BPCI-A Model Overview and Request for Applications Model Year 7 Webinar
March 9, 2023

>> Smith, TJ, Deloitte: Good afternoon, everyone, and thank you for joining today's Model Overview and Request for Applications Model Year 7 Webinar. Next slide, please.

Before we begin, there's a few housekeeping items to discuss for today's presentation. All participants will be in listen-only mode. We would also like you to know that today's presentation is being recorded. If you have any objections, please hang up at this time. This slide deck, a recording of today's presentation, and a transcript will be made available on the Model on the Model website in about a week. Next slide, please.

Before we dive into content, let me give a brief overview of the agenda for today's Webinar. We will begin with some opening remarks from Amy Giardina, the Director of the Division of Payment Models at the CMS Innovation Center, followed by Model highlights and design elements. The Model team will then present details of the pricing methodology, followed by an overview of the application process, and who is eligible to apply.

Following that, we have allocated the last 15 min or so for a Q&A session where the Model team will answer questions submitted by audience members. Please do feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window. Given time constraints, we may not get to every question, but we will collect them for future events, and Frequently Asked Questions documents.

Again, thank you so much for joining us today. We do have a great presentation planned for you, and it's now my pleasure to turn the webinar over to Amy for some opening remarks. Next slide, please.

>> Amy Giardina, CMS: Thanks so much TJ. Hi, everyone. My name is Amy Giardina, and I'm the Director of the Division of Payment Models, welcome. I don't know if you can see the list of attendees, but I can, and it's great to see some familiar names here. It also looks like there are some new names and organizations, so welcome to all. I'm super happy to have you here today to talk about the extension of BPCI Advanced for two more years, so exciting, right? So, you being here is a testament to providing value-based care to our beneficiaries. So, thank you.

As we all know, health care changes quickly, and it's really important that we continue to evolve and create our payment Models so that we're delivering the best care to our beneficiaries. You've probably seen the evaluation reports. And what we found, is that episode payment Models are doing what they are supposed to do, which is provide better, more efficient care to our beneficiaries and reduce waste. So, this is why we're extending the Bundle Payments for Care Improvement Advanced Model, it works.

I was looking at my Twitter feed this morning, and someone posted, "the time is now" with a link to the application, to our application, the BPCI Advanced application. And I thought, what a great slogan, because the time is now to get involved and apply to each part of the BPCI Advanced Model, at such an exciting time. So, I'm happy to be here today to work with all of you as we continue to push forward in providing better and more efficient care to our beneficiaries. I hope that you'll consider participating and

working together with us to deliver high-quality care that improves outcomes and lowers costs. So again, thanks for joining us today. I look forward to our productive discussion.

And now I'm going to introduce the team of analysts who I work with on BPCI Advanced. They will be the presenters for today's webinar. We have nine speakers, including Jen Lippy, who is the Deputy Director for Division and Payment Models, Agnelli Sybel, who is the Application Lead. And then analysts, who each have their own specialty in the division, which are Dara Clay, Aaron Broun, Jessica Dawson, David Bowen, Tom Ensor, her and Naa Minnoh. So now I hand it over to Agnelli Sybel to share some Model highlights. Next slide, please.

>> Agnelli Sybel, CMS: Thank you, Amy. Hello, my name is Agnelli Sybel and I'm a Public Health Analyst, and the lead for the BPCI Advanced Model two-year extension application opportunity. We are grateful to all of you for making time to be here this afternoon.

The goal for today's presentation is to highlight certain aspects of the Model, but it's not intended to be fully comprehensive of the Model or outline all the Participant requirements and responsibilities. We encourage you to read the Request for Application document and the Model Overview Fact Sheet and the various resources that have been created to support the application process. Next slide, please.

Let's take a quick look at the Model timeline for implementation. Right now, we are in Model Year 6, which was supposed to be the last year of the Model. We are all here today because CMS has extended the Model for two more years. The first cohort of BPCI Advanced Participants started on October 1st, 2018. The second cohort started in January 2020, for Model Year 3. Since February 21st and through May 31st, we will be accepting applications from organizations that want to join the Model in 2024, and be part of the third cohort. The BPCI Advanced Model will end on December 31st 2025. Next slide, please.

Now I'll walk us through a bit of the background information related to BPCI Advanced. We are a voluntary, episode payment Model developed by the CMS Innovation Center with the goal to test whether linking payments for a Clinical Episode can reduce medical expenditures while maintaining the quality of care. Organizations that become a Participant will aim to facilitate coordination among various health care providers, working to meet the patients' full needs throughout the duration of the episode of care.

BPCI Advanced operates under a total-cost-of-care concept by seeing the Medicare beneficiaries in a holistic way, not just as one medical problem at a time. We're called bundle payments, so what's in the bundle? All items and services furnished to a BPCI Advanced Model beneficiary during the Clinical Episode will be part of the Clinical Episode expenditures for purposes of the Target Price and reconciliation calculations, unless specifically excluded. That means inpatient or outpatient hospital services, hospital readmissions, emergency room visits, physician consults, laboratory, durable medical equipment, and a few more items listed on the screen. So, what is not in the bundle? All those Medicare claims are included unless they are specifically excluded. For that, please look at the exclusion list posted on the Model's webpage. Next slide, please.

A patient enrolled in Medicare Parts A and B, for the duration of the 90-day Clinical Episode qualifies as a BPCI Advanced beneficiary. There are four circumstances where a beneficiary would be excluded from triggering an episode in the Model. They're listed on this slide, but the two most common I want to call to your attention. If the beneficiaries are covered under United Mine Workers health plan, or under a

managed care plan. The second most common is, if Medicare is not the primary payer at any time during the Clinical Episode.

So, the welfare of our beneficiaries is our north star. Therefore, we expect participants to have protections and notify beneficiaries that they're part of the Model by ensuring that they receive a copy of the CMS Beneficiary Notification Letter prior to discharge. Participants may not restrict access to medically-necessary care. An example of this would be suggesting to a beneficiary that a skin biopsy procedure be delayed until after the 90 days of the Clinical Episode are over, so the expenditures associated with that procedure are not included in the Participants' bundle. Also, Participants may not limit the beneficiaries' choice of providers or suppliers. We want to emphasize that the co-pay for which a beneficiary is responsible will not change if they are in the Model.

Something that is also different is that Participants in the Model may provide beneficiaries with certain incentives, as long as the items and services are reasonably connected to medical care or advance a clinical goal, under the special waiver from the Office of Inspector General. One common example of beneficiary incentive is providing transportation vouchers to ensure compliance with the treatment plan. Next slide, please.

CMS has expectations and requirements that are aligned in the BPCI Advanced Participation Agreement that organizations must abide if they want to join the Model. I want to highlight a few of them. First, is the submission of required deliverables, some are annually, others semi-annually or quarterly. You'll see them referred to in various documents as PP (for Participant Profiles), CRP (which means Care Redesign Plan), the Quality Payment Program List, and the FAL (Financial Arrangements List).

We expect participants to have organizational readiness to implement the Model on day one, January 1st, 2024, and to have participating practitioners ready to provide clinical care and engage in BPCI Advanced activities. We also want Participants to actively engage in learning system's activities and expect them to comply with requests regarding evaluation, monitoring and/or compliance activities. Model Participants may enter into financial arrangements with individual clinicians or other health care providers, and share in the savings as long as the terms of the fraud and abuse waiver requirements are met by both parties. Since BPCI Advanced is a voluntary Model, Participants may terminate their participation at any time with their 90-day written notice to CMS. Okay, we got the next slide on the screen.

Through the activities of the learning system and the evaluation reports from the first iteration of bundled payments and our current experience, we have identified certain strategies that Model Participants have implemented with success. This is just a quick list, we will be developing a webcast in a live event, to delve more into these best practices, like care navigation, post-acute care preferred provider networks, the use of data and dashboard to educate patient and caregiver education, changing or standardizing care protocols, and the use of multidisciplinary steering committees. Now I'll pass the microphone to David and Jessica to talk about the Model design elements. Next slide, please.

>> David Bowen, CMS: Thank you, Agnelli. Hi, everyone, my name is David Bowen, and I'm a Health Insurance Specialist on the BPCI Advanced Model. As Agnelli mentioned, the upcoming section will provide more information on the BPCI Advanced Model design. Next slide, please.

So, BPCI Advanced bundles the payments for physicians, hospital, and other health care services into a single Target Price for an episode of care to reduce Medicare expenditures while preserving or enhancing the quality of care accountability. On this slide, you'll notice how the Model works. So first, a Clinical Episode is triggered by either an inpatient hospital stay or an outpatient procedure. Then, that Clinical Episode is attributed to a physician group practice or a hospital that is participating in the Model. Care is then provided under standard fee-for-service payments and billing processes do not change. And finally, at the end of each Performance Period, quality and cost performance are assessed in the semi-annual reconciliation phase. Next slide, please.

So, Participants are an entity that enter into a BPCI Advanced Model Participation Agreement with CMS, meaning they are accepting to bear financial risk for Clinical Episodes under the Model for the agreement Performance Period. We based reconciliation on comparing the actual Medicare fee-for-service expenditures to a final Target Price. CMS conducts a semi-annual reconciliation against Clinical Episodes specific Target Prices, and if during the semi-annual reconciliation process all non-excluded Medicare fee-for-service expenditures for a Clinical Episode are less than the final Target Price, then there will be a positive reconciliation amount, which we call a Net Payment Reconciliation Amount, or NPRA. By contrast, if all non-excluded Medicare fee-for-service expenditures for a Clinical Episode are greater than the final Target Price, then there will be a negative reconciliation amount, meaning that the participant may owe CMS money, which we call a Repayment Amount. Any Participant that wishes to share on the savings may enter into financial arrangements with NPRA sharing partners that might be an individual or an organization.

Now I’ll pass it over to my colleague, Jessica Dawson, to talk more about some of the Clinical Episode triggers.

>> Jessica Dawson, CMS: Thank you, David. Hi everyone, I'm Jessica Dawson a Social Science Research Analyst with the BPCI Advanced Model team. Let's dive right into the discussion about Clinical Episode triggers.

Now we've touched on a few of these terms earlier in our presentation, but I will be providing a little more detail about how and when a Clinical Episode is triggered. In the BPCI Advanced a Clinical Episode is the defined period of time, triggered by the submission of a claim for an Anchor Stay for any patient Clinical Episodes or Anchor Procedure for outpatient Clinical Episodes by an Episode Initiator. During which, all Medicare fee-for-service expenditures for all non-excluded items and services furnished to a BPCI Advanced beneficiary are bundled together for reconciliation purposes.

An Anchor Stay is the inpatient stay at an acute care hospital as a qualifying Medical Severity Diagnosis Related Group or MS-DRG, for which an Episode Initiator submits a claim to Medicare fee-for-services, which in turn triggers a Clinical Episode. An Anchor Procedure is a hospital outpatient procedure identified by a qualifying Healthcare Common Procedure Coding System, HCPCS, which we pronounce “hick picks” code, for which an Episode Initiator submits a claim to Medicare fee-for-service, which in turn triggers a Clinical Episode. Next slide, please.

For inpatient Clinical Episodes, the episode length is the Anchor Stay, or however, I’m sorry, however many days of beneficiary is hospitalized up to a maximum of 60 days plus 90 days, beginning the day of discharge. For the outpatient Clinical Episodes, the episode length is the Anchor Procedure plus 90 days beginning on the day of completion of the outpatient procedure. Next slide, please.

Another unique aspect of the BPCI Advance Model are our Clinical Episode Service Line Groups. The BPCI Advanced has eight Service Line Groups made up of 29 inpatient, three outpatient, and two multi-setting Clinical Episodes. Participants will be accountable for all Clinical Episode categories within a Clinical Episode Service Line Group.

Why did CMS create these Service Line Groups? For one, they force Participants to improve care across multiple conditions. They inhibit selection bias. Participants tend to pick Clinical Episodes for which they predict they'll achieve good results or a positive Net Payment Reconciliation Amount. Also, they make for a stronger evaluation, so more Participants will be involved in more episodes. And they limit CMS total losses, since Participants are now exposed to two-sided risks.

How do the Service Line Groups help Participants? They have the ability to increase a Participant's Clinical Episode volume and spread their risk across multiple Clinical Episodes. Greater Clinical Episode volume can mean greater opportunity to achieve savings, which we call an NPRA. A greater uptake across multiple Clinical Episodes can make the transition to mandatory participation easier. And, they also help Participants scale their existing Care Redesign Processes, since many of the groups have similar Clinical Episodes with similar clinical management pathways and needs. I will now pass it back to my colleague, David, to speak a little bit more about the precedence rules, and what the Participant Profiles are. Next slide, please.

>> David Bowen, CMS: Thanks, Jess.

Well in BPCI Advance, when we talk about precedence, we mean that if multiple BPCI Advanced Participants are all caring for the same beneficiary, then who would be held responsible for the said Clinical Episode? Well, in BPCI Advanced, Clinical Episodes will be attributed at the Episode Initiator level. The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators is listed on your screen, and in descending order of precedence. So, first being the attending Physician Group Practice. Second being the operating Physician Group Practice. And third, the hospital itself. BPCI Advanced will not use time-based precedence rules. So essentially, what this means is that Participants who started in the Model in October of 2018, will not have precedence over participants that started in the Model in January of 2024. Next slide, please.

CMS recognizes that Episode Initiators may be having conversations with multiple Conveners at this time, and we do not intend to limit the number of applications in which a potential Episode Initiator may be listed. However, once a participant submits a Participation Agreement, their selections on the submitted Participant Profile become critical. Episode Initiators may only participate with either one Convener Participant, or as a Non-Convener Participant. CMS will send a Participant Profile template to each applicant later in the summer. That Participant Profile template will include all potential episodes, episode initiators that were listed within an application. When the Participant Profiles are submitted back to CMS, an Episode Initiator that was listed in multiple applications must appear in only one Participant Profile with the status of "active." Each Participant will be required to submit a Participant Profile with their selection of Episode Initiators, and Clinical Episodes Service Line Groups for which they will be held accountable for until the end of the Model on December 31st, 2025. Now I'll hand it over to my colleagues, Tom Ensor and Jessica Dawson, to tell us some more about the pricing methodology.

>> Thomas Ensor, CMS: Thanks. Hi, everyone. Thanks for being here today. My name is Tom Ensor, and I am a Social Science Research Analyst on the BPCI Advance team. In the next section of the webinar, I will discuss the Model's pricing methodology and reconciliation process. The next slide, please.

So, CMS will provide historical claims data and preliminary target prices to applicants prior to their decision to participate in BPCI Advanced. In order to access this data, applicants must make the selection in the Data Request and Attestation form, or DRA, section of the application, and maintain a DRA with at least two data points of contact from your organization. These two data POCs will be granted access to the BPCI Advanced Data Portal where CMS will upload the data files. All applicants and active Model Participants who have submitted a DRA form will receive Model Year 7 Target Prices for all of the Clinical Episode categories within a Service Line Group that they meet the minimum baseline threshold for. So, the minimum threshold requirements are as follows. For Hospital EIs, the minimum baseline threshold is at least 41 Clinical Episodes in the baseline period. And for PGP EIs the hospitals where they will initiate Clinical Episodes must meet the 41 Clinical Episode threshold in the baseline period. We recommend reviewing the Clinical Episode Construction Specification document which is located on the BPCI Advanced webpage. This document explains these exclusions and others in more detail. Next slide, please.

BPCI Advanced Target Prices are calculated using the following variables: the benchmark price and the CMS discount of two percent or three percent, depending on the Clinical Episode type. These preliminary Target Prices are shared with Participants before the start of the Model year and Participants will then aim to treat Medicare beneficiaries at a cost below the given Target Price. Next slide, please.

Model Year 7 Convener applicants will receive Target Prices for all potential Episode Initiators and Non-Convener applicants will receive their own Target Prices. The final Target Price is constructed during the reconciliation cycle to account for updated patient case mix and realized trends. I will discuss final Target Prices and reconciliation in more detail in an upcoming slide. Again, for more information on the technical specifications that go into creating Target Prices, we recommend visiting the BPCI Advanced Model webpage and navigating to the technical documents section of the Participant Resources. Next slide, please.

So, in the previous slides we discussed the creation of Target Prices, and how participants are held accountable for the total-cost-of-care. But now I'm going to transition here into a brief discussion of how Participants are evaluated on the quality of care they provide and the effect that quality measures have on reconciliation results. So, Participants are given the option to choose which type of quality measures will be used for the calculation of their Composite Quality Score or CQS at the Clinical Episode category level. The Administrative Quality measure set contains six exclusively claims based measures directly collected by CMS, while the Alternate Quality measure set includes a combination of up to five claims based and registry-based measures for each Clinical Episode. The Participant will be assessed based on the applicable quality measures and given a Composite Quality Score. The same calculation methodology will apply to both measure sets and will adjust the reconciliation results by up to 10%, either up or down. Next slide, please.

So, reconciliation is when CMS takes the actual Medicare fee-for-service expenditure for all Clinical Episodes attributed to the Episode Initiator and compares it to the final Target Price for those Clinical Episodes. This reconciliation cycle happens on a semi-annual basis and Clinical Episodes will be reconciled based on which Performance Period the episode ends in. During reconciliation, Participants will either receive a Net Payment Reconciliation Amount, NPRA, or a Repayment Amount. NPRA occurs when a Participants' Medicare fee-for-service expenditures for a Clinical Episode is less than the final Target Price for that Clinical Episode. This results in a positive reconciliation amount which is paid by CMS to the Participant. Meanwhile, a Repayment Amount is generated if the total Medicare fee-for-service expenditures for the Clinical Episode exceeds the amount of the final Target Price. This results in a

negative reconciliation result that is paid by the Participant to CMS. I will now pass it back to my colleague Jessica, to close out this discussion about pricing methodology. Next slide, please.

>> Jessica Dawson, CMS: Thank you, Tom. I'll be discussing the limitations to the financial risk associated with the BPCI Advanced Model.

CMS recognizes the financial risks associated with participation in the Model, and has instituted limitations to the financial risk accepted by participants. These limitations occur in the form of a Risk Track and Stop-Loss/Stop-Gain limits. For the Risk Track, the risk cap is applied to Clinical Episodes at the first and the 99% of spending. Additionally, the risk cap is applied to Clinical Episodes in both the Performance Period and the baseline period. For the Stop-Loss/Stop-Gain limits, reconciliation payments, both to Participants from CMS and from Participants to CMS are capped at plus or minus 20% of the volume-weighted sum of final Target Prices across all Clinical Episodes netted to the Episode Initiator level within the Performance Period. I will now pass it to my colleague Naa, who will talk about the application process and who can apply. Next slide, please.

>> Naa Minnoh, CMS Thanks, Jessica. Hello, everyone, my name is Naa Minnoh, and I am a Public Health Analyst within the learning system that supports the BPCI Advanced Model team. Thank you so very much for your time today.

In this section I will walk you through a few of the application process details for this two-year Model extension. And just like my colleagues have done in other sections of this webinar, I will also call out key points for eligible applicants. Before we dive deeply into the application process, and who can apply content, we would like to request audience participation in a poll. Next slide, please.

So, to understand who is in the audience today, we would appreciate you answering the poll question you see on your screen: Are you representing a Potential Applicant, Former Participant or Episode Initiator, Active Model Year 6 Participants, or Other?

I'll give folks a few more minutes to select an option that best represents them. Five more seconds and we can close the polls, please. Thank you. The results of the polls are up on the screen, and thank you to everyone for your submission. Please also feel free to use the question and answer function to elaborate on your answer. And with that we will begin to discuss more about the application process, and who can apply. Next slide, please.

So, who is eligible to apply? To apply, Non-Convener Participants are required to be either Acute Care Hospitals (APHs) or Physician Group Practices (PGPs). Convener Participants, are required to be Medicare-enrolled providers or suppliers, or Medicare Accountable Care Organizations (ACOs). Episode Initiators, whether AHCs 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 during this application period.

So, you may be wondering what, if you're an active Model Participant in Model Year 6, what options are available to you. Active participants in our Model will have the opportunity to sign an amended and restated Participation Agreement for Model Year 7, without the need to submit an application. Convening Participants active during Model Year 6, even if they're not a Medicare-enrolled provider, our supplier or Accountable Care Organization will also have the opportunity to continue in the Model during the two-year extension. Next slide, please.

Applicants may access the BPCI Advanced Application Portal "How-to Guide" on the Model website, and through the link provided on your screen. Please note that CMS will only accept applications and attachments that are submitted to the BPCI Advanced Application Portal. The deadline to apply is May 31st, 2023 at 5 PM Eastern Daylight Savings Time. There are several printable materials that can be found on the applicant resources webpage that can help you throughout the application process.

A few things to note, once you start an application in the application portal. One, the user who begins the application process must be the user who submits the finalized version. Another user will not be able to access this application. Two, applications do not need to be completed in one sitting. Please save your work as you go, as the application portal times out after 30 minutes of inactivity. Be sure to save any changes before navigating away from any page, as all unsaved changes will be lost. Now, I'll pass it over to my colleague David again to tell us more about the required deliverables.

>> David Bowen, CMS: Thanks, Naa.

So, after an organization submits their application, there are several deliverables that must be completed and submitted before CMS can approve the submitted application and execute the Model Year 7 Participation Agreement. The templates for all the required deliverables will be distributed in early September, and the Participant or Participation Agreements, and all the applicable deliverables will be due in October of 2023.

Those deliverables that are required prior to the start of Model Year 7 are, the BPCI Advanced Participation Agreement for Model Year 7, the Participant Profile, which is where the selection of Clinical Episodes Service Line Groups for each active Episode Initiator is documented. We're also collecting the BPCI Advanced QPP List, the Care Redesign Plan, and the Financial Arrangements List, if applicable. Next slide, please.

We've created a number of resources that aim to help support applicants throughout this process. Please refer to our BPCI Advanced applicants' resources page. The web link is also provided here on your screen as well, to review these additional materials. In the coming weeks, and throughout the application process, we will be posting additional resources. The recording of today's event will be available in about a week's time. Next slide, please.

So, if you're having any trouble with the registration process, password issues, and navigating the Application Portal, please contact our Salesforce IT Help Desk. If you fail the IDM identification process, which is part of CMS IT Security Protocols, during the initial registration on the Application Portal – Please contact Experian through the phone number listed on screen. If you have any questions about the BPCI Advanced Model, please contact the Model Help Desk at BPCIAdvanced@cms.hhs.gov. Or, if you require more information about the Model, Clinical Episodes, pricing methodology, quality measures, or evaluation reports, please visit the BPCI Advanced Model general webpage. For resources and materials that help address and educate the public interested in applying to the BPCI Advanced Model, please visit the applicant resources webpage.

And with that, we will now begin our Q&A section of today's webinar. So, I'll pass it over to my colleague, Dara Clay, to get us started.

>> Dara Clay, CMS: Awesome, thank you so much, David. Good afternoon everyone. My name is Dara Clay, and I'm a Health Insurance Specialist along with my colleague, Aaron Broun, who we'll hear from just a minute.

We're going to answer a few questions that were provided to us at the events' registration. As a reminder, due to the high volume of attendance, we may not be able to get to every question. We will take note of each question coming through on the chat, and try to ensure future materials help address any common themes. You are welcome to submit additional questions to our Model help desk, which is BPCIAdvanced@cms.hhs.gov. And next slide, please.

Our first question is: How many applications can an organization submit? So, CMS imposed no limits on the number of applications that an organization that is a Medicare-approved provider supplier or ACO may submit. Each application will identify the potential Episode Initiator in the participating organization's template, which must be an ACH or a PCP, a PGP, Excuse me. Each application, if approved, will result in a separate Participation Agreement for Model Year 7. However, if an Episode Initiator, however an Episode Initiator may only participate in the Model starting on January 1st, 2024 under one Convener, or as a Non-Convener Participant, or, in other words, as its own Episode Initiator. On to you, Aaron.

>> Aaron Broun, CMS: Thanks, Dara. As Dara mentioned, my name is Aaron Broun, and I am a Social Science Research Analyst for the Model.

Our next question is: If a Medicare Shared Savings Program ACO decides to participate, are all the providers under the ACO required to join the Model as downstream Episode Initiators?

And the answer there is, no. There is no requirement that all providers under an ACO must join the Model as downstream Episode Initiators. On the application, the ACO will be required to identify potential to downstream Episode Initiators, either Acute Care Hospitals or Physician Group Practices. These potential downstream Episode Initiators may or may not be providers under the ACO. Next slide, please.

>> Dara Clay, CMS: Okay, our next question is: Client billing is complicated as it is, I'm concerned that patient billing will be impacted, and the beneficiary may or may not be balance billed correctly if they are in the Model.

Okay, and so the answer for that is that the process for billing services that are provided to the Medicare beneficiary will not change. The BPCI Advanced Model is a retrospective payment Model, meaning that through the reconciliation process is when Participants will receive a payment or be directed to reimburse CMS. Next slide, please.

>> Aaron Broun, CMS: Our next questions are related to data. What type of data will we receive when we apply? And will we get the same data if we are an active Model Participant? Next slide, please.

The answer there is that, along with active Model Participants, applicants who complete an application and Data Request and Attestation, or DRA form, will receive preliminary Model Year 7 Target Prices and baseline Medicare claims data. Both applicants and active Model Participants will receive Target Prices, and up to three years of historical claims data for all Clinical Episode categories in which they meet the

minimum baseline threshold for episode volume. This allows both applicants and Participants to assess potential performance across Clinical Episode categories. With that, I'd also like to note that in BPCI Advanced, the baseline periods used to create benchmark prices shift forward every Model Year. So, for example, the baseline period for Model Years, one and two included all Anchor Stays and Anchor Procedures, ending between January 1st, 2013, and December 31st, 2016. So, going forward for Model Year 7, we anticipate the baseline period will be between October, through October 1st, 2018 and September 30th, 2022. Next slide, please.

So those were some of the questions that we received during webinar registration. Now let's go to some of the questions we are receiving in the chat.

>> Thomas Ensor, **CMS:** Thanks, Aaron.

So, I have a good question that we have seen a number of times since the application announcement, and it is: Will Model Year 6 Convener Participants have the opportunity to withdraw currently active downstream Episode Initiators for Model Year 7?

The answer to that one is, yes. Active Model Year 6 Convener Participants who wish to continue participating in Model Year 7 will be allowed to remove downstream episode initiators from their Model Year 7 Participant Profile, but they must maintain at least one EI if they wish to continue as a Convener. I also want to mention that active, Non-Convener Participants and Convener Participants in Model Year 6 will be allowed to add downstream Episode Initiators from Model Year 7 by submitting an Episode Initiator Addition Request to CMS via the Participant Portal. I'm going to pass it over to Jessica now for the next question.

>> Jessica Dawson, **CMS:** Thank you, Tom.

So, here's a question that just came in: We are a group of eight podiatrists in outpatient, inpatient, and nursing facilities. Can we apply and participate in BPCI Advanced? And if so, how?

This is a great question. So, the answer to that is, yes, you can apply to participate in BPCI Advanced. Since you are a Medicare-enrolled supplier, you are eligible to apply as a Non-Convener Participant, and the PGP group would be the Episode Initiator. Or, you also have the option of applying as a Convener Participant, in which case you would bring multiple Episode Initiators together that are PGPs or hospitals. For more information on those options. Please look at the RFA. It can give you more details on the responsibilities and participants in the Model. I'll now pass it off to David to address the next question.

>> David Bowen, **CMS:** Thanks, Jess.

Looks like we just had this one come in, and it says: Those that are interested in what Model, so what Model changes occurred in Model Year 6 and what will apply for 2024 and Model Year 7 going forward?

So, the answer is, Model Year 7 will continue with the changes that we implemented for Model Year 6, which include reducing the CMS discount for medical Clinical Episodes from 3 to 2%. We also reduced the Peer Group Trend or PGT factor adjustment cap for all Clinical Episodes from 10% to 5%. We're also holding Participants accountable for all Clinical Episodes in which the beneficiary has a COVID-19 diagnosis during the Clinical Episode. And, we're making the major joint replacement of the upper

extremity a multi- setting Clinical Episode category by including the outpatient to total shoulder arthroplasty procedures in the Model. So now I'll pass it over to Agnelli for our next question.

>> Agnelli Sybel, CMS: Hi, sorry I couldn't find my unmute button.

So, the question is: Are there any road blocks for currently or active, participating non-Medicare Conveners that want to add additional PGPs under a separate Participation Agreement with the new BPCI-A, to the new BPCI Advanced program?

I was expecting a question like this, because it refers to the new requirements that we have for Conveners to be Medicare-enrolled providers suppliers, or ACOs. However, we want to be good partners with our current, active Convener Participants that are not Medicare-enrolled, and so they will be grandfather in. For Model Year 7, they have the option to continue with the structure they have the active BPCI Advanced, and sign an amended and restated Participation Agreement for Model Year 7. But if they want to bring new Episode Initiators under them as the Convener, they can do so by submitting new applications. The key element on that new application would be the Tax Identification Number should be an active team in the Model. So, if you're active in the Model right now, and you do not meet the new Convener requirements you are allowed to apply as many times as you want as a Convener, and bring new Episode Initiators that are PGPs or hospitals.

This brings to mind one important element that I want to highlight, and is that once the application process closes, CMS will be doing Quality Assurance checks on the applications. And one of those checks would be to go and verify that the HECA status for Medicare-enrolled providers or suppliers that apply is active as of May 31st, 2023. If the organization that submitted an application fails that QA check, CMS will reject the application.

I think Jessica has another question to address.

>> Jessica Dawson, **CMS:** I do, thank you, Agnelli.

So the next question that just came through is: Will Participants have the opportunity to drop from the Model once they've received their baseline data prior to the start of the extension? This is a great question.

So, applicants will receive baseline data and Target Prices in September, and they'll have about four weeks to review that data before making the decision of whether to sign the BPCI Advanced Participation Agreement for Model Year 7. And then, once a Participation Agreement is signed and executed by CMS, the Participant is in the Model. So, to answer your question, Participants will have the opportunity to review the data before entering into the Model, but once the Participation Agreement is signed, they are committed. Since we are a voluntary Model, Participants can choose to withdraw. Therefore, after January 2024, a Model Year 7 Participant can choose to terminate their participation at any time. However, a 90-day written notice to CMS is required, and that is spelled out in more detail in the Participation Agreement. Thank you for the question.

I'll now pass it to my colleague Tom, who, I believe, has the next question that just came in.

>> Thomas Ensor, CMS: Yeah, thanks, Jess.

So, I have a question here from a provider that's new to the BPCI Advanced application process, and is asking if it's possible for someone to walk them through the process. And that is a great question.

I would highly recommend, referring to our Model applicants' resources webpage that we displayed earlier. We've released a number of resources here that can help support our applicants through this process. We recommend starting with the Model Overview Factsheet, the Request for Applications, and then we have a nine-minute animated video that provides a quick overview of the Model. After reviewing those resources, please review the application template and make note of all the information that's required. And then at that point, once you're comfortable with the application template and gather the necessary information, we recommend using the Application Portal How-to Guide, and this resource will help you create the ID and account, which is part of the CMS IT security protocol, and also walk you through the process of submitting an application in the portal.

And I'm going to pass it back to you, Jess.

>> Jessica Dawson, CMS: Thank you, Tom.

So, here's our next question, and one we've actually seen before: Will current Model Year 6 Participants have the ability to select Service Line Groups for Model Year 7, which is calendar year 2024, that are different from their current ones?

And the answer to that is, yes. Participants that are currently active in the Model will be able to make new selections of their Clinical Episode, Service Line Groups from Model Year 7, and make changes to what they've currently selected.

And I'll pass it to my colleague Dara for our next question. Oops, I'm passing it to Agnelli, my apologies.

>> Agnelli Sybel, CMS: Thank you, Jess. It's just that, there's two questions that are related to the one you answered with Service Lines Groups.

So, will Participants only need to choose one Clinical Episode Service Line Group?

And the answer is, yes. At least one Service Line Group, and you would be accepting financial risk for all the Clinical Episode categories within that group.

A related question is: Can we change our Service Line Group after we see the data?

And so, I think it's important for applicants to understand that they will get baseline and Target Prices for all Clinical Episodes, Service Line Groups and all Clinical Episode categories that meet the baseline requirements. It's after you have the opportunity to review that data that you, the applicant, would decide if they want to sign a Participation Agreement and then make the selection of Service Line Groups for which they want to be held financially responsible.

Amy, do you have something that you want to answer from the chat?

>> Amy Giardina, CMS: I see a question here, and it says: We have applied with a potential Convener. If we are potentially going to be a Non-Convener applicant, do we need to submit two applications?

So, if you're interested in potentially being a Non-Convener Participant, then your organization would need to submit a Non-Convener application, and then also be on the Convener Participants' application as we discussed earlier.

So, I will pass it to Jen.

>> Jen Lippy, CMS: Hi everybody.

So, a question came in that I wanted to answer. They're asking: Could you clarify, Episode Initiators seem to be included as part of the application. Are there opportunities to add Episode Initiators at any later point?

And the answer there is, no. All potential Episode Initiators will need to be included as part of the application, and there will not be an opportunity to add them at a later point. So, thanks for that, and let's see who's next. Who from the Model team has a question next?

>> Agnelli Sybel, CMS: I think that Dara, can you take the next Dara?

>> Dara Clay, CMS: A lot of orthopedic surgeons are asking to have Medicare patients be allowed to have their surgery at an ambulatory surgical center. Is this possible if participating in the Model?

And the answer to this question is: We recognize stakeholders have been requesting BPCI Advanced allowing Clinical Episodes to initiate. While BPCI Advanced does not anticipate allowing Clinical Episodes to initiate an ambulatory surgical center, we are considering including ambulatory surgical centers as we think about the future of bundled payments.

And I'll pass it over to you, Tom.

>> Thomas Ensor, CMS: Thanks, Dara.

I have a question here about the timing for data, it reads: When are we getting the claims data, and how much time will we have for analysis and review?

So, we intend to distribute baseline data and preliminary Target Prices in September and then provide applicants and active Model Participants about four weeks for review of the data before having to make the decision of whether or not they want to submit a signed Participation Agreement for Model Year 7. And then, we intend to announce the third cohort of Model Participants later in the year, in December. And again, for more information on this timeline, I suggest using the application process timeline, which is posted in the applicant resources webpage.

I'm going to hand it over to David for the next question.

>> David Bowen, CMS: Thanks, Tom.

Looks like we have a question about quality measures here. An applicant is wondering: Is there any information on how to submit data for the quality measures? And do we have to upload the data to a portal.

And the answer is, BPCI Advanced will use a combination of claims and registry data sources. The BPCI Advanced website has a page dedicated to quality, where you can find our fact sheets that detail the data sources and submission methods and other nuances for each of our quality measures as well. There's also a question and answers document for quality on the webpage, and that document has some specific information on how to submit health care common procedure coding system, or HCPCS fix codes, on claims as well.

So, with that one, I think, Amy, I think I see another question for you. So, I'll toss it over to you.

>> Aaron Broun, CMS Actually, David, I'm getting the signal that that is all the time we have for questions and answers today. So, thank you everyone for your attention and engagement during today's session. I'm going to pass the mic to the Deputy Director of the Division of Payment Models, Jen Lippi, to wrap up the webinar.

>> Jen Lippy, CMS Thanks, Aaron. And thanks for those great questions, and to the Model team for providing those comprehensive answers. I just have to say, we have such a great group of analysts working on this Model, and we are so glad that they were here today to provide their knowledge and expertise. So, thanks to you all, and to all of our attendees, thanks so much for coming to today's webinar, we hope it was helpful.

On behalf of the Model team, we're so happy to see all of you. As Amy said earlier in our opening remarks, we see some names that are familiar to us, and some names that are new, and we appreciate all of you being here and your time and interest. We hope that you found today's webinar and the information presented helpful, and will continue to have resources and sessions available. As we go through this application process, we are here to help, we are here for you. So please, don't hesitate to reach out to us.

We believe in value-based care through episode payment Models, and the impact it can have on cost, efficiency, as well as the improvement of both the patient experience and the quality of care we can offer to Medicare beneficiaries.

We thank you for your continued support in the BPCI Advanced Model, and we look forward to seeing you at upcoming events. And now, I'm going to give the floor to T J Smith, our event facilitator, to share some administrative items and wrap up the webinar.

>> Smith, TJ, Deloitte: Thanks, Jen, and thank you all again for attending the BPCI Advanced Overview Webinar. Resources shared during this webinar will be available in the participant portal later this month, on or after March 16th.

Please do participate in the survey for today's event. We'll be putting that in the chat, and you'll be receiving it later. And again, you can send any additional input on today's sessions or concepts to BPCIAdvanced@cms.hhs.gov.

Please also take note of the following actions to continue engagement and learn more about the Model. Again, you can submit any input or additional questions to the mailbox. And if you've not done so already, please do sign up for our listserv to receive updates regarding the application process, upcoming

events and deadlines, and notice on when new resources are available on our Model webpage. Go to the next slide, please.

This does conclude today's webinar. Thank you all so much again for joining, and we hope you have a good rest of your day. Take care.

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