Bundled Payments for Care Improvement Advanced | BPCI Advanced

Model Year 6

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

Model Year 6: General Frequently Asked Questions (FAQ) Last Updated: November 2022

Table of Contents

Table of Contents 1

BPCI Advanced Overview and Model Operations 3

Q1: What is BPCI Advanced? 3

Q2: How does BPCI Advanced support the goals of reducing Medicare expenditures and improving the quality of care for Medicare Beneficiaries? 3

Q3: Where has CMS implemented BPCI Advanced? 4

Q4: What types of organizations can participate in BPCI Advanced? 4

Q5: What types of organizations cannot participate in BPCI Advanced? 4

Q6: What is the difference between Participants and Participating Practitioners? 5

Q7: Can Accountable Care Organizations (ACOs) participate in BPCI Advanced? 5

Q8: When did BPCI Advanced start and how long does it run? 5

Q9: What are the main design characteristics of the BPCI Advanced Model? 6

Q10: What learning and technical assistance support is available to Participants in BPCI Advanced? 6

Q11: Does BPCI Advanced exclude Post-Acute Care (PAC) providers from participating? 6

Q12: Does BPCI Advanced meet the Advanced APM criteria? 7

Q13: How does a Participant exit the Model? 7

Q14: Do Participants need to have a set amount of money in reserve to participate in BPCI Advanced? 7

Q15: Can two or more Physician Group Practices (PGPs) that have merged continue to participate in the Model? 8

Q16: If a Skilled Nursing Facility (SNF) changes ownership, such that its business and doing business as (dba) names also change, is the SNF still eligible to use the 3-Day SNF waiver? 8

Q17: What kind of deliverables do Participants have to complete? When are they due and how frequently? 8

Q18: Can a Physician Group Practice (PGP) Episode Initiator (EI) providing services in multiple locations, including a hospital that is also an EI, participate in the Model under the same Convener? 9

Q19: Does CMS encourage preferred networks for Skilled Nursing Facility (SNF) and home health providers if Beneficiaries know they have a choice of any provider? 10

Q20: What are the CMS Beneficiary Notification Letter requirements? 10

Q21: Can CMS provide further guidance regarding the "Merit-based Incentive Payment System (MIPS) Improvement Activities" requirement and the annual certification that Participants must complete via submission of the Participant Profile? 10

Q22: What are the different portals that Participants must navigate and the purposes of each? 11

Q23: Will BPCI Advanced use time-based precedence rules like the BPCI Initiative? 12

Q24: How does BPCI Advanced overlap with the Medicare Shared Savings Program (MSSP)? 12

Q25: How will the BPCIA Advanced Model manage Clinical Episodes with a COVID-19 diagnosis? 12

Policy Changes to Model Year 5 13

Q26: What policy changes were made in Model Year 5? 13

Clinical Episode Service Line Groups 13

Q27: What are the CESLG categories for Model Year 5? 13

Q28: How does CMS determine when a Clinical Episode is triggered? 15

Q29: When does a Clinical Episode exclude a Medicare Beneficiary? 15

Q30: Which service locations do the three outpatient Clinical Episodes include? Does BPCI Advanced include Clinical Episodes that initiate in outpatient hospital departments, freestanding cardiac catheterization labs, and ambulatory surgical centers (ASCs)? 15

Q31: How many risk tracks are in BPCI Advanced? 16

Q32: Where can I find the list of Medicare Severity Diagnosis Related Group (MS-DRGs) Exclusions List that applies to Clinical Episodes in the Model? 16

Q33: Will Episode Initiators (EIs) have to treat every Medicare Beneficiary that presents for the Clinical Episodes in which the EI selected to participate under BPCI Advanced? 16

Q34: Must all Physician Group Practices (PGPs) under the same Taxpayer Identification Number (TIN) choose the same Clinical Episode Service Line Groups? 16

Q35: Can a hospital be an EI under a Convener Participant for some Clinical Episodes and a Non-Convener Participant for others? 17

Q36: Where can I find the MS-DRGs and HCPCS trigger codes for BPCI Advanced Clinical Episodes in MY5?16 17
Q37: If we are participating in inpatient MJRLE, do we also have to participate in the outpatient MJRLE episode?....17
Q38: Are Medicare Beneficiaries that enter hospice at any time during the 90-day episode excluded from meeting the quality measures?....17
Q39: Is there more information about the Cardiac Rehabilitation incentive that is mentioned in the RFA? .17
Payment....18
Q40: How does the Model affect Beneficiary cost sharing?....18
Q41: Can CMS provide guidance about how Participants can engage in Net Payment Reconciliation Amount (NPRA) sharing?....18
Q42: How much financial risk will Model Participants take on?....18
Waivers....19
Q43: Is BPCI Advanced offering Participants any Medicare Payment Policy Waivers?....19

BPCI Advanced Overview and Model Operations

Q1: What is the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model?

A1: The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is a voluntary value-based payment model from the CMS Innovation Center (CMMI). It tests whether linking payments for a Clinical Episode can reduce Medicare expenditures while maintaining or improving the quality of care. BPCI Advanced aims to support healthcare providers who invest in practice innovation and care redesign to better coordinate care, improve quality of care, and reduce expenditures. The Model Performance Period for BPCI Advanced started on October 1, 2018 and will now run through December 31, 2025. Model Year 6 (MY6) begins on January 1, 2023.

Q2: How does BPCI Advanced support the goals of reducing Medicare expenditures and improving the quality of care for Medicare Beneficiaries?

A2: BPCI Advanced contributes to these goals through retrospective reconciliation of payments made by the Centers for Medicare and Medicaid Services (CMS) for selected Clinical Episodes in

a bundled payment model with only one risk track. Under BPCI Advanced, the Participant bears financial risk and redesigns care delivery to reduce Medicare fee-for-service (FFS) expenditures while maintaining or improving performance on specific quality measures.

Q3: Where has CMS implemented BPCI Advanced?

A3: CMS supports the development and testing of innovative health care payment and service delivery models throughout the country; therefore, participation was open to eligible organizations in all states, U.S. territories, and the District of Columbia. BPCI Advanced has had Medicare providers representing 49 states, Puerto Rico, and the District of Columbia.

Q4: What types of organizations can participate in BPCI Advanced?

A4: There are two categories of Participants under BPCI Advanced: Convener Participants and Non-Convener Participants.

- A Convener Participant:
  - Is a type of Participant that brings together at least one Downstream Episode Initiator (Downstream EI). Downstream EIs must be either Acute Care Hospitals (ACH) or Physician Group Practices (PGP)
  - Facilitates coordination among and promotes participation by Downstream EIs
  - Bears and apportions financial risks
  - Enters into agreements with Downstream EIs, whereby Downstream EIs agree to participate in BPCI Advanced and comply with all applicable Model requirements
  - May be eligible entities that are either Medicare-enrolled or not Medicare-enrolled providers or suppliers
  - May be an ACH or PGP
- A Non-Convener Participant:
  - Is any Participant that is itself an Episode Initiator
  - Is a Medicare-enrolled ACH or PGP that can trigger a Clinical Episode under BPCI Advanced
  - Bears financial risk only for itself and not on behalf of multiple Downstream EIs
  - May only be an ACH or PGP

Q5: What types of organizations cannot participate in BPCI Advanced?

A5: The ACH definition in BPCI Advanced excludes Prospective Payment System-exempt cancer hospitals, inpatient psychiatric facilities, critical access hospitals, hospitals in Maryland,

hospitals participating in the Rural Community Hospital Demonstration, and hospitals participating in the Pennsylvania Rural Health Model. Because of their unique payment methodologies, they may not participate in the Model in any capacity. Note that PGPs who only practice in Maryland are similarly not eligible to participate in BPCI Advanced. However, PGPs that practice in Maryland and another state or the District of Columbia are eligible to participate in the BPCI Advanced Model for care provided outside of Maryland.

Q6: What is the difference between Participants and Participating Practitioners?

A6: Participants, whether Convener Participants or Non-Convener Participants, are the risk-bearing entities under the Model that enter into direct agreements with CMS. Participating Practitioners are the downstream Medicare-enrolled physicians and non-physician practitioners who participate in BPCI Advanced activities by furnishing direct patient care. Participating Practitioners do not enter into agreements with CMS, but instead enter into agreements with the Participant. These agreements require the Participating Practitioners to comply with the applicable requirements of the BPCI Advanced Model Participation Agreement.

Q7: Can Accountable Care Organizations (ACOs) participate in BPCI Advanced?

A7: Yes, ACOs can participate in BPCI Advanced as a Convener Participant. Participants may also add ACOs to the Financial Arrangements List (FAL) as an organization with which the Participant has a Financial Arrangement.

Q8: When did BPCI Advanced start and how long does it run?

A8: The Model Performance Period of BPCI Advanced began on October 1, 2018, and the Model runs through December 31, 2025. BPCI Advanced defines a Model Year as a full or partial calendar year during which Participants may initiate Clinical Episodes. While BPCI Advanced was originally expected to have six Model Years, it was recently extended to include two additional Model Years. The Model Years are as follows:

- Model Year 1: October 1, 2018 – December 31, 2018
- Model Year 2: January 1, 2019 – December 31, 2019
- Model Year 3: January 1, 2020 – December 31, 2020
- Model Year 4: January 1, 2021 – December 31, 2021
- Model Year 5: January 1, 2022 – December 31, 2022
- Model Year 6: January 1, 2023 – December 31, 2023
- Model Year 7: January 1, 2024 – December 31, 2024

- Model Year 8: January 1, 2025 – December 31, 2025

Q9: What are the main design characteristics of the BPCI Advanced Model?

A9: CMS has designed BPCI Advanced according to five main characteristics:

1. It has a single retrospective payment and risk track for selected Clinical Episodes included in one of the 8 Clinical Episode Service Line Groups (CESLGs) with a 90-day post-anchor episode length
2. It has 29 inpatient Clinical Episodes and three outpatient Clinical Episodes, and two multi-setting Clinical Episodes, all grouped in to 8 CESLGs
3. It is an Advanced Alternative Payment Model (Advanced APM)
4. It provides preliminary Target Prices for each Clinical Episode in advance of each Model Year, which are adjusted during the year to account for fiscal and calendar Medicare payment system changes. The adjusted prices will be used to calculate the final Target Price during the Reconciliation process, which will reflect the actual patient case mix and realized trend adjustment during the applicable Performance Period
5. It is a voluntary model for Medicare providers

Q10: What learning and technical assistance support is available to Participants in BPCI Advanced?

A10: BPCI Advanced offers Participants a variety of learning opportunities to support their transformation needs with virtual, web-based learning events and other materials. Learning events and materials help orient BPCI Advanced Participants to the Model characteristics and compliance requirements. Online collaboration tools and web-based portals facilitate knowledge sharing among Participants. The BPCI Advanced Team also provides technical assistance by responding to questions submitted to the inbox: BPCIAdvanced@cms.hhs.gov.

Q11: Does BPCI Advanced exclude Post-Acute Care (PAC) providers from participating?

A11: BPCI Advanced does not exclude PAC providers from participating; they can participate in BPCI Advanced as Convener Participants. Participants may also add PAC providers to the FAL as organizations with which the Participant has a Financial Arrangement.

However, PAC providers may not participate in the Model as Non-Convener Participants, since they cannot trigger Clinical Episodes. PAC providers do not have the authority to submit a claim for an Anchor Stay (inpatient Clinical Episode) or Anchor Procedure (outpatient Clinical Episode).

Q12: Does BPCI Advanced meet the Advanced APM criteria?

A12: Yes, BPCI Advanced meets the criteria and is an Advanced APM. The first criterion is that a model must require Participants to bear risk for monetary losses of more than a nominal amount under the Model. In BPCI Advanced, Participants are financially at risk for up to 20% of the final Target Price for each Clinical Episode they have selected to participate, which exceeds the minimum requirement (3%) of expected expenditures for the generally applicable nominal amount standard under the Quality Payment Program (QPP). Second, a model must require Participants to use Certified Electronic Health Record Technology (CEHRT). In BPCI Advanced, Participants must attest to their use of CEHRT as a condition of participation. For non-hospital Participants, at least 75% of eligible clinicians in the entity must use the CEHRT definition of certified health IT functions to participate in this initiative. Third, payments under the Model must be linked to quality measures comparable to Merit-based Incentive Payment System (MIPS) quality measures. In BPCI Advanced, CMS calculates a score for each quality measure at the Clinical Episode level. These scores are volume-weighted and scaled across all Clinical Episodes attributed to a given EI to calculate an EI-specific Composite Quality Score.

Q13: How does a Participant exit the Model?

A13: Since BPCI Advanced is voluntary, Convener Participants and Non-Convener Participants may terminate their participation at any time without penalty after providing 90 days' advance written notice, per Article 21 of the BPCI Advanced Model Participation Agreement. Convener Participants could withdraw a Downstream EI from BPCI Advanced, prior to the beginning of Model Year 3 and Model Year 4.

Note that Downstream EIs are not precluded from ending their arrangements with a Convener Participant if such action is permitted in the agreement between the Convener Participant and the Downstream EI. However, the Convener Participant remains at risk for Clinical Episodes initiated by that Downstream EI until the end of the Agreement Performance Period, regardless of when the Downstream EI terminates its agreement with that Convener Participant.

Q14: Do Participants need to have a set amount of money in reserve to participate in BPCI Advanced?

A14: Yes, certain Participants with a "Secondary Repayment Source (SRS) Covered Participant" designation will be required to fund an escrow account or obtain a letter of credit in an amount that CMS will calculate based on the Participant's CESLG and/or EI selections. Participants can

find more details about SRS requirements and their calculation methodology in Articles 7.6 and 7.7 and Appendixes B and C of the 2021 BPCI Advanced Participation Agreement.

Q15: Can two or more Physician Group Practices (PGPs) that have merged continue to participate in the Model?

A15: If two or more participating PGPs merge under a Taxpayer Identification Number (TIN) that is also participating in BPCI Advanced, CMS may permit the PGPs to continue to participate in the Model in the same role as before (Downstream Episode Initiator or Participant).

If two or more participating hospitals merge to form a single, multi-campus hospital under a CMS Certification Number (CCN) that is also participating in BPCI Advanced, CMS may permit the hospitals to continue to participate in the Model in the same role as before (Downstream Episode Initiator or Participant).

If an organization participating in BPCI Advanced merges with another organization under a TIN/CCN that is **not** participating in BPCI Advanced, the non-participating TIN/CCN is not eligible to participate in the Model and the organization formerly participating in the Model no longer triggers Clinical Episodes as of the effective date of the merger.

Q16: If a Skilled Nursing Facility (SNF) changes ownership, such that its business and doing business as (dba) names also change, is the SNF still eligible to use the 3-Day SNF waiver?

A16: SNFs that change ownership and, as a result, also change their business names and dba names are still eligible to use the 3-Day SNF waiver, as long as they retain the CMS Certification Number (CCN) of a SNF that is currently on the SNF Waiver List posted quarterly on the BPCI Advanced website.

Q17: What kind of deliverables do Participants have to complete? When are they due and how frequently?

A17: There are four different types of deliverables that Participants must regularly submit to CMS, as applicable:

1. **Participant Profile (PP)**
   - Required as specified by CMS, approximately 30 days before the start of the Model Year
   - Indicates the Clinical Episode Service Line Groups to which the Non-Convener Participant commits under BPCI Advanced, or, for a Convener Participant, the list of

Downstream Episode Initiators (Downstream EIs) and their specific Clinical Episode Service Line Group selections

- Participants also indicate which Quality Measure Set at the Clinical Episode level they wish to be held accountable for

2. **Care Redesign Plan (CRP)**
   - Required annually, approximately 30 days before the start of the Model Year
   - Describes the specific planned interventions and changes to the Participant's current health care delivery system
3. **Quality Payment Program (QPP) List**
   - Required quarterly, approximately 30 days before the start of the quarter
   - Identifies the individuals that meet the requirements included in the quarterly report that the BPCI Advanced Model submits to the QPP for the Qualifying APM Participant determinations
   - For the Participant to include an individual on the Participation List tab of the QPP List, the individual must be a Participating Practitioner
   - For the Participant to include an individual on the Affiliated Practitioners List tab of the QPP List, the individual must: (a) be a Participating Practitioner; and (b) meet the definition of Affiliated practitioner in 42 C. F. R. § 414. 1305
4. **Financial Arrangements List (FAL)**
   - Submitted on a semi-annual basis, if applicable
   - Includes the list of organizations and/or individuals with whom the Participant intends to have a financial arrangement in BPCI Advanced. The types of organizations/individuals are a Net Payment Reconciliation Amount (NPRA) Sharing Partner, an NPRA Sharing Group Practice Practitioner, or a BPCI Advanced Entity.

Q18: Can a Physician Group Practice (PGP) Episode Initiator (EI) providing services in multiple locations, including a hospital that is also an EI, participate in the Model under the same Convener?

A18: A PGP and an Acute Care Hospital (ACH) can participate under the same Convener Participant. The PGP and ACH can participate in the same or different Clinical Episodes; however, CMS only attributes a Clinical Episode to one EI. Precedence rules, including Model overlap rules, dictate to which EI CMS attributes the Clinical Episode.

Q19: Does CMS encourage preferred networks for Skilled Nursing Facility (SNF) and home health providers if Beneficiaries know they have a choice of any provider?

A19: Participants can create and/or recommend preferred PAC networks; however, they may not limit Beneficiary choice of provider in any way. Participants must notify Beneficiaries of their participation in the Model with the CMS Beneficiary Notification Letter and require their Downstream Episode Initiators and Participating Practitioners do the same.

Q20: What are the CMS Beneficiary Notification Letter requirements?

A20: The CMS Beneficiary Notification Letter is a requirement of Article 9 of the BPCI Advanced Participation Agreement. As part of a Beneficiary Notification Plan, the Participant and all of its EIs should provide the Beneficiary Notification Letter to each BPCI Advanced Beneficiary prior to their discharge from an inpatient stay or completion of an outpatient procedure. The goal of the letter is to communicate the existence and purpose of the BPCI Advanced Model, the BPCI Advanced Beneficiary's right of access to medically necessary covered services, and the Beneficiary's right to choose any provider or supplier for covered services. Participants may not modify the CMS Beneficiary Notification Letter and should use the template provided by CMS. The only exception is that Participants may translate the CMS Beneficiary Notification Letter into other languages, if the content stays the same.

Participants must begin distributing the CMS Beneficiary Notification Letter on the first day of their participation in the Model. Participants can find the template of the CMS Beneficiary Notification Letter on the BPCI Advanced website.

Q21: Can CMS provide further guidance regarding the "Merit-based Incentive Payment System (MIPS) Improvement Activities" requirement and the annual certification that Participants must complete via submission of the Participant Profile?

A21: To ensure compliance with the terms of the BPCI Advanced Participation Agreement, Participants must submit a Participant Profile to identify "Current" EIs and their CESLG selection prior to the start of each Model Year. In the same document, Participants must attest to the performance of a minimum of four MIPS Improvement Activities in the upcoming Model Year by the Participant, if applicable, and their Participating Practitioners who are MIPS-eligible clinicians. MIPS-eligible clinicians may receive a credit for the MIPS Improvement Activity performance category score for an applicable performance year by performing these activities as a part of their participation in BPCI Advanced. For more information regarding MIPS

Improvement Activities or the MIPS generally, please contact the QPP help desk here – QPP@cms.hhs.gov.

Q22: What are the different portals that Participants must navigate and the purposes of each?

A22: The BPCI Advanced Model uses three platforms to manage deliverables, distribute data, and collaborate with Model stakeholders.

1. **BPCI Advanced Participant Portal –** https://app.innovation.cms.gov/bpciadv

The Participant Portal allows access to the Model's templates of deliverables, submission of deliverables and legal documents, verification of Participant's profile information, and management of Points of Contact (POCs). The individuals who have access to this portal are those listed on the application as a POC as well as the individual who submitted the application, known as the primary POC. This person may add other POCs once access to the Participant Portal is granted.

2. **CMS Enterprise Data Portal –** https://portal.cms.gov

The CMS Enterprise Data Portal allows Participants to access data files (e.g., monthly claims data, reconciliation results, Target Prices).

When the Data Request and Attestation (DRA) Form was submitted to the Participant Portal, it identified two individuals employed by the Participant organization to act as Data POCs. A new Participant DRA must be submitted to CMS (via the Participant Portal) to change the names of Data POCs listed on a DRA.

3. ***CMMI Connect –*** https://app.innovation.cms.gov/CMMIConnect/idmlogin

CMMI Connect allows individuals participating in BPCI Advanced to join the online community and engage in peer-to-peer learning, collaboration, communication, and knowledge sharing.

Access is granted automatically when the Primary POC provides a name to the Learning Systems (LS) Team via Email. If an individual completes "self-registration," the LS Team will seek authorization from the Primary POC of the BPID identified in the registration. After registering, the individual will receive a welcome Email from

CMMIConnectNotification@cms.hhs.gov containing their username and a unique link to create a password for the site. Participant Portal POCs are automatically granted access to *CMMI Connect*.

Q23: Will BPCI Advanced use time-based precedence rules like the BPCI Initiative?

A23: No. BPCI Advanced will not use time-based precedence rules. What this means is that Model Participants that started on October 1, 2018 will not have precedence over those that started on January 1, 2020 (MY3). In BPCI Advanced, CMS will attribute Clinical Episodes at the Episode Initiator level. The hierarchy for attribution of a Clinical Episode among different types of EIs is as follows, in descending order of precedence:

1. The PGP that has the attending physician's National Provider Identifier (NPI) listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) billed under the participating PGP's Tax Identification Number for the Anchor Stay or Anchor Procedure on its PGP List
2. The PGP that has the operating physician's NPI listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) during the Anchor Stay or Anchor Procedure billed under the participating PGP's Tax Identification Number for the Anchor Stay or Anchor Procedure on its PGP List
3. The ACH where services during the Anchor Stay or Anchor Procedure were furnished

Q24: How does BPCI Advanced overlap with the Medicare Shared Savings Program (MSSP)?

A24: Since January 2020, BPCI Advanced has not excluded Clinical Episodes (or Medicare FFS expenditures) for BPCI Advanced Beneficiaries assigned to Shared Savings Program ACOs participating under Tracks 1, 1+, or 2, the BASIC track, or the ENHANCED Track (Track 3). The BPCI Advanced Model will exclude Clinical Episodes (and Medicare FFS expenditures) for BPCI Advanced Beneficiaries aligned or assigned to an ACO participating in the Next Generation ACO, the Comprehensive End-Stage Renal Disease (ESRD) Care Initiative, the Vermont Medicare ACO Initiative, the Global and Professional Direct Contracting Model, the Comprehensive Kidney Care Contracting Options of the Kidney Care Choices Model, the ACO Realizing Equity, Access, and Community Health (REACH) Model, or any successor track or initiative.

Q25: How will the BPCIA Advanced Model manage Clinical Episodes with a COVID-19 diagnosis?

A25: In previous Model Years, generally COVID-19 Clinical Episodes were excluded from Reconciliation. For Model Year 6, Participants will be held accountable for Clinical Episodes where the

beneficiary has a COVID-19 diagnosis. These episodes will be risk-adjusted for COVID-19 through census-tract level COVID-19 infection rates for each eligible provider.

Policy Changes to Model Year 6

Q26: What policy changes were made in Model Year 6?

A26: CMS made the following key changes to the BPCI Advanced Model, which will take effect at the beginning of Model Year 6 (MY6) in January 2023:

To improve the pricing methodology and keep providers and suppliers engaged in value-based care through the BPCI Advanced Model in Model Year 6 (2023), CMS is implementing the following changes:

- Reduction of the CMS Discount for medical Clinical Episodes from 3% to 2%.
- Reduction of the Peer Group Trend (PGT) Factor Adjustment cap for all Clinical Episodes from 10% to 5%.
- Make major joint replacement of the upper extremity 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.
- Participants would be accountable for all Clinical Episodes in which the beneficiary has a COVID-19 diagnosis during the Clinical Episode.

Clinical Episode Service Line Groups

Q27: What are the CESLG categories for Model Year 6?

A27: There are eight CESLG categories in Model Year 6:

1. **Cardiac Care**
   - Acute Myocardial Infarction (AMI)
   - Cardiac Arrhythmia
   - Congestive Heart Failure

2. **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)

3. Gastrointestinal Surgery

- Bariatric Surgery
- Major Bowel Procedure

4. Gastrointestinal Care

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

5. Neurological Care

- Seizures
- Stroke

6. Medical and Critical Care

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

7. Spinal Procedures

- Back and Neck Except Spinal Fusion (Inpatient)

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

8. 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 (MJRUE) (Multi-setting inpatient/outpatient)

Q28: How does CMS determine when a Clinical Episode is triggered?

A28: The submission of a claim for either an inpatient stay at an ACH (Anchor Stay) or an outpatient procedure at an ACH (Anchor Procedure) by an EI for an eligible BPCI Advanced Beneficiary triggers a Clinical Episode.

Q29: When does a Clinical Episode exclude a Medicare Beneficiary?

A29: BPCI Advanced excludes the following types of Medicare Beneficiaries:

1. Medicare Beneficiaries covered under United Mine Workers or managed care plans (i.e., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations)
2. Beneficiaries eligible for Medicare based on End-Stage Renal Disease (ESRD)
3. Medicare Beneficiaries for whom Medicare is not the primary payer
4. Medicare Beneficiaries who die during the Anchor Stay or Anchor Procedure

Q30: Which service locations do the three outpatient Clinical Episodes include? Does BPCI Advanced include Clinical Episodes that initiate in outpatient hospital departments, freestanding cardiac catheterization labs, and ambulatory surgical centers (ASCs)?

A30: Anchor Procedures initiate an outpatient Clinical Episode when they occur in an outpatient hospital department, which are paid under the Outpatient Prospective Payment System. Other

outpatient settings, such as ASCs and freestanding cardiac catheterization labs, are not eligible to initiate Clinical Episodes.

Q31: How many risk tracks are in BPCI Advanced?

A31: There is only one risk track. Individual Clinical Episodes have spending capped at the first and 99th percentile of total standardized allowed amounts within the Clinical Episode.

Q32: Where can I find the list of Medicare Severity Diagnosis Related Group (MS-DRGs) Exclusions List that applies to Clinical Episodes in the Model?

A32: The MY6 BPCI Advanced Exclusion List that identifies by MS-DRG or Healthcare Common Procedure Coding System (HCPCS) code the excluded Medicare Part A and Part B items and services was provided to Participants in October 2022 and is available on the BPCI Advanced webpage under Technical Resources.

Q33: Will Episode Initiators (EIs) have to treat every Medicare Beneficiary that presents for the Clinical Episodes in which the EI selected to participate under BPCI Advanced?

A33: Yes. EIs do not have the option of excluding Medicare Beneficiaries from a Clinical Episode within the Clinical Episode Service Line Groups in which they selected to participate, regardless of a patient's acuity. Additionally, neither EIs nor Participating Practitioners may restrict Beneficiaries' access to medically necessary care. To that end, CMS monitors utilization and referral patterns, conducts medical record audits, tracks patient complaints and appeals, and monitors patient outcome measures to assess improvement, deterioration, and/or any deficiencies in the quality of care under the Model.

It is important to note that not every Medicare Beneficiary triggers a Clinical Episode because of Beneficiary eligibility exclusions.

Q34: Must all Physician Group Practices (PGPs) under the same Taxpayer Identification Number (TIN) choose the same Clinical Episode Service Line Groups?

A34: Yes, participation decisions, including Clinical Episode Service Line Group selection, are at the Episode Initiator (EI) level. For PGPs, CMS classifies the EI by the billed TIN on the claim to determine the Clinical Episode initiated within a Clinical Episode Service Line Group. For ACHs, CMS uses the CCN on the institutional claim to identify the Clinical Episode initiated within a Clinical Episode Service Line Group.

Q35: Can a hospital be an EI under a Convener Participant for some Clinical Episodes and a Non-Convener Participant for others?

A35: No, an Acute Care Hospital (ACH) may not allocate Clinical Episodes within a Clinical Episode Service Line Groups under multiple Convener Participants or in combination as a Non-Convener Participant. An EI can only trigger Clinical Episodes with a Convener Participant or as a Non-Convener Participant.

Q36: Where can I find the MS-DRGs and HCPCS trigger codes for BPCI Advanced Clinical Episodes in MY6?

A36: The MY6 Clinical Episode List, which includes the MS-DRG and HCPCS codes that may initiate a Clinical Episode, was provided to Participants in October 2022 and is available on the BPCI Advanced webpage under Technical Resources.

Q37: If we are participating in inpatient MJRLE, do we also have to participate in the outpatient MJRLE episode?

A37: MJRLE is a multi-setting Clinical Episode that may be initiated in both the inpatient and outpatient setting. If a Participant selected the Orthopedic CESLG, the Participant is accountable for all Clinical Episode categories within that CESLG, including both Clinical Episode settings for MJRLE and starting in MY6, MJRUE.

Q38: Are Medicare Beneficiaries that enter hospice at any time during the 90-day episode excluded from meeting the quality measures?

A38: No. Beneficiaries that enter hospice during the 90-day episode are included in the quality measures calculations. Hospice services are included in BPCI Advanced Clinical Episodes unless otherwise excluded. The specifications for the quality measures do not exclude hospice patients, assuming the other denominator criteria are met. Note that Medicare Beneficiaries who die during the Anchor Stay or Anchor Procedure are excluded from triggering a Clinical Episode in BPCI Advanced.

Q39: Is there more information about the Cardiac Rehabilitation incentive that is mentioned in the RFA?

A39: For Model Year 3, BPCI Advanced started excluding Cardiac Rehabilitation from Target Prices and Clinical Episode spending so that providers wouldn't be disincentivized from

recommending Cardiac Rehabilitation in the Performance Period. This policy has continued in MY4 through MY6 and Participants may find the excluded Cardiac Rehabilitation codes in the respective BPCI Advanced Exclusions List for MY3, MY4, MY5, and MY6 posted on the BPCI Advanced website under Technical Resources.

Payment

Q40: How does the Model affect Beneficiary cost sharing?

A40: Beneficiaries have the same cost-sharing responsibility for services received from a Medicare provider participating in BPCI Advanced. Providers must continue to submit Medicare FFS claims for clinical services furnished to Beneficiaries.

Q41: Can CMS provide guidance about how Participants can engage in Net Payment Reconciliation Amount (NPRA) sharing?

A41: The U.S. Department of Health and Human Services Office of the Inspector General and CMS jointly issued Fraud and Abuse Waivers for specified arrangements pursuant to BPCI Advanced. These waivers permit Participants in BPCI Advanced to engage in sharing NPRA when specified conditions are met. Additional information is available on the CMS website at https://www.cms.gov/files/document/notice-amended-waivers-certain-fraud-and-abuse-laws-connection-bundled-payments-care-improvement.pdf .

Q42: How much financial risk will Model Participants take on?

A42: Model Participants may receive payments from CMS under the Model for providing efficient care but may owe payments to CMS if costs are higher than the Target Price. Starting in Model Year (MY4), the Target Price for each 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 Factor Adjustment, which is subject to a 5% cap for MY6, 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 CMS Discount is applied to the Benchmark Price in Model Years 1 through 6 to calculate the Target Price for each Clinical Episode category for each Episode Initiator. Starting in MY6, the CMS Discount will be 2% for medical Clinical Episodes and 3% for surgical Clinical Episodes.

Additionally, payments from CMS to Model Participants and payments to CMS from Model Participants will be subject to a stop-gain and stop-loss policy which is 20% of the Target Price for a given EI. Both Negative Total Reconciliation Amounts and Positive Total Reconciliation Amounts will also be subject to an adjustment based on quality performance. For the first five Model Years, the maximum amount by which quality performance may adjust Negative and Positive Total Reconciliation Amounts will be 10%.

Waivers

Q43: Is BPCI Advanced offering Participants any Medicare Payment Policy Waivers?

A43: Separate from any Fraud and Abuse Waivers, CMS is providing BPCI Advanced Participants conditional waivers of certain Medicare payment rules. Participants may elect to use the 3-Day SNF Rule Payment Policy Waiver, the Telehealth Payment Policy Waiver, and/or the Post Discharge Home Visit Services Payment Policy Waiver when redesigning care to be delivered to Medicare Beneficiaries.