BPCI ADVANCED MODEL YEAR 4 FACT SHEET

September 2020

BPCI ADVANCED MODEL OVERVIEW

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, a voluntary value-based payment model from the CMS Innovation Center, tests whether linking payments for a Clinical Episode can reduce Medicare expenditures while maintaining or improving quality of care. BPCI Advanced started on October 1, 2018 for the first cohort of Participants and on January 1, 2020 for the second cohort of Participants. The Model is expected to run through December 31, 2023.

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

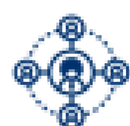
At the end of each Performance Period, actual Medicare fee-for-service (FFS) expenditures are reconciled against a Target Price, which is calculated by CMS based on historical claims data. Participants may receive a payment (Net Payment Reconciliation Amount, NPRA) if the Clinical Episode expenditures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

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

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

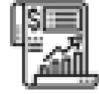
A **Convener Participant** is a type of Participant that brings together at least one Downstream Episode Initiator (EI). A Convener Participant facilitates coordination among its EIs and bears financial risk under the Model.

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



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

Establishes an **accountable party = Participant**



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

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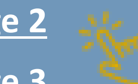


TIMELINE, DRIVERS, AND CHARACTERISTICS

2018
Jan. 8, 2018: CMS announced new Model
Oct. 1, 2018: Start of Model (Model Year 1)

2019
Jan. 1, 2019: Start Model Year 2
Mar. 1, 2019: Retroactive withdrawal deadline
Dec. 2019: Add/Drop EIs & CEs prior to Model Year 3

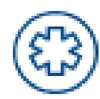
2020
Jan. 1, 2020: Start Model Year 3
Jun. 22, 2020: COVID-19 flexibilities announced
Dec. 2020: Drop EIs and/or Add/Drop CEs prior to Model Year 4

2021
Jan. 1, 2021: Start Model Year 4

2022
Jan. 1, 2022: Start Model Year 5

2023
Jan. 1, 2023: Start Model Year 6
Dec, 31, 2023: Model ends

BPCI ADVANCED MODEL DRIVERS


Care Coordination: Continuously reengineering care

Data Analysis & Feedback: Eliminating low-value care and fostering quality improvement

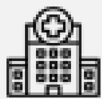
Financial Accountability: Testing a payment model for the outcomes of improved quality and reduced spending

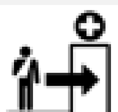
Health Care Provider Engagement: Stimulating rapid development of new evidence-based knowledge with providers

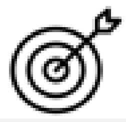
Beneficiary Engagement: Increasing the likelihood of better health at a lower cost through education and ongoing communication

MAIN CHARACTERISTICS OF BPCI ADVANCED

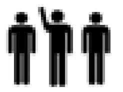
Payment
A single retrospective payment for selected Clinical Episodes included in Clinical Episode Service Line Groups (CESLGs)*, which begin on the first day of the initiating inpatient stay (Anchor Stay) or outpatient procedure (Anchor Procedure) and extend through the 90-day period starting on the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


Inpatient Clinical Episode Triggers
Thirty-one (31) Clinical Episodes are triggered by the submission of a claim to Medicare FFS by an EI for the inpatient hospital stay, identified by Medicare Severity-Diagnosis Related Group (MS-DRG).


Outpatient Clinical Episode Triggers
Four (4) Clinical Episodes are triggered by the submission of a claim to Medicare FFS by an EI for the outpatient procedure, identified by a Healthcare Common Procedure Coding System (HCPCS) code.

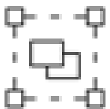

Target Prices
Preliminary Target Prices are provided in advance of the first Performance Period of each Model Year and will be adjusted during the semi-annual Reconciliation process to calculate a final Target Price that reflects actual patient case mix and realized trend adjustment during the applicable Performance Period.

Advanced Alternative Payment Model (Advanced APM)
Three criteria distinguish the BPCI Advanced Model as an Advanced Alternative Payment Model: (1) bearing of financial risk, (2) use of Certified Electronic Health Record Technology (CEHRT), and (3) tying payment to performance on quality measures.


Participation in Value-Based Payment Model
BPCI Advanced is a voluntary model for Medicare providers.

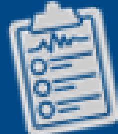
** Clinical Episode Service Line Groups are new in Model Year 4 (MY4). Additional information can be found on the next page.*

CLINICAL EPISODE SERVICE LINE GROUPS (CESLGs) – *NEW!*



In MY4, Participants will be required to select Clinical Episode Service Line Groups (CESLGs) instead of one or more Clinical Episode categories. Participants will not be required to participate in Clinical Episode categories-within a CESLG that do not meet the minimum volume threshold during the baseline period.

Clinical Episode Service Line Groups (CESLGs)



Cardiac Care

- Acute Myocardial Infarction (AMI)
- Cardiac Arrhythmia
- Congestive Heart Failure

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)

Gastrointestinal Surgery

- Bariatric Surgery
- Major Bowel Procedure

Gastrointestinal Care

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

Neurological Care

- Seizures
- Stroke

Medical & Critical Care

- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Asthma
- Renal Failure
- Sepsis
- Simple Pneumonia and Respiratory Infections
- Urinary Tract Infection

Spinal Procedures

- Back and Neck Except Spinal Fusion (Inpatient)
- Back and Neck Except Spinal Fusion (Outpatient)
- Spinal Fusion

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

CLINICAL EPISODES (Cont.)

CRITERIA FOR BENEFICIARY INCLUSION IN A CLINICAL EPISODE

A Medicare beneficiary entitled to benefits under **Part A** and enrolled under **Part B** for **the entirety of a Clinical Episode** on whose behalf an Episode Initiator submits a claim to Medicare FFS for the Anchor Stay or Anchor Procedure associated with the Clinical Episode for which a Participant has committed to be held accountable.

The term BPCI Advanced Beneficiary specifically excludes:

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

CLINICAL EPISODE DEFINITIONS

Clinical Episode Trigger:

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

Clinical Episode Length:

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

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

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

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

TYPES OF ITEMS AND SERVICES INCLUDED IN A CLINICAL EPISODE:
(Unless Specifically Excluded)

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

CLINICAL EPISODES (Cont.)

CLINICAL EPISODE EXCLUSIONS

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

- **Clinical Episode Exclusions –** All Medicare Part A and Part B services furnished to a BPCI Advanced Beneficiary during certain specified ACH admissions and readmissions (i.e., ACH admissions assigned at discharge to an MS-DRG for an organ transplant, trauma, cancer-related care, or ventricular shunts);
- **Excluded readmissions –** Contralateral procedures with the same MS-DRG (e.g., Major Joint Replacement of the Lower Extremity Clinical Episode that has a joint replaced in the opposite leg within 90 Days);
- **Excluded Cardiac Rehab Codes –** Payments for items and services for cardiac rehabilitation and intensive cardiac rehabilitation described in 42 C.F.R. § 410.49;
- **Excluded Part B drugs; Excluded IBD Part B drugs; Excluded Hemophilia drugs**
- New technology add-on payments made pursuant to 42 C.F.R. § 412.87 and 42 C.F.R. § 412.88;
- Payments for items and services with transitional pass-through payment status made pursuant to 42 C.F.R. § 419.62

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

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

CLINICAL EPISODE ATTRIBUTION PROCESS AND PRECEDENCE RULES

Precedence Rules during the Reconciliation Process

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

Clinical Episode Attribution Process

Clinical Episode Triggered
- An Anchor Stay or Anchor Procedure

Clinical Episode Created
- Specifications are applied

Precedence Rules/Exclusions are applied
- Attending PGP
- Operating PGP
- ACH

Clinical Episode Attribution
- To Episode Initiator at Reconciliation

Precedence Rules for Episode Initiators

Potential Clinical Episode is identified.

Is the attending physician NPI associated with a PGP? Yes → Assign Clinical Episode to that PGP.

No

Is the operating physician NPI associated with a PGP? Yes → Assign Clinical Episode to that PGP.

No

Does the Anchor Stay/Anchor Procedure occur at a participating ACH? Yes → Assign Clinical Episode to that ACH.

No

No BPCI Advanced Clinical Episode is attributed.

PRICING METHODOLOGY

CHANGES FOR MY4

CMS is adjusting the pricing methodology to ensure that Reconciliation payments reflect actual decreases in spending due to Care Redesign in response to BPCI Advanced and to make BPCI Advanced less susceptible to unpredictable changes in policy, coding, and clinical practice for future Model Years. The following changes will occur:

- **Utilize a Realized Trend Adjustment:** In MY4, CMS will adjust final Target Prices at Reconciliation for peer group trends found in Performance Period Clinical Episodes 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.
- **Remove the PGP Offset:** In MY4, CMS will remove the PGP Offset used in PGP Target Prices construction. As a result, each Clinical Episode category at each eligible 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.
- **Clinical Episode Overlap Methodology:**
  [1] In MY4, Clinical Episodes will not overlap in either the baseline or PP 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 and Performance Periods, 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 in the Performance Periods. **[2]** Any clinical episode that is triggered during a Beneficiary's ongoing clinical episodes (overlapping) will be excluded during both the baseline and Performance Period, regardless of whether it was attributed or not.
- **Clinical Episode Service Line Groups:** In MY4, Participants will be required to select Clinical Episode Service Line Groups (CESLGs) instead of one ore more Clinical Episode categories. Participants will not be required to participate in Clinical Episodes categories within a CESLG that do not meet the minimum volume threshold during the baseline period.
- **MJRLE Risk Adjustment:** In order to improve the accuracy of payment for MJRLE Clinical Episodes, CMS will add the following procedure flags to 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.

RECONCILIATION

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

Reconciliation occurs semi-annually. Clinical Episodes will be reconciled based on the Performance Period in which they end. Clinical Episodes with an Anchor Stay discharge date or Anchor Procedure completion date in Calendar Year (CY) 2020 and Clinical Episode end dates in CY2021 will be considered MY3 Clinical Episodes, but will still be reconciled in the Performance Period (PP) in which they end (PP5).

Composite Quality Score (CQS)

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

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

PRICING METHODOLOGY (Cont.)

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

CALCULATING THE TARGET PRICE FOR A CLINICAL EPISODE

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

PRICING METHODOLOGY (Cont.)

DETERMINING THE BENCHMARK PRICE

Benchmark Price for ACHs:

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

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

Benchmark Price for PGPs:

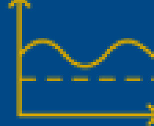
The PGP Offset will be removed for all PGP Target Prices. As a result, there will be a single average Target Price for each Clinical Episode category at each eligible hospital that is independent of the individual provider who triggered the Clinical Episode.

Clinical Episodes' volume thresholds

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

- **Risk Cap:** The risk cap is applied to Clinical Episodes at the 1st and 99th percentile of spending in both the Performance Period and the baseline period.
- **Post-Episode Spending Monitoring Period:** Any Medicare FFS expenditures for items and services furnished to a BPCI Advanced Beneficiary during the 30-day Post-Episode Monitoring Period that exceed an empirically titrated risk threshold, must be paid by the Participant to Medicare. The Post-Episode Spending Calculation will be performed by CMS on a semi-annual basis during the first true-up Reconciliation.
- **Stop-loss/stop-gain limits:** Reconciliation payments, both to Participants from CMS, and from Participants to CMS, are capped at +/-20% of the volume-weighted sum of the final Target Prices across all Clinical Episodes netted to the level of the Episode Initiator within the Performance Period.

BASELINE PERIODS USED TO CREATE BENCHMARK PRICES



In BPCI Advanced, the baseline periods shift forward every Model Year.

- For Model Years 1 and 2, the baseline period includes all Anchor Stays/Anchor Procedures ending between January 1, 2013 and December 31, 2016.
- For Model Year 3, the baseline period is between October 1, 2014 and September 30, 2018.
- For Model Year 4, the baseline period is between October 1, 2015 and September 30, 2019.

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

QUALITY MEASURES

In MY4, BPCI Advanced Participants will be 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 for each Clinical Episode in a CESLG for which the Participant has committed to be accountable. The new Alternate Quality Measures Set 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 additional information regarding Quality Measures, please review the resources available in the BPCI Advanced website: https://innovation.cms.gov/innovation-models/bpci-advanced/quality-measures-fact-sheets.

Resource	Website Address
MY4 Clinical Episode to Quality Measure Correlation Table (September 2020)	https://innovation.cms.gov/media/document/bpci-advanced-my4-episode-measure-correlation-table
MY4 Quality Measures Fact Sheet Package (August 2020)	https://innovation.cms.gov/media/document/bpci-advanced-my4-all-fact-sheets
MY4 Quality Measures FAQ (August 2020)	https://innovation.cms.gov/media/document/bpci-advanced-quality-faqs
Quality Methodology Webcast Slides (January 2020)	https://innovation.cms.gov/files/slides/bpciadvanced-wc-jan2020qualmethodology-slides.pdf

OVERLAP WITH OTHER CMMI MODELS

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

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

Medicare Shared Savings Programs –

Since January 2020, BPCI Advanced **will not exclude** Clinical Episodes (or Medicare FFS expenditures) for Beneficiaries assigned to Shared Savings Program Accountable Care Organizations (ACOs) participating under Tracks 1, 1+, or 2, the BASIC track, or the ENHANCED Track (Track 3).

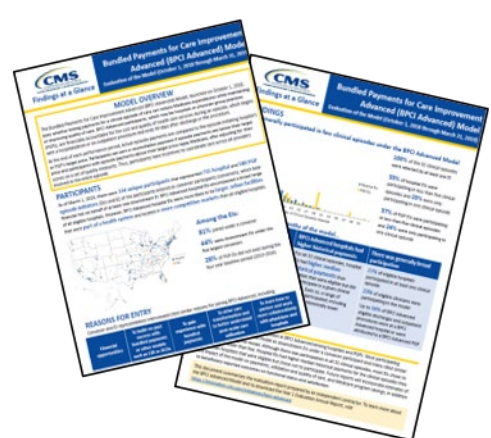
The BPCI Advanced Model **will exclude** Clinical Episodes (and Medicare FFS expenditures) for BPCI Advanced Beneficiaries aligned to a Next Generation ACO, to the Comprehensive ESRD Care, or to the Vermont Medicare ACO.

EVALUATION AND MONITORING

- Findings At-a-Glance First Evaluation Report
- BPCI Advanced First Evaluation Report
- BPCI Advanced First Evaluation Report Appendices

CMS may monitor model performance by:

- Claims data tracking
- Ad-hoc audits and analysis of performance measurements
- Site visits, surveys, and interviews with Participants, EIs, Participating Practitioners, and other parties



First Annual Evaluation Report (June 2020)

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

Key Findings:

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

REASONS FOR ENTRY

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

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

NEED MORE INFORMATION?

BPCI Advanced Portals

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

Need To find more Information about the Model?

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

Public information can be found on the **BPCI Advanced Website:** https://innovation.cms.gov/initiatives/bpci-advanced

Have a Question?

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