- and peer-standardized Clinical Episode spending.



Next, the Model calculates the PCMA.

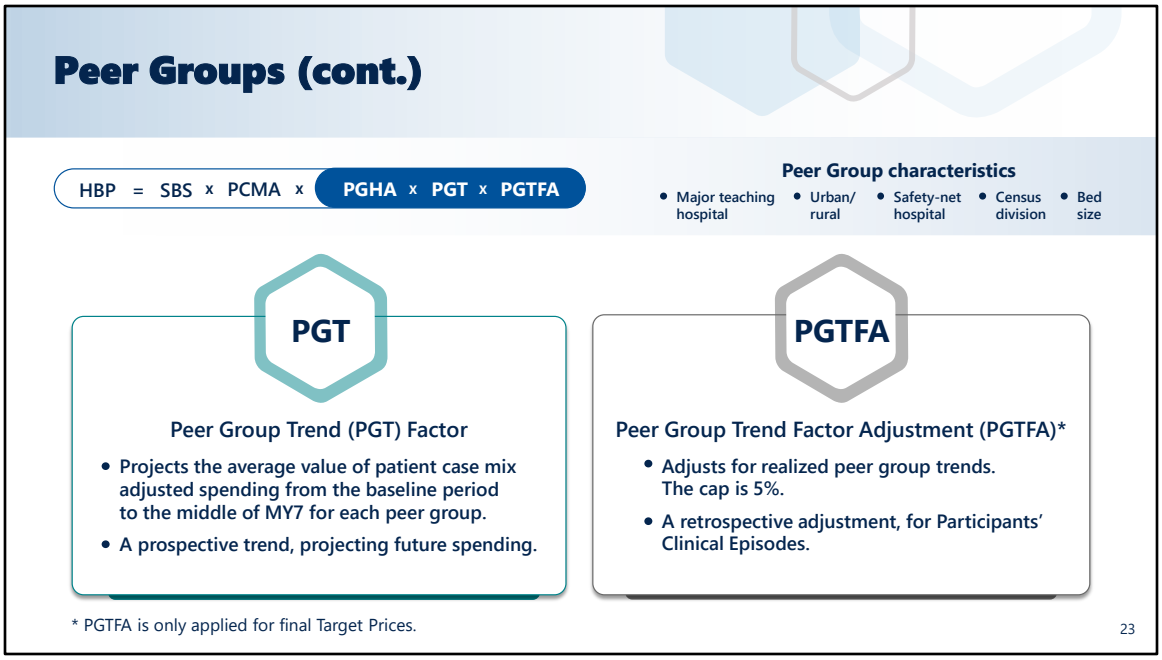
The PCMA adjusts for varying levels of severity in an ACH's patient case mix that are outside the control of the ACH. This value is only representative of the spending conditional on an ACH's patient case mix.

All the factors on the slide contribute toward the PCMA. The preliminary PCMA is based on Clinical Episodes from the baseline period, but the final calculation is based on Clinical Episodes in the Performance Period.



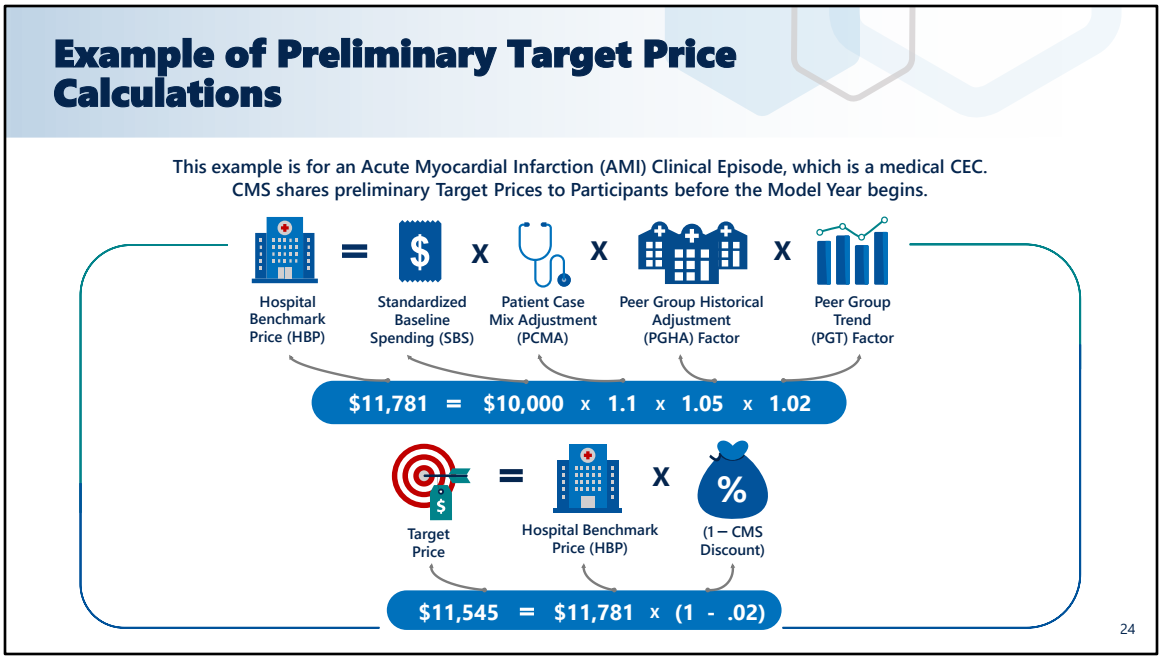
The peer group component of the Hospital Benchmark Price calculation consists of the PGHA, the PGT Factor and the subsequent PGT Factor Adjustment. These are currently calculated based on the hospital's peer group characteristics listed on the right side of the slide.

The PGHA adjusts for persistent differences in patient case mix adjusted spending across peer groups, over the entire baseline period.



The PGT Factor projects the average value of patient case mix adjusted spending from the baseline period to the middle of Model Year 7 for each peer group. The PGT is the "prospective trend" in peer group spending, projected by baseline period data.

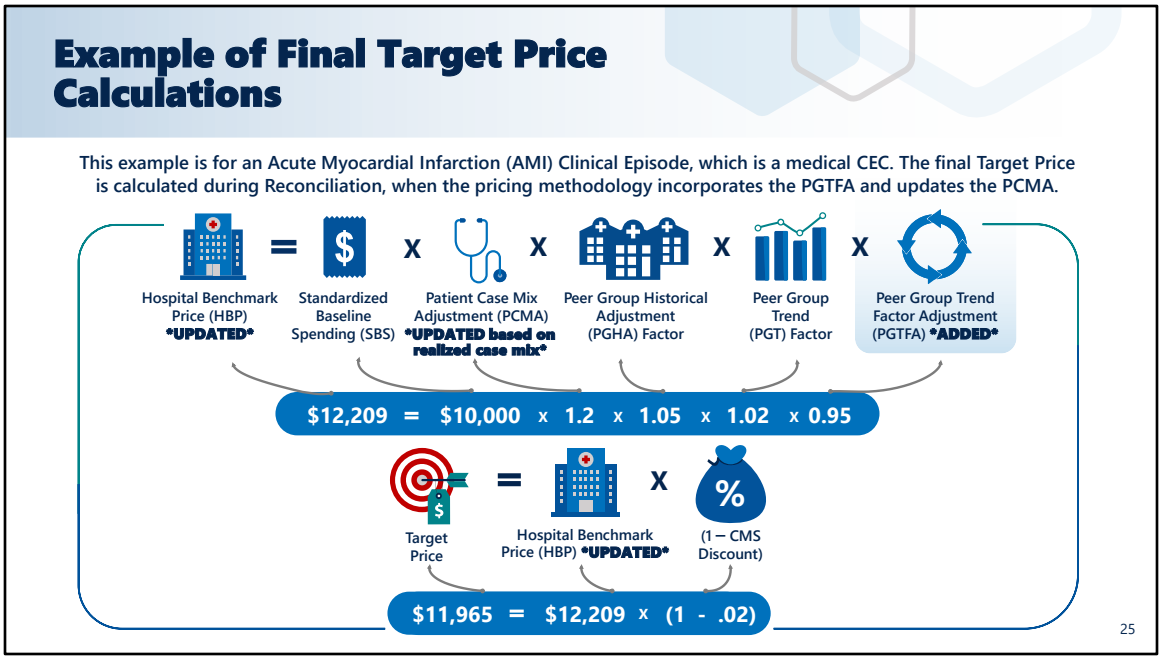
The PGT Factor Adjustment, or "retrospective adjustment," adjusts for realized peer group trends that are driven by unanticipated, systemic factors, such as the patient population changing over time.



Using each component of the Hospital Benchmark Price or HBP, we can calculate the HBP by multiplying all the components together.

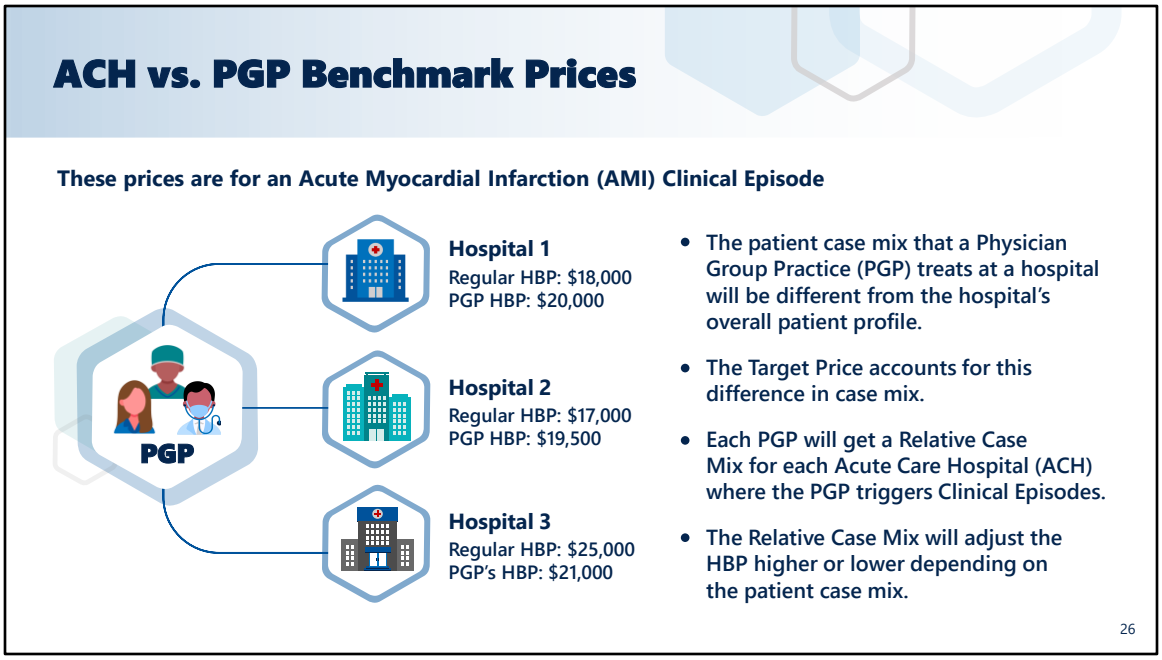
For example, this slide shows an example preliminary Target Price for a medical Acute Myocardial Infarction, or AMI, Clinical Episode, where an SBS of $10,000 is multiplied with a PCMA of 1.1, a PGHA of 1.05 and a PGT of 1.02, to yield a Hospital Benchmark Price of $11,781.

Since AMI is a medical Clinical Episode, the Model applies the CMS discount of 2% to the HBP for a preliminary Target Price of $11,545. Next, let's show how the Model reaches the final Target Price.



The Model only calculates the final Target Price when it incorporates the PGTFA and updates the PCMA. The PGTFA is a retrospective adjustment that the Model applies after Participants have completed Clinical Episodes in the Model. Therefore, Participants need to wait until Reconciliation results are released to see the PGTFA and its impact on the final Target Price. At the same time, the PCMA is also updated to reflect the realized case mix during the Performance Period.

On the slide, you can see on the right side that the PGTFA is included in the formula with a value of 0.95. This, along with the updated PCMA, adjusts the Hospital Benchmark Price to $12,209, and after applying the CMS discount, the final Target Price becomes $11,965.



As covered earlier, an ACH will receive one preliminary Target Price for each Clinical Episode Category. A PGP may receive multiple preliminary Target Prices for each Clinical Episode Category for the ACHs where the PGP triggers Clinical Episodes.

BPCI Advanced recognizes that the patient case mix of a PGP's Clinical Episodes at an ACH will be different from the patient case mix of the entire hospital.

The Target Price will account for this difference in case mix. The Model will account for this by calculating a Relative Case Mix for each PGP and each ACH where they trigger Clinical Episodes.

The Relative Case Mix will then raise or lower the Hospital Benchmark Price depending on the patient case mix.

For example, the slide shows sample numbers for the AMI Clinical Episode Category. Target Prices have been calculated for three hospitals and each hospital has an ACH price and a PGP price for a particular PGP. On the top, Hospital 1 has a Benchmark Price of $18,000, but the PGP's Benchmark Price at that same ACH is $20,000 because the Relative Case Mix adjusts the price higher to account for a riskier patient case mix. Meanwhile, in Hospital 3, the PGP's Benchmark Price at that ACH is lower than the regular Hospital Benchmark Price, because the case mix of the PGP's patients there is less risky.

What is the Timeline for Preliminary Target Price Distribution?

- **Anticipated Date for MY7 Target Prices: September 2023**

  Baseline Period for MY7:
  October 1, 2018 – September 30, 2022

- **Anticipated Date for MY8 Target Prices: September 2024**

  Anticipated Baseline Period for MY8:
  October 1, 2019 – September 30, 2023

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We have covered the calculations for Target Pricing and can now take a look at the timeline.

Preliminary Target Prices are based on claims from the baseline period, which, for Model Year 7, is October 2018 through September 2022. Model Applicants and Participants are expected to receive their preliminary Target Prices in September 2023.

For Model Year 8, the anticipated baseline period is October 2019 through September 2023 and the anticipated date for receiving preliminary Target Prices is September 2024.

Episode Initiator Eligibility and Preliminary Target Prices

To receive preliminary Target Prices, hospitals must have at least 41 Clinical Episodes in the baseline period.

- The threshold stabilizes Clinical Episode Target Prices and protects ACHs against outlier cases.
- PGPs can select any CEC even if they do not receive a preliminary Target Price.
- ACHs can only select a CEC if they receive a preliminary Target Price.

Episode Initiator	PGP/ ACH	Hospital CCN/TIN	Associated Hospital	4-Year Baseline Period Clinical Episode Count for 1 CEC	Eligible for Participation	Preliminary Target Price Calculated
1	ACH	CCN1		39	N	N
2	ACH	CCN2		40	N	N
3	ACH	CCN3		41	Y	Y
4	ACH	CCN4		42	Y	Y
5	PGP	TIN1	CCN1	20	Y	N
6	PGP	TIN2	CCN2	21	Y	N
7	PGP	TIN3	CCN3	20	Y	Y
8	PGP	TIN2	CCN4	21	Y	Y
9	PGP	TIN3	CCN4	20	Y	Y

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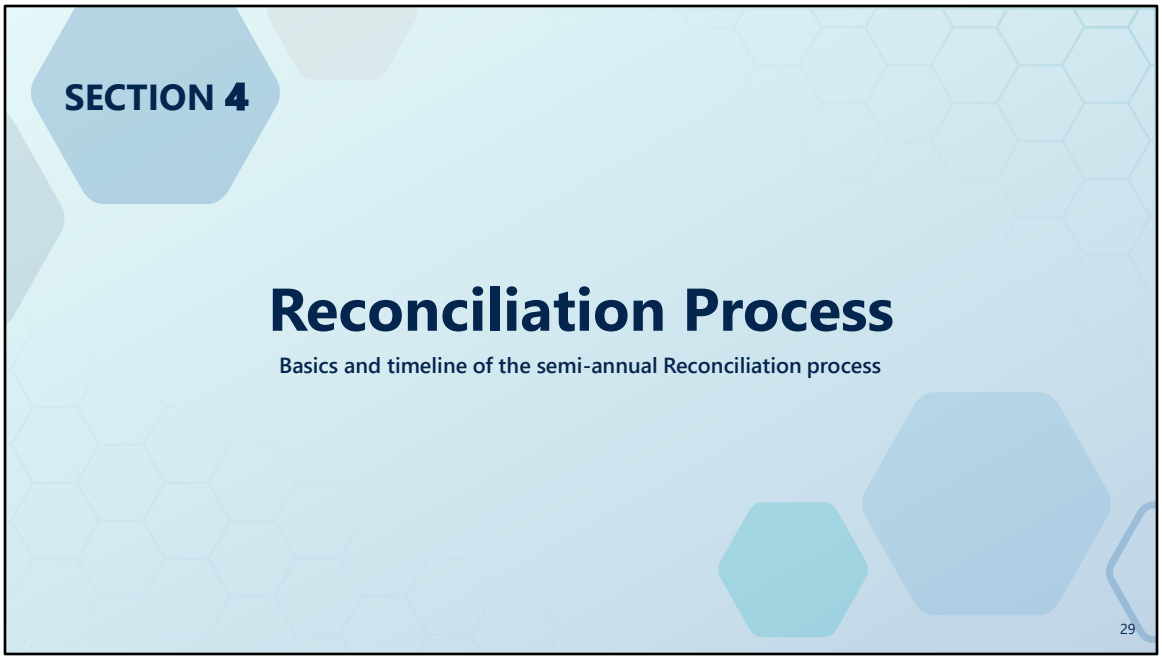
Now let us look at how Episode Initiators can be eligible for participation in a Clinical Episode Category and whether they will receive preliminary Target Prices. To receive preliminary Target Prices, hospitals must initiate at least 41 Clinical Episodes during the baseline period. This threshold stabilizes Target Prices and protects hospitals against outlier cases.

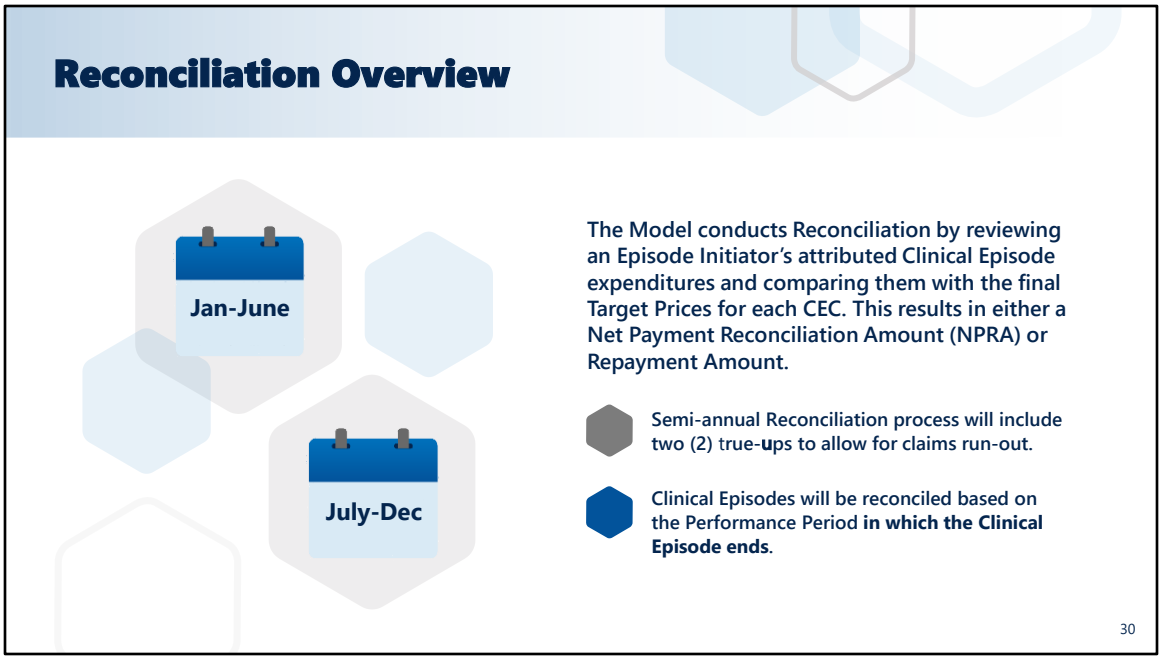
The table shows examples for hospitals and PGPs.

Let's look at what happens with ACH Participants first. Hospitals one and two do not meet the 41 Clinical Episode threshold and, therefore, are ineligible for participation and will not have preliminary Target Prices. Hospitals three and four do meet the threshold and are both eligible for participation and will receive preliminary Target Price calculations.

Now let's look at what happens with PGP Participants in the second half of the table. PGPs can always participate in any Clinical Episode, so you can see all the rows indicate 'yes' for participation. However, if the associated ACH where the PGP initiates Clinical Episodes does not meet the 41-episode threshold, no preliminary Target Price will be calculated for the PGP. Remember how Hospitals one and two did not have enough Clinical Episodes? A PGP will, therefore, not receive a preliminary Target Price for those locations, even if they are eligible for participation. A PGP will receive a preliminary Target Price if they have at least one hospital that meets the 41 Clinical Episode threshold.

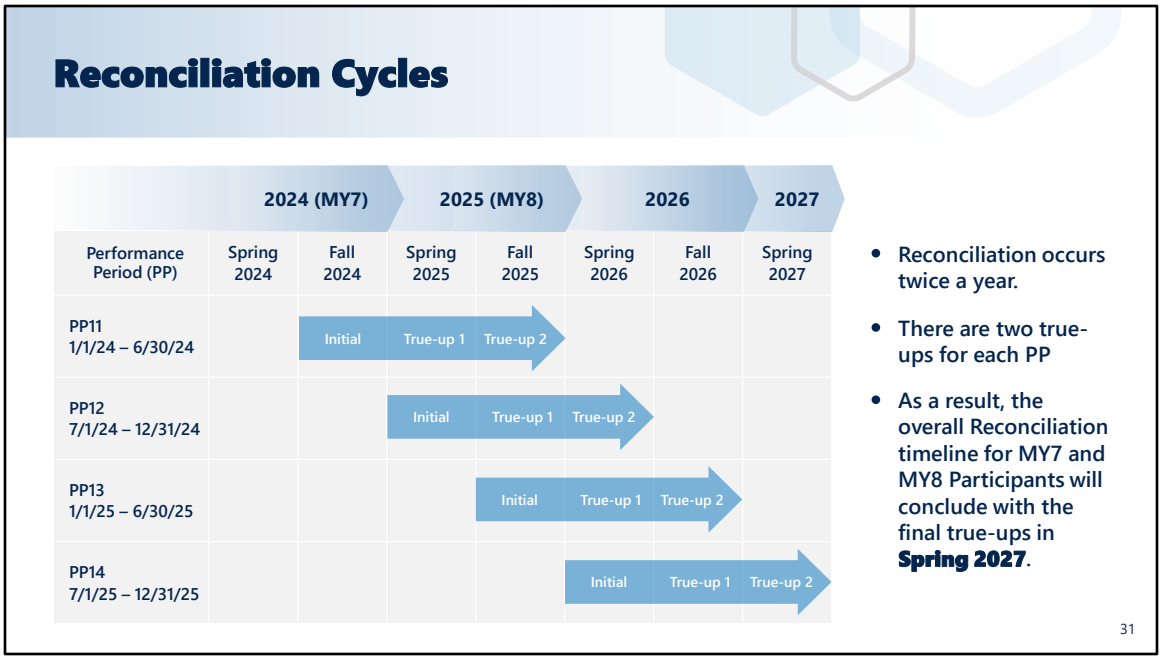


After going through HBP and Target Pricing calculations, the last stage of the pricing process is Reconciliation. Next, we will cover the basics and timeline of the semiannual Reconciliation process.



Performance Periods are specified as January through June and July through December. Clinical Episodes will be reconciled based on the Performance Period in which the Clinical Episode ends. During the Reconciliation process, CMS will compare the aggregate Medicare Fee-for-Service expenditures for all items and services included in the attributed Clinical Episodes against the final Target Price to determine whether the Participant is eligible to receive a payment from CMS or is required to pay a Repayment Amount to CMS.

Additionally, each Performance Period will be subject to two true-ups to allow for additional claims run-out. For instance, for Clinical Episodes ending between July 1, 2024 and December 31, 2024, the reconciliation will occur in the spring of 2025.

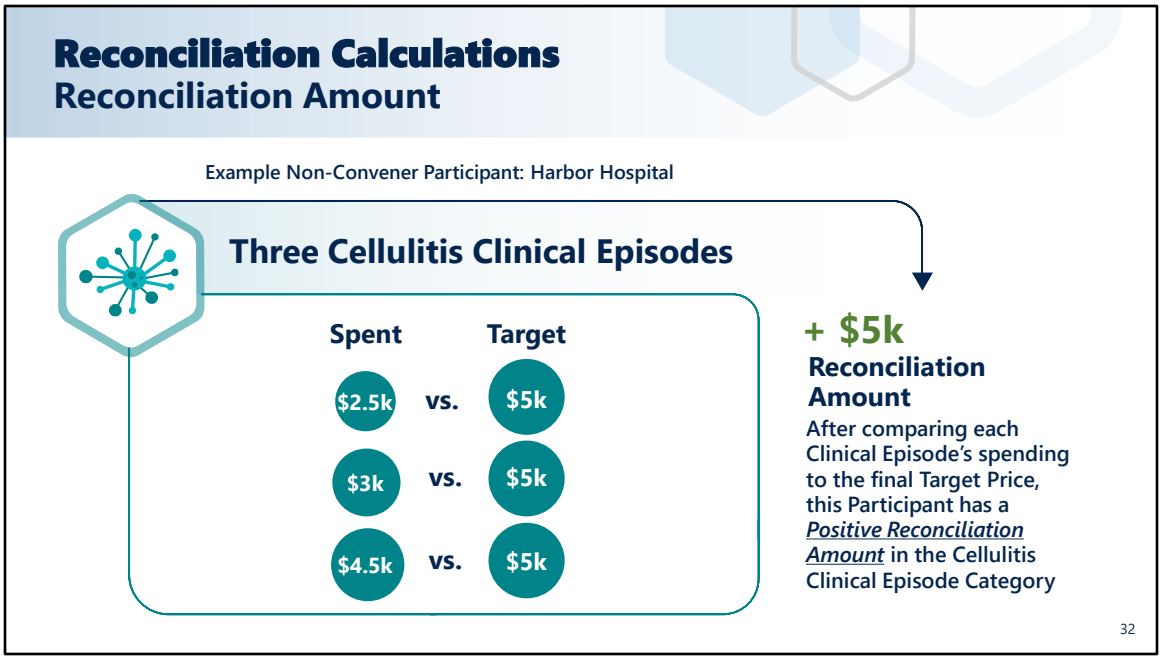


Let's take a closer look at the Reconciliation cycle.

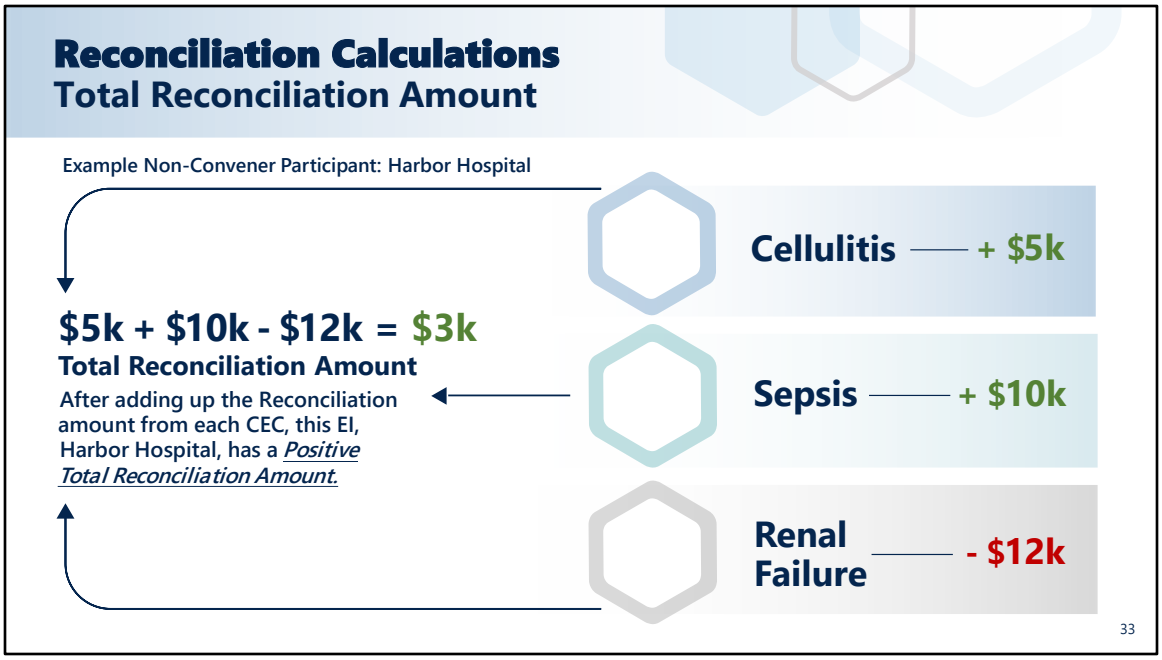
Reconciliation occurs twice a year. Initial Reconciliation occurs at the end of each Performance Period. Clinical Episodes will then be reconciled semi-annually, around June and December, based on the six-month Performance Period in which the Clinical Episode ends. Reconciliation amounts will be updated at least two more times, also known as "true-ups", to account for claims being submitted and updated over time, otherwise known as claims run-out.

While Model Year 8 ends in 2025, the iterative updates during Reconciliation mean Participants will continue to receive financial adjustments until spring of 2027.

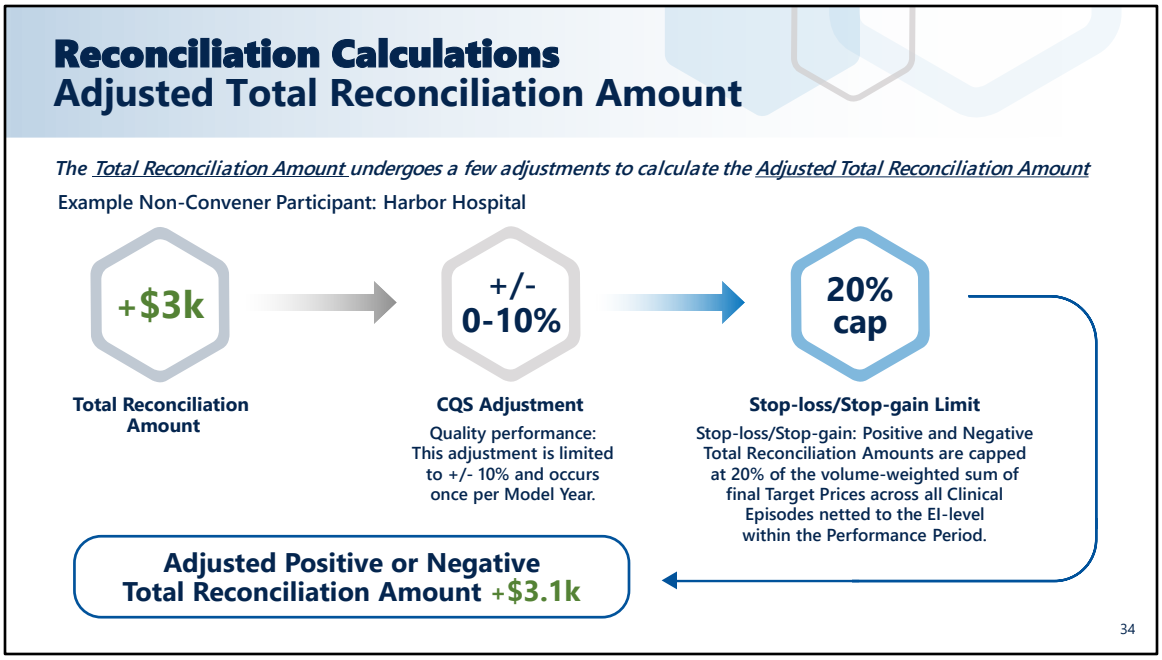
The Composite Quality Scores, or CQSs are incorporated in the true-up at the end of the next model year. These scores assess Participant performance on quality measures associated with their chosen Clinical Episode Categories.



Now that we've reviewed the Reconciliation timeline, let's break down the fundamental steps in Reconciliation calculations. In the first step of Reconciliation calculations, CMS compares the spending for each Clinical Episode with the calculated Target Price to determine the Reconciliation amount. In the example on the slide, the Participant has a positive Reconciliation amount of $5,000 in the cellulitis Clinical Episode Category after calculating the difference between the amount spent and the Target Price.



Next, CMS sums the Reconciliation amounts across the Clinical Episode Categories the Episode Initiator participates in. In the example, adding the Reconciliation amounts for cellulitis, sepsis and renal failure results in a Total Reconciliation Amount of $3,000.



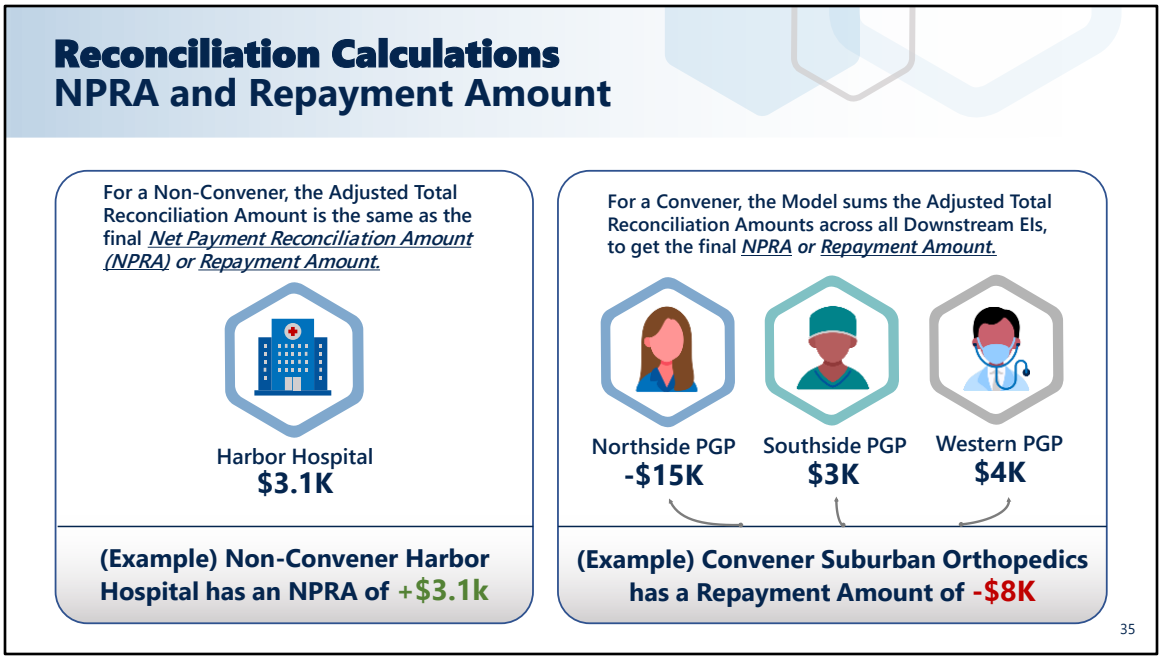
After the Reconciliation amounts for all attributed Clinical Episodes are summed to yield the Positive or Negative Total Reconciliation Amount, this amount is then adjusted based on the CQS, accounting for quality performance, and a separate stop-loss or stop-gain cap.

The CQS Adjustment Amount will not adjust the Positive Total Reconciliation Amount downward by more than 10%, nor will it adjust the Negative Total Reconciliation Amount upward by more than 10%. The stop-loss or stop-gain limit caps Reconciliation payments to 20% of the volume-weighted sum of the final Target Prices across all Clinical Episodes netted to the Episode Initiator level.

These adjustments are made such that Participants will only receive increases or no change in the Adjusted Total Reconciliation Amount based on their CQS during true-up calculations.

Additional information on CQS and quality performance can be found on the BPCI Advanced Quality Measures webpage.

In the example of Harbor Hospital, the Adjusted Total Reconciliation Amount is $3,100, with a CQS Adjustment Amount of $100.

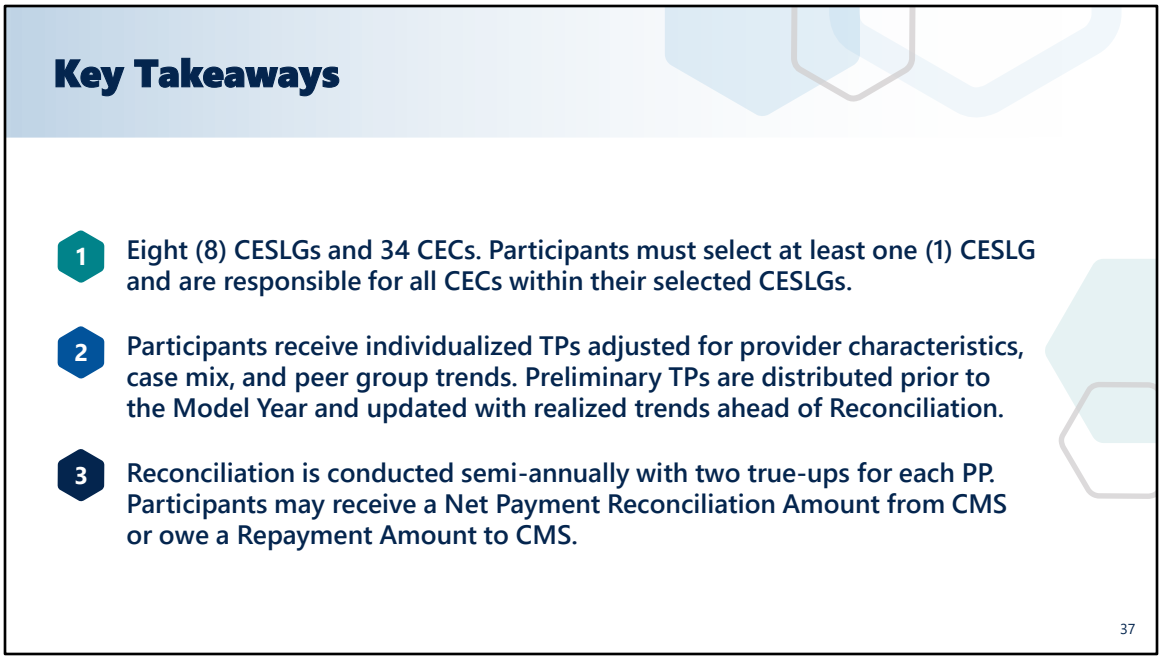


For a Non-Convener, the Adjusted Total Reconciliation Amount is the same as the final Net Payment Reconciliation Amount. Harbor Hospital, a Non-Convener, has an Adjusted Total Reconciliation Amount of $3,100. The hospital's Net Payment Reconciliation Amount is also $3,100.

However, for a Convener, the Model sums the Adjusted Total Reconciliation Amounts across all of its Downstream Episode Initiators to yield the final result. As seen in the example, Convener Suburban Orthopedics takes the negative $15,000 from Northside PGP, $3,000 from Southside PGP and $4,000 from Western PGP to yield their final Repayment Amount of $8,000.

Now I'll hand it back to David Bowen to sum up some of the critical points from today's webcast.

We've now completed the overview of BPCI Advanced pricing methodology. Let's summarize and go ahead and move on to the additional resources.



In the webcast we covered Clinical Episode Category and Service Line Group selection, the components of the Target Pricing methodology and Reconciliation.

In the BPCI Advanced Model, Participants have a choice of up to eight Service Line Groups that cover 34 Clinical Episode Categories (CECs). Participants must select at least one Service Line Group and are responsible for all of the Clinical Episode Categories (CECs) within their selected Service Line Groups.

Participants receive individualized Target Prices adjusted for provider characteristics, case mix and peer group trends. Preliminary Target Prices are distributed prior to the Model Year and updated with realized trends at Reconciliation.

Reconciliation occurs semi-annually around June and December with two true-ups for each Performance Period. Participants may receive a Net Payment Reconciliation Amount from CMS or owe a Repayment Amount to CMS.

Pricing Methodology Technical Resources

- *These resources are updated for every Model Year.*
- *All resources listed below are for MY7 and are available in the BPCI Advanced Participant Portal > Document Library section. They can also be downloaded by clicking on each file name.*
- *Prior Model Years' Technical Resources can be found in the BPCI Advanced: Participant Resources webpage and the BPCI Advanced Participant Portal > Document Library section.*

- BPCI Advanced Clinical Episode List – MY7
- BPCI Advanced Exclusions List - MY7
- Target Price Specifications – MY7
- Clinical Episode Construction Specifications – MY7
- Clinical Episode Construction Specifications – MY7 – Appendix: HH Update Factors
- Clinical Episode Construction Specifications – MY7 – Appendix: SNF Update Factor Calculation
- MY7 Target Price Data Dictionary
- Convener MY7 CY2023/FY2023 Preliminary Target Price template
- PGP MY7 CY2023/FY2023 Preliminary Target Price template
- ACH MY7 CY2023/FY2023 Preliminary Target Price template
- National ACH MY7 CY2023/FY2023 Preliminary Target Price template
- Convener MY7 Baseline Summary template
- PGP MY7 Baseline Summary template
- ACH MY7 Baseline Summary template

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Additional pricing methodology resources, such as the Clinical Episode Construction, Target Price and Reconciliation Specifications are available on the Participant Resources page on the BPCI Advanced website. These resources are also laid out in the new Pricing Methodology Technical Specifications Guide. Note that these resources are updated every Model Year and additional learning opportunities are forthcoming. Thank you for watching. We hope you found the explanations useful.