

## **BPCI Advanced FAQs**

(updated 3/1/18)

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) recently announced the Bundled Payments for Care Improvement (BPCI) Advanced (the Model). This highly anticipated model comes with significant and unexpected changes to the BPCI initiative. BPCI began in 2013 and will continue unchanged until its conclusion on September 30, 2018. *For additional questions, please contact Dena McDonough, Manager, Payment Policy at [mcdonough@aaos.org](mailto:mcdonough@aaos.org).*

### **Q1. What is BPCI Advanced?**

**A1.** BPCI Advanced is a new voluntary payment model meant to build upon the BPCI initiative. However, it is a separate and distinct model. Preliminary target prices will be provided for each Clinical Episode in advance of the performance period of each model year. This Model consists of a single payment and risk track, with a 90-day Clinical Episode duration. Reconciliation will occur semi-annually. BPCI Advanced will qualify as an Advanced Alternative Payment Model (APM) under the Quality Payment Program. Episodes will be triggered by DRG specific Medicare fee-for-service claims. Managed care plans will not trigger the Model.

### **Q2. What Clinical Episodes are included in the Model?**

**A2.** There are a total of 32 Clinical Episodes included in the Model, 3 of which are outpatient. There are 10 inpatient and 1 outpatient orthopaedic episodes. Episode duration begins on the day of discharge for inpatient episodes and day of procedure for the outpatient episodes. Additional episodes may be added and current episodes may be altered. Outpatient TKA is not currently under consideration.

- Back and neck (except spinal fusion)
- Cervical spinal fusion
- Combined anterior-posterior spinal fusion
- Bilateral lower extremity joint replacement
- Fractures of femur and hip, or pelvis
- Hip and femur procedures (except major joint)
- Lower extremity (except hip, foot, and femur) and humerus procedures
- Major joint replacement of the lower extremity
- Major joint replacement of the upper extremity
- Spinal fusion (non-cervical)
- Outpatient back or neck procedures (except spinal fusion)

### **Q3. What is the biggest change affecting orthopaedic surgeons?**

**A3.** When Comprehensive Care for Joint Replacement (CJR) was introduced, Physician Group Practices (PGP) and Acute Care Hospitals (ACH) already participating in the previously established BPCI initiative were exempt from the mandatory CJR model. Moreover, BPCI participants took precedence over hospitals in CJR and PGPs took precedence over ACHs. **On October 1, 2018, BPCI hospitals in mandatory CJR Metropolitan Statistical Areas (MSA) will become CJR participating hospitals. They will not be eligible to participate in BPCI Advanced.**

This causes concern for several reasons. First, by allowing hospital-controlled models to take precedence over PGPs, we lose ground on the limited opportunities for physician leadership in alternative payment models. Second, with little faith in a return on investment, this lowers the incentive for the next round of innovators.

**Q4. What else do I need to know about precedence and attribution?**

**A4.** Until September 30, 2018, BPCI episodes will continue to have precedence over CJR. Once BPCI ends, all hospitals participating in CJR (either in mandatory or voluntary MSAs) will have precedence over a PGP participating in BPCI Advanced Lower Extremity Joint Replacement (LEJR) Clinical Episodes. All other, non-LEJR Clinical Episodes in BPCI Advanced will continue to have unchanged precedence rules. BPCI Advanced PGPs will still have precedence over hospitals. Clinical Episode attribution for BPCI Advanced is as follows:

Attending PGP → Operating PGP → ACH

There are no time-based precedence rules in BPCI Advanced. Those participants starting in October 2018 will not have precedence over those who might start in future years.

**Q5. How did this happen?**

**A5.** In the recently finalized CJR Final Rule, CMS decreased the number of mandatory MSAs from 67 to 34. Because of the decrease in potential participants in CJR, the decision to maximize episode capture in that demonstration became the priority. While we have taken every opportunity to strongly oppose this decision, CMMI maintains their position and states there is no plan to alter this policy. They have pointed out that there are still several other episodes in which to participate, as this restriction only effects one of the 32 bundles.

**Q6. When will BPCI Advanced begin?**

**A6.** The first cohort of participants will start on October 1, 2018, and the performance period will run through December 31, 2023. For those who are not yet ready to participate, there will be an additional opportunity to apply in Model year 2020.

**Q7. What is the deadline for applications for the period beginning on October 1, 2018?**

**A7. Applications are due March 12, 2018 at 11:59pm.**

**Q8. What else do I need to know about applying?**

**A8.** The target prices will not be available before the application is due, but will be sent out in June with the Participant Profile agreements. However, all potential EIs must be in the application and cannot be added later. This is necessary because the data for each EI included in an application will be used to determine the target price. EIs may appear in multiple applications as inclusion does not ultimately require participation. Once applications are received, CMMI will perform analysis to provide target pricing for all Convener and non-Convener participants in the Model. Target pricing will be made available in June. EIs can then decide in which, if any, bundle they wish to participate. This decision must be made prior to submitting the Participant Profile by August 1, 2018, as EIs may only appear in ONE Participant Profile. Those appearing in more than one will be rejected from all participation in this participation period.

To download a Request for Applications document (RFA), the application template, and the necessary attachments, please visit: <https://innovation.cms.gov/initiatives/bpci-advanced>. Applications must be submitted via the [Application Portal](#).

**Q9. Who can participate in BPCI Advanced?**

**A9.** Only ACHs and PGPs can be Episode Initiators (EI). An EI can participate as a Convener or Non-Convener. A Non-Convener bears risk only for itself, whereas a Convener brings multiple EIs together and bears and apportions financial risk for all Participants. Medicare-enrolled providers or suppliers, Physician Group Practices (PGPs), eligible entities that are not enrolled in Medicare, and Acute Care Hospitals (ACHs) may all participate as convener participants.

During the Model, if two PGPs merge under a TIN that is participating in BPCI Advance, they can continue to participate. If two hospitals merge under a CMS Certification Number (CCN) that is participating, they can continue to participate.

**Q10. Who cannot participate in BPCI Advanced?**

**A10.** Hospitals in Maryland, Critical Access Hospitals, hospitals in the Rural Community Hospital Demonstration and Pennsylvania Rural Health model are ineligible to participate in the Model. PGPs operating in Maryland and another state (or DC) CAN participate. During the model, if an organization participating in BPCI Advanced merges with another that is not participating merge under a new CCN/TIN, they CANNOT continue to participate.

**Q11. Will there be any waivers available for this model?**

**A11.** CMMI is requesting fraud and abuse waivers on BPCI Advanced. If issued, they are expected to be available prior to execution of the Participant Agreement and effective on October 1, 2018. CMS also intends to offer conditional waivers related to the 3-day SNF Rule, telehealth, and post-discharge home services.

**Q12. What do we know about the financial methodology for BPCI Advanced?**

**A12.** The target pricing methodology produces benchmark pricing for ACHs and PGPs that compares populations with similar expenditure risk and hospital-level characteristics (peer groups). The Hospital Benchmark Price (HBP) is comprised of baseline spending, patient case mix adjustment (PCMA), and the peer-adjusted trend (PAT) factor. The PAT replaces the National Trend Factor and adjusts for peer group characteristics.

PGPs will receive hospital-specific target pricing for each hospital where they practiced in the baseline period. Because all PGP episodes will be initiated at an ACH, the PGP benchmark price will build upon the HBP. The HBP will then be adjusted by substituting the PCMA with the PGP's relative case mix and the PAT with the PGP's historical spending efficiency.

The baseline period is January 1, 2013 through December 31, 2016. Preliminary target prices will be set prospectively, provided prior to the start of each model year, and rebased annually beginning with model year 3 on January 1, 2020. The CMS discount is 3% and reconciliation will happen semiannually. Adjustments will also be made when new CMS payment changes are released.

One preliminary prospective target price will be provided for all lower extremity joint replacement (LEJR) episodes. The target price will incorporate the proportion of fracture vs. nonfracture episodes occurring in the baseline period. Changes in cost for fracture vs. non-fracture will be accounted for in the case mix adjustment. If the proportion of fracture increases in the performance period, the case mix adjustment would increase and potentially raise the target price at reconciliation. CMS is aware of shift to outpatient setting for TKAs and is currently working on finalizing the details to account for change in target pricing. Any change in policy will be communicated as soon as feasible.

Semiannual reconciliation cycles will take place for the first time in the fall for episodes occurring on or before June 30th and in the following spring for those from July 1 through December 31st (with the exception of 2018). Each initial reconciliation period will have two true ups on the same cycle. Episodes will have one to one and half years of claims runout at their final reconciliation.

**Q13. How will the stop loss be applied?**

**A13.** The twenty percent stop loss and stop gain policies will be applied at the level of the Episode Initiator (EI), rather than the awardee level, as it was in BPCI. The results of all clinical episodes are aggregated to the EI prior to applying the stop loss/gain cap. At the individual clinical episode, the annual pool of all clinical episodes is capped at the 1<sup>st</sup> and 99<sup>th</sup> percentile of the allowable amounts using the national data set of clinical episodes.

**Q13. Does BPCI Advanced qualify as an advanced APM?**

**A13.** Yes. Providers can reach Qualifying Participant (QP) status in Performance Year 2019. In 2019, the QP status threshold for the advanced APM is 50% of payments or 35% of patients. In BPCI Advanced,

- Participants will be financially at risk for up to 20% of the final target price for each clinical episode.
- Participants must use Certified Electronic Health Record Technology.
- Payment will be linked to quality measures.

**Q14. How will quality be measured?**

**A14.** In the first two model years, Participants must report on seven claims-based quality measures. CMS may introduce additional non-claims based measures in future years. For the time being, Participants will not be required to submit quality data to CMS for purposes of BPCI Advanced. Performance will be assessed for each measure at the episode level and rolled up to the EI. These scores will then be used to generate a Composite Quality Score (CQS) and CQS adjustment amount for each Clinical Episode. For the first two model years, any adjustment by the CQS Adjustment Amount to a positive or negative Total Reconciliation Amount will be capped at 10 percent.