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CMS Policy Updates

1. Major Joint Replacement of the Lower Extremity: Episode Creation Specification

CMS wants to highlight a difference between the new BPCI Advanced Model and the BPCI initiative, which we have implemented based on stakeholder’s input.

In BPCI Advanced, when a second Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode is triggered during the 90-day post-discharge period, the first Major Joint Clinical Episode is canceled and a new Clinical Episode begins. That new Clinical Episode will be attributed according to the precedence rules of the Model using the Anchor Stay billed claims.

Currently, in the BPCI initiative this second MJRLE surgery is included in the bundle costs of the Clinical Episode.

General

Q1: Will Participants (Conveners and Non-Conveners) have to treat every Medicare patient for the Clinical Episodes for which they participate in under the BPCI Advanced Model?

A1: Participants do not have the ability to exclude patients for the Clinical Episodes for which they participate, regardless of a patient's acuity. Also, Participants may not restrict beneficiary access to medically necessary care. To that end, CMS will monitor utilization and referral patterns, as well as conduct medical record audits, track patient complaints and appeals, and monitor 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 will trigger a Clinical Episode due to beneficiary eligibility exclusions.

Q2: Do Participants need a patient’s consent to treat if participating in the Model?

A2: The Participant will need to develop a plan for ensuring that each beneficiary included in a Clinical Episode under the Model receives a Beneficiary Notification Letter prior to discharge from the Anchor Stay, or prior to the completion of the Anchor Procedure, as applicable. CMS will provide a template of the Beneficiary Notification Letter prior to Model launch.

Q3: Since CMS allowed potential Episode Initiators to be listed in multiple applications (see FAQs- February 2018: CMS Policy Update #1), but made clear that Episode Initiators can only be listed as “Active” by one Applicant at the time of submission of the Participant Profile or risk not being approved to participate in the Model effective 10/1/18, what safety measures will be in place to ensure multiple submissions don’t occur?

A3: When Participant Profiles are created, they will reflect all the Participating Organizations that were listed in the application. When they are submitted to CMS, the Applicant is solely responsible for the accuracy of the information and must ensure that those Episode Initiators that have made the decision to participate in the Model with them reflect a status of “Active” in the Entity List and Episode List tabs. For those Episode Initiators that have made the decision not to participate with a given Applicant, the appropriate status in the Participant Profile will be “Withdraw”.

When processing submitted Participant Profiles, CMS will search for duplicate TINs and/or CCNs of Episode Initiators and verify that only one assigned unique identifier called a Bundled Payment Identification (BPID) has a status of “Active”; if that is not the case, that Episode Initiator will be rejected and will not be able to participate in the Model starting 10/1/18. They will still have the opportunity to reapply for the Second Cohort that will start in January 2020.

Q4: What kind of “deliverables” will Participants have to complete? When will they be due, and how frequently?

A4: There are four (4) different types of “deliverables” that Participants will have to submit to CMS, as applicable to their circumstances:

- Participant Profile (PP) – Yearly. Required - due 60 days before the start of the Model Year.
This document will indicate the Clinical Episodes to which the Non-Convener Participant commits to be held accountable under BPCI Advanced; or if a Convener Participant, it will identify the list of Downstream Episode Initiators and their specific Clinical Episode selections.
For Model Years 1 & 2, CMS will only require one submission – due on August 1, 2018.
- Care Redesign Plan (CRP) – Yearly. Required - due 60 days before the start of the Model Year.
This document will describe the specific planned interventions and changes to the Participant’s current healthcare delivery system.
For Model Years 1 & 2, CMS will only require one submission – due on August 1, 2018.
- PGP List (PGP) – Quarterly. If applicable – the first submission will be due 60 days before the start of the Model Year; subsequent submissions are due 30 days before the start of the quarter.
This document identifies all the physicians who have reassigned their rights to receive Medicare payment to a Physician Group Practice (PGP) participating in BPCI Advanced. CMS will use this PGP List for purposes of the Qualifying APM Participant (QP) determinations under the Quality Payment Program and to attribute Clinical Episodes to such applicable PGPs for purposes of reconciliation under certain circumstances.
- Financial Arrangements List (FAL) – Quarterly. If applicable – the first submission will be due 60 days before the start of the Model Year; subsequent submissions are due 30 days before the start of the quarter.
This document will include the list of organizations and/or individuals with whom the Participant has a Financial Arrangement in BPCI Advanced as one of the following: an NPRA Sharing Partner; an NPRA Sharing Group Practice Practitioner; and a BPCI Advanced Entity.

Q5: Will a Physician Group Practice (PGP) be able to select which individual physicians want to participate in the Model or will all the physicians under the Tax Identification Number (TIN) be included?

A5: In BPCI Advanced, a PGP is defined at the TIN level. Therefore, PGPs will not be able to select which individual physicians are able to participate in the Model. During the performance period, if an individual physician's National Provider Identifier (NPI) is assigned to a PGP's TIN that is participating in BPCI Advanced, they will have the ability to trigger Clinical Episodes for that PGP.

Q6: Must all Physician Group Practices (PGPs) under the same Taxpayer Identification Number (TIN) choose the same Clinical Episodes?

A6: Yes, participation decisions, including Clinical Episode selection, are at the Episode Initiator level. For PGPs, the Episode Initiator is grouped by the TIN and billed on the Clinical Episode's carrier claims. For Acute Care Hospitals (ACHs), the CMS Certification Number (CCN) on the institutional claim is used to identify the Clinical Episode.

Q7: If a Physician Group Practice (PGP) starts participation in January 2020, and a hospital has entered into the same Clinical Episode in October 2018, does the hospital retain the Clinical Episodes or does the PGP still get precedence?

A7: 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 would take precedence over the hospital.

Q8: How does a Physician Group Practice (PGP) Episode Initiator that provides services at multiple locations, and a hospital which is one of those locations, both participate in BPCI Advanced under one Convener Participant?

A8: A Physician Group Practice (PGP) and a hospital can participate under the same Convener Participant. The PGP and hospital could participate in the same or different Clinical Episodes, however a Clinical Episode can only be attributed to one Episode Initiator. Precedence rules, including model overlap rules, would dictate which Episode Initiator would be attributed the Clinical Episode.

Q9: Does a Physician Group Practice (PGP) need to have a specific case mix or Clinical Episodes volume to participate?

A9: The BPCI Advanced Model accounts for an extensive range of patient characteristics and there is no specific case mix requirements to participate. PGPs will not have minimum volume thresholds. However, since PGP Target Prices are based on the hospital in which the Clinical Episode initiates, a hospital Target Price must be available for the Clinical Episode category in order for the PGP to trigger these Clinical Episodes at the hospital. In order to generate a Target Price, hospitals must meet a minimum volume threshold of at least 41 Clinical Episodes in the category during the applicable baseline period. Consequently, PGPs will only initiate Clinical Episodes for each category at those hospitals with sufficient volume.

Q10: We are an integrated delivery system whose doctors and hospitals share the same Taxpayer Identification Number (TIN). If we apply as a Convener Participant, would that mean that all of our doctors would be included as Episode Initiators?

A10: In BPCI Advanced only Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) can be Episode Initiators, so the individual physicians would not be considered Episode Initiators.

Q11: Can a hospital be a “Convener Participant” for some Medicare Severity Diagnosis Related Groups (MS-DRGs) and be a “Non-Convener Participant” and Episode Initiator for others?

A11: An Episode Initiator, either a hospital or a Physician Group Practice (PGP), cannot allocate Clinical Episodes under multiple Convener Participants or in combination with themselves as a Non-Convener Participant. An Episode Initiator can only trigger episodes under one Convener Participant or as the Non-Convener Participant themselves.

Q12: Are preferred networks for Skilled Nursing Facilities (SNFs) and Home Health providers encouraged as long as beneficiaries are informed that they have a choice of any provider?

A12: Participants can create and/or recommend preferred Post-Acute Care networks, however, a beneficiary's freedom of choice of provider cannot be affected. Therefore, Participants must notify beneficiaries of their participation in the Model and require their downstream Participating Practitioners and Episode Initiators to do the same.

Q13: Do we need to state the Clinical Episodes we are interested in the application?

A13: When submitting an application, the Applicant will not be selecting Clinical Episodes. Clinical Episode selection will occur through the submission of the Participant Profile (PP). The PP is the deliverable due 60 days before the start of the Model Year, where Non-Convener Participants select Clinical Episodes for themselves and Convener Participants select for their Downstream Episode Initiators, as well as indicate which Episode Initiators listed in the application will be participating in the Model or need to be withdrawn. At time of the PP submission, Participants must commit to be held accountable for one or more Clinical Episodes.

The Participant Profile due in August 2018 will account for Model Years 1 and 2 (10/1/2018-12/31/2019). Participants will not be allowed to add or drop Clinical Episodes except when specifically permitted by CMS, which will next occur on January 2020 and 2021. BPCI Advanced may add additional Clinical Episodes, or revise certain existing Clinical Episodes, potentially occurring in future Model Years.

Q14: Can we see what the Target Prices will be for our hospital, so that we can determine if this works for us or not?

A14: Yes, in order to receive Preliminary Target Prices in May 2018, you must have applied to the BPCI Advanced Model by March 12, 2018 and submitted a Data Request and Attestation (DRA) form. Participants do not need to commit to participate in the Model until August 1, 2018.

Q15: If we employ the Episode Initiators, can we apply as a Convener or does that require that we share risk with them even if they are employed?

A15: The Participant is the risk-bearing entity under BPCI Advanced.

Application Process

Q16: Is there consideration being given to pushing out the initial application deadline past March 12, 2018?

A16: The March 12th, 2018, 11:59pm EST, deadline is a hard date and cannot be pushed back. The date was set to ensure adequate time for screening of Applicants, as well as to maximize the amount of time Applicants will have to review and analyze data and pricing information, determine participation feasibility, and secure agreements from partnering entities, before submitting a binding Participation Agreement to CMS. For Applicants that need more time, a Second Cohort of Participants will start in Model Year 3 (January 2020). The next application opportunity is anticipated to be announced in spring 2019.

Q17: What are the required attachments to the application?

A17: There are three attachments associated with the BPCI Advanced Application:

For Non-Convener Participants

- a. If you are applying as a Non-Convener Participant who is an Acute Care Hospital (ACH), you will need to submit one Data Request and Attestation (DRA) attachment.
- b. If you are applying as a Non-Convener Participant who is a Physician Group Practice (PGP), you will need to submit one PGP Practitioners attachment and one Data Request and Attestation (DRA) attachment.

For Convener Participants

- a. If you are applying as a Convener Participant, with both ACHs and PGPs, you will need to submit one Participating Organizations attachment, one PGP Practitioners attachment, and one Data Request and Attestation (DRA) attachment.
- b. If you are applying as a Convener Participant, with only ACHs, you will need to submit one Participating Organizations attachment and one Data Request and Attestation (DRA) attachment.
- c. If you are applying as a Convener Participant, with only PGPs, you will need to submit one Participating Organizations attachment, one PGP Practitioners attachment, and one Data Request and Attestation (DRA) attachment.

Q18: Is there a limit to the number of applications an organization can submit?

A18: Applicants can submit multiple applications to account for the different permutations of application submission. For example, an Applicant may want to apply as a Convener Participant, but it is unsure if they want to apply with Physician Group Practices (PGPs) and Acute Care Hospitals (ACHs) in one application or separately. Therefore, they could:

- Submit one Convener application that includes all potential PGPs and ACHs in the Participating Organizations attachment; or
- Submit two Convener applications where one application would include all their potential PGPs in the Participating Organizations attachment and the other application would include all their potential ACH in the Participating Organizations attachment; or
- Submit three applications that accounts for the above two scenarios.

Nonetheless, each of the submitted applications needs to ensure all Episode Initiators and/or Physician Group Practice (PGP) Practitioners are listed in their respective application attachments at time of submission, as there are no revisions allowed once an application is submitted.

Q19: As a Convener Participant, we want to submit many applications because our potential Downstream Episode Initiators that are Physician Group Practices (PGPs) want to avoid being lumped together with other PGPs at the time when the Qualifying APM Participant (QP) determinations will be made, but that is a lot of work. How can CMS make the process less onerous?

A19: If your intent as a Convener is for a PGP to be assessed as a single “group” for QP determination, separate applications for each PGP that is to be a Downstream Episode Initiator are required. However, to reduce administrative burden on Applicants, for each subsequent application submitted after the initial application, CMS will accept a standard response in the free text fields that states “See initial Convener Application submission for (Participants Legal Name, Initial Application ID)” (e.g. “See initial Convener Application submission for Convener Inc., C0001).

Therefore, for each separate application the Convener Applicant will have to:

1. Submit all Organization Information for Question #1
2. Submit all three attachments (Participating Organizations, PGP Practitioners, Data Request & Attestation)
3. Add the following statement in the free text field - “See initial Convener Application submission for (Participants Legal Name, Initial Application ID)”
4. Submit any Sanctions, Investigations, Probations, Corrective Action Plans or Outstanding Debt to CMS
5. Certify and sign the Application
6. Submit all applications by 3/12/2018 - 11:59pm EST.

Q20: When can a Convener Participant join BPCI Advanced? Do they need to be part of the initial application or can a Convener bring together Episode Initiators who have already submitted their applications?

A20: A potential Convener Participant must have submitted an application and included the names and details of all Participating Organizations that want to participate as Downstream Episode Initiators effective October 1, 2018, by the deadline of March 12th. CMS will not allow a Convener Participant to add Episode Initiators until the start of Model Year 3, in January 2020.

Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) which are the only Medicare providers able to be Episode Initiators in BPCI Advanced are eligible to apply by themselves as Non-Convener Participants, but cannot join a Convener Participant later if they were not included in the Convener’s original application.

Q21: Please clarify the level of commitment that a Convener Participant would need from potential Downstream Episode Initiators or Participating Practitioners, prior to submitting an application.

A21: CMS is not defining the level of commitment a Convener Participant needs with potential Episode Initiators, Participating Practitioners, or Partnering Entities. However, by March 12th, all potential Episode Initiators and Physician Group Practice (PGP) Practitioners need to be listed in the Participating

Organizations and PGP Practitioners attachments, respectively. As a reminder, once an application is submitted, there will be no revisions to the applications or any of its attachments.

Q22: Can you explain the difference between a Hospital System applying as a "system" vs. the individual hospitals within the system?

A22: The Hospital System can apply to participate in BPCI Advanced as a Convener Participant, which brings together multiple downstream entities referred to as "Episode Initiators"; in this case it would be their hospitals. As a Convener Participant, the Hospital System would facilitate coordination among its hospitals, and would also bear and apportion financial risk.

The individual hospitals within the Hospital System also have the opportunity to apply as Non-Convener Participants, which bears financial risk only for itself and does not bear financial risk on behalf of multiple downstream Episode Initiators.

Q23: As a Convener, I have a large number of Participating Organizations. How many Participating Organizations attachments must I submit with my application?

A23: If you are submitting one application, you must submit only one attachment per attachment type. This means that if you are filling out a Participating Organizations attachment, please list all potential Episode Initiators in one attachment. Do NOT submit a separate attachment for each potential Participating Organization. Likewise, with the PGP Practitioners attachment, only one PGP Practitioners attachment should be submitted, even if multiple PGPs are interested in participating. Both attachments can accommodate thousands lines of data.

Q24: We have so many physicians to be listed in the PGP Practitioners attachment that they all do not fit in the spreadsheet, do I submit a second file?

A24: If on the PGP Practitioners attachment or the Participating Organizations attachment you run out of lines for data entry, you can add more lines by highlighting the number of rows you wish to add and then click on the Insert button or right click and select insert. Do NOT submit two separate files, because CMS will only process the last version of multiple copies of the same attachment.

Q25: As a large multi-specialty group practice, do all members of the Physician Group Practice (PGP) have to be listed in the PGP Practitioners attachment or is that list only for the Episode Initiators within the practice?

A25: All physicians who have reassigned their rights to Medicare payments to the PGP Episode Initiator need to be listed on the PGP Practitioners attachment to the application.

Q26: Are columns F and G required fields in the PGP Practitioners attachment? I don't have all those dates and the application deadline is fast approaching.

A26: To alleviate administrative burden, Applicants who need to fill out a PGP Practitioners attachment will no longer be required to indicate the date the physician entered the group (column F) or left the group (column G)---you may leave both of these columns blank; however, DO NOT delete the columns from the spreadsheet.

CMS will be requiring start and end dates for each physician in the quarterly submission of the PGP List, which is a required deliverable for Non-Convener Participants that are PGPs, or Convener Participants that have PGPs as Downstream Episode Initiators.

Q27: Can a Skilled Nursing Facility be listed as a Participating Organization?

A27: The Participating Organizations attachment is for Convener Participants to list out their potential Downstream Episode Initiators. In BPCI Advanced, Episode Initiators can only be Acute Care Hospitals (ACHs) or Physician Group Practices (PGPs), therefore Post-Acute Care providers and/or Net Payment Reconciliation Amount (NPRA) Sharing partners should not be listed in this attachment. NPRA Sharing partners should be listed in the Financial Arrangements List (FAL).

Q28: I need to make revisions to an attachment that is already uploaded in the BPCI Application Portal, what should I do?

A28: If the application is in a status of “In Progress”, then delete the first version of the document and upload the new attachment. If the application has a status of “Submitted”, then no changes are allowed.

During the review of applications, if there are several versions of the same required attachment, CMS will only keep the last version submitted and delete earlier copies of the attachment. Likewise, CMS will delete any attachments submitted in the BPCI Advanced Application Portal that are extraneous or not required (i.e. a Non-Convener Participant submitting a Participating Organizations attachment; or a Non-Convener Participant that is an Acute Care Hospital (ACH) submitting a PGP Practitioners attachment).

Q29: Can you clarify what information needs to be entered when the application asks for “Specify Current/Future Medicare Model or Program”?

A29: On the BPCI Advanced Application and the Participating Organizations attachment there is a question asking for “Specify Current/Future Medicare Model or Program”. CMS is interested in collecting data about cross-participation on other models by Applicants to BPCI Advanced. Please enter the information to the best of your ability. Some examples of Medicare Models or Programs that can be listed include, but are not limited to:

- Comprehensive Care for Joint Replacement (CJR) Model
- Comprehensive ESRD Care (CEC) Model
- Comprehensive Primary Care Plus (CPC+) Model
- Oncology Care Model (OCM)
- Next Generation ACO Model
- Medicare Shared Savings Program (MSSP)
- Transforming Clinical Practice Initiative (TCPI)

Q30: The application requests the “Date Established” for each organization. What do you mean by “Date Established”?

A30: The “Date Established” is a required field in the application and the Participating Organizations attachment.

- For Non-Convener Participants who are Acute Care Hospitals (ACHs), please provide the date when the CMS Certification Number (CCN) became active.
- For Non Convener Participants who are Physician Group Practices (PGPs), please provide the date when the Taxpayer Identification Number (TIN) became active.
- For Convener Participants who are not ACHs or PGPs, please provide the date when the TIN became active.
 - For Convener Participants who have Participating Organizations that are ACHs, please provide the date when the CMS Certification Number (CCN) became active.
 - For Convener Participants who have Participating Organizations that are PGPs, please provide the date when the Taxpayer Identification Number (TIN) became active.

Q31: Please provide some guidance on how to answer the Net Payment Reconciliation Amount (NPRA) Sharing section of the application, if I have no intention to do so?

A31: If you do not plan on sharing NPRA, on Question #2 select “No” from the drop down menu and enter “N/A” for questions 3,4, & 5 in that section. If you plan to share NPRA, you must select “Yes” from the drop down menu and provide answers to the subsequent questions for that section.

Q32: Can you clarify whether an organization must specify which providers they plan to share Net Payment Reconciliation Amount (NPRA) with, in the application?

A32: In the application we are asking that you identify the types of organizations with which you intend to share Net Payment Reconciliation Amount (NPRA), but not the specific name of the physicians or entities. The Financial Arrangement List (FAL) is one of the deliverables that must be submitted by Participants 60 days before the start of the Model Year and will list all potential NPRA Sharing partners. Participants will have the opportunity to update the list quarterly.

Q33: How do we comply with the required certification of the application in the last page?

A33: On the last page of the application, “the certification page”, you must check the certification box and enter the authorized signatory’s first and last name. DO NOT upload a PDF signature page.

Q34: Our Physician Group Practice (PGP) has had more than one Taxpayer Identification Number (TIN) in the last four (4) years, do we have to list them all in the Participating Organizations attachment that will be used to generate Preliminary Target Prices for our group?

A34: When completing the Participating Organizations attachment, PGPs should only include the TIN that will be used to initiate Clinical Episodes in the BPCI Advanced Model.

Q35: Is the Data Request and Attestation (DRA) form a required attachment to the BPCI Advanced application?

A35: If an Applicant wants to receive historical claims data, a Data Request and Attestation (DRA) form must be submitted with the application; DRAs submitted after March 12, 2018 will not be processed. The data you will receive relates to the potential Episode Initiators listed on the Participating Organizations attachment.

Q36: Can I include a Skilled Nursing Facility or any other type of Post-Acute Care provider in the Participating Organizations attachment?

A36: Skilled Nursing Facilities (SNFs) can apply to participate as a Convener Participant in BPCI Advanced, however, they cannot be included in the Participating Organizations attachment since that document identifies potential Downstream Episode Initiators. Only Physician Group Practices (PGPs) and Acute Care Hospitals (ACHs) can participate as Episode Initiators and initiate Clinical Episodes in the BPCI Advanced Model. Skilled Nursing Facilities and other Post-Acute Care providers can be added to the Financial Arrangements List (FAL) as an organization with whom the Participant has a Financial Arrangement. (See Question #4)

Q37: We are a Physician Group Practice (PGP), how do we answer the question in the application about the number of beds?

A37: If you are applying as a Non-Convener PGP or a Convener Participant, enter 0 as the number of beds.

Q38: In the Organization Information section of the application - Question #5 asks to list the organization governing bodies, but we are a complex hospital system - what should we list?

A38: For Applicants with multiple governing bodies within their organization, for purposes of this application, the applicant may limit their response to the governing body or bodies that would interface with the organization's participation in BPCI Advanced.

Q39: For Applicants who are applying as a Convener Participant for a large number of Episode Initiators, do you have a template that we can populate for the table in Question # 6 regarding Sanctions, in the Quality Assurance section of the application?

A39: There is no template for the table that must be completed in Question #6 regarding Sanctions. Responses to this question must be completed through the BPCI Advanced Application Portal. The Portal can accommodate an unlimited number of rows, however, each response will need to be entered individually.

It's important to note that the PDF application document, available on the website, was created as a guide for Applicants. Responses to all application questions and application attachments will only be accepted when submitted via the BPCI Advanced Application Portal.

Q40: In the Quality Assurance section of the application - Question #6 asks to list "Sanctions", how much detail we need to provide?

A40: CMS requires that any sanctions, investigations, Corrective Action Plans, and/or probations within the last 5 years that involve the Applicant, the potential Downstream Episode Initiators included on the Participating Organizations attachment, and/or the PGP Practitioners listed in the attachment, must be included in this table. All the information must be manually entered into the Application Portal since upload of a separate document is not acceptable.

Q41: We are a Convener Applicant that is not a Medicare provider, but the application has two (2) fields for which we do not have the required information - National Provider Identification (NPI) and CMS Certification Number (CCN), what should we do?

A41: Conveners Participants that are not Medicare providers will need to enter 10 zeroes in the NPI required field and 6 zeroes in the CCN required field in order to submit their application.

If the incorrect character length is entered for the TIN, NPI, and/or CCN, the Application Portal will clear out the field since it does not meet the required character length. The character length is as follows: TIN= 9 digits, NPI= 10 digits, CCN= 6 digits.

Q42: If we submit the application as an Acute Care Hospital (as a Non-Convener Participant), do we need to submit a list of the physicians in our hospital?

A42: No, you do not need to submit a PGP Practitioners attachment if you are an Acute Care Hospital (ACH) submitting a BPCI Advanced Application as a Non-Convener Participant.

Q43: I forgot my username for the Application Portal, what do I do? I can't log into the Portal, please help.

A43: The username for accessing the BPCI Advanced Application portal will be the email you used to register, plus the extension.bpciadv (e.g. name@gmail.com.bpciadv). If you have technical problems with the Application Portal, please contact the Help Desk at CMMIForceSupport@cms.hhs.gov or call 1-888-734-6433, option 5. Do not email the BPCI Advanced Team, as that will only delay action on your inquiry.

Q44: What happens to applications that are "In Progress" at midnight March 13, 2018?

A44: Any application not submitted by 11:59 pm EST on March 12, 2018 via the BPCI Advanced Application Portal will be considered "Incomplete" and will not be processed by CMS.

After the BPCI Advanced Application Portal closes, users will still be able to log in and view/download pdf versions of any "Submitted" applications.

Pricing Methodology

Q45. What are the Clinical Episodes' volume thresholds for Episode Initiators that are Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs)?

A45: 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 Preliminary 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.

Since PGPs receive prices based on a hospital-based price, PGPs will only receive Preliminary 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.

More information on the volume thresholds are available in the Target Pricing Specifications document that is currently available on our website - <https://innovation.cms.gov/Files/x/bpciadvanced-targetprice-my1-2.pdf>.

Q46: What happens when a Clinical Episode is triggered because of an admission/Anchor Stay for a Medicare Severity-Diagnosis Related Group (MS-DRG) included on the definitions 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 definition list?

A46: In most cases, once a Clinical Episode is triggered and attributed to a Participant, the Clinical Episode will continue, unaffected, regardless of whether an additional Clinical Episode could be triggered by a readmission.

The one exception to this policy is for the Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episode. When a second Major Joint Clinical Episode is triggered during the 90-day post-discharge period, the first Major Joint Clinical Episode is canceled. However, if the 2nd Major Joint admission occurred at the initial hospital or at another hospital that is a BPCI Advanced Participant, a new Clinical Episode would begin, which will be assigned according to the precedence rules of the Model using the Anchor Stay billed claims.

Q47: Would you please explain how the potential 10% quality adjustment is applied to negative or positive Net Payment Reconciliation Amounts (NPRA)?

A47: 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%.

Q48: Will the true-ups for this Model be 15 months long as they are in the current BPCI initiative?

A48: BPCI Advanced will have semi-annual reconciliations, with two subsequent true-ups occurring at six-month intervals. For instance, for episodes ending between July 1, 2019 and December 31, 2019, Reconciliation will occur in the spring of 2020. Subsequent true-ups will occur in the fall of 2020 and spring of 2021, which is approximately 15 months after the Performance Period ends, depending on when the episode ended during the performance period.

Q49: Will all Clinical Episodes be included in the baseline, regardless of precedence or overlap with other models, like the Comprehensive Care for Joint Replacement (CJR) model?

A49: The baseline period will include all Clinical Episodes, without consideration of the precedence rules used in the BPCI Advanced Model Performance Period.

Q50: If multiple hospitals bill under the same Tax Identification Number (TIN), must they all participate in the Model and must they all select the same Clinical Episodes?

A50: If multiple hospitals bill under the same TIN, they do not all have to participate in the Model. A hospital that is a Non-Convener Participant and hospitals that are Downstream Episode Initiators under a Convener Participant will be defined and priced at the CMS Certification Number (CCN) level. Each

individual CCN that wants to participate as a Non-Convener Participant will need to apply separately. The TIN level is how we define PGPs in BPCI Advanced.

Q51: If a Physician Group Practice (PGP) Episode Initiator begins practice at a new hospital, will episodes triggered at that hospital be included in the Model?

A51: Yes, the PGP will be able to trigger Clinical Episodes at the new hospital, as long as the hospital has sufficient volume in its baseline period to establish a hospital-based Target Price. However, the PGP would not receive a specific Preliminary Target Price for the new hospital. We would only be able to provide the hospital price and the PGP would receive the Final Target Price at Reconciliation.

Q52: What will trigger getting the Clinical Episode attribution? Which fields on the claim are key?

A52: Per the precedence rules in BPCI Advanced, the Attending and Operating Physician National Provider Identifiers (NPIs) and the hospital's CMS Certification Number (CCN) for BPCI Advanced MS-DRGs on the institutional claim are the key fields for Clinical Episodes attribution.

More information regarding the precedence rules and the episode attribution methodology can be found in the BPCI Advanced RFA on our website - <https://innovation.cms.gov/Files/x/bpciadvanced-rfa.pdf>.

Q53: Is CMS planning to make available any additional details about the pricing methodology any time soon?

A53: We're currently working on the BPCI Advanced Episode Construction Specifications for Model Years 1 and 2 and plan to make them available soon.

Q54: When will the revised version of the Exclusions List be available?

A54: The MS-DRGs Exclusions from Clinical Episodes List is now posted on our website - <https://innovation.cms.gov/Files/x/bpciadvanced-msdrg-exclusions.xlsx>.

Q55: Formulas refer to Case Mix factors [Patient Case Mix Adjusters (PCMA) for Acute Care Hospitals (ACHs)] and Relative Case Mix for Physician Group Practices (PGPs) as "preliminary". Are they the only factors that will change with actual Model Year Clinical Episodes (other than ratio of real dollars to standardized dollars)?

A55: Yes, the Target Price may be adjusted for fee schedule updates, as applicable, on October 1 or January 1, if a new Target Price does not go into effect on the same date.

Q56: In BPCI Advanced, are Target Prices calculated at the Clinical Episode category level, and no longer at the DRG level within categories like in the BPCI initiative?

A56: Correct, in BPCI Advanced the Target Prices will be adjusted based on the specific MS-DRG billed, which will account for severity and, in some cases, procedure type. The Target Price continues to account for MS-DRG, but it will not be the only criteria that stratifies the Target Price.

Q57: When different cardiac related Clinical Episodes occur or overlap in the same 90-day period, how is this handled?

A57: Most inpatient cardiac-related readmissions within 90 days following the Anchor Stay or Anchor Procedure will be bundled into the initial Clinical Episode. If the readmission has a MS-DRG on the Exclusions List, those costs for the admission, including any Part B claims incurred during the time period of the readmission will not be included in the Clinical Episode.

Q58: How does regional peer-standardization impact Standardized Baseline Spending for ACH Baseline Prices? I.e. would a provider that performs well (for their case mix and compared and their peer group) continue to receive bonuses in a program if all stays equal (straight-line trends)?

A58: If we assume that the PAT Factor=1 (indicating that there is no trend), a provider that historically performed well for their case mix and compared to their peer group would have an Efficiency Measure below 1. In that case, if the trend stays the same, the provider would receive achieve a Positive Total Reconciliation Amount if they outperform their historical spending, conditional on the case mix of their Model Year clinical episodes.

Q59: The spec document lists goals that the methodology accomplishes. Can you provide more information as to which components of the methodology address the 1st two goals (encouraging both high and low cost providers to participate and rewarding participant improvement over time)?

A59: The BPCI Advanced methodology encourages both high and low cost providers to participate through the efficiency measure. The efficiency measure, as described in Step 8, measures Participants' Clinical Episode spending, relative to other Episode Initiators, for Clinical Episodes with the same patient and peer group characteristics. So both high and low cost providers will have incentives to participate in the model as Participants will be rewarded relative to their own historical spending.

Additionally, the PAT factor is derived from peer groups, so Participants will be continually benchmarked against their peers. A Participant's PAT factor will only trend downward over time if their peers spending is declining. Thus, Participant's will be rewarded for continually outperforming their peers during the BPCI Advanced Model Years.

Q60: For peer group characteristics, there is reference to census division 1-9 - is this region and What is the derivation of the Predicted Ratio from Peer Group Factor (step 4b)? What is the derivation of the PAT factors (step 1)? Given the magnitude of these factors in the examples provided, we would like to better understand how they are derived.

A60: The derivation of the PAT Factor is as follows—Sum the product of each of the coefficients from the Stage 2 regression (Step 4b) derived from the baseline period Clinical Episodes and the respective current peer group characteristic with values for time trend variables updated to the middle of Model Year 2.

Q61: What information will be used to determine the palliative care cost that will now be incorporated into the target price?

A61: Medicare claims from Hospice providers will be used to determine palliative care costs.

Data

Q62: Why do Applicants will receive only 3 years of historical data (2014-2016) and not the 4 years (2013-2016) of data used to calculate the Target Prices?

A62: Per the guidelines of the Applicant Data Request and Attestation (DRA) form that is posted on the BPCI Advanced website, we are only able to provide data that contains beneficiary-identifiable claims for health care operations purposes as defined under HIPAA. This data must also be the "minimum

necessary” to carry out that intended purpose. It has been determined that 3 years of raw claims data meets that legal requirement.

Q63: Will CMS provide sample file formats for the historical claims files that are expected to be provided to Applicants in May 2018?

A63: We are still finalizing the data file layouts and variables that will be used in BPCI Advanced. Once complete, we plan to provide sample file layouts to Applicants prior to the release of the historical data and also plan to provide similar monthly file layouts to Participants prior to the release of the first monthly data feed.

Q64: Are baseline Clinical Episodes created using the Episode Admission Dates for that period? For example - will baseline period episodes starting on December 31, 2016 will be included in claims 90 days past discharge?

A64: The initial baseline period for BPCI Advanced contains potential Clinical Episodes that began on or after January 1, 2013 and ended on or before December 31, 2016.

Q65: Our Physician Group Practice (PGP) has a fairly new Taxpayer Identification Number (TIN), what kind of data will we receive?

A65: CMS will provide raw claims or aggregate claims data (or both) to Applicants for their historical episodes. Since the newly formed PGPs will not have any historical Clinical Episodes during the baseline period, we cannot provide any raw or aggregate data for these potential Episode Initiators.

Additionally, it’s important to note that newly formed PGPs will not receive a PGP-specific Preliminary Target Price. Instead, they will receive the Target Price of the hospital at which they initiate a given episode. At the time of reconciliation, once we know at what hospitals the PGP initiated its Clinical Episodes, we will calculate the PGP-specific Target Prices based on those hospitals’ historic baseline prices and the PGP’s realized case mix.

Q66: Who can have access to the data that CMS will provide to Applicants?

A66: Applicants will need to fill out a Data Request and Attestation (DRA) form and submit it with the application in order to receive any data. On this form they will identify two Primary Points of Contact (PPOCs) for their organization and these PPOCs will be able to directly access the data. However, they will also have the ability to provide downstream users access to the data if they have Business Associate Agreements (BAAs). 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.*

Models Overlap

Q67: If a current Awardee in the BPCI initiative is located in a mandatory Metropolitan Statistical Area (MSA) for the Comprehensive Care for Joint Replacement (CJR) model (and does not have rural or low-volume status), will the provider be automatically moved into CJR once the BPCI initiative ends in September 30, 2018, or do they have an option to enroll in BPCI Advanced for Major Joint Replacement of the Lower Extremity (MJRLE) episodes instead of CJR?

A67: The hospital will automatically be moved to the Comprehensive Care for Joint Replacement (CJR) Model effective October 1, 2018. The organization will have the opportunity to participate in BPCI Advanced when the BPCI initiative ends, but will not be able to participate for Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episodes.

Q68: Comprehensive Care for Joint Replacement (CJR) hospitals can't enter BPCI Advanced for Medicare-Severity Diagnosis Related Groups (MS-DRGs) 469 and 470, but can they enter for other joint related episodes?

A68: Yes, a Comprehensive Care for Joint Replacement (CJR) hospital is able to participate in BPCI Advanced for other Clinical Episodes except Major Joint Replacement of the Lower Extremity (MS-DRGs 469 & 470), including other orthopedic related episodes.

Q69: Can an independent Orthopedics group in a Comprehensive Care for Joint Replacement (CJR) market participate in BPCI Advanced?

A69: Yes, an Orthopedic Physician Group Practice (PGP) in a CJR metropolitan statistical area can participate in BPCI Advanced. However, any procedures under Medicare-Severity Diagnosis Related Groups (MS-DRGs) 469 or 470 performed at a CJR hospital will be included in the CJR model and not in BPCI Advanced. Also, PGPs that select Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episodes in BPCI Advanced will not receive Target Prices for that episode at any CJR hospital.

Q70: If a BPCI Advanced Congestive Heart Failure (CHF) Clinical Episode is triggered and the patient is subsequently admitted for a Major Joint Replacement of the Lower Extremity (MJRLE) procedure in a Comprehensive Care for Joint Replacement (CJR) hospital, will the CHF Clinical Episode be dropped, and the CJR Major Joint Clinical Episode be retained?

A70: Yes, the CHF Clinical Episode will be dropped in the BPCI Advanced Model because CJR takes precedence and the Major Joint replacement procedure would trigger a Clinical Episode in the CJR model.

Q71: In reading the Request for Applications (RFA), it states that entities that are part of the Next Generation Accountable Care Organization (Next Generation ACO) Model can still apply for BPCI Advanced, however it also says that Next Generation ACOs' beneficiaries cannot participate in BPCI Advanced. Can you provide some clarity on this question?

A71: Entities that are a part of the Next Generation ACO model, Medicare Shared Savings Program (MSSP) Track 3, and Comprehensive ESRD Care (CEC) model are still able to apply for the new Model. BPCI Advanced does not exclude these entities based on their participation in these other models.

However, beneficiaries that are prospectively aligned to the Next Generation ACO Model, Medicare Shared Savings Program Track 3, and the CEC model are not able to trigger BPCI Advanced Clinical Episodes.

But if the Medicare provider serves other beneficiaries that are not prospectively aligned to the excluded models, they would be able to potentially trigger a BPCI Advanced Clinical Episode. So essentially, providers can be in both models, but beneficiaries cannot.

Q72: Will there be a way to identify patients who are in a Track 3 Accountable Care Organization (ACO) who will not trigger Clinical Episodes for BPCI Advanced?

A72: We are looking into ways to provide this information.

Q73: We will begin to participate in a Track 1+ Accountable Care Organization (ACO) on January 1, 2019. How would the savings work if we had a patient who is a part of the ACO and also has a claim that triggers a Clinical Episode in BPCI Advanced?

A73: Beneficiaries aligned to Accountable Care Organization (ACOs) in Track 1, 1+ and 2, 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 aligned with an Medicare Shared Savings Program ACO in Track 1, 1+, or 2 that achieved shared savings, and 2) began a BPCI Advanced Clinical Episode that was attributed to a BPCI Advanced Episode Initiator that participated with the ACO to which the beneficiary was also aligned. More information on the actual recoupment calculation methodology will be provided in the future.

Q74: Are patients in the Comprehensive Primary Care Plus (CPC+) model excluded from BPCI Advanced?

A74: No, CPC+ beneficiaries can trigger Clinical Episodes in BPCI Advanced.

Waivers

Q75: Can Internal Cost Savings (ICS) be part of a Net Payment Reconciliation Amount (NPRA) sharing arrangement?

A75: Yes, CMS intends to include Internal Cost Savings (ICS) in BPCI Advanced.

Q76: Is a Participant limited to share its Net Payment Reconciliation Amount (NPRA) with only providers on the Participating Organizations attachment, or is it allow to share with others?

A76: The Participating Organizations attachment is only submitted during the application process. Once a Participant commits to BPCI Advanced by signing a Participation Agreement, if they intend to engage in NPRA Sharing they must submit a Financial Arrangements List (FAL) identifying those organizations and/or individuals with which they intend to do NPRA Sharing. This is a required deliverable due 60 days before the start of the Model Year. That list can be updated on a quarterly basis.

Q77: What type of Net Payment Reconciliation Amount (NPRA) sharing is permitted for Accountable Care Organizations (ACOs) in the BPCI Advanced Model?

A77: Accountable Care Organizations (ACOs) are allowed to apply to participate in the Model as Convener Participants. ACOs may also participate as NPRA Sharing Partners.

Quality Payment Program

Q78: What is a Qualifying Alternative Payment Model Participant (QP)?

A78: Under the Quality Payment Program, a Qualifying APM Participant (QP) is an eligible clinician (EC) who has a certain percentage of their patients or payments through an Advanced APM (via the APM Entity or as an individual, depending on how they participate). QPs are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustment and will instead receive a 5% APM Incentive Payment.

Q79: When are Participants in BPCI Advanced exempt from MIPS?

A79: Eligible clinicians who earn QP status for a year are exempt from MIPS reporting requirements and payment adjustment for that year. Eligible clinicians participating in an Advanced APM can also earn Partial Qualifying APM Participant (Partial QPs) status by meeting a lower threshold. Partial QPs have the option to be excluded from MIPS and receive a neutral payment adjustment or to participate in MIPS. Participants in BPCI Advanced will have the opportunity to earn QP or partial QP status beginning in 2019.

Q80: How will Qualifying APM Participant (QP) determinations be made?

A80: QP determinations will vary depending on the type of Participant and Episode Initiators:

1. For **Non-Convener Participants that are Hospitals**, eligible clinicians will be assessed individually for purposes of QP determinations.
2. For **Non-Convener Participants that are PGPs**, eligible clinicians will be assessed as a group for purposes of QP determinations.
3. For **Convener Participants** who will have hospitals and PGPs as Episode Initiators, the QP determinations for eligible clinicians will be made for those eligible clinicians participating through PGPs only, and they will be assessed as a group.
4. In order to avoid this action for hospital-based eligible clinicians, **Convener Participants** may choose to enter into separate agreements with CMS for hospital Episode Initiators and PGPs Episode Initiators.
5. In order to avoid multiple PGPs be assessed as ONE group, **Convener Participants** may choose to enter into separate agreements with CMS for individual PGPs.

If a Convener Participant chooses to do either options 4 or 5, they must submit separate applications before the March 12th deadline.

Q81: What kind of documentation will Participants have to submit for Qualifying APM Participant (QP) determinations under BPCI Advanced?

A81: Eligible clinicians participating in BPCI Advanced will be able to earn Qualifying Participant (QP) status beginning for performance year 2019. In order for a QP determination to be made for an eligible clinician, they must be identified on either a **Participation List** or an **Affiliated Practitioner List** collected by CMS. In BPCI Advanced, eligible clinicians will be identified in the following ways for purposes of QP determinations:

- For Non-Convener Participants that are hospitals and Convener Participants who do not have any downstream Episode Initiators that are Physician Group Practices (PGPs), eligible clinicians who are NPRA Sharing Partners included on the [Financial Arrangements List \(FAL\)](#) will be considered **Affiliated Practitioners** in the Model for purposes of QP determinations. QP determinations for these eligible clinicians will be made at the individual level.
- Eligible clinicians who have reassigned their rights to receive Medicare payment to a Non-Convener Participant that is a PGP or PGP Episode Initiator and are included on the [PGP List](#) will be on the **Participation List** used for purposes of QP determinations under the Quality Payment Program. QP determinations for these eligible clinicians will be made at the group level.

Q82: What are the Certified Electronic Health Record Technology (CEHRT) requirements for participants in BPCI Advanced?

A82: As of the Participant's start date in BPCI Advanced (October 1, 2018), the Participant must use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care to their patients or other healthcare providers.

- For hospitals that are Non-Convener Participants, the hospital must use CEHRT.
- For Physician Group Practices (PGPs) that are Non-Convener Participants, at least 50% of the PGP's eligible clinicians must use CEHRT.
- For Convener Participants who will have hospitals and PGPs as Episode Initiators, the hospitals must use CEHRT and at least 50% of the eligible clinicians in each PGP must use CEHRT.