General Frequently Asked Questions (FAQ)

Quick Links to Questions

Q1: What has the Centers for Medicare & Medicaid Services (CMS) announced?

A1: On April 24, 2019, CMS announced the application period for the second cohort in a voluntary episode payment Model called Bundled Payments for Care Improvement Advanced (BPCI Advanced). 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 October 1, 2018 and runs through December 31, 2023. Participants in the second cohort will start in Model Year 3, which begins on January 1, 2020.

Q2: How does BPCI Advanced support the goals of reducing Medicare expenditures and improving 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, CMS expects the Participant to bear financial risk and redesign 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 supports the development and testing of innovative health care payment and service delivery models throughout the country; therefore, participation is open to eligible organizations in all states, U.S. territories, and the District of Columbia. For Model Years 1 and 2, we had Medicare providers 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 multiple entities referred to as "Downstream Episode Initiators" (Downstream EIs)—which must be either Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs)—to participate in BPCI Advanced, facilitate coordination among them, and bear and apportion financial risks. Convener Participants enter into agreements with Episode Initiators (EIs), whereby EIs agree to participate in BPCI Advanced and comply with all applicable Model requirements. Eligible entities that are either Medicare-enrolled or not 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 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 a Non-Convener Participant.

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 ACH definition in BPCI Advanced excludes Prospective Payment System-exempt cancer hospitals, inpatient psychiatric facilities, critical access hospitals, hospitals in Maryland,

hospitals participating in the Rural Community Hospital Demonstration, and hospitals participating in the Pennsylvania Rural Health Model. Because of their unique payment methodologies, they may not participate in the Model in any capacity. Note that PGPs that only practice in Maryland are similarly not eligible to participate in BPCI Advanced. However, PGPs that practice in Maryland and another state or the District of Columbia are eligible to participate in the BPCI Advanced Model for care provided outside of Maryland.

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 Financial Arrangements List (FAL) as an organization with which the Participant has a financial 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 runs through December 31, 2023. BPCI Advanced defines a Model Year as a full or partial calendar year during which Participants may initiate Clinical Episodes. BPCI Advanced plans to have six Model Years, with the fourth quarter of 2018 counting as Model Year 1, 2019 being Model Year 2, 2020 being Model Year 3 and so forth; 2023 is the sixth and last Model Year.

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

A9: CMS defines BPCI Advanced by four main characteristics:

1. It has a single retrospective payment and risk track with a 90-day episode length
2. It has 33 inpatient Clinical Episodes and four outpatient Clinical Episodes
3. It qualifies as an Advanced Alternative Payment Model (Advanced APM)
4. It provides preliminary Target Prices for each Clinical Episode in advance of each Model Year

Q10: What Clinical Episodes are included in BPCI Advanced for Model Year 3?

A10: There are 37 total Clinical Episodes in Model Year 3 (33 Inpatient and four Outpatient).

Inpatient Clinical Episodes (33):

- Bariatric Surgery **(New for Model Year 3)**
- Inflammatory Bowel Disease **(New for Model Year 3)**
- Seizures **(New for Model Year 3)**
- Transcatheter Aortic Valve Replacement **(New for Model Year 3)**
- Disorders of the liver, excluding malignancy, cirrhosis, alcoholic hepatitis

- Acute myocardial infarction
- Back and neck, except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- Chronic obstructive pulmonary disease (COPD), bronchitis, asthma
- Combined anterior posterior spinal fusion
- Congestive heart failure
- Coronary artery bypass graft
- Double joint replacement of the lower extremity
- Fractures of the femur and hip or pelvis
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Hip and femur procedures, except major joint
- Lower extremity/humerus procedure, except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity (MJRLE)*****
- Major joint replacement of the upper extremity
- Pacemaker
- Percutaneous coronary intervention
- Renal failure
- Sepsis
- Simple pneumonia and respiratory infections
- Spinal fusion (non-cervical)
- Stroke
- Urinary tract infection

Outpatient Clinical Episodes (4):

- Major joint replacement of the lower extremity (MJRLE)*****
- Percutaneous Coronary Intervention
- Cardiac defibrillator
- Back and neck, except spinal fusion

*This is a multi-setting Clinical Episode category. Total Knee Arthroplasty (TKA) procedures can trigger episodes in both inpatient and outpatient settings.

Q11: How does CMS determine when a Clinical Episode is triggered?

A11: The submission of a claim for either an inpatient stay at an ACH (Anchor Stay) or an outpatient procedure at an ACH (Anchor Procedure) by an EI for an eligible BPCI Advanced Beneficiary triggers Clinical Episodes.

Q12: When does a Clinical Episode exclude a Medicare beneficiary?

A12: BPCI Advanced excludes the following types of Medicare beneficiaries:

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

Q13: What learning and technical assistance support is available to Applicants and Participants in BPCI Advanced?

A13: BPCI Advanced offers Applicants and 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 compliance 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.

Q14: Does BPCI Advanced exclude Post-Acute Care (PAC) providers from participating?

A14: BPCI Advanced does not exclude PAC providers from participating. They can apply to participate in BPCI Advanced as Convener Participants. Participants may also add PAC providers to the Financial Arrangements List (FAL) as an organization with which the Participant has a financial arrangement.

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

Q15: Does BPCI Advanced meet the Advanced APM criteria?

A15: Yes, BPCI Advanced meets the criteria to qualify as an Advanced APM. The first criterion is that a model must require participants to bear risk for monetary losses of more than a nominal amount under the Model. In BPCI Advanced, Participants are financially at risk for up to 20 percent of the final Target Price for each Clinical Episode they have selected to participate, which exceeds the minimum requirement (three percent) for the benchmark-based standard under the Quality Payment Program (QPP). Second, a model must require participants to use Certified Electronic Health Record Technology (CEHRT). 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 entity must use the CEHRT definition of certified health IT functions to participate in this initiative. Third, payments under the model must be linked to quality measures 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 EI to calculate an EI-specific Composite Quality Score.

Q16: How does the Model affect beneficiary cost sharing?

A16: 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.

Q17: Is BPCI Advanced offering Participants any Medicare Payment Policy Waivers?

A17: Separate from any Fraud and Abuse Waivers, CMS is providing BPCI Advanced Participants conditional waivers of certain Medicare payment rules. Participants might 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.

Q18: How does a Participant exit the Model?

A18: Since 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. If a Convener Participant wishes to withdraw a Downstream EI from BPCI Advanced, they can do so prior to the beginning of the next Model Year before Participants submit Participant Profiles, and at other times as specified by CMS. During Model Year 2 (2019), current Participants can withdraw EIs prior to the start of Model Year 3 (2020). After January 2020, the next opportunity for Convener Participants to withdraw EIs is prior to the start of Model Year 4 (2021).

This does not preclude Downstream EIs from ending their arrangements with a Convener Participant if 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 start of next Model Year, regardless of when the EI terminated its agreement with that Convener Participant.

Q19: Will the Model add any new Clinical Episodes?

A19: CMS may add Clinical Episodes to BPCI Advanced, or revise certain existing Clinical Episodes, beginning Model Year 3, which begins January 1, 2020, and potentially for each Model Year thereafter.

Q20: How much time do Applicants have between when they receive historical claims data and the deadline for submitting the signed BPCI Advanced Participation Agreement for Model Year 3?

A20: During the second application period, April 24, 2019 through June 24, 2019, CMS plans to distribute the historical claims data and the preliminary Target Prices available in late September 2019. Also in September 2019, CMS plans to make the BPCI Advanced Participation Agreement for Model Year 3 available for review by Applicants. The signed Model Year 3 Participation Agreements will be due to CMS in November 2019, giving organizations a few months to review their data before they commit to participating in the Model.

Q21: Which service locations do the four 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)?
A21: Anchor Procedures initiate an outpatient Clinical Episode when they occur in an outpatient hospital department, which are paid under the Outpatient Prospective Payment System. Other outpatient settings, such as ASCs and freestanding cardiac catheterization labs, are not eligible to initiate Clinical Episodes.

Q22: Do Participants need to have a set amount of money in reserve to participate in BPCI Advanced?
A22: Yes, a Convener Participant with a "Secondary Repayment Source (SRS) Covered Participant" designation needs to fund an escrow account or a letter of credit in an amount that CMS will calculate based on the Participant's Clinical Episode selections. Participants can find more details about SRS requirements and their calculation methodology in Article 7 and Appendixes B and C of the BPCI Advanced Participation Agreement.

Q23: How many risk tracks are in BPCI Advanced?
A23: 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.

Q24: Can CMS provide guidance about how Participants can engage in Net Payment Reconciliation Amount (NPRA) sharing?
A24: On May 25, 2018, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) and CMS jointly issued Fraud and Abuse Waivers for specified arrangements pursuant to BPCI Advanced. These waivers permit Participants in BPCI Advanced to engage in sharing NPRA when specified conditions are met. Additional information is available on the CMS website at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/BPCI-Advanced-Model-Waivers.pdf.

Q25: Where can I find the list of Medicare Severity Diagnosis Related Group (MS-DRGs) Exclusions List that applies to Clinical Episodes in the Model?
A25: The BPCI Advanced Exclusions List for Model Years 1 and 2 is available on the BPCI Advanced website at https://innovation.cms.gov/Files/x/bpciadvanced-msdrg-exclusions.xlsx. CMS will post the Exclusion List for Model Year 3 in the summer of 2019.

Q26: Can two or more PGPs that have merged continue to participate in the Model?
Q26: 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 (EI 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 (EI 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.

Q27: If a SNF changes ownership, such that its business and doing business as (dba) names also change, is the SNF still eligible to use the 3-Day SNF waiver?

A27: SNFs that change ownership and, as a result, also change their business names and dba names are still eligible to use the 3-Day SNF waiver, as long as they retain the CCN of a SNF that is currently on the SNF Waiver List posted quarterly on the BPCI Advanced website.

Q28: Will EIs have to treat every Medicare beneficiary that presents for the Clinical Episodes in which the EI selected to participate under BPCI Advanced?

A28: EIs do not have the option of excluding Medicare beneficiaries from the Clinical Episodes 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.

Q29: What kind of deliverables do Participants have to complete? When are they due and how frequently?

A29: There are four different types of deliverables that Participants must regularly submit to CMS, as applicable:

1. **Participant Profile (PP)**
    - Required annually, approximately 60 days before the start of the Model Year
    - This document indicates the Clinical Episodes to which the Non-Convener Participant commits under BPCI Advanced, or, for a Convener Participant, the list of Downstream EIs and their specific Clinical Episode selections
2. **Care Redesign Plan (CRP)**
    - Required annually, approximately 30 days before the start of the Model Year
    - This document describes the specific planned interventions and changes to the Participant's current health care delivery system
3. **Quality Payment Program (QPP) List**
    - Required quarterly, approximately 30 days before the start of the quarter
    - This document identifies the individuals that meet the requirements included in the quarterly report that the BPCI Advanced Model submits to the QPP for the Qualifying APM Participant (QP) determinations
    - For the Participant to include an individual on the Participation List tab of the QPP List, the individual must: (a) be a Participating Practitioner; and (b) have reassigned his or her rights to receive Medicare payments to the TIN of the Participant or to a Downstream EI

- For the Participant to include an individual on the Affiliated Practitioners 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 Arrangement List (FAL)**
    - Quarterly, if applicable, approximately 30 days before the start of the quarter
    - This document includes the list of organizations and/or individuals with whom the Participant intends to enter into a financial arrangement in BPCI Advanced as one of the following: an NPRA Sharing Partner, an NPRA Sharing Group Practice Practitioner, or a BPCI Advanced Entity

Q30: Must all PGPs under the same TIN choose the same Clinical Episodes?

A30: Yes, participation decisions, including Clinical Episode selection, are at the EI level. For PGPs, CMS groups the EI by the billed TIN on the claims, to identify the Clinical Episode. For ACHs, CMS uses the CCN on the institutional claim to identify the Clinical Episode.

Q31: If a PGP starts participation in Model Year 3 (January 1, 2020), and a hospital entered the same Clinical Episode in Model Year 1 (October 1, 2018), does the hospital retain the Clinical Episode or does the PGP get precedence?

A31: In BPCI Advanced, there are no time-based precedence rules. Assuming the PGP and the hospital are participating in the same Clinical Episode, and excluding overlap with other Innovation Center Models, the PGP takes precedence over the hospital.

Q32: Can a PGP EI providing services in multiple locations, including a hospital that is also an EI, participate in the Model under the same Convener?

A32: A PGP and an 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 which EI CMS attributes to the Clinical Episode.

Q33: How do the precedence rules and selection of Clinical Episodes differ in the baseline and Performance Period?

A33: In the Performance Period, only one Clinical Episode can occur at a given time for a beneficiary. For all ongoing Clinical Episodes (with the exception of Major Replacement of the Lower Extremity (MJRLE)) during which the start date of a second Clinical Episode could occur during the initial Clinical Episode, the initial Clinical Episode would be retained and the subsequent Clinical Episode would be canceled. However, if an initial potential Clinical Episode was initiated by a non-BPCI Advanced Participant and the subsequent Clinical Episode was triggered by a BPCI Advanced Participant, the subsequent Clinical Episode would be retained. As an exception, if an MJRLE Anchor Stay occurs within the 90-day Post-Anchor period of an MJRLE Anchor stay for the same beneficiary, CMS cancels the first Clinical Episode and selects the second.

In the baseline period, Clinical Episodes may overlap. This means that in the baseline, if an ACH admits a beneficiary for BPCI Advanced MS-DRG trigger code, during an ongoing Clinical Episode, a new Clinical Episode initiates.

The Target Price Speculations for Model Years 1 & 2 can be found on the BPCI Advanced website at https://innovation.cms.gov/Files/x/bpciadvanced-targetprice-my1-2.pdf

Q34: Can a hospital be an EI under a Convener Participant for some Clinical Episodes and a Non-Convener Participant for others?

A34: No, an ACH may not allocate Clinical Episodes under multiple Convener Participants or in combination as a Non-Convener Participant. An EI can only trigger episodes as either a Convener Participant or as a Non-Convener Participant.

Q35: Does CMS encourage preferred networks for SNFs and home health providers if beneficiaries know they have a choice of any provider?

A35: Participants can create and/or recommend preferred PAC networks; however, they may not limit beneficiary choice of provider in any way. Participants must notify beneficiaries of their participation in the Model with the CMS Beneficiary Notification Letter and require their Downstream EIs and Participating Practitioners do the same.

Q36: How and when can Applicants get access to preliminary Target Prices, so that they can determine whether they want to commit to participate in Model Year 3?

A36: In order to receive historical claims data files and preliminary Target Prices in September 2019, an organization must first apply to participate in Model Year 3 during the application period opening in April 2019, and complete the Data Request and Attestation (DRA) section of the application. Applicants will have until November 2019 when the BPCI Advanced Participation Agreement is due to CMS to decide whether they want to commit to participate for Model Year 3, which starts January 1, 2020.

Q37: What are the CMS Beneficiary Notification Letter requirements?

A37: 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 EIs 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.

Q38: Can CMS provide further guidance regarding the "MIPS Improvement Activities" requirement and the annual certification that Participants must complete via submission of the Participant Profile?

A38: To ensure compliance with the terms of the BPCI Advanced Participation Agreement, Participants must submit a Participant Profile to identify "Current" EIs and their Clinical Episode selection prior to the start of each Model Year. In the same document, the

Participant must attest to the performance of a minimum of four MIPS Improvement Activities in the upcoming Model Year by the Participant, if applicable, and its Participating Practitioners who are MIPS-eligible clinicians. MIPS-eligible clinicians may receive a credit for the MIPS Improvement Activity performance category score for an applicable 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.

Q39: What are the different portals that Applicants and Participants must navigate and the purposes of each?

A39: The BPCI Advanced Model uses four platforms to receive applications, manage deliverables, distribute data, and collaborate with Model stakeholders.

A. **BPCI Advanced Application Portal –** https://app1.innovation.cms.gov/bpciadvancedapp
   - Applicants use this platform to submit, edit or delete applications for Model Year 3, along with the required attachments.
   - The Application Portal will only accept applications during the open application period. Information submitted through the Application Portal populates the Participant profile page on the Participant Portal.

B. **BPCI Advanced Participant Portal –** https://app1.innovation.cms.gov/bpciadv
   - Applicants and Participants use this platform to access templates and submit deliverables and manage (add or delete) Participant Points of Contacts (POCs)—individuals that receive regular communication from CMS and are authorized to submit deliverables. The individuals who automatically have access to this portal are those listed on the application as a POC as well as the individual who submitted the application. The primary POC may add other POCs once access to the Participant Portal is granted to Applicants.

C. **CMS Enterprise Data Portal –** https://portal.cms.gov
   - Applicants and Participants use this platform to access data files (e.g., historical claims data, preliminary Target Prices, monthly claims data, reconciliation results, and quality data)
   - Applicants that submitted a complete Data Request and Attestation (DRA) with two Data POCs can expect to receive instructions for accessing the Data Portal and instructions for approving/rejecting additional users

D. **BPCI Advanced Connect –** https://app.innovation.cms.gov/BPCIAdvancedConnect/CommunityLogin
   - This platform is ONLY available for Participants to collaborate, ask questions, and share knowledge