

BPCI ADVANCED MODEL OVERVIEW

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, a voluntary value-based payment model from the Center for Medicare & Medicaid Innovation, tests whether linking payments for a Clinical Episode can reduce Medicare expenditures while maintaining or improving 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. The Model is expected to run through December 31, 2023.

Participants are financially accountable for the expenditures and quality of health care services during a Clinical Episode, which begins with an inpatient hospitalization (Anchor Stay) or an outpatient procedure (Anchor Procedure) and ends 90 days after discharge from the hospital or completion of the procedure.

At the end of each Performance Period, actual Medicare fee-for-service (FFS) expenditures are reconciled against a target price (TP), which is calculated by the Centers for Medicare & Medicaid Services (CMS) based on historical claims data. Participants may receive a payment (Net Payment Reconciliation Amount, NPRA) if the Clinical Episode expenditures are below the TP or may owe money back to CMS (Repayment Amount) if expenditures are higher than the TP.

A **Non-Convener Participant** is any Participant that is itself an Episode Initiator (EI) and bears financial risk only for itself and does not bear risk on behalf of multiple Downstream EIs.

Eligible Non-Convener Participant or EI Entities – Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs)

A **Convener Participant** is a type of Participant that brings together multiple entities, referred to as Downstream EIs. A Convener Participant facilitates coordination among its EIs and bears financial risk under the Model.

Eligible Convener Participant Entities – ACHs and PGPs; other providers, suppliers, or organizations, regardless of whether they are Medicare-enrolled, may participate as Convener Participants only



Shifts emphasis from individual services towards a **coordinated Clinical Episode = Bundles**



Establishes an **accountable party = Participant**



Links physician, hospital, and post-acute care payments **to quality and cost = Value-Based Care**

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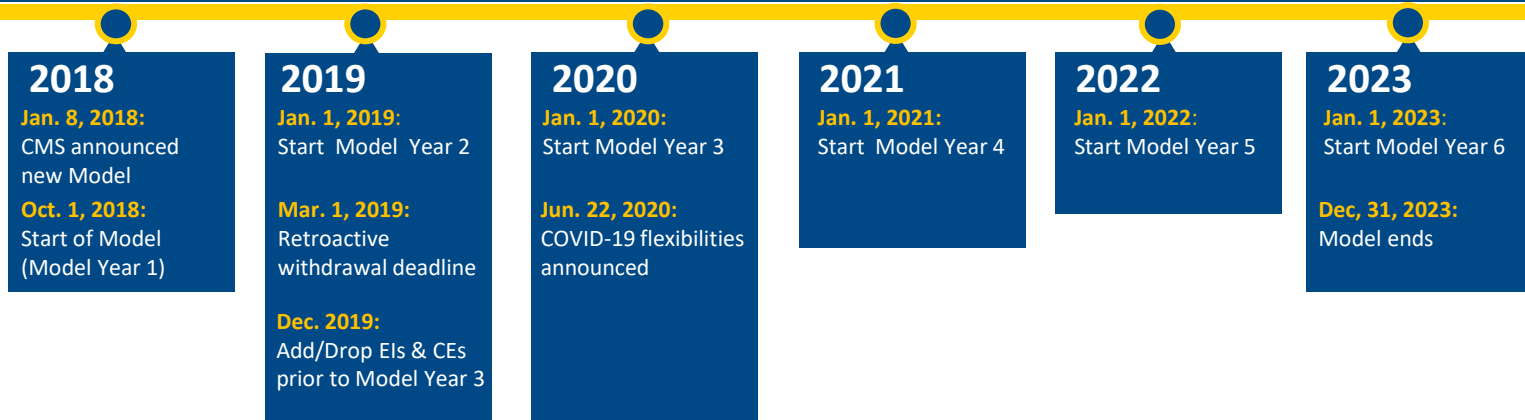
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TIMELINE, DRIVERS, AND CHARACTERISTICS




BPCI ADVANCED MODEL DRIVERS


-  **Care Coordination:** Continuously reengineering care
-  **Financial Accountability:** Testing a payment model for the outcomes of improved quality and reduced spending
-  **Beneficiary Engagement:** Increasing the likelihood of better health at a lower cost through education and ongoing communication
-  **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

MAIN CHARACTERISTICS OF BPCI ADVANCED


Payment

 A single retrospective payment for selected Clinical Episodes included in Clinical Episode Service Line Groups (CESLGs)*, which begin on the first day of the initiating inpatient stay (Anchor Stay) or outpatient procedure (Anchor Procedure) and extend through the 90-day period starting on the day of discharge from the inpatient stay or the completion of the outpatient procedure, as applicable.


Inpatient Clinical Episode Triggers

 Thirty-one (31) Clinical Episodes 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 Clinical Episode Triggers

 Four (4) Clinical Episodes 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.


TPs

 Preliminary TPs are provided in advance of the first Model Performance Period of each Model Year and will be adjusted during the year to account for fiscal and calendar Medicare payment system changes. Final TPs are constructed during the semi-annual reconciliation process, which reflects actual patient case mix and realized trend adjustment during the applicable Performance Period.

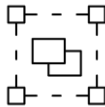
Advanced Alternative Payment Model


 Three criteria distinguish 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.

Participation in Value-Based Payment Model

 BPCI Advanced is a voluntary model for Medicare providers.

CESLGs


 Starting in MY4, Participants were required to select CESLGs instead of Clinical Episode categories. For the remainder of the Model, Participants are accountable for each Clinical Episode within the CESLGs they selected in MY4 unless they did not meet the minimum volume threshold during the baseline period.

CESLGs 	
Cardiac Care <ul style="list-style-type: none"> Acute Myocardial Infarction (AMI) Cardiac Arrhythmia Congestive Heart Failure 	Cardiac Procedures <ul style="list-style-type: none"> 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)
Gastrointestinal Surgery <ul style="list-style-type: none"> Bariatric Surgery Major Bowel Procedure 	Gastrointestinal Care <ul style="list-style-type: none"> Disorders of the Liver Except Malignancy, Cirrhosis, or Alcoholic Hepatitis Gastrointestinal Hemorrhage Gastrointestinal Obstruction Inflammatory Bowel Disease
Neurological Care <ul style="list-style-type: none"> Seizures Stroke 	Medical & Critical Care <ul style="list-style-type: none"> Cellulitis Chronic Obstructive Pulmonary Disease, Bronchitis, Asthma Renal Failure Sepsis Simple Pneumonia and Respiratory Infections Urinary Tract Infection
Spinal Procedures <ul style="list-style-type: none"> Back and Neck Except Spinal Fusion (Inpatient) Back and Neck Except Spinal Fusion (Outpatient) Spinal Fusion 	Orthopedics <ul style="list-style-type: none"> 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

CRITERIA FOR BENEFICIARY INCLUSION IN A CLINICAL EPISODE

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 term BPCI Advanced Beneficiary specifically excludes:

- 1) 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)
- 2) Beneficiaries eligible for Medicare on the basis of End-Stage Renal Disease (ESRD)
- 3) Medicare beneficiaries for whom Medicare is not the primary payer, at any time during the Clinical Episode
- 4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure

CLINICAL EPISODE DEFINITIONS

Clinical Episode Trigger:

An inpatient claim from an ACH with a qualifying MS-DRG or hospital outpatient claim with a qualifying HCPCS code.

Clinical Episode Length:

Anchor Stay: The **inpatient** stay that includes a qualifying MS-DRG code billed to Medicare FFS by an Episode Initiator.

- **Clinical Episode length: Anchor Stay + 90 days; the date of discharge is day 1 of the 90-day period**

Anchor Procedure: The **outpatient** procedure that includes a qualifying HCPCS code billed to Medicare FFS by an Episode Initiator.

- **Clinical Episode length: Anchor Procedure + 90 days; the date the outpatient procedure is completed is day 1 of the 90-day period**

TYPES OF ITEMS AND SERVICES INCLUDED IN A CLINICAL EPISODE:

(Unless Specifically Excluded)

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



CLINICAL EPISODE EXCLUSIONS

The following are examples of what will be excluded from each Clinical Episode.

- **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 to the **MY4 Exclusion List** workbook to be posted in the BPCI Advanced website (<https://innovation.cms.gov/innovation-models/bpci-advanced>) for the specific MS-DRG and HCPCS code exclusions.

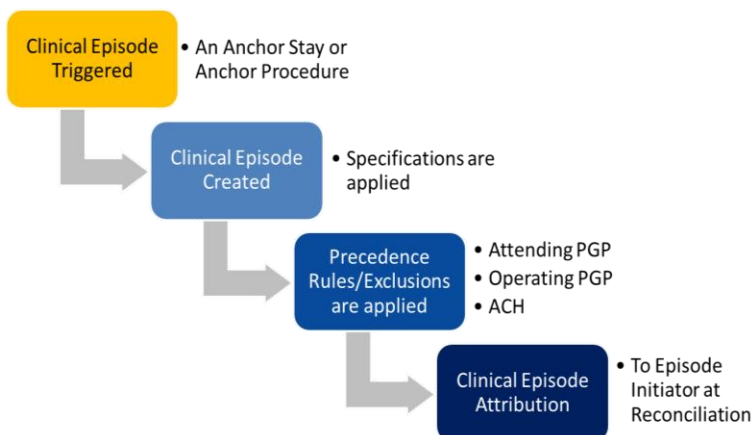
CMS reserves the right to modify this list at any time to add or remove MS-DRGs and HCPCS codes.

CLINICAL EPISODE ATTRIBUTION PROCESS AND PRECEDENCE RULES

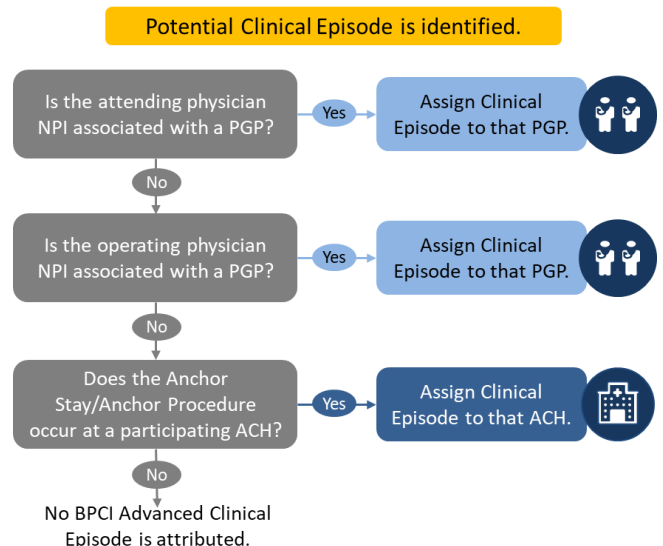
Precedence Rules during the Reconciliation Process

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

Clinical Episode Attribution Process



Precedence Rules for Episode Initiators



CHANGES FOR MY5

CMS will make minimal modifications for calendar year (CY) 2022. Given the significant changes implemented in MY4 (CY2021) and the narrow design flexibilities available with only two remaining Model Years, a stable methodology will provide Participants greater predictability with Model pricing. The following changes will occur:

- **MY5 Baseline:** In MY5, CMS will maintain existing policy and roll forward the baseline period for MY5 to include Clinical Episodes with anchor end dates between FY2017 - FY2020 (October 1, 2016 -September 30, 2020). CMS understands the COVID-19 public health emergency has left a long-term imprint on the health care system. Therefore, COVID-19 Clinical Episodes will continue to be excluded in MY5
- **Inclusion of Outpatient Total Hip Arthroplasty (THA) in Multi-setting MJRLE:** In CY2020, Medicare removed THA from the Inpatient-Only List, allowing for payment under the Outpatient Prospective Payment System. In MY5, CMS will include outpatient THA as a trigger for the multi-setting MJRLE Clinical Episode. Outpatient THA procedures will be priced using a similar methodology to that used for outpatient Total Knee Arthroplasty procedures
- **Hierarchical Condition Categories (HCC) Extension and Inclusion of Dementia:** In MY5, the HCC lookback period will increase from 90 days to 180 days to improve Model fit by better capturing chronic conditions. Additionally, dementia will be included in HCC as a covariate in the risk adjustment models

RECONCILIATION



Reconciliation is based on comparing actual Medicare FFS expenditures to the final TP.

Reconciliation occurs semi-annually. Clinical Episodes will be reconciled based on the Performance Period in which they end. Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in CY2021 and Clinical Episode end dates in CY2022 will be considered MY4 Clinical Episodes but will still be reconciled in the Performance Period (PP) in which they end (PP7). Clinical Episodes will be reconciled based on the Performance Period in which they end. Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in CY2021 and Clinical Episode end dates in CY2022 will be considered MY4 Clinical Episodes but will still be reconciled in the Performance Period (PP) in which they end (PP7). Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in CY2022 and Clinical Episode end dates in CY2022 or CY2023 will be considered MY5 Clinical Episodes.

Composite Quality Score (CQS)

Quality scores from individual Clinical Episodes are rolled up into a CQS at the EI level. They are then assigned a CQS adjustment amount. The CQS Adjustment Amount is applied to Positive Total Reconciliation Amounts and Negative Total Reconciliation Amounts.

Additional information on the NPRA and Repayment Amount can be found on page 7.

	 NPRA – <i>Payment by CMS to Participant</i>	 Repayment Amount – <i>Payment By Participant to CMS</i>
	If all non-excluded Medicare FFS expenditures for a Clinical Episode are less than the final TP for that Clinical Episode, there will be a Positive Reconciliation Amount.	If all non-excluded Medicare FFS expenditures for a Clinical Episode are more than the final TP for that Clinical Episode, there will be a Negative Reconciliation Amount.
Convener Participants	All Adjusted Positive Total Reconciliation Amounts are netted against all the Adjusted Negative Total Reconciliation Amounts for the Participant’s EIs to calculate either an NPRA or a Repayment Amount.	
Non-Convener Participants	For an EI that is also a Non-Convener Participant, the Adjusted Positive Total Reconciliation Amount is the NPRA that CMS will pay to the Participant.	If instead this calculation results in an Adjusted Negative Total Reconciliation Amount for Non-Convener Participants, this amount is the Repayment Amount that the Participant must pay to CMS.

CALCULATING THE TP FOR A CLINICAL EPISODE



- **CMS Discount:** A 3% discount will be applied to the BP to calculate the TP
- **Preliminary and Final TP:**
 - Preliminary TPs will be provided to Participants prior to the beginning of the Model Year.
 - The final TP will be adjusted at Reconciliation by replacing the historic patient case-mix adjustment (PCMA) with the actual PCMA. Final TPs will also be adjusted based on the difference between the prospective and realized peer group trend factor
- **Benchmark Price:** Information on how the benchmark price is calculated can be found on page 8

DETERMINING THE BENCHMARK PRICE

Benchmark Price for ACHs:

CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode:

1. Patient case-mix
2. Patterns of spending relative to the ACH's peer group over time
3. Historical Medicare FFS expenditures efficiency in resource use specific to the ACH's Baseline Period

Benchmark Price for PGP:

The PGP Offset will be removed for all PGP TPs. As a result, there will be a single average TP for each Clinical Episode category at each eligible hospital that is independent of the individual provider who triggered the Clinical Episode.

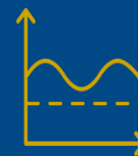
- **Clinical Episodes' volume thresholds**

- Unusual patient cases can distort performance for low volume Participants. As a protection, risk will be constrained for particular Clinical Episode volumes
- For the hospital to receive a preliminary TP, it must have at least 41 Clinical Episodes for a given Clinical Episode category, during the applicable baseline period

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 exceed 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 TPs across all Clinical Episodes netted to the level of the EI within the Performance Period

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

When CMS makes changes to the payment rates paid under Medicare FFS, CMS will update preliminary TPs but will not rebase with new baseline period data until the next Model Year.

QUALITY MEASURES

In MY5, BPCI Advanced Participants will continue to have the opportunity to select to report either the Administrative Quality Measures Set that has been available since the beginning of the Model, or the Alternate Quality Measures Set, launched in Model Year 4, for each of the Clinical Episodes in a CESLG for which the Participant has committed to be accountable.

For additional information regarding Quality Measures, please review the resources available in the BPCI Advanced website: <https://innovation.cms.gov/innovation-models/bpci-advanced/quality-measures-fact-sheets>.

Resource	Website Address
MY5 Clinical Episode to Quality Measure Correlation Table (September 2021)	https://innovation.cms.gov/media/document/bpci-adv-my5-clin-ep-qual-meas
MY5 Administrative Quality Measures Fact Sheet Package (August 2021)	https://innovation.cms.gov/media/document/bpci-adv-my5-admin-qual-measu-fs
MY5 Alternate Quality Measures Fact Sheet Package (August 2021)	https://innovation.cms.gov/media/document/bpci-adv-my5-alt-qual-meas-fs
MY3 Quality Methodology Webcast Slides (January 2020)	https://innovation.cms.gov/files/slides/bpciadvanced-wc-jan2020qualmethodology-slides.pdf

OVERLAP WITH OTHER CMMI MODELS

Comprehensive Care for Joint Replacement Model (CJR) – CJR Clinical Episodes have precedence over BPCI Advanced Clinical Episodes and will be excluded from Reconciliation for BPCI Advanced Model Participants.

Oncology Care Model (OCM) – If an Episode Initiator in BPCI Advanced is also a Participant in OCM, the BPCI Advanced Clinical Episodes and OCM Episodes will run concurrently.

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) 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, or any successor track or initiative including the Global and Professional Direct Contracting Model and the Comprehensive Kidney Care Contracting Options of the Kidney Care Choices Model.

EVALUATION AND MONITORING

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

Second Annual Evaluation Report (March 2021)

The Lewin Group is under contract to CMS to independently evaluate the impact of BPCI Advanced. The second annual report focuses on the providers and organizations participating in the Model, their participation decisions and Clinical Episode selection, and the reach of the Model. Subsequent annual reports will describe the impact of BPCI Advanced on Medicare payments, utilization, and quality.

Key Findings:

- **Hospital EIs** were more likely to participate in **medical** Clinical Episodes such as congestive heart failure
- **PGP EIs** were more likely to participate in **surgical** Clinical Episodes such as major joint replacement of the lower extremity

- [Findings At-a-Glance Second Evaluation Report](#)
- [BPCI Advanced Second Evaluation Report](#)
- [BPCI Advanced Second Evaluation Report Appendices](#)
- [BPCI Advanced Second Evaluation Report Webinar](#)



REASONS FOR ENTRY

Convener and EI representatives interviewed cited similar reasons for joining BPCI Advanced, including:

Financial opportunities	To build on past success with bundled payments or other models such as CJR or ACOs	To gain experience with bundled payments	To drive care transformation and to better understand post-acute care utilization	To learn how to partner and work more collaboratively with physicians and hospitals
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NEED MORE INFORMATION?

BPCI Advanced Portals

The [BPCI Advanced Participant Portal](#), [CMMI Connect](#), and the [CMS Enterprise Data Portal](#) are important portals used by Participants to manage deliverables, engage in peer-to-peer learning, and receive data from CMS.



Need To find more Information about the Model?

Participants can visit the “Libraries” on [CMMI Connect](#) ([BPCI Advanced Connect](#) and [Participant Portal POCs](#)) and also on the [BPCI Advanced Participant Portal](#) > [Documents Library](#) section.

Public information can be found on the [BPCI Advanced Website](#): <https://innovation.cms.gov/initiatives/bpci-advanced>

Have a Question?

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