

Quick Links

| | |
|--|----------|
| CMS Policy Updates | 4 |
| 1. Episode Initiators included on multiple applications..... | 4 |
| 2. Total Knee Arthroplasty (TKA) procedures on an outpatient setting | 5 |
| 3. Providers in the State of Maryland are not allowed to participate in BPCI Advanced..... | 5 |
| 4. MS-DRGs Exclusions from the Clinical Episode List | 5 |
| 5. Mergers | 5 |
| 6. Reconciliation of Clinical Episodes..... | 6 |
| General | 6 |
| Q1: What happens to current Bundled Payment for Care Improvement (BPCI) Awardees? | 6 |
| Q2: Will current BPCI Awardees be able to extend their current Awardee Agreements past September 30, 2018?..... | 6 |
| Q3: Why isn't there a "Model 3" in BPCI Advanced? | 6 |
| Q4: Can an organization apply for only a handful of the Clinical Episodes, instead of the entire list of Clinical Episodes? Is it an all or nothing deal? | 6 |
| Q5. Will there be quarterly opportunities to exit the Model?..... | 7 |
| Q6: Will there be any additional Clinical Episodes added to the Model?..... | 7 |
| Q7: Can Physician Group Practices (PGPs) not affiliated with a hospital apply? If so, can a small practice participate in the Model?..... | 7 |
| Q8: Can select physicians within a Physician Group Practice (PGP) choose to participate in BPCI Advanced as an Episode Initiator or do all the physicians in a PGP have to participate? | 7 |
| Q9: How much time will Applicants have between when they receive their historical performance data and when they have to sign the BPCI Advanced Model Participation Agreement? | 8 |
| Q10: Which service locations will be included for the three (3) outpatient Clinical Episodes? Will BPCI Advanced include Clinical Episodes that initiate in Outpatient Hospital Departments, freestanding Cardiac Catheterization Labs, and Ambulatory Surgical Centers (ASCs)?..... | 8 |
| Q11: Can Accountable Care Organizations (ACOs) participate in BPCI Advanced? | 8 |
| Q12: What is the difference between "Participants" and "Participating Practitioners"?..... | 8 |
| Q13: Why were Post-Acute Care providers not included on the list of eligible Non-Convener Participants?..... | 8 |
| Q14: Do Participants need have a set amount of money in reserve to participate in BPCI Advanced? | 8 |
| Q15: How many risk tracks are in BPCI Advanced? | 9 |

Q16: Given CMS recent policy change on Total Knee Arthroplasty (TKA) being removed as an Inpatient-Only procedure, is there any consideration to adding outpatient Major Joint Replacement of Lower Extremity (MJRLE) to the list of Clinical Episodes in BPCI Advanced? 9

Q17: Can organizations located in Puerto Rico apply for this model?..... 9

Q18: How many Model Years are in BPCI Advanced? Does Model Year 1 start and end in 2018 (Oct 1 – Dec 31, 2018) or does it extend through Dec 31, 2019?..... 9

Q19: Can you provide more guidance about Net Payment Reconciliation Amount (NPRA) Sharing?..... 9

Application Process..... 9

Q20: If I submit an Application, am I obligated to participate in the Model?..... 9

Q21: As a Convener Participant, can we submit an initial application with the required attachments (Participating Organizations, Physician Group Practice (PGP) List and Data Request and Attestation (DRA) form)) with a partial list of Episode Initiators, and then submit updated documents with additional Episode Initiators, before the March 12th deadline? 10

Q22: As a Convener Participant, can I add Episode Initiators to my application, after the March 12th deadline?..... 10

Q23: Can a hospital or Physician Group Practice (PGP) apply to participate in BPCI Advanced beginning in 2020, if the hospital or PGP did not apply for BPCI Advanced in 2018? 10

Q24: A hospital Non-Convener Applicant and a PGP Non-Convener Applicant include numerous overlapping physicians. Can both of these entities apply separately for BPCI Advanced despite this overlap?..... 10

Q25: When will I know if my application has been approved to participate in BPCI Advanced? 10

Q26: Can a Physician Group Practice (PGP) and a hospital with overlapping Medicare beneficiaries both apply as Non-Convener Participants or participate as Downstream Episode Initiators?..... 11

Q27: Do I need to list all my Net Payment Reconciliation Amount (NPRA) Sharing Partners on the application due on March 12, 2018?..... 11

Q28: Will CMS take a SNFs Star ratings into consideration when reviewing applications?..... 11

Pricing Methodology..... 11

Q29: When will the Model pricing methodology be available?..... 11

Q30: How are the Target Prices assigned (e.g., regional, national or a comparison of an organization’s own past performance)? 11

Q31: What is the baseline period?..... 12

Q32: When will Target Prices be set, and how will they change during the course of the Model?..... 12

Q33: How does the Physician Group Practice (PGPs) Target Price work with the hospital Target Price?12

Q34: In calculating the Net Payment Reconciliation Amount (NPRA) in BPCI Advanced, will the National Trend Factor be part of the calculation, as is the case in the BPCI initiative? 12

Q35: Is there any stop loss for individual cases? 12

Q36: In the Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode, will there be a separate Target Price for elective procedures and a Target Price for hip fractures? 13

Q37: What is the claims run-out period? 13

Q38: How will you create Target Prices for a Physician Group Practice (PGP) Episode Initiator that has a new or fairly recent Taxpayer Identification Number (TIN) or a very low volume of Clinical Episodes during the baseline period? 13

Q39: Will potential Applicants have access to Target Prices prior to submitting an application?..... 14

Q40: How will the advance payment work?..... 14

Q41: Are different Target Prices going to be assigned in Model Year 1 and Model Year 2? If 2019 is considered Model Year 2, can we expect a new set of Target Prices for January 2019? 14

Q42: Will Target Prices have a Hierarchical Condition Categories (HCCs) adjustment?..... 14

Q43: If a hospital was established at the end of the baseline period (ex: January 2016), and therefore has a low volume of Clinical Episodes during the baseline period, will CMS adjust the Target Price for this new and low volume hospital? 14

Q44: How will CMS measure historic Medicare Fee-For-Service expenditure efficiency in resource use during the baseline period and how will this be applied in calculating the Target Price?..... 14

Q45: To calculate an Acute Care Hospital (ACH’s) benchmark price, CMS will account for the hospital’s spending patterns relative to the ACH’s peer group over time. How is a peer group defined – by the region, the nation, Metropolitan Statistical Area (MSA), or number of beds?..... 15

Q46: On what basis will CMS attribute a Clinical Episode to an Episode Initiator? Which fields on the claim are key?..... 15

Q47: In an outpatient Clinical Episode, how will an Anchor Procedure be assigned to a HCPCS code when multiple triggering HCPCS codes are in the claim?..... 15

Q48: Critical Access Hospitals (CAHs) are excluded from participating in the Model. If a Sole Community Hospital (SCH) with a Rural Referral Center (RRC) designation owns a CAH that has a separate CMS Certification Number (CCN) - can the SCH participate in the Model or would that hospital be excluded as well?..... 15

Q49: Are Indirect Medical Education (IME) and Disproportionate Share (DSH) payments excluded from Target Prices and Reconciliation calculations? Is capital from inpatient hospital claims also excluded?..... 15

Data 16

Q50: What claims data may Applicants request from CMS? 16

Q51: When a valid Data Request and Attestation (DRA) form is submitted to CMS, will Applicants receive historical data for all potential Clinical Episodes for those Episode Initiators listed in the Applicant’s attachment? 16

Q52: Will monthly claims data still be offered to Participants? If so, how will it be provided?..... 16

Q53: Will CMS allow Business Associates operating under HIPAA Business Associate Agreements (BAAs) with Applicants to directly access the BPCI Advanced data portal? Once an Applicant becomes a

Participant, will CMS allow Business Associates operating under BAAs with Participants to directly access the BPCI Advanced data portal?..... 16

Q54: Are potential Downstream Episode Initiators guaranteed access to their own data if they are under a Convener Participant?..... 17

Q55: What is considered sufficient volume to receive Clinical Episode data? 17

Models Overlap..... 17

Q56: In a Comprehensive Care for Joint Replacement (CJR) market, who gets precedence - the CJR Hospital or the Physician Group Practice (PGP) that is participating in BPCI Advanced? 17

Q57: In BPCI Advanced, will the Accountable Care Organizations (ACOs) in Medicare Shared Savings Programs Track 1, Track 1+, and Track 2 be able to participate? 18

Q58: If a Medicare Beneficiary is aligned to a Next Generation ACO (NGACO), and the Beneficiary qualifies for one of the BCPI Advanced Clinical Episodes, where are the savings accrued? Does the NGACO get the savings, or does the BCPI Advanced Participant get the savings?..... 18

Quality Measures 18

Q59: Can you please share the Composite Quality Score (CQS) calculation and scoring methodology?..... 18

Q60: What is the impact of quality measures on the Reconciliation results? 18

Q61: How will Participants have to submit data for the quality measures?..... 18

Q62: Will the quality measures reduce the CMS Discount percentage from 3% to 2%? 19

Q63: Will data on the quality measures be provided to organizations during the application process? 19

Learning System..... 19

Q64: Will any training material be made available to the public before May 2018, other than the January 30th Open Forum? 19

Q65: Will CMS be providing a formal mechanism through which "external learning communities" can contribute best practices or other resources relevant to BPCI Advanced Clinical Episodes?..... 19

CMS Policy Updates

1. Episode Initiators included on multiple applications

CMS will allow potential Episode Initiators (i.e., Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs) that wish to participate in BPCI Advanced as either a Participant or a Downstream Episode Initiator) to appear in multiple applications that are submitted by the application deadline of March 12, 2018. However, Episode Initiators may only participate with either a Convener Participant or as a Non-Convener Participant.

The Participant Profile that each Applicant will receive from CMS, will include all the potential Episode Initiators that were listed in the application. In that document, the Convener Participant will identify its

Downstream Episode Initiators and their specific Clinical Episode selections for Model Years 1 and 2; a Non-Convener Participant will identify its own Clinical Episode selections for Model Years 1 and 2.

Therefore, Episode Initiators that are listed in multiple applications must ensure that, when the Participant Profiles are submitted to CMS by August 1, 2018, **the Episode Initiator appears in only ONE Participant Profile with a status of “Begin BPCI Advanced”**. Otherwise, that Episode Initiator will be rejected and not be eligible to participate in the Model effective October 1, 2018. The organization can apply again during the next application opportunity, which will be for Model Year 3 beginning in January 2020.

2. Total Knee Arthroplasty (TKA) procedures on an outpatient setting

CMS is aware that some total knee replacement procedures are shifting to the outpatient setting given that the procedure is no longer included on the CMS Inpatient-Only list effective January 1, 2018.

CMS acknowledges that this policy change could affect Target Prices for the inpatient Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode and is currently working on finalizing the details to account for this change in pricing and will communicate the policy as soon as feasible.

3. Providers in the State of Maryland are not allowed to participate in BPCI Advanced

CMS had previously stated that hospitals in Maryland could not participate in BPCI Advanced. Because Maryland is participating in a separate Center for Medicare and Medicaid Innovation Center Model, the Maryland All-Payer Model, Maryland hospitals are excluded from bundled payment initiatives, including BPCI Advanced. We are now clarifying that Physician Group Practices (PGPs) that ONLY practice in Maryland are also not eligible to participate in the BPCI Advanced Model.

If the PGP practices in Maryland, as well as another state and/or the District of Columbia, then they are eligible to participate in the BPCI Advanced Model.

4. MS-DRGs Exclusions from the Clinical Episode List

CMS is revising the MS-DRGs Exclusions List that was initially posted on the BPCI Advanced website to add more MS-DRGs associated with neoplasm/malignancy or trauma. The revised BPCI Advanced Exclusions List will be posted on the BPCI Advanced website very soon.

5. Mergers

If two or more participating Physician Group Practices (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 (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 (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 will no longer trigger Clinical Episodes as of the effective date of the merger.

6. Reconciliation of Clinical Episodes

CMS would like to correct the statement in the Fact Sheet and the “Model Overview” webcast that says: “Clinical Episodes will be reconciled based on the Performance Period in which they are triggered, which is determined by the start of the Anchor Stay or Anchor Procedure.”

The correct Policy is –

Clinical Episodes will be reconciled based on the last day of the 90-day post-discharge period.

In a given Model Year, there will be two (2) Performance Periods for Reconciliation. Performance Period #1 will cover Clinical Episodes that end during the period of January 1 – June 30. Performance Period #2 will cover Clinical Episodes that end during the period of July 1- December 31. The exception is Model Year 1, which extends from 10/1/18 – 12/31/18. Clinical Episodes that end during Model Year 1 will be reconciled along with the Clinical Episodes from the first 6 months of 2019.

General

Q1: What happens to current Bundled Payment for Care Improvement (BPCI) Awardees?

A1: Bundled Payment for Care Improvement (BPCI), the initiative that started in 2013, will end its Period of Performance on September 30, 2018. BPCI Awardees are still bound by the terms of the Awardee Agreement in accordance with the terms therein.

Q2: Will current BPCI Awardees be able to extend their current Awardee Agreements past September 30, 2018?

A2: BPCI Advanced is a new model. Current Awardees in the BPCI initiative are eligible to apply to participate in BPCI Advanced. Like other applicants, BPCI Awardees must apply, be selected by CMS, and then enter into a Participation Agreement with CMS before they may participate in BPCI Advanced. Organizations have the option to participate in BPCI Advanced as either a Convener Participant or a Non-Convener Participant, provided that they satisfy the applicable eligibility criteria.

Q3: Why isn't there a “Model 3” in BPCI Advanced?

A3: BPCI Advanced was designed using the lessons learned and successes of the BPCI initiative while also incorporating new features - providing prospective Target Prices, adding a risk adjustment component, and having the model satisfy the criteria to be an Advanced Alternative Payment Model (Advanced APM). The model pricing was also designed to recognize rather than penalize historical efficiency achievements, including those of current BPCI Awardees. Incorporating all of this into a pricing approach that had Post-Acute Care providers as Episode Initiators (as is the case with Model 3 under BPCI) proved too challenging. Therefore, BPCI Advanced does not include a component that is analogous to Model 3 in the BPCI initiative.

Q4: Can an organization apply for only a handful of the Clinical Episodes, instead of the entire list of Clinical Episodes? Is it an all or nothing deal?

A4: When submitting an application, the Applicant will not be selecting Clinical Episodes. The Clinical Episode selection will occur when Participant Profiles are submitted on August 1, 2018. A Participant

Profile is the deliverable where Convener Participants identify the list of the Convener Participant's Downstream Episode Initiators, and where all Participants identify the Clinical Episodes for which the Participant commits to be held accountable under BPCI Advanced. At the time of the Participant Profile submission, Participants must commit to be held accountable for one or more Clinical Episodes.

It is up to the Participant to determine how many and which Clinical Episodes they wish to be held accountable for under BPCI Advanced. It is important to note, you will be able to choose Clinical Episodes for each Episode Initiator separately. For example, if you want one Episode Initiator to participate in sepsis, but not any of your other Episode Initiators, you can elect to do that.

Q5: Will there be quarterly opportunities to exit the Model?

A5: BPCI Advanced is a voluntary model. Therefore, Convener Participants and Non-Convener Participants may terminate their participation in the Model at any time, with no penalty, in accordance with the terms of the BPCI Advanced Model Participation Agreement. Should a Convener Participant wish to withdraw a Downstream Episode Initiator from the Model, they will have the opportunity to withdraw Downstream Episode Initiators effective January 2020 and during other specified times in future Model Years.

However, this does not preclude Downstream Episode Initiators from ending their arrangements with a Convener Participant, as that would be outlined in the agreement between the Convener Participant and the Downstream Episode Initiator. However, if a Convener Participant allows a Downstream Episode Initiator to terminate its agreement with the Convener Participant prior to January 2020 or the other specified times in future Model Years, the Convener Participant will remain at risk for Clinical Episodes initiated by that Downstream Episode Initiator until the Participant Profile is updated, regardless of when the Episode Initiator terminated its agreement with that Convener Participant.

Q6: Will there be any additional Clinical Episodes added to the Model?

A6: CMS may add additional Clinical Episodes to BPCI Advanced, or revise certain existing Clinical Episodes, beginning for Model Year 3, which begins January 1, 2020, and potentially for each Model Year thereafter.

Q7: Can Physician Group Practices (PGPs) not affiliated with a hospital apply? If so, can a small practice participate in the Model?

A7: Yes, Physician Group Practices (PGPs) not affiliated with a hospital can apply to participate in BPCI Advanced as Non-Convener Participants or as Convener Participants. Also, small practices can apply as there is no restriction on practice size.

Q8: Can select physicians within a Physician Group Practice (PGP) choose to participate in BPCI Advanced as an Episode Initiator or do all the physicians in a PGP have to participate?

A8: To the extent a PGP participates in BPCI Advanced as an Episode Initiator, all physicians who have reassigned his or her rights to receive Medicare payment to the PGP's TIN will participate, meaning that any such physicians may trigger Clinical Episodes under BPCI Advanced.

Q9: How much time will Applicants have between when they receive their historical performance data and when they have to sign the BPCI Advanced Model Participation Agreement?

A9: CMS plans to make the historical data and the Target Prices available in May 2018 and Participation Agreements send out to Applicants in June 2018 for their review.

The signed Participation Agreements will be due to CMS by August 1, 2018, giving organizations a few months to review their data before they have to commit to participating in the Model.

Q10: Which service locations will be included for the three (3) outpatient Clinical Episodes? Will BPCI Advanced include Clinical Episodes that initiate in Outpatient Hospital Departments, freestanding Cardiac Catheterization Labs, and Ambulatory Surgical Centers (ASCs)?

A10: Anchor Procedures will initiate an outpatient Clinical Episode when it occurs in an Outpatient Hospital Department, which are paid under the Outpatient Prospective Payment System (OPPS). Other outpatient settings, such as Ambulatory Surgical Centers (ASCs) and freestanding Cardiac Catheterization Labs, are not eligible to initiate Clinical Episodes...

Q11: Can Accountable Care Organizations (ACOs) participate in BPCI Advanced?

A11: Yes, Accountable Care Organizations (ACOs) can participate in BPCI Advanced as a Convener Participant. However, Medicare expenditures for beneficiaries aligned or assigned to an ACO participating in the Next Generation ACO Model, Track 3 of the Medicare Shared Savings Program (MSSP), and Comprehensive End Stage Renal Disease Care (CEC) Initiative will be excluded from Reconciliation calculations under BPCI Advanced.

Q12: What is the difference between “Participants” and “Participating Practitioners”?

A12: “Participants”, either Convener Participants or Non-Convener Participants, are the risk-bearing entity 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 require the Participating Practitioners to comply with the applicable requirements of the BPCI Advanced Model Participation Agreement.

Q13: Why were Post-Acute Care providers not included on the list of eligible Non-Convener Participants?

A13: For BPCI Advanced, Non-Convener Participants must be an Episode Initiator and bear full risk on behalf of itself. To be an Episode Initiator under BPCI Advanced, the Participant must be able to initiate a Clinical Episode. Clinical Episodes in BPCI Advanced are initiated on the first day of an Anchor Stay (for inpatient Clinical Episodes) or an Anchor Procedure (for outpatient Clinical Episodes). Since Post-Acute Care providers cannot submit a claim for an Anchor Stay or Anchor Procedure, as those terms are defined for purposes of BPCI Advanced, they are precluded from being a Non-Convener Participant in BPCI Advanced.

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

A14: Yes, Convener Participants that do not wholly own all of their Downstream Episode Initiators and any Participant that is itself a Physician Group Practice, will need to establish and maintain a Secondary

Repayment Source (SRS). The calculations for the SRS will be released as part of the BPCI Advanced Model Participation Agreement.

Q15: How many risk tracks are in BPCI Advanced?

A15: There is only one risk track. Individual Clinical Episodes will have spending capped at the 1st and 99th percentile of total standardized allowed amounts within the Clinical Episode.

Q16: Given CMS recent policy change on Total Knee Arthroplasty (TKA) being removed as an Inpatient-Only procedure, is there any consideration to adding outpatient Major Joint Replacement of Lower Extremity (MJRLE) to the list of Clinical Episodes in BPCI Advanced?

A16: Currently, there are no plans to add an outpatient Clinical Episode for Major Joint Replacement of the Lower Extremity (MJRLE) in BPCI Advanced. CMS is still considering how to address the effects of Total Knee Arthroplasty (TKA) being removed as an Inpatient-Only procedure through potential updates to the pricing methodology.

Q17: Can organizations located in Puerto Rico apply for this model?

A17: Yes, organizations located in all the territories of the USA, the District of Columbia and all the states are eligible to apply, provided that they satisfy the applicable eligibility criteria.

Q18: How many Model Years are in BPCI Advanced? Does Model Year 1 start and end in 2018 (Oct 1- Dec 31, 2018) or does it extend through Dec 31, 2019?

A18: A Model Year is defined as a full or partial calendar year during which Clinical Episodes may initiate. BPCI Advanced will have 6 Model Years, with the 4th quarter of 2018 counting as Model Year 1, and 2019 being Model Year 2, 2020 being Model Year 3 and so forth; 2023 is the last Model Year.

Q19: Can you provide more guidance about Net Payment Reconciliation Amount (NPRA) Sharing?

A19: CMS is requesting Fraud and Abuse Waivers for BPCI Advanced. If issued, we intend the waivers to be effective at the start of the Model Performance Period on October 1, 2018 and it would allow Participants in BPCI Advanced to engage in NPRA Sharing with partners.

Application Process

Q20: If I submit an Application, am I obligated to participate in the Model?

A20: No. Application submission does not obligate your organization to participate in BPCI Advanced. Likewise, submission of a complete application does not guarantee applicants will be selected by CMS for participation. A signed and executed BPCI Advanced Model Participation Agreement with CMS is required to participate in the Model. CMS will not execute Agreements until Applications have been reviewed and Applicants have successfully passed a provider vetting by the CMS Center for Program Integrity (CPI) and completed a law enforcement screening process.

Q21: As a Convener Participant, can we submit an initial application with the required attachments (Participating Organizations, Physician Group Practice (PGP) List and Data Request and Attestation (DRA) form) with a partial list of Episode Initiators, and then submit updated documents with additional Episode Initiators, before the March 12th deadline?

A21: Once an application and the required application attachments are submitted, revisions will not be allowed. Therefore, it is recommended that Applicants who have not finalized contractual terms with potential Episode Initiators wait to submit their application closer to the submission deadline. Please be mindful that the deadline is March 12th at 11:59 pm ET, and we will not accept applications for model participation beginning on October 1, 2018 after this date. Additionally, all applications must be submitted via the application portal (<https://app1.innovation.cms.gov/bpciadvancedapp>), and paper applications submitted via email or regular mail will not be considered.

Q22: As a Convener Participant, can I add Episode Initiators to my application, after the March 12th deadline?

A22: No, the names and details of all Downstream Episode Initiators that you want to participate effective October 1, 2018 must be submitted with the application and required attachments by 11:59 pm ET March 12, 2018. CMS will not allow a Convener Participant to add Downstream Episode Initiators until the next application opportunity for Model Year 3, which begins in January 2020.

Q23: Can a hospital or Physician Group Practice (PGP) apply to participate in BPCI Advanced beginning in 2020, if the hospital or PGP did not apply for BPCI Advanced in 2018?

A23: Yes, any organization – whether a Medicare-enrolled provider or a not Medicare-enrolled provider, can apply to participate in BPCI Advanced in 2020, even if they do not apply to participate in BPCI Advanced in 2018. CMS wants to encourage organizations to apply during this first enrollment period. However, we understand that some organizations may require more time to prepare and set-up the infrastructure for BPCI Advanced participation, which is why we are offering the second enrollment period in 2020.

Q24: A hospital Non-Convener Applicant and a PGP Non-Convener Applicant include numerous overlapping physicians. Can both of these entities apply separately for BPCI Advanced despite this overlap?

A24: In answering this question we first need to clarify roles. A Non-Convener Participant has no Downstream Episode Initiators, and is the Episode Initiator itself. An Episode Initiator is a Medicare provider that can initiate a Clinical Episode under BPCI Advanced. Therefore, the “overlapping physicians” are not Episode Initiators themselves, and their names overlapping on the submitted Physician Group Practice (PGP) Lists is not a problem. Physicians are allowed to furnish services at multiple locations that are participating in BPCI Advanced.

What is not allowed is for the same organization to simultaneously be an Episode Initiator under multiple Convener Participants, or to simultaneously be an Episode Initiator under a Convener Participant and itself be a Convener Participant or Non-Convener Participant.

Q25: When will I know if my application has been approved to participate in BPCI Advanced?

A25: Receipt of Target Prices in May and receipt of the BPCI Advanced Model Participation Agreement in June does NOT mean that your application has been approved. Only after the Applicant has been selected

by CMS, passed the provider vetting process and law enforcement screenings successfully, and CMS executes the Participation Agreement signed by the organization will an organization be considered a Participant in the BPCI Advanced Model.

Q26: Can a Physician Group Practice (PGP) and a hospital with overlapping Medicare beneficiaries both apply as Non-Convener Participants or participate as Downstream Episode Initiators?

A26: Yes, Physician Group Practices (PGPs) and hospitals that share or have overlapping Medicare beneficiaries can apply as Non-Convener Participants who would bear risk and initiate Clinical Episodes themselves. Additionally, both entities could be listed as Downstream Episode Initiators on a Convener Participant's application, even if they have overlapping Medicare beneficiaries.

Q27: Do I need to list all my Net Payment Reconciliation Amount (NPRA) Sharing Partners on the application due on March 12, 2018?

A27: Applicants do not need to list out all potential NPRA Sharing Partners on their application, as that level of detail is not required at this time. However, please provide a high-level summary that identifies whom those potential NPRA Sharing Partners may be (i.e. Physicians, Skilled Nursing Facilities, Home Health Agencies, etc.). The detailed list of organizations and/or individuals will be part of the deliverables that Participants will have to submit before engaging in Financial Arrangements under the Model.

Q28: Will CMS take a SNFs Star ratings into consideration when reviewing applications?

A28: When reviewing applications for BPCI Advanced, CMS will not take a SNFs Star ratings into consideration.

Pricing Methodology

Q29: When will the Model pricing methodology be available?

A29: CMS released the Target Price specifications on 2/9/18. The specifications are available at: <https://innovation.cms.gov/Files/x/bpciadvanced-targetprice-my1-2.pdf>.

Q30: How are the Target Prices assigned (e.g., regional, national or a comparison of an organization's own past performance)?

A30: Target Prices for hospitals are constructed to account for multiple aspects of the Clinical Episode:

1. The hospital's own past performance
2. The characteristics of patients treated during the Clinical Episodes, and
3. The hospital's peer group characteristics

CMS accounts for each component through a series of regression models for each Clinical Episode category based upon a national dataset of Clinical Episodes constructed that were initiated during the baseline period and priced using the official CMS standardized spending amounts.

The patient characteristics that are adjusted for, include demographic data, the patient's comorbidities using the Hierarchical Condition Categories (HCCs), severity based upon MS-DRGs for the inpatient

Clinical Episodes, and Ambulatory Payment Classifications (APCs) for outpatient Clinical Episodes, and other variables that will be described in the pricing specifications.

The peer group characteristics that we adjust for using the Peer Adjusted Trend Factor (PAT factor) include US Census region, urban versus rural status, hospital size, and others.

Detailed specifications, including information on the risk adjustment models and the covariates included in them, are available at <https://innovation.cms.gov/Files/x/bpciadvanced-targetprice-my1-2.pdf>.

Q31: What is the baseline period?

A31: The first baseline period will contain data from potential Clinical Episodes that would have been attributed from January 1, 2013 through December 31, 2016.

Q32: When will Target Prices be set, and how will they change during the course of the Model?

A32: Preliminary Target Prices will be set and provided prospectively before the start of each Model Year. They will be rebased annually, beginning with Model Year 3 on January 1, 2020. However, when CMS makes changes to the payment rates paid under Medicare FFS, CMS will update the Target Price to account for the changes, but will not rebase episodes entirely.

Q33: How does the Physician Group Practice (PGPs) Target Price work with the hospital Target Price?

A33: Physician Group Practices (PGPs) will receive Target Prices that are hospital-specific. In other words, a PGP will receive unique Target Prices for each Clinical Episode based on the hospital at where the Anchor Stay or Anchor Procedure occurs. From this base hospital price, we first remove the effects of the hospital-wide patient case mix adjuster and replace it with the patient case mix adjuster specific to the PGP's Clinical Episodes initiated by an Anchor Stay or Anchor Procedure at the hospital. In addition, the hospital base price will be adjusted based on the PGP's overall historical spending efficiency relative to the hospital's historical spending efficiency, both of which are standardized based on the patient characteristics previously described. In other words, the hospital base price is adjusted to account for the relative case mix and the relative standardized historical efficiency.

Additionally, we will update Target Prices when new CMS payment changes are finalized and CMS determines that they are material to BPCI Advanced, similar to how it is done in the Comprehensive Care for Joint Replacement (CJR) Model.

Q34: In calculating the Net Payment Reconciliation Amount (NPRA) in BPCI Advanced, will the National Trend Factor be part of the calculation, as is the case in the BPCI initiative?

A34: No, the National Trend Factor will be replaced by the Peer Adjusted Trend Factor (PAT Factor). This is a new prospective adjustment to Target Prices that is unrelated to the BPCI National Trend Factor conceptually. The PAT Factor adjusts the Target Price forward from the baseline period to the Performance Period, which varies based upon a set of peer group characteristics, including Census regions, hospital size, and others, and how each of these vary across time.

Q35: Is there any stop loss for individual cases?

A35: The 20% stop-loss and stop-gain policies are applied at the level of the Episode Initiator. This differs from the BPCI initiative, which sets stop loss and stop gain at the Awardee level. In other words, under BPCI Advanced, the results of all the Clinical Episodes during the Performance Period are aggregated to

the Episode Initiator prior to applying the stop-loss or stop-gain cap. At the individual Clinical Episode level, the Clinical Episodes for which the Participant has committed to be accountable are Winsorized, or capped, at the 1st and 99th percentiles of the total standardized allowable amounts within the Clinical Episode based on the national dataset of Clinical Episodes.

Q36: In the Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode, will there be a separate Target Price for elective procedures and a Target Price for hip fractures?

A36: In BPCI Advanced, one preliminary Target Price will be provided for all Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episodes, but this price will incorporate the proportion of fracture vs. non-fracture Clinical Episodes that occurred during the baseline period. We will then account for the varying costs of fracture vs. non-fracture Clinical Episodes in the case mix adjustment that will be applied at Reconciliation for those Clinical Episodes.

If the proportion of fracture cases increases during the performance period, then the case mix adjustment would increase and could potentially raise the final Target Price at reconciliation. CMS will not split out the Target Prices by fracture or elective procedures, but will be accounting for the cost differences as part of the Target Price calculation methodology.

Q37: What is the claims run-out period?

A37: BPCI Advanced will have a semi-annual Reconciliation cycle for the immediately preceding Performance Period. The initial Reconciliation for each Performance Period will be performed using two months of claims run out.

In a given Model Year, there will be two (2) Performance Periods for Reconciliation. Performance Period #1 will cover Clinical Episodes that end during the period of January 1 – June 30. Performance Period #2 will cover Clinical Episodes that end during the period of July 1- December 31. The exception is Model Year 1, which extends from 10/1/18 – 12/31/18. Clinical Episodes that end during Model Year 1 will be reconciled along with the Clinical Episodes from the first 6 months of 2019.

Additionally, each Performance Period will be subject to at least two (2) true-ups with additional claims run out.

As a result of the first two true-ups, Clinical Episodes will have about 1 - 1.5 years of claims run out at their final Reconciliation, depending on when they ended during a Performance Period.

Q38: How will you create Target Prices for a Physician Group Practice (PGP) Episode Initiator that has a new or fairly recent Taxpayer Identification Number (TIN) or a very low volume of Clinical Episodes during the baseline period?

A38: CMS will calculate Target Prices for Episode Initiators that are Physician Group Practices (PGPs) Target Prices beginning with a hospital-specific Target Price and then incorporate a PGP offset. If a PGP has a new or fairly recent TIN for which CMS does not have enough data to calculate a PGP offset, then the PGP's preliminary and final Target Prices will be based on the hospital's data where the Anchor Stay or Anchor Procedure occurred.

Q39: Will potential Applicants have access to Target Prices prior to submitting an application?

A39: Potential Applicants will not have access to Target Prices prior to the deadline for submitting an application – March 12, 2018. Target Prices cannot be created or distributed without the details of the potential Episode Initiators included on the BPCI Advanced application, or the submission of a Data Request and Attestation (DRA) form. Preliminary Target Prices will be provided to Applicants in May 2018.

Q40: How will the advance payment work?

A40: There is no advanced payment in BPCI Advanced. This is a retrospective bundled payment model. Preliminary Target Prices for each Clinical Episode will be set and provided to Participants prospectively. However, providers and suppliers will continue to bill Medicare for Medicare-covered items and services furnished as part of a Clinical Episode under the applicable Medicare Fee-For-Service payment system, and at the end of the Clinical Episode, Medicare Fee-For-Service expenditures on non-excluded items and services are netted and reconciled against the Final Target Price to determine whether the Participant has earned a Net Payment Reconciliation Amount payment from CMS, or owes CMS a Repayment Amount.

Q41: Are different Target Prices going to be assigned in Model Year 1 and Model Year 2?**If 2019 is considered Model Year 2, can we expect a new set of Target Prices for January 2019?**

A41: The initial Preliminary Target Prices will cover both Model Year 1 (10/1/18-12/31/18) and Model Year 2 (1/1/19-12/31/19), and we will rebase and provide new Preliminary Target Prices beginning for Model Year 3 (1/1/20-12/31/20). When CMS makes changes to the payment rates paid under Medicare FFS, CMS will update the preliminary Target Prices provided for Model Years 1 and 2 to account for the changes, but will not rebase these preliminary Target Prices entirely until Model Year 3.

Q42: Will Target Prices have a Hierarchical Condition Categories (HCCs) adjustment?

A42: CMS incorporates the Hierarchical Condition Categories (HCCs) as part of the Target Price calculation, specifically in the Patient Case Mix Adjustment. They are represented in three different ways: the individual HCCs, relevant combinations of HCCs, and the HCC count (1-3, 4-6, and more than 7) used to determine beneficiary complexity.

Q43: If a hospital was established at the end of the baseline period (ex: January 2016), and therefore has a low volume of Clinical Episodes during the baseline period, will CMS adjust the Target Price for this new and low volume hospital?

A43: Information on the low volume threshold for hospitals is included in the Target Price Specifications document available at <https://innovation.cms.gov/Files/x/bpciadvanced-targetprice-my1-2.pdf>.

Q44: How will CMS measure historic Medicare Fee-For-Service expenditure efficiency in resource use during the baseline period and how will this be applied in calculating the Target Price?

A44: Efficiency refers to Clinical Episode spending, relative to other Episode Initiators, for Clinical Episodes with the same patient and peer group characteristics. A value less than one indicates that a hospital's baseline period Clinical Episode spending was lower than the average hospital, controlling for patient and peer group influences on spending. In other words, the hospitals with lower efficiency measure values have historically treated the same Clinical Episode with lower spending than hospitals with higher efficiency measure values. Historical efficiency is incorporated into the Target Price by including historical

expenditures as a base amount, to which the patient and peer group adjusters modify to appropriately account for the specifics of the episode.

Q45: To calculate an Acute Care Hospital (ACH's) benchmark price, CMS will account for the hospital's spending patterns relative to the ACH's peer group over time. How is a peer group defined - by the region, the nation, Metropolitan Statistical Area (MSA), or number of beds?

A45: Peer groups are based on relevant hospital's characteristics, such as region, size, teaching status, safety net status, urban versus rural status, and interactions between these characteristics and time.

Q46: On what basis will CMS attribute a Clinical Episode to an Episode Initiator? Which fields on the claim are key?

A46: When determining Clinical Episodes attribution to Episodes Initiators, CMS will first look to the Attending National Provider Identification (NPI) number listed on the institutional claim (UB-04), which will subsequently lead to a check for the Attending NPI's Part B claim during the Anchor Stay or Anchor Procedure for a participating Taxpayer Identification Number (TIN). If the Physician Group Practice (PGPs) TIN is listed as participating in BPCI Advanced, the Clinical Episode is attributed to that PGP. If that TIN is not a BPCI Advanced Episode Initiator, we then start over again by looking at the institutional claim to conduct the same check for the Operating NPI-TIN. If neither NPIs yield a Part B claim billed under a participating TIN, we then check for whether the hospital CCN on the claim is a BPCI Advanced Episode Initiator.

Q47: In an outpatient Clinical Episode, how will an Anchor Procedure be assigned to a HCPCS code when multiple triggering HCPCS codes are in the claim?

A47: The first day of an Anchor Procedure initiates a Clinical Episode. HCPCS codes identify the claim as an Anchor Procedure for CMS. The Anchor Procedure will be assigned based on the Comprehensive Ambulatory Payment Classification (C-APC). This is analogous to the MS-DRG grouping that determines payment from the inpatient claim for an Anchor Stay.

Q48: Critical Access Hospitals (CAHs) are excluded from participating in the Model. If a Sole Community Hospital (SCH) with a Rural Referral Center (RRC) designation owns a CAH that has a separate CMS Certification Number (CCN) - can the SCH participate in the Model or would that hospital be excluded as well?

A48: The Sole Community Hospital would be able to participate in BPCI Advanced. Each hospital with a separate CMS Certification Number (CCN) is considered separately.

Q49: Are Indirect Medical Education (IME) and Disproportionate Share (DSH) payments excluded from Target Prices and Reconciliation calculations? Is capital from inpatient hospital claims also excluded?

A49: Clinical Episode-level payments are created by summing official CMS standardized payments for all non-excluded services, subject to certain exclusions. These standardized payments reflect the cost of services after removing variation in spending arising from geographical adjustment of reimbursement in CMS payment systems (e.g., hospital wage index and GPCI) and from policy-driven adjustments (e.g., indirect medical education (IME) adjustments). For more information on the official CMS standardization methodology, please visit:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350>

Data

Q50: What claims data may Applicants request from CMS?

A50: Applicants will have the choice to request aggregate historical and/or raw historical claims data. Both of these data sets will include claims from the final 3 years of the initial 4-year Baseline Period, related to all 32 Clinical Episodes offered under the BPCI Advanced Model. Line level data will incorporate the following: Inpatient, Outpatient, Carrier (Part B), Durable Medical Equipment (DME), Post-Acute Care (Skilled Nursing Facility, Home Health Agency, & Inpatient Rehab Facility), Hospice, and Diagnosis/Procedure Code Research Identifiable Files (RIF). The data will be provided through a secure portal through the CMS Enterprise data portal.

Q51: When a valid Data Request and Attestation (DRA) form is submitted to CMS, will Applicants receive historical data for all potential Clinical Episodes for those Episode Initiators listed in the Applicant's attachment?

A51: Yes, CMS will provide Applicants the requested data and Preliminary Target Prices for all 32 Clinical Episodes for the listed Episode Initiators that have sufficient volume in the baseline period.

Q52: Will monthly claims data still be offered to Participants? If so, how will it be provided?

A52: Yes, Applicants that are selected to become Participants will have the opportunity to request monthly claims data in raw and/or summary formats by completing a Participant Data Request and Attestation (DRA) form. The data will be provided through a secure portal through the CMS Enterprise data portal.

Q53: Will CMS allow Business Associates operating under HIPAA Business Associate Agreements (BAAs) with Applicants to directly access the BPCI Advanced data portal? Once an Applicant becomes a Participant, will CMS allow Business Associates operating under BAAs with Participants to directly access the BPCI Advanced data portal?

A53: Applicants will need to fill out a valid Data Request and Attestation (DRA) form in order to receive the data used by CMS to calculate the preliminary Target Prices and/or historical Medicare claims data. As a Data Requestor, the Applicant will identify two Primary Points of Contact (PPOCs) for their organization and these PPOCs will be able to directly access the CMS Enterprise data portal. Access is granted after an account is created in the Enterprise Identity Management (EIDM) portal and the individual successfully pass the authenticity check. Business Associates could also have access if they are authorized Data Users. 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.*

The same rules and processes will apply to organizations that become Participants in BPCI Advanced.

Q54: Are potential Downstream Episode Initiators guaranteed access to their own data if they are under a Convener Participant?

A54: No, data and Target Prices will be provided by CMS to the Applicant (either a potential Non-Convener Participant or a potential Convener Participant) who has applied to participate in BPCI Advanced and for which CMS has received and accepted a Data Request and Attestation (DRA), not the potential Episode Initiator.

Q55: What is considered sufficient volume to receive Clinical Episode data?

A55: The minimum volume to participate in BPCI Advanced occurs at the level of the hospital for a specific Clinical Episode. In order for the hospital to receive a Target Price, the hospital must have at least 41 episode cases for a Clinical Episode type during the applicable baseline period from January 1, 2013 thru December 31, 2016. And since the Physician Group Practices (PGPs) receive prices based on a hospital-based price, PGPs will only receive Target Prices for hospitals with at least 41 Clinical Episodes in specific episode types in the hospital's baseline period.

Also, if PGP volume is less than 41 Clinical Episodes overall, the PGP will receive the preliminary hospital-based Target Price in lieu of a Target Price specific to the PGP that includes a PGP offset.

Additional information can be found in the Target Price Specifications Document available at <https://innovation.cms.gov/Files/x/bpciadvanced-targetprice-my1-2.pdf>.

Models Overlap

Q56: In a Comprehensive Care for Joint Replacement (CJR) market, who gets precedence - the CJR Hospital or the Physician Group Practice (PGP) that is participating in BPCI Advanced?

A56: The CJR Model consists of only one type of Clinical Episode –Lower Extremity Joint Replacement (LEJR). BPCI Advanced has 32 Clinical Episodes, one of which is Major Joint Replacement of the Lower Extremity (MJRLE). For practical purposes, LEJR and MJRLE are referring to the same type of Clinical Episode comprised by DRGs 469 & 470.

- A CJR participant Hospital in one of the 34 mandatory Metropolitan Statistical Areas (MSAs) will have precedence on the MJRLE Clinical Episode, over a Physician Group Practice (PGP) in BPCI Advanced; meaning that the Clinical Episode will be attributed to the CJR participant Hospital and not the PGP participating in BPCI Advanced.
- A CJR participant Hospital in a voluntary MSA that did not elect to “Opt In” by the deadline of January 31, 2018 is no longer a CJR participant Hospital, and therefore will not have precedence over a PGP in BPCI Advanced for the MJRLE Clinical Episode when BPCI Advanced commences on October 1, 2018.
- For all other 31 Clinical Episodes, PGPs participating in BPCI Advanced will have precedence over a CJR participant Hospital that is also participating in BPCI Advanced for those Clinical Episodes.
- Hospitals currently participating in the BPCI initiative that are located in a mandatory CJR MSA will become CJR participant hospitals as of October 1, 2018, once the BPCI initiative ends. They still have the option of applying to participate in BPCI Advanced for the other 31 Clinical Episodes.
- The Model’s overall precedence rules are –
 - Clinical Episodes will be attributed at the Episode Initiator level.

- The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators is:
 - (1) the Attending Physician Group Practice;
 - (2) the Operating Physician Group Practice; and
 - (3) The Hospital.
- There are no time-based precedence rules in BPCI Advanced. What this means is that Participants starting on October 2018 will not have precedence over those that might start in future Model Years.

Q57: In BPCI Advanced, will the Accountable Care Organizations (ACOs) in Medicare Shared Savings Programs Track 1, Track 1+, and Track 2 be able to participate?

A57: Beneficiaries assigned to ACOs participating in Track 1, Track 2, or the Track 1+ ACO Model will be able to trigger Clinical Episodes in BPCI Advanced. However, CMS will recoup a portion of the BPCI Advanced discount amount for any Medicare Fee-For-Service beneficiary who: 1) was assigned to a Medicare Shared Savings Program ACO in Track 1, Track 2, or the Track 1+ ACO Model that achieved shared savings, and 2) began a BPCI Advanced episode that was attributed to a BPCI Advanced Episode Initiator that participated in the ACO to which the beneficiary was assigned.

Q58: If a Medicare Beneficiary is aligned to a Next Generation ACO (NGACO), and the Beneficiary qualifies for one of the BCPI Advanced Clinical Episodes, where are the savings accrued? Does the NGACO get the savings, or does the BCPI Advanced Participant get the savings?

A58: The NGACO would get the savings because the total dollar amount of Medicare FFS expenditures for items and services included in a Clinical Episode would be excluded from BPCI Advanced Reconciliation Calculations.

Quality Measures

Q59: Can you please share the Composite Quality Score (CQS) calculation and scoring methodology?

A59: CMS will provide information regarding the Composite Quality Score (CQS) and CQS Adjustment Amount calculation methodology in future model specifications.

Q60: What is the impact of quality measures on the Reconciliation results?

A60: The Composite Quality Score (CQS) Adjustment Amount is applied at the Episode Initiator level to any Positive Total Reconciliation Amount or Negative Total Reconciliation Amount. The amount by which these reconciliation amounts may be adjusted is capped at 10%.

So essentially, at the Episode Initiator level, the CQS adjustment cannot make a Negative Total Reconciliation Amount more negative and cannot reduce a Positive Total Reconciliation Amount more than 10%.

Q61: How will Participants have to submit data for the quality measures?

A61: For Model Year 1 and Model Year 2, the quality measures are claims-based and the quality performance data will be pulled directly from administrative claims submitted to CMS. At this time,

Participants will not be required to submit quality data to CMS for purposes of BPCI Advanced. This may change in future Model Years if we introduce additional non-claims based measures.

Q62: Will the quality measures reduce the CMS Discount percentage from 3% to 2%?

A62: No, the CMS Discount remains 3% for all Clinical Episodes.

Q63: Will data on the quality measures be provided to organizations during the application process?

A63: No, quality measures data will not be provided as a part of the application process.

Learning System

Q64: Will any training material be made available to the public before May 2018, other than the January 30th Open Forum?

A64: Yes, right now we have 3 Webcasts, Fact Sheets, Frequently Asked Questions, and technical documents available on the BPCI Advanced website (<https://innovation.cms.gov/initiatives/bpci-advanced>). Additional webcasts, learning modules, onboarding support, and more Open Forums will be provided in the future.

Q65: Will CMS be providing a formal mechanism through which "external learning communities" can contribute best practices or other resources relevant to BPCI Advanced Clinical Episodes?

A65: BPCI Advanced Participants will be invited to join the learning community and the BPCI Advanced Connect site. We always look for opportunities to share learning and promising practices that may also be emerging from other learning communities.