Pricing Methodology
Frequently Asked Questions (FAQ)

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Target Price Calculations and Components

Q1: How will Target Prices be calculated by CMS?
A1: Using claims-based historical data and risk adjustment models to account for variation in the Clinical Episode's standardized amounts, the Centers for Medicare & Medicaid Services (CMS) will calculate a Benchmark Price. Starting in Model Year (MY) 4, the Benchmark Price during the Performance Period will also account for realized national trends in the Performance Period that are driven by unanticipated, systematic factors. Realized trends are captured in the final Target Price by a Peer Group Trend (PGT) Factor Adjustment, which is subject to a cap, and based on the difference between a retrospective peer group trend and the prospective peer group trend used to calculate the initial Target Price. In BPCI Advanced, a 3 percent CMS Discount is applied to the Benchmark Price in Model Years 1 through 5 to calculate the Target Price for each Clinical Episode Category for each Episode Initiator (EI). Starting in MY6, the PGT Factor Adjustment is capped at 5 percent for all Clinical Episode Categories (CECs) and the 3 percent CMS Discount is reduced to 2 percent for medical Clinical Episodes. The 3 percent CMS Discount remains the same for surgical Clinical Episodes.

Q2: How frequently will Model Year 7 Target Prices be updated for Participants?
A2: The initial preliminary Target Prices, released in late August 2023, will cover Model Year 7 (January 1, 2024 – December 31, 2024). Applicants and Participants may use these preliminary Target Prices to help make participation decisions for Model Year 7.

Twice annually when Medicare sets new payment rates for a new fiscal year and calendar year, the preliminary Target Prices will be updated and revised workbooks will be provided. Specifically, the update tentatively planned for spring 2024 will be for Calendar Year (CY) 2024 and Fiscal Year (FY) 2024 payment rates, and the update tentatively planned for winter 2024 will be for CY 2024 and FY 2025 payment rates.

All Target Prices will be updated to reflect actual Performance Period beneficiary data and realized peer group trends during Reconciliation cycles.

Q3: How are the Target Prices assigned (e.g., regional, national or a comparison of an organization's own past performance)?
A3: Target Prices for hospitals are constructed to account for multiple aspects of the Clinical Episode:

1. Historical Medicare fee-for-service (FFS) expenditures specific to the hospital's Baseline Period
2. Patient case mix
3. The hospital's characteristics
4. Projected trends in spending among the hospital's peer group
5. Starting in Model Year 4, final Target Prices are adjusted for realized peer group trends during the Performance Period. This methodology continues into Model Year 7.

CMS accounts for each component through a series of regression models for each Clinical Episode Category based upon a national dataset of Clinical Episodes that were initiated during the baseline period and priced using the official CMS standardized spending amounts.

The patient characteristics that are adjusted for include demographic information, the patient's comorbidities using the Hierarchical Condition Categories (HCCs), severity based upon Medicare Severity-Diagnosis Related Groups (MS-DRGs) for the inpatient Clinical Episodes, and Ambulatory Payment Classifications for outpatient Clinical Episodes, along with other variables described in the Target Price specifications.

The peer group characteristics that CMS adjusts for as part of the Peer Group Historical Adjustment (PGHA) and Peer Group Trend factor (PGT) include the US census division, urban versus rural status, safety net status, and teaching hospital status.

Detailed specifications, including information on the risk adjustment models and the covariates included in them, are available in the Target Price Specifications – Model Year 7.

Q4: What is the baseline period for Model Year 7 and why do Participants only receive three years of baseline data?
A4: The 4-year baseline period for MY7 contains data from potential Clinical Episodes that would have been attributed from October 1, 2018, to September 30, 2022. CMS makes three years of baseline (historical) data available for Participants to request for health care operations activities, such as care coordination and quality improvement, under the Model. Consistent with the Health Insurance Portability and Accountability Act requirements to limit protected health information to the minimum necessary to accomplish the intended purpose of the request. Participants may receive baseline claims data in raw and/or summary formats, from October 1, 2019, to September 30, 2022, for health care operations purposes.

Q5: Given that Target Prices are calculated at the Clinical Episode Category level, can CMS explain how to calculate the correct spending at the individual Clinical Episode level in order to compare it to the Target Price?
A5: To identify what to include in the Performance Period Clinical Episodes, follow the steps in the Clinical Episode Construction Specifications – Model Year 7 document, Sections 5, 6, and 9, in particular.

This will help determine the sum of spending for Clinical Episodes initiated at the same hospital for which the Target Price is applicable. After the Clinical Episodes are built, the step-by-step details to aggregate the Performance Period spending are provided in the Reconciliation Specifications document. Since this document is not yet available for Model Year 6, Participants can reference Section 4 of the Reconciliation Specifications – Model Year 5.

Q6: How does the Physician Group Practices (PGPs) Target Price work with the hospital Target Price for Model Year 7?
A6: PGPs will receive Target Prices that are hospital-specific. In other words, a PGP will receive unique Target Prices for each Clinical Episode Category based on the hospital at which the Anchor Stay or Anchor Procedure occurs. From the Hospital Benchmark Price, CMS first removes the effects of the hospital-wide Patient Case Mix Adjustment (PCMA) and replaces it with the PCMA specific to the PGP's Clinical Episodes initiated by an Anchor Stay or Anchor Procedure at the hospital. In other words, to form the PGP Benchmark Price for each hospital at which the PGP practices, the Hospital Benchmark Price from that hospital is adjusted to account for the PGP's relative case mix.

Q7: Why would a Physician Group Practice (PGP) receive a preliminary Target Price, but not receive baseline claims data? What if a PGP begins to treat beneficiaries at a new hospital, will Clinical Episodes triggered at that hospital be included in the Model?
A7: PGPs, whether Participants or Downstream Episode Initiators (EIs), do not receive baseline claims if they did not initiate any Clinical Episodes in the baseline period. However, they are still eligible to receive preliminary Target Prices based upon the hospital prices. PGPs are also eligible to trigger Clinical Episodes at the new hospital as long as the hospital itself is not new and has

sufficient Clinical Episode volume in the baseline period to receive a preliminary Target Price. The PGP will receive the preliminary Target Price for eligible hospitals in the National Set of Acute Care Hospital (ACH) Preliminary Target Prices (see below for details), and a final Target Price at Reconciliation.

The national set of ACH Target Prices is available only to BPCI Advanced Applicants and Participants via the BPCI Advanced Participant Portal. The National ACH Preliminary Target Price workbook contains all of the BPCI Advanced preliminary Target Prices for all eligible ACHs in the country (including hospitals that are not currently participating in BPCI Advanced). The workbook summarizes preliminary Target Prices for a national set of ACHs with at least 41 Clinical Episodes in a given Clinical Episode Category in the baseline period and contains a breakdown of relevant Target Price components. It also includes the parameter estimates from the Stage 1 and Stage 2 Risk Adjustment models. For Model Year 7, a workbook containing preliminary Target Prices for the national set of hospitals was made available in September 2023.

Q8: How do you price value-based bundled service delivery for multidisciplinary chronic disease care?
A8: The BPCI Advanced Model is designed to capture the total cost of care during acute care hospitalizations or procedures and the 90 days following the discharge or procedure. Naturally, people with multiple chronic conditions may see physicians from multiple specialties and may have higher episode costs. The BPCI Advanced risk-adjustment model includes variables that capture many chronic conditions and also the number of comorbid conditions a beneficiary has. The coefficients from the risk-adjustment model are used together with the actual patients the participant is attributed in the performance period to finalize their Patient Case Mix Adjustment Amount. If everything else about them is the same, a participant that receives many patients with multiple chronic conditions will receive a higher Patient Case Mix Adjustment Amount and hence a higher Target Price than a participant that receives mostly healthy patients.

Q9: Will Target Prices have a Hierarchical Condition Categories (HCCs) adjustment? What is the measurement period?
A9: CMS incorporates the HCCs as part of the Target Price calculation, specifically in the Patient Case Mix Adjustment (PCMA). They are represented in three different ways: the individual HCCs, relevant combinations of HCCs, and the HCC count (zero, one to three, four to six, and more than seven) used to determine beneficiary complexity.

Starting with Model Year 5, for HCC determinations, CMS will use the inpatient, outpatient, and carrier/physician claims in the 180-day lookback period from the start of the Clinical Episode. Construction of HCCs does not take into account claims data from the Clinical Episode period. CMS takes into account all the diagnosis codes on the outpatient, inpatient, and carrier/physician claims.

Q10: For the Target Price Calculation, one of the Risk Adjuster Categories is "Recent Resource Use," which is defined as "Indicates whether a Clinical Episode was preceded by a relevant utilization of health care services." What constitutes a relevant utilization of health care services? Over what time period does this look? Is it a fixed time period before the claim that initiates an episode?
A10: In Model Year 7, Recent Resource Use is accounted for in the risk adjustment model through indicators for inpatient hospitalization in the 180 days prior to episode and for Post-Acute Care use (LTCH, SNF, HH, IRF) in the 180 days prior to episode. All inpatient admissions in the 180-day lookback window, regardless of the participation status or MS-DRG, are considered for resource use.

Q11: How will CMS measure historic Medicare FFS expenditure efficiency during the baseline period and how will this be applied in calculating the Target Price?
A11: The ACH Historical Adjustment term, which was known as the ACH efficiency term in MY1&2, captures how the ACH's baseline resource use per episode (as measured by baseline standardized updated Clinical Episode spending), differs from the baseline resource use per episode of other ACHs in their peer group with the same measured patient characteristics. A value less than one indicates that the

hospital has historically treated the same Clinical Episode with lower spending than other hospitals in its peer group with the same measured patient mix. The ACH Historical Adjustment is incorporated into the Target Price by scaling up (for historically high-cost hospitals) or scaling down (for historically low-cost hospitals) the amount of spending that the patient and peer group adjusters indicate is appropriate for the specific Clinical Episode. Since MY4, the BPCI Advanced Model no longer adjusts for how PGPs' historical resource use differs from the average historical resource use at their host ACHs for PGPs with the same patient mix. Note that historical efficiency was the primary determinant of Target Price in the BPCI Initiative, whereas historical spending is but one component of the Target Price in BPCI Advanced.

In Model Year 7, the ACH Historical Adjustment term is calculated as the ratio of average observed to average predicted Clinical Episode spending. Prior to Model Year 6, it was calculated as the average of the ratio of observed to predicted Clinical Episode spending. This change was made to bring it into line with the construction of the PGT Factor Adjustment and aims to reduce the average variability between preliminary and final Target Prices, all else equal, thus reducing variation of the PGT Factor Adjustment.

Q12: Does BPCI Advanced use the Patient Driven Payment Model (PDPM) to determine prospective reimbursement?
A12: PDPM weights and rates are incorporated into the BPCI Advanced Clinical Episode spending and Target Price calculations for episodes which occurred in FY2020 and after. For Clinical Episodes which occurred prior to FY2020, the associated costs are converted from Resource Utilization Group (RUG-IV) weights and rates to PDPM weights and rates. The methodology is listed in the SNF Update Factor Appendix, which can be found in the Participant Portal.

Q13: Will the 3.1% payment increase, based on the FY2024 IPPS Final Rule, be accounted for in BPCI Advanced Target Prices?
A13: FY2024 base rates and MS-DRG weights will be incorporated during the Model Year 7 FY2024/CY2024 Target Price update, scheduled for delivery in Spring 2024. IPPS rate changes are applied to both the triggering DRG's anchors costs and relevant inpatient costs grouped to the post-discharge period.

Q14: Can a hospital's peer group characteristics, such as hospital size, change quarter over quarter due to an addition to hospital beds in a given year after a capital investment? Or does CMS evaluate the peer group characteristics at a specific point in time?
A14: Most of the peer group characteristics are constructed using the latest available data as of the processing date for the cut-off that was used to construct Target Prices. However, the safety net characteristic is an exception, and this covariate is constructed for each calendar year and thus may vary across quarters in the baseline period. In the Stage 2 Risk Adjustment model, peer group characteristics are taken from the Acute Care Hospital (ACH)-quarter-year level for a given Clinical Episode Category. In the construction of Peer Group Trend (PGT) and Peer Group Historical Adjustment (PGHA) factors, peer group characteristics are taken from the last available quarter of the baseline period when the Clinical Episode occurred for a given ACH in a particular Clinical Episode Category. Take note that the peer groups do not change in preliminary Target Price updates and Final Target Price construction.

Q15: Can CMS please clarify the statement from the Model Year 7 Target Price specifications that states, "At the ACH-quarter level, calculate the average of the ratio of observed Clinical Episode spending to Clinical Episode level patient case mix adjustment amount and regress this average ratio..."?
A15: The ratio of observed Clinical Episode spending to Clinical Episode level patient case mix adjustment (output from Stage 1 of the risk adjustment model) is the proportion of observed Clinical Episode spending that is not explained by patient case mix. The average of this ratio across a baseline year-quarter represents the dependent variable in the Stage 2 ordinary least squares (OLS) regression

for a hospital. Once the average is built, the Stage 2 OLS regression is run to project the trends in the Clinical Episode spending to the middle of the Performance Period of interest. In other words, CMS uses this regression to estimate what portion of Clinical Episode spending is explained by differences in peer group characteristics and trends.

Q16: How is the Performance Period Hospital Benchmark Price (HBP) different from the baseline period HBP in Model Year 7?
A16: In Model Year 7, the Patient Case Mix Adjustment (PCMA) and the real-to-standardized ratio will be updated for the Performance Period HBP. Additionally, the PGT Factor Adjustment (i.e., the retrospective adjustment) will also be applied.

The final PCMA is constructed using the actual case mix from an EI's attributed Clinical Episodes in the applicable Model Year. The PGT Factor Adjustment will be added to the Performance Period HBP calculation to account for realized peer group trends in the Performance Period that are driven by unanticipated, systematic factors such as payment system reforms. Additionally, final Target Prices will be updated to real dollars using the realized real-to-standardized ratio. CMS notes that the Standardized Baseline Spending (SBS), PGT, and Peer Group Historical Adjustment (PGHA) will be adjusted at the beginning of each fiscal and calendar year to account for CMS setting-specific payment rate changes from the finalized rules.

Q17: In the overall process of setting Target Prices, will the Patient Case Mix coefficients be re-estimated?
A17: The risk adjustment coefficients will not be re-estimated in the Performance Period. Rather, the risk adjustment parameters from the baseline period will be re-applied to the realized case mix that occurs in the Performance Period. However, twice annually, when Medicare sets new payment rates for payment systems in a new fiscal year and calendar year, new setting-specific update factors will be applied to the baseline period Clinical Episodes to make their spending comparable to the new prices. At these times, risk adjustment will be rerun on newly updated baseline Clinical Episodes and coefficients may change. Please note these changes will only reflect in Medicare pricing updates and, because prices increase every fiscal year and calendar year on average, it is expected that these changes will on average lead to increases in Target Prices.

Q18: What is the functional difference between the Peer Group Historical Adjustment (PGHA) and the Peer Group Trend (PGT)?
A18: The PGHA is designed to capture how much a particular peer group's case mix adjusted spending differs from a reference peer group on average across the baseline. In other words, the PGHA captures a "level" difference in case mix adjusted spending between peer groups. The PGT is designed to project each peer group's case mix adjusted spending from its baseline average to the Performance Period.

Q19: What is the Peer Group Trend (PGT) Factor Adjustment?
A19: The PGT Factor Adjustment is the component which accounts for the change between the preliminary (or prospectively determined) trend (i.e., PGT) and the realized trend in case mix adjusted spending. The numerator of the uncapped PGT Factor Adjustment reflects average realized spending across all episodes initiated at all eligible ACHs (including both Participant and non-Participant ACHs) within each CEC-Peer Group-Performance Period (PP). The denominator reflects the average prospective prediction of spending, accounting for the PP mix of patient/episode covariates (i.e., the prospective benchmark price with an updated PCMA term) across the same set of episodes as the numerator. Taking the numerator and denominator together, the PGT Factor Adjustment denotes how realized PP spending differed from the prospective prediction (updated for PP patient/episode covariates).

Q20: How is the Peer Group Trend Factor Adjustment incorporated into final Target Price calculation in Model Year 7?
A20: The Peer Group Trend (PGT) Factor Adjustment is used to adjust the final Target Prices for peer

group trends that are driven by unanticipated, systematic factors such as payment system reforms occurring during the Performance Period and that cannot be predicted using a prospective pricing methodology. The PGT Factor Adjustment is calculated by re-centering the Benchmark Price around realized Performance Period Clinical Episode spending within each peer group nationally. Prior to Model Year 6, the PGT Factor Adjustment was capped to within 10% of the prospectively calculated PGT value. Starting in Model Year 6, CMS will reduce the cap to 5% to narrow the variability between preliminary and final Target Prices. As an example, for an Acute Care Hospital (ACH) that has Standardized Baseline Spending (SBS) of $42,962, a preliminary Patient Case Mix Adjustment (PCMA) of 0.81, a Peer Group Historical Adjustment (PGHA) of 1.51, and a Peer Group Trend (PGT) Factor of 0.90, its preliminary Hospital Benchmark Price (HBP) would be $47,292 (i.e., $42,962 * 0.81 * 1.51 * 0.90). If the updated PCMA is 0.92 and the capped PGT Adjustment Factor is 0.95, then the final Target Price of this ACH would be $51,029 (i.e., $42,962 * 0.92 * 1.51 * 0.90 * 0.95).

Q21: What is the point of the Peer Group Trend (PGT) Factor Adjustment?
A21: PGT is a prospective prediction and can only account for smooth and gradual changes to case-mix-adjusted spending over time, while PGT Factor Adjustment, being a retrospective adjustment, can help account for discrete, unanticipated systematic shocks that are common to all ACHs (including non-Participant ACHs) in the Peer Group during the PP. For example, if a Peer Group experienced a resource-intensive procedure roll-out to high-risk patients that occurred gradually over the baseline period for both participant and non-participant ACHs, the PGT helps project this upward trend in case mix adjusted spending to the PP. In contrast, if there is a sudden change in discharge policy during the PP that required some types of patients to be discharged to SNF, applicable to all the Peer Group's ACHs uniformly, this impact on case mix adjusted spending will be captured via a higher Factor Adjustment. The PGT Factor Adjustment ensures Participants are rewarded for resource use improvements that are only attributable to themselves under the BPCI Advanced Model, as opposed to that common to the whole Peer Group; and correspondingly, also ensures Participants are not penalized for increased resource use that are attributable to the whole Peer Group.

Q22: What is the National Retrospective Trend and when does it get incorporated into the Target Price equation?
A22: Peer groups with inadequate volume receive a modified PGT Factor Adjustment that effectively replaces their realized peer group trend for a given Clinical Episode Category with the National Retrospective Trend for that same Clinical Episode Category. Inadequate volume is defined as having 1 ACH, or less than 11 Clinical Episodes in a given Performance Period. The National Retrospective Trend Adjustment value is calculated as the total national observed spending for a Clinical Episode Category divided by the total Benchmark Price accounting for the realized case-mix in the Performance Period for that Clinical Episode Category. The National Retrospective Trend applied to the Final Benchmark Price is the Clinical Episode Category's prospective PGT multiplied by the National Retrospective Trend Adjustment.

Q23: When a PGT Factor Adjustment value for an ACH's Peer Group is <1, would this mean that spending for that Peer Group is trending downwards from the baseline to Performance Period?
A23: Not necessarily. PGT Factor Adjustment by itself does not constitute the retrospective trend, but rather the retrospective trend is composed of PGT*PGT Factor Adjustment.

Q24: We are observing Medicare FFS spending to be trending upwards; why isn't the BPCI-A retrospective trend of my ACH's relevant Peer Group going up (i.e., why isn't PGT*PGT Factor Adjustment>1)?
A24: First, BPCI Advanced is a specialty model based on 34 CECs, which does not cover the universe of all Medicare FFS. Each CEC can have distinct patterns in spending trends. Second, changes in episode mix (patient pool costliness) within a CEC from the baseline to the Performance Period can also impact trends. Third, trends in Medicare FFS spending in nominal dollars wouldn't be equivalent to trends in updated dollars, which the BPCI Advanced Model trends are based on. Lastly, the BPCI

Advanced model has additional differences, such as episode exclusion criteria, that may contribute to differences with Medicare FFS spending trends.

Q25: Should we expect Uncapped PGT Factor Adjustment to proportionally change with the percentage change in average baseline episode spending to average Performance Period episode spending for a peer group?
A25: The percentage change in average baseline episode spending to average Performance Period (PP) episode spending will not necessarily move proportionally to Uncapped PGT Factor Adjustment, as in addition to spending, the PCMA also receives an update to the PP patient mix from the baseline to the PP. This PCMA update would affect the denominator of the uncapped PGT Factor Adjustment. Further, the prospective PGT may have already predicted some of this spending change.

Q26: How does the Clinical Episode level patient case mix adjustment amount differ from the PCMA?
A26: The Clinical Episode level patient case mix adjustment amount is calculated as the predicted Clinical Episode spending based on patient characteristics only. The coefficients for this prediction come from a risk-adjustment model. The PCMA is calculated as the average Clinical Episode level patient case mix adjustment amount for each CEC-ACH combination, divided by the Average Observed Clinical Episode Spending. In other words, the Clinical Episode level patient case mix adjustment amount is the numerator of the PCMA.

Q27: Why doesn't the PCMA average to 1 across all ACHs (including non-Participant ACHs) in a CEC?
A27: Target Prices are constructed such that the ratio of average predicted baseline spending to average observed baseline spending is close to 1. The average predicted baseline spending for a Peer Group is composed of predicted spending based on patient case mix characteristics as well as provider characteristics. However, the numerator of the PCMA, referred to as patient case mix adjustment amount, only represents the patient characteristics portion of expected spending, and does not account for provider characteristics. The latter is captured via the PGHA in the baseline. Thus, once the patient case mix adjustment amount is scaled by average national baseline CEC spending (as the PCMA is defined), it is not expected to equal 1 on average.

Q28: If the performance information, conveyed in the hospital baseline and the monthly files, is expressed as standardized dollars, why is there then a need to convert the performance information to real dollars? Shouldn't the actual targets be standardized as well?
A28: CMS constructs Clinical Episodes using standardized allowed amounts that reflect the cost of services after removing variation in spending arising from geographical adjustment of reimbursement and CMS payments systems, such as:

- Hospital Wage Index and Geographic Practice Cost Index (GPCI), and
- Indirect medical education (IME) and Disproportionate Share Hospital (DSH) payment adjustments.

The complete description of the official CMS Standardization Methodology by setting can be found on the ResDAC website. Real dollars represent the true amount the providers are reimbursed for their provision of Medicare covered care. Since Reconciliations amounts are calculated in real dollars, Target Prices are converted into real dollars to allow a comparison of Target Prices and actual spending in a consistent manner.

Q29: Could you summarize the key changes in pricing methodology compared to prior Model Years?
A29: Depending on when an organization was last in the Model, there have been a number of changes in the pricing methodology. First, there have been some changes in how Clinical Episodes are grouped, triggered, and priced. Since Model Year 4 (2021), Participants must choose Clinical Episode Service Line Groups, which are groupings of CECs, instead of individual CECs. Please note that both Applicants and current Participants can make new Clinical Episode Service Line Group selections for Model Year 7 in the Participant Profile. There have also been updates to the joint-related CECs. These categories now include outpatient procedures—outpatient knee arthroplasty and outpatient hip arthroplasty for Major Joint Replacement of the Lower Extremity (MJRLE), and outpatient shoulder arthroplasty for Major Joint Replacement of the Upper Extremity (MJRUE). One more change regarding Clinical Episodes is that, starting in Model Year 6, the CMS discount factor was lowered from 3% to 2% for medical Clinical Episodes. The discount remains at 3% for surgical Clinical Episodes.

There have also been several changes to the Target Price and Reconciliation calculations. The Patient Case Mix Adjustment (PCMA) has several new factors added, including dementia in Model Year 5 and CEC-specific adjustments and COVID-19 infection rate in Model Year 6. The Hierarchical Condition Category, or HCC, look-back period also increased to 180 days in Model Year 5. In Model Year 4, the retrospective Peer Group Trend Factor Adjustment was introduced to capture realized trends. More recently, in Model Year 6, the cap on this PGT Factor Adjustment was reduced from 10% to 5%. For PGPs, the PGP Offset was removed in Model Year 4. Lastly, in line with Participant feedback, the COVID-19 methodology was adjusted from MY5 to MY6 so that Participants could be accountable for Clinical Episodes with a COVID-19 diagnosis.

Clinical Episode Categories and Construction

Q30: Which CECs are considered medical and which are surgical for MY7 purposes?
A30: The medical/surgical classification for BPCI Advanced CECs in MY7 is as follows:

Medical/Surgical Classification	Clinical Episode Category
Medical	• Acute Myocardial Infarction • Cardiac Arrhythmia • Cellulitis • Chronic Obstructive Pulmonary Disease, Bronchitis, Asthma • Congestive Heart Failure • Disorders of Liver Except Malignancy, Cirrhosis or Alcoholic Hepatitis • Fractures of the Femur and Hip or Pelvis • Gastrointestinal Hemorrhage • Gastrointestinal Obstruction • Inflammatory Bowel Disease • Renal Failure • Seizures • Sepsis • Simple Pneumonia and Respiratory Infections • Stroke • Urinary Tract Infection
Surgical	• Back and Neck Except Spinal Fusion (Inpatient) • Back and Neck Except Spinal Fusion (Outpatient) • Bariatric Surgery • Cardiac Defibrillator (Inpatient) • Cardiac Defibrillator (Outpatient) • Cardiac Valve • Coronary Artery Bypass Graft • Double Joint Replacement of the Lower Extremity • Hip and Femur Procedures Except Major Joint • Lower Extremity and Humerus Procedures Except Hip, Foot, Femur • Major Bowel Procedure • Major Joint Replacement of the Lower Extremity (Multi-setting) • Major Joint Replacement of the Upper Extremity (Multi-setting) • Pacemaker • Percutaneous Coronary Intervention (Inpatient) • Percutaneous Coronary Intervention (Outpatient) • Spinal Fusion • Transcatheter Aortic Valve Replacement

Q31: What are the Clinical Episodes' volume thresholds for Episode Initiators (EIs) that are ACHs and PGPs?
A31: In order for a hospital to receive a preliminary Target Price, the hospital must have at least 41 Clinical Episodes in a Clinical Episode Category during the applicable baseline period. Since PGPs receive Target Prices based on a hospital's benchmark price, PGPs will only receive preliminary Target Prices for hospitals with at least 41 Clinical Episodes in a Clinical Episode Category during the baseline period. PGP Applicants and Participants that did not meet the threshold to receive preliminary Target Prices for a given hospital can use the National ACH Preliminary Target Price workbook to determine preliminary Target Prices at eligible ACHs.

More information on the volume thresholds, including low-volume thresholds for hospitals, are available in the Target Price Specifications – Model Year 7.

Starting with Model Year 4, the Clinical Episode Categories are sorted under eight Clinical Episode Service Line Groups. Participants will be accountable for all Clinical Episode Categories within a Clinical Episode Service Line Group for which the Participant has committed to be accountable but will not be eligible to initiate a Clinical Episodes in which they do not meet the minimum Clinical Episode volume threshold during the baseline period, if part of a selected Clinical Episode Service Line Group.

Q32: I'm interested in signing up for the Medical & Critical Care Clinical Episode Service Line Group. I didn't receive a preliminary Model Year 7 Target Price for the Cellulitis Clinical Episode Category because I didn't meet the minimum baseline threshold. Is it possible that I could trigger Cellulitis in Model Year 8?

A32: Yes, if a Participant selects to be accountable for the Medical & Critical Care Clinical Episode Service Line Group on their Model Year 7 Participant Profile, it is possible that they may not be able to trigger a Cellulitis Clinical Episode in Model Year 7 but may be able to in Model Year 8. This is because every Model Year, CMS recalculates Target Prices and moves the baseline period forward one year, which may change the volume of episodes triggered in the baseline period for a given Clinical Episode Category. As a result, it is possible that for Model Year 8 the Participant meets the minimum baseline threshold of at least 41 episodes, such that CMS is able to construct a Target Price and the Participant could trigger a Cellulitis Clinical Episode. The reverse scenario is also true; a Participant could be eligible to trigger a specific Clinical Episode Category in Model Year 7 but not in Model Year 8.

Q33: On what basis will CMS attribute a Clinical Episode to an Episode Initiator (EI)? Which fields on the claim are key?

A33: When determining Clinical Episodes attribution to EIs, CMS will first look to the Attending National Provider Identification (NPI) number listed on the institutional claim (UB-04/CMS-1450) that initiated the Clinical Episode, which will subsequently lead to a check for the Attending NPI's Part B claim during the Anchor Stay or Anchor Procedure for a participating Tax Identification Number (TIN). If the Physician Group Practice (PGP) TIN is listed as participating in BPCI Advanced, the Clinical Episode is attributed to that PGP. If that TIN is not a BPCI Advanced EI, CMS then starts over by looking at the institutional claim that initiated the episode to conduct the same check for the Operating NPI-TIN. If neither NPIs yield a Part B claim billed under a participating TIN, CMS then checks for whether the hospital CMS Certification Number (CCN) on the claim is a BPCI Advanced EI. Please see Appendix A of the BPCI Advanced Participation Agreement and Sections 8 and 9 of the Clinical Episode Construction Specifications – Model Year 7 for more details.

Q34: If a PGP begins to treat beneficiaries at a hospital not included in the baseline data, will Clinical Episodes triggered at that hospital be included during the Performance Period?

A34: A PGP may be able to initiate Clinical Episodes during the Performance Period at a hospital it didn't receive baseline data for as long as the hospital where the PGP is practicing during the Performance Period has met the minimum volume threshold of at least 41 episodes in the baseline period.

Q35: What is the duration of the Anchor Procedure for outpatient episodes in Model Year 7? Additionally, if the Anchor Procedure overlaps with an Anchor Stay, how are the Clinical Episodes treated?

A35: In Model Year 7, Clinical Episodes initiated by an Anchor Procedure also begin on the first day of the BPCI Advanced beneficiary's Anchor Procedure and end 90 days after completion of the Anchor Procedure. If an Anchor Procedure and an Anchor Stay occur on the same day, then the inpatient Clinical Episode will be retained regardless of the Clinical Episode participation status in both the baseline and Performance Period. Please refer to the Clinical Episode Construction Specifications – Model Year 6 document for more details on the Clinical Episode selection logic.

Q36: Will CMS define what Part B charges will appear in the Anchor versus Post-Anchor summaries, and can CMS share the rules for allocating charges to the Anchor and Post-Anchor?
A36: First, the rules for assigning the standardized allowed amount to Anchor versus Post-Anchor period by claim setting do not affect Clinical Episode costs that are used in Target Price and Reconciliation calculations. That being said, costs for Skilled Nursing Facilities (SNF), Home Health Agencies (HHA), and Hospice claims that do not require proration and occur during the Anchor Stay/ Anchor Procedure, excluding the last day of the Anchor Stay, are included in the Anchor spending. The remaining SNF, HHA, and Hospice claims that do not require proration are in the Post-Anchor spending. All three types of claims that overlap the Anchor Period/Post-Anchor Period and Post-Episode period are prorated, and the relevant proportion of costs are assigned to each period. For the exact proration methodology for all settings, refer to the Clinical Episode Construction Specifications – Model Year 7 document.

Q37: How often are the Excluded Part B Drug lists updated and what Model Years are they applicable to?
A37: The Excluded Part B Drugs list is created in the baseline period for a given Model Year and is not updated until that Model Year's first Reconciliation cycle. For example, the MY6 Excluded Part B Drugs list was created in the FY2022/CY2022 Preliminary TP Run, and will be updated in the Fall 2023 (PP9 Initial) Reconciliation cycle. The list will be updated again in subsequent Reconciliation cycles as more Performance Period episodes are constructed. The exclusion lists differ between Model Years since HCPCS may meet the exclusion criteria in certain Model Years and not others, which is why some HCPCS may be excluded from MY5 claims but not MY6 claims. Please note that the updated exclusion lists are based on Performance Period Clinical Episodes and are not applied to any preliminary Target Price updates, but they are applied during Final Target Price and Reconciliation calculations. The latest excluded Part B drugs lists for each Model Year are available on the CMS BPCI Advanced Participant Resources webpage:

https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced/participant-resources

Q38: Will Clinical Episodes where the beneficiary has a COVID-19 diagnosis be excluded from the Model Year 7 baseline and Performance Period? If not, how will CMS risk-adjust for COVID-19?
A38: Clinical Episodes where the beneficiary has a COVID-19 diagnosis will not be excluded from the Model Year 7 baseline period or Performance Period.

In order to risk-adjust for COVID-19, CMS will incorporate a census tract-level COVID-19 infection rate and its interaction with time period variables in the Stage 1 risk adjustment model to allow the effect of community COVID-19 rates to be reflected on episode spending and adjusted for all the pandemic-afflicted time periods in the baseline. Please note, only the time period interaction terms will be used for the COVID-19 risk adjustment.

The COVID-19 infection rate[1] will be measured for the week of the Clinical Episode start date and based on the hospital's census tract where the beneficiary initiated an episode. This infection rate will be interacted with one of five dummy variables that represent the five distinct time periods impacted by the pandemic during the baseline.

[1] The COVID-19 infection rate is calculated as the ratio of all COVID-19 positive beneficiaries to the total number of Medicare beneficiaries in the anchor provider's census tract and its neighboring tracts. Beneficiaries are considered COVID-19 positive in the week of, the week before and the week after the following diagnosis codes are found in either their IP, OP, SNF or Carrier Claims: i) B97.29 with either J12.89, J20.8, J22, J40, J80 or J98.8 (prior to April 1, 2020); ii) U07.1 or B97.29 (on or after April 1, 2020)

The first time period will include episodes with start dates on or between March 1, 2020 to October 31, 2020; the second time period will include episodes with start dates on or between November 1, 2020 and February 28, 2021; the third time period will include episodes with start dates on or between March 1, 2021 and October 31, 2021; the fourth time period will include episodes with start dates on or between November 1, 2021 and February 28, 2022; and the fifth time period will include episodes with start dates on or after March 1, 2022. For example, if Clinical Episode X is initiated at ACH Y on October 14, 2020, CMS will first map the anchor start date of the episode to the COVID-19 infection rate in the census tract where ACH Y is located in the week that the Clinical Episode was initiated. The interaction between the infection rate and the March 1, 2020 – Oct 31, 2020 time period dummy variable will be included as a covariate in the model. This means the coefficients on this risk adjuster will have different estimates in each time period, and thus would allow the implication of COVID-19 on episode costs to vary over time. This risk adjustment strategy effectively treats a community-level COVID-19 measure in each period as a separate patient characteristic term, which would then be incorporated to the Patient Case Mix Adjustment Amount and thereby the Patient Case Mix Adjustment (PCMA) term. In the Performance Period, the PCMA term will be updated using the actual Performance Period COVID-19 infection rate and the coefficient estimate for the final time period impacted by the pandemic during the baseline (episodes with start dates on or after March 1, 2022).

Q39: How long is the Hierarchical Condition Categories (HCC) lookback period for a Clinical Episode in Model Year 7?

A39: Starting in Model Year 5, CMS expanded the HCC lookback period before the start of a Clinical Episode shell from 90 days to 180 days. This period will include risk adjusters defined by beneficiary clinical history as observed in the claims in the 180-day period prior to the start of the Clinical Episode shell, and will be used solely for risk-adjusting Target Prices.

Additionally, the 180-day lookback period will also apply to the Clinical Episode-level exclusions that are dependent on the lookback period. As such, Clinical Episodes will be excluded where the beneficiary:

- Is not continuously enrolled in Medicare Part A and Part B during the Clinical Episode period of the 180-day lookback period.
- Is covered through managed care plans (such as Medicare Advantage) during the Clinical Episode period or the 180-day lookback period.
- Is receiving services for End-Stage Renal Disease (ESRD) during the Clinical Episode period or the 180-day lookback period.
- Has a primary payer other than Medicare during the Clinical Episode period or the 180-day lookback period.

Q40: In an outpatient Clinical Episode, how will an Anchor Procedure be assigned to a Healthcare Common Procedure Coding System (HCPCS) code when multiple triggering HCPCS codes are in the claim?

A40: In case of multiple triggering HCPCS codes on the same outpatient claim, the following tie-breaking rules are applied:

- Select the outpatient line with the higher standardized line allowed amount.
- Select the outpatient line with the later processing date.
- Select the outpatient line with the higher charge amount.
- Select the outpatient line with the smaller claim identifier number.
- Select the outpatient line with the smaller line item number.

The first day of an Anchor Procedure initiates an outpatient Clinical Episode. HCPCS codes identify the claim as an Anchor Procedure for CMS. The Anchor Procedure will be assigned based on the Comprehensive Ambulatory Payment Classification (C-APC). This is analogous to the Medicare Severity-Diagnosis Related Groups (MS-DRGs) grouping that determines payment from the inpatient

claim for an Anchor Stay.

Q41: Are Indirect Medical Education (IME) and Disproportionate Share (DSH) payments excluded from Target Prices and Reconciliation calculations? Is capital from inpatient hospital claims also excluded?
A41: Clinical Episode-level payments are created by summing official CMS standardized payments for all non-excluded services. These standardized payments reflect the cost of services after removing variation in spending arising from geographical adjustment of reimbursement in CMS payment systems (e.g., hospital wage index and geographic pricing cost index) and from policy-driven adjustments (e.g., IME adjustments). For more information on the official CMS standardization methodology, please visit the ResDac website: https://resdac.org/articles/cms-price-payment- standardization-overview.

For a complete list of payment exclusions from Clinical Episodes (for items and services and provided for certain readmissions, which are defined by MS-DRG; for some Part B drugs, which are defined by HCPCS codes; and for Cardiac Rehabilitation spending, which is identified by HCPCS code and place of service), please visit the CMS BPCI Advanced website: https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced/participant-resources.

Q42: What happens when a Clinical Episode is triggered because of an admission/Anchor Stay for a Medicare Severity-Diagnosis Related Group (MS-DRG) included on the Clinical Episode list, but then following discharge (but still during the 90-day episode window), a second admission occurs for a different MS-DRG/episode on the Clinical Episode list in Model Year 7?
A42: In Model Years 4-7, Clinical Episodes cannot overlap either in the baseline period or the Performance Period. As a general rule, the initial Anchor Stay/Anchor Procedure is kept and any readmissions that occur within the 90-day Post-Anchor Period are grouped to the initial Clinical Episode. Additionally, Clinical Episodes attributed to BPCI Advanced Participants take no special precedence over other Clinical Episodes. For instance, even when the original inpatient admission could not be attributed to a Participant, but a subsequent outpatient procedure could be attributed to a Participant, the updated policy would retain the initial inpatient Clinical Episode for the non-Participant and therefore, would not initiate an outpatient Clinical Episode due to the outpatient procedure for the Participant.

One caveat to this rule is when two Clinical Episodes for the same beneficiary are initiated on the same day, which can only occur if one episode is in the inpatient setting and one is in the outpatient setting. In this case, the inpatient Clinical Episode is always retained, and the outpatient episode is canceled. Two Clinical Episode Category-specific exceptions should also be noted. If a Major Joint Replacement of the Lower Extremity (MJRLE) Anchor Stay occurs within the 90-day Post-Anchor Period of an initial MJRLE Anchor Stay for the same beneficiary, the first Clinical Episode is canceled and the second one is retained regardless of the Clinical Episode participation status. If the initial Clinical Episode is a Percutaneous Coronary Intervention (PCI) and the subsequent Clinical Episode is a Transcatheter Aortic Valve Replacement (TAVR) or if a PCI and a TAVR Clinical Episode start on the same day, the TAVR Clinical Episode will be retained regardless of the Clinical Episode participation status.

A more detailed discussion of the precedence rules for selecting Clinical Episodes can be found in the Clinical Episode Construction Specifications – Model Year 7.

Q43: What are the location or setting exclusions for triggering Clinical Episodes?
A43: The following hospitals are excluded as Episode Initiators from the model: PPS-Exempt Cancer Hospitals, Critical Access Hospitals, hospitals in Maryland, hospitals participating in the Rural Community Hospital (RCH) demonstration, and all Participant Rural Hospitals in the Pennsylvania Rural Health Model. RCH and Pennsylvania Rural Health Model hospitals will be excluded if their participation in the RCH demonstration or Pennsylvania Rural Health Model overlaps with the Clinical Episode window in BPCI Advanced.

Q44: What does CMS consider short-term hospitals and which claim types or facilities would be included?
A44: The following hospitals are considered short-term hospitals for purposes of BPCI Advanced, and they would fall under the definition of acute-to-acute transfers in the specifications:

- Short term hospitals can be identified by a CCN with the last four digits between 0001-0899;
- Critical Access Hospitals (CAH) can be identified by a CCN that ends between 1300-1399;
- Emergency hospitals can be identified by a CCN that has either an E or F as the sixth digit; and
- Veterans' hospitals can be identified by a CCN that has a V as the fifth digit.

However, if such combined stays involve CAH or Cancer hospitals in any leg of the transfer, the stay will not trigger a Clinical Episode as those hospitals are excluded from BPCI Advanced. For additional information, please refer to the Research Data Assistant Center (or ResDAC) website for the provider number table to provide more information.

Q45: When different cardiac-related Clinical Episodes occur or overlap in the same 90-day period, how is this handled?
A45: Inpatient cardiac-related readmissions within 90 days of the end date of the Anchor Stay or Anchor Procedure will be bundled into the initial Clinical Episode. If the readmission maps to a Medicare Severity-Diagnosis Related Group (MS-DRG) on the Exclusions List, the costs for the admission, including any Part B claims paid during the readmission, will not be included in the Clinical Episode spending amount.

In the Model Year 3 Performance Period and Model Years 4-7 baseline period and Performance Period, if the initial Clinical Episode is a Percutaneous Coronary Intervention (PCI) and the subsequent Clinical Episode is a Transcatheter Aortic Valve Replacement (TAVR) or if a PCI and a TAVR Clinical Episode start on the same day, the TAVR Clinical Episode is retained regardless of the Clinical Episode participation status.

Q46: How will CMS account for the removal of Total Hip Arthroplasty (THA) from Medicare's Inpatient-Only List starting calendar year 2020?
A46: In response to the removal of THA procedures from Medicare's Inpatient-Only List starting calendar year 2020, outpatient THA was added as part of the multi-setting Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode, in addition to inpatient THA, in Model Year 5. Specifically, inpatient THA Clinical Episodes without Major Complication or Comorbidities (MCC) prior to CY2020 are selected for conversion to "pseudo-outpatient THA" Clinical Episodes, which means their observed Clinical Episode spending is edited to mimic that of an outpatient THA Clinical Episode during the Performance Period. This approach is similar to the treatment of outpatient Total Knee Arthroplasty (TKA) that has been implemented since Model Year 3. For additional information on how MJRLE Benchmark Prices are constructed, please refer to the Appendix in the Target Price Specifications MY7 document.

Q47: How will CMS account for the removal of Total Shoulder Arthroplasty (TSA) from Medicare's Inpatient-Only List starting calendar year 2021?
A47: In response to the removal of TSA procedures from Medicare's Inpatient-Only List starting calendar year 2021, the Major Joint Replacement of the Upper Extremity (MJRUE) has been made a multi-setting Clinical Episode to include outpatient TSA episodes (triggered by HCPCS 23472) in the model. This change remains consistent with how other procedures removed from the Inpatient Only List (e.g. Total Knee Arthroplasty & Total Hip Arthroplasty) were addressed. For additional information on how MJRUE Benchmark Prices are constructed, please refer to the Appendix in the Target Price Specifications MY7 document. Additionally, elbow replacements/reattachments and hand/wrist/lower arm replacements/reattachments procedures will be dropped from the MJRUE CEC. Only Clinical Episodes with Total Shoulder or Partial Shoulder procedure codes will be eligible to

trigger Clinical Episodes in this CEC.

Q48: With the inclusion of OP-TSA episodes, are there any changes to the risk-adjustment model specific to MJRUE?
A48: MS- MJRUE Clinical Episodes will be risk-adjusted based on two procedure groups (Total Shoulder and Partial Shoulder), a trauma/fracture flag, as well as the interactions between the procedure group and the trauma/fracture flag.

Q49: Per Article 5 of the Participation Agreement, an example of what will be excluded from each Clinical Episode includes "Contralateral procedures with the same MS-DRG or HCPCS". What CEC is this exclusion applicable to?
A49: Contralateral procedures with the same MS-DRG or HCPCS for a Major Joint Replacement of the Lower Extremity Clinical Episode (e.g., MJRLE that has a joint replaced in the opposite leg within 90 days) will be excluded. This exclusion is not applicable to any other CEC.

Q50: Will all Clinical Episodes be included in the baseline period, regardless of precedence or overlap with other models, such as the Comprehensive Care for Joint Replacement (CJR) model?
A50: In Model Years 1 & 2 and Model Year 3, the baseline period includes all Clinical Episodes, without consideration of the precedence rules used in the BPCI Advanced Model Performance Period. This overlap during the baseline period is allowed in order to maximize the number of baseline period Clinical Episodes that are used to create robust preliminary Target Prices. To address the concerns that Clinical Episodes that overlap may have different cost patterns from those that do not, a recent resource-use risk adjustment flag captures such cases in the data files. During the Performance Period, only one Clinical Episode can occur at a given time for a beneficiary.

This methodology was updated in Model Year 4, and continues in Model Year 7, where Clinical Episodes will not be allowed to overlap either in the baseline period or the Performance Period. However, beneficiaries aligned to CMS ACO models such as the ACO Realizing Equity, Access, and Community Health (ACO Reach) Model (formerly known as the Global and Professional Direct Contracting Model) and the Next Generation Accountable Care Organization (NGACO) Model are included in BPCI Advanced in the baseline period, and their spending is included when determining preliminary Target Prices.

Q51: What happens to BPCI Advanced Clinical Episodes at a CJR participant hospital? Will this change when CJR ends at the end of 2024?
A51: In Model Year 7, two outcomes are possible when a Clinical Episode is triggered at a CJR participant hospital.

The CJR Model consists of only one type of episode of care—Lower Extremity Joint Replacement (LEJR). In contrast, BPCI Advanced has multiple Clinical Episodes, one of which is Major Joint Replacement of the Lower Extremity (MJRLE). For practical purposes, LEJR and MJRLE are referring to the same type of episode. If a LEJR episode is triggered, the CJR episode of care has precedence over all BPCI Advanced Clinical Episodes, including MJRLE. This means that the LEJR episode would be attributed to the CJR participant hospital, and the BPCI Advanced Clinical Episode would not be attributed.

However, if a LEJR or MRJLE episode is not triggered, PGPs participating in BPCI Advanced have precedence over a CJR participant hospital that is also participating in BPCI Advanced for all other Clinical Episodes. Thus, all other Clinical Episodes, including Clinical Episodes in the orthopedic Clinical Episode Service Line Group minus MJRLE, that were triggered may be attributed to the PGP for BPCI Advanced.

The CJR Model is set to end after December 31, 2024. This means that CJR participant hospitals who participate in BPCI Advanced and who selected the Orthopedic Clinical Episode Service Line Group (CESLG) for Model Year 7 (2024) may be able to trigger MJRLE Clinical Episodes in Model Year 8

(2025). Please note that Model Year 7 CESLG selections are binding through Model Year 8, and Participants will not be able to add or change CESLG selections prior to Model Year 8.

Q52: How do CMS ACO initiatives impact BPCI Advanced Clinical Episodes?
A52: Participants in the Next Generation Accountable Care Organization (NGACO) Model; Vermont Medicare ACO Initiative; the Global and Professional Direct Contracting (GPDC) Model, now known as the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model; and the Comprehensive Kidney Care Contracting (CKCC) Options of the Kidney Care Choices (KCC) Model can participate in BPCI Advanced. In the baseline period, beneficiaries aligned to ACO models are included in BPCI Advanced and their spending is included when determining preliminary Target Prices. However, beneficiaries who are aligned or assigned to participants in these ACOs are not able to trigger BPCI Advanced Clinical Episodes in the Performance Period. If the Medicare provider serves other beneficiaries who are not aligned or assigned for purposes of these ACOs, those beneficiaries may be able to trigger a BPCI Advanced Clinical Episode.

An exception is participation in an ACO in the Medicare Shared Savings Program (MSSP). Beneficiaries assigned to any MSSP ACO are not excluded.

Starting in Model Year 6, BPCI Advanced Participants were provided access to the 4Innovation (4i) platform, which allows users to look up beneficiary alignment/assignment to certain CMS ACO initiatives. Resources are available in the Participant Portal to help users access and utilize the 4i platform.

Q53: How is ACO REACH attribution factored into baseline data since ACO REACH started after the baseline period? Based on the baseline data, will we need to internally identify the number of beneficiaries we would expect to align to ACO REACH during future years to assess the volume to expect in BPCI Advanced?
A53: In the baseline period, beneficiaries aligned to ACO models are included in BPCI Advanced and their spending is included when determining preliminary Target Prices. While the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model started after the baseline period, the predecessor model – the Global and Professional Direct Contracting Model – was present and those aligned beneficiaries were included in the Model Year 7 baseline. In the Performance Period, beneficiaries who are aligned to excluded ACOs, such as ACO REACH, are not eligible to trigger a BPCI Advanced Clinical Episode. The BPCI Advanced Model does not provide projections on the anticipated number of ACO REACH beneficiaries during the Performance Period given the voluntary nature of ACO REACH and the market for ACO REACH may differ geographically. It is up to the Participant to determine how they may want to account for the number of ACO REACH beneficiaries and what data sources to use when estimating potential Performance Period episode volume for BPCI Advanced. For reference, the ACO REACH model does publicly share an estimated volume of aligned beneficiaries for Performance Year 2023 as well as the list of Participants and their Core Service Area locations.

Q54: How will the newer Innovation Center models and initiatives impact BPCI Advanced payments?
A54: The Enhancing Oncology Model (EOM), which began in July 2023, can overlap with BPCI Advanced. However, BPCI Advanced will exclude carrier claims with an EOM per beneficiary per month (PBPM) payment, as defined by HCPCS code M0010, during the Performance Period. When BPCI Advanced and EOM episodes overlap, CMS will prorate the BPCI Advanced Reconciliation amount to capture overlapping expenditures. This prorated BPCI Advanced Reconciliation amount is included in EOM payment calculations such that episode expenditures are not double counted across the two models. This aligns with the overlap approach between BPCI Advanced and the Oncology Care Model (OCM), which impacted Model Years 1-5.

Regarding the models to come in CY2024, the Making Care Primary (MCP) Model and Guiding an Improved Dementia Experience (GUIDE) Model, BPCI Advanced will run concurrently with these

models. One model will not take precedence over the other, and CMS may adjust a BPCI Advanced Participant's Reconciliation amount to account for overlap with these models.

Q55: Why is the count of Clinical Episodes that appeared in the Performance Period different from the count seen in the baseline period for the same calendar year?
A55: Performance Periods from earlier Model Years of BPCI Advanced become part of the baseline period in later Model Years. For example, the Model Year 3 Performance Period, CY2020, is part of the Model Year 6 baseline period, FY2018-FY2021. BPCI Advanced exclusions vary between Model Years and between the baseline and the Performance Periods. For example, Clinical Episodes where a beneficiary is aligned or assigned to certain ACO models are excluded in the Performance Period but not in the baseline period. Similarly, the BPCI Advanced Natural Disaster exclusion policy is only applicable in the Performance Period. These differences can result in different episode volumes for the same time period when comparing the baseline period data with the Performance Period data.

Q56: How can a Clinical Episode have a drop flag turned on in the monthly files, but be included and attributed to a Participant during Reconciliation?
A56: There are several elements that can differ between the monthly files and Reconciliation cycles. First, the claims used for monthly files can differ from the claims used for Reconciliation. CMS will always note the claims processing date for a Reconciliation cycle, which will align with a specific monthly file run (e.g., Spring 2023 Reconciliation aligns with the March 2023 monthly files run). Previous and subsequent monthly files will use claims and Master Data Management (MDM) cuts processed at a different date and may contain varying information for a particular Clinical Episode, such as alignments with other ACO models, updated secondary insurance payer information, COVID- 19 diagnosis, etc.

Secondly, an episode may be flagged for overlap with another episode in the monthly files, but since only a limited number of Performance Periods are reconciled in a given cycle, certain overlaps may not be flagged during Reconciliation. For example, in Spring 2023 Reconciliation, overlap resolution was not performed between PP8 and PP9 Clinical Episodes. An episode may be flagged for overlap with a PP9 Clinical Episode in the monthly files, but it will not be flagged as such until overlap resolution is performed between PP8 and PP9 during Reconciliation. Please note that data in the monthly files should always be considered preliminary and is subject to change as updated information is processed.

Reconciliation and Payment

Q57: What is CMS's approach to Reconciliation?
A57: Approximately every six months, CMS will do a retrospective Reconciliation comparing the total of actual non-excluded Medicare FFS expenditures for each Clinical Episode to the final Target Price for that Clinical Episode. Clinical Episodes will be reconciled based on the Performance Period during which the Clinical Episode ends, which is determined by the last day of the post-discharge period. The initial Reconciliation for each Performance Period will be performed using two months of claims run-out. In a given Reconciliation cycle, there will be multiple Performance Periods being reconciled based on the Clinical Episode end date. The previous Reconciliation cycles, upcoming Fall 2023 cycle, and the cycles slated for 2024, along with the Performance Periods being reconciled, are listed below:

- Fall 2019
    - Model Years 1&2 Performance Period 1 (initial): Clinical Episode end date in October 1, 2018 – June 30, 2019 and anchor start date on or after October 1, 2018.
- Spring 2020
    - Model Years 1&2 Performance Period 1 (True-Up 1): Clinical Episode end date in October 1, 2018 – June 30, 2019 and anchor start date on or after October 1, 2018.
    - Model Years 1&2 Performance Period 2 (initial): Clinical Episode end date in July 1, 2019 – December 31, 2019.
- Fall 2020

    - Model Years 1&2 Performance Period 1 (True-Up 2): Clinical Episode end date in October 1, 2018 – June 30, 2019 and anchor start date on or after October 1, 2018
    - Model Years 1&2 Performance Period 2 (True-Up 1): Clinical Episode end date in July 1, 2019 – December 31, 2019.
    - Model Years 1&2 Performance Period 3 (initial): Clinical Episode end date in January 1, 2020 – March 31, 2020 and anchor end date on or before December 31, 2019.
    - Model Year 3 Performance Period 3 (initial): Clinical Episode end date in January 1, 2020 – June 30, 2020 and anchor end date on or after January 1, 2020.
- Spring 2021
    - Model Years 1&2 Performance Period 2 (True-Up 2): Clinical Episode end date in July 1, 2019 – December 31, 2019.
    - Model Years 1&2 Performance Period 3 (True-Up 1): Clinical Episode end date in January 1, 2020 – March 31, 2020 and anchor end date on or before December 31, 2019.
    - Model Year 3 Performance Period 3 (True-Up 1): Clinical Episode end date in January 1, 2020 – June 30, 2020 and anchor end date on or after January 1, 2020.
    - Model Year 3 Performance Period 4 (initial): Clinical Episode end date in July 1, 2020 – December 31, 2020.
- Fall 2021
    - Model Years 1&2 Performance Period 3 (True-Up 2): Clinical Episode end date in January 1, 2020 – March 31, 2020 and anchor end date on or before December 31, 2019.
    - Model Year 3 Performance Period 3 (True-Up 2): Clinical Episode end date in January 1, 2020 – June 30, 2020 and anchor end date on or after January 1, 2020.
    - Model Year 3 Performance Period 4 (True-Up 1): Clinical Episode end date in July 1, 2020 – December 31, 2020.
    - Model Year 3 Performance Period 5 (initial): Clinical Episode end date in January 1, 2021 – March 31, 2021 and anchor end date on or before December 31, 2020.
    - Model Year 4 Performance Period 5 (initial): Clinical Episode end date in January 1, 2021 – June 30, 2021 and anchor end date on or after January 1, 2021.
- Spring 2022
    - Model Year 3 Performance Period 4 (True-Up 2): Clinical Episode end date in July 1, 2020 – December 31, 2020.
    - Model Year 3 Performance Period 5 (True-Up 1): Clinical Episode end date in January 1, 2021 – March 31, 2021 and anchor end date on or before December 31, 2020.
    - Model Year 4 Performance Period 5 (True-Up 1): Clinical Episode end date in January 1, 2021 – June 30, 2021 and anchor end date on or after January 1, 2021.
    - Model Year 4 Performance Period 6 (initial): Clinical Episode end date in July 1, 2021 – December 31, 2021.
- Fall 2022
    - Model Year 3 Performance Period 5 (True-Up 2): Clinical Episode end date in January 1, 2021 – March 31, 2021 and anchor end date on or before December 31, 2020.
    - Model Year 4 Performance Period 5 (True-Up 2): Clinical Episode end date in January 1, 2021 – June 30, 2021 and anchor end date on or after January 1, 2021.
    - Model Year 4 Performance Period 6 (True-Up 1): Clinical Episode end date in July 1, 2021 – December 31, 2021.
    - Model Year 4 Performance Period 7 (initial): Clinical Episode end date in January 1, 2022 – March 31, 2022 and anchor end date on or before December 31, 2021.
    - Model Year 5 Performance Period 7 (initial): Clinical Episode end date in January 1, 2022 – June 30, 2022 and anchor end date on or after January 1, 2022.
- Spring 2023

    - Model Year 4 Performance Period 6 (True-Up 2): Clinical Episode end date in July 1, 2021 – December 31, 2021.
    - Model Year 4 Performance Period 7 (True-Up 1): Clinical Episode end date in January 1, 2022 – March 31, 2022 and anchor end date on or before December 31, 2021.
    - Model Year 5 Performance Period 7 (True-Up 1): Clinical Episode end date in January 1, 2022 – June 30, 2022 and anchor end date on or after January 1, 2022.
    - Model Year 5 Performance Period 8 (initial): Clinical Episode end date in July 1, 2022 – December 31, 2022.
- Fall 2023
    - Model Year 4 Performance Period 7 (True-Up 2): Clinical Episode end date in January 1, 2022 – March 31, 2022 and anchor end date on or before December 31, 2021.
    - Model Year 5 Performance Period 7 (True-Up 2): Clinical Episode end date in January 1, 2022 – June 30, 2022 and anchor end date on or after January 1, 2022.
    - Model Year 5 Performance Period 8 (True-Up 1): Clinical Episode end date in July 1, 2022 – December 31, 2022.
    - Model Year 5 Performance Period 9 (initial): Clinical Episode end date in January 1, 2023 – March 31, 2023 and anchor end date on or before December 31, 2022.
    - Model Year 6 Performance Period 9 (initial): Clinical Episode end date in January 1, 2023 – June 30, 2023 and anchor end date on or after January 1, 2023.
- Spring 2024
    - Model Year 5 Performance Period 8 (True-Up 2): Clinical Episode end date in July 1, 2022 – December 31, 2022.
    - Model Year 5 Performance Period 9 (True-Up 1): Clinical Episode end date in January 1, 2023 – March 31, 2023 and anchor end date on or before December 31, 2022.
    - Model Year 6 Performance Period 9 (True-Up 1): Clinical Episode end date in January 1, 2023 – June 30, 2023 and anchor end date on or after January 1, 2023.
    - Model Year 6 Performance Period 10 (initial): Clinical Episode end date in July 1, 2023 – December 31, 2023.
- Fall 2024
    - Model Year 5 Performance Period 9 (True-Up 2): Clinical Episode end date in January 1, 2023 – March 31, 2023 and anchor end date on or before December 31, 2022.
    - Model Year 6 Performance Period 9 (True-Up 2): Clinical Episode end date in January 1, 2023 – June 30, 2023 and anchor end date on or after January 1, 2023.
    - Model Year 6 Performance Period 10 (True-Up 1): Clinical Episode end date in July 1, 2023 – December 31, 2023.
    - Model Year 6 Performance Period 11 (initial): Clinical Episode end date in January 1, 2024 – March 31, 2024 and anchor end date on or before December 31, 2023.
    - Model Year 7 Performance Period 11 (initial): Clinical Episode end date in January 1, 2024 – June 30, 2024 and anchor end date on or after January 1, 2024.

Q58: What safeguards are in place to protect Participants against significant financial risk?
A58: In Model Years 1 through 7, a 20 percent stop-loss and stop-gain policy is applied at the level of the Episode Initiator (EI). In other words, the results of all the Clinical Episodes during the Performance Period are aggregated to the EI level prior to applying the stop-loss or stop-gain cap.
The stop-loss and stop-gain policy prevents Adjusted Negative/Positive Total Reconciliation Amounts from being in excess of 20 percent of the final Target Price for a given Episode Initiator. At the individual Clinical Episode level, the Clinical Episodes for which the Participant has committed to be accountable are Winsorized, or capped, at the 1st and 99th percentiles of the total standardized allowable amounts within the Clinical Episode Category, based on the national dataset of Clinical Episodes. Winsorization helps to limit the effects of extreme values or outliers.

Q59: Would CMS please explain how the potential 10 percent quality adjustment is applied to Negative or Positive Total Reconciliation Amounts?
A59: The Composite Quality Score (CQS) Adjustment Amount is applied at the Episode Initiator (EI) level to any Positive Total Reconciliation Amount or Negative Total Reconciliation Amount. The amount by which these Reconciliation amounts may be adjusted is capped at 10 percent.

At the EI level, the CQS adjustment cannot make a Negative Total Reconciliation Amount more negative and cannot reduce the magnitude of a Positive or Negative Total Reconciliation Amount by more than 10 percent.

For more information, please review the Reconciliation Specifications – Model Year 5. CMS anticipates releasing the Model Year 6 and Model Year 7 Reconciliation Specifications in the future.

Q60: How are the Reconciliation payment amounts calculated in the demand letters/payment made to Participants in the Spring and Fall Reconciliation cycles?
A60: CMS combines the NPRA and Repayment amounts across the Model Years and Performance Periods in a given Spring or Fall Reconciliation cycle to create one combined Reconciliation amount for each Parent BPID. These amounts can be found in the *Recon_Total* tab and the *True-up_Amount* tabs in the Reconciliation Reports released by CMS every Spring and Fall.

Below is an example of how the combined payment amount is calculated using fabricated values. Parent

BPID: H200-0000's Spring 2023 Combined Reconciliation payment amount:

- Model Year 4 Performance Period 6 True-Up 2 amount: (-$97,450.00)
- Model Year 4 Performance Period 7 True-Up 1 amount $145,560.56
- Model Year 5 Performance Period 7 True-Up 1 amount: $201,006.77
- Model Year 5 Performance Period 8 Initial amount: (-$178,534.20)
- **Total combined Spring 2023 Reconciliation payment amount: $70,583.13**

Q61: Is it possible for a Clinical Episode to be incorrectly attributed to my organization at Reconciliation?
A61: If a Participant suspects there is a Clinical Episode that is incorrectly attributed to them or suspects there is an error in the calculation of a final Target Price or a Reconciliation amount, then the Participant may submit a Calculation Error Notice. Calculation Error Notices must be submitted within 29 days from when CMS releases Reconciliation Reports. CMS will review the Calculation Error Notice and will provide a CMS Calculation Error Response. If a Participant does not agree with the CMS Calculation Error Response, then the Participant may submit a Reconsideration Review within 10 days. A CMS Reconsideration Official reviews the request and makes a Reconsideration Determination. If the Participant does not agree with the determination, then they may submit a request for CMS Administrator Review within 30 days. This request may be granted or denied. If it's denied, then the Reconsideration Determination is deemed final. If the CMS Administrator Review is granted, then the Participant will receive a written determination which will be deemed final.

Q62: Will Participants receive non-reconciled Clinical Episode data in the Reconciliation files?
A62: Yes, Participants will receive data for both final and non-final Clinical Episodes in the Reconciliation files. Non-final Clinical Episodes will have drop flags turned on which specify the reason as to why the Clinical Episode was excluded from the model.

Q63: Where should Participants download Reconciliation reports from?
A63: CMS uploads the Reconciliation Reports for every Spring and Fall cycle to the CMS Enterprise Data Portal (https://portal.cms.gov/portal/). If a Participant does not find a report uploaded for a specific BPID it may be due to the Episode Initiator not having any final Clinical Episodes for the relevant Reconciliation cycle.

During the Performance Period, it may be easier for Participants to estimate the number of ACO

REACH beneficiaries because Participants are eligible to receive monthly claims data on potential Clinical Episodes, which includes variables on whether the beneficiary may be aligned to an excluded ACO. Additionally, new Participants will be given access to an online platform, 4innovation (4i), that allows them to look-up beneficiary alignment/assignment to certain CMS ACO initiatives, including ACO REACH.

Q64: If we won't receive final Target Prices until Reconciliation, how will I know how well I'm performing during the Performance Period?
A64: The BPCI Advanced Model provides Participants data throughout the Performance Period to help Participants gauge and predict their performance. This data includes:

- Monthly claims data that provides potential Clinical Episodes that are triggered by the Participant and/or their Episode Initiators for each month of the Performance Period. Data is provided in raw and/or summary formats.
- A monthly Peer Group Average Clinical Episode Spending Report that helps Participants compare their Clinical Episode spending against their Peer Group's average Clinical Episode spending.
- A Peer Group Trend Factor Adjustment Calculation Quarterly Report which provides updated preliminary PGT Factor Adjustment values to help Participants estimate Target Prices.
- Updated Target Prices that factors in new fiscal year and calendar year payment rates.

While we do have limitations on the data that we can share, we're always open to hearing suggestions on other data that may be helpful for Participants to have.

Q65: When will CMS release the Secondary Repayment Source (SRS), such as a letter of credit or escrow account, if a Participant has terminated from the BPCI Advanced Model?
A65: The SRS must remain in effect until at least 24 months after the conclusion of the Performance Period ongoing at the end of the Agreement Performance Period or until all of the Participant's financial obligations to CMS pursuant to the BPCI Advanced Participation Agreement have been fulfilled, whichever is later**.**