Application Process – Questions and Answers (Q&A) Last Updated: April 2023

BPCI Advanced Policy Update: In response to stakeholder feedback, CMS is extending the period for data review to at least 8 weeks after distribution of baseline data and preliminary Target Prices. Applicants can still expect to receive these baseline data and Target Prices in September 2023. Applicants will then be required to submit a signed Model Year 7 Participation Agreement and a completed Participant Profile by December 4, 2023. Additional required deliverables will be due on December 18, 2023. Please refer to the updated Timeline - Application Process for 2023 for a full timeline of the application process.

Please reference the questions in the "Pricing Methodology/Data" sections of this document for additional information about how and when data will be shared with new applicants.

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A. Who can Apply/Participate?

A-1. Who can apply to participate in Bundled Payments for Care Improvement (BPCI) Advanced starting in 2024 (Model Year 7)?

The following eligible entities may apply during the application period in early 2023 to participate in BPCI Advanced starting in 2024 (Model Year 7) as a Non-Convener Participant or as a Convener Participant:

- Acute Care Hospitals (ACHs)
- Physician Group Practices (PGPs)
- Medicare-enrolled providers or suppliers
- Medicare Accountable Care Organizations (ACOs)
- Active Convener Participants in Model Year 6 that are not Medicare-enrolled providers, suppliers or Medicare ACOs
- Please note:
    - The provider must be Medicare-enrolled by the application deadline. This means the provider must have an "Approved" enrollment status in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) database by the application deadline – May 31, 2023, at 5:00 pm EDT.
    - The supplier must be Medicare-enrolled by the application deadline. This means the supplier must have an "Approved" enrollment status in the PECOS database by the application deadline – May 31, 2023, at 5:00 pm EDT.

CMS is not placing limitations on Applicants based on geographic region (i.e., Applicants are not limited to a specific Medicare Administrative Contractor jurisdiction), geographic type (e.g., urban, rural) or facility size. Additionally, there is no restriction based on current or past participation in other CMS Innovation Center models and Medicare demonstrations, including past participation in the Bundled Payments for Care Improvement (BPCI) Initiative or the BPCI Advanced Model or current participation in the Comprehensive Care for Joint Replacement (CJR) Model.

Submitting an application does not obligate the Applicant to participate in BPCI Advanced. Likewise, submission of an application does not guarantee Applicants will be offered to sign a Participation Agreement by CMS.

A-2. What types of organizations cannot participate in BPCI Advanced?

The Acute Care Hospital (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, these organizations may not participate in the Model in any capacity. Note that Physician Group Practices (PGPs) solely practicing 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.

A-3. Are providers in the state of Maryland allowed to participate in BPCI Advanced?

The CMS Innovation Center has implemented the Maryland Total Cost of Care Model, and due to its unique payment structure, hospitals and Physician Group Practices (PGPs) in Maryland may not participate in the BPCI Advanced Model in any capacity. As such, hospitals in Maryland are excluded from the definition of a hospital for the purposes of 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.

A-4. Can individual physicians apply for the Model?

Yes; as long as they are registered as a single Physician Group Practice (PGP) with a Taxpayer Identification Number (TIN) for billing and tax purposes.

A-5. What is the difference between a Participant and a Participating Practitioner?

Participants may be either Convener Participants (Participants that bring together one or more Downstream Episode Initiators to participate in the Model) or Non-Convener Participants (the risk-bearing entities under the Model that enter into direct agreements with CMS). Participating Practitioners are the Medicare-enrolled physicians and non-physician practitioners who furnish direct beneficiary care covered under the BPCI Advanced Model and participate in BPCI Advanced activities (e.g., care redesign, quality measure reporting and use of Certified Electronic Health Record (EHR) Technology). Participating Practitioners do not enter into agreements with CMS, but instead enter into agreements with the Participant, which requires the Participating Practitioners to comply with the applicable requirements of the BPCI Advanced Model Participation Agreement.

A-6. Can an Acute Care Hospital and a Physician Group Practice with overlapping Medicare beneficiaries both apply as Non-Convener Participants or participate as Downstream Episode Initiators under the same Convener Participant?

Yes; Acute Care Hospitals (ACH) and Physician Group Practices (PGP) that share or have overlapping Medicare beneficiaries can apply as Non-Convener Participants who bear risk and initiate Clinical Episodes themselves.

Additionally, a Convener Participant may list both entities as Downstream Episode Initiators (EI) on its application, even if they have overlapping Medicare beneficiaries.

A-7. Can CMS explain the difference between a hospital system applying as a "system" versus the individual hospitals within the system?

A hospital system can apply to participate in BPCI Advanced as a Convener Participant, which brings together multiple Downstream Episode Initiators (EI) and must either be an Acute Care Hospital (ACH) or Physician Group Practice (PGP). In this case, the Downstream EIs would be hospitals within the system. As a Convener Participant, a hospital system would facilitate coordination among its hospitals and would also bear and apportion financial risk.

A-8. Can Applicants include a Skilled Nursing Facility or any other type of post-acute care provider in the Participating Organizations Attachment?

No; Skilled Nursing Facilities (SNF) and other Post-Acute Care (PAC) Providers can apply to participate as a Convener Participant in BPCI Advanced, but they cannot appear in the Participating Organizations Attachment. This is because that document identifies potential Downstream Episode Initiators (EIs). SNFs and other PAC providers can qualify as “Net Payment Reconciliation Amount (NPRA) Sharing Partners,” and appear in the Financial Arrangement List (FAL) as an organization with whom the Participant has a Financial Arrangement. Only Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) can participate as EIs and initiate Clinical Episodes in BPCI Advanced.

A-9. Can a hospital be a Convener Participant for some Medicare Severity-Diagnosis Related Groups and be a Non-Convener Participant and Episode Initiators for other Medicare Severity-Diagnosis Related Groups?

No; an Episode Initiator (EI) such as an Acute Care Hospital (ACH) can only trigger Clinical Episodes (via Medicare Severity-Diagnosis Related Groups (MS-DRG)) as either a Convener Participant or as a Non-Convener Participant. Clinical Episodes cannot be allocated under multiple Convener Participants or in combination as a Non-Convener Participant.

A-10. Are Applicants obligated to participate in BPCI Advanced if they submit an application?

No; submitting an application does not obligate the Applicant to participate in BPCI Advanced. Likewise, submission of an application does not guarantee applicants will be offered to sign a Participation Agreement by CMS. Additionally, receipt of preliminary Target Prices and the BPCI Advanced Participation Agreement does not mean that CMS has approved an application. CMS requires potential Participants to have signed and executed a BPCI Advanced Participation Agreement with CMS to participate in the Model. CMS does not execute Participation Agreements until it has reviewed applications and Applicants have successfully passed a provider vetting by the CMS Center for Program Integrity (CPI) and completed a law enforcement screening process.

A-11. Can current Participants (active) submit unlimited applications under the grandfathered non-Medicare entity organization? *(April 2023 Update)*

Yes; Participants who are currently active in Model Year 6 (MY6) can submit unlimited applications under a grandfathered non-Medicare entity organization. Each application they submit would result in a new BPCI Advanced Participant ID (BPID).

Please note, after the application portal deadline on May 31, 2023, at 5:00 pm EDT, CMS will conduct Quality Assurance (QA) checks on the submitted applications for accuracy and completeness. One of the QA checks will be to verify that new applicants, who must be Medicare enrolled, have an ACTIVE status in the Provider Enrollment, Chain and Ownership System (PECOS) as of May 31, 2023. If that is not the case, CMS will reject the application.

A-12. Can Episode Initiators be added after the application? Are there opportunities to add Episode Initiators at a later point? Is there any opportunity to drop Episode Initiators? *(April 2023 Update)*

All potential Episode Initiators (EIs) will need to be included as part of the Model Year 7 (MY7) application; there will not be an opportunity at a later point to add EIs.

Adding EIs on the MY7 application:

- Non-Convener Participants who are currently active in Model Year 6 (MY6) and plan to participate in MY7 can add Downstream EIs and become a Convener.
- Convener Participants who are currently active in MY6 and plan to participate in MY7 can add Downstream EIs when they submit their MY7 Participant Profile.
- Each additional EI will result in the creation of a new BPCI Advanced Participant ID (BPID).

Removing EIs on the MY7 application:

- Convener Participants who are currently active in MY6 and plan to participate in MY7 will be allowed to drop Downstream Episode Initiators (EIs) from their MY7 Participant Profile. They must maintain at least one EI to continue as Convener.

A-13. How many applications can an organization submit? *(April 2023 Update)*

There are no limits on the number of applications that an organization (which is a Medicare enrolled provider, supplier or Accountable Care Organization) may submit. Each application will identify the potential Episode Initiator (EI) in the Participating Organization's template. The potential EI must be an Acute Care Hospital (ACH) or a Physician Group Practice (PGP).

Each application, if approved, will result in a separate Participation Agreement for Model Year 7 (MY7). Though an EI may appear in multiple applications, it can only be on one MY7 executed Participation Agreement, participating either as their own EI (as a Non-Convener Participant) or under one Convener as a Downstream EI.

A-14. Do previous Participants (who are currently withdrawn) need to submit a new application or do they only need to sign an amendment to rejoin in Model Year 7? *(April 2023 Update)*

Participants who are no longer active in the BPCI Advanced Model must submit a new application to rejoin the Model in Model Year 7 (MY7) (Calendar Year 2024). Please note, CMS reserves the right to not approve new applications for MY7.

A-15. Is a Non-Medicare enrolled Convener, that is currently active in Model Year 6 and plans to participate in Model Year 7, able to add new Physician Group Practices under a separate Participation Agreement with a new BPCI Advanced Participant ID? *(April 2023 Update)*

BPCI Advanced Convener Participants that are currently active in Model Year 6 (MY6) and plan to participate in Model Year 7 (MY7) will be grandfathered in, and therefore, exempt from meeting the new MY7 Convener requirements (which requires Conveners to be either a Medicare enrolled provider or supplier or an ACO). Therefore, an organization active in MY6 that is not Medicare enrolled will be able to submit as many MY7 applications as they wish, listing the Downstream EIs when they submit their MY7 Participant Profile. However, the Taxpayer Identification Number (TIN) used in the application must match the TIN of the currently active Convener Participant. Each application will result in a separate BPCI Advanced Participant ID (BPID).

A-16. For providers applying to the model for the first time, what resources are available to guide them through the application process? *(April 2023 Update)*

Please refer to the Model's Applicant Resources webpage. CMS recently released resources to support applicants throughout the application process.

For broad information on the Model, applicants should first reference the Model Overview Fact Sheet, the Request for Applications and the Model Overview Animated video. After reviewing these resources, applicants should then review the application template and take note of all the information that is required.

Once the application template is complete and applicants have gathered the necessary information, CMS recommends using the Application Portal "How to Guide". This resource will provide guidance on how to create an Identity Management (IDM) account (part of CMS's IT Security Protocols) and submitting an application in the Portal.

A-17. A group of eight podiatrists practice in outpatient, inpatient and nursing facilities. How can they apply and participate in BPCI Advanced? *(April 2023 Update)*

If these organizations are classified as Medicare enrolled suppliers, they are eligible to apply as Non-Convener Participants and the Physician Group Practice (PGP) group would be the Episode Initiator (EI).

They also have the option of applying as a Convener Participant, in which case they would bring multiple EIs together that are PGPs or hospitals.

For more information on these options, please look at the Request for Applications (RFA), which includes details on the responsibilities of Participants in the Model.

A-18. If a Medicare Shared Savings Program Accountable Care Organization decides to participate, are all the providers under the organization required to join the Model as downstream Episode Initiators? *(April 2023 Update)*

No; there is no requirement that all providers under a Medicare Accountable Care Organization (ACO) must join the Model as downstream Episode Initiators. On the application, the Medicare ACO will be required to identify potential downstream Episode Initiators, which must be either Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs). These potential downstream Episode Initiators may or may not be providers under the Medicare ACO.

A-19. If a Medicare Shared Savings Program Accountable Care Organization decides to participate, are all the Participant Taxpayer Identification Numbers in the Medicare Accountable Care Organization required to participate together? Or can some Taxpayer Identification Numbers participate and others opt out? Can one Taxpayer Identification Number in the Medicare Accountable Care Organization participate via one Convener and another via another Convener? *(April 2023 Update)*

The Medicare Accountable Care Organization (ACO) can only participate in the BPCI Advanced Model as a Convener. When the Medicare ACO applies as a Convener, it may choose its' Downstream Episode Initiators (EIs) by deciding to have:

- All their Downstream EIs be Acute Care Hospitals (ACHs) and/or Physician Group Practices (PGPs) that are members of the Medicare ACO. It is not necessary to include all members of the Medicare ACO.
- Their Downstream Episode Initiators be a combination of ACHs and/or PGPs that are a combination of Medicare ACO members and Medicare ACO non-members.
- All their Downstream Episode Initiators be ACHs and/or PGPs that are not members in the Medicare ACO.

When submitting an application, the Medicare ACO will need to populate a "Participating Organizations" template listing potential Downstream EIs. If the Applicant Medicare ACO chooses to submit a signed Participation Agreement for Model Year 7 (MY7), then the Medicare ACO would submit their final determination of EIs on the MY7 Participant Profile.

An Medicare ACO that is applying as a Convener may apply as many times as they want, with different applications including different Downstream EIs. Each application, if approved, will result in a separate Participant in the BPCI Advanced Model. Although a Downstream EI may be listed on multiple applications, ultimately, they can only participate under one Convener.

B. Physician Group Practice

B-1. Will a Physician Group Practice be able to select which individual physicians will participate in the Model?

In BPCI Advanced, since a Physician Group Practice (PGP) is defined at the Taxpayer Identification Number (TIN) level, individual providers may not be excluded from a group TIN. During the performance period, if an individual physician's National Provider Identifier (NPI) is assigned to a PGP's TIN that is participating in BPCI Advanced, they will trigger Clinical Episodes for that PGP.

B-2. Must all Physician Group Practices under the same Taxpayer Identification Number choose the same Clinical Episode Service Line Group?

Yes; participation decisions, including Clinical Episode Service Line Group (CESLG) selection, are made at the Episode Initiator (EI) level. For Physician Group Practices (PGP), the EI is grouped by the Taxpayer Identification Number (TIN) and billed on the Clinical Episode's carrier claims. Therefore, all PGPs under the same TIN must choose the same CESLGs. In the case of Acute Care Hospitals (ACH), the Episode Initiator is grouped under the CMS Certification Number (CCN) and the institutional claim is used to identify the Clinical Episode. Therefore, all Participating Providers under the same CCN are obligated to choose the same CESLGs for which the Participant commits to be held accountable for in their Participant Profile.

B-3. In BPCI Advanced, how are Clinical Episodes attributed to a Physician Group Practice Episode Initiator providing services in multiple locations, including a hospital?

In BPCI Advanced, Clinical Episode attribution is based on the Taxpayer Identification Numbers (TIN) for Physician Group Practices (PGP) and CMS Certification Numbers (CCN) for the Acute Care Hospitals (ACH), regardless of the site of services. If both the PGP and the hospital have the same selection of Clinical Episode Service Line Groups (CESLG), the Model's precedence rules would always attribute the Clinical Episode to the PGP.

B-4. Are there any time-based precedence rules in BPCI Advanced? For example, if a Physician Group Practice starts participation in January 2024 and a hospital started participation in October 2018, and both participate in the same Clinical Episode Service Line Group, does the hospital retain the Clinical Episodes or does the Physician Group Practice still get precedence?

In BPCI Advanced, there are no time-based precedence rules. In the example provided above, the Physician Group Practice (PGP) and the hospital are participating in the same Clinical Episode Service Line Group (CESLG) and trigger the same clinical episode, and excluding overlap with other CMS Innovation Center models, the PGP would have precedence over the hospital.

B-5. According to the precedence rules, does a Physician Group Practice get precedence over a hospital with regards to Clinical Episode attribution?

Yes; a Physician Group Practice (PGP) does get precedence over a hospital. Although a PGP and a hospital can both participate in the same or different Clinical Episode Service Line Groups (CESLG), if both the PGP and the hospital are associated with a specific clinical episode, CMS will use precedence rules to attribute the clinical episode to just one EI (in this case, either the PGP or the hospital).

Precedence rules are implemented to ensure that a given Clinical Episode is attributed to only one Episode Initiator. Clinical Episodes will be attributed at the Episode Initiator level during the Reconciliation Process. The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators in BPCI Advanced 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) during the Anchor Stay or Anchor Procedure billed under the participating PGP's Taxpayer Identification Number;
(2) The PGP that has the operating physician's National Provider Identifier (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 Taxpayer Identification Number; and
(3) The Acute Care Hospital (ACH) was where services during the Anchor Stay or Anchor Procedure were furnished.

There is no time-based precedence in BPCI Advanced.

B-6. Will bundled payments reduce the administrative expense of payment billing or the burden of billing? Is this going to potentially delay the billing processes or payment?

The Medicare Fee-for-Service (FFS) billing process will not change within the Model. Items and services included in a Clinical Episode under the Model will be paid through the existing Medicare FFS mechanisms and will not result in any changes to the billing processes or FFS payment amounts. The Model will assess Participants' performance on a semi-annual basis via a reconciliation process, which compares FFS expenditures for non-excluded items and services furnished as part of a Clinical Episode against the applicable Target Price.

B-7. How do the new Convener requirements impact current Convener Participants that are not Medicare enrolled providers, suppliers or Accountable Care Organizations? *(April 2023 Update)*

Active Convener Participants will be grandfathered in and exempt from meeting the new Convener requirements. An organization active in Model Year 6 that is not Medicare enrolled will be able to submit as many applications as they wish. Each application results in a separate BPCI Advanced Participant ID (BPID) as long as the Taxpayer Identification Number (TIN) used in the application matches the TIN of the currently active Convener Participant.

B-8. Do potential Non-Convener applicants, who are also Physician Group Practices (PGPs), need to submit two applications? *(April 2023 Update)*

Entities that are interested in potentially being a Non-Convener applicant (whether new to BPCI Advanced, former Participants or former Downstream Episode Initiators) will have the opportunity of applying as either a new Non-Convener Participant or a Convener Participant. They may also be listed as Downstream Episode Initiators under a Convener Participant application for Model Year 7 (2024).

Non-Convener applicants will not need to submit two applications. However, Non-Convener Applicants who are Physician Group Practices' (PGPs) will be required to submit a "Participating Organizations template" to the Application Portal. This submission is due at the same time as the submission of the BPCI Advanced application for MY7, which is May 31, 2023, at 5:00 pm EDT.

B-9. Can an Acute Care Hospital convene other acute care hospitals? *(April 2023 Update)*

Yes; an Acute Care Hospital can be a Convener Participant and have Acute Care Hospitals as Downstream Episode Initiators (EIs).

B-10. Can a health system serve as a Convener, or do they have to have a Medicare Enrolled Taxpayer Identification Number to be a Convener? *(April 2023 Update)*

A health system that is not currently participating in the Model would not be eligible to submit an application as a Convener for the two-year extension, since they are not a Medicare-enrolled provider, supplier or Accountable Care Organization (ACO). However, a hospital that is part of the health system may apply as a Convener and list any number of hospitals or Physician Group Practices (PGPs) in the Participating Organizations template as potential Downstream Episode Initiators (EIs).

B-11. Will Model Year 6 Convener Participants have the opportunity to withdraw currently active Downstream Episode Initiators for Model Year 7? *(April 2023 Update)*

Yes; Active Model Year 6 (MY6) Convener Participants, who wish to continue participating in Model Year 7 (MY7), will be allowed to remove Downstream Episode Initiators (EIs) from their MY7 Participant Profile. They must maintain at least one EI to continue as Convener.

Also, active Non-Convener Participants and Convener Participants in MY6 will be allowed to add Downstream EIs for MY7 by submitting an "Episode Initiator Addition Request" to CMS via the Participant Portal.

C. Application Template/Portal

C-1. How can organizations apply to participate in BPCI Advanced?

CMS will only accept applications via the BPCI Advanced Application Portal.

CMS encourages all Applicants to review the Request for Applications (RFA) and supporting materials offline before logging into the Portal. To access all the supporting materials please visit the Applicant Resources webpage.

The application period opened on February 21, 2023 and closes on May 31, 2023 at 5:00 PM EDT. More details are available on the BPCI Advanced webpage.

C-2. Do current BPCI Advanced Participants need to submit an application?

Existing Convener Participants and Non-Convener Participants would not need to apply for participation in the two-year extension period; these Participants can continue to participate in the Model by signing an Amended and Restated Participation Agreement for Model Year 7 (2024), provided that neither the Participant nor CMS has terminated the entity's participation in the Model during 2023.

C-3. How can active Participants in Model Year 6 add an Episode Initiator?

An Active Model Participant in Model Year 6 (MY6) will be allowed to add Downstream Episode Initiators (whether new, former or current Episode Initiators) for Model Year 7 (MY7) by submitting an "Episode Initiator Addition Request" to CMS, via the Participant Portal. The deadline for "Episode Initiator Addition Request" forms is May 31, 2023. Additionally, Active Convener Participants in MY6 who wish to continue participating in MY7 will be allowed to remove Downstream Episode Initiators from their MY7 Participant Profile.

C-4. What are the required attachments to the application?

For Non-Convener Participants

a. If you are applying as a Non-Convener Participant who is an Acute Care Hospital (ACH), you will need to submit one Data Request and Attestation (DRA) attachment.
b. If you are applying as a Non-Convener Participant who is a Physician Group Practice (PGP), you will need to submit one PGP Practitioners attachment and one DRA attachment.

For Convener Participants

a. If you are applying as a Convener Participant, with both ACHs and PGPs, you will need to submit one Participating Organizations attachment and one DRA attachment.
b. If you are applying as a Convener Participant, with only ACHs, you will need to submit one Participating Organizations attachment and one DRA attachment.
c. If you are applying as a Convener Participant, with only PGPs, you will need to submit one Participating Organizations attachment and one DRA attachment.

The application template which includes the DRA form, as well as further instructions, are available on the BPCI Advanced Model webpage.

C-5. If necessary, how can a Convener Applicant submit multiple applications for potential Downstream Episode Initiators with the same information as one that was previously submitted?

The "clone" function allows you to create a new application with the same information as a previously submitted one so that you don't need to re-enter the information. The clone function is only available for "**Submitted"** applications. For example, if the application status says, **"In Progress"** the clone function option will not be available for that application until the status changes to "**Submitted**". For a cloned application, you are required to upload a new Participating Organizations attachment, and sign/certify the Data Request and Attestation (DRA) form and the certification page.

C-6. In the application, do the Clinical Episode Service Line Groups the Applicant is interested in need to be stated?

No; when submitting an application, the Applicant will not be selecting Clinical Episode Service Line Groups (CESLGs). CESLGs selection will occur through the submission of the Participant Profile (PP) in December 2023. In the PP, Non-Convener Participants select CESLGs for themselves and Convener Participants select for their Downstream Episode Initiators, as well as indicate which Episode Initiators listed in the application will be participating in the Model or need to be withdrawn. At the time of PP submission, Participants must commit to be held accountable for one or more CESLGs.

Since CMS does not intend to offer a new Model Year 8 (MY8) Amended and Restated Agreement, the Participant Profile will formalize Model Year 7 (MY7) (2024) and MY8 (2025) CESLG selections. The submission of the Participant Profile deliverable will occur at the same time an Applicant submits a signed Participation Agreement for MY7.

C-7. If an Active Model Convener Participant is not a Medicare enrolled provider, supplier or Medicare Accountable Care Organization wants to submit a new application, but the application has two (2) fields for which they will not have the required information – National Provider Identification and CMS Certification Number – what steps should be taken?

Active Model Participants that are not Medicare enrolled providers, suppliers or Medicare Accountable Care Organizations (ACOs) will need to enter 10 zeroes in the National Provider Identification (NPI) required field and six zeroes in the CMS Certification Number (CCN) required field in order to submit their application.

If the incorrect character length is entered for the Taxpayer Identification Number (TIN), NPI and/or CCN, the Application Portal will clear out the field since it does not meet the required character length. The character length is as follows: TIN = nine digits, NPI = 10 digits, CCN = six digits.

C-8. Does an Acute Care Hospital that is applying as a Non-Convener Participant need to submit a list of the physicians in their hospital?

No; an Acute Care Hospital (ACH) submitting a BPCI Advanced Application as a Non-Convener Participant or Convener Participant, does not need to a list of physicians.

C-9. Do Physician Group Practices need to list all historical Taxpayer Identification Numbers on the application?

No; Physician Group Practices (PGPs) should include only the Taxpayer Identification Numbers (TINs) they plan to use to initiate Clinical Episodes in BPCI Advanced.

C-10. Can Episode Initiators appear on multiple applications?

Yes; CMS allows potential Episode Initiators (EIs) (e.g., Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs) that wish to participate in BPCI Advanced as either a Participant or a Downstream EI) to appear in multiple applications submitted by the application deadline. Even though EIs may appear in multiple applications, they may only participate with one Convener Participant or as a Non-Convener Participant.

If CMS accepts the Applicant's application, CMS will send a Participant Profile, which includes all potential EIs in the application. In that document, the Convener Participant identifies its Downstream EIs and their Clinical Episode Service Line Groups (CESLGs) selections for Model Year 7 (MY7). A Non-Convener Participant identifies its CESLGs selections for MY7.

EIs that appear in multiple applications need to ensure that when CMS receives the Participant Profiles, the EI appears in only one Participant Profile with a status of "Active." Otherwise, CMS will reject that EI and the EI will not be eligible to participate in BPCI Advanced.

C-11. Is there a limit to the number of applications an organization can submit to account for different types of arrangements?

No; Applicants may submit multiple applications to account for the different types of arrangements. For example, an Applicant may want to apply as a Convener Participant but may be unsure whether they want to apply with Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) in one application or separately. The Applicant can:

- Submit one Convener Participant application that includes all potential ACHs and PGPs in the Participating Organizations Attachment
- Submit two Convener Participant applications where one application would include all potential PGPs in the Participating Organizations Attachment and the other application would include all potential ACHs in Participating Organizations Attachment
- Submit three applications that account for the above two scenarios

Regardless, each application must list all Episode Initiators (EIs) in the Participating Organizations Attachment at the time of submission. Applicants cannot revise an application after it has been submitted. EIs can appear in multiple applications but can only appear in one Participant Profile with a status of "Active." Otherwise, CMS will reject that EI and the EI will not be eligible to participate in BPCI Advanced.

C-12. Does CMS require an Applicant to specify in the application those organizations with which it plans to share any Net Payment Reconciliation Amount?

No; the application asks Applicants to identify the types of organizations with which they intend to share any Net Payment Reconciliation Amount (NPRA), but not the specific names of NPRA Sharing Partners. Participants must submit the Financial Arrangement List (FAL) deliverable bi-annually, 30 days before the start of the Q1 and Q3 quarters. The FAL is where the Participant will list all potential NPRA Sharing Partners.

C-13. What happens if an Applicant gets locked out of the BPCI Advanced application portal and is prompted to reset the application password?

If an Applicant is locked out of the BPCI Advanced application portal and requests a change of password, the Applicant must act immediately. If the initial password reset time expires, the application portal will NOT allow for another change of password request until 24 hours (not a calendar day) have elapsed.

C-14. What happens to applications that are "In Progress" at 5:00 pm EDT on May 31, 2023?

Any application not submitted by 5:00 pm EDT on May 31, 2023, via the BPCI Advanced Application Portal will be considered "Incomplete" and will not be processed by CMS. After the BPCI Advanced Application Portal closes, users will still be able to log in and view/download pdf versions of any "Submitted" applications.

C-15. Can Convener Participants add Episode Initiators to applications after the submission deadline?

No; Convener Participants must submit the names and details of all potential Downstream Episode Initiators with whom they want to participate at the beginning of Model Year 7 (MY7) (January 1, 2024) with the application by the submission deadline of **May 31, 2023, at 5:00 PM EDT.**

C-16. Will current Model Year 6 Participants be able to select Clinical Episode Service Line Groups for Model Year 7 (which is calendar year 2024) that are different from their current ones? *(April 2023 Update)*

Yes; Participants that are currently active in the BPCI Advanced Model will be able to make new selections of their Clinical Episode Service Line Groups (CESLGs) for Model Year 7.

C-17. Will Participants only need to choose one Clinical Episode Service Line Group? *(April 2023 Update)*

Participants need to select at least one Clinical Episode Service Line Group (CESLG) in order to participate in the Model. However, they can choose more than one CESLG.

C-18. Can we change our Clinical Episode Service Line Groups after we see the data? *(April 2023 Update)*

Since Clinical Episode Service Line Group (CESLG) selection occurs after applicants and Participants have received baseline data and preliminary Target Prices, BPCI Advanced Participants must select the CESLGs for which they will commit to being held accountable, concurrent with the signing of their BPCI Advanced Model Participation Agreement. Participants are not permitted to change CESLG selection(s) once identified for Model Year 7, unless expressly permitted to do so by CMS. CMS does not intend to allow Participants to change CESLG selections for Model Year 8 or allow the addition or removal of Episode Initiators.

C-19. If a hospital decides to participate in BPCI Advanced in Model Year 7 (2024), would the first episodes begin in October 2023, so that the episode end dates are past January 1, 2024, allowing for a full six month performance period? Or would the episodes commence January 1, 2024? *(April 2023 Update)*

The first day a Participant may trigger a Clinical Episode in Model Year 7 (2024) will be January 1, 2024.

C-20. Would a Physician Group Practice be able to capture an episode initiated by a hospital? *(April 2023 Update)*

The answer to this question is based on the BPCI Advanced precedence rules. In the BPCI Advanced Model, the precedence rules ensure only one Episode Initiator (EI) is attributed a Clinical Episode. If there is a Clinical Episode that could be attributed to either a Physician Group Practice (PGP) or a hospital, the precedence rules dictate that the PGP would be attributed the Clinical Episode.

C-21. Where can I see which quality measures would apply to us? *(April 2023 Update)*

The BPCI Advanced website has a page dedicated to Quality, where you can find a "Clinical Episodes to Quality Measures Correlation Table".

C-22. Are Medicare Part D drugs included? *(April 2023 Update)*

The BPCI Advanced Model does not include Medicare Part D (Part D) expenditures, therefore Participants are not accountable for Part D costs.

C-23. If hospitals must set up new processes to check the Advance Care Plan for every patient, how do they know who can have those conversations? *(April 2023 Update)*

Any Medicare health care provider, including physicians, advanced practice nurses and physician assistants, can have those conversations and submit the Advance Care Plan (ACP) codes on the health care claim. For more information, the BPCI Advanced webpage has a page dedicated to Quality, where you can find fact sheets for each quality measure.

D. About the Model

D-1. When did BPCI Advanced start and when is it anticipated to end?

BPCI Advanced began October 1, 2018 and will end December 31, 2025. BPCI Advanced defines a Model Year as a full or partial calendar year during which Participants may initiate Clinical Episodes. BPCI Advanced will have eight Model Years, with the fourth quarter of 2018 counting as Model Year 1 (MY1), 2019 as Model Year 2, 2020 as Model Year 3 (MY3) and so forth. 2025 is the eighth and last Model Year. An initial cohort of Participants started in MY1, which began on October 1, 2018.

Participants in the second cohort started in MY3, which began on January 1, 2020. Participants in the third cohort will start in Model Year 7 (MY7), which begins on January 1, 2024.

D-2. Will Participants (Conveners and Non-Conveners) have to treat every Medicare beneficiary for the Clinical Episodes for which they participate in under the BPCI Advanced Model? What about Episode Initiators?

Participants and Episode Initiators (EI) do not have the ability to exclude beneficiaries for the Clinical Episodes in which they participate, regardless of a beneficiary's acuity, and the Model does not allow beneficiaries to “opt out” of the Model’s payment methodology. Also, Participants may not restrict beneficiary access to medically necessary care. To that end, CMS will monitor utilization and referral patterns, as well as conduct medical record audits, track beneficiary complaints and appeals and monitor beneficiary 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 will trigger a Clinical Episode due to beneficiary eligibility exclusions.

D-3. Will participating in BPCI Advanced require renegotiation of physician contracts to adhere to certain standards?

BPCI Advanced does not establish specific standards or require renegotiation of physician contracts. BPCI Advanced requires that Participants provide information on organizational readiness for the Model. Please refer to Request for Applications (RFA) Section IV.D.2 for additional information about organizational readiness.

D-4. Is there any information on how to submit data for the quality measures? Do we have to upload data to a portal? *(April 2023 Update)*

BPCI Advanced will use a combination of claims and registry data sources to collect data on quality measures. The BPCI Advanced website has a page dedicated to quality, where you can find fact sheets that detail the data sources and submission methods for each quality measure. There is also a Question and Answers document for quality, that has specific information on how to submit Healthcare Common Procedure Coding System (HCPCS) codes on claims.

D-5. Will Participants have the opportunity to unenroll from the Model once they have received their baseline data, prior to the start of the extension? *(April 2023 Update)*

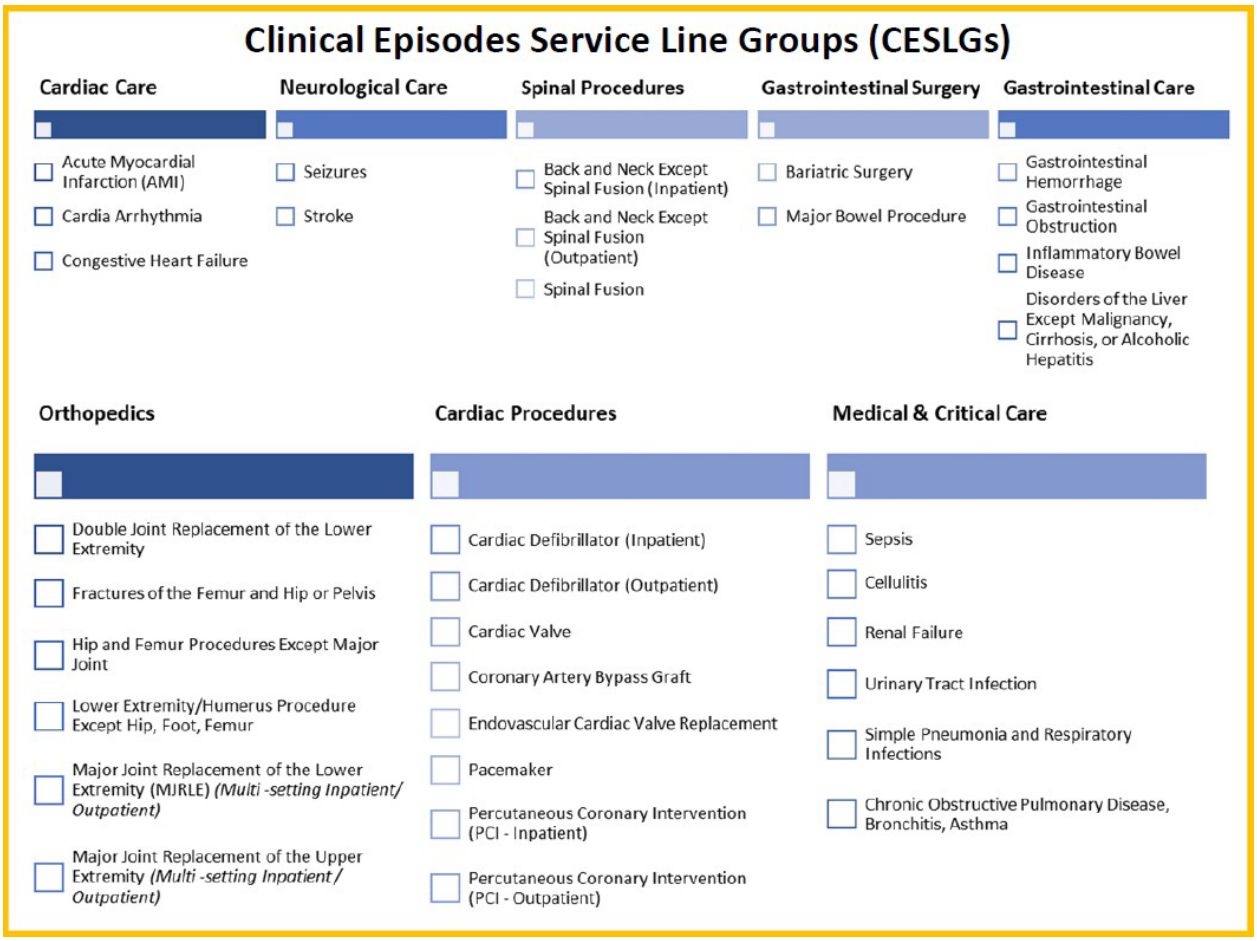
Applicants will receive baseline data and Target Prices in September and will have time to review that data before making the decision of whether to sign the BPCI Advanced Participation Agreement for Model Year 7 (MY7). Once the Participation Agreement is signed and executed by CMS, the Participants are in the Model. Therefore, Participants will have the opportunity to review data before entering into the Model. However, once the Participation Agreement is signed, they are committed to the Model.

Since BPCI Advanced is a voluntary model, Participants can choose to withdraw. Therefore, after January 2024, a MY7 Participant can choose to terminate their participation at any time. However, a 90-day written notice to CMS is required (details of which are further explained in the Participation Agreement.)

E. Clinical Episodes

E-1. What Clinical Episodes are included in BPCI Advanced for Model Year 7?

There are eight Clinical Episode Service Line Groups (CESLG) that cover 29 Inpatient Clinical Episodes, three Outpatient Clinical Episodes and two Multi-Setting Clinical Episodes in Model Year 7 (MY7), as outlined below. Participants must select at least one CESLG and be accountable for all of the Clinical Episodes Categories within the CESLG. Participants cannot select individual Clinical Episode Categories.



E-2. Can an organization apply for a subset of the Clinical Episode Categories, instead of an entire Clinical Episode Service Line Group?

No; the Participant must be accountable for all Clinical Episode Categories within the selected Clinical Episode Service Line Group (CESLG). It is up to the Participant to determine how many and which CESLGs they wish CMS to hold them accountable for under BPCI Advanced. It is important to note that the Participant chooses CESLGs for each EI separately.

The Applicant will not select CESLGs when submitting an application. All Participants will identify the CESLGs for which CMS will hold the Participant accountable when they complete their Participant Profile. Additionally, Convener Participants will identify the list of the Convener Participant's Downstream Episode Initiators (EI) when they complete their Participant profile.

E-3. How does CMS determine when a Clinical Episode is triggered?

The submission of a claim for either an inpatient stay at an Acute Care Hospital (ACH) (Anchor Stay) or an outpatient procedure at an ACH (Anchor Procedure) by an Episode Initiator (EI) for an eligible BPCI Advanced Beneficiary triggers a Clinical Episode. There are specific Medicare Severity Diagnosis Related Groups (MS-DRGs) and Healthcare Common Procedure Coding System (HCPCS) codes on the claim that will correspond to each Clinical Episode.

E-4. Which service locations do the outpatient Clinical Episodes include? Does BPCI Advanced include Clinical Episodes that initiate in outpatient hospital departments, freestanding cardiac catheterization labs and ambulatory surgical centers?

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 Ambulatory Surgical Centers (ASC) and freestanding cardiac catheterization labs, are not eligible to initiate Clinical Episodes.

E-5. What Model Year 6 (2023) changes will CMS continue for Model Year 7 (2024)? *(April 2023 Update)*

Model Year 7 will continue the changes CMS implemented for Model Year 6, which include:

- Reducing the CMS Discount for medical Clinical Episodes from 3% to 2%.
- Reducing the Peer Group Trend (PGT) Factor Adjustment cap for all Clinical Episodes from 10% to 5%.
- Holding Participants accountable for all Clinical Episodes in which the beneficiary has a COVID-19 diagnosis during the Clinical Episode.
- Making major joint replacement of the upper extremity (MJRUE) a multi-setting Clinical Episode category by including outpatient total shoulder arthroplasty (TSA) procedures (triggered by Healthcare Common Procedure Coding 23472) in the Model.

F. Pricing Methodology/Data

F-1. Can an Applicant see Target Prices before committing to participate in the Model?

Yes; organizations that submitted an application by May 31, 2023 will receive baseline claims data and Preliminary Target Prices for all Clinical Episode categories by September 2023.

F-2. Will all Clinical Episodes be included in the baseline, regardless of precedence or overlap with other models, like the Comprehensive Care for Joint Replacement Model?

The baseline period takes into account Clinical Episodes that overlap with each other and with certain CMS models. This means the baseline period excludes episodes that overlap with each other and excludes episodes that overlap with the Comprehensive Care for Joint Replacement (CJR) Model.

Additionally, beneficiaries aligned or assigned to an excluded Medicare Accountable Care Organization (ACO) are removed from the baseline period as well. We recommend reviewing the Clinical Episode Constructions Specification, located on the BPCI Advanced webpage, which details these and other exclusions.

F-3. If multiple hospitals bill under the same Taxpayer Identification Number, must they all participate in the Model, and must they all select the same Clinical Episode Service Line Groups?

If multiple hospitals bill under the same Taxpayer Identification Number (TIN), they do not all have to participate in the Model. Hospitals can Participate in BPCI Advanced separately and select their own Clinical Episode Service Line Groups (CESLG). This is because hospitals are defined and priced at the CMS Certification Number (CCN) level. The TIN level is how we define Physician Group Practices (PGP) in BPCI Advanced.

F-4. If a Physician Group Practice Episode Initiator begins practice at a new hospital, will episodes triggered at that hospital be included in the Model?

Yes; the Physician Group Practice (PGP) will be able to trigger Clinical Episodes at the new hospital, as long as the hospital has sufficient volume in its baseline period to establish a hospital-based Target Price. However, the PGP would not receive a specific Preliminary Target Price for the new hospital. CMS would only be able to provide the hospital benchmark price and the PGP would receive the Final Target Price at Reconciliation.

F-5. Where can details about the BPCI Advanced pricing methodology be found?

The most current information regarding the BPCI Advanced pricing methodology can be referenced from the links to the BPCI Advanced webpage below:

- The MY6 Target Price Specifications
- The Clinical Episode Construction Specifications
- The Pricing Methodology FAQs

F-6. When will the revised version of the Exclusions List be available?

BPCI Advanced will automatically exclude certain Clinical Episodes from calculation or reconciliation if it is associated with certain exclusion codes, related to items such as specific readmissions, Part B drugs, hemophilia codes and cardiac rehabilitation codes. The current Medicare Severity-Diagnosis Related Groups (MS-DRG) Exclusions from Clinical Episodes List is now posted on our webpage.

F-7. Why do Applicants receive only three years of historical data (2018-2021) and not the four years (2017-2021) of data used to calculate the Target Prices?

It has been determined that three years is the minimum necessary period according to the Applicant Data Request and Attestation (DRA) form.

Following the application review process, and in accordance with applicable law, CMS intends to release up to three years of historical (baseline period) Medicare claims data for Medicare FFS beneficiaries who would have been included in a Clinical Episode during a baseline period. Per the guidelines of the DRA that is posted on the BPCI Advanced website, BPCI Advanced is only able to provide data that contains beneficiary-identifiable claims to enable Applicants to evaluate which Clinical Episode Service Line Groups (CESLG) provide the greatest opportunity for process improvement through quality improvement and care coordination. This data must also be the "minimum necessary" to carry out that intended purpose. It has been determined that three years of raw claims data meets that legal requirement.

F-8. If a Physician Group Practice has a fairly new Taxpayer Identification Number, what kind of data will they receive?

Since the newly formed Physician Group Practices (PGP) will not have any historical claims data for Clinical Episodes during the baseline period, we cannot provide any raw or aggregate data for these potential Episode Initiators.

Newly formed PGPs will not receive a PGP-specific Preliminary Target Price. Instead, they will receive the Target Price of the hospital where they initiate a given episode, as long as the hospital has sufficient volume in its baseline period to establish a hospital-based Target Price. At the time of reconciliation, once we know the hospitals where the PGP initiated its Clinical Episodes, we will calculate the PGP-specific Target Prices based on those hospitals' historic baseline prices and the PGP's realized case mix.

F-9. Who can have access to the data that CMS will provide to Applicants?

Applicants will need to fill out a Data Request and Attestation (DRA) form and submit it with the application in order to receive any data. On this form, they will identify two Data Points of Contact (Data POCs) for their organization and these Data POCs will be able to directly access the data in the BPCI Advanced Data Portal. They will also have the ability to provide downstream users access to the data if they have Business Associate Agreements (BAAs). Per the BPCI Advanced Applicant DRA: The Data Requestor asserts that the BPCI Advanced Applicant will be solely responsible for approving and granting any disclosure of BPCI Advanced data to "business associates," as that term is used in 45 C.F.R. §§ 164.502(e), 164.504(e), 164.532(d) and (e), of the BPCI Advanced Applicant.

F-10. Comprehensive Care for Joint Replacement hospitals can't enter BPCI Advanced for Medicare-Severity Diagnosis Related Groups 469 and 470, but can they enter for other joint related episodes? What about when Comprehensive Care for Joint Replacement ends?

Yes; though a Comprehensive Care for Joint Replacement (CJR) hospital is not able to participate in Medicare Severity-Diagnosis Related Groups (MS-DRG) 469 and 470 (Major Joint Replacement of the Lower Extremity Clinical Episode), they are able to participate in all Clinical Episode Service Line Groups (CESLG); from the Orthopedic CESLG, they can trigger all other Clinical Episode categories.

Once the CJR Model ends on December 31, 2024, CJR participant hospitals that also participate in BPCI Advanced may be eligible to initiate the Major Joint Replacement of the Lower Extremity Clinical Episode, as long as the Orthopedic CESLG was selected on the Participant Profile submitted for Model Year 7 (2024).

F-11. Can an independent orthopedics group in a Comprehensive Care for Joint Replacement market participate in BPCI Advanced?

Yes; an Orthopedic Physician Group Practice (PGP) in a Comprehensive Care for Joint Replacement (CJR) metropolitan statistical area (MSA) can participate in BPCI Advanced. However, any procedures under Medicare-Severity Diagnosis Related Groups (MS-DRGs) 469 or 470 performed at a CJR hospital will be included in the CJR Model and not in BPCI Advanced for as long as the CJR Model is active. Also, Physician Group Practices (PGP) that select the Orthopedic Clinical Episode Service Line Group (CESLG) will not receive Target Prices for Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode category at any CJR hospital.

F-12. What type of data will we receive when we apply? And will we receive the same data if we are an active Model Participant? *(April 2023 Update)*

Along with active Model Participants, applicants who complete an application and Data Request and Attestation (DRA) form will receive preliminary Model Year 7 (MY7) 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.

Please note, in BPCI Advanced, the baseline periods used to create benchmark prices shift forward every Model Year. For example, the baseline period for Model Years 1 & 2 included all Anchor Stays and Anchor Procedures, ending between January 1, 2013 and December 31, 2016. Therefore, for MY7, CMS anticipates that the baseline period will be October 1, 2018, through September 30, 2022.

F-13. Is the process for billing services provided to a Medicare beneficiary different when participating in the Model? *(April 2023 Update)*

The process for billing services that are provided to the Medicare beneficiary will not change. The BPCI Advanced Model is a retrospective payment model. This means that throughout the reconciliation process, Participants will either receive a payment or be directed to reimburse CMS.

F-14. Client billing is complicated and there is concern that, when participating in BPCI Advanced, patient billing will be impacted, and the beneficiary may or may not be billed correctly for their balance. *(April 2023 Update)*

The Medicare beneficiary billing will not change due to participation in BPCI Advanced. Neither the calculation of the beneficiary copayments nor the billing of the beneficiary's insurance will change.

F-15. What happens if the participating entity gets more money – will there be any impact to what the Medigaps pay? *(April 2023 Update)*

The process for billing services that are provided to the Medicare Beneficiary will not change due to participation in BPCI Advanced. Any amounts the Participant receives is a result of the Reconciliation process and their success in meeting the target pricing. The payments for services provided to the Medicare beneficiary are not involved in that process.

G. Legal

G-1. What are the Certified Electronic Health Record Technology requirements for Participants in BPCI Advanced?

As of the Participant's start date in BPCI Advanced, the Participant must use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care to their beneficiaries or other health care providers.

- For hospitals that are Non-Convener Participants, the hospital must use CEHRT
- For Physician Group Practices (PGPs) that are Non-Convener Participants, at least 75% of the PGP's eligible clinicians must use CEHRT
- For Convener Participants who will have hospitals and PGPs as Episode Initiators, the hospitals must use CEHRT and at least 75% of the eligible clinicians in each PGP must use CEHRT

To learn which Electronic Health Records (HER) systems and modules are certified for the Medicare and Medicaid EHR Incentive Programs such as Advanced APMs, please visit the Certified Health IT Product List (CHPL) on the Office of the National Coordinator for Health Information Technology (ONC) webpage.

G-2. The Quality Assurance section of the application asks to list "sanctions." How much detail do Applicants need to provide?

CMS requires Applicants to include any sanctions, investigations, corrective action plans, probations and/or outstanding Medicare debt within the last five years that involve the Applicant, potential Downstream Episode Initiators and potential Participating Practitioners.

Responses to this question on the application must address all required fields, capturing sufficient detail while maintaining the character limit.

H. Financial Risk

H-1. How much financial risk do BPCI Advanced Participants have?

In BPCI Advanced, there are multiple factors that determine how much financial risk the Participant will be accountable for. At the Clinical Episode level, CMS winsorizes Clinical Episode spending at the 1st and 99th percentiles. Winsorizing, or capping Clinical Episode spending, helps to limit the effects of extreme values or outliers.

In addition to winsorizing, BPCI Advanced includes a stop-gain and stop-loss provision, which limits Participant risk at the Episode Initiator level. The stop-gain provision prevents an Adjusted Positive Total Reconciliation Amount from being in excess of 20% of the final Target Price for a given Episode Initiator. Conversely, the stop-loss provision prevents an Adjusted Negative Total Reconciliation Amount from being in excess of 20% of the final Target Price for a given Episode Initiator.

Lastly, depending on how well a Participant does on certain quality measures, a Composite Quality Score (CQS) Adjustment Amount is applied to any Positive Total Reconciliation Amounts and any Negative Total Reconciliation Amount. The CQS Adjustment Amount is up to 10% and will not adjust the Positive Total Reconciliation Amount down by more than 10%, nor will it adjust the Negative Total Reconciliation Amount up (meaning more towards a positive amount) by more than 10%.

H-2. Do Participants need to have a set amount of money in reserve to participate in BPCI Advanced?

Yes; all Applicants must include information regarding their ability to bear financial risk. This must include enforceable assurances of each Participant's ability to repay Medicare. This assurance, called the Secondary Repayment Source (SRS), could take the form of an irrevocable letter of credit for the full amount of risk undertaken or funds placed in escrow, where CMS is the recipient of those funds if payment is due to CMS.

CMS will calculate the SRS amount required based on which Clinical Episode Service Line Groups (CESLG) the Participant selects. A Convener Participant with a "Secondary Repayment Source (SRS) Covered Participant" designation needs to fund an escrow account or a letter of credit in an amount that CMS will calculate based on the Participant's CESLG selections. Participants can find more details about SRS requirements and their calculation methodology in Section IV.D.4 of the Request for Application.

I. Physician-Focused Questions

I-1. How will practices benefit from participation in this Model?

If successful, the Model will result in reduced expenditures, improved quality and streamlined, coordinated care episodes that enhance the beneficiary experience and improve outcomes. The Model affords new flexibilities in care delivery in an effort to improve provider satisfaction.

BPCI Advanced is an Advanced Alternative Payment Model under the Quality Payment Program and eligible clinicians that participate sufficiently in the Model may be eligible for an incentive payment. As both commercial and public payers transition away from paying for volume and toward paying for value, experience with value-driven care will become ever more essential.

I-2. Does this apply to all Medicare beneficiaries? How about Medicaid beneficiaries? Are private payers part of this Model?

Medicare beneficiaries:

- BPCI Advanced applies to Medicare beneficiaries only

Medicaid beneficiaries:

- BPCI Advanced does not apply to Medicaid beneficiaries unless they have dual Medicare eligibility

Private payers:

- BPCI Advanced does not allow private payers to participate

I-3. Which Medicare beneficiaries are excluded from the Model?

The following **Medicare beneficiaries are excluded from the Model:**

- [1] beneficiaries covered under United Mine Workers or managed care plans such as Medicare Advantage, Health Care Prepayment Plans or cost-based health maintenance organizations
- [2] beneficiaries for whom Medicare is not the primary payer
- [3] beneficiaries eligible for Medicare on the basis of End-Stage Renal Disease
- [4] patients not entitled to benefits under Part A or enrolled in Part B for any portion of the clinical episode
- [5] beneficiaries who die during the Anchor Stay or Anchor Procedure

I-4. Does a practice need to have a specific case mix to participate?

No; a practice does not have to have a specific case mix to participate. The Model accounts for an extensive range of beneficiary characteristics and there is no specific case mix requirement to participate. However, Practices must opt into Clinical Episode Service Line Groups (CESLGs) that cover participation in a set number of Clinical Episode Categories. Practices will only be accountable for a Clinical Episode if they meet a minimum volume threshold for that specific Clinical Episode Category.

I-5. If a practice is participating in another payment model, can it still participate in BPCI Advanced?

Practices may participate in multiple bundled payment models or other CMS models at once; however, they will be subject to model overlap policies. For more details on the models overlap policy, please refer to Section V.E in the "Request for Applications" (RFA) document available in the BPCI Advanced website.

I-6. If a practice does everything it can to achieve a given outcome and engage the beneficiary, and the beneficiary does not adhere to clinician guidance, is the practice still at financial risk?

Yes; BPCI Advanced Participants will have the same risk for all their selected Clinical Episode Service Line Groups (CESLGs), because they face the same challenges as their peers.

Beneficiary engagement in their own care is a critical factor in their adherence with the care plan. Clinicians influence beneficiary engagement in many ways, including through clear communication, rapport and trust and shared decision-making. While beneficiaries ultimately make their own choices, beneficiary engagement is important for all beneficiaries – whether in or out of the Model.

I-7. What is a Qualifying Alternative Payment Model Participant?

Under the Quality Payment Program, a Qualifying Alternative Payment Model Participant (QP) is an eligible clinician (EC) who has a certain percentage of payments through an Advanced Alternative Payment Model (APM) (via the APM Entity or as an individual, depending on how they participate). QPs are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustment and will instead receive a 5% APM Incentive Payment during 2017-2022 and an increased physician fee schedule update in 2024 onwards.

I-8. When are Participants in BPCI Advanced exempt from Merit-based Incentive Payment System?

Eligible clinicians who earn Qualifying Alternative Payment Model Participant (QP) status for a year are exempt from Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustment for that year. Eligible clinicians participating in an Advanced Alternative Payment Model (APM) can also earn Partial Qualifying APM Participant (Partial QP) status by meeting a lower threshold. Partial QPs have the option to be excluded from MIPS and receive a neutral payment adjustment or to participate in MIPS. All Participants in BPCI Advanced have the opportunity to earn QP or partial QP status.

I-9. How will Qualifying Alternative Payment Model Participant determinations be made?

Qualifying Alternative Payment Model Participant (QP) determinations will vary depending on the type of Participant and Episode Initiators:

1. For Non-Convener Participants that are Hospitals, eligible clinicians will be assessed individually for purposes of QP determinations.
2. For Non-Convener Participants that are Physician Group Practices (PGP), eligible clinicians will be assessed as a group for purposes of QP determinations.
3. For Convener Participants that will have hospitals and PGPs as Episode Initiators, the QP determinations for eligible clinicians will be made for those eligible clinicians participating through PGPs only, and they will be assessed as a group.
4. In order to avoid this action for hospital-based eligible clinicians, Convener Participants may choose to enter into separate agreements with CMS for hospital Episode Initiators and PGP Episode Initiators.
5. In order to avoid multiple PGPs being assessed as one group, Convener Participants may choose to enter into separate agreements with CMS for individual PGPs.

If a Convener Participant chooses option four or five above, they must submit separate applications before the May 31, 2023 deadline.
For more information on QP status, see the CMS webpage.

I-10. What kind of documentation will Participants have to submit for Qualifying Alternative Payment Model Participant determinations under BPCI Advanced?

Participants have to submit the BPCI Advanced Quality Payment Program (QPP) List quarterly.

The QPP list provides information on Eligible Clinicians to be used by CMS for purposes of the Qualifying Alternative Payment Model Participant (QP) determinations.

J. After Submission

J-1. What kind of deliverables do Participants have to complete? When are they due and how frequently?

There are four deliverables that Participants must regularly submit to CMS, as applicable:

1. **Participant Profile (PP)**
   - Required annually
   - This document indicates the Episode Initiators, Clinical Episode Service Line Groups (CESLGs) and quality measures for which they will be held accountable

2. **Care Redesign Plan (CRP)**
   - Required annually
   - This document describes the specific planned interventions and changes to the Participant's current health care delivery system

3. **Quality Payment Program (QPP) List**
   - Required quarterly, 30 days before the start of the quarter
   - This document identifies the individuals that meet the requirements included in a report the BPCI Advanced Model submits quarterly to the QPP for the Qualifying APM Participant (QP) determinations
   - For the Participant to include an individual on the Participation List tab of the QPP List, the individual must be a Participating Practitioner as defined in the BPCI Advanced Participation Agreement;
   - For the Participant to include an individual on the Affiliated Practitioners List tab of the QPP List, the individual must be a Participating Practitioner as defined in the BPCI Advanced Participation Agreement; and (b) meet the definition of Affiliated practitioner in 42 C.F.R. § 414.1305

4. **Financial Arrangement Lists (FAL)**
   - If applicable, required bi-annually, 30 days before the start of the Q1 and Q3 quarters
   - This document includes the list of organizations and/or individuals with whom the Participant intends to enter into a financial arrangement in BPCI Advanced as one of the following: A Net Payment Reconciliation Amount (NPRA) Sharing Partner, an NPRA Sharing Group Practice Practitioner or a BPCI Advanced Entity

J-2. How does a Participant exit the Model?

Since BPCI Advanced is voluntary, Convener Participants and Non-Convener Participants may terminate their participation at any time without penalty after providing written notice 90 days in advance. However, Participants will still be held accountable for any Clinical Episodes triggered during the 90-day termination window.

K. Additional Resources

K-1. Where are the supporting documents for the Application located?

The supporting documents listed below can be accessed via the BPCI Advanced Applicant Resources Page:

- **Timeline** – of the Application process
- **Application Portal "How-To" Guide** – with instructions on how to submit an application
- **How to Apply? – Guide for New Applicants** – with summary information for new applicants
- **MY7 Options for Active Model Participants** – with summary information for currently active BPCI Advanced Participants
- **Physician Fact Sheet**
- **Why should you Participate in BPCI Advanced?**
- Model Overview Animated Video – with a summary of how BPCI Advanced operates

K-2. Where are the other FAQ documents located?

There are several FAQs located on the BPCI Advanced webpage.

- General FAQs
- Data FAQs
- Pricing Methodology FAQs
- Model Overlap FAQs
- QPP FAQs

K-3. Where can other technical resources be found *(April 2023 Update)*?

Other technical resources are located on the BPCI Advanced Participant resources webpage.

Quality measure resources can be found on this webpage.

- Quality Measure Q&As
- Introduction to Quality Strategy goals and Quality Measures Options (Infographic)

K-4. What learning and technical assistance support will be offered to Participants in BPCI Advanced?

BPCI Advanced will offer Participants a variety of learning opportunities to support their transformation needs with virtual, web-based, peer-to-peer, interactive learning and on-demand events and information. Learning events and materials will orient BPCI Advanced Participants to the Model characteristics and compliance requirements.

Online collaboration tools and web-based portals will facilitate knowledge-sharing among Participants in their efforts to meet the aim of the Model.

The BPCI Advanced Team will also provide technical assistance by responding to questions submitted to the inbox: BPCIAdvanced@cms.hhs.gov.