Bundled Payments for Care Improvement Advanced | BPCI Advanced

Model Year 4

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Pricing Methodology

Frequently Asked Questions (FAQ)

Quick Links to Questions

September 2020

Q1: How will Target Prices be calculated by CMS?

A1: Using claims based historical data and risk adjustment models to account for variation in the Clinical Episode's standardized amounts, the Centers for Medicare & Medicaid Services (CMS) will calculate a Benchmark Price. Starting in Model Year (MY) 4, the Target Price for each Performance Period will also account for realized national trends in the Performance Period that are driven by unanticipated, systematic factors. Realized trends are captured in the final Target Price by a Peer Group Trend (PGT) Factor Adjustment, which is subject to a cap, and based on the difference between a retrospective peer group trend and the prospective peer group trend used to calculate the initial Target Price. In Bundled Payments for Care Improvement Advanced (BPCI Advanced), a 3 percent discount is applied to the Benchmark Price in Model Years 1 through 4 to calculate the Target Price for each Clinical Episode category for each Episode Initiator (EI).

Q2: How frequent will MY4 Target Prices be updated for Participants?

A2: The initial preliminary Target Prices, released in October 2020, will cover MY4 (January 1, 2021 – December 31, 2021). Participants may use these preliminary Target Prices to help make participation decisions for MY4.

Twice annually when Medicare sets new payment rates for payment systems on the fiscal year and calendar years, the preliminary Target Prices will be updated and revised workbooks will be provided. Specifically, the update tentatively planned for January 2021 will be for Calendar Year (CY) 2021 and Fiscal Year (FY) 2021 payment rates, and the update tentatively planned for October 2021 will be for CY 2021 and FY 2022 payment rates.

All Target Prices will be updated to reflect actual Performance Period beneficiary data and realized peer group trends during semi-annual Reconciliation.

Q3: How often will CMS make payments to BPCI Advanced Participants?

A3: Approximately every six months, CMS will do a retrospective Reconciliation comparing the total of actual non-excluded Medicare FFS expenditures for each Clinical Episode to the final Target Price for that Clinical Episode. Clinical Episodes will be reconciled based on the Performance Period during which the Clinical Episode ends, which is determined by the last day of the post-discharge period.

Q4: When will the MY4 pricing methodology be available?

A4: CMS released the Target Price and Clinical Episode Construction specifications for MY4 in September 2020, prior to releasing Participants' workbooks with baseline data and preliminary Target Prices in October 2020.

Q5: How are the Target Prices constructed (e.g., regional, national or a comparison of an organization's own past performance)?

A5: Target Prices for hospitals are constructed to account for multiple aspects of the Clinical Episode, such as:

1. Historical Medicare fee-for-service (FFS) expenditures specific to the hospital's Baseline Period
2. Patient case-mix
3. The hospital's characteristics (i.e. peer group characteristics)

4. Projected trends in spending among the hospital's peer group
5. Starting in MY4, final Target Prices are adjusted for realized peer group trends during the Performance Period. Adjustment occurs through the PGT Factor Adjustment, which is subject to a cap.

CMS accounts for each component through a series of regression models for each Clinical Episode category based upon a national dataset of Clinical Episodes 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 Medicare Severity-Diagnosis Related Groups (MS-DRGs) for the inpatient Clinical Episodes, and Ambulatory Payment Classifications for outpatient Clinical Episodes, along with other variables described in the Target Price specifications.

The peer group characteristics that CMS adjusts for as part of the Peer Group Historical Adjustment (PGHA) and Peer Group Trend factor (PGT) include the U.S. Census Divisions, urban versus rural status, hospital bed size, safety net status, and major teaching hospital status.

Detailed specifications, including information on the risk adjustment models and the covariates included in them, are available in the Target Price Specifications – Model Year 4.

Q6: What is the baseline period for MY4 and why do Participants only receive three years of baseline data?

A6: The 4-year baseline period for MY4 contains data from potential Clinical Episodes that would have been attributed from October 1, 2015 to September 30, 2019. CMS makes 3 years of baseline (historical) data available for Participants to request for health care operations activities, such as care coordination and quality improvement, under the model. Consistent with HIPAA requirements to limit protected health information to the minimum necessary to accomplish the intended purpose of the request, Participants will have the opportunity to request baseline claims data in raw and/or summary formats only from October 1, 2016 to September 30, 2019 for health care operations purposes.

Q7: How does the Physician Group Practice (PGPs) Target Price work with the hospital Target Price for MY4?

A7: Beginning inMY4, the PGP Offset will be removed from the PGP's Target Price calculation to simplify the pricing methodology. PGPs will receive Target Prices that are hospital-specific. In other words, a PGP will receive unique Target Prices for each Clinical Episode category based on the hospital at which the Anchor Stay or Anchor Procedure occurs. From the Hospital Benchmark Price, CMS first removes the effects of the hospital-wide Patient Case Mix Adjustment and replaces it with the Patient Case Mix Adjustment specific to the PGP's Clinical Episodes initiated by an Anchor Stay or Anchor Procedure at the hospital. In other words, to form the PGP Benchmark Price for each hospital at which the PGP practices, the Hospital Benchmark Price from that hospital is adjusted to account for the PGP's relative case mix.

Q8: Is there any stop-loss for individual cases?

A8: In BPCI Advanced, a 20 percent stop-loss and stop-gain policy is applied at the level of the EI. In other words, the results of all the Clinical Episodes during the Performance Period are aggregated to the EI level prior to applying the stop-loss or stop-gain cap. At the individual Clinical Episode level, the Clinical Episodesare Winsorized, or capped, at the 1st and 99th percentiles of the total standardized allowable amounts within the Clinical Episode category for each MS-DRG or APC for each fiscal year in the baseline period and Performance Period, based on the national dataset of Clinical Episodes.

Q9: What is CMS's approach to reconciliation?

A9: 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 approximately two months of claims run-out. In a given Reconciliation cycle, there may be multiple Performance Periods reconciled based on the Clinical Episode end date. Reconciliation cycles will also include true-up Reconciliation calculations that capture additional claims run-out. The previous Reconciliation cycles and the cylcles slated for 2020, along with the Performance Periods being reconciled are listed below:

- Fall 2019:
    - MY1&2 Performance Period 1 (initial): Clinical Episode end date in October 1, 2018 – June 30, 2019 and Anchor Procedure or Anchor Stay start date on or after October 1, 2018.
- Spring 2020:
    - MY1&2 Performance Period 1 (true-up 1): Clinical Episode end date in October 1, 2018 – June 30, 2019 and Anchor Procedure or Anchor Stay start date on or after October 1, 2018.
    - MY1&2 Performance Period 2 (initial): Clinical Episode end date in July 1, 2019 – December 31, 2019.
- Fall 2020:
    - MY1&2 Performance Period 1 (true-up 2): Clinical Episode end date in October 1, 2018 – June 30, 2019 and Anchor Procedure or Anchor Stay start date on or after October 1, 2018.
    - MY1&2 Performance Period 2 (true-up 1): Clinical Episode end date in July 1, 2019 – December 31, 2019.
    - MY1&2 Performance Period 3 (initial): Clinical Episode end date in January 1, 2020 – March 31, 2020 and Anchor Procedure or Anchor Stay end date on or before December 31, 2019.
    - MY3 Performance Period 3 (initial): Clinical Episode end date in January 1, 2020 – June 30, 2020 and Anchor Procedure or Anchor Stay end date on or after January 1, 2020.
- Spring 2021
    - MY1&2 Performance Period 2 (true-up 2): Clinical Episode end date in July 1, 2019 – December 31, 2019.
    - MY1&2 Performance Period 3 (true-up 1): Clinical Episode end date in January 1, 2020 – March 31, 2020 and Anchor Procedure or Anchor Stay end date on or before December 31, 2019.

    - MY3 Performance Period 3 (true-up 1): Clinical Episode end date in January 1, 2020 – June 30, 2020 and Anchor Procedure or Anchor Stay end date on or after January 1, 2020.
    - MY3 Performance Period 4 (initial): Clinical Episode end date in July 1, 2020 – December 31, 2020.
- Fall 2021
    - MY1&2 Performance Period 3 (true-up 2): Clinical Episode end date in January 1, 2020 – March 31, 2020 and Anchor Procedure or Anchor Stay end date on or before December 31, 2019.
    - MY3 Performance Period 3 (true-up 2): Clinical Episode end date in January 1, 2020 – June 30, 2020 and Anchor Procedure or Anchor Stay end date on or after January 1, 2020.
    - MY3 Performance Period 4 (true-up 1): Clinical Episode end date in July 1, 2020 – December 31, 2020.
    - MY3 Performance Period 5 (initial): Clinical Episode end date in January 1, 2021 – March 31, 2021 and Anchor Procedure or Anchor Stay end date on or before December 31, 2020.
    - MY4 Performance Period 5 (initial): Clinical Episode end date in January 1, 2021 – June 30, 2021 and Anchor Procedure or Anchor Stay end date on or after January 1, 2021.

Q10: Will Target Prices have a Hierarchical Condition Categories (HCCs) adjustment? What is the measurement period?

A10: CMS incorporates the Hierarchical Condition Categories (HCCs) as part of the Target Price calculation, specifically in the Patient Case Mix Adjustment (PCMA). They are represented in three different ways: the individual HCCs, relevant combinations of HCCs, and the HCC count (one to three, four to six, and more than seven) used to determine beneficiary complexity.

For HCC determinations, CMS uses the inpatient, outpatient, and carrier/physician claims in the 90-day look-back period from the start of the Clinical Episode. Construction of HCCs does not take into account claims data from the Clinical Episode period. CMS takes into account all the diagnosis codes on the outpatient, inpatient, and carrier/physician claims.

Q11: If a hospital has a low volume of Clinical Episodes during the baseline period, will CMS adjust the Target Price for this low volume hospital?

A11: Preliminary Target Prices are only built for hospitals with at least 41 Clinical Episodes in a given Clinical Episode category in the baseline period. Information on the low volume threshold for hospitals is included in the Target Price Specifications – Model Year 4.

Q12: How will CMS measure historic Medicare FFS expenditure efficiency in resource use during the baseline period and how will this be applied in calculating the Target Price?

A12: Efficiency refers to Clinical Episode spending, relative to other EIs, for Clinical Episodes with the same patient and peer group characteristics. For hospitals, a value less than one indicates that the 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, hospitals with lower efficiency

measure values have historically treated the same Clinical Episode with lower spending than hospitals with higher efficiency measure values.

The historical efficiency is incorporated into the Target Price by scaling up (for historically low cost hospitals) or scaling down (for historically high cost hospitals) the amount of spending that the patient and peer group adjusters indicate is appropriate for the specific Clinical Episode. Note that historical efficiency was the primary determinant of Target Price in the BPCI Initiative, whereas historical spending is but one component of the Target Price in BPCI Advanced.

Q13: 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?
A13: Peer groups are based on relevant hospital characteristics, such as U.S. Census Divisions, hospital bed size, major teaching hospital status, safety net status, and urban versus rural status.

Q14: On what basis will CMS attribute a Clinical Episode to an EI? Which fields on the claim are key?
A14: When attributing Clinical Episodes to EIs, CMS will first look to the Attending National Provider Identification (NPI) number listed on the institutional claim (UB-40) that initiated the Clinical Episode, 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 Tax Identification Number (TIN). If the PGP TIN is listed as participating in BPCI Advanced, the Clinical Episode is attributed to that PGP. If that TIN is not a BPCI Advanced EI, CMS then starts over by looking at the institutional claim that initiated the episode to conduct the same check for the Operating NPI-TIN. If neither NPIs yield a Part B claim billed under a participating TIN, CMS then checks for whether the hospital CMS Certification Number (CCN) on the claim is a BPCI Advanced EI. Please see Appendix A of the BPCI Advanced Participation Agrement and Sections 7 and 8 of the Clinical Episode Construction Specifications – Model Year 4 for more details.

Q15: In an outpatient Clinical Episode, how will an Anchor Procedure be assigned to a Healthcare Common Procedure Coding System (HCPCS) code when multiple triggering HCPCS codes are in the claim?
A15: In case of multiple triggering HCPCS codes on the same outpatient claim, the following tie-breaking rules are applied:

- Select the outpatient line with the higher standardized line allowed amount.
- Select the outpatient line with the later processing date.
- Select the outpatient line with the higher charge amount.
- Select the outpatient line with the smaller claim identifier number.
- Select the outpatient line with the smaller line item number.

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 from the inpatient claim that may initiate an Anchor Stay.

Q16: 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?

A16: Clinical Episode-level payments are created by summing official CMS standardized payments for all non-excluded services. 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 geographic pricing cost index (GPCI) and from policy-driven adjustments (e.g., IME adjustments). For more information on the official CMS standardization methodology, please visit the CMS Quality Net website www.qualitynet.org.

For a complete list of payment exclusions from Clinical Episodes (for items and services provided for certain readmissions, which are defined by MS-DRG, for some Part B drugs, which are defined by HCPCS codes, and for Cardiac Rehabilitation spending, which is identified by HCPCS code and place of service), please visit the CMS BPCI Advanced website https://innovation.cms.gov/innovation-models/bpci-advanced/participant-resources

Q17: What are the Clinical Episodes' volume thresholds for constructing Target Prices for EIs that are ACHs and PGPs?

A17: In order for a hospital to receive a preliminary Target Price, the hospital must have at least 41 Clinical Episodes in a Clinical Episode category during the applicable baseline period. Since PGPs receive Target Prices based on a hospital's Benchmark Price, PGPs will only receive preliminary Target Prices for hospitals with at least 41 Clinical Episodes in a Clinical Episode category during the baseline period.

More information on the volume thresholds, including low-volume thresholds for hospitals, are available in the Target Price Specifications – Model Year 4.

In MY4, the Clinical Episode categories are sorted into eight Clinical Episode Service Line Groups. Participants will be accountable for all Clinical Episode categories within a Clinical Episode Service Line Group for which the Participant has committed to be accountable but will not be eligible to initiate a Clinical Episode in which they do not meet the minimum Clinical Episode volume threshold during the baseline period, if part of a selected Clinical Episode Service Line Group.

Q18: What happens when a Clinical Episode is triggered because of an admission/Anchor Stay for a MS-DRG included on the Clinical Episode list, but then following discharge (but still during the 90-day episode window), a second admission occurs for a different MS-DRG/episode on the Clinical Episode list in MY4?

A18: In MY4, Clinical Episodes cannot overlap either in the baseline period or the Performance Period. The initial Anchor Stay/ Anchor Procedure is kept and any readmissions that occur within the 90-day Post-Anchor Period or post-Anchor Procedure period are grouped to the initial Clinical Episode. Additionally, Clinical Episodes attributed to BPCI Advanced Participants take no special precedence over other Clinical Episodes. For instance, even when the original inpatient admission could not be attributed to a Participant, but a subsequent outpatient procedure could be attributed to a Participant, the updated policy would retain the initial inpatient Clinical Episode for the non-

Participant and therefore would not initiate an outpatient Clinical Episode, due to the outpatient procedure, for the Participant.

Two exceptions should be noted. If a Major Joint Replacement of the Lower Extremity (MJRLE) Anchor Stay occurs within the 90-day Post-Anchor Period of an initial MJRLE Anchor Stay for the same beneficiary, the first Clinical Episode is canceled and the second one is retained regardless of the Clinical Episode participation status. If the initial Clinical Episode is a Percutaneous Coronary Intervention (PCI) and the subsequent Clinical Episode is a Transcatheter Aortic Valve Replacement (TAVR) or if a PCI and a TAVR Clinical Episode start on the same day, the TAVR Clinical Episode will be retained regardless of the Clinical Episode participation status.

A more detailed discussion of the precedence rules for the selecting Clinical Episodes can be found in the Clinical Episode Construction Specifications – Model Year 4.

Q19: Would CMS please explain how the potential 10 percent quality adjustment is applied to negative or positive Net Payment Reconciliation Amounts (NPRA)?
A19: The Composite Quality Score (CQS) Adjustment Amount is applied at the EI 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 percent.

At the EI level, the CQS adjustment cannot make a Negative Total Reconciliation Amount more negative and cannot reduce the magnitude of a Positive or Negative Total Reconciliation Amount by more than 10 percent.

For more information, please review the document Reconciliation Specification Model Years 1-2 (PDF). CMS anticipates releasing a MY3 and MY4 Reconciliation Specification document in the future.

Q20: Will all Clinical Episodes be included in the baseline period, regardless of precedence or overlap with other models, such as the Comprehensive Care for Joint Replacement (CJR) model?
A20: In MY1&2 and MY3, the baseline period included all Clinical Episodes, without consideration of the precedence rules used in the BPCI Advanced Model Performance Period. This overlap during the baseline period s allowed in order to maximize the number of baseline period Clinical Episodes which were used to create robust preliminary Target Prices. To address the concerns that Clinical Episodes that overlap may have different cost patterns from those that do not, a recent resource-use risk adjustment flag captured such cases in the data files.

This methodology will be updated in MY4 where Clinical Episodes will not be allowed to overlap in the baseline period. For all Model Years, only one Clinical Episode can occur at a given time for a beneficiary during the Performance Period.

Q21: If a PGP EI begins to treat beneficiaries at a new hospital, will Clinical Episodes triggered at that hospital be included in the Model?
A21: Yes, the PGP will be able to trigger Clinical Episodes at the new hospital as long as the hospital itself is not new and has sufficient Clinical Episode volume in the baseline period to receive a preliminary Target Price. The PGP will receive the preliminary Target Price for eligible hospitals in the

National Set of ACH Preliminary Target Prices (see below for details), and a final Target Price at Reconciliation.

The national set of ACH Target Prices is available only to BPCI Advanced Participants via the BPCI Advanced Participant Portal. The National ACH Preliminary Target Price workbook contains all of the BPCI Advanced preliminary Target Prices for all eligible ACHs in the country (including hospitals that are not currently participating in BPCI Advanced). The workbook summarizes preliminary Target Prices for a national set of ACHs with at least 41 Clinical Episodes in a given Clinical Episode category in the baseline period and contains a breakdown of relevant Target Price components. It also includes the parameter estimates from the Stage 1 and Stage 2 Risk Adjustment models. ForMY4, a workbook containing preliminary Target Prices for the national set of hospitals will be available in October 2020.

Q22: When different cardiac-related Clinical Episodes occur or overlap in the same 90-day period, how is this handled?

A22: Inpatient cardiac-related readmissions within 90 days of the end date of the Anchor Stay or Anchor Procedure will be bundled into the initial Clinical Episode. If the readmission maps to an MS-DRG on the Exclusions List, the costs for the admission, including any Part B claims paid during the readmission, will not be included in the Clinical Episode spending amount.

In the MY3 Performance Period and MY4 baseline period and Performance Period, if the initial Clinical Episode is a Percutaneous Coronary Intervention (PCI) and the subsequent Clinical Episode is a Transcatheter Aortic Valve Replacement (TAVR) or if a PCI and a TAVR Clinical Episode start on the same day, the TAVR Clinical Episode is retained regardless of the Clinical Episode participation status. An implication of this is that a MY1&2 PCI Clinical Episode that overlaps with a MY3 TAVR Clinical Episode will be deleted during overlap resolution.

Q23: Can a hospital's peer group characteristics, such as hospital size, change quarter over quarter due to an addition to hospital beds in a given year after a capital investment? Or does CMS evaluate the peer group characteristics at a specific point in time?

A23: Most of the peer group characteristics are constructed using the latest available data as of the processing date for the cut off that was used to construct Target Prices. However, the safety net characteristics is an exception, and this covariate is constructed for each calendar year and thus may vary across quarters in the baseline period. Peer group characteristics are taken from the last available quarter of the baseline period when the Clinical Episode occurred, for inclusion in the risk adjustment model. Take note that the peer groups do not change in preliminary Target Price updates and final Target Price construction.

Q24: Can CMS please clarify the statement from the MY4 Target Price specifications that states: "At the ACH-quarter level, calculate the average of the ratio of observed Clinical Episode spending to Clinical Episode level patient case mix adjustment amount and regress this average ratio..."?

A24: The ratio of observed Clinical Episode spending to Clinical Episode level patient case mix adjustment (output from Stage 1 of the risk adjustment model) is the proportion of observed Clinical Episode spending that is not explained by patient case mix. The average of this ratio across a baseline year-quarter represents the dependent variable in the Stage 2 ordinary least squares (OLS)

regression for a hospital. Once the average is built, the Stage 2 OLS regression is run to project the trends in the Clinical Episode spending to the middle of the Performance Period of interest. In other words, CMS uses this regression to to estimate what portion of Clinical Episode spending is explained by differences in peer group characteristics and trends.

Q25: Given that Target Prices are calculated at the Clinical Episode category level, can CMS explain how to calculate the correct spending at the individual Clinical Episode level in order to compare it to the Target Price?

A25: To identify what to include in the Performance Period Clinical Episodes, follow the steps in the Clinical Episode Construction Specifications – Model Year 4 document, Sections 6 and 9, in particular.

This will help determine the sum of spending for Clinical Episodes initiated at the same hospital for which the Target Price is applicable. After the Clinical Episodes are built, the step-by-step details to aggregate the Performance Period spending are provided in the Reconciliation Specifications document. Since this document is not yet available for MY3 or MY4, Participants can reference Section 4 of the Reconciliation Specification Model Years 1-2 (PDF) document.

Q26: How is the Performance Period Hospital Benchmark Price (HBP) different from the baseline period HBP in MY4?

A26: In MY4 the Patient Case Mix Adjustment (PCMA), the Peer Group Trend (PGT), and the real-to-standardized ratio will be updated for the Performance Period Hospital Benchmark Price (HBP). The final PCMA is constructed using the actual case mix from an EI's attributed Clinical Episodes in the applicable Model Year. The PGT Factor Adjustment will be added to the Performance Period HBP calculation to account for realized peer group trends in the Performance Period that are driven by unanticipated, systematic factors such as payment system reforms. Additionally, final Target Prices will be updated to real dollars using the realized real-to-standardized ratio. CMS notes that Standardized Baseline Spending (SBS), PGT, and Peer Group Historical Adjustment (PGHA) will be adjusted at the beginning of each fiscal and calendar year to account for CMS setting-specific payment rate changes from the finalized rules.

Q27: Is the 1st and 99th percentile Winsorization applied to all observed Clinical Episode spending in MY4?

A27: In MY4, Clinical Episode spending amounts are Winsorized at the 1st and 99th percentile at the Clinical Episode Category level for each MS-DRG or APC for each fiscal year, both in the baseline period and in the Performance Period.

No further Winsorization is applied to Target Prices after risk adjustment. This method ensures that baseline periodand Performance Period Clinical Episodes are comparably truncated to remove extreme outliers.

Q28: Why would a PGP Participant receive a preliminary Target Price, but not receive raw baseline claims data?

A28: PGPs, whether Participants or downstream EIs, do not receive raw claims data if they did not initiate any Clinical Episodes in the baseline period. However, they are still eligible to receive

preliminary Target Prices based upon the hospital prices. CMS will make available a national set of preliminary ACH Target Prices.

The national set of preliminary ACH Target Prices is available only to BPCI Advanced Participants via the BPCI Advanced Participant portal. The National ACH preliminary Target Price workbook contains all of the BPCI Advanced preliminary Target Prices for all eligible ACHs in the country (including hospitals that are not currently participating in BPCI Advanced). The workbook summarizes preliminary Target Prices for a national set of ACHs with at least 41 Clinical Episodes in a given Clinical Episode category in the baseline periodand contains a breakdown of relevant Target Price components. It also includes the parameter estimates from the Stage 1 and Stage 2 Risk Adjustment models. For MY4, a workbook containing preliminary Target Prices for the national set of hospitals will be available in October 2020.

Q29: If the performance information, conveyed in the hospital baseline and the monthly files, is expressed as standardized dollars, why is there then a need to convert the performance information to real dollars? Shouldn't the actual targets be standardized as well?
A29: CMS constructs Clinical Episodes using standardized allowed amounts that reflect the cost of services after removing variation in spending arising from geographical adjustment of reimbursement and CMS payments systems, such as:

- Hospital Wage Index and Geographic Practice Cost Index (GPCI), and
- Indirect Medical Education (IME) and Disproportionate Share Hospital (DSH) payment adjustments.

The complete description of the official CMS Standardization Methodology by setting can be found on the CMS QualityNet website. Real dollars represent the true amount the providers are reimbursed for their provision of Medicare covered care. Since reconciliations amounts are calculated in real dollars, Target Prices are converted into real dollars to allow comparison of Target Prices and actual spending in a consistent manner.

Q30: In the overall process of setting Target Prices, will the Patient Case Mix coefficients be re-estimated?
A30: The risk adjustment coefficients will not be re-estimated in the Performance Period. Rather, the Risk Adjustment parameters from the baseline period will be re-applied to the realized case mix that occurs in the Performance Period. However, twice annually, when Medicare sets new payment rates for payment systems in a new fiscal year and calendar year, new setting specific update factors will be applied to the baseline period Clinical Episodes to make their spending comparable to the new prices. At these times, risk adjustment will be rerun on newly updated baseline Clinical Episodes and coefficients may change. Please note these changes will only reflect in Medicare pricing updates and, because prices increase every fiscal year and calendar year on average, it is expected that these changes will on average lead to increases in Target Prices.

Q31: What is the duration of the Anchor Procedure for outpatient episodes in MY4? Additionally, if the Anchor Procedure overlaps with an Anchor Stay, how are the Clinical Episodes treated?
A31: In MY4, Clinical Episodes initiated by an Anchor Procedure also begins on the first day of the BPCI Advanced Beneficiary's Anchor Procedure and end 90 days after completion of the Anchor

Procedure. If a BPCI Advanced Beneficiary initiates an Anchor Procedure and an Anchor Stay on the same day, then only the Anchor Stay will be retained and eligible for attribution while the Anchor Procedure will not be eligible for attribution, both in baseline period and Performance Period. Please refer to the Clinical Episode Construction Specification – Model Year 4 document for more details on the Clinical Episode selection logic.

Q32: What does CMS consider short-term hospitals and which claim types or facilities would be included?

A32: The following hospitals are considered short-term hospitals for purposes of BPCI Advanced, and they would fall under the definition of acute-to-acute transfers in the specifications:

- Short term hospitals can be identified by a CCN with the last four digits between 0001-0879;
- Critical Access Hospitals (CAH) can be identified by a CCN that ends between 1300-1399;
- Emergency hospitals can be identified by a CCN that has either an E or F as the sixth digit; and
- Veterans' hospitals can be identified by a CCN that has a V as the fifth digit.

However, if such combined stays involve CAH or PPS-exempt cancer hospitals in any leg of the transfer, the stay will not trigger a Clinical Episode as those hospitals are excluded from BPCI Advanced. For additional information please refer to the Research Data Assistant Center (or RESDAC) website for the provider number table to provide more information.

Q33: Will CMS define what Part B charges will appear in the anchor versus post-anchor summaries, and can CMS share the rules for allocating changes to the anchor and post-anchor?

A33: First, the rules for assigning the standardized allowed amount to the Anchor Stay or Anchor Procedure versus the Post-Anchor Periodriod are prorated, and the relevant proportion of costs are assigned to each period. For the exact proration methodology for all settings, refer to the Clinical Episode Construction Specifications – Model Year 4 document.

Q34: Is there any reason that organizations might not receive Target Prices for all Clinical Episodes provided that we accurately and timely completed an Data Request and Attestation form?

A34: Yes, there are two (2) possible scenarios where an Applicant might not receive Target Prices for all Clinical Episodes:

1. If an ACH does not have at least 41 Clinical Episodes for a given Clinical Episode category within the BPCI Advanced baseline period, then it will not receive a preliminary Target Price.
2. If a PGP does not have any Clinical Episode at a BPCI Advanced eligible ACH for a given Clinical Episode category in the baseline period, it will not receive Target Price for that Clinical Episode category.

Likewise, PGPs that solely practice at ACHs that do not have at least 41 Clinical Episodes during the baseline period will not receive any Target Prices, since PGP Target Prices are based on the hospital in which the Clinical Episode initiates.

Q35: For the Target Price Calculation, one of the Risk Adjuster Categories is "Recent Resource Use." It defines this as "Indicates whether a Clinical Episode was preceded by a relevant utilization of health care services." What constitutes a relevant utilization of health care services? Over what time period does this look? Is it a fixed time period before the claim that initiates an episode?
A35: In MY4, Recent Resource Use is accounted for in the risk adjustment model through indicators for inpatient hospitalization in the 90 days prior to the Clinical Episode being initiated and in the 90 days prior to the Clinical Episode being initiated for Post-Acute Care use (long term care hospital, SNF, HHA, and inpatient rehabilitation) . All inpatient admissions in the 90-day look back window, regardless of the participation status or MS-DRG, are considered for resource use.

Q36: CMS approved two additional MS-DRGs (521 and 522) for principal diagnosis of hip fracture, with and without multiple chronic conditions (MCC) in the FY2021 IPPS Final Rule. Is it the Innovation Center's (CMMI) intention to include these new MS-DRGs in BPCI Advanced? If so, would the intent be to create a new Clinical Episode or to blend them into the existing MJRLE Clinical Episode?
A36: MS-DRGs 521 and 522 will be included in all FY2021 Target Price updates (including MY3 FY2021/CY2020 and MY4 FY2021/CY2021 update) in BPCI Advanced. They will be included under the multi-setting MJRLE Clinical Episode category.

Q37: How will the BPCI Advanced risk adjustment model account for the new hip replacement MS-DRGs 521 and 522 introduced beginning for FY2021?
A37: The BPCI Advanced risk adjustment model contains an MS-DRG risk adjustor that accounts for differences in Clinical Episode spending that are specific to MS-DRGs during the Anchor Stay. Additionally, in MY4 the risk adjustment model for MJRLE Clinical Episodes will contain procedure group flags and their interactions with MS-DRG flags and fracture flags to account for the differences in Clinical Episodes spending between various procedure types and their combined effect with MS-DRGs and fracture status. The coefficient estimates associated with these additional risk adjusters for MJRLE Clinical Episodes will be provided to Participants in the MY4 preliminary Target Price workbooks.

Q38: How will the new Peer Group Trend Factor Adjustment be incorporated into final Target Price calculation in MY4?
A38: The Peer Group Trend (PGT) Factor Adjustment is used to adjust the final Target Prices for peer group trends that are driven by unanticipated, systematic factors such as payment system reforms occurring during the Performance Period, and that cannot be predicted using a prospective pricing methodology. The PGT Factor Adjustment is calculated by re-centering the Benchmark Price around realized Performance Period Clinical Episode spending within each peer group nationally, and then capped to within 10 percent of the prospectively calculated PGT value. As an example, for an ACH that has Standardized Baseline Spending (SBS) of $42,962, a preliminary Patient Case Mix Adjustment (PCMA) of 0.81, a Peer Group Historical Adjustment (PGHA) of 1.51, and a Peer Group Trend (PGT) Factor of 0.90, its preliminary HBP would be $47,292 (i.e., $42,962 * 0.81 * 1.51 * 0.90). If the updated PCMA is 0.92 and the capped PGT Adjustment Factor is 0.95, then the final Target Price of this ACH would be $51,029 (i.e., $42,962 * 0.92 * 1.51 * 0.90 * 0.95).