Clinical Episode Construction Specifications
Model Years 1 and 2

Centers for Medicare & Medicaid Services (CMS)
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1 INPUTS

Table 1 – Clinical Episode and Setting-Specific Price Update Factor Inputs[1]

#	Name	Source	Description
Clinical Episode Construction Datasets			
1	Common Working File (CWF)	CMS	BPCI Advanced National Clinical Episodes are constructed using all Part A and B claims (Inpatient, Carrier, Outpatient, Home Health Agency Services, Skilled Nursing Facility, Durable Medical Equipment, and Hospice) with a service date in the given baseline period or Performance Period.
2	BPCI Advanced Participant Profile[2]	CMS	The Participant Profile identifies the Non-Convener Participants (Hospital and PGP Participants), Convener Participants and their Downstream Episode Initiators in the BPCI Advanced model.
3	Medicare Enrollment Database (EDB) and Common Medicare Enrollment (CME) files	CMS	The EDB and CME files are used to determine beneficiaries' eligibility.
4	Official CMS Standardized Allowed Amounts	CMS	Payments from the claims taken from the CWF are standardized using the official CMS payment standardization algorithm.
5	Provider Specific Files (PSF)	https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_SAS.html	The file contains information about the facts specific to the provider that affects computations for Prospective Payment Systems.
6	Geometric Mean Length of Stay (GMLOS) data	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending See Table 5	The GMLOS data are used to prorate non-outlier payments for the Inpatient Prospective Payment System (IPPS), Inpatient Rehabilitation Facility (IRF), and Long-Term Care Hospital settings.
8	Blood clotting factors HCPCS list	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html	List of HCPCS to identify blood clotting factors to control bleeding for hemophilia patients. In addition to this list, HCPCS J7199 is considered a blood clotting factor.

[1] Table 1 contains sources current as of March 2018, when these specifications were published. The model will use the most up-to-date sources available when constructing Clinical Episodes.
[2] The baseline period uses BPCI Advanced Applicant Profile.

#	Name	Source	Description
Setting-Specific Price Update Datasets			
9	IPPS Base Rates and MS-DRG Weights	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending	Used to update historical prices for the IPPS setting.
10	Geographic Practice Cost Index (GPCI), Relative Value Units (RVU), County/Locality Crosswalk, and Physician and Anesthesia Conversion Factors (CF)	GPCI : https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending RVU/Physician CF: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU18A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending Anesthesia CF: https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html	Used to update historical prices for the Physician Fee Schedule (PFS) setting.
11	IRF Conversion Factor (most recent only)	https://www.federalregister.gov/documents/2017/08/03/2017-16291/medicare-program-inpatient-rehabilitation-facility-prospective-payment-system-for-federal-fiscal See Table 4	Used to update historical prices for the IRF setting.
12	Medicare Economic Index (MEI) (most recent only)	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html	Used to update historical prices for the "Other" setting.
13	Skilled Nursing Facility (SNF) Resource Utilization Group (RUG) weights	https://www.federalregister.gov/documents/2017/10/04/2017-21327/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities See Tables 4 and 5	Used to update historical prices for the SNF setting.
14	Home Health Agency (HHA) base rates and Home Health Resource Group (HHRG) weights (most recent only)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html	Used to update historical prices for the HHA setting.
15	Addendum B and J from the Outpatient Prospective Payment System (OPPS) Final Rule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html	Used to update historical prices for the OPPS setting.

2 OUTPUTS

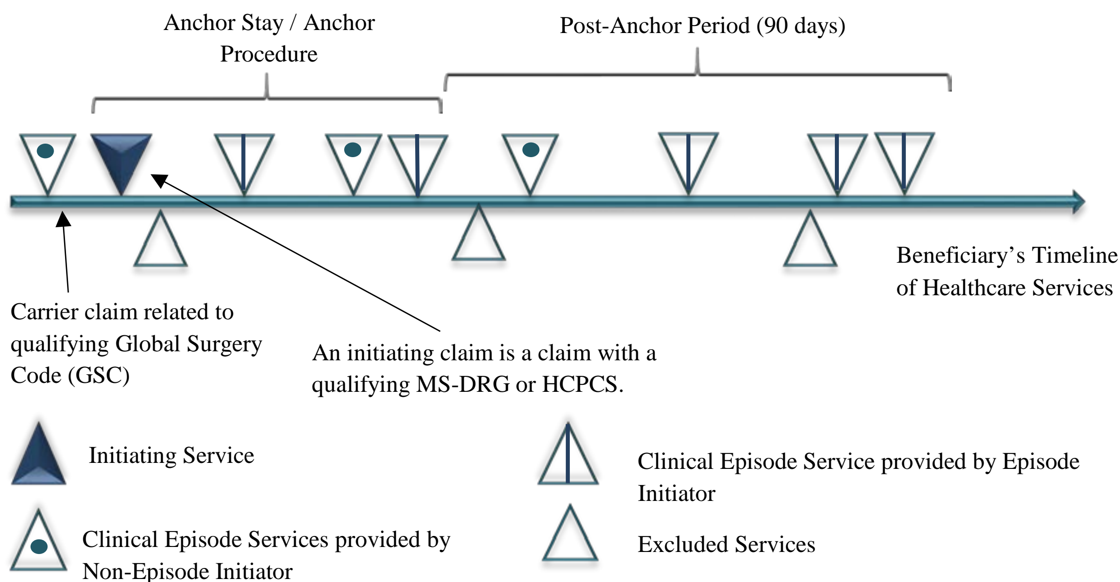
Table 2 – Clinical Episode Outputs

#	Name	Description
1	BPCI Advanced National and Applicant Baseline Period Clinical Episodes	The National and Applicant set of Clinical Episodes used to construct preliminary Target Prices for the BPCI Advanced model.
2	BPCI Advanced National and Participant Performance Period Clinical Episodes	The National and Participant set of Clinical Episodes used to construct final Target Prices and determine reconciliation and repayment amounts for the BPCI Advanced model.

3 CLINICAL EPISODE CONSTRUCTION OVERVIEW

The following document describes the specifications used to construct Clinical Episodes for the Bundled Payments for Care Improvement Advanced (BPCI Advanced) model. Clinical Episodes are constructed using all inputs in Table 1. The main components of Clinical Episodes are Parts A and B claims from the Common Working File (CWF). Figure 1 below outlines the basic principles of a Clinical Episode.[3]

Figure 1 – Clinical Episode Window and Services



Notes: 1) Triangles above the Beneficiary's Timeline of Healthcare Services represent services included in the Clinical Episode.
2) The Clinical Episode includes payments from up to one day prior to the Anchor Stay /Anchor Procedure to capture Emergency Department (ED) claims and Global Surgery Codes (GSC).

[3] All terms used in Figure 1 are defined in **Section 5**.

The twenty-nine inpatient and three outpatient Clinical Episode categories are identified by the MS-DRGs of an inpatient admission or the HCPCS of a procedure performed in an outpatient setting.[4] Clinical Episodes are constructed to include all services that overlap the Clinical Episode window, with some exceptions.[5] Clinical Episode-level payments are created by summing official CMS standardized allowed amounts for all non-excluded services.[6] 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 practice cost index (GPCI)) and from policy-driven adjustments (e.g. indirect medical education (IME) adjustments). This process produces spending for each Clinical Episode; henceforth, all references to spending are assumed to be in standardized allowed amounts.

After Clinical Episodes are constructed, standardized payments for each Clinical Episode in the baseline period are updated to Model Year dollars using setting-specific price update factors. This allows the model to update the standardized allowed amount that providers would receive based on how inputs have changed in the various Medicare payment systems while holding constant the mix of services in the baseline period. This approach is referred to as index-price trending.

These index-price trended historical Clinical Episodes represent the basis for comparing Episode Initiator performance in subsequent periods.[7] Other changes in Clinical Episode spending, due to efficiency gains, peer group trends, or changes in patient case-mix, are discussed in the Target Price specifications methodology document.[8]

The specifications are divided into the 6 sections that correspond to detailed descriptions of the sequential stages of the Clinical Episode construction process. This document contains specifications for constructing Clinical Episodes in both the baseline period and Performance Periods of a Model Year. The steps in **Section 4, Section 5,** and **Section 6** discuss general specifications used in the construction of baseline period and Performance Period Clinical

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[4] A complete list of the MS-DRGs and HCPCS that initiate a BPCI Advanced Clinical Episode can be found in the "Episode Definitions – Model Year 1" xls file on https://innovation.cms.gov/initiatives/bpci-advanced/.

[5] A list of Clinical Episode exclusions can be found in Step 14 and in the "MS-DRGs Exclusions from Clinical Episodes - March 2018" xls file on https://innovation.cms.gov/initiatives/bpci-advanced/.

[6] "CMS Standardization Methodology for Allowed Amount, Version 5." QualityNet - Measure Methodology, Centers for Medicare & Medicaid Services (CMS), Acumen, LLC, 24 Aug. 2016. Available at: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772057350.

[7] The setting-specific prices update factors will be updated to reflect the changes in Medicare payment systems as more recent fee schedules become available during the Model Year.

[8] Target Price Specifications for Model Years 1 and 2 can be found in the "BPCI Advanced Target Price Specifications - Model Years 1-2" PDF file on https://innovation.cms.gov/initiatives/bpci-advanced.

Episodes. The steps in **Section 7** and **Section 8** are applied to construct baseline period Clinical Episodes, which are the inputs used to construct preliminary Target Prices. The steps in **Section 9** are applied to construct Performance Period Clinical Episodes, which are inputs used to construct final Target Prices and Performance Period Clinical Episode payments.

- **Section 4** describes the mapping of MS-DRG and APC changes over time
- **Section 5** describes defining Clinical Episode shells
- **Section 6** describes assigning payments and services to Clinical Episodes
- **Section 7** describes updating historical payments from the baseline period to the Model Year
- **Section 8** describes finalizing baseline period Clinical Episodes
- **Section 9** describes finalizing Performance Period Clinical Episodes

Table 3 below contains the baseline period and the Performance Periods for Model Years 1 and 2 (10/1/2018-12/31/2019). This document will be updated for Model Year 3.

Table 3 – Model Years 1 and 2 Clinical Episode Period Date Ranges

Clinical Episode Period	Date Range
Baseline Period	Clinical Episodes that have Anchor Stays with a discharge date or Anchor Procedures with a procedure completion date between 1/1/2013 and 12/31/2016.[9]
Performance Period 1 (Model Years 1 and 2)	Clinical Episodes with a Clinical Episode end date between 10/1/18 and 6/30/19.[10,11]
Performance Period 2 (Model Year 2)	Clinical Episodes with a Clinical Episode end date between 7/1/19 and 12/31/19.[12]

[9] Procedure completion date for Anchor Procedures is indicated by the revenue center date.
[10] When an agreement is set to terminate off-cycle (prior to the start of the new Model Year), a Clinical Episode will be eligible for Performance Period reconciliation if the Anchor Stay/Anchor Procedure end date is prior to the agreement's termination effective date. When an agreement is set to expire beginning of the new Model year, a Clinical Episode will be eligible for Performance Period reconciliation if the Clinical Episode start date is prior to the expiration date. In both cases, Performance Period attribution will be based on Clinical Episode end date.
[11] Participants will not be assigned Clinical Episodes that begin before the model goes live on 10/1/18.
[12] See 10.

4 MAP MS-DRG AND APC CHANGES OVER TIME

When an MS-DRG or APC[13] changes in an annual update, comparing Clinical Episode spending between different time periods requires mapping between existing codes to new codes. Such a mapping ensures that comparisons of Clinical Episode payments across different time periods represent the same clinical content. This mapping aids in the consistent construction of Clinical Episodes between historical baseline periods and subsequent Performance Periods.

As the model progresses, mappings for MS-DRG and APC will be incorporated in accordance with the most recent IPPS/OPPS Final Rules. These steps are applicable to both baseline period Clinical Episodes and Performance Period Clinical Episodes to ensure consistency between these periods. Specifically, for Model Years 1 and 2, the Clinical Episodes in both the baseline period and Performance Period will be mapped to FY2018 MS-DRGs and CY2018 APCs.

Table 4 – Section 4 Inputs and Outputs

Inputs
• IPPS Final Rules (Fiscal Year 2013 – Fiscal Year 2018)
• OPPS Final Rule Addendums B and J (Calendar Year 2013- Calendar Year 2018)
• Inpatient and Outpatient CWF claims
Outputs
• Inpatient and Outpatient CWF claims with applicable mapped MS-DRGs and APCs

- **Step 1. Map MS-DRG and APC changes over time:**
  - **Step 1a.** For all MS-DRGs in the baseline period map the changes in MS-DRG between the baseline year and Fiscal Year 2018 using IPPS annual addendums to Final Rules.[14] For the MS-DRGs in the Performance Period, map back the MS-DRGs to Fiscal Year 2018.

[13] Effective January 1, 2015, CMS established Comprehensive-APC (C-APCs) to provide all-inclusive payments for certain procedures. All sections of this document use APCs to refer to both APCs and C-APCs.
[14] For a complete description of MS-DRG mapping specifications, see "Appendix_A_BPCI_Advanced_MS_DRG_Mapping_Model_Years_1_2.docx."

        - Assigns each inpatient stay with the original MS-DRG related to that hospitalization and the mapped MS-DRGs[15] for other years.
    - **Step 1b.** For all HCPCS, map all APC changes using the OPPS Final Rules.[16]
        - Assigns each outpatient claim the mapped APC, if any, for the relevant years.

[15] If there are no changes in the MS-DRG between the years, assign the original MS-DRG as the mapped MS-DRG for the other year.
[16] The HCPCS-APC mapping also takes into account APCs that undergo complexity adjustments, if any.

5 DEFINE CLINICAL EPISODE SHELLS

This section describes the specifications to define National inpatient and outpatient Clinical Episodes shells. **Section 5** and **Section 6** use the following key terms:

- **Anchor Stay:** an inpatient stay at an Acute Care Hospital (ACH) with a qualifying MS-DRG, which in turn initiates a Clinical Episode. Anchor Stays start on admission to the ACH and end upon discharge, inclusively.
- **Anchor Procedure:** an outpatient procedure performed at an ACH with a qualifying HCPCS, which in turn initiates a Clinical Episode. Anchor Procedures start and end on the revenue center date of the qualifying procedure.
- **Post-Anchor period:** starts on the day the Anchor Stay/Anchor Procedure ends and is 90 days long. It encompasses all the relevant spending incurred for that beneficiary during that period.

Clinical Episode shells start with the admission to an inpatient Anchor Stay or the revenue center date of an outpatient Anchor Procedure and end 90 days after the end of the Anchor Stay/Anchor Procedure. The Clinical Episode shells define the period for which services can be included in the Clinical Episode payment and are comprised of Anchor Stay/Anchor Procedure and Post-Anchor Period. There is a 90-day lookback period before the start of the Clinical Episode shell. This period will include risk adjustors defined by beneficiary clinical history as observed in claims in the 90-day period prior to the start of the Clinical Episode shell, and will be used solely for risk adjusting Target Prices.

- **Section 5.1** explains the methodology to identify potential National Anchor Stays for inpatient Clinical Episodes.
- **Section 5.2** describes the methodology to identify potential National Anchor Procedures for outpatient Clinical Episodes.
- **Section 5.3** describes the process of creating the Post-Anchor period.
- **Section 5.4** describes the Clinical Episode-level exclusions.

These steps of constructing Clinical Episodes shells are identical for the baseline period and all Performance Periods for Model Years 1 and 2. For the Model Years 1 and 2, the baseline period includes all Anchor Stays/Anchor Procedures ending between January 1, 2013, and December 31, 2016. Model Years 1 and 2 contain two Performance Periods, as defined in Table 3. Performance Period 1 will span Clinical Episodes that start and end between 10/1/18 and 6/30/19.[17,18] Performance Period 2 will span Clinical Episodes that end between 7/1/19 and 12/31/19.[19]

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[17] Participants will not be assigned Clinical Episodes that begin before the model goes live on 10/1/18.
[18] See 10
[19] Ibid.

Table 5 – Section 5 Inputs and Outputs

Inputs
• BPCI Advanced MS-DRGs and HCPCS
• Inpatient and Outpatient CWF claims with applicable mapped MS-DRGs and APCs
• Beneficiary Enrollment Datasets (EDB and CME)
Outputs
• Clinical Episode shells

5.1 Identify Potential National Anchor Stays for Inpatient Clinical Episodes

The following steps are used to identify potential National Anchor Stays from the universe of CWF inpatient claims. Anchor Stays initiate inpatient Clinical Episodes.

- **Step 2. Limit to inpatient stays with positive standardized allowed amounts.**
- **Step 3. Apply transfer logic:** Define an acute-to-acute transfer as consecutive inpatient stays for a beneficiary where the admission date of the latter stay is the same as the discharge date of the previous stay for different short-term hospitals. Acute-to-acute transfers are treated as one continuous hospitalization and are assigned the admission date and provider from the first leg of the transfer and the MS-DRG and discharge date from the last leg.[20,21]
- **Step 4. Construct Anchor Stays:** Restrict to inpatient stays at an ACH[22] that are initiated by a qualifying MS-DRG[23] for Clinical Episode categories. The start and end dates of the Anchor Stay are the admission date and discharge date respectively.

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[20] If any of the legs in a chain of inpatient transfers occur at a Cancer Hospital or Critical Access Hospital, exclude the Clinical Episode.

[21] Payments from both inpatient stays will be considered when services and associated payments are assigned in **Section 6.**

[22] ACH provider numbers include those with the last four digits of the CCN in 0001-0879, or the whole provider number between 450880 and 450894, excluding PPS-Exempt Cancer Hospitals (05-0146, 05-0660, 10-0079 , 10-0271, 22-016, 33-0154, 33-0354, 36-0242, 39-0196, 45-0076, and 50-0138), Critical Access Hospitals (the last four digits of the CCN in 1300-1399) and hospitals in Maryland (CCN begins with “21” or “80”). Additionally for the Performance Period, exclude hospitals participating in the Rural Community Hospital (RCH) demonstration and all Participant Rural Hospitals in the Pennsylvania Rural Health Model. These RCH and PA Rural hospitals are identified by CMS Participation list.

[23] Uses MS-DRGs mapped to FY2018 as described in **Section 4**.

5.2 Identify Potential National Anchor Procedures for Outpatient Clinical Episodes

The following steps are used to identify potential National Anchor Procedures from the universe of CWF outpatient claims. Anchor Procedures initiate outpatient Clinical Episodes.

- **Step 5. Limit to outpatient lines with positive standardized allowed amounts.**
- **Step 6. Apply same day, tie-breaking precedence rules:** For cases where multiple potential Anchor Procedures are possible on the same day for the same beneficiary, apply the following steps in the order listed until the ties are broken.
  - **Step 6a.** Select the outpatient line with the higher standardized line allowed amount.
  - **Step 6b.** Select the outpatient line with the later processing date.
  - **Step 6c.** Select the outpatient line with the higher charge amount.
  - **Step 6d.** Select the outpatient line with the smaller claim identifier number.
  - **Step 6e.** Select the outpatient line with the smaller line item number.
- **Step 7. Construct Anchor Procedures:** Take all outpatient lines at an ACH that are initiated by HCPCS for the three outpatient Clinical Episode categories. Set the start and end of the Anchor Procedure equal to the revenue center date.

5.3 Construct Post-Anchor Period

The following steps are used to define the second component of the Clinical Episode shell, the Post-Anchor period.

- **Step 8. Define Post-Anchor period:** Inpatient and outpatient Clinical Episodes' Post-Anchor periods respectively begin on the day Anchor Stays (**Step 4**) and Anchor Procedures (**Step 7**) end and extend for 90 days.[24]
- **Step 9. Truncate Clinical Episode shells where a beneficiary dies during the Post-Anchor period**: For Clinical Episode shells where a beneficiary dies during the Post-Anchor period, truncate the end date of the Post-Anchor period to match the beneficiary death date.[25]

5.4 Exclude Clinical Episode Shells

Implement the following exclusions for Clinical Episode shells.

- **Step 10. Enact Clinical Episode-level exclusions:** Exclude Clinical Episode shells where:

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[24] The discharge date and the procedure completion date are both day one of the Post-Anchor period.
[25] Beneficiary death date is taken from the EDB.

- o The Clinical Episode shell is not in the relevant study period.
  - For the baseline period, exclude Clinical Episodes with an Anchor Stay/Anchor Procedure that ends outside of the relevant study period. For example, if constructing Clinical Episodes for the baseline period, limit to inpatient Clinical Episodes with a discharge date and outpatient Clinical Episodes with a procedure completion date between 1/1/2013 and 12/31/2016.
  - For the Performance Period, exclude Clinical Episodes that end outside of the relevant study period.[26,27]
- o The beneficiary is not continuously enrolled in Medicare Part A and Part B during the Clinical Episode period or the 90-day lookback period.
- o The beneficiary is covered through managed care plans (such as Medicare Advantage) during the Clinical Episode period or the 90-day lookback period.
- o The beneficiary is receiving services for End-Stage Renal Disease (ESRD) during the Clinical Episode period or the 90-day lookback period. Specifically, a beneficiary is considered to be receiving ESRD services for any of the following conditions:
  - The start date and end date of Medicare ESRD coverage or dialysis in the EDB overlap any time with the Clinical Episode period or the 90-day lookback period or;
  - Any portion of the Clinical Episode period or the 90-day lookback period overlaps the period defined by the 36 months following the transplant start date in the EDB.
- o The beneficiary has a primary payer other than Medicare during the Clinical Episode period or the 90-day lookback period.[28]
- o The beneficiary dies during the Anchor Stay or Anchor Procedure.
- o The Anchor Stay lasts 60 days or more (the Clinical Episode shell lasts 150 days or more).
- o The Anchor Procedures initiated by outpatient lines do not have the highest ranking J1[29] status indicator on the claim.
- o Beneficiaries are prospectively aligned to Accountable Care Organizations (ACOs) that have sufficient two-sided risk: (1) a Next Generation ACO; (2) a Vermont All-payer ACO, which follows the Next Generation ACO Model design; (3) an ESRD

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[26] Clinical Episodes that start before the model goes live in 10/1/2018 are not considered.
[27] See Footnote 10
[28] This restriction satisfies excluding Clinical Episodes where beneficiary is covered through United Mine Workers of America Health and Retirement Funds.
[29] J1 indicates Hospital Part B services paid through C-APC.

Seamless Care Organization; or (4) a Track 3 Shared Savings Program ACO from initiating a BPCI Advanced Clinical Episode. This exclusion is only applicable to Clinical Episodes in the Performance Period.

6 ASSIGN SERVICES AND ASSOCIATED PAYMENTS TO CLINICAL EPISODES

This section describes the process of determining which items and services are included in Clinical Episodes. It is intended to provide a general understanding of the payment aggregation methodology for BPCI Advanced.

- **Section 6.1** describes the general rules for payment aggregation.
- **Section 6.2** discusses payments that are excluded from Clinical Episodes.
- **Section 6.3** describes the process for prorating payments from claims.
- **Section 6.4** discusses calculating the total Clinical Episode payment amount.

All steps in this Section are the same for construction of both baseline period and Performance Period Clinical Episodes.

Table 6 – Section 6 Inputs and Outputs

Inputs
• Clinical Episode shells
• All Part A and B claims and related standardized payments for the following settings: Inpatient, Carrier, Outpatient, Home Health Agency Services, Skilled Nursing Facility, Durable Medical Equipment, and Hospice from the CWF
• GMLOS data
• PFS
• Blood clotting factors HCPCS list
• BPCI Advanced exclusion list
Outputs
• National set of Clinical Episodes

6.1 General Rules for Payment Aggregation

This section describes the methodology to determine which items and services are included in the Clinical Episode and how payments from those services are allocated to the Clinical Episode. The methodology identifies all qualifying items and services occurring concurrent to at least one day of a Clinical Episode to determine if all payments, or a subset of

payments, are grouped to the Clinical Episode. Regardless of setting, all non-excluded payments are assigned as occurring during the Clinical Episode.

- **Step 11. Consider Parts A and B claims for payment aggregation:** Consider payments from claims from all Medicare Part A and B care settings, including inpatient, Carrier, outpatient, Home Health Agency Services, Skilled Nursing Facility, Durable Medical Equipment, and Hospice.
- **Step 12. Limit to eligible claims:** Restrict to claims that satisfy the following criteria:
  - Have a standardized payment amount greater than zero, and
  - The claim's service start dates overlap at least one day of the Clinical Episode or one day prior to the Clinical Episode.
- **Step 13. Assign claims as occurring during the Clinical Episode:** Assign all claims that have service dates during the Clinical Episode and all payments from the initiating Anchor Stay or Anchor Procedure. Additionally, include claims with Global Surgery Code (GSC) line items or Emergency Department (ED) in the one day prior to the Anchor Stay/Anchor Procedure to capture all associated payments.[30]
  - **Step 13a.** Identify Carrier claims related to a qualifying GSC as all Carrier claims with global surgery indicators of 000, 010, 090 and YYY.[31] Assign all Carrier claims related to a qualifying GSC on the start date or one day prior to the Clinical Episode.
  - **Step 13b.** Identify ED claims as outpatient claims with revenue center codes starting with 0450, 0451, 0452, 0456, 0459, 0981 or Carrier claims with a place of service (POS) equal to 23 (Emergency Department) occurring on the same day as an ED outpatient claim. Assign all these ED claims that occur on the start date or one day prior to the Clinical Episode.

6.2 Excluded Payments

Although the BPCI Advanced model operates under a total-cost-of-care concept, in which all Medicare Fee-For-Service (FFS) payments for services furnished during the Clinical Episode are generally included, payments from the following claims are removed from Clinical Episodes.

- **Step 14. Apply BPCI Advanced exclusions logic:** Remove payments for the following BPCI Advanced specific exclusions:

[30]Participants will be responsible for all Clinical Episode costs, including costs from the one-day prior.
[31]Global surgery indicators are modifiers on procedure codes that indicate the presence of surgical procedures and the length of the post-operative period.

- Blood clotting factors to control bleeding for hemophilia patients identified through the blood clotting factors HCPCS list on the outpatient, Carrier, and Durable Medical Equipment claims.[32]
- New technology add-ons, identified through value code 77 on IPPS hospital claims.[33]
- All Part A and B payments that occur during an inpatient readmission based on the excluded readmission MS-DRGs list.
- Pass-through payments for medical devices on OPPS hospital outpatient claims, identified through OPPS status indicator H.
- Claims that represent per-beneficiary-per-month (PBPM) payments from Carrier and Hospice claims. Specifically,
  - Remove Carrier claims for an Oncology Care Model PBPM payment as defined by HCPCS code G9678.
  - Remove Hospice claims for a Medicare Care Choices Model PBPM payment as defined by Demo Code = 73 and Type of Bill = 81x or 82x.

6.3 Prorate Claims

This section describes the methodology used to prorate claims and payments that span beyond the Clinical Episode as to appropriately allocate the payments to the Clinical Episode. Table 7 lists all claim and payment types and the respective proration methodology. For a full description of the various proration methodology, see **Steps 15 – 17**.

Table 7 – Proration Methodology by Claim and Payment Type

Claim Type	Proration Methodology
Carrier	Never Prorate
Critical Access Hospitals	Per Diem
Durable Medical Equipment	Never Prorate
Home Health Agency	Per Diem
Hospice	Per Diem
Inpatient Psychiatric Facility	Per Diem

[32] Inpatient claims with diagnosis codes for hemophilia and clotting factors are identified and excluded during the payment standardization process.
[33] This exclusion is applied during the payment standardization process.

Claim Type	Proration Methodology
Inpatient Rehabilitation Facility (Non-Outlier Payments)	GMLOS Method[34]
Inpatient Rehabilitation Facility (Outlier Payments)	Per Diem
IPPS (Non- Outlier Payments)	GMLOS Method
IPPS (Outlier Payments)	Per Diem
Long-Term Care Hospital (Non-Outlier Payments)	GMLOS Method
Long-Term Care Hospital (Outlier Payments)	Per Diem
OPPS	Never Prorate
Skilled Nursing Facility	Per Diem

- **Step 15. Identify claims to prorate:** Identify all claims that overlap with the Clinical Episode but end after the Clinical Episode to determine if all or a subset of payments are assignable to the Clinical Episode.
  - Never prorate outpatient, Carrier and Durable Medical Equipment claims. Assign them to the Clinical Episode.
- **Step 16. Identify and prorate applicable claims based upon a per-diem rate:** To prorate on a per diem basis, assign payments to the Clinical Episodes based on the number of days in the claim that occur during the Clinical Episode. Prorate the following types of claims on a per diem basis.
  - Critical Access Hospitals
  - Home Health Agency[35]
  - Hospice
  - Inpatient Psychiatric Facilities
  - Skilled Nursing Facility
- **Step 17. Identify and prorate remaining claims:** For the remaining claim types, Inpatient Rehabilitation Facility, Long-Term Care Hospital, and IPPS prorate outlier and non-outlier payment amount separately.

[34] Step 17b explains the GMLOS methodology.
[35] For Low Utilization Payment Adjustment (LUPA) Home Health Agency claims, only consider the visits that occur within the Clinical Episode window since these claims are paid on a per visit basis.

- **Step 17a.** Prorate outlier payments. Prorate outlier payments on a per-diem basis using the methodology described in **Step 16**.
- **Step 17b.** Prorate non-outlier payments. For non-outlier payments, compare the number of days of the inpatient stay (that needs to be prorated) overlapping the Post-Anchor period with the GMLOS by MS-DRG and the fiscal year of the discharge date.
  - If the number of days overlapping the Post-Anchor period is greater than the GMLOS, assign the full non-outlier payment amount to the Post-Anchor period.
  - Otherwise, prorate on a per diem basis, giving double weight to the first day of the overlap.

6.4 Calculate Total Clinical Episode Payment Amounts

After assigning payment amounts to Clinical Episodes for all claim payments across all settings, sum payment amounts at the Clinical Episode level.

- **Step 18. Calculate the overall Clinical Episode payment amounts:** Sum all payments assigned to the Clinical Episode to calculate total Clinical Episode payment.

For the baseline period, the Clinical Episode dataset created at the end of **Step 18** is inflated to Model Year dollars as described in **Section 7** and then used as an input in **Section 8** to create the final set of baseline period Clinical Episodes. For the Performance Period, the Clinical Episodes from **Step 18** are used as an input in **Section 9** to create a final National and Participant set of Clinical Episodes.

7 CALCULATE SETTING-SPECIFIC PRICE UPDATE FACTORS

This section describes the process of updating historical prices from the baseline period to the Model Year. Prior to estimating the model of Clinical Episode payments on data from the baseline period, the standardized payments of each Clinical Episode are inflated to Model Year dollars using setting-specific price update factors. This allows the model to update the standardized allowed amount that providers would receive based on how payment rates have changed in the various Medicare payment systems while holding constant the mix of services in the baseline period.

Use the most recently available inputs during preliminary Target Price construction to calculate setting-specific price update factors. Since there is a lag between the baseline period and Model Year, the inputs to calculate update factors for the Model Year may not be available at the time of calculation. In such cases, incorporate newly published payment rates into the price update methodology as the model is active to ensure that all prices in the baseline period reflect the most updated set of official rates for all settings.

Setting-specific price update factors are only applied to the Clinical Episodes in the baseline period as a means of ensuring consistency and comparability with Performance Period Clinical Episodes.

Table 8 – Section 7 Inputs and Outputs

Inputs
• National set of Clinical Episodes
• Setting-Specific Price Update Datasets (See Table 1)
Outputs
• National set of Clinical Episodes with updated prices

- **Step 19. Update payments from the initiating inpatient stay during the Anchor Stay:** For payments from the inpatient claim that initiates the Anchor Stay the update factor is calculated as a ratio of MS-DRG rates, calculated as the product of the IPPS base rate and MS-DRG weight in the Performance Period to the baseline period.[36]

[36] MS-DRGs in the baseline period are mapped forward to the Model Year using the methodology described in Section 4.

- The following example adjusts forward an Anchor Stay with MS-DRG 483 from Fiscal Year 2015 in the baseline period. To update the payments from this stay to Fiscal Year 2018, use the following equation:
  - (2018 IPPS Base Rate * 2018 MS-DRG Weight 483)/(2015 IPPS Base Rate * 2015 MS-DRG Weight 483)
- Multiply payments from the initiating institutional claim for the Anchor Stay by the update factor.

- **Step 20. Update payments from the initiating outpatient claim during the Anchor Procedure:** For payments from the initiating outpatient claim during the Anchor Procedure, use a separate approach depending on whether the C-APCs had been adopted or not in the baseline year.
  - **Step 20a.** Update HCPCS payments for the Anchor Procedure in the baseline year after adoption of C-APCs. For Anchor Procedure HCPCS that are paid after the adoption of C-APCs in both periods:
    - Calculate the numerator of the update factor as the payment rate of the APC that the Anchor Procedure's HCPCS maps to in the Performance Period.[37,38]
    - Calculate the denominator as the payment rate of the APC the Anchor Procedure HCPCS maps to in the baseline year.
    - Once the update factor is calculated, multiply the Anchor Procedure outpatient line amount by the update factor.
  - **Step 20b.** Update HCPCS payments for the Anchor Procedure in the baseline year before adoption of C-APCs. For these Anchor Procedure HCPCS where the baseline year was before the adoption of C-APC and the Performance Period was after the adoption of C-APC:
    - Calculate the numerator of the update factor as the payment rate of the APC the Anchor Procedure's HCPCS maps to in the Performance Period.
    - Calculate the denominator as the average of line payments of the Anchor Procedure's HCPCS and other eligible services on the same claim across all the Clinical Episodes in that baseline year using the following steps:

[37] APCs in the baseline period are mapped forward to the Model Year using the methodology described in **Section 4**.
[38] The APC payment rates can be found from OPPS Final Rule Addendums B and J. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html.

- Calculate outpatient Anchor Procedure payments as the sum of line payments from the Anchor Procedure's HCPCS and line payments for the following services on the same claim to mimic the OPPS modeling of C-APC payments:
    - Packaged or conditionally packaged procedure codes, indicated by claim-reported status indicators N, Q1, or Q2;
    - Major separately paid OPPS procedure codes, indicated by claim-reported status indicators P, S, T, or V;
    - Major separately paid OPPS procedure codes that may qualify for composite, indicated by claim-reported status indicator Q3;
    - Non-pass-through drugs and biologicals, indicated by claim-reported status indicator K;
    - Blood products, indicated by claim-reported status indicator R.
    - *Exceptions:* Do not include payments for services that are explicitly excluded from comprehensive packaging:
        - ambulance services (status indicator A);
        - mammography services (status indicator A);
        - pass-through drugs and devices (status indicators G and H);
        - brachytherapy services (status indicator U);
        - preventive services; corneal tissue, CRNA services, hepatitis B vaccine (status indicator F); and
        - influenza and pneumococcal pneumonia vaccines (status indicator L).
        - Additionally, exclude outpatient lines related to costs for blood clotting factors to control bleeding for hemophilia patients as mentioned in **Step 14**.
- Calculate the average of outpatient Anchor Payments from all the Clinical Episodes in the baseline year for that Anchor Procedure HCPCS and mapped APC. The mapped APC will have already taken into account the presence of complexity adjustment (if any) on the claim.

- After calculating the factors for each HCPCS/APC (taking into account complexity adjustment if any) for each year of the baseline period, multiply the relevant outpatient Anchor Payments by the relevant update factor.

Table 9 – Price Update Schedule for Standardized Clinical Episode Payments

Clinical Episode Payments	Update Schedule	Calendar Year (CY)/Fiscal Year (FY) Update
IPPS	IPPS average yearly MS-DRG weights and base rates	FY
PFS	GPCI, RVU and anesthesia conversion factors	CY
IRF	IRF conversion factors	FY
SNF	SNF RUG weights	FY
HHA	HHRG and HH base rates	CY
OPPS	Addendum B and J from the OPPS Final Rule	CY
Other	MEI	CY

- **Step 21. Update payment for non-initiating payments during the Anchor Stay/Anchor Procedure and Post-Anchor period:** For non-initiating payments during the Anchor Stay/Anchor Procedure[39] and Post-Anchor period, split payments into six categories. The six categories and their respective sources are illustrated in Table 9 above.[40] After dividing these payments into six categories, use the following factors to calculate category-level update factors for each initiating ACH and baseline year:

  For the factors, except for "Other," updated every calendar year (Physician Fee Schedule and Home Health Agency), calculate the update factor as the ratio of Performance Period factors to baseline year factors.

$$\textbf{Update Factor}(UF)_{category(c)} = \frac{\textbf{Factor}(F)_{Performance\ Period\ (PP)}}{F_{Baseline\ Year(BY)}}$$

  - For the factors updated every fiscal year (IPPS, Inpatient Rehabilitation Facility, and Skilled Nursing Facility), calculate update factor as the ratio of Performance Period factor to a weighted sum of factors from corresponding fiscal years in the baseline year.

$$UF_c = \frac{F_{PP}}{F_{BY+1} * 0.25 + F_{BY} * 0.75}$$

  - For the Other setting, use the MEI to calculate the update factor. Specifically, multiply the MEI factors for all the years between the baseline year and the most recently available year (inclusive).

$$UF_c = \prod_{\{BY<year\leq PP\}} (1 + MEI_{year})$$

  - Calculate the overall update factor using the following equation. Specifically, calculate payment ratio as the ratio of the ACH's non-initiating Clinical Episode

[39] Also includes non-eligible payments from the initiating institutional outpatient claim for the Anchor Procedure.
[40] Non-initiating OPPS payments are updated by the "Other" category.

payment for each category and baseline year to its total non-initiating Clinical Episode payments for the same year. The sum of these payment ratios for each ACH and baseline year across the six categories is 1. Then, sum the Update factor for each category weighted by the specific payment ratio.

$$\boldsymbol{Overall\ UF} = \sum_{c \in \{\mathbf{IPPS,PFS,IRF,SNF,HHA,Other}\}} \boldsymbol{UF_c * Payment\ Ratio_c}$$

- Where **UF_c** is the category-level update factor and **Payment $Ratio_c$** is the payment ratio of total service payment in that category to total non-initiating Clinical Episode payment, such that:

$$\sum_{c \in \{\mathbf{IPPS,PFS,IRF,SNF,HH\ A,Other}\}} \boldsymbol{Payment\ Ratio_c = 1}$$

- For each ACH and baseline year, multiply the non-initiating payment by the overall update factor calculated above.

At the end of **Step 21,** the Clinical Episode dataset in the baseline period will have payments inflated to the Model Year using the most recently available fee schedules. This dataset will be used as an input to **Section 8** to finalize baseline period Clinical Episodes.

8 FINALIZE BASELINE PERIOD CLINICAL EPISODES

This section describes the methodology to create a final set of inpatient and outpatient Clinical Episodes for National and Applicant populations in the baseline period. The first steps are to winsorize Clinical Episode payment on the upper and lower bounds and to assign Clinical Episodes to Applicant(s). This final set of Clinical Episodes are the inputs to the risk adjustment model used to construct the preliminary Target Prices.

Table 10 – Section 8 Inputs and Outputs

Inputs
• National set of Clinical Episodes with updated prices
• BPCI Advanced Applicants Profile
Outputs
• Final National set of Clinical Episodes with winsorized prices, indicating whether it was assigned to any Applicant

- **Step 22. Winsorize Clinical Episode payments**: To limit extreme values, winsorize Clinical Episode payments at the 1st and 99th percentile within each MS-DRG or APC pooled for each calendar year.
  - Set all values below the 1st percentile to the 1st percentile.
  - Set all values above the 99th percentile to the 99th percentile.
- **Step 23. Identify Clinical Episodes eligible for PGP assignment:** To be eligible for PGP assignment, only consider Clinical Episodes with at least one concurrent Carrier claim that has positive standardized payment and is billed by an Applicant PGP during the Anchor Stay/Anchor Procedure. A Carrier claim is concurrent with an Anchor Stay or Anchor Procedure if: (1) it is for the same beneficiary and (2) the expense date on the Carrier claims falls within the Anchor Stay/Anchor Procedure of the Clinical Episode, including the one day prior.
  - **Step 23a.** For each Clinical Episode, identify all the concurrent Carrier claims.
  - **Step 23b.** Limit to Clinical Episodes that have at least one concurrent Carrier claim billed by an Applicant PGP (**Step 23a**). Only these Clinical Episodes are eligible for PGP assignment.
- **Step 24. Create a list of PGP-NPI combination:** For Clinical Episodes identified in **Step 23**, create a list of PGP-NPI combinations using the Applicant PGPs on the

concurrent Carrier claims first with an attending NPI (on the Anchor Stay/Anchor Procedure) and then with an operating NPI[41] (on the Anchor Stay/Anchor Procedure). For example, if a Clinical Episode has two Applicant PGPs that bill concurrent Carrier claims and the attending and operating NPIs on the Anchor Stay are different, then the PGP-NPI list will include four pairs. Each Applicant PGP in this example will be paired first with the attending NPI and then with the operating NPI.

- **Step 25. Assign Applicant PGP Clinical Episodes:** For Clinical Episodes identified in **Step 23**, apply the following steps to identify all PGP-NPI combinations (**Step 24**) that can be assigned the Clinical Episode: [42]
    - **Step 25a.** Pull all the Carrier claims[43] occurring during the Anchor Stay/Anchor Procedure, including the one day prior, for any beneficiary.
    - **Step 25b.** For each Clinical Episode, check whether the performing NPI and TIN on the Carrier claims (**Step 25a**) match any of the PGP-NPI combinations (**Step 24**). Assign the Clinical Episode to all the Applicant PGPs that are matched.
- **Step 26. Assign Applicant ACH Clinical Episodes:** If the Clinical Episode is initiated by an Applicant ACH, assign it to that ACH.

[41] Assumes that the attending NPI and operating NPI are different.
[42] Including the one day prior to the Anchor Stay/Anchor Procedure.
[43] Only consider Carrier claims with positive standardized allowed amount.

9 FINALIZE PERFORMANCE PERIOD CLINICAL EPISODES

This section describes the methodology to create the final set of inpatient and outpatient Clinical Episodes both for the National and Participant populations in each Performance Period during the Model Year. First, Clinical Episode payments are winsorized on the upper and lower bounds. Next, Clinical Episodes are linked to Participants. Then, only one Clinical Episode for an individual beneficiary is allowed to occur at a given time. That is, if a beneficiary has multiple Clinical Episodes occurring at the same time, only one is retained. Finally, Clinical Episodes are subset to only those that can be assigned to Participants.

Table 11 – Section 9 Inputs and Outputs

Inputs
• National set of Clinical Episodes
• BPCI Advanced Participant Profile
Outputs
• Final National set of Clinical Episodes with winsorized prices
• Participants Clinical Episodes

- **Step 27. Winsorize Clinical Episode payments:** To limit extreme values, winsorize Clinical Episode payments at the 1st and 99th percentile within each MS-DRG or APC pooled for each Performance Period.
  - Set all values below the 1st percentile to the 1st percentile.
  - Set all values above the 99th percentile to the 99th percentile.
- **Step 28. Identify Participant Clinical Episodes:** Consider Participant Clinical Episodes as those initiated by a participating ACH or where the attending NPI or operating NPI had a billing relationship with a participating PGP during the Anchor Stay/Anchor Procedure.[44] Apply the following steps to identify participating PGP Clinical Episodes:
  - **Step 28a.** For each Clinical Episode, consider all the concurrent Carrier claims with a positive standardized allowed amount (i.e. Carrier claims for that beneficiary occurring during the Anchor Stay/Anchor Procedure, including the one day prior.)

[44] Includes one day prior.

- **Step 28b.** Limit to Clinical Episodes with at least one concurrent Carrier claim billed by a participating PGP. These are the Clinical Episodes that may be assigned to a participating PGP.

- **Step 29. Create PGP-NPI lists:** For the Clinical Episodes that may assigned to a participating PGP, create a list of PGP-attending NPI combinations, where participating PGPs are the TINs on the concurrent Carrier claims and attending NPIs are those on the Anchor Stay/Anchor Procedure. Create another list of PGP-operating NPI combinations using the operating NPI[45] on the Anchor Stay/Anchor Procedure.

At the end of **Step 29**, all the Clinical Episodes that may be assigned to a Participant are identified.

- **Step 30. Allow no more than one Clinical Episode to occur at a given time for a beneficiary:** For all the ongoing non-MJRLE Clinical Episodes for the same beneficiary where the start date of a second, newly initiated Clinical Episode occurs between the start and end date (inclusive) of the initial Clinical Episode, implement the following logic in Table 12.[46]

Table 12 – Clinical Episode Selection Logic

Initial Clinical Episode	Subsequent Clinical Episode[47]	Retained Clinical Episode
Participant	Non-Participant	Initial
Participant	Participant	Initial
Non-Participant	Non-Participant	Initial
Non-Participant	Participant	Subsequent

  - In cases where inpatient and outpatient initiated Clinical Episodes start on the same day, exclude the outpatient initiated Clinical Episode unless it was initiated by the Participant.

- **Step 31. Always select the second Clinical Episode for MJRLE Clinical Episodes:** If a potential MJRLE Anchor Stay occurs within the 90-day Post-Anchor period of an initial MJRLE Anchor Stay for the same beneficiary, cancel the first one and initiate the

[45] Assumes that the attending NPI and operating NPI are different.
[46] The exception is specific to Clinical Episode pairs where both the initial Clinical Episode and the following readmissions are MJRLE.
[47] Subsequent Clinical Episode starts between the start date and end date (inclusive) of the initial Clinical Episode. It is either treated as a readmission of the initial Clinical Episode or a new Clinical Episode canceling the initial one.

Clinical Episode with the second one. See Table 13 for MJRLE Clinical Episode Selection Logic.

Table 13 – MJRLE Clinical Episode Selection Logic

Initial Clinical Episode	Subsequent[48]	Retained Clinical Episode
Participant	Non-Participant	Subsequent
Participant	Participant	Subsequent
Non-Participant	Non-Participant	Subsequent
Non-Participant	Participant	Subsequent

- **Step 32. Exclude Clinical Episodes that overlap with CJR/BPCI initiatives:** Apply the following exclusions to the Clinical Episodes:
    - Exclude Clinical Episodes that overlap the Comprehensive Care for Joint Replacement (CJR) model.
    - Exclude Clinical Episodes that overlap the BPCI model.

The Clinical Episode dataset at the end of **Step 32** is used to update patient case mix for the final Target Price.

- **Step 33. Assign Clinical Episodes to participating PGP:** For Clinical Episodes that may be assigned to a participating PGP as identified in **Step 28**, apply the following steps:
    - **Step 33a.** Pull all the Carrier claims[49] occurring during the Anchor Stay/Anchor Procedure, including the one day prior, for any beneficiary.
    - **Step 33b.** For each Clinical Episode, check whether the performing NPI and TIN on the Carrier claims (**Step 33a**) match any of the PGP-attending NPI combinations (**Step 29**).
        - If there is exactly one PGP-attending NPI combination that is a match, assign the Clinical Episode to that participating PGP.
        - If the TIN and performing NPI on Carrier claims during the Anchor Stay/Anchor Procedure match multiple PGP-attending NPI combinations, use the following hierarchy to assign the Clinical Episode:

[48] See Footnote 477.
[49] Only consider Carrier claims with positive standardized allowed amount.

    - Check whether the TIN and performing NPI on Carrier claims during the Anchor Stay/ Anchor Procedure are for the same beneficiary as the Clinical Episode. If so assign the Clinical Episode to that PGP.
    - If the application of the hierarchy still results in more than one PGP-NPI combination, do not assign that Clinical Episode to a PGP.
  - For the remaining Clinical Episodes not assigned to a participating PGP (through a billing relationship with the attending NPI), repeat the above steps to determine whether there are Carrier Claims during the Anchor Stay/ Anchor Procedure with a TIN and performing NPI that match a PGP-operating NPI[50] combination (**Step 29**).

- **Step 34. Assign Clinical Episodes to participating ACHs:** If the Clinical Episode eligible for ACH assignment per **Step 28** is not assigned to a PGP per **Step 33**, then assign it to that participating ACH's CCN.
  - By the end of this step, all Clinical Episodes attributable to the Performance Period are identified. As described above, the hierarchy applied is as follows: a) assign first to the PGP that has an attending NPI for the Anchor Stay/Anchor Procedure, b) assign second to the PGP that has operating NPI for the Anchor Stay/Anchor Procedure, c) assign third to the ACH that initiates the Anchor Stay/Anchor Procedure.

- **Step 35. Subset Clinical Episodes to Participants:** Subset the Clinical Episodes remaining after **Step 34** to only those assigned to a Participant. This dataset is used to calculate Performance Period spending for reconciliation purposes.

[50] Assumes that the attending NPI and operating NPI are different.