Model Year 4:
General Frequently Asked Questions (FAQ)
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Table of Contents

Click on each of the topics below to navigate to the FAQs associated with that specific topic:

Quick Links to Questions by Topic

BPCI Advanced Overview and Model Operations

Q1: What is BPCI Advanced and when did Model Year 4 begin?

A1: The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is a voluntary value-based payment model from the CMS Innovation Center. It tests whether bundling payments within a Clinical Episode can reduce Medicare expenditures while maintaining or improving the quality of care. BPCI Advanced aims to support healthcare providers who invest in practice innovation and care redesign to better coordinate care, improve quality of care, and reduce expenditures. The Model Performance Period for BPCI Advanced started on October 1, 2018 and is expected to run through December 31, 2023. Model Year 4 (MY4) began on January 1, 2021.

Q2: How does BPCI Advanced support the goals of reducing Medicare expenditures and preserving or enhancing the quality of care for Medicare beneficiaries?

A2: BPCI Advanced contributes to these goals through retrospective Reconciliation of payments made by CMS for selected Clinical Episodes in a bundled payment model with only one risk track. Under BPCI Advanced, the Participant bears financial risk and redesigns care delivery to reduce Medicare fee-for-service (FFS) expenditures while maintaining or improving performance on specific quality measures.

Q3: Where has CMS implemented BPCI Advanced?

A3: CMS is testing the BPCI Advanced Model throughout the country; therefore, participation was open to eligible organizations in all states, U.S. territories, and the District of Columbia. For Model Year 4, we have Medicare providers and suppliers representing 49 states, Puerto Rico, and the District of Columbia.

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

A4: There are two categories of Participants under BPCI Advanced: Convener Participants and Non-Convener Participants. A Convener Participant is a type of Participant that brings together at least one entity referred to as a "Downstream Episode Initiator" (Downstream EI)—which must be either an Acute Care Hospital (ACH) or Physician Group Practice (PGP)—to participate in BPCI Advanced, facilitate coordination among them, and bear and apportion financial risks. Convener Participants enter into agreements with each Downstream EI, whereby the Downstream EI agrees to participate in BPCI Advanced and comply with all applicable Model requirements. Eligible entities that are either Medicare-enrolled or non Medicare-enrolled providers or suppliers may be Convener Participants. ACHs and PGPs may be Convener Participants or Non-Convener Participants.

A Non-Convener Participant is an Episode Initiator (EI) that bears financial risk only for itself and does not have any Downstream EIs. Only ACHs and PGPs may participate in BPCI Advanced as

Non-Convener Participants. An EI is a Medicare-enrolled ACH or PGP that can trigger a Clinical Episode under BPCI Advanced.

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

A5: 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 the unique methodologies under which they are paid, these hospitals may not participate in the Model in any capacity. Note that PGPs that practice only in Maryland are similarly not eligible to be Episode Initiators in BPCI Advanced. However, PGPs that practice in Maryland and another state or the District of Columbia are eligible to be Episode Initiators in the BPCI Advanced Model for care provided outside of Maryland.

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

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

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

A7: Yes, ACOs can participate in BPCI Advanced as a Convener Participant. Participants may also add ACOs to the Participant's Financial Arrangement List (FAL) as an organization that is participating in BPCI Advanced Activities and with which the Participant has an NPRA Sharing Arrangement.

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

A8: The Model Performance Period of BPCI Advanced began on October 1, 2018, and the Model is expected to run through December 31, 2023. BPCI Advanced defines a Model Year as a full or partial calendar year during which participating EIs may initiate Clinical Episodes. BPCI Advanced is expected to have six Model Years. The Model Years are as follows:

- Model Year 1: Oct. 1, 2018 – Dec. 31, 2018
- Model Year 2: Jan. 1, 2019 – Dec. 31, 2019
- Model Year 3: Jan. 1, 2020 – Dec. 31, 2020
- Model Year 4: Jan. 1, 2021 – Dec. 31, 2021
- Model Year 5: Jan. 1, 2022 – Dec. 31, 2022
- Model Year 6: Jan 1, 2023 – Dec. 31, 2023

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

A9: CMS defines BPCI Advanced by five main characteristics:

1. It has a single retrospective payment for selected Clinical Episodes included in Clinical Episode Service Line Groups (CESLGs) with a 90-day post-anchor episode length
2. It has 30 inpatient Clinical Episodes, three outpatient Clinical Episodes, and one multi-setting Clinical Episode.
3. It is an Advanced Alternative Payment Model (Advanced APM)
4. It provides preliminary Target Prices for each Clinical Episode in advance of each Model Year, which will be adjusted during the semi-annual Reconciliation process. During the semi-annual Reconciliation Process, CMS calculates the final Target Price, which will reflect the actual patient case mix and realized trend adjustment during the applicable Performance Period
5. It is a voluntary model for Medicare providers and suppliers.

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

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

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

A11: BPCI Advanced does not exclude PAC providers from participating; they can participate in BPCI Advanced as Convener Participants. Participants may also add a PAC provider to the Financial Arrangements List (FAL) as an organization that is participating in BPCI Advanced Activities and with which the Participant has an NPRA Sharing Arrangement.

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

Q12: Does BPCI Advanced meet the Advanced APM criteria?

A12: Yes, BPCI Advanced meets the criteria specified in regulation at 42 CFR § 414.1415 to qualify as an Advanced APM. First, an APM must require participants to bear risk for monetary losses of more than a nominal amount under the terms of the APM. In BPCI Advanced, Participants are financially at risk for up to 20 percent of the final Target Price for each Clinical Episode in the Clinical Episode Service Groups for which they have selected to participate, which exceeds the minimum requirement (three percent) for the benchmark-based standard under the Quality Payment Program (QPP). Second, an APM must also require certain levels of Certified Electronic Health Record Technology (CEHRT) use by participants. In BPCI Advanced, Participants must attest to their use of CEHRT as a condition of participation. For non-hospital

Participants, at least 75 percent of eligible clinicians in the Participant entity must use the CEHRT definition of certified health IT functions to participate in this initiative. Third, payments under the APM must be based in part on performance on quality measures which are comparable to Merit-Based Incentive Payment System quality measures. In BPCI Advanced, CMS calculates a score for each quality measure at the Clinical Episode level. These scores are volume-weighted and scaled across all Clinical Episodes attributed to a given Episode Initiator (EI) to calculate an EI-specific Composite Quality Score.

Q13: How does a Participant exit the Model?

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

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

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

A14: Yes, certain Participants with a "Secondary Repayment Source (SRS) Covered Participant" designation will be required to fund an escrow account or obtain a letter of credit in an amount that CMS will calculate based on the Participant's Clinical Episode Service Line Group (CESLG) and, if applicable, Downstream Episode Initiator selections. Participants can find more details about SRS requirements and their calculation methodology in Article 7.6 and 7.7 and Appendices B and C of the 2021 BPCI Advanced Participation Agreement.

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

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

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

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

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

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

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

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

1. **Participant Profile (PP)**
   - Required to be submitted when specified by CMS, approximately 30 days before the start of the Model Year
   - Indicates the Clinical Episode Service Line Groups to which the Non-Convener Participant commits under BPCI Advanced, or, for a Convener Participant, the list of Downstream Episode Initiators (Downstream EIs) and their specific Clinical Episode Service Line Group selections
   - Participants also indicate which Quality Measure Set they wish to be held accountable for at the Clinical Episode level.
2. **Care Redesign Plan (CRP)**
   - Required to be submitted annually by a date specified by CMS, approximately 30 days before the start of the Model Year
   - Describes the specific planned interventions and changes to the current health care delivery system of the Participant, Downstream EIs, Participating Practitioners, NPRA Sharing Partners, and NPRA Sharing Group Practice Practitioners.
3. **Quality Payment Program (QPP) List**
   - Required to be submitted quarterly by a date specified by CMS, approximately 30 days before the start of the quarter
   - Identifies the individuals that the BPCI Advanced Model submits to the Quality Payment Program for the Qualifying Alternative Payment Model (APM) Participant (QP) determinations
   - For the Participant to include an individual on the Participation List tab of the QPP List, the individual must: (a) be a Participating Practitioner; and (b) have reassigned his or her rights to receive Medicare payments to the Taxpayer Identification Number (TIN) of the Participant or to a Downstream EI

- For the Participant to include an individual on the Affiliated Practitioner List tab of the QPP List, the individual must: (a) be a Participating Practitioner; and (b) meet the definition of Affiliated Practitioner in 42 C.F.R. § 414.1305

4. **Financial Arrangements List (FAL)**
    - Submitted on a semi-annual basis, if applicable, at a time specified by CMS
    - Includes the list of organizations and/or individuals with whom the Participant intends to have a financial arrangement in BPCI Advanced. The types of organizations/individuals are: a Net Payment Reconciliation Amount (NPRA) Sharing Partner, an NPRA Sharing Group Practice Practitioner, or a BPCI Advanced Entity

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

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

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

A19: Participants can create and/or recommend preferred Post-Acute Care (PAC) networks; however, they may not limit beneficiary choice of healthcare provider in any way. Participants must notify beneficiaries of their participation in the Model using the CMS Beneficiary Notification Letter and must require their Downstream Episode Initiators and Participating Practitioners do the same.

Q20: What are the CMS Beneficiary Notification Letter requirements?

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

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

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

A21: To ensure compliance with the terms of the BPCI Advanced Participation Agreement, Participants must submit a Participant Profile to identify current Episode Initiators (EIs) and their Clinical Episode Service Line Group selection prior to the start of each Model Year. In the same document, Participants must attest to intending to complete a minimum of four MIPS Improvement Activities in which the Participant will participate during the upcoming Model Year. Participating Practitioners who are MIPS-eligible clinicians may receive a credit for the MIPS Improvement Activity performance category score for an applicable MIPS performance year by performing these activities as a part of their participation in BPCI Advanced. For more information regarding MIPS Improvement Activities or the MIPS generally, please contact the QPP help desk here – QPP@cms.hhs.gov.

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

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

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

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

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

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

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

3. ***CMMI Connect –*** https://cmmi.my.salesforce.com/

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

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

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

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

A23: No. BPCI Advanced will not use time-based precedence rules. What this means is that Model Participants that started on October 1, 2018 (MY1) will not have precedence over those that started on January 1, 2020 (MY3). In BPCI Advanced, CMS will attribute Clinical Episodes at the Episode Initiator level. The hierarchy for attribution of a Clinical Episode among different types of EIs is as follows, in descending order of precedence:

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

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

A24: Since January 2020, BPCI Advanced does not exclude Clinical Episodes (or Medicare FFS expenditures) for Beneficiaries assigned to Shared Savings Program Accountable Care Organizations (ACOs) participating under Tracks 1, 1+, or 2, the BASIC track, or the ENHANCED Track (Track 3). The BPCI Advanced Model will exclude Clinical Episodes (and Medicare FFS expenditures) for BPCI Advanced Beneficiaries aligned or assigned to an ACO participating in the Next Generation ACO model, the Comprehensive End-Stage Renal Disease (ESRD) Care Initiative, the Vermont Medicare ACO initiative, or any successor track or initiative including the Direct Contracting Model and the Comprehensive Kidney Care Contracting (CKCC) option of the Kidney Care Choices (KCC) Model.

Policy Changes to Model Year 4

Q25: What policy changes were made in Model Year 4?

A25: CMS made the following key changes to the BPCI Advanced Model, which took effect at the beginning of Model Year 4 (MY4) in January 2021:

- **Addition of the Alternate Quality Measures Set:** In MY4, Participants were able to select either the existing Administrative Quality Measures Set used in Model Years 1, 2, and 3, or a new Alternate Quality Measures Set, which was developed with extensive input from stakeholders, including professional health associations, clinical data registries, and clinicians. This new set of measures allows BPCI Advanced Participants to have more choice about how their quality of care is measured in the Model. For more information on the BPCI Advanced Quality Measures, please review the BPCI Advanced MY4 Quality Measures FAQ.
- **Exclusion of BPCI Advanced Beneficiaries aligned or assigned to Accountable Care Organizations (ACOs) participating in select models with anticipated start dates during MY4**. Additional information on this policy change can be found in Appendix A of the Participation Agreement.
- **Inclusion of a Peer Group Trend Adjustment used to calculate the final Target Price:** CMS will adjust final Target Prices at Reconciliation for peer group trends found in Performance Period Clinical Episode spending. CMS will cap the difference between the realized peer group trend factor from the preliminary peer group trend factor at 10-percent of the preliminary trend. Capping the deviation from the preliminary peer group trend factor, as compared to applying the full realized peer group trend factor, creates some predictability and stability in Target Prices.
- **Removal of physician group practice (PGP) offset used in Target Price construction:** In MY4, CMS will remove the PGP Offset used in PGP Target Prices construction. As a result, each Clinical Episode category at each eligible Acute Care Hospital (ACH) will have a single Target Price that does not vary irrespective of the individual PGP who triggered the Clinical Episode. With the exception of Patient Case Mix Adjustment (PCMA) for the average case mix specific to their subset of patients, the PGP's Target Prices (preliminary and final) will be the same as the ACH's Target Price. Removal of the PGP Offset simplifies the pricing methodology for ease of scaling and has the potential to save money for CMS.
- **Inclusion of Clinical Episode Service Line Groups:** Beginning in MY4, Participants were required to select Clinical Episode Service Line Groups (CESLGs) instead of one or more Clinical Episode categories. Participants are not required, however, to participate in Clinical Episode categories within a CESLG that does not meet the minimum volume threshold during the baseline period.
- **Inclusion of Clinical Episode Overlap Methodology:** In MY4, Clinical Episodes will not overlap in either the baseline or Performance Period and will be attributed without regard to participation status in both periods. This change will create consistency in the way that Clinical Episodes are constructed in both the baseline period and Performance Period and

has the potential to improve Target Price accuracy. However, this may reduce the number of eligible ACHs and the number of Clinical Episodes attributed to Participants for the Performance Periods. A subsequent Clinical Episode that is triggered during a Beneficiary's ongoing Clinical Episode (overlapping) will be excluded during both the baseline period and Performance Period, regardless of whether it was attributed to the Participant.

- **Adjustment of Major Joint Replacement of the Lower Extremity (MJRLE) Risk:** In order to improve the accuracy of payment for MJRLE Clinical Episodes, CMS will add the following procedure flags to the Model Year 4 risk adjustment model for the MJRLE: (i) Partial Knee Arthroplasty; (ii) Total Knee Arthroplasty; (iii) Partial Hip Arthroplasty; (iv) Total Hip Arthroplasty and Hip Resurfacing; and (v) Ankle and Reattachments and/or Others. CMS will also use combinations of flags, where applicable, to improve the precision of the MJRLE risk adjustment and Target Prices.
- **Extension for removal of COVID-19 Clinical Episodes from Reconciliation:** COVID-19 Clinical Episodes that end on or before December 31, 2021 will be excluded from Reconciliation and the Post-Episode Spending Calculation.
- **MY4 Natural Disaster Policy:** For a natural disaster to be included under the BPCI Advanced Natural Disaster policy, the HHS secretary must have issued a Section 1135 Waiver, and the Federal Emergency Management Agency (FEMA) needs to have issued an accompanying Major Disaster Declaration.
- The policy applies to Clinical Episodes that (1) were triggered at an ACH located in a Federal Information Processing Standard (FIPS) county designated by FEMA as a disaster-impacted area; and (2) have an Anchor Stay or Anchor Procedure begin date in the period up to and including 29 days before the FEMA-designated disaster start date and up to and including 29 days after the disaster end date (60-day window).
- Clinical Episodes that meet the above criteria of being impacted by a natural disaster, regardless of Clinical Episode spending greater than/less than the Target Price, will be excluded from Reconciliation. As such, these Clinical Episodes will not be included in Performance Period spending or in Clinical Episode-based quality measure scores.
- Participants can identify natural disaster impacted Clinical Episodes in raw claims files by using the NATURAL_DISASTER_CCN_FLAG indicator in the EPI file.

Clinical Episode Service Line Groups

Q26: What are the Clinical Episode Service Line Group categories for Model Year 4?

A26: There are eight Clinical Episode Service Line Group categories in Model Year 4:

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

2. **Cardiac Procedures**

- Cardiac Defibrillator (Inpatient)
- Cardiac Defibrillator (Outpatient)
- Cardiac Valve
- Coronary Artery Bypass Graft (CABG)
- Endovascular Cardiac Valve Replacement
- Pacemaker
- Percutaneous Coronary Intervention (PCI – Inpatient)
- Percutaneous Coronary Intervention (PCI – Outpatient)

3. **Gastrointestinal Surgery**
   - Bariatric Surgery
   - Major Bowel Procedure

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

5. **Neurological Care**
   - Seizures
   - Stroke

6. **Medical and Critical Care**
   - Cellulitis
   - Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Asthma
   - Renal Failure
   - Sepsis
   - Simple Pneumonia and Respiratory Infections
   - Urinary Tract Infection

7. **Spinal Procedures**
   - Back and Neck Except Spinal Fusion (Inpatient)
   - Back and Neck Except Spinal Fusion (Outpatient)
   - Spinal Fusion

8. **Orthopedics**
   - Double Joint Replacement of the Lower Extremity
   - Fractures of the Femur and Hip or Pelvis
   - Hip and Femur Procedures Except Major Joint
   - Lower Extremity/Humerus Procedure Except Hip, Foot, Femur

- Major Joint Replacement of the Lower Extremity (MJRLE) (Multi-setting Inpatient / Outpatient)
- Major Joint Replacement of the Upper Extremity

Q27: How does CMS determine when a Clinical Episode is triggered?

A27: 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.

Q28: When does a Clinical Episode exclude a Medicare beneficiary?

A28: BPCI Advanced excludes the following types of Medicare beneficiaries:

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

Q29: Which service locations do the three outpatient Clinical Episodes include? Does BPCI Advanced include Clinical Episodes that initiate in outpatient hospital departments, freestanding cardiac catheterization labs, and ambulatory surgical centers (ASCs)?

A29: Anchor Procedures initiate an outpatient Clinical Episode when they occur in an outpatient hospital department of an ACH, which are paid under the Outpatient Prospective Payment System. Other outpatient settings, such as ASCs and freestanding cardiac catheterization labs, are not eligible to initiate Clinical Episodes.

Q30: How many risk tracks are in BPCI Advanced?

A30: There is only one risk track. Individual Clinical Episodes have spending capped at the first and 99th percentile of total standardized allowed amounts within the Clinical Episode.

Q31: Where can I find the list of Medicare Severity Diagnosis Related Group (MS-DRGs) Exclusions List that applies to Clinical Episodes in the Model?

A31: The MY4 BPCI Advanced Exclusion List that identifies by MS-DRG or Healthcare Common Procedure Coding System (HCPCS) code the excluded Medicare Part A and Part B items and services was provided to Participants in September 2020 via the Participant Portal. The BPCI Advanced Exclusions List for Model Year 4 is also on the BPCI Advanced website at https://innovation.cms.gov/media/document/bpciadvanced-my4-exclusion-list.

Q32: Will Episode Initiators (EIs) have to treat every Medicare beneficiary that presents for the Clinical Episodes in which the EI selected to participate under BPCI Advanced?

A32: Yes. EIs do not have the option of excluding Medicare beneficiaries from a Clinical Episode within the Clinical Episode Service Line Groups in which they selected to participate, regardless

of a patient's acuity. Additionally, neither EIs nor Participating Practitioners may restrict Beneficiaries' access to medically necessary care. To that end, CMS monitors utilization and referral patterns, conducts medical record audits, tracks patient complaints and appeals, and monitors patient outcome measures to assess improvement, deterioration, and/or any deficiencies in the quality of care under the Model.

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

Q33: Must all Physician Group Practices (PGPs) under the same Taxpayer Identification Number (TIN) choose the same Clinical Episode Service Line Groups?

A33: Yes, participation decisions, including Clinical Episode Service Line Group selection, are at the Episode Initiator (EI) level. For PGPs, CMS classifies the EI by the billed TIN on the claims to determine the Clinical Episode initiated within a Clinical Episode Service Line Group. For Acute Care Hospitals (ACHs), CMS uses the CMS Certification Number (CCN) on the institutional claim to identify the Clinical Episode initiated within a Clinical Episode Service Line Group.

Q34: If a Physician Group Practice (PGP) that started participation in MY3 (January 1, 2020), and an ACH that started participation in MY1 (October 1, 2018) furnished services during the same Clinical Episode, does the ACH retain the Clinical Episode or does the PGP receive precedence?

A34: In BPCI Advanced, Clinical Episodes are attributed at the Episode Initiator (EI) level. The hierarchy for attribution of a Clinical Episode among different types of EIs is as follows, in descending order of precedence:

1. The PGP that submits a claim that includes the National Provider Identifier (NPI) of the attending physician
2. The PGP that submits a claim that includes the NPI of the operating physician
3. The Acute Care Hospital (ACH) where the services that triggered the Clinical Episode were furnished.

There are no time-based precedence rules in BPCI Advanced; therefore, in the example asked, the PGP takes precedence over the ACH, assuming the PGP and the ACH are participating in the same Clinical Episode and the Clinical Episode or beneficiary cannot be attributed to particular CMS models, initiatives, or programs that may take precedence over BPCI Advanced (e.g., CJR).

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

A35: No, an Acute Care Hospital (ACH) may not allocate Clinical Episodes within a Clinical Episode Service Line Group under a Convener Participant in combination with its own participation as a Non-Convener Participant. Similarly, an ACH may not allocate Clinical Episodes within a Clinical Episode Service Line Group under multiple Convener Participants. An EI can only trigger Clinical Episodes by participating in BPCI Advanced as a Downstream EI with a Convener Participant or as a Non-Convener Participant.

Q36: Where can I find the Medicare Severity Diagnosis Related Groups (MS-DRGs) and Healthcare Common Procedure Coding System (HCPCS) trigger codes for BPCI Advanced Clinical Episodes in MY4?

A36: The MY4 Clinical Episode List, which includes the MS-DRG and HCPCS codes that may initiate a Clinical Episode, was provided to Participants in September 2020 via the Participant Portal. Participants can also find the MY4 Clinical Episode List on the BPCI Advanced website at https://innovation.cms.gov/media/document/bpciadvanced-my4-clinical-episode-list.

Q37: We are considering selecting the Clinical Episode Major Joint Replacement Lower Extremity (MJRLE). If we want to participate in inpatient MJRLE, do we also have to participate in the outpatient MJRLE episode?

A37: Major Joint Replacement of the Lower Extremity (MJRLE) is a multi-setting Clinical Episode that may be initiated in both the inpatient and outpatient setting. If a Participant selects the orthopedic Clinical Episode Service Line Group (CESLG), the Participant will be accountable for all Clinical Episode categories within that CESLG, including both Clinical Episode settings for MJRLE.

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

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

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

A39: For Model Year 3, BPCI Advanced started excluding Cardiac Rehabilitation from Target Prices and Clinical Episode spending so that healthcare providers wouldn't be disincentivized from recommending Cardiac Rehabilitation in the Performance Period. This policy has continued in MY4 and Participants may find the excluded Cardiac Rehabilitation codes in the MY4 BPCI Advanced Exclusions List posted on the BPCI Advanced website at https://innovation.cms.gov/media/document/bpciadvanced-my4-exclusion-list.

Payment

Q40: How does the Model affect beneficiary cost sharing?

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

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

A41: Article 8 of the BPCI Advanced Participation Agreement describes the requirements for Participants who have elected to enter into Financial Arrangements for purposes of making NPRA Shared Payment(s), Shared Repayment Amount(s), or contributing or receiving Internal Cost Savings.

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

A42: Model Participants may receive payments from CMS under the Model for providing efficient care but may owe payments to CMS if costs are higher than the Target Price. Starting in Model Year (MY) 4, the Target Price for each Performance Period will also account for realized national trends in the Performance Period that are driven by unanticipated, systematic factors. Realized trends are captured in the final Target Price by a Peer Group Trend Factor Adjustment, which is subject to a cap, and based on the difference between a retrospective peer group trend and the prospective peer group trend used to calculate the initial Target Price. In BPCI Advanced, a 3 percent discount is applied to the Benchmark Price in Model Years 1 through 4 to calculate the Target Price for each Clinical Episode category for each Episode Initiator. Additionally, payments from CMS to Model Participants and payments to CMS from Model Participants will be subject to a stop-gain and stop-loss policy which is 20 percent of the Target Price for a given EI. Both Negative Total Reconciliation Amounts and Positive Total Reconciliation Amounts will also be subject to an adjustment based on quality performance. For the first four Model Years, the maximum amount by which quality performance may adjust Negative and Positive Total Reconciliation Amounts will be 10 percent.

Payment Policy Waivers

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

A43: CMS is providing BPCI Advanced Participants conditional waivers of certain Medicare payment rules. Participants may elect to use the 3-Day Skilled Nursing Facility (SNF) Rule Payment Policy Waiver, the Telehealth Payment Policy Waiver, and/or the Post-Discharge Home Visit Services Payment Policy Waiver when redesigning care to be delivered to Medicare beneficiaries subject to the conditions of those waivers.