Bundled Payments for Care Improvement Advanced | BPCI Advanced

Model Overview Fact Sheet – Model Year 6 (2023)

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is a voluntary value-based payment model from the Center for Medicare and Medicaid Innovation, and tests whether linking payments for a Clinical Episode can reduce Medicare expenditures while maintaining or improving the quality of care.

BPCI Advanced started on October 1, 2018 for the first cohort of Participants, and on January 1, 2020 for the second cohort of Participants. Now that the Model has been extended for two years**, a third cohort of Participants will commence on January 1, 2024. The Model will conclude on December 31, 2025.**

Model Drivers

Care Coordination: Continuously reengineering care

Financial Accountability: Testing a payment model for the outcomes of improved quality and reduced spending

Data Analysis & Feedback: Eliminating low-value care and fostering quality improvement

Health Care Provider Engagement: Stimulating rapid development of new evidence-based knowledge with providers

Beneficiary Engagement: Increasing the likelihood of better health at a lower cost through education and ongoing communication

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Model Timeline Two-Year Extension

2018
- Jan. 8, 2018 – CMS announced new Model
- Oct. 1, 2018 – Start Model Year 1 and First Cohort of Participants

2019
- Jan. 1, 2019 – Start Model Year 2
- Mar. 1, 2019 – Retroactive withdrawal deadline

2020
- Jan. 1, 2020 – Start Model Year 3 and Second Cohort of Participants
- June 22, 2020 – COVID-19 flexibilities announced & Bilateral Amendment MY3

2021
- Jan. 1, 2021 – Start Model Year 4
- Dec. 10, 2021 - COVID-19 flexibilities Unilateral Amendment MY4

2022
- Jan. 1, 2022 – Start Model Year 5
- Sept. 2022 - COVID-19 Bilateral Amendment MY5
- Oct. 14, 2022 – Two-Year Model Extension and Methodology Changes announced

2023
- **Jan. 1, 2023 – Start Model Year 6**
- **Early 2023 – Request for Applications (RFA) for Model Year 7 released & Application Portal Opens**
- **Late Fall – Selection of new Participants for MY7**

2024
- Jan. 1, 2024 – Start Model Year 7 and Third Cohort of Participants

2025
- Jan. 1, 2025 – Start Model Year 8
- Dec. 31, 2025 – End Model's period of performance

October 2022

Pricing Methodology Changes for Model Year 6 (2023)

CMS is changing the pricing methodology of BPCI Advanced to keep Participants engaged in value-based care through the Model.

In Model Year 6 (2023), the following changes will be implemented:

- ❑ Reducing the CMS Discount for medical Clinical Episodes from 3% to 2%.
- ❑ Reducing the Peer Group Trend (PGT) Factor Adjustment cap for all Clinical Episodes from 10% to 5%.
- ❑ Making major joint replacement of the upper extremity (MJRUE) a multi-setting Clinical Episode category by including outpatient total shoulder arthroplasty (TSA) procedures (triggered by HCPCS 23472) in the model. CMS will also include a trauma/fracture flag and MJRUE procedure group flag along with their interactions in the risk adjustment for this Clinical Episode.
- ❑ Holding participants for all Clinical Episodes in which the beneficiary has a COVID-19 diagnosis during the Clinical Episode.

https://innovation.cms.gov/innovation-models/bpci-advanced

Request for Applications (RFA) for Model Year 7 (2024) Coming Early 2023

To apply, **Non-Convener Participants** are required to be either Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs).

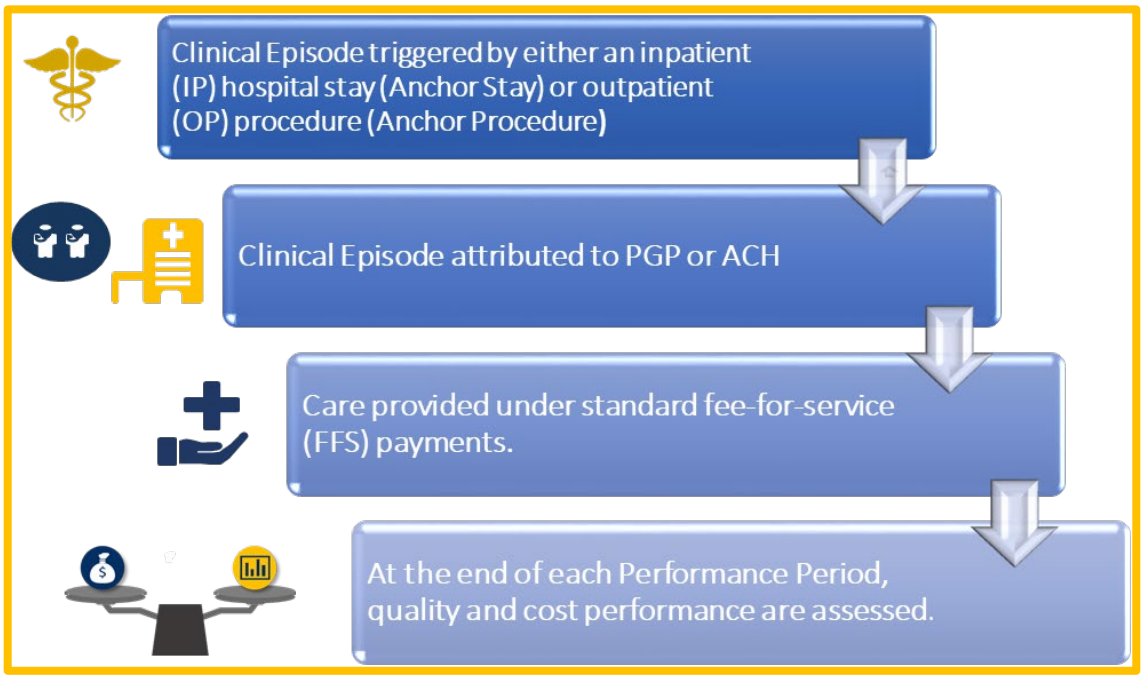
To apply, **Convener Participants** are required to be Medicare-enrolled providers or suppliers, or Medicare Accountable Care Organizations (ACO).

Episode Initiators (ACHs or PGPs) who have **previously participated** in the BPCI Advanced Model but are no longer active will also have the opportunity to apply for Model Year 7 (2024) during this application period.

Non- Convener Participants and Convener Participants active during Model Year 6 (2023), even if they are not a Medicare-enrolled provider or supplier or ACO, will have the opportunity to sign an Amended and Restated Participation Agreement for Model Year 7 (2024).

More details will be made available when the RFA is released in early 2023.

How Does BPCI Advanced Works?



Main Characteristics of the BPCI Advanced Model

- **Participation in Value-Based Care Model**

  BPCI Advanced is a voluntary model.

- **Payment**

  A single retrospective payment for Clinical Episodes included in Clinical Episode Service Line Groups (CESLGs) for which the Participant has accepted financial liability. (see the complete list of CESGLs on page 6).

- **Clinical Episodes**

  Participants are required to select from 8 CESLGs. For Model Year 6 (2023), Participants are accountable for each Clinical Episode (inpatient or outpatient) within the CESLGs they selected in Model Year 4 (2021).

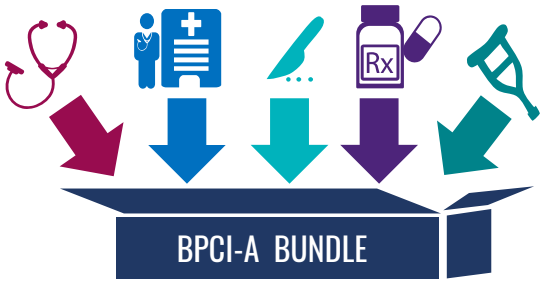
- **Target Prices**

  Preliminary TPs are provided to Participants in advance of the start of the Model Year. Final TPs are adjusted during the semi-annual Reconciliation process to reflect actual patient case mix and realized trend adjustment during the applicable Performance Period.

- **Advanced Alternative Payment Model**

  Three criteria qualifies the BPCI Advanced Model as an Advanced Alternative Payment Model: (1) bearing of financial risk, (2) use of Certified Electronic Health Record Technology, and (3) tying payment to performance on Quality Measures.

What is in a "Bundle"?



Items and Services Included in a Clinical Episode:

(Unless Specifically Excluded)

- ✓ Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure (respectively)
- ✓ Clinical laboratory services, durable medical equipment
- ✓ Inpatient hospital readmission services; Other hospital outpatient services
- ✓ Physicians' services
- ✓ Part B drugs
- ✓ Skilled nursing facility services
- ✓ Inpatient rehabilitation facility services
- ✓ Long-term care hospital services
- ✓ Home health agency services
- ✓ Hospice services

A Beneficiary is Included in a Clinical Episode when:

A Medicare beneficiary entitled to benefits under Part A and enrolled under Part B for the entirety of a Clinical Episode on whose behalf an Episode Initiator submits a claim to Medicare FFS for the Anchor Stay or Anchor Procedure associated with the Clinical Episode for which a Participant has committed to be held accountable.

The Following are Examples of What Will Be Excluded from Clinical Episodes:

Excluded readmissions – All Medicare Part A and Part B services furnished to a BPCI Advanced beneficiary during certain specified ACH admissions and readmissions (i.e., ACH admissions assigned at discharge to an MS-DRG for an organ transplant, trauma, cancer-related care, or ventricular shunts)

Excluded procedures – Contralateral procedures with the same MS-DRG (e.g., MJRLE Clinical Episode that has a joint replaced in the opposite leg within 90 Days)

Excluded Cardiac Rehab Codes – Payments for items and services for cardiac rehabilitation and intensive cardiac rehabilitation described in 42 C.F.R. § 410.49

Excluded Part B drugs; excluded IBD Part B drugs; excluded Hemophilia drugs

New technology add-on payments made pursuant to 42 C.F.R. § 412.87 and 42 C.F.R. § 412.88

Payments for items and services with transitional pass-through payment status made pursuant to 42 C.F.R. § 419.62 and 42 C.F.R. § 419.66

Please review the BPCI Advanced Exclusion List – MY5 workbook currently available in the BPCI Advanced website.

CMS reserves the right to modify this list at any time to add or remove MS-DRGs and HCPCS codes.

The MY6 Exclusion List will be posted in early 2023.

The Term 'BPCI Advanced Beneficiary' Specifically Excludes:

- ✓ Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage Health Care Prepayment Plans, or cost-based Health Maintenance Organizations)
- ✓ Beneficiaries eligible for Medicare on the basis of End-Stage Renal Disease (ESRD)
- ✓ Medicare beneficiaries for whom Medicare is not the primary payer, at any time during the Clinical Episode
- ✓ Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure

The Model has 34 Clinical Episodes Grouped in Eight Service Line Groups.
There are 29 Inpatient CEs, 3 Outpatient CEs and 2 Multi-Setting Clinical Episode Categories.

Clinical Episodes Service Line Groups (CESLGs)

Cardiac Care

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

Neurological Care

- Seizures
- Stroke

Spinal Procedures

- Back and Neck Except Spinal Fusion (Inpatient)
- Back and Neck Except Spinal Fusion (Outpatient)
- Spinal Fusion

Gastrointestinal Surgery

- Bariatric Surgery
- Major Bowel Procedure

Gastrointestinal Care

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

Orthopedics

- Double Joint Replacement of the Lower Extremity
- Fractures of the Femur and Hip or Pelvis
- Hip and Femur Procedures Except Major Joint
- Lower Extremity/Humerus Procedure Except Hip, Foot, Femur
- Major Joint Replacement of the Lower Extremity (MJRLE) *(Multi -setting Inpatient/ Outpatient)*
- Major Joint Replacement of the Upper Extremity *(Multi -setting Inpatient / Outpatient)*

Cardiac Procedures

- 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)

Medical & Critical Care

- Sepsis
- Cellulitis
- Renal Failure
- Urinary Tract Infection
- Simple Pneumonia and Respiratory Infections
- Chronic Obstructive Pulmonary Disease, Bronchitis, Asthma

Clinical Episodes Definitions

Clinical Episode (CE) Triggers:

Inpatient CEs are triggered by the submission of a claim to Medicare FFS by an EI for the inpatient hospital stay, identified by Medicare Severity-Diagnosis Related Group (MS-DRG).

Outpatient CEs are triggered by the submission of a claim to Medicare FFS by an EI for the outpatient procedure, identified by a Healthcare Common Procedure Coding System (HCPCS) code.

Clinical Episode (CE) Length:

Inpatient CE / Anchor Stay: Anchor Stay + 90 days; the date of discharge is day 1 of the 90-day period.

Outpatient CE / Anchor Procedure: Anchor Procedure + 90 days; the date the outpatient procedure is completed is day 1 of the 90-day period.

KEY POINT: Precedence Rules during the Reconciliation Process

1. The PGP that submits a claim that includes the National Provider Identifier for the attending physician
2. The PGP that submits a claim that includes the NPI of the operating physician
3. The ACH where the services that triggered the Clinical Episode were furnished

Potential Clinical Episode is Identified

Is the attending physician's NPI* associated with a participating PGP?

Yes → Assign Clinical Episode to that PGP.

No

Is the operating physician's NPI associated with a participating PGP?

Yes → Assign Clinical Episode to that PGP.

No

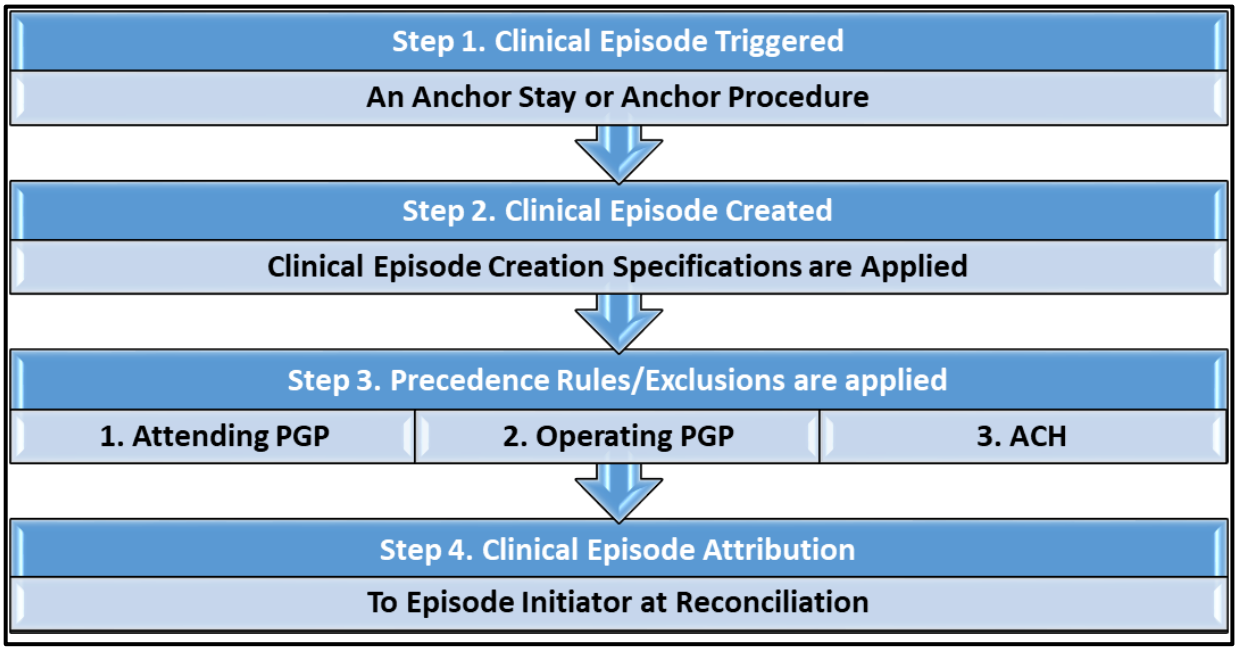
Does the Anchor Stay/Anchor Procedure occur at a participating ACH?

Yes → Assign Clinical Episode to that ACH.

No

No BPCI Advanced Clinical Episode is triggered.

Clinical Episodes Attribution Process



Target Price Definition

Target Price = **Benchmark Price** × **(1- CMS Discount)**

KEY POINT:
Starting in Model Year 6, CMS Discount for
Medical Clinical Episodes = 2%
Surgical Clinical Episodes = 3%

Baseline Periods Used to Create Benchmark Prices

In BPCI Advanced, the baseline periods shift forward every Model Year.

For Model Years 1 and 2, the baseline period includes all Anchor Stays/Anchor Procedures ending between January 1, 2013 and December 31, 2016

For Model Year 3, the baseline period is between October 1, 2014 and September 30, 2018

For Model Year 4, the baseline period is between October 1, 2015 and September 30, 2019

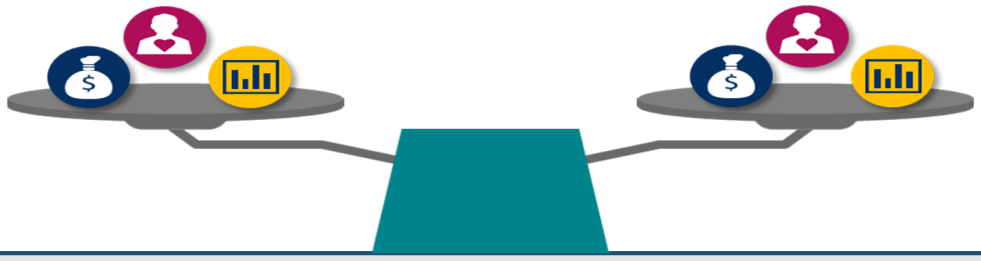
For Model Year 5, the baseline period is between October 1, 2016 and September 30, 2020

For Model Year 6, the baseline period is between October 1, 2017 and September 30, 2021 (Will include Medicare Beneficiaries with a COVID-19 diagnosis at any time during the Clinical Episode.)

Determining The Benchmark Price

Benchmark Price for ACHs:

CMS will use risk adjustment models to account for the three central factors (illustrated below) in the standardized spending amounts for the applicable Clinical Episode.



The **Hospital's Benchmark Price** accounts for three central factors:

- Patient case-mix
- Historic Medicare FFS expenditures during the ACH's Baseline Period
- Patterns of spending relative to the ACHs peer group

Benchmark Price for ACHs:

- ❑ To calculate an Acute Care Hospital (ACH's) Benchmark Price, CMS will account for the hospital's spending patterns relative to the ACH's peer group over time. Peer groups are based on relevant hospital characteristics, such as census division, bed size, major teaching hospital status, safety net status, and urban versus rural status.

Benchmark Price for PGPs:

- ❑ 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.

When Creating Target Prices the Concept is Simple, but the Math is Complex

- ❑ 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.

Preliminary Target Prices = [Standardized Baseline Spending (SBS) **X** Patient Case Mix Adjustment (PCMA) **X** Peer Group Historical Adjustment (PGHA) **X** Peer Group Trend (PGT) **X** CMS Discount

Final Target Prices = [Standardized Baseline Spending (SBS) **X** Patient Case Mix Adjustment (PCMA) **X** Peer Group Historical Adjustment (PGHA) **X** Peer Group Trend (PGT) **X** PGT Factor Adjustment **X** CMS Discount

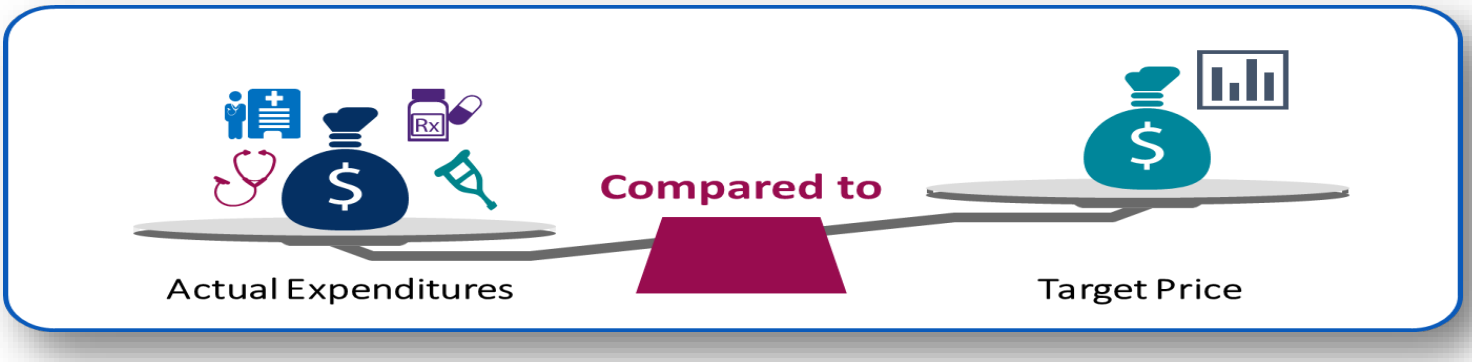
- ❑ Preliminary Target Prices will be provided to Participants prior to the beginning of each Model Year.
- ❑ Final Target Prices will be constructed during Reconciliation and will include updated patient case mix and realized trends.
- ❑ For the technical specifications on creating Target Prices, visit the BPCI Advanced webpage Participants Resources - Technical documents

KEY POINT:
Starting in Model Year 6, the Peer Group Trend (PGT) Factor Adjustment will be capped at 5% for all Clinical Episodes.

Pricing Adjustments

- ❑ **Risk Cap:** The risk cap is applied to Clinical Episodes at the 1st and 99th percentile of spending in both the Performance Period and the baseline period.
- ❑ **Post-Episode Spending Monitoring Period:** Any Medicare FFS expenditures for items and services furnished to a BPCI Advanced beneficiary during the 30-day Post-Episode Monitoring Period that exceeds an empirically titrated risk threshold must be paid to Medicare by the Participant. The Post-Episode Spending Calculation will be performed by CMS on a semi-annual basis during the first true-up Reconciliation.
- ❑ **Stop-loss/stop-gain limits:** Reconciliation payments, both to Participants from CMS and from Participants to CMS, are capped at +/-20% of the volume-weighted sum of the final Target Prices across all Clinical Episodes netted to the level of the EI within the Performance Period.

Reconciliation is Based on Comparing Actual Medicare FFS Expenditures to the Final Target Price



KEY POINTS:

- ❑ Clinical Episodes will be reconciled based on the Performance Period in which the Clinical Episode ends.
- ❑ Semi-annual Reconciliation will include two (2) "True-Ups" to allow for claims run-out.
- ❑ Performance Periods: January – June and July - December

- ❑ Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in CY2022 and Clinical Episode end dates in CY2023 will be considered MY5 Clinical Episodes, but will still be reconciled in the Performance Period (PP) in which they end (PP9).
- ❑ Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in CY2023 and Clinical Episode end dates in CY2023 will be considered MY6 Clinical Episodes but will still be reconciled in the Performance Period (PP) in which they end.
- ❑ Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in CY2023 and Clinical Episode end dates in CY2024 will be considered MY6 Clinical Episodes.

Reconciliation Process

Positive or Negative Reconciliation Amount

Determined for each Clinical Episode

All non-excluded Medicare FFS expenditures will be compared against the final Target Price

The resulting dollar amount may be positive or negative

Positive or Negative *Total* Reconciliation Amount

All Positive and Negative Reconciliation Amounts will be netted across all Clinical Episodes attributed to an Episode Initiator (EI)

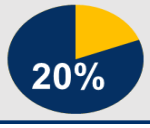
The result is a TOTAL Reconciliation Amount

The TOTAL Reconciliation dollar amount may be Positive or Negative

Adjusted Positive or Negative *Total* Reconciliation Amount

The Positive or Negative Total Reconciliation Amount for an EI is then adjusted based on quality performance, resulting in the Adjusted Positive or Negative Total Reconciliation Amount

The Composite Quality Score (CQS) adjustment is limited to a maximum of 10%



A stop loss/stop gain of 20% will apply to the Reconciliation Amount at the EI level

KEY POINTS:

Net Payment Reconciliation Amount (NPRA) - **Payment by CMS to Participant**

Repayment Amount - **Payment by Participant to CMS**

Quality Measures

Participants will have the flexibility to be assessed on quality by selecting either the Administrative Quality Measures Set or the Alternate Quality Measures Set, for each CE within a CESLG that they have committed to be held accountable. The established Composite Quality Score (CQS) calculation methodology will apply to both measure sets.

Administrative Quality Measures Set

The Administrative Quality Measures Set, used starting in Model Year 1, contains seven exclusively claims-based measures directly collected by CMS.

Alternate Quality Measures Set

The Alternate Quality Measures Set, used starting in Model Year 4, includes a combination of up to five claims-based and registry-based measures for each Clinical Episode. The Alternate Quality Measures Set was developed after CMS gathered information from various stakeholders and established registries to identify a set of tailored quality measures that align with each of the specialty-specific Clinical Episodes in the Model.

Clinical Episodes to Quality Measures Correlation Table

To aid the Participants in their selections, the Correlation Table identifies Clinical Episodes by Code and Quality Measures Sets.

Updated Quality Measures resources for MY6 will be posted to the BPCI Advanced webpage, prior to the start of 2023.

Monitoring and Compliance

CMS may monitor Model performance by:

- ❑ Claims data tracking
- ❑ Ad-hoc audits and analysis of performance measurements
- ❑ Site visits, surveys, and interviews with Participants, EIs, Participating Practitioners, and other parties

The Learning System develops events and creates resources to support and engage Participants in care redesign activities. The Reflect and Reset for MY5 provides key insights about Participants' successes and challenges.

BPCI Advanced Reflect and Reset Infographic – MY5 CRP Takeaways

Evaluation Reports Published

Third Evaluation Report *(February 2022)*

- Findings At-a-Glance
- Full Report
- Appendices

Second Evaluation Report *(April 2021)*

- Findings At-a-Glance
- Full Report
- Appendices

First Evaluation Report *(June 2020)*

- Findings At-a-Glance
- Full Report
- Appendices

Fourth Evaluation Report to be released in Spring 2023

Overlap with Other CMMI Models

The BPCI Advanced Model has policies to address overlap with other CMS models, programs, or initiatives.

- ❑ **Comprehensive Care for Joint Replacement Model (CJR) –** CJR episodes have precedence over BPCI Advanced Clinical Episodes and will be excluded from Reconciliation for BPCI Advanced Model Participants.
- ❑ **Medicare Shared Savings Programs –** Since January 2020, BPCI Advanced will not exclude Clinical Episodes (or Medicare FFS expenditures) for beneficiaries assigned to Shared Savings Program Accountable Care Organizations (ACOs).
- ❑ **ACO REACH -** In early 2022, CMS announced the Global and Professional Direct Contracting (GPDC) Model will transition to the ACO Realizing Equity, Access, and Community Health (REACH) Model on January 1, 2023. The BPCI Advanced Model currently excludes beneficiary overlap with the GPDC Model and will continue that policy when ACO REACH participation begins on January 1, 2023. Therefore, BPCI Advanced Participants may also participate in ACO REACH. However, beneficiaries who are aligned to a REACH ACO are not able to trigger BPCI Advanced Clinical Episodes. If the BPCI Advanced Participant serves other beneficiaries who are not aligned to a REACH ACO, those beneficiaries would be able to trigger a BPCI Advanced Clinical Episode.
- ❑ ACO models that are not allowed to overlap with BPCI Advanced Clinical Episodes include - the **Vermont Medicare ACO Initiative** and the **Comprehensive Kidney Care Contracting (CKCC)** Options of the Kidney Care Choices (KCC) Model.

BPCI Advanced Portals

Model Participants use various portals to manage deliverables, engage in peer to peer learning, and receive data from CMS. They all require prior authorization for access.

- ❑ BPCI Advanced Participant Portal – Access to deliverable templates, upload documents due to CMS, and review Profile information. This portal is also a repository of historical records and legal documents.
- ❑ CMMI Connect – Online learning community allows for communication, and knowledge sharing with other Participants. Plus, library of educational resources and prior Learning System events.
- ❑ CMS Enterprise Data Portal – CMS delivers data files, Target Prices, and Reconciliation workbooks.

Need to find more Information about the Model?

- ❑ Model Participants can visit the "Libraries" on CMMI Connect and/or the Documents section of the BPCI Advanced Participant Portal .
- ❑ Public information can be found on the **BPCI Advanced webpages** - General Information or Participants Resources - Technical documents

Have a Question?

BPCI Advanced Team: BPCIAdvanced@cms.hhs.gov
BPCI Advanced Learning System Team: lsbpciadvanced@deloitte.com