Bundled Payments for Care Improvement Advanced | BPCI Advanced

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

Model Overview Animated Video

February 2023

Bundled Payments for Care Improvement Advanced

BPCI Advanced

Investing in Practice Innovation and Care Redesign

Reduce Expenditures

Improving Quality

Bundled Payments for Care Improvement Advanced, or BPCI Advanced, aims to support healthcare providers who invest in practice innovation and care redesign to better coordinate care and reduce expenditures while improving the quality of care for Medicare beneficiaries.

Join the BPCI Advanced Model

January 1, 2024

Ends on December 31, 2025

The Model started in 2018 and was originally planned to last six years. It has now been extended for two more years and will end in December 2025. This is your opportunity to join the Bundled Payments for Care Improvement Advanced Model from the CMS Innovation Center.

Model Objectives

- 01 Care Redesign
- 02 Data Analysis and Feedback
- 03 Financial Accountability
- 04 Healthcare Provider Engagement
- 05 Patient and Caregiver Engagement

The Model has five objectives: Care Redesign, Data Analysis and Feedback, Financial Accountability, Healthcare Provider Engagement, and Patient and Caregiver Engagement.

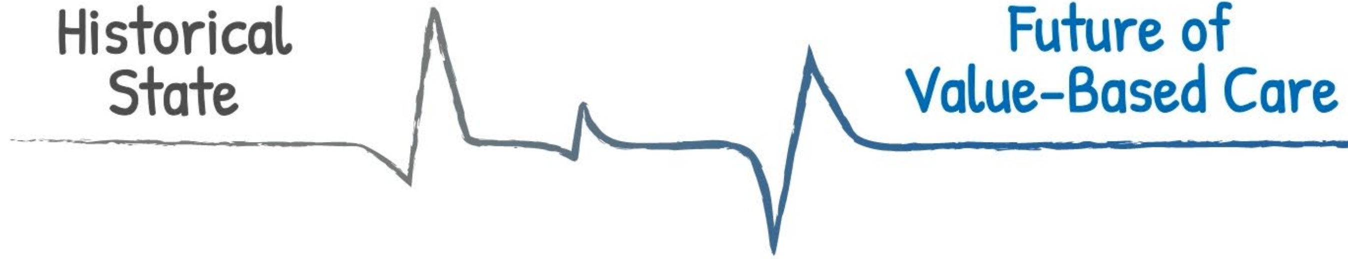
CMS is Testing a Different Approach to Value-Based Care

Fragmented and Uncoordinated FFS Services

Accountable Party

Total Cost of Care

To test a different approach to value-based care, BPCI Advanced is moving away from individual fee-for-services towards a coordinated approach to the beneficiary's needs. A provider becomes the accountable party in this "total cost of care" approach.



Provider-Centered Patient-Centered

Incentives for Volume Incentives for Outcomes

Unsustainable Sustainable

Fragmented Care Market-driven

Coordinated Care

As a Model Participant, you'll have a unique opportunity to help shape the future of value-based care, resulting in patient-centered, market-driven reforms that drive quality and improve outcomes.

01 Clinical Episode: Inpatient or Outpatient + 90 Days

02 Acute Care Hospital (ACH) or Physician Group Practice (PGP)

BPCI Advanced takes all the costs of care provided to a Medicare beneficiary during a 90-day episode and "bundles" them into a single payment. How does it work? First, an anchor event occurs – either an inpatient hospital stay or an outpatient procedure. The Clinical Episode includes the 90 days of care following discharge or once the procedure is completed. The episode is then attributed either to the hospital or a physician group practice participating in the Model.

01 Clinical Episode: Inpatient or Outpatient + 90 Days

02 Acute Care Hospital (ACH) or Physician Group Practice (PGP)

03 Standard Fee-For-Service (FFS) Payments

04 Every Performance Period → Costs and Quality Assessed

Care is provided and billed under standard fee-for-service payments. Twice a year, cost and quality are assessed. Depending on how you perform relative to a Target Price, you may receive additional payments from CMS. If not, you'll owe money to CMS.

A Participant is an Entity that Enters into a BPCI Advanced Model Participation Agreement with CMS

Now let's take a closer look. A Participant is an entity that enters into a BPCI Advanced Model Participation Agreement with CMS. There are two kinds of Participants.

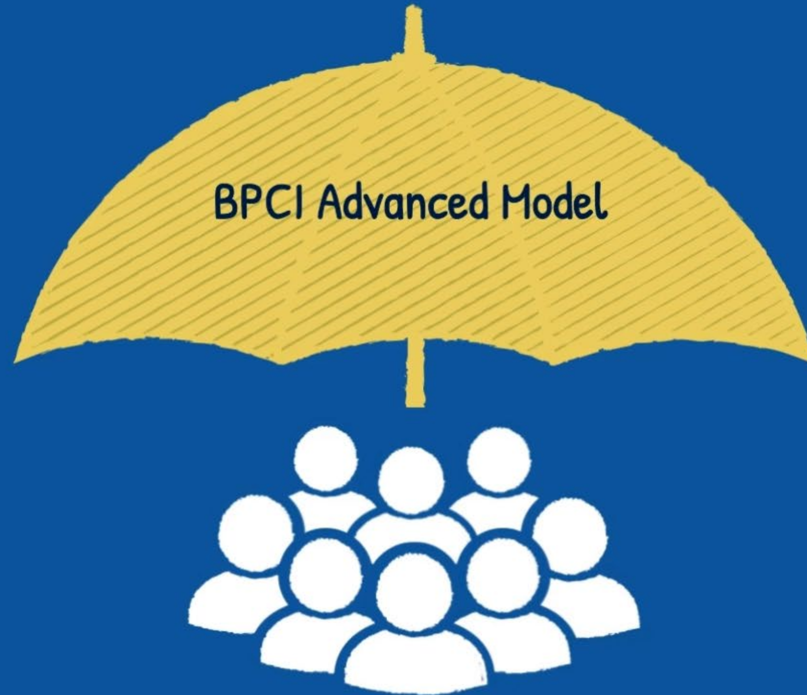
Non-Convener Participant

Acute Care Hospital (ACH)

Physician Group Practice (PGP)

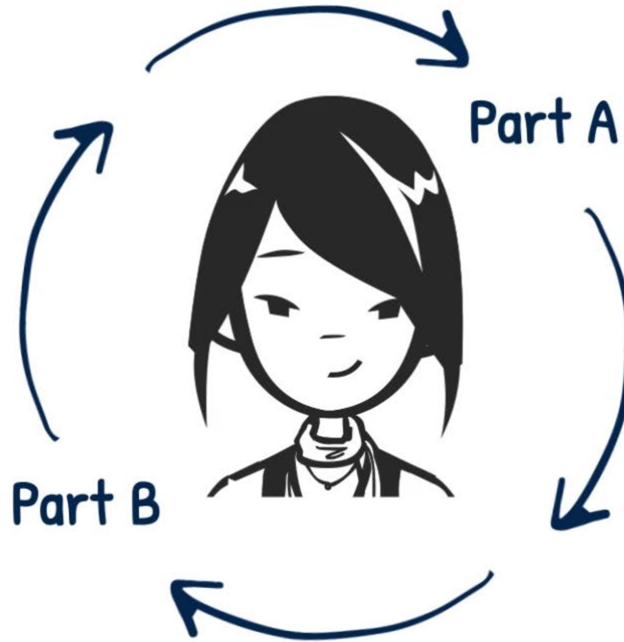
A Non-Convener Participant is a hospital or PGP that is an Episode Initiator and bears financial risk only for itself.

Convener Participant



A Convener must be a Medicare enrolled provider or supplier, or an Accountable Care Organization that brings together at least one downstream Episode Initiator that is a hospital or PGP. The Convener Participant bears and apportions financial risk. The types of entities eligible to be a Non-Convener Participant haven't changed, but the requirements for Convener Participants are different from previous years.

A Patient Enrolled in Medicare Part A and Part B for the Duration of the 90-Day Episode



Who is a BPCI Advanced Beneficiary? A patient enrolled in Medicare Parts A and B for the duration of the 90-day episode. There are some exceptions.

Beneficiary Protections

Participants may not restrict beneficiary access to medically necessary care, nor the beneficiary choice of providers or suppliers

The beneficiary's Medicare benefits will remain the same as if the provider or supplier providing the care was not participating in the Model

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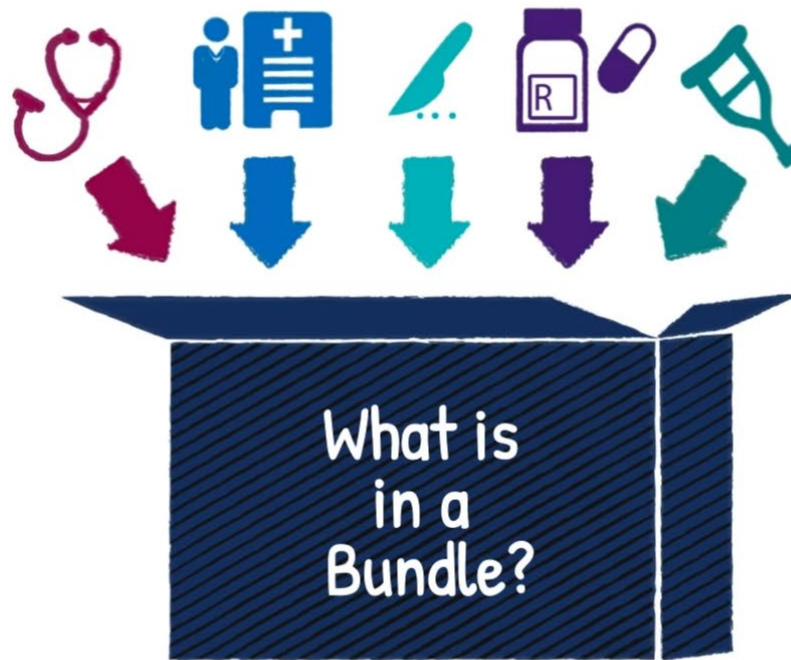
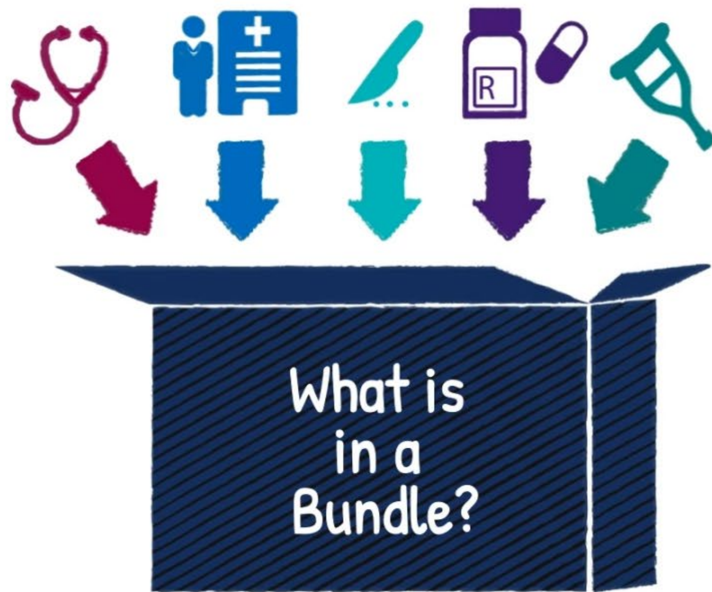
Services and Items Included in a Clinical Episode:
(Unless Specifically Excluded)

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

At this point, maybe you're wondering "What's in a bundle?" Well, it's the set of services and items included in a BPCI Advanced Clinical Episode – unless specifically excluded –



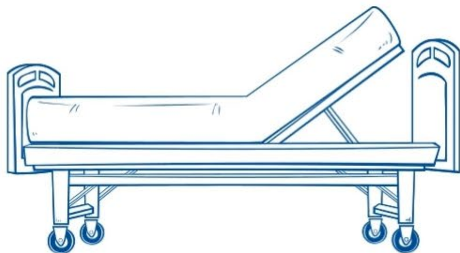
starting with the inpatient hospital stay or outpatient procedure, to all other related services provided to the beneficiary during the next 90 days.



Retrospective Reconciliation

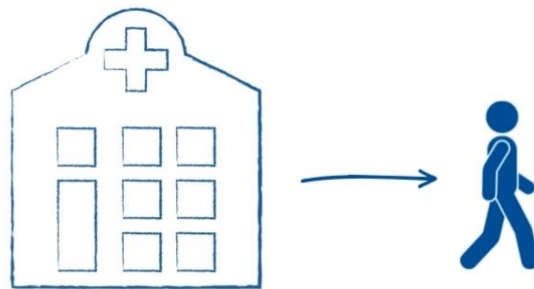
All these fee-for-service claims, paid by CMS, will be bundled together to calculate a Target Price during the retrospective reconciliation process.

Clinical Episode Length



Inpatient Episode (Anchor Stay)

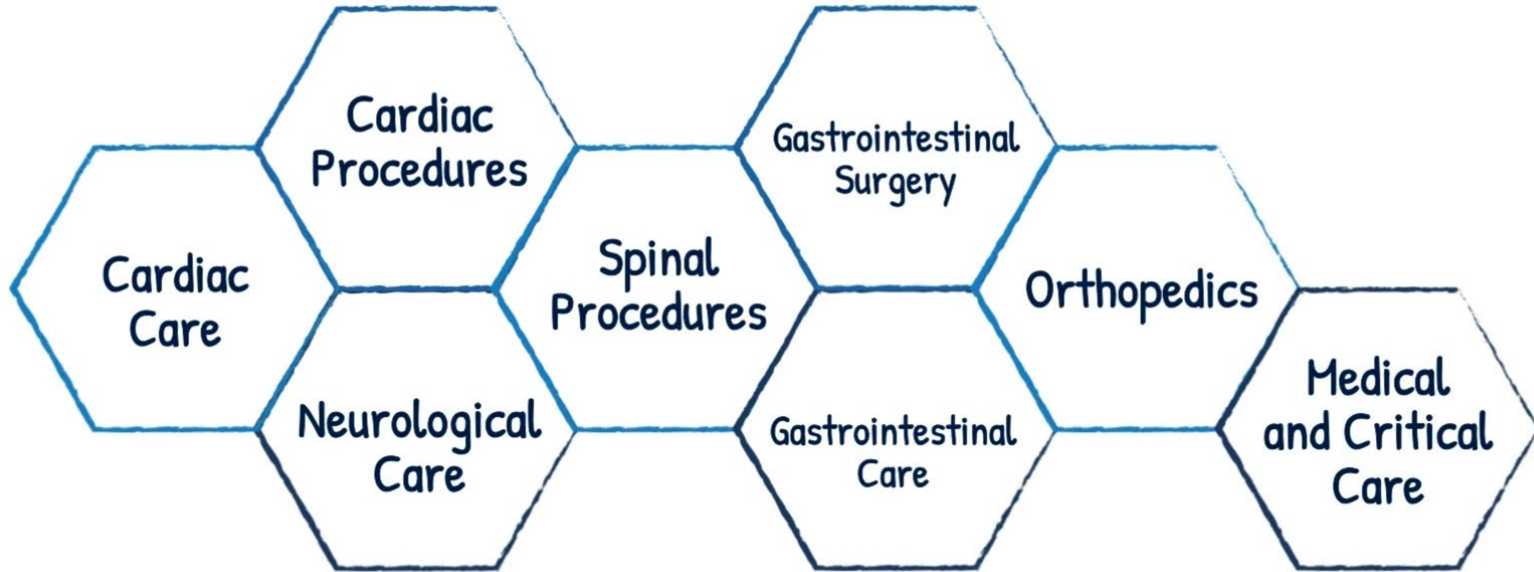
+90 Days Beginning the Day of Discharge



Outpatient Episode (Anchor Procedure)

+90 Days Beginning on the Day of Completion of the Outpatient Procedure

An inpatient episode begins with a hospitalization – called the Anchor Stay – and lasts for an additional 90 days, beginning the day of discharge. An outpatient episode begins with an outpatient procedure – called an Anchor Procedure – and lasts for 90 days beginning on the day of completion of the procedure. CMS will use Medicare DRG codes to identify the inpatient stay and HCPCS codes to identify the outpatient procedure.



BPCI Advanced has eight Clinical Episode Service Line Groups made up of 29 inpatient, three outpatient, and two multi-setting Clinical Episodes. Participants must select at least one group, accepting financial risk for all Clinical Episode categories in that group. For details of the DRG and HCPCS codes included in each group, please go to the Model webpage.

This Model has a Pricing Methodology Made Up of Several Components

When creating Target Prices, the concept is simple, but the math is complex. BPCI Advanced calculates a Target Price specific to each hospital, based on a Benchmark Price and a discount. Participants aim to treat Medicare beneficiaries at a cost below this Target Price.

Patient Case Mix

Historic Medicare FFS Expenditures During ACH's Baseline Period

Patterns of Spending Relative to ACH's Peer Group

- Census Division
- Number of Beds
- Teaching Hospital Status
- Safety Net Status
- Urban Vs Rural

CMS calculates Benchmark Prices for each Clinical Episode category, for each Episode Initiator. A hospital Benchmark Price accounts for three central factors – the hospital's patient mix, its expenditures during a four-year baseline period, and its spending patterns relative to its peers. For PGP Benchmark Pricing details, review the Model Overview Fact Sheet available on the Model's webpage.

Example for a COPD Clinical Episode (medical)

$35,500	Benchmark Price
- $710	Medical Episodes 2% Discount
$34,790	Target Price

The CMS discount is a set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price. Starting in 2023, the discount is two percent for medical episodes and three percent for surgical episodes.

CMS Provides Participants with Preliminary Target Prices for Each Clinical Episode Category for Each Episode Initiator

Before each Model Year, CMS provides Participants with preliminary Target Prices for each Clinical Episode category. They are unique to each Episode Initiator

Final Target Prices will be constructed during Reconciliation and will include updated patient case mix and realized trends

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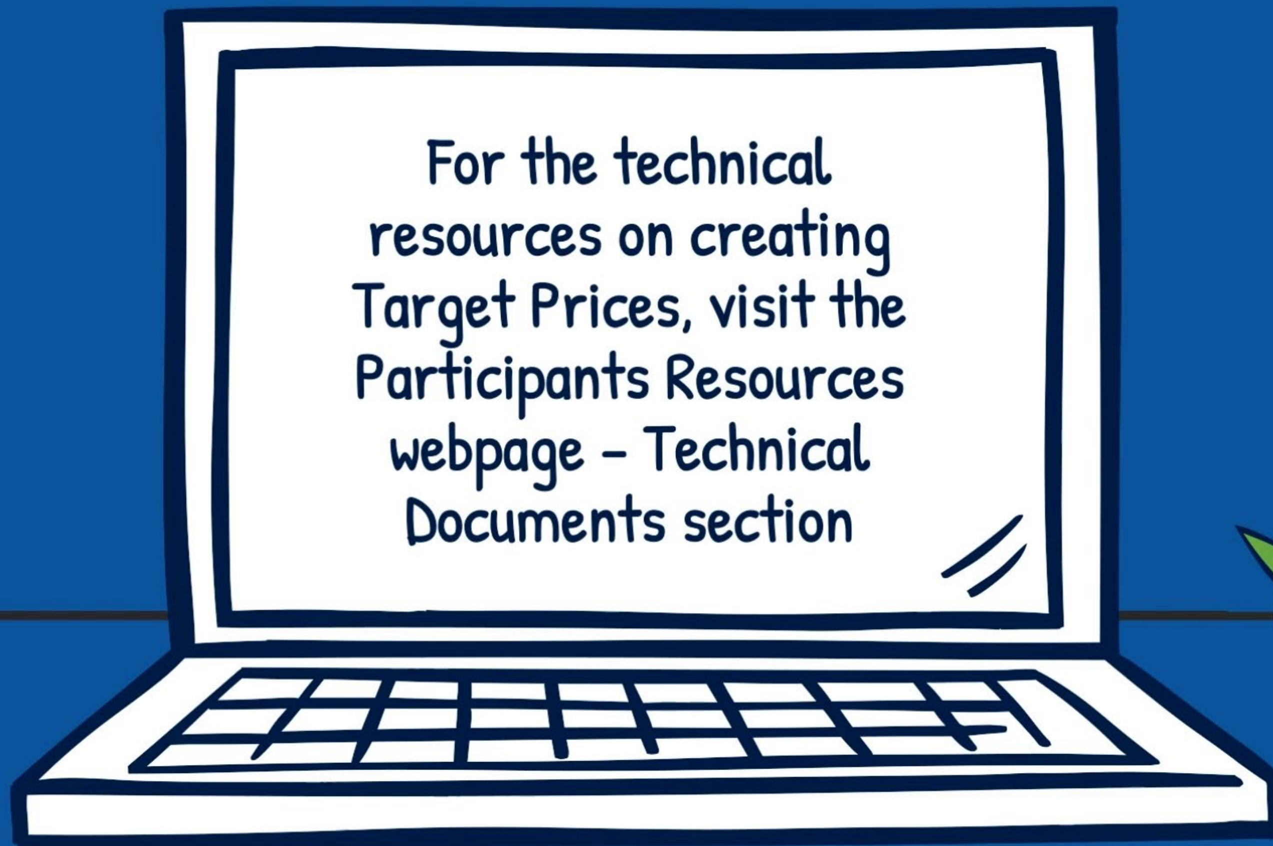


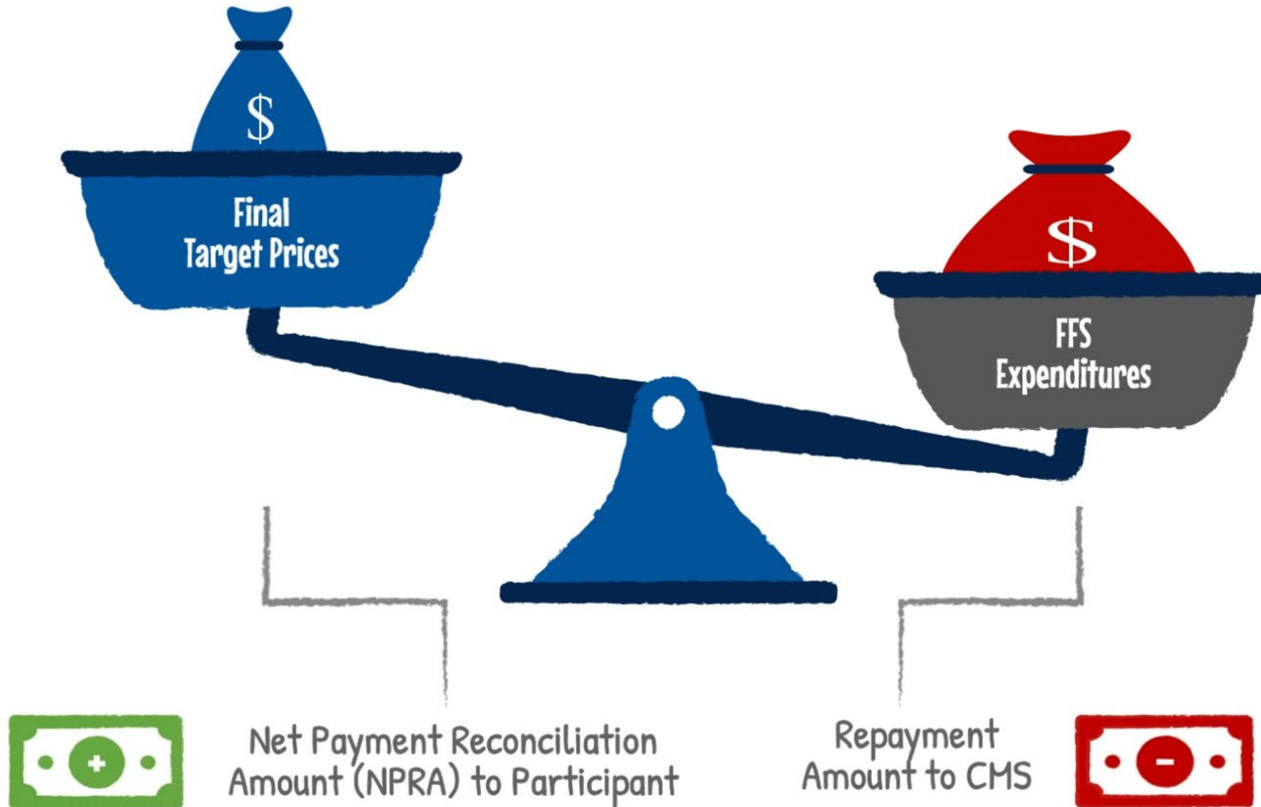
For the technical specifications on creating Target Prices, visit the Participants Resources -Technical Documents section of the Model webpage.

2 reconciliations per year covering

2 performance periods

each 6 months long

More on reconciliation. Twice a year, a reconciliation is conducted, comparing the aggregate fee-for-service expenditures to final Target Prices across all Clinical Episodes.



This results in a positive or negative amount per episode, and all of these amounts are netted, resulting in either a Net Payment Reconciliation Amount (also called NPRA, meaning the Participant may receive a payment from CMS) or a repayment amount (meaning the Participant owes CMS).

Administrative Quality Measures 6 claims-based measures collected by CMS

Alternate Quality Measures 5 claims- and registry-based measures for each episode

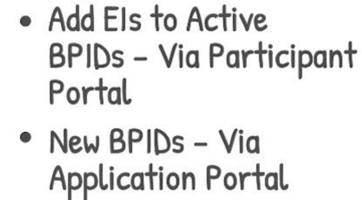
CMS evaluates Participants on the quality of care they provide, and how well they do impacts their reconciliation. Fortunately, Participants get to choose which measures CMS uses, either the Administrative Quality Measures Set or the Alternate Quality Measures Set.

Participating in other CMS Models and concerned about overlap?

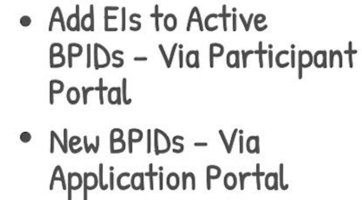
There is no short answer

Read the RFA

By now, maybe you're wondering about overlap between BPCI Advanced and another CMS Innovation Model you participate in. Well, there's no short answer. Check out the Request for Applications for details.



Thinking about applying to BPCI Advanced? Great! The kind of organization you are will determine your options. Convener Applicants must be Medicare enrolled providers or suppliers or ACOs. Non-Convener Applicants must be a hospital or PGP.



Former Participants may apply as either a Convener or Non-Convener or as an Episode Initiator under a Convener. Active Model Participants do not have to apply to continue in Model Year 7. They may also add Episode Initiators to active BPIDs or apply for new BPIDs. Don’t delay. Apply soon!

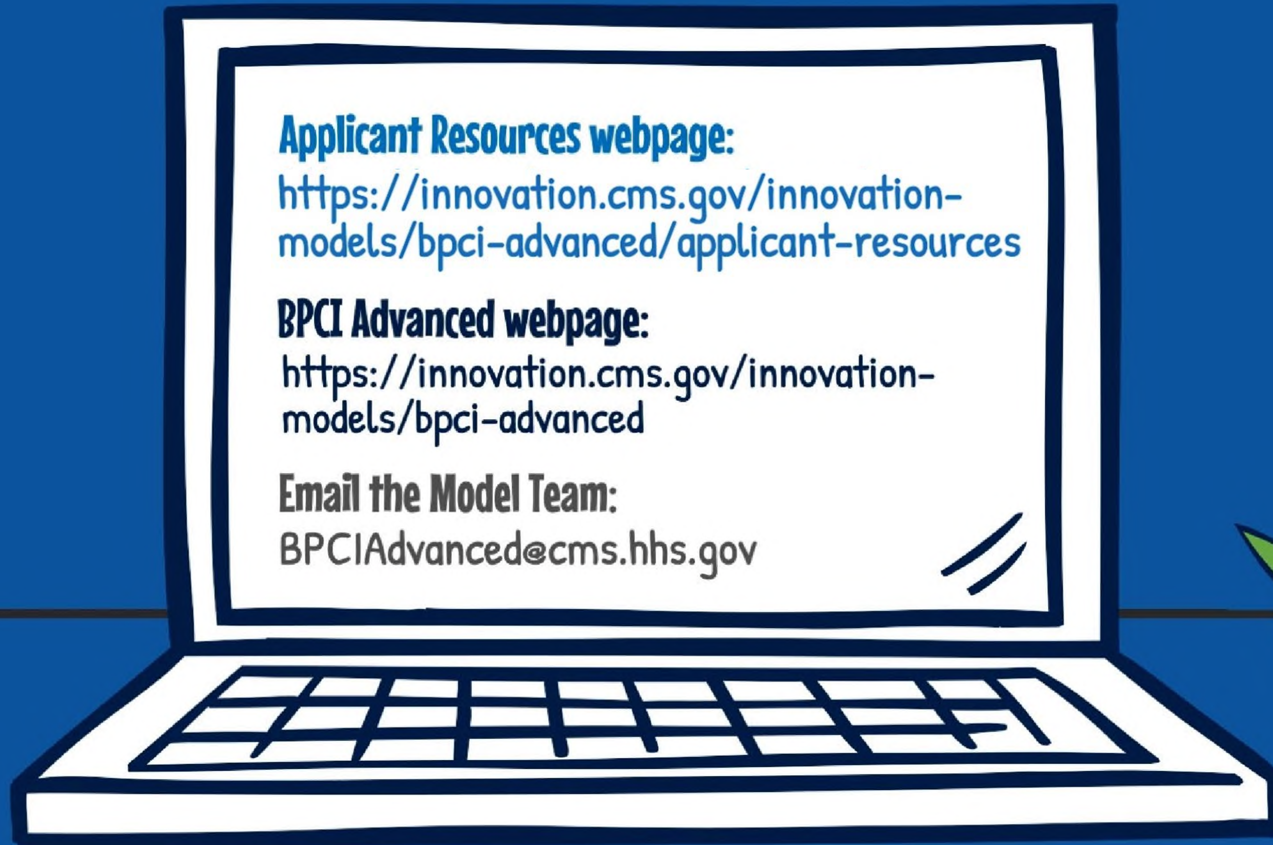
MY7 Request for Applications (RFA)

Application Resources Webpage

Apply via Application Portal only

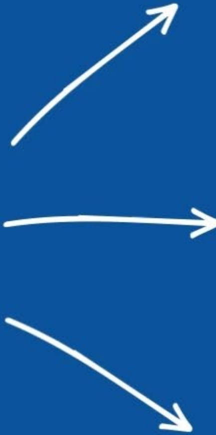
https://app.innovation.cms.gov/bpciadvancedapp/IDMLogin

The Request for Applications provides the necessary information to potential applicants to allow an informed decision on Model participation. Interested? Download the RFA from the Model webpage. There you'll also find a template of the application and additional resources to help you navigate the application process. When you're ready to apply, you must do it through the BPCI Advanced Application Portal.



Stay up to date on BPCI Advanced through the BPCI Advanced webpage, the BPCI Advanced listserv (which you'll find a link to subscribe near the top of the webpage), and by emailing us!

We Hope You'll Join Us in 2024



Improve Quality of Care

Manage Cost

Improve the Patient Experience

After this overview of the BPCI Advanced Model, we hope you'll consider joining us in 2024 in our efforts to improve quality of care, manage cost, and improve the patient experience. Thank you and we hope to hear from you soon.

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