

## Model Purpose

To better support healthcare providers who invest in practice innovation, care redesign, and enhanced care coordination, the Center for Medicare and Medicaid Innovation (CMS Innovation Center) has launched the Bundled Payments for Care Improvement Advanced (BPCI Advanced) voluntary bundled payment model. BPCI Advanced qualifies as an Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program.

## Key Milestones and Dates



**Request for Applications (RFA) Released:**  
January 9, 2018



**Application Portal Opens:**  
January 11, 2018



**Application Portal Closes:**  
March 12, 2018 at 11:59 PM EST.



**Model Go Live:**  
October 1, 2018



**Next Application Period Start Date:**  
January 1, 2020

## Key Stakeholders



A **Convener Participant** is a type of Participant that brings together multiple downstream entities, referred to as “Episode Initiators (EIs).” A Convener Participant facilitates coordination among its EIs and bears and apportions financial risk under the Model.



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

## Model Overview

BPCI Advanced builds upon lessons gleaned from current and previous CMS models, demonstrations, and programs. Participation in BPCI Advanced starts on October 1, 2018 and the Model Performance Period runs through December 31, 2023.

## BPCI Advanced is defined by four characteristics:

### Payment and Risk Track

A single payment and risk track for Clinical Episodes, which begin on the first day of the triggering inpatient stay or outpatient procedure and extend through the 90-day period starting on the day of discharge from the inpatient stay or the completion of the outpatient procedure, as applicable.



### Inpatient Clinical Episode Triggers

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

### Outpatient Clinical Episode Triggers

3 Clinical Episodes are triggered by the submission of a claim to Medicare FFS by an EI for the outpatient procedure - Percutaneous Coronary Intervention (PCI), Cardiac Defibrillator, or Back & Neck except Spinal Fusion - identified by a Healthcare Common Procedure Coding System (HCPCS) code.



**Additional Clinical Episodes** may be included in future Model Years.

### Target Prices

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



## Implementing BPCI Advanced: Model Highlights

Criteria

**Entities eligible to be Participants in the Model:** Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) may participate as Convener Participants or Non-Convener Participants; other entities that are either Medicare-enrolled or not Medicare-enrolled providers or suppliers may participate as Convener Participants only.

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

**Beneficiary Exclusions:** The term BPCI Advanced Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of end-stage renal disease (ESRD); (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure.

Episodes

### 29 Inpatient Clinical Episodes

- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis \*(New episode added to BPCI Advanced)
- Acute myocardial infarction
- Back & neck except spinal fusion
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Cellulitis
- Cervical spinal fusion
- 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 & femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major bowel procedure
- Major joint replacement of the lower extremity
- 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



### 3 Outpatient Clinical Episodes

- Percutaneous Coronary Intervention (PCI)
- Cardiac Defibrillator
- Back & Neck Except Spinal Fusion

## Implementing BPCI Advanced: Model Highlights

**Clinical Episode trigger:** Inpatient claim from an ACH with a qualifying MS-DRG or Hospital outpatient claim with a qualifying HCPCS code.

**Clinical Episode length:** Inpatient Clinical Episode: Anchor Stay + 90 days following discharge; Outpatient Clinical Episode: Anchor Procedure + 90 days following completion of the outpatient procedure.

**Types of services included in Clinical Episode (unless specifically excluded):** Physicians' services, inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure (respectively), other hospital outpatient services, inpatient hospital readmission services, long term care hospital (LTCH) services, inpatient rehabilitation facility (IRF) services, skilled nursing facility (SNF) services, home health agency (HHA) services, clinical laboratory services, durable medical equipment (DME), Part B drugs, and hospice services.

**Exclusions:**

- Part B Services Exclusions: Most Part B costs incurred during the Clinical Episode will be included in the episode. BPCI Advanced will not follow the clinically related criteria guiding Part B exclusions used in BPCI. Part B costs will be excluded only if incurred during an inpatient readmission to an ACH that is excluded based on its MS-DRG.
- Readmission Exclusions: Single list of excluded MS-DRGs will include 122 MS-DRGs: Transplant & Tracheostomy, Trauma, Cancer (when cancer is explicitly indicated by MS-DRG), and Ventricular Shunts.

Blanket Exclusions:

Blood clotting factors to control bleeding for hemophilia patients, new technology add-on payments, and Outpatient Prospective Payment System (OPPS) pass-through devices.

**Clinical Episode Attribution:** Clinical Episodes will be attributed at the EI level. The hierarchy for attribution of a Clinical Episode among different types of EIs in BPCI Advanced is as follows, in descending order of precedence: (1) the PGP that submits a claim that includes the National Provider Identifier (NPI) for the attending physician; (2) the PGP that submits a claim that includes the NPI of the operating physician; and (3) the ACH where the services that triggered the Clinical Episode were furnished.

**Payment from CMS:** BPCI Advanced involves Medicare FFS payments with retrospective reconciliation based on comparing all actual non-excluded Medicare FFS expenditures for a Clinical Episode for which the Participant has committed to be held accountable to the final Target Price for that Clinical Episode, resulting in a Positive Reconciliation Amount or a Negative Reconciliation Amount. All Positive Reconciliation Amounts and Negative Reconciliation Amounts will be netted across all Clinical Episodes attributed to an EI, resulting in a Positive Total Reconciliation Amount or Negative Total Reconciliation Amount.

## Implementing BPCI Advanced: Model Highlights

**Payment from CMS (Continued):** The Positive Total Reconciliation Amount or Negative Total Reconciliation Amount for an EI is then adjusted based on quality performance, resulting in the Adjusted Positive Total Reconciliation Amount or Adjusted Negative Total Reconciliation Amount, respectively.

- For an EI that is also a Non-Convener Participant, the Adjusted Positive Total Reconciliation Amount is the Net Payment Reconciliation Amount (NPRA), which CMS will pay to the Participant.
- If instead this calculation results in an Adjusted Negative Total Reconciliation Amount for Non-Convener Participants, this amount is the Repayment Amount, which must be paid by the Participant to CMS.
- For Convener Participants, all Adjusted Positive Total Reconciliation Amounts are netted against all the Adjusted Negative Total Reconciliation Amounts for the Participant's EIs to calculate either an NPRA or a Repayment Amount.

**CMS Discount:** During the initial years of the Model, a 3 percent discount will be applied to the Benchmark Price (described below) to calculate the Target Price.

**Benchmark Price:** To determine the Episode Initiator-specific Benchmark Price for an ACH, CMS will use risk adjustment models to account for the following contributors to variation in the standardized spending amounts for the applicable Clinical Episode:

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

CMS will use an alternative method to determine the PGP's Benchmark Price. Specifically, since physician affiliation to a PGP changes over time, discrepancies often occur between the pool of Clinical Episodes in the Baseline Period and the pool of Clinical Episodes in the Performance Period.

Consequently, BPCI Advanced will base the PGP's Benchmark Price on the Benchmark Price for the ACH where the Anchor Stay or Anchor Procedure occurs. CMS will adjust this ACH -specific Benchmark Price to calculate a PGP-specific Benchmark Price that accounts for the PGP's level of efficiency in the past and the PGP's patient case mix, each relative to the ACH.

## Implementing BPCI Advanced: Model Highlights

**Target Price:** Target Price (TP) equals the Benchmark Price (BP) times one minus the CMS discount (e.g.,  $TP=BP * (1-CMS \text{ Discount})$ ). Preliminary Target Prices will be provided prospectively, before each Applicant finalizes its Participation Agreement with CMS and prior to selection of Clinical Episodes. Els will receive a preliminary Target Price, determined prospectively based upon its historical patient case-mix. A final Target Price will be set retrospectively at the time of Reconciliation by replacing the historic Patient Case Mix Adjustment with the realized value in the Performance Period, which will be transparent and specific to the Participant's beneficiaries.

**Risk Track:** The risk cap is applied to Clinical Episodes at the 1st and 99th percentile of spending in both the Performance Period and the Baseline Period.

**Clinical Episode Reconciliation:** If aggregate Medicare FFS expenditures for items and services included in the Clinical Episode (other than those that are specifically excluded) are less than the final Target Price (the Target Price updated to account for actual patient case-mix) for that Clinical Episode, this is a Positive Reconciliation Amount. If aggregate Medicare FFS payments for items and services included in the Clinical Episode exceed the final Target Price, this results in a Negative Reconciliation Amount.

**Frequency of Reconciliation:** Semi-Annually. 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.

**Post-Episode Spending Monitoring Period:** Any Medicare FFS expenditures for items and services furnished to a Beneficiary during the 30-day Post-Episode Monitoring Period that exceed an empirically titrated risk threshold must be paid by the Participant to Medicare. Frequency of Post-Episode Spending monitoring: Once per Model Year.

**Stop-loss/stop-gain limits:** Reconciliation payments, both to Participants from CMS, and from Participants to CMS, are capped at +/- 20% of the volume-weighted sum of the final Target Prices across all Clinical Episodes netted to the level of the Episode Initiator within the Performance Period.

**Payment Policy Waivers:** Participants will have the opportunity to choose to furnish services to BPCI Advanced Beneficiaries pursuant to one or more Medicare Payment Policy Waivers, which involve conditional waivers of certain payment rules; these waivers relate to the 3-Day SNF Rule, Telehealth services, and Post-Discharge Home Visits services.



## Implementing BPCI Advanced: Model Highlights

**Payment:** Payment will be linked to quality using a pay-for-performance methodology. A quality score will be calculated for each quality measure at the Clinical Episode level and rolled up to the Episode Initiator level, as applicable. These scores will be scaled across all Clinical Episodes triggered by a given EI, weighted based on Clinical Episode volume and summed to calculate an Episode Initiator-specific Composite Quality Score (CQS) and related CQS Adjustment Amount. For the first two Model Years, the amount by which any Positive Total Reconciliation Amount or Negative Total Reconciliation Amount may be adjusted by the CQS Adjustment Amount is capped at 10 percent. The Required Quality Measure List for BPCI Advanced includes both process and outcome quality measures.

### Quality measures for:

All Clinical Episodes	All-cause Hospital Readmission Measure (National Quality Forum [NQF] #1789)
	Advance Care Plan (NQF #0326)
Specific Clinical Episodes	Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
	AHRQ Patient Safety Indicators (PSI 90)

## Objectives of the Initiative

BPCI Advanced seeks to improve the quality of care furnished to Medicare beneficiaries and to reduce expenditures:



**Care Redesign:** Supporting and encouraging Participants, Participating Practitioners, and EIs who are interested in continuously reengineering care.



**Data Analysis and Feedback:** Decreasing the cost of each Clinical Episode by eliminating unnecessary or low-value care, increasing care coordination, and fostering quality improvement.



**Financial Accountability:** Testing a payment model that creates extended financial accountability for the outcomes of improved quality and reduced spending, in the context of acute and chronic Clinical Episodes.



**Health Care Provider Engagement:** Creating environments that stimulate rapid development of new evidence-based knowledge, i.e. the Learning System.



**Patient & Caregiver Engagement:** Increase the likelihood of better health at lower cost through patient education and on-going communication throughout the Clinical Episode.

## Evaluation and Monitoring

The Innovation Center will monitor performance under BPCI Advanced for the Model Performance Period through data reporting requirements and other oversight activities. The goal of monitoring is to ensure objectives are met in redesigning care, achieving quality measure thresholds and patient experience of care standards, and demonstrating improved care coordination.

CMS may monitor model performance by:

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



There will also be an independent evaluation of BPCI Advanced that will assess the quality of care and changes in spending under the model.



## Overlap with Other CMS Models

When overlap exists between models, CMS aims to avoid duplicate payments and counting reductions in expenditures twice across initiatives. Models that may have some overlap with BPCI Advanced include the following:

- Comprehensive Care for Joint Replacement (CJR)
- Oncology Care Model (OCM)

In addition, BPCI Advanced Clinical Episodes may overlap with beneficiaries aligned or assigned to Accountable Care Organizations (ACOs). Information regarding how these interactions will be addressed can be found in the BPCI Advanced RFA.

*For more details and a comparison table of the above listed models visit:*

<https://innovation.cms.gov/initiatives/bpci-advanced>

## How to Apply

The Request for Applications (RFA) document provides more details about the Model and its requirements. Download the RFA, the Application template, and the required Application attachments from the BPCI Advanced website at:

<https://innovation.cms.gov/initiatives/bpci-advanced>

The actual submission of the application must be made via the Application Portal which will go live on January 11, 2018 and will close on 11:59 pm EST March 12, 2018. Applications submitted via email will not be accepted.

The BPCI Advanced Application Portal can be accessed here:  
<https://app1.innovation.cms.gov/bpciadvancedapp>

## Data Request and Attestation Form (DRA)

To request the data used to calculate prospectively determined preliminary Target Prices and/or historical Medicare claims data from CMS, Applicants must submit a DRA form along with their completed application.

CMS intends to provide the opportunity to request certain aggregate data and line-level beneficiary claims data. The requested data elements, as well as the time period for such data are requested must be described in greater detail on the Applicant's DRA form. Applicants must also specify the legal basis that justifies the disclosure of the requested claims data under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, where indicated on the DRA. *CMS expects to distribute the data to Applicants in late May 2018.*

The DRA template form and further instructions can be downloaded from the BPCI Advanced website:

<https://innovation.cms.gov/initiatives/bpci-advanced>

## Have Questions or Need More Information?

Email the BPCI Advanced Team at:  
[BPCIAdvanced@cms.hhs.gov](mailto:BPCIAdvanced@cms.hhs.gov)

Visit the website at:

<https://innovation.cms.gov/initiatives/bpci-advanced>

