TEMPLATE

Do not submit as official application

Bundled Payments for Care Improvement (BPCI) Advanced Application for Model Year 7 (2024)

In this application, all references to “applicant” or "participant" either mean the potential non-convener risk-bearing Participant or the potential risk-bearing Convener. For questions that require information about the applicant only, provide information about the potential Non-Convener Participant or Convener Participant organization only. Only Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs) may apply as a Non-Convener Participant. With the exception to Active Convener Participants in Model Year 6, entities interested in applying as a new Convener Participant must either be a Medicare-enrolled provider or supplier, or an Accountable Care Organization (ACO). Please refer to the Model Year 7 BPCI Advanced Request for Applications (RFA) for how an ACH, PGP, Medicare-enrolled provider or supplier, and ACO are defined and additional details.

Many questions require information more broadly about the applicant’s partners. For the purposes of this initiative, these partners fall into two categories:

1. Participating practitioners, including suppliers who may be separately paid by Medicare for their professional services (e.g., physicians, nurse practitioners, physician assistants, physical therapists); and

2. Participating organizations, providers or suppliers that initiate episodes with whom the Participant plans to partner (e.g., acute care hospitals, physician group practices).

In each question, we will specify whether to answer the question about the applicant alone, its participating practitioners, its participating organizations, and/or its episode-initiating participating organizations.

Complete all questions. If a question is not applicable, enter “N/A.” Unless otherwise specified, there is a limit of 4000 characters for each answer.

Organization Information

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Applicant Type

Period of Performance Start Date

Participants must use Certified Electronic Health Record Technology (CEHRT) to document and communicate care with patients and other healthcare professionals. For non-hospital participants, at least 75% of eligible clinicians in an entity must use the CEHRT definition of certified health IT functions to participate in this initiative. Will you be able to attest to the use of CEHRT as described at the time that you would begin participating in this initiative?

1. **Organization Details**

Applicant Organization Legal Name

"Doing Business As" if Different from Applicant Organization Legal Name

Street Address

Address Line 2

City

State

Zip Code

(+4)

Please check this box if Billing Address is the same as Street Address

Billing Address

Billing Address Line 2

Billing City

Billing State

Billing Zip Code

Billing (+4)

Organization Information

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Organization Type

If Organization Type is "Other", specify below

Has the applicant previously participated in BPCI Advanced? [Yes/No

If applicant has previously participated in BPCI Advanced, in what capacity? [Convener Participant, Non-Convener Participant, or Episode Initiator]

Does the applicant currently participate in a Medicare ACO model? [Yes/No]

If the applicant currently participates in a Medicare ACO model, please provide the Medicare ACO model ID number.

TIN

NPI

CCN

Entity Type

If Entity Type is "Other", specify below

Per the Model Year 7 RFA, Applicants applying as Convener Participants must either be an approved Medicare-enrolled provider or supplier, or ACO by the application deadline, or an Active Convener Participants in Model Year 6. Are you able to certify that your organization meets this requirement by the application deadline?

2. **Applicant Contact Person at Applicant Organization**

Email Address

First Name

Last Name

Title/Position

Business Phone Number

Business Phone Extension

Alternative Phone Number

3. Provide an executive summary of the application. Include a summary of the overall approach to redesigning care to maximize coordination, patient-centeredness, efficiency, and high-quality health care through accountability for an episode of care. Also, include a summary of the applicant's governing bodies, including the positions of each governing body; whether or not there is meaningful representation from consumer advocates, Medicare beneficiaries, and all participating organization types; how the governing body will conduct oversight of participation in this initiative; how key personnel will be integrated organizationally to this project; and the financial resources that will be made available to key personnel to implement this initiative and improve care processes.

4. **Convener Applicants:** Please populate the Participating Organizations template by providing information on all participating organizations, which would participate as Downstream Episode Initiators (EIs) under the Model, and then upload the completed document in the Application Portal. For any Downstream EI that is a Physician Group Practice (PGP) please list all the hospitals in which you expect to trigger Clinical Episodes. Please be sure to populate all fields, indicating "N/A" for fields that are not applicable.

Non-Convener Applicants who are Physician Group Practices (PGPs): Please populate the Participating Organizations template providing information on the PGP, ensuring to list all the hospitals in which you expect to trigger Clinical Episodes. Please be sure to populate all fields, indicating "N/A" for fields that are not applicable, and then upload the completed document in the Application Portal.

Practitioner Engagement

1. Describe the applicant's plan to disclose participation in this initiative to practitioners practicing at the applicant organization or its participating organizations, as well as applicant's plan to obtain consent from physicians/practitioners prior to committing them to participate in this initiative.

2. Describe the applicant's plan to obtain widespread endorsement and engagement by practitioners at the applicant organization and its participating organizations for this initiative. Describe the applicant's plan to retain participating practitioners and participating organizations in care redesign activities related to this initiative.

1. Describe the applicant's plan for care redesign to achieve BPCI Advanced outcomes. Include specific mechanisms and actions to redesign care processes in the following areas, at a minimum:
    - Evidence-based medicine
    - Beneficiary/caregiver engagement
    - Quality and coordination of care
    - Care transitions

    Describe a single universal approach for the applicant and its participating organizations.

2. Describe the current capacity and readiness of the applicant and its participating organizations to redesign care. If there are deficiencies in the applicant's capacity or readiness at the time of the application, describe the steps that the applicant will take in preparation for the start of this initiative.

3. Describe how the applicant's plan to conduct a routine assessment of the beneficiary's, caregiver's, and/or family's experience of care will lead to improved care throughout participation in this initiative. Describe a single universal approach for the applicant and its participating organizations.

Net Payment Reconciliation Amount (NPRA) Sharing

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1. Does the applicant plan to share NPRA between or among the applicant, its participating organizations, and/or practitioners?

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2. Describe the applicant's and its participating organization's prior or current experience with any NPRA Sharing or pay-for-performance initiatives, including Medicare, Medicaid, or commercial purchasers.

3. Describe the applicant's proposed methodology for NPRA Sharing among participating organizations and participating practitioners, including with whom gains will be shared, the proportion of gains to be shared with participating organizations and with participating practitioners, the mechanism for calculating gains, include any quality metrics associated with the sharing of gains. Describe how the allocation of gains will incorporate best-practice norms, quality, patient safety, patient experience, and efficiency measures. Describe a single universal approach for the applicant and its participating organizations.

4. Describe how the applicant's NPRA Sharing methodology will support care improvement, and specify the proposed safeguards and quality-control mechanisms to ensure that medically necessary care is not reduced to achieve savings. Describe a single universal approach for the applicant and its participating organizations.

5. Describe the eligibility requirements, such as quality thresholds and quality improvement requirements, for individuals or entities to participate in NPRA Sharing. Include a discussion of how an individual or entity may become eligible or ineligible to participate in NPRA Sharing.

Quality Improvement

1. Using evidence from past experiences and research, describe how the applicant's and its participating organizations' planned care improvement interventions described in the previous sections will result in improved quality and patient experience of care.

2. Describe how the applicant plans to perform well on the quality measures required in this initiative.

3. Describe the applicant's, its participating organizations', and its participating practitioners' experience reporting quality measures, including the system(s) through which these measures were reported.

4. Describe the applicant's and its participating organizations' experience with other mandatory CMS quality measurement and improvement initiatives, such as Merit-Based Incentive Payment System (MIPS) and Nursing Home Compare. Include a description of past performance achievements in quality improvement. CMS expects that the applicant and its participating organizations will maintain or improve their performance on the measures reported in this initiative and any other mandatory CMS quality measurement and improvement initiatives.

5. Describe the applicant's, its participating organizations', and its participating practitioners' experience with voluntary Medicare quality measurement and improvement initiatives. Include a description of past performance and achievements in quality improvement. Describe the extent and percentage of participating practitioners who are included in these programs. Include whether the applicant, its participating organizations, and its participating practitioners will participate in reporting additional voluntary quality measures that may be available under this initiative either immediately or in future Performance Periods. If participation or performance shows a marked decline, CMS may terminate the agreement.

6. In order to participate in this initiative, the Participant must use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care with patients and other health care professionals. For non-hospital Participants, at least 75% of eligible clinicians in an entity must use the CEHRT definition of certified health IT functions to participate in this initiative*. Describe the applicant's and its participating organizations' experience using CEHRT to document and communicate clinical care with patients and other health care professionals, to measure and improve quality of care, to enable care redesign, and to coordinate care across multiple providers.

7. Add any additional comments about the applicant's and its participating organizations' participation in the initiatives listed in the Organization Information section of this application, and/or describe participation in quality improvement initiatives not listed here, including HHS or private-sector care improvement, quality improvement, and care coordination activities.

1. Describe the internal quality assurance/monitoring that the applicant and its participating organizations will use to ensure clinical quality, patient experience of care, and clinical appropriateness throughout participation in this initiative. Include plans to monitor:
    - Inappropriate reductions in beneficiary care
    - Clinical and functional outcomes in each participating organization
    - Clinical and functional outcomes across the course of an episode of care
    - Clinical appropriateness of procedures

2. How would the applicant's participation in this initiative fit with existing quality assurance and continuous quality improvement processes, standards, and strategies?

3. Describe how the applicant and its participating organizations will use this quality information to improve the project design, resolve any identified deficiencies, and constantly improve beneficiary care and satisfaction.

4. Describe a detailed plan for implementing the applicant's and its participating organizations' quality assurance procedures and how these procedures will ensure that the mandatory quality measure thresholds for this initiative are met or exceeded, with a description of what aspects are already in use and what steps would be needed to implement new measures. Describe the feasibility of this plan based on ongoing operations and past experiences.

5. Describe the role of the beneficiaries, physicians, hospital staff, and post-acute care staff on the applicant's and its participating organizations' quality assurance and quality improvement committees.

6. Complete the following Sanctions, Investigations, Probations, or Corrective Action Plans table to report the applicant, its practitioners, and/or its participating organizations who are undergoing or have undergone any of these actions in the last five years.

   Also use this table to document any current outstanding debt your organization has with Medicare. Be sure to provide the debt amount along with the Medicare model/program name this debt is attributed to in the Description field of the table.

   ☐ Not Applicable

Organization or Physician/ Practitioner Name	Nature of Sanction, Investigation, Corrective Action Plan, and/or Outstanding Debt	Name of Federal or State Agency or Accrediting Organization (e.g. DOG, OIG, The Joint Commission, State Survey Agencies)	Description	Status

Beneficiary Protections

1. Describe the applicant's and its participating organizations' plan for beneficiary protections.

2. Describe the applicant's and its participating organizations' plan to ensure beneficiary freedom of choice of providers.

3. Describe the applicant's plan for beneficiary notification of participation in this initiative as well as ongoing processes to handle and track beneficiary questions and concerns.

4. Describe the applicant's plan for beneficiary engagement and education.

Financial Arrangements

If the applicant is selected, in addition to accepting the pay-for-performance methodology for quality performance, the applicant must agree to accept some financial risk as part of participating in this initiative. Participants must repay Medicare for expenditures for the episode that are above the episode target price. CMS will also monitor and measure the care provided to beneficiaries by participating and non-participating providers during a Post-Episode Monitoring Period of 30 days following the end of the episode. All non-excluded Medicare Part A and Part B expenditures for beneficiaries during the Post-Episode Monitoring Period will be compared to a baseline of trended historical aggregate Medicare expenditures beyond an empirically titrated risk threshold. If spending exceeds the risk threshold, then the Participant must pay Medicare for the excess expenditures.

At a date and time specified by CMS, entities that applied as Convener Participants must provide proof of ability to bear financial risk and to repay Medicare for any Medicare expenditures during a Clinical Episode or during the Post-Episode Monitoring Period. This must include enforceable assurances by the Participant in the form of an irrevocable line of credit for the full amount of risk executable by CMS or a similarly enforceable mechanism made available by CMS that covers either the full amount or a percentage of the risk, as specified by CMS. After CMS has reviewed the applications and received Participant Profiles, CMS will provide information regarding the amount of financial risk for which each recommended Participant would be accountable as well as other details regarding this financial assurance. We encourage applicants to start soliciting guidance from a bank or other financial institution on the application processes and underwriting criteria for such enforceable assurances (e.g., application documentation requirements, application approval lead time, collateral requirements, credit rating thresholds, transaction costs, and recurring financial institution fees).

1. Describe any financial arrangements with participating organizations and participating practitioners to share or delegate the financial risk associated with this initiative. For Convener applicants, describe all financial arrangements with episode-initiating participating organizations, participating practitioners, or participating organizations that will allow the applicant to bear financial risk, and describe the mechanisms that will allow the applicant to repay Medicare if need be.

Financial Arrangements

2. Describe the financial and logistical mechanisms for distributing any gains resulting from care improvement under this initiative.

Organizational Capabilities and Readiness

1. Describe how participation in this initiative relates to the applicant's overall strategic planning for better care for individuals, better health for populations, and lower costs through improvement.

2. Provide a detailed implementation plan, including the following:

    - Descriptions of the processes in place to handle tasks occurring simultaneously
    - Resource allocations (e.g. staff, systems, related departments)
    - Evidence of the feasibility of this plan based on ongoing operations and past experiences
    - Description of how the applicant will participate in learning system activities

Are you able to certify that your organization will be ready and capable of implementing the BPCI Advanced Model by January 1, 2024?

1. Describe the applicant's history with its participating organizations, in general, including prior business relationships and collaboration on care improvement/redesign initiatives.

2. Describe any partnerships that the applicant, its participating organizations, and/or its participating practitioners, have entered into with state Medicaid programs, private payers, or multi-payer collaboratives to redesign care.

Certification

I certify that all information and statements provided in this application are true, complete, and accurate to the best of my knowledge, and are made in good faith. The authorized signatory attests that he or she is qualified to make the assertions contained herein as an agent of the applicant.

Authorized CEO/Senior Executive Applicant Organization	Date

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Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

Applicant Data Request and Attestation Form

Under the BPCI Advanced initiative, CMS will offer BPCI Advanced Applicants an opportunity to request certain data in accordance with this form and applicable law, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164).

CMS believes the care coordination and quality improvement work of BPCI Advanced Applicants would benefit from receipt of certain beneficiary-identifiable claims data for Medicare fee-for-service beneficiaries who would have been included in a Clinical Episode attributed to the BPCI Advanced Applicant or its potential Episode Initiators, in line-level claim formats, for a 3-year historical baseline period and an approximate one-year period from the current calendar year. These data would enable BPCI Advanced Applicants to understand spending patterns during a Clinical Episode, appropriately coordinate care, identify patients for whom they could implement quality improvement activities for population-based quality improvement efforts, and target care strategies for particular beneficiaries.

To that end, CMS believes that subsets of the following beneficiary line-level claims are generally those that BPCI Advanced Applicants would need to successfully perform the activities described above, and therefore should be offered to Applicants in connection with their potential participation in BPCI Advanced and in accordance with applicable law: Inpatient, Outpatient, Carrier (Part B), Durable Medical Equipment (DME), Skilled Nursing Facility (SNF), Home Health Agency (HHA), Inpatient Rehabilitation Facility (IRF), Hospice, and Diagnosis/Procedure Code Research Identifiable Files (RIF). These data elements are a subset of CMS claims data that were carefully tailored in an attempt to establish a dataset that would best serve the needs of the majority of Applicants and are described in detail at https://resdac.org/cms-data?tid_1%5B1%5D=1&tid%5B4931%5D=4931 In addition, summary data will be available upon request and will contain higher-level summary statistics of all Clinical Episodes for the same RIF categories with total and average expenditure data.

Instructions: In order to receive CMS claims data for the Medicare beneficiaries who would have been included in a Clinical Episode attributed to the BPCI Advanced Applicant and/or its potential Episode Initiators under the BPCI Advanced initiative during the historical baseline period or current calendar year, you must request the data you wish to receive (data elements and time periods) and the legal basis justifying your receipt of the data under the HIPAA Privacy Rule.

In doing so, you may use this form, provided that it captures your situation and that the assertions contained herein are true and accurate with respect to your specific request. The assertions contained herein are premised on a request for "protected health information" by a HIPAA "covered entity" or "business associate," as those terms are understood under the HIPAA Privacy Rule, to carry out one or more health care operations activities listed in paragraph (1) or (2) of the definition of "health care operations" in 45 C.F.R. § 164.501.

Data access for purposes of such health care operations using this form is currently limited to instances in which the Requestor is a BPCI Advanced Applicant. As such, data access using this form is further premised on the covered entity or business associate being a BPCI Advanced Applicant. Any data access approval obtained using this form will be revoked if at any time the Requestor ceases to be a BPCI Advanced Applicant and/or fails to comply with the provisions in this form.

In providing this form, CMS does not represent that you are qualified to make the assertions contained herein. To the extent this form does not capture your situation or the assertions you wish to make, or if you are unsure as to whether it does so, you should consult with your own legal counsel prior to requesting the data from CMS. All requests for CMS data will be granted or denied at CMS's sole discretion based on CMS's available resources, the limitations in this form, and applicable law.

☐ I am not interested in receiving historical claims data prior to making a decision to commit to participate in the Model.

Data Requestor:

Organization Name

Organization CCN (if applicable) Organization EIN/TIN

Organization NPI

Organization Address

Organization City State --- ZIP

The Data Requestor is (select one):

☐ A HIPAA Covered Entity (CE), as defined in 45 C.F.R. § 160.103, and an Applicant for BPCI Advanced

☐ A HIPAA Business Associate (BA), as defined in 45 C.F.R. § 160.103, and an Applicant for BPCI Advanced

☐ Other (please attach detailed explanation)

The Data Requestor is seeking protected health information (PHI), as defined in 45 C.F.R. § 160.103, for (select one):

☐ Its own use

☐ On behalf of a HIPAA CE that is a potential Episode Initiator and for which the BPCI Advanced Applicant isa BA

☐ Other (please attach detailed explanation)

The Data Requestor requests (select all that apply):

☐ **1. Aggregate Historical Claims Data and Current Calendar Year:** That CMS provide the Data Requestor with the data described above as "summary data" for the final 3 years of the initial 4 year historical baseline period from October 1, 2019 – September 30, 2022 (or 3 years of data under a subsequent baseline period over the course of the model depending on the Applicant's requested start date) and for the current calendar year from January 1, 2023 - December 31, 2023 for the Medicare beneficiaries who would have been included in a Clinical Episode attributed to the BPCI Advanced Applicant under the BPCI Advanced initiative using the methodology described in the BPCI Advanced Technical Specifications that will be provided.

☐ **2. Raw Historical Claims Data and Current Calendar Year:** That CMS provide the Data Requestor with the data described above as "beneficiary line-level claims" for the final 3 years of the initial 4 year historical baseline period from October 1, 2019 – September 30, 2022 (or 3 years of data under a subsequent baseline period over the course of the model depending on the Applicant's requested start date) and for the current calendar year from January 1, 2023 - December 31, 2023 for the Medicare beneficiaries who would have been included in a Clinical Episode attributed to the Applicant under the BPCI Advanced initiative using the methodology described in the BPCI Advanced Technical Specifications that will be provided.

☐ **3. Other:** (Please attach detailed description, including legal justification supporting the desired disclosure.

For BPCI Advanced Applicants that are applying as Convener Participants, these selections will apply to all Episode Initiators that the BPCI Advanced Applicant listed in the Participating Organizations attachment in the Organizational Information section of the BPCI Advanced Application. By signing this form, a Data Requestor that is a BPCI Advanced Applicant applying as a Convener Participant hereby attests that it is requesting data as a HIPAA business associate on behalf of its covered entity Episode Initiators, and those covered entities have consented to CMS sharing their data with the BPCI Advanced Applicant.

Also, Requestors that only select "Aggregate Historical Claims Data", do not need to attest to all HIPAA attestations and requirements on this form because they only apply to requests for beneficiary-identifiable data.

The Data Requestor intends to use the data requested herein for the following purpose (select one):

☐ To perform "health care operations" that fall within the first and second paragraphs of the definition of that term under the HIPAA Privacy Rule

☐ Other (please attach detailed explanation)

The data requested herein is (select one):

☐ The "minimum necessary" to carry out the intended purpose as described in 45 C.F.R. § 164.502(b)

☐ Other (please attach detailed explanation)

The Data Requestor attests that the individuals identified below are employed by the BPCI Advanced Applicant's organization and authorized to act as points of contact on behalf of the BPCI Advanced Applicant for purposes of the BPCI Advanced initiative. If at any time a point of contact identified below ceases to be employed by the BPCI Advanced Applicant, the BPCI Advanced Applicant is responsible for terminating the point of contact's access to the data requested herein and must also submit a new DRA to CMS that identifies a replacement point of contact.

BPCI Advanced Data Point of Contact #1:

Name | Title

Organization Name

Phone Number | Extension

Work Email Address

BPCI Advanced Data Point of Contact #2:

Name | Title

Organization Name

Phone Number | Extension

Work Email Address

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.

The Data Requestor agrees to protect the requested data as required by applicable law, including the establishment of appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it.

The Data Requestor attests that it will immediately notify CMS of any actual access, use, or disclosure of the data requested herein that is not in accordance with applicable law, including, but not limited to, the HIPAA Privacy Rule. To do so, the Data Requestor further attests that it will report any breaches of personally identifiable information (PII) and/or PHI from the CMS data files, loss of these data or disclosure to any unauthorized persons to the CMS IT Help Desk by telephone at (410) 786-2580 or by email notification at cms_it_service_desk@cms.hhs.gov within one hour and will cooperate fully in the federal security incident process. Compliance with these attested activities does not relieve the Data Requestor of the breach reporting obligations under 45 C.F.R. part 164, subpart D.

Disposition of CMS BPCI Advanced Data files:

In submitting its request, the Data Requestor asserts that if the BPCI Advanced Applicant does not sign a BPCI Advanced Participation Agreement and transition to Participant status for the upcoming performance period all beneficiary-identifiable data received under this request will be destroyed unless the retention of such data is required by law (as defined at 45 C.F.R. § 164.103), or is needed for future treatment or health care operations purposes (as those terms are defined in 45 C.F.R. § 164.501). If retained, the Data Requestor further asserts that it will protect any retained beneficiary identifiable data as a HIPAA covered entity would protect PHI under 45 CFR Parts 160-164.

Also, if the Applicant does become a Participant, a separate request must be made for additional data and the data sharing provisions of the participation agreement also will apply to the data disclosed pursuant to this form.

The Authorized Representative of the Data Requestor attests that it is qualified to make the assertions contained herein and that the assertions contained herein are true and accurate with respect to this request.

Work Email Address: _____

First Name _____ Last Name _____

Title _____

Phone Number _____ Extension _____

Date _____

Certification

☐ The Authorized Representative of the Data Requestor attests that it is qualified to make the assertions contained herein and that the assertions contained herein are true and accurate with respect to this request.

First and Last Name _____