Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Patient Care Models Group

Bundled Payments for Care Improvement Advanced (BPCI Advanced)

Request for Applications (RFA) for participation beginning Model Year 7

(January 1, 2024-December 31, 2024)

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Center for Medicare & Medicaid INNOVATION

Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

Request for Application – Model Year 7 (2024)

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I. Executive Summary of the RFA

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model started October 1, 2018 and was originally scheduled to end December 31, 2023. However, on October 13, 2022, CMS announced a two-year extension to BPCI Advanced, with an amended end date of December 31, 2025. This extension includes an application period for an additional model cohort. The application period will occur in the spring of 2023, and the new model cohort will begin model participation on January 1, 2024. This Request for Application (RFA) provides the necessary information to potential BPCI Advanced Model applicants to allow an informed decision on Model participation.

The first cohort of BPCI Advanced Model Participants started on October 1, 2018 (Model Year 1). The second cohort of Participants started on January 1, 2020 (Model Year 3). The current application opportunity is for the third cohort of Participants, who will start in Model Year 7 (January 1, 2024). CMS does not intend to have any additional application opportunities for Model Year 8 (January 1, 2025 – December 31, 2025). The application period will be open for 90 days in the spring of 2023. The application can be accessed via the Application Portal[1]. An application template is available for review on the BPCI Advanced webpage.[2]

In addition to the announcement of the two-year extension, CMS also announced changes to the BPCI Advanced methodology that started in Model Year 6 (2023).

The Model Year 6 changes are:

- Reducing the CMS Discount for medical Clinical Episodes from 3% to 2%.
- Reducing the Peer Group Trend (PGT) Factor Adjustment cap for all Clinical Episodes from 10% to 5%.
- Holding Participants accountable for all Clinical Episodes in which the beneficiary has a COVID-19 diagnosis during the Clinical Episode.
- Making major joint replacement of the upper extremity (MJRUE) a multi-setting Clinical Episode category by including outpatient total shoulder arthroplasty (TSA) procedures (triggered by HCPCS 23472) in the model.

The changes to the Model Year 6 pricing methodology will continue into the two-year extension, allowing the testing of the changes over a 3-year period, yielding more robust data than would testing the changes for only one year. This will help to determine whether the changes produce results supporting a longer-term approach to benchmarking episodes and adjusting for future public health emergencies. In addition to further testing the changes to the Model's payment methodology, a two-year extension would also allow for further exploration of health equity outcomes and the impact of the model on historically underserved populations.

Please see detailed language in this RFA on information related to the model design, criteria for new and existing model participation, and model timelines, including the application deadline.

[1] https://app.innovation.cms.gov/bpciadvancedapp/IDMLogin
[2] https://innovation.cms.gov/innovation-models/bpci-advanced

II. Introduction and Background

A. Introduction

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing costs while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. To this end, CMS is interested in working with healthcare providers who are driving to redesign care to achieve these aims. Episode payment approaches, which are designed to improve the efficiency and quality of care for an episode of care, or "Clinical Episode," through the use of bundled payments, are potential mechanisms for developing these partnerships.

In a 2022 CMS blog post[3], CMMI outlined their comprehensive specialty care strategy to test models and innovations that support access to high-quality, integrated specialty care across the patient journey. Part of this strategy is to continue the focus on acute episode payment models and condition-based models, and then, moving forward, to build on this care transition to better align episodic and longitudinal, population-based incentives. The BPCI Advanced two-year extension is an integral part of this strategy, and will work to maintain momentum among providers and health systems that are committed to value-based care and have invested in transformation of episodic care.

Episode payment models hold healthcare providers accountable for the cost, quality, and patient outcomes during an episode of care. Holding healthcare providers jointly accountable for resource management and total costs of care by bundling payment for multiple healthcare providers across multiple care-delivery settings for items and services furnished during a Clinical Episode improves care coordination and creates incentives for healthcare providers to deliver care more efficiently. These bundled payment approaches may therefore spur hospitals, physicians, and other healthcare providers to better coordinate care, improve the quality of care, and consider the financial implications of their treatment decisions, and can help align healthcare provider incentives in pursuit of improved quality and reduced spending. Bundled payment approaches can be implemented as either retrospective or prospective, described in more detail later.

Through the voluntary initiative, Bundled Payments for Care Improvement Advanced (BPCI Advanced or the "Model"), described in this Request for Applications - 2023 (RFA), the CMS Innovation Center will continue to test an alternative payment model that bundles the payment for physician, hospital, and other health care provider services into a single target price for an episode of care to reduce Medicare expenditures while preserving or enhancing the quality of care accountability. This alternative payment model will include a single payment and risk track.

B. History of Bundled Payment Models at the CMS Innovation Center

In 2013, the CMS Innovation Center began testing the Bundled Payments for Care Improvement (BPCI) Initiative. The BPCI Initiative, implemented for 5 years (2013-2018), was created as a way to link payments across all healthcare providers delivering care during an episode of care. The BPCI Initiative intended to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and

[3] "The CMS Innovation Center's Strategy to Support Person-Centered, Value-based Specialty Care"; https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care

readmissions. Evaluation results from the BPCI initiative are also informative as to the potential for bundled payments to reduce Medicare expenditures while generally maintaining quality of care.[4]

In addition to the BPCI Initiative and BPCI Advanced, which are voluntary model tests, the CMS Innovation Center has also tested bundled payments through other initiatives, including the Comprehensive Care for Joint Replacement (CJR) model. The CJR model is a mandatory test that started in 2016 and is an episode payment model that uses bundled payments for clinical episodes focused on lower extremity joint replacements. In 2020, the model was extended for three additional years (through December 2024) for specific participant hospitals to allow further testing.

C. Launch of BPCI Advanced

In 2018, the BPCI Advanced Model was launched to test innovative payment strategies that promote care redesign in an effort to reduce expenditures and improve the quality of care for Medicare beneficiaries. BPCI Advanced was designed based on lessons learned from Model 2 of the BPCI Initiative. Lessons learned from BPCI that have been incorporated into BPCI Advanced include:

- Providing preliminary Target Prices prospectively to help Participants make informed Clinical Episode selections
- Risk-adjusting the Target Price to account for more than just historical spending
- Focusing on 90-day post-anchor Clinical Episode length to maintain a consistent episode duration across all Participants
- Narrowing the number of Clinical Episodes tested to avoid episodes that have a significant variation in spending and/or clinical heterogeneity
- Requiring a minimum baseline Clinical Episode volume in order to construct a more reliable Target Price

D. Evaluation Reports

To date, CMS has released three evaluation reports for BPCI Advanced.[5,6,7] The Third Annual Report reported that hospitals and Physician Group Practices participating in the BPCI Advanced Model reduced Medicare fee-for-service payments primarily by reducing post-acute care use. For surgical episodes overall, BPCI Advanced achieved net savings to Medicare and possibly improved quality of care, driven mostly by orthopedic procedures. Savings from surgical episodes, however, were fully offset by losses from medical episodes. Evidence indicates that, generally, target prices were too high for medical episodes but were more accurate for surgical episodes. CMS made significant design changes starting in Model Year 4 (2021) to improve the model's target pricing, which will be analyzed in future evaluation reports. We anticipate future evaluation reports to exhibit more favorable results for Medicare savings, even in the presence of observed attrition, given the substantial changes to the Model's pricing methodology that were implemented for Model Year 4 (2021).[8]

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[4] Marrufo, G., et al. CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 7 Evaluation & Monitoring Annual Report. The Lewin Group for the Center for Medicare and Medicaid Services. March 2021. Available at: https://innovation.cms.gov/data-and-reports/2021/bpci-models2-4-yr7evalrpt

[5] BPCI Advanced – First Annual Evaluation Report; At-A-Glance Report

[6] BPCI Advanced – Second Annual Evaluation Report; At-A-Glance Report

[7] BPCI Advanced – Third Annual Evaluation Report; At-A-Glance Report

[8] For further information on Model Year 4 changes, please see the Model Year 4 Pricing Methodology Memo

III. Authority

A. Authority to Test the Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 USC § 1315a) established the Innovation Center to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, and Children's Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of beneficiaries' care.

Section 1115A(b)(2) of the Act requires the Secretary to select models to be tested where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The statute also provides a non-exhaustive list of examples of models that the Secretary may select to test, which includes models under which the Innovation Center contracts directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment (see Section 1115A(b)(2)(B)(ii) of the Act).

B. Authority to Waive Program Requirements

The authority for the BPCI Advanced Model is Section 1115A of the Act. Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII of the Act and of Sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of Section 1934 of the Act as may be necessary solely for purposes of carrying out Section 1115A with respect to testing models described in Section 1115A(b).

C. Fraud and Abuse Law Waivers

Consistent with the authority under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII, and of Sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than sub-Sections (b)(1)(A) and (c)(5) of such sub-Section) of the Act as may be necessary solely for purposes of testing models described in Section 1115A(b). For purposes of this Model and consistent with this standard, the Secretary has exercised such waiver authority with respect to the fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act as may be necessary to develop and implement the BPCI Advanced Model, pursuant to Section 1115A(b).

The Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Bundled Payments for Care Improvement Advanced Model ("Notice of Waivers") can be found here: [https://www.cms.gov/files/document/notice-amended-waivers-certain-fraud-and-abuse-laws-connection-bundled-payments-care-improvement.pdf.](https://www.cms.gov/files/document/notice-amended-waivers-certain-fraud-and-abuse-laws-connection-bundled-payments-care-improvement.pdf)

These fraud and abuse waivers apply solely to BPCI Advanced and differ in scope and design from fraud and abuse waivers granted for other programs or models. Notwithstanding any other provision of this RFA, individuals and entities must comply with all applicable fraud and abuse laws and regulations, except as explicitly provided in the Notice of Waivers issued in January 2020, specifically for BPCI Advanced pursuant to Section 1115A(d)(1).

IV. Model Scope and Participation

A. Model Objectives

BPCI Advanced has identified the following objectives as part of the Model test:

1. Care Coordination: Continuously reengineering care
2. Financial Accountability: Testing a payment model for the outcomes of improved quality and reduced spending
3. Data Analysis & Feedback: Eliminating low-value care and fostering quality improvement
4. Health Care Provider Engagement: Stimulating rapid development of new evidence-based knowledge with providers
5. Beneficiary Engagement: Increasing the likelihood of better health at a lower cost through education and ongoing communication

B. Description of the Model

BPCI Advanced is a voluntary episode-based payment model which started on October 1, 2018, and was designed to test innovative payment strategies that promote care redesign in an effort to reduce expenditures and improve the quality of care for Medicare beneficiaries. Model Participants can choose among eight Clinical Episode Service Line Groups (CESLGs), encompassing 34 inpatient and outpatient Clinical Episodes, for which they are then held accountable for cost and quality. The healthcare providers and suppliers participating in BPCI Advanced continue to bill Medicare under the traditional FFS system for services furnished to Medicare FFS beneficiaries throughout the episode. Clinical Episodes are initiated by an inpatient stay ("Anchor Stay") or by an outpatient procedure ("Anchor Procedure") and conclude 90 days after completion of the Anchor Stay or Anchor Procedure.

The BPCI Advanced Model uses a retrospective bundled payment approach. Twice a year after a Performance Period ends, CMS reconciles all non-excluded Medicare FFS claims paid by Medicare for a Clinical Episode against a Target Price for that Clinical Episode. If the Aggregate FFS Payment (AFP) for a Clinical Episode is less than the final Target Price, then the Participant may receive a payment from CMS. If the AFP for a Clinical Episode exceeds the final Target Price, then the Participant may owe a payment to CMS.

The Target Price is calculated by applying a discount, referred to as the "CMS Discount," to the Benchmark Price. During the first 5 Model Years of the Model, the CMS Discount was 3 percent for all Clinical Episodes. However, starting in Model Year 6 (2023), CMS adjusted the CMS Discount to 2 percent specifically for medical Clinical Episodes while maintaining a 3 percent CMS Discount for surgical Clinical Episodes. The Benchmark Price is, in turn, calculated based on the historical Medicare FFS expenditures for most items and services furnished during the Clinical Episode.

C. Model Participants and Participating Entities

For purposes of BPCI Advanced, a Participant is defined as an entity that enters into a BPCI Advanced Model Participation Agreement with CMS to participate in the Model. The types of entities eligible to be a Non-Convener Participant have not changed, but the requirements for Convener Participants are different for this application opportunity than in previous years; more details are provided in Section VI.B.2. BPCI Advanced requires all Participants to take on downside financial risk starting in the Model Year for which they first sign a BPCI Advanced Participation Agreement with CMS.

1. Convener Participants and Non-Convener Participants

There are two categories of Participants under BPCI Advanced: Convener Participants and Non-Convener Participants. A Convener Participant is a type of Participant that brings together at least one downstream entity referred to as a "Downstream Episode Initiator"—which must be either an Acute Care Hospitals (ACHs) or a Physician Group Practices (PGPs)—to participate in BPCI Advanced, facilitates coordination among them, and bears and apportions financial risks. A Non-Convener Participant is either an ACH or PGP that bears financial risk only for itself and does not bear financial risk on behalf of multiple downstream Episode Initiators.

2. Episode Initiators

Under BPCI Advanced, Clinical Episodes are triggered by the submission of a claim for either an inpatient hospital stay (Anchor Stay) or an outpatient procedure (Anchor Procedure) by an Episode Initiator. An Episode Initiator includes the Participant (if the Participant is an ACH or a PGP) or to the extent, the Participant is a Convener Participant, any ACH or PGP that participates in BPCI Advanced pursuant to an agreement with the Convener Participant under which the ACH or PGP agrees to participate in BPCI Advanced and to comply with all of the applicable requirements under the Model. Individual physicians may participate as PGP Episode Initiators; however, they must be registered as a single physician PGP with a Tax Identification Number (TIN) for billing and tax purposes. The Target Price calculations, the Reconciliation calculations, and the attribution of Clinical Episodes to Participants will each occur at the Episode Initiator level. If the Participant is a Convener Participant, these calculations are ultimately rolled up to the Participant level to calculate the Net Payment Reconciliation Amount (NPRA) owed by CMS to the Participant or the Repayment Amount owed by the Participant to CMS, as applicable.

3. Participating Practitioners

Convener Participants and Non-Convener Participants may enter into arrangements with downstream practitioners, referred to as Participating Practitioners, who furnish care under this initiative and participate in BPCI Advanced Activities (i.e., care redesign, quality measure reporting, and use of Certified EHR Technology). A Participating Practitioner is an Eligible Clinician as defined in 42 C.F.R § 414.1305 as may be amended from time to time. A "Participating Practitioner" means an Eligible Clinician who: (1) is identified by an individual NPI; (2) is Medicare enrolled and has reassigned his or her right to receive Medicare payment to the TIN of the Participant or a Downstream Episode Initiator, if the Participant or such Downstream Episode Initiator is a PGP; (3) is participating in BPCI Advanced Activities; (4) has a written agreement with the Participant that requires the individual to comply with all applicable terms and conditions of this Agreement; and (5) is identified on the CMS Quality Payment Program (QPP) List.

4. NPRA Sharing Partners and NPRA Sharing Group Practice Practitioners

Both Convener Participants and Non-Convener Participants that select to participate in Financial Arrangements may enter into such arrangements with entities that qualify as "NPRA Sharing Partners," as defined in Appendix A, which may include a Participating Practitioner, PGP, ACH, an Accountable Care Organization (ACO), or a post-acute care provider (PAC Provider). A PAC provider may be a cardiac rehabilitation facility, physical therapy facility, a Medicare-certified Skilled Nursing Facility (SNF), Home Health Agency (HHA), Long Term Care Hospital (LTCH), or Inpatient Rehabilitation Facility (IRF).

In addition, both Convener Participants and Non-Convener Participants that select to participate in Financial Arrangements may enter into such arrangements with entities that qualify as "NPRA Sharing Group Practice Practitioners," as defined in Appendix A, which are Medicare-enrolled physician or non-physician practitioners.

5. BPCI Advanced Beneficiaries

The BPCI Advanced Model test is designed to address all Medicare FFS beneficiaries entitled to benefits under Part A and enrolled under Part B who receive care during a Clinical Episode for which a Participant has selected to be held accountable. See Appendix A for the full definition of a BPCI Advanced Beneficiary.

The BPCI Advanced model does not allow beneficiaries to "opt-out" of the Model's payment methodology. That is, a beneficiary who receives an item or service included in a Clinical Episode from a provider or supplier who is participating in BPCI Advanced cannot receive such care without being subject to the Model's Medicare payment methodology (and the related care processes of that provider or supplier) for as long as the provider or supplier is participating in the Model and the beneficiary is receiving such items and services. Permitting beneficiaries to opt out in this manner would create a great risk for adverse selection and gaming in the Model. The ability to opt-out could also result in harm to beneficiaries and skewing of the Model's evaluation results.

Although BPCI Advanced will not allow beneficiaries to opt out of the payment methodology, the initiative will not affect beneficiaries' freedom to choose their healthcare provider, meaning that beneficiaries may elect to see a provider or supplier that does not participate in BPCI Advanced. If the beneficiary only sees a provider or supplier not participating in BPCI Advanced, the beneficiary would not be included in the Model's payment methodology. Participants, Episode Initiators, and Participating Practitioners may not restrict the beneficiary choice of providers or suppliers. The Model will also not affect the beneficiary's out-of-pocket costs for care furnished under the Model.

Participants also must notify beneficiaries that Participants are a part of the BPCI Advanced Model and require Participating Practitioners and Episode Initiators to do the same. Prior to discharge from the Anchor Stay, or prior to the completion of the Anchor Procedure, as applicable, the Participant shall ensure that the BPCI Advanced Beneficiary receives a copy of a template beneficiary notification letter provided by CMS (the "Beneficiary Notification Letter").

D. Model Participation Agreement

To participate in BPCI Advanced, Applicants that pass the pre-screening process for participation in the Model, as described in Section VI.D of this RFA, must both: (1) commit to being held accountable for one or more CESLGs; and (2) enter into a BPCI Advanced Model Participation Agreement for Model Year 7 with CMS. Active Participants in Model Year 6 will be required to sign an Amended and Restated BPCI Advanced Model Participation Agreement for Model Year 7 with CMS to continue participation in the Model.

The below lists items that are pursuant to the terms of the BPCI Advanced Model Participation Agreement between each Participant and CMS:

1. During each semi-annual Reconciliation, the actual Medicare FFS expenditures for all Clinical Episodes attributed to the Participant and, for Convener Participants, to the Participant's Downstream Episode Initiators, are compared to the final Target Price for those Clinical

Episodes. Based on the results of this Reconciliation, and subject to adjustments based on quality performance, the Participant will either receive an NPRA payment from CMS or the Participant must make a payment (the Repayment Amount) to CMS. These calculations are each described in Section V.D.2 of this RFA.

2. The Participant must assume financial risk for increases in Medicare FFS expenditures during the 30-day Post-Episode Monitoring Period above a specified threshold (described in Section V.D.3 of this RFA), if applicable.
3. The Participant must participate in BPCI Advanced Activities, which include implementing care redesign activities (i.e., care delivery enhancements such as reengineered care pathways using evidence-based medicine, and standardized care pathways); reporting on all applicable quality measures (described in greater detail in Appendix B of this RFA); using Certified Electronic Health Record Technology (CEHRT) per the BPCI Advanced Model Participation Agreement; attesting to a minimum of four MIPS Improvement Activities, and any other related activities to be specified by CMS.
4. The Participant must participate in Learning System activities as required by CMS (described in greater detail in Section XII and Appendix C of this RFA).
5. The Participant may enter into Financial Arrangements, per the terms of the BPCI Advanced Model Participation Agreement and applicable law, with entities or Participating Practitioners that qualify as NPRA Sharing Partners (described in greater detail in Section IV.A.4 of this RFA).
6. The Participant may furnish items and services to BPCI Advanced Beneficiaries pursuant to CMS Payment Policy Waivers (described in greater detail in Section VIII.A of this RFA) and the Fraud and Abuse Waivers (reference Section III.C and Section VIII.B of this RFA), per the terms of the BPCI Advanced Model Participation Agreement.

After the submission of an application, there are a number of deliverables that must be completed and submitted before CMS makes a determination of approving the submitted application and executing the Participation Agreement. The templates for all the required deliverables will be distributed in the summer of 2023 and, at that time, CMS will announce the deadline for the submission of these deliverables.

Those deliverables are:

- BPCI Advanced Participation Agreement for Model Year 7
- Participant Profile
  - This is where Applicants will identify the Episode Initiators, CESLGs, and quality measures for which they will be accountable.
- BPCI Advanced QPP List
  - This is where Applicants will identify the Participating Practitioners that will be implementing the Model and engaged in BPCI Advanced Activities.
- Care Redesign Plan
- Financial Arrangements List (if applicable)

1. Model Period of Performance

The BPCI Advanced Model Participation Agreement for Model Year 7 for all Participants will begin on January 1, 2024, and terminate on December 31, 2024, unless sooner terminated per the terms thereof. Active Convener Participants and active Non-Convener Participants in Model Year 6 will need to sign an Amended and Restated BPCI Advanced Model Participation Agreement for Model Year 7 for continued

participation in the Model. At this time, CMS is not intending to offer a Model Year 8 Amended and Restated Agreement. Therefore, the terms of the Model Year 7 Participation Agreement or Amended and Restated Agreement will continue for Model Year 8 (the end of the Model Period of Performance) on December 31, 2025.

The Performance Period of the Model for BPCI Advanced began on October 1, 2018, and will end on December 31, 2025.

The performance period for the Participation Agreement is the only period of time when a Participant may initiate a Clinical Episode. The start date for a given Participant's BPCI Advanced Model Participation Agreement will depend on whether they were part of the First Cohort (October 1, 2018), the Second Cohort (January 1, 2020), or the upcoming Third Cohort of Participants (January 1, 2024).

The Agreement Performance Period began on October 1, 2018, for the First Participant Cohort; on January 1, 2020, for the Second Participant Cohort; and will begin on January 1, 2024, for the Third Participant Cohort. The Agreement Performance Period ends on the applicable date specified in the executed Participation Agreement unless the Agreement or, if applicable, an Amended and Restated Agreement is terminated earlier by either Party – CMS or the Participant.

Participants that are continuing in the Model from either the first or second cohort, and new Participants in the Model from the third cohort, will be required to execute a BPCI Advanced Participation Agreement if offered by CMS, in order to participate in the Model for Model Year 7.

The Agreement Performance Period of the Model for BPCI Advanced will end on December 31, 2025. Participants' legal responsibilities as outlined in the BPCI Advanced Model Participation Agreement will extend for two years beyond this date until after the final semi-annual Reconciliation unless the agreement was terminated sooner in accordance with its terms.

2. Organizational Readiness

BPCI Advanced Participants will be required to provide CMS information on organizational readiness within 10 days of the date of request by CMS. This includes:

1. Information confirming the organizational readiness of the Participant, and the systems to be used, for the measurement of clinical quality and cost-effectiveness across all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;
2. Information confirming the organizational readiness of the Participant, and accounting systems to be used, to measure and track NPRA payments received from CMS, Repayment Amounts and Excess Spending Amounts owed to CMS, Internal Cost Savings, and Administrative Services, and to provide feedback to all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;
3. Other information, as requested by CMS, to verify and confirm the Participant's and all Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', and NPRA Sharing Group Practice Practitioners' readiness for implementation of the Care Redesign Plan;
4. Other information as requested by CMS to verify, confirm, monitor, or evaluate the performance of this Agreement as carried out by the Participant and all Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners, NPRA Sharing Group Practice Practitioners, and BPCI Advanced Entities;
5. Information, as requested by CMS, for determining and verifying the eligibility to participate in Medicare of the Participant (if the Participant is itself a provider or supplier), and all

Downstream Episode Initiators, Participating Practitioners, NPRA Sharing Partners (for those NPRA Sharing Partners that are providers or suppliers), and NPRA Sharing Group Practice Practitioners; and

6. Information regarding the Participant's plan for implementing and tracking the implementation of all BPCI Advanced Beneficiary protections, including items and services furnished to BPCI Advanced Beneficiaries during the Clinical Episodes included in each Clinical Episode Service Line Group for which the Participant has committed to be held accountable.

3. BPCI Advanced Activities

Certain structural and process improvement activities are cornerstones for success in episode payment models. Participants will therefore be required to engage in BPCI Advanced Activities, including implementing care redesign activities (i.e., care delivery enhancements, such as reengineered care pathways using evidence-based medicine, standardized care pathways, and care coordination), reporting on quality measures, using CEHRT per the BPCI Advanced Model Participation Agreement, attesting to a minimum of four MIPS Improvement Activities, participation in Learning System activities as required by CMS, and any other related activities to be specified by CMS.

a) Care Redesign

The BPCI Advanced Model requires Participants to implement Care Redesign, which are the specific planned interventions and changes to the Participant's, its Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', or NPRA Sharing Group Practice Practitioners' current healthcare delivery system and set forth with particularity in the Participant's Care Redesign Plan.

The Care Redesign Plan (CRP) consists of four Sections:

- *General Information* – Requests basic information about the Participant.
- *Attestation Requirements for Participation* – Enables the Participant to attest to meeting the various requirements for participation in the Model, as defined in the Participation Agreement.
- *Model Plan* - Identifies the basic organizational infrastructure and processes needed to operationalize BPCI Advanced within the Participant's organization and among its Episode Initiators and Participating Practitioners.
- *Care Redesign Interventions: Primary Drivers for Success* – Identifies the planned interventions and changes to the Participant's current healthcare delivery system, the intervention's priority, and the corresponding timeframe for implementation.

b) Use of CEHRT

Since the BPCI Advanced Model is an Advanced Alternative Payment Model, Applicants will be required to certify that they are using CEHRT, as defined in 42 C.F.R. § 414.1305, as may be amended from time to time.

Participants must use CEHRT to document and communicate clinical care with patients and other healthcare professionals and as part of care redesign across treating healthcare providers to ensure coordination of care across settings.

c) Quality Measures

CMS will adjust Reconciliation Amounts based on quality performance on the applicable quality measures. Adjusting payment for quality performance helps align resources while ensuring that cost-

saving strategies do not lower the quality of care for beneficiaries. CMS may incorporate new quality measures, re-evaluate and improve existing quality measures, and adjust the quality measure set and/or CQS calculation methodology on an annual basis during the Performance Period of the Model.[9]

- Participants will have the opportunity to select from an Administrative Quality Measure set or an Alternate Quality Measure set.
- Payment will be linked to quality using a pay-for-performance methodology.
- A quality score will be calculated for each quality measure at the Clinical Episode level, if applicable. These scores will be scaled across all Clinical Episodes attributed to a given Episode Initiator, weighted based on Clinical Episode volume, and summed to calculate an Episode Initiator-specific Composite Quality Score (CQS).
- A CQS Adjustment Amount will be applied to the Positive Total Reconciliation Amount if any, or the Negative Total Reconciliation Amount, if any, resulting in the Adjusted Positive Total Reconciliation Amount or the Adjusted Negative Total Reconciliation Amount, respectively, which either becomes a Non-Convener Participant's NPRA or Repayment Amount or is used to determine the Convener Participant's NPRA or Repayment Amount. There is a 10 percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount. This policy is subject to change on a prospective basis.

For more details about the BPCI Advanced Quality Measures, please review Appendix B.

4. Financial Responsibility to CMS – Secondary Repayment Source (SRS)

All applications must identify a single entity that seeks to participate in BPCI Advanced as a Participant—either as a Non-Convener Participant or as a Convener Participant—that will accept and bear financial responsibility to Medicare under BPCI Advanced. Except for Convener Participants that are not themselves enrolled in Medicare as a provider or supplier, a condition of continuing participation in BPCI Advanced is that the Participant continues to offer its services as a Medicare provider or supplier.

All applications must also identify, in the "Participating Organizations" template, to the extent that the Applicant is a Convener Participant, all proposed Episode Initiators in a manner specified by CMS, and demonstrate the necessary partnerships between the designated Applicant and each of these individuals and organizations, if applicable. Note that Applicants selected to participate in BPCI Advanced beginning on January 1, 2024, will not be allowed to add Episode Initiators that were not included on their original application.

Applicants must include information regarding their ability to bear financial risk and to repay Medicare for any Medicare FFS spending during a Clinical Episode in excess of the Target Price, as well as any excess Medicare expenditures identified during the Post-Episode Monitoring Period. This must include enforceable assurances of each Participant's ability to repay Medicare. This assurance, called the Secondary Repayment Source (SRS), could take the form of an irrevocable letter of credit for the full amount of risk undertaken, or funds placed in escrow, where CMS is the recipient of funds held in escrow if payment is due to CMS.

Certain Convener Participants with Downstream Episode Initiators may be eligible for exemption from the Secondary Repayment Source requirement provided that all of their Downstream Episode Initiators enter into a written agreement, called the SRS Reduction Agreement, consenting to CMS directly recovering any monies owed by the Participant under BPCI Advanced from any of their present and future Medicare payments in accordance with the terms of the BPCI Advanced Participation Agreement

[9] Applicants may review the Model Year 6 Quality Measure Sets on the BPCI Advanced Quality Measures webpage to get a sense of the types of quality measure used in the Model.

provisions related to this policy. An SRS Reduction Agreement with any Downstream Episode Initiators and CMS must be entered into voluntarily and without penalty for nonparticipation.

The amount guaranteed by the Participant's Secondary Repayment Source must be for the applicable amount calculated by CMS, per the methodology described in the BPCI Advanced Participation Agreement and specified in the Secondary Repayment Source File described in the BPCI Advanced Participation Agreement. CMS calculates the Secondary Repayment Source amount for each SRS Covered Participant based on the Clinical Episodes in each Clinical Episode Service Line Group for which the Participant has committed to be held accountable that are attributable to the Participant (if applicable) and, if the Participant is a Convener Participant, to each of the Participant's applicable Downstream Episode Initiators during the applicable baseline period.

The submission of the Participant Profile deliverable (which identifies their selection of CESLGs) at the time an Applicant submits a signed Participation Agreement will be used by CMS to calculate the amount the SRS must be funded, per the terms of the BPCI Advanced Participation Agreement Article 7.7 and Appendix B.

The SRS must become effective by a date specified by CMS. The SRS must remain in effect until at least 24 months after the conclusion of the Performance Period ongoing at the end of the Agreement Performance Period or until all of the Participant's financial obligations to CMS pursuant to the BPCI Advanced Participation Agreement have been fulfilled, whichever is later. The Participant shall remain liable for any amount owed to CMS in excess of the amount specified in the Secondary Repayment Source File.

If the Participant fails to comply with the SRS requirement by the date specified by CMS, or CMS rejects the Secondary Repayment Source obtained by the Participant or does not approve changes to such Secondary Repayment Source, CMS may terminate the Agreement with the Participant according to the terms of the Participation Agreement and the Participant shall remain liable for any amount owed to CMS.

5. Remedial Actions

When it is determined—through monitoring or otherwise--that the Participant, a Downstream Episode Initiator, Participating Practitioner, NPRA Sharing Partner, NPRA Sharing Group Practice Practitioner, BPCI Advanced Entity, or another individual or entity performing functions or services related to BPCI Advanced Activities, are not in compliance with the Model's requirements, CMS may determine that remedial action is warranted pursuant to the Participation Agreement. If CMS determines that such action is warranted, CMS may: send a Participant a Notification of Non-Compliance with 10 days to resolve the identified deficiency; terminate the Participant's BPCI Advanced Model Participation Agreement if remedial actions were insufficient to correct the noncompliance; require the Participant to terminate its relationship with any other individual or entity with respect to their performance of functions or services related to BPCI Advanced Activities (such as terminating arrangements with one or more Downstream Episode Initiators, Participating Practitioners, or others); require Participants to implement a corrective action plan (CAP) approved by CMS; and/or take other remedial actions as determined by CMS if remedial actions were insufficient to correct the noncompliance. Any CAP implemented for purposes of BPCI Advanced will require the Participant to submit a proposed written plan for achieving compliance and allow CMS to determine whether such approved actions were made. Failure to comply with the requirements of the CAP, or with the BPCI Advanced Model Participation Agreement itself, may result in termination of the Participant's BPCI Advanced Model Participation Agreement or referral to law enforcement, or both, if necessary.

6. Termination of the BPCI Advanced Model Participation Agreement

CMS reserves the right to terminate a BPCI Advanced Model Participation Agreement with a Participant, or require a Participant to terminate its agreement with an Episode Initiator or Participating Practitioner under BPCI Advanced, for the reasons stated below, or if otherwise required under Section 1115A of the Act, including, but not limited to, the following:

- If the Participant consistently does not meet quality performance thresholds or benchmarks required under the BPCI Advanced Model Participation Agreement.
- If the Participant consistently demonstrates increased Medicare FFS expenditures during the Post-Episode Monitoring Period for items and services included in the applicable Clinical Episodes.
- If the Participant is subject to action by HHS or the Department of Justice involving violations of applicable laws, statutes, and regulations, including but not limited to: federal criminal laws, the federal False Claims Act, antitrust laws, the federal anti-kickback statute, the federal civil monetary penalties law, the federal physician self-referral law or any other applicable Medicare laws, rules or regulations that are relevant to this Model.
- If the Participant, or any of its Episode Initiators or Participating Practitioners, are identified as noncompliant through monitoring of the Model or otherwise, which includes but is not limited to restricting access to medically necessary care.
- If the Participant fails to pay back money owed to the Medicare program as specified in the BPCI Advanced Model Participation Agreement or any Reconciliation or Post-Episode Spending Reports issued pursuant thereto, including any Repayment Amount calculated during the semi-annual Reconciliation or an amount owed based on increases in aggregate Medicare FFS spending during the Post-Episode Monitoring Period.
- If the Participant unreasonably interferes with or impedes CMS's and its designees' monitoring and evaluation activities.
- If the Participant is determined to not comply with any of the Federal requirements for participation as a Medicare-enrolled provider or supplier, including the Conditions of Participation, Conditions for Coverage, or Requirements of Participation.

The BPCI Advanced Model Participation Agreement may detail additional reasons for termination.

While not anticipating this circumstance, CMS also reserves the right to end the Model in whole or in part, at any time prior to the end of the Performance Period of the Model in 2025. If CMS determines, in CMS's sole discretion, that there are no longer sufficient funds to implement the Model or that continuing the Model is no longer in the public interest. CMS also reserves the right to modify or terminate the Model if it no longer satisfies the requirements of Section 1115A of the Act. In the event of any such conclusion, modification, or termination, CMS will promptly notify the Participants, in writing, of the reasons and the effective date thereof.

V. Model Design Elements

A. Clinical Episode Selection and Clinical Episode Service Line Groups (CESLGs)

In Model Years 1 and 2 (October 1, 2018 – December 31, 2019), BPCI Advanced included 29 inpatient Clinical Episode categories, as well as 3 outpatient Clinical Episode categories. In Model Years 3-5 (January 1, 2020 – December 31, 2022), BPCI Advanced included 30 inpatient, 3 outpatient, and 1 multi-setting Clinical Episode category. However, starting in Model Year 4 (2021), Participants were required

to commit to being accountable for at least one CESLG, and their CESLG selections were binding for Model Years 4-6 (January 1, 2021 – December 31, 2023).

Starting in Model Years 6 (January 1, 2023 – December 31, 2023), there will be 29 inpatient, 3 outpatient, and 2 multi-setting Clinical Episode categories. Before starting Model Year 7 (January 1, 2024 – December 31, 2024), BPCI Advanced Participants must select the CESLGs for which they will commit to being held accountable, concurrent with the signing of their BPCI Advanced Model Participation Agreement. Participants are not permitted to change CESLG selection(s) once identified for Model Year 7 (January 1, 2024 – December 31, 2024), unless expressly permitted to do so by CMS. CMS does not intend to allow Participants to change CESLG selections for Model Year 8 (January 1, 2025 – December 31, 2025) or allow the addition or removal of Episode Initiators. See Appendix D for the Clinical Episode Service Line Group (CESLGs) List.

Clinical Episode List: CMS will maintain a list of MS-DRGs and HCPCS codes that may initiate a Clinical Episode. CMS plans to update this list whenever CMS elects to add or remove Clinical Episodes. Applicants may review the Model Year 6 Clinical Episode List on the BPCI Advanced Participant Resources webpage.

Clinical Episode Service Line Group List: CMS will maintain a list of Clinical Episodes and their corresponding Clinical Episode Service Line Groups, which CMS plans to update whenever CMS elects to add or remove Clinical Episodes or Clinical Episode Service Line Groups. See Appendix D of this RFA for the Clinical Episode Service Line Group List.

At this time, CMS expects that the Clinical Episodes in the eight CESLGs for Model Year 7 (2024) will be the same as the list for Model Year 6 (2023).

B. Items and Services Included/Excluded in the Clinical Episode

BPCI Advanced operates under a total-cost-of-care concept, in which the total Medicare FFS spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode, including outlier payments, is part of the Clinical Episode expenditures for purposes of the Target Price and semi-annual Reconciliation calculations unless specifically excluded. While participating hospitals, physicians, and PAC providers are encouraged to communicate with each other as partners in the Clinical Episode, Applicants should recognize that Participants in the Model will generally be financially liable for all Medicare FFS payments beyond the Target Price, including care furnished to BPCI Advanced Beneficiaries by providers and suppliers who are not participating in BPCI Advanced. NPRA payments and Repayment Amounts will be subject to a 20 percent stop-gain/stop-loss policy; therefore, no outlier payments will be made at Reconciliation for catastrophic cases.

Inclusions: Each Clinical Episode includes Medicare FFS expenditures for:

1. Part A and Part B non-excluded items and services that are furnished during the Anchor Stay or Anchor Procedure
    - Physicians’ services
    - Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure, respectively
    - Other hospital outpatient services
    - Inpatient hospital readmission services
    - Long-term care hospital (LTCH) services

- Inpatient rehabilitation facility (IRF) services
- Skilled nursing facility (SNF) services
- Home health agency (HHA) services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs
- Hospice services

2. Part A and Part B non-excluded items and services furnished in the 90-day period following the Anchor Stay or Anchor Procedure, including hospice services and both related and unrelated readmissions;

3. With respect to those Clinical Episodes triggered by an Anchor Stay:
    a. All non-excluded hospital diagnostic testing and certain therapeutic services furnished by the admitting hospital or an entity wholly owned or wholly operated by the admitting hospital in the three days prior to the Anchor Stay (in accordance with the 3-day payment window rule); and
    b. If the BPCI Advanced Beneficiary was transferred from the Emergency Department (ED) at another facility either the day of or the day before admission for the Anchor Stay, charges from that ED visit.

Exclusions: CMS excludes from a Clinical Episode those Medicare FFS expenditures for:

1. All Part A and Part B services furnished to a BPCI Advanced Beneficiary during certain specified ACH admissions and readmissions (i.e., an admission assigned at discharge to MS-DRGs for organ transplants, major trauma, cancer-related care, ventricular shunts);
2. Contralateral procedures with the same MS-DRG or HCPCS code (e.g., Major Joint Replacement of the Lower Extremity Clinical Episode that has a joint replaced in the opposite leg within 90 Days);
3. New technology add-on payments under the IPPS;
4. Payments for items and services for cardiac rehabilitation and intensive cardiac rehabilitation described in 42 C.F.R. § 410.49; and
5. Payment for blood clotting factors made pursuant to 42 C.F.R. § 410.63(b).

The BPCI Advanced Exclusions List for Model Year 6 can be found here: https://innovation.cms.gov/media/document/bpci-adv-my6-exclusion-list.

BPCI Advanced Clinical Episodes will not be eligible to initiate when any of the following scenarios occur:

1. The Medicare beneficiary is covered under managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations);
2. The Medicare beneficiary is eligible based on end-stage renal disease (ESRD);
3. Medicare beneficiaries for whom Medicare is not the primary payer;
4. Medicare beneficiaries who died during the Anchor Stay or Anchor Procedure, as applicable; and
5. Beneficiaries not enrolled in Medicare A/B for the entire Clinical Episode.

C. Clinical Episode Definition

Criteria for Beneficiary inclusion in a Clinical Episode:

- Medicare FFS beneficiary who receives inpatient care during an Anchor Stay (identified by a qualifying MS-DRG) or outpatient care during an Anchor Procedure (identified by an HCPCS code) billed to Medicare FFS by an Episode Initiator.

Clinical Episode Triggers:

- Inpatient Clinical Episodes are triggered by the submission of a claim to Medicare FFS by an Episode Initiator for the inpatient hospital stay, identified by Medicare Severity-Diagnosis Related Group (MS-DRG).
- Outpatient Clinical Episodes are triggered by the submission of a claim to Medicare FFS by an Episode Initiator for the outpatient procedure, identified by a Healthcare Common Procedure Coding System (HCPCS) code.

Clinical Episode Length:

- Inpatient Clinical Episode / Anchor Stay: Anchor Stay + 90 days; the date of discharge is day 1 of the 90-day period.
- Outpatient Clinical Episode / Anchor Procedure: Anchor Procedure + 90 days; the date the outpatient procedure is completed is day 1 of the 90-day period.

D. Pricing Methodology

CMS aims to ensure that total Medicare FFS expenditures will decrease relative to what they would have been in the absence of the Model. Under the terms of the BPCI Advanced Model Participation Agreement, Participants may not alter care delivery practices, adopt billing practices, or take any other actions that are expected to reduce Medicare FFS expenditures on Clinical Episodes by intentionally increasing Medicare FFS expenditures on items and services not included in the Clinical Episode (e.g., excluded items and services).

BPCI Advanced involves retrospective Reconciliation of Medicare FFS expenditures on items and services included in each Clinical Episode against a Target Price for that Clinical Episode. Such Target Prices will be calculated by applying the CMS Discount to the Benchmark Price. CMS Discount percentage applied to the Benchmark Price to calculate the Target Price is 2% for medical Clinical Episodes and 3% for surgical Clinical Episodes.

BPCI Advanced pricing methodology involves a retrospective bundled payment mechanism that consists of a semi-annual Reconciliation against preliminary Clinical Episode-specific Target Prices subject to adjustment by CMS, reliant upon the Participant's actual patient case mix and realized peer group trend (PGT) during the Performance Period. Realized trends are captured in the final Target Price by a Peer Group Trend (PGT) Factor Adjustment, which is subject to a cap, and based on the difference between a retrospective peer group trend and the prospective peer group trend used to calculate the initial Target Price. For example, if the prospective peer group trend was accurately predicted, meaning the prospective peer group trend equals the retrospective peer group trend, the PGT Factor Adjustment would have a value of 1.0. For Model Year 7, the PGT Factor Adjustment is capped at ±5 percent, meaning it can take a maximum upward adjustment value of 1.05 and a minimum downward adjustment value of 0.95 This trend adjustment makes the model responsive to realized peer group spending trends unrelated to performance and maintains pricing accuracy while limiting pricing instability.

The applicable Target Price for each Clinical Episode depends on the Episode Initiator that triggered the Clinical Episode. Each Episode Initiator that is an ACH receives its own Target Price for each Clinical Episode, while each Clinical Episode triggered by an Episode Initiator that is a PGP will be assigned a Target Price specific to the ACH where the services during the Anchor Stay or Procedure was furnished by physicians billing those Part B services for the Anchor Stay or Anchor Procedure to the PGP's TIN, subject to certain adjustments.

This allows for more granularity in estimating the true costs of Clinical Episodes, which will vary based on the ACH where the Anchor Stay or Anchor Procedure occurred, and avoids the potentially significant discrepancy between the preliminary Target Price and final Target Price inherent in calculating these prices based on data from a frequently-evolving group of physicians (as opposed to the more stable nature of an ACH).

A preliminary Target Price will be determined prospectively, with a final Target Price set retrospectively at the time of Reconciliation by adjusting the preliminary Target Price based on the actual patient case-mix and realized peer group trend. BPCI Advanced will also limit risk to Participants through a risk track that applies Winsorization at the 1st/99th percentile of total standardized allowed amounts within the Clinical Episode during each baseline calendar year and of national Medicare FFS spending on each MS-DRG and HCPCS code to account for random variation. Further details regarding this methodology will be provided to Applicants prior to executing a BPCI Advanced Model Participation Agreement with CMS.

For additional technical details regarding the Reconciliation process and the creation of Target Prices, please review – Reconciliation Specifications MY5 [https://innovation.cms.gov/media/document/bpci-advanced-my5-recon-specs] and Target Price Specifications MY6 [https://innovation.cms.gov/media/document/bpci-adv-targetprice-specs-my6]

1. Clinical Episode Attribution

Clinical Episodes will be attributed at the Episode Initiator level during the Reconciliation Process. The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators in BPCI Advanced is as follows, in descending order of precedence:

1. The PGP that has the attending physician's National Provider Identifier (NPI) listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) during the Anchor Stay or Anchor Procedure billed under the participating PGP's Tax Identification Number;
2. The PGP that has the operating physician's National Provider Identifier (NPI) listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) during the Anchor Stay or Anchor Procedure billed under the participating PGP's Tax Identification Number; and
3. The ACH was where services during the Anchor Stay or Anchor Procedure were furnished.

There is no time-based precedence in BPCI Advanced.

For additional technical details please review the Clinical Episode Construction Specifications – MY6 (PDF).

2. Reconciliation

CMS conducts semi-annual Reconciliation against preliminary Clinical Episode-specific Target Prices, adjusted by CMS based on the Participant's actual patient case mix and realized peer group trend (subject to a ±5 percent cap) during the Performance Period to calculate the final Target Price. If during the semi-annual Reconciliation process, all non-excluded Medicare FFS expenditures for a Clinical

Episode for which the Participant has committed to be held accountable are less than the final Target Price for that Clinical Episode, this results in a Positive Reconciliation Amount. By contrast, if all non-excluded Medicare FFS expenditures for a Clinical Episode are greater than the final Target Price, this results in a Negative Reconciliation Amount. All Positive Reconciliation Amounts and Negative Reconciliation Amounts will then be netted across all Clinical Episodes attributed to the Episode Initiator to calculate either a Positive Total Reconciliation Amount or a Negative Total Reconciliation Amount.

If this calculation results in a Negative Total Reconciliation Amount, this amount will be adjusted by the Composite Quality Score (CQS) Adjustment Amount, as described in the Pricing Methodology Section of the RFA (Section V.D.2), based on quality performance, resulting in the Adjusted Negative Reconciliation Amount. For Non-Convener Participants, this amount is the Repayment Amount. If this calculation results in a Positive Total Reconciliation Amount, this amount will be adjusted by the CQS Adjustment Amount, based on quality performance, resulting in the Adjusted Positive Total Reconciliation Amount. For Non-Convener Participants, this Adjusted Positive Total Reconciliation Amount is the NPRA. There is a 10 percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount and the Negative Total Reconciliation Amount. Therefore, an Adjusted Positive Total Reconciliation Amount or an Adjusted Negative Reconciliation Amount will be 90 percent to 100 percent of the Positive Total Reconciliation Amount or Negative Total Reconciliation Amount, respectively. This policy could be subject to change on a prospective basis.

For Convener Participants, all Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts are netted across the Participant's Episode Initiators to calculate either the NPRA or a Repayment Amount, as applicable.

These amounts will be specified in a Reconciliation Report to be provided to the Participant by CMS. If applicable, CMS will pay the NPRA specified in the Reconciliation Report to the Participant, subject to a 20-percent stop-gain provision at the Episode Initiator level. To the extent the Participant enters into Financial Arrangements under BPCI Advanced, the Participant may distribute this NPRA payment to the Participant's NPRA Sharing Partners pursuant to such Financial Arrangements, consistent with the terms of the BPCI Advanced Model Participation Agreement and applicable law (including any waivers of applicable law).

If applicable, the Participant will owe CMS the Repayment Amount specified in the Reconciliation Report, subject to a 20 percent stop-loss provision applied at the Episode Initiator Level. To the extent the Participant selects to participate in Financial Arrangements under BPCI Advanced, the Participant may apportion the Repayment Amount among the Participant's NPRA Sharing Partners pursuant to such Financial Arrangements, consistent with the terms of the BPCI Advanced Model Participation Agreement, any waivers issued under the Model, and applicable law. The Participant may not receive any Shared Repayment Amounts from NPRA Sharing Partners unless the Participant owes CMS a Repayment Amount as set forth in a Reconciliation Report that is deemed final.

For additional technical details regarding the Reconciliation process and the creation of Target Prices, please review: Reconciliation Specifications MY5 [https://innovation.cms.gov/media/document/bpci-advanced-my5-recon-specs] and Target Price Specifications MY6 [https://innovation.cms.gov/media/document/bpci-adv-targetprice-specs-my6]

3. Post-Episode Monitoring Period

CMS will measure the cost of care furnished during the 30-day Post-Episode Monitoring Period, to ensure the aggregate Medicare FFS expenditures for BPCI Advanced Beneficiaries do not increase due to

cost shifting or other reasons. This review will include measuring Medicare FFS expenditures for items and services furnished to BPCI Advanced Beneficiaries by healthcare providers that are not participating in BPCI Advanced. All non-excluded Medicare FFS expenditures for BPCI Advanced Beneficiaries during the Post-Episode Monitoring Period will be compared to the 99.5% confidence interval of predicted spending for post-discharge days 90-120 under the statistical model used for setting Target Prices. If Medicare FFS expenditures during the Post-Episode Monitoring Period exceed this risk threshold, then the Participant must pay Medicare the difference.

E. Overlap with Other CMS Models

If Applicants are selected, Participant-specific issues pertaining to overlapping participation in other CMS initiatives (e.g., related to transition timing) will be addressed by CMS, at CMS' sole discretion, as necessary.

As healthcare transformation often requires some alignment between new payment methods and care improvement strategies, and because the BPCI Advanced initiative is not a shared savings initiative, entities may concurrently participate in BPCI Advanced and the Medicare Shared Savings Program and other shared savings initiatives. Concurrent participation in BPCI Advanced and medical home initiatives is similarly permitted. However, for entities that simultaneously participate in these initiatives, including current or future CMS initiatives, CMS reserves the right to potentially include additional requirements, revise initiative parameters, exclude overlapping beneficiaries and/or episodes, or ultimately prohibit simultaneous participation in multiple initiatives, based on several factors, including CMS' capacity to avoid counting savings twice in interacting initiatives and ability to conduct a robust evaluation of each such initiative.

For example, currently, there is an exclusion of Clinical Episodes from Reconciliation calculations for beneficiaries aligned or assigned to ACOs participating in: (1) the Vermont Medicare ACO Initiative; (2) the Global and Professional Direct Contracting Model; (3) the Comprehensive Kidney Care Contracting (CKCC) Options of the Kidney Care Choices (KCC) Model; or (4) the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model. Additional information regarding how CMS Innovation Center Model's overlap will be addressed will be provided in future correspondence and the BPCI Advanced Participation Agreement.

1. Comprehensive Care for Joint Replacement (CJR) Model Participants

If a Participant or, if applicable, a Downstream Episode Initiator, is also participating in the Comprehensive Care for Joint Replacement (CJR) model, the Participant will not be held accountable for any Clinical Episodes included in that model for purposes of BPCI Advanced and CMS will exclude from the BPCI Advanced Reconciliation calculation all clinical episodes included in that model.

Furthermore, CJR Model participant hospitals are not precluded from applying to the BPCI Advanced Model for the extension years, and if selected, may be eligible to participate in all BPCI Advanced Clinical Episodes except for Clinical Episodes also included in CJR (e.g. the major joint replacement of the lower extremity Clinical Episode) for Model Years 7 & 8 (2024-2025). However, CJR participant hospitals that also participate in BPCI Advanced may be eligible to initiate the major joint replacement of the lower extremity Clinical Episode once the CJR Model has ended on December 31, 2024, as long as the Orthopedic CESLG was selected on the Participant Profile submitted for Model Year 7 (2024).

VI. Application Process

CMS seeks participation in the Model by healthcare providers who are already implementing care redesign under bundled episode payments, as well as those who are eager to experiment with transforming their care delivery system from one reliant on Medicare FFS to one that is more focused on value-based care.

Applicants should be able to demonstrate their current capacity and readiness to redesign care and have experience with quality improvement efforts, be able to enter into a BPCI Advanced Model Participation Agreement with CMS that includes financial and performance accountability for CESLGs and be capable of meeting the quality measure reporting requirements under the BPCI Advanced Model Participation Agreement. CMS will offer Applicants the opportunity to request certain data to support informed CESLG selection, self-evaluation, and quality and process improvement, as described in greater detail below. CMS will also offer Applicants substantial Learning System activities around the model requirements, pricing methodology, quality measures, and how to access, protect, and use the data offered by CMS to Applicants.

A. Timeline for Applications

Applicants that wish to be considered for participation in Model Year 7, which begins on January 1, 2024, must submit their completed application, which includes the Data Request and Attestation (DRA) form and the Participating Organizations template, as applicable, via the BPCI Advanced Application Portal, which will be accessible at: https://app.innovation.cms.gov/bpciadvancedapp/IDMLogin

Applicants will have 100 days to apply to the BPCI Advanced Application Portal.

- CMS will begin accepting applications on February 21, 2023
- CMS will stop accepting applications after May 31, 2023

CMS may not review applications submitted after the deadline. CMS reserves the right to request additional information from Applicants in order to assess their applications.

Application resources may be accessed at the Model's webpage: https://innovation.cms.gov/initiatives/bpci-advanced.

For technical assistance accessing the BPCI Advanced Application Portal, Applicants may contact CMMIForceSupport@cms.hhs.gov or call 1-888-734-6433, option 5. For questions about the RFA or application itself, Applicants may contact the Model Team at BPCIAdvanced@cms.hhs.gov.

B. Who Can Apply

An Applicant may be any entity eligible to participate in BPCI Advanced as a Convener Participant or as a Non-Convener Participant.

CMS is not placing limitations on Applicants based on geographic region (e.g., Applicants are not limited to a specific MAC jurisdiction), geographic type (e.g., urban, rural), facility size, past participants of the Bundled Payments for Care Improvement (BPCI) Initiative or the BPCI Advanced Model, current participants of the Comprehensive Care for Joint Replacement (CJR) Model, as well as participants in other current and past CMS Innovation Center models and Medicare demonstrations.

Applications received from current and past Participants of the BPCI Advanced Model will be subject to the same application submission and review processes, as well as selection criteria, as are applications received from Applicants that did not participate in BPCI Advanced prior to this application period.

1. Non-Convener Applicants

The following eligible entities may apply to participate in BPCI Advanced starting in 2024 (Model Year 7) as a Non-Convener Participant or as a Convener Participant:

- *Acute Care Hospitals (ACHs):* means a Medicare-enrolled "sub-Section (d) hospital" as defined in Section 1886(d)(1)(B) of the Act, including ACHs where outpatient procedures are performed in hospital outpatient departments (HOPDs). PPS-exempt cancer hospitals, inpatient psychiatric facilities, critical access hospitals (CAHs), hospitals in Maryland, hospitals participating in the Rural Community Hospital demonstration, and Rural Hospitals participating in the Pennsylvania Rural Health Model, are excluded from the definition of an ACH for purposes of BPCI Advanced.

- *Physician Group Practices (PGPs):* means a Medicare-enrolled physician group practice.

Entities that are ACHs or PGPs, whether new to BPCI Advanced or former Participants or Downstream Episode Initiators, will have the opportunity of applying as either a new Non-Convener Participant, Convener Participant, or may be listed as Downstream Episode Initiators under a Convener Participant application for Model Year 7 (2024).

2. Convener Applicants

For Model Year 7 (2024), the following eligible entities may apply to participate in BPCI Advanced as a new Convener Participant: Medicare-enrolled providers or suppliers, Accountable Care Organizations (ACOs), or Active Convener Participants in Model Year 6 that are not Medicare-enrolled providers or suppliers, or ACOs.

  - *Provider:* is defined at 42 CFR 400.202 and generally means a hospital[10], critical access hospital[11], skilled nursing facility, comprehensive outpatient rehabilitation facility (CORF), home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.[12]

  - *Supplier*: is defined in 42 CFR 400.202 and means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.[13]

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[10] For the BPCI Advanced Model, exceptions to the definition of an Acute Care Hospital apply to the following types of providers because of their unique payment methodologies: PPS-Exempt Cancer Hospitals, inpatient psychiatric facilities, Critical Access Hospitals (CAHs), hospitals in Maryland, hospitals participating in the Rural Community Hospital Demonstration, and Participant Rural Hospitals in the Pennsylvania Rural Health Model.

[11] Ibid

[12] The provider must be Medicare-enrolled by the application deadline. This means the provider must have an "Approved" enrollment status in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) database by the application deadline.

[13] The supplier must be Medicare-enrolled by the application deadline. This means the supplier must have an "Approved" enrollment status in the PECOS database by the application deadline

- *ACO:* is defined as a legal entity that is recognized and authorized under applicable law, identified by a Taxpayer Identification Number (TIN), and formed by one or more ACO participant(s). For the purposes of this Model, an ACO includes a participant in the Shared Savings Program, ACO Realizing Equity, Access, and Community Health (REACH) Model, Kidney Care Choices (KCC) model, Vermont All-Payer ACO Model, or other Medicare-specific ACO-related initiatives administered by CMS.

- *Active Convener Participants in Model Year 6 that are not Medicare-enrolled providers or suppliers, or ACOs:*

  - An organization, as identified by a Tax Identification Number (TIN) and that has at least one executed Amended and Restated Participation Agreement with CMS for Model Year 6, at the time an application is submitted for Model Year 7.

  - CMS reserves the right of not approving new applications for Model Year 7 if the organization's participation in the Model is terminated prior to December 31, 2023.

C. Application Requirements

1. Application

Applicants must submit their application, before the announced deadline, via the BPCI Advanced Application Portal, which will be accessible at: https://app.innovation.cms.gov/bpciadvancedapp/IDMLogin. The application contains the following sections:

- Organization Information
  - Identification of entity to be designated as Participant (either Convener Participant or Non-Convener Participant)
  - An executive summary of the application that includes the overall approach to redesigning care to maximize coordination, patient-centeredness, efficiency, and high-quality health care through accountability for an episode of care. The summary should also, include 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 model and improve care processes.
- Participating Organizations [14],
  - Identification of Participating organizations; Participating Organizations are defined as providers or suppliers that initiate episodes and with whom the Participant plans to partner (e.g., acute care hospitals, physician group practices).
  - Identification of proposed Downstream Episode Initiators
- Practitioner Engagement
  - Description of the Applicant's plan to disclose participation in this initiative to practitioners practicing at the Applicant organization or its participating organizations, as well as the Applicant's plan to obtain consent from physicians/practitioners prior to committing them to participate in this model.

[14] The term "Participating Organizations" used in the application template and the BPCI Advanced Application Portal is synonymous to "Episode Initiators" and refers to ACHs or PGPs implementing the Model.

    - Description of the Applicant's plan to obtain widespread endorsement and engagement by practitioners at the Applicant organization and its participating organizations for this initiative. The description should include the applicant's plan to retain Participating Practitioners and participating organizations in Care Redesign activities related to this model.
- Care Improvement
    - Description of the Applicant's plan for Care Redesign to achieve BPCI Advanced outcomes. The description should 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
    - Description of 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 model.
    - Description of 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.
- NPRA Sharing
    - Description of whether the Applicant intends to share NPRA
    - Description of the Applicant's and its participating organizations' prior or current experience with any NPRA Sharing or pay-for-performance initiatives, including Medicare, Medicaid, or commercial purchasers
    - Description of 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 Participating Practitioners, the mechanism for calculating gains, include any quality metrics associated with the sharing of gains. The description should include how the allocation of gains will incorporate best-practice norms, quality, patient safety, patient experience, and efficiency measures.
    - Description of 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.
    - Description of 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
    - Using evidence from past experience and research, a description of how the Applicant's and its participating organizations' planned care improvement interventions will result in improved quality and patient experience of care.
    - Description of how the Applicant plans to perform well on the quality measures required in this initiative.

- Description of the Applicant's, its Participating Organizations’, and its Participating Practitioners' experience reporting quality measures, including the system(s) through which these measures were reported.
- Description of 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. The description should include past performance achievements in quality improvement.
- Description of the Applicant’s, Participating Organizations’, and its Participating Practitioners’ experience with voluntary Medicare quality measurement and improvement initiatives. The description should include past performance and achievements in quality improvement, and the extent, and percentage of Participating Practitioners who are included in these programs.
- Description of 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.

- Quality Assurance
    - Description of 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 BPCI Advanced. This includes 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
    - Description of how the Applicant’s participation in BPCI Advanced will fit with existing quality assurance and continuous quality improvement processes, standards, and strategies.
    - Description of 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.
    - Description of 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 model are met or exceeded, with a description of what aspects are already in use and what steps would be needed to implement new measures. The description should include the feasibility of this plan based on ongoing operations and past experiences.
    - Description of 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.
    - Description of the Applicant, participating organizations, and its Participating Practitioners sanctions, investigations, probations, corrective action plans, and current outstanding Medicare debt in the last five years.
- Beneficiary Protections
    - Description of the Applicant’s and its participating organizations’ plan for beneficiary protections.

- Description of the Applicant's and its participating organizations' plan to ensure beneficiary freedom of choice of providers.
    - Description of the Applicant's plan for beneficiary notification of participation in BPCI Advanced as well as ongoing processes to handle and track beneficiary questions and concerns.
    - Description of the Applicant's plan for beneficiary engagement and education.
- Financial Arrangements
    - Description of any financial arrangements with participating organizations and Participating Practitioners to share or delegate the financial risk associated with this initiative. For Convener Applicants, a description of 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.
    - Description of the financial and logistical mechanisms for distributing any gains resulting from care improvement under this initiative.
- Organizational Capabilities and Readiness
    - Description of how participation in BPCI Advanced relates to the applicant's overall strategic planning for better care for individuals, better health for populations, and lower costs through improvement.
    - Description of a detailed implementation plan, including the processes in place to handle tasks occurring simultaneously, resource allocations (e.g. staff, systems, related departments), and evidence of the feasibility of this plan based on ongoing operations and past experiences.
- Partnerships
    - Description of the Applicant's history with its participating organizations, in general, including prior business relationships and collaboration on care improvement/redesign initiatives.
    - Description of 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.
- Data Request and Attestation
- Certification

2. Participating Organizations Template

The Participating Organizations template is a required element of the application for Convener Applicants and Non-Convener Applicants that are a PGP. The Participating Organization template identifies the Convener applicant's potential Downstream Episode Initiators. The template is also used to identify Participating Practitioners and the hospitals where they anticipate initiating Clinical Episodes for Non-Convener applicants.

The template must be downloaded from the Application Portal, the required information populated, and then uploaded back as a .csv file to the Application Portal.

Convener Applicants:

- Please provide 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 that are a PGP:

- Please provide 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.

3. Data Request and Attestation (DRA) Form

Applicants will be required to submit an "Applicant Data Request and Attestation (DRA)" form to CMS along with their completed application, in order to be eligible to receive certain data from CMS. Applicants will have the opportunity to request the data used to calculate the prospectively determined preliminary Target Prices that will be provided by CMS to all Applicants and/or other historical Medicare claims data from CMS.

To request such Medicare claims data from CMS, the Applicant must specify the requested data elements, as well as the time period for which such data are requested. At a minimum, CMS intends to provide the opportunity to request certain summary beneficiary claims data and line-level beneficiary claims data, to be described in greater detail on the Applicant DRA form. Applicants must also specify the legal basis that justifies the disclosure of the requested claims data under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, where indicated on the DRA. For example, Applicants may request beneficiary-identifiable data under the BPCI Advanced initiative under the HIPAA Privacy Rule provisions that permit disclosures of protected health information for purposes of the recipient's health care operations.[15]

The application template which includes the DRA form, as well as further instructions, are available on the BPCI Advanced Model webpage at: https://innovation.cms.gov/innovation-models/bpci-advanced.

If accepted into BPCI Advanced, Participants will be required to submit a "Participant DRA" form, to be provided by CMS, prior to the start of Model Year 7, in order to receive similar data during their participation in the Model.

4. Certifications

All Applicants will need to certify that the statements below are true as part of the application process:

1. Entities applying as Convener Participants will certify that they are an approved Medicare-enrolled provider or supplier, ACO, or an active Convener Participant in Model Year 6, before the deadline for submission of an application, May 31, 2023.
2. Applicants will certify they have systems, processes, and personnel that demonstrate organizational readiness to implement the Model starting January 1, 2024.
3. Applicants will certify that they are using CEHRT, as defined in 42 C.F.R. § 414.1305, in order to comply with the requirement of an Advanced Alternative Payment Model.
4. Applicants will certify that all information and statements provided in the application are true, complete, and accurate, and are made in good faith. Additionally, the authorized signatory attests

[15] 45 CFR § 164.506(c)(4).

that they are qualified to make the assertions contained in the application and is an agent of the Applicant.

D. Applicant Screening

Entities that apply to the BPCI Advanced Model are accepted based on the content of their application and their ability to pass multiple levels of program integrity and law enforcement screening. All applications will first be assessed to determine an Applicant's eligibility to participate in this Model. In addition, CMS may deny an application on the basis of information found during a program integrity screen regarding the Applicant, its proposed Episode Initiators, or any other relevant individuals or entities.

Applicants must disclose all present or past history of any sanctions or other actions of an accrediting organization or a federal, state, or local governmental agency; investigations including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, or being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action; probations; corrective action plans; or any other administrative enforcement actions; each related to the Applicant, its affiliates or any other relevant persons and entities. Applicants must also disclose all debts currently due and owing to CMS by the Applicant, its affiliates, or any other relevant persons or entities.

Exception Process

CMS will consider exception requests to the application criteria outlined in this RFA specific to participation in BPCI Advanced and will reserve the right, in CMS's sole judgment, to admit an Applicant that does not strictly meet such criteria under limited circumstances. In addition, CMS may consider applications submitted by entities that do not meet the application criteria at the time of application, but that are anticipated to qualify by the application deadline for the applicable enrollment date.

Applicants seeking an exception should do so in writing by submitting an exception request to BPCIAdvanced@cms.hhs.gov describing the specific application criteria for which an exception is sought and why the exception is needed under the Applicant's specific circumstances. Applicants are strongly encouraged to make such requests well in advance of the applicable application deadline.

In circumstances where an Applicant seeks an exception from the quality-related criteria outlined in the RFA, CMS will apply a high degree of scrutiny to the request and is unlikely to approve such an exception without undertaking additional monitoring or imposing additional conditions through the BPCI Advanced Model Participation Agreement. CMS will not grant an exception to an Applicant that failed to pass the Applicant screening process described above, or that fails to demonstrate how their requested exception if granted, will not undermine the integrity of the model test or the Medicare program generally.

E. Withdrawal of Pending Application or Removal of Proposed Episode Initiator Included on the Application

Applicants seeking to withdraw an entire application or to remove one or more proposed Episode Initiators from an application after it has been submitted on the application portal, but prior to the execution of the BPCI Advanced Model Participation Agreement for Applicants selected to participate in the Model, should submit a written request on the Applicant organization's letterhead, signed by an

official authorized to act on behalf of the organization, via email to the Model Team to: BPCIAdvanced@cms.hhs.gov.

The following Applicant information must be included in any such request:

- Applicant Organization's Legal Name, as it appears in the application, as well as any "Doing Business As" name;
- Applicant Identification Number provided by CMS at the time the application is created;
- Address and Point of Contact information for the Applicant organization; and
- Exact Description of the Nature of the Withdrawal/Removal (e.g., Withdrawal of the entire application or removal of individual providers/suppliers).

F. Options for Active Participants in Model Year 6

Active Participants in Model Year 6, regardless of the updated application requirements, who wish to continue participating as-is in Model Year 7 will not be required to apply, and if offered, will be required to sign an Amended and Restated Participation Agreement for Model Year 7 and submit all required deliverables by the applicable deadlines.

Active Convener Participants in Model Year 6, regardless of Medicare enrollment or ACO status, will be allowed to add Downstream Episode Initiators (whether new or former Episode Initiators) for Model Year 7 to existing non-terminated Model Year 6 Participation Agreement(s) by submitting an "Episode Initiator Addition Request" to CMS, via the Participant Portal. Additionally, Active Convener Participants in Model Year 6 who wish to continue participating in Model Year 7 will be allowed to remove Downstream Episode Initiators from their Model Year 7 Participant Profile.

VII. Advanced APM And Merit-Based Incentive Payment System (MIPS) Status

A. Advanced APM Status

The BPCI Advanced Model is an Advanced Alternative Payment Model (Advanced APM) in the CMS Quality Payment Program (QPP). The quarterly submission of the BPCI Advanced QPP List is a requirement for participation in the BPCI Advanced Model and serves a dual purpose:

1. The identification of Participating Practitioners implementing the Model and engaged in BPCI Advanced Activities (as defined in Appendix A); and
2. The identification of eligible clinicians associated with an Alternative Payment Model (APM) Entity will be included in the quarterly report to the CMS QPP for Qualifying APM Participant (QP) determinations.

CMS will use the information reported to make the QP determinations "snapshots" several times per year. To better understand how QP determinations will be made for clinicians participating in the BPCI Advanced Model, please refer to Appendix E.

For Non-Convener Participants that are ACHs and Convener Participants who do not have any downstream Episode Initiators that are PGPs, eligible clinicians who meet the definition of Affiliated Practitioner in 42 C.F.R. § 414.1305 and are included on the BPCI Advanced Quality Payment Program (QPP) List will be considered Affiliated Practitioners in the Model for purposes of QP determinations. For any Non-Convener Participant that is a PGP and for Convener Participants with at least one downstream

Episode Initiator that is a PGP, each eligible clinician who has reassigned his or her rights to receive Medicare payment to a PGP Participant and is included on the BPCI Advanced QPP List will be on a Participation List for purposes of QP determinations under the QPP.

B. MIPS APM Status

In addition to being an Advanced APM, BPCI Advanced is also a Merit-Based Incentive Payment System (MIPS) APM, and we anticipate it will continue as such for Model Year 7, which begins on January 1, 2024. Therefore, MIPS-eligible clinicians who are physicians who have reassigned their rights to receive Medicare payment to a PGP Non-Convener Participant (or a Convener Participant with at least one Downstream Episode Initiator that is a PGP) and are included on the BPCI Advanced QPP List (the Participation List), and who do not become QPs or partial QPs for the year, will be subject to reporting to traditional MIPS and/or reporting to MIPS via the APM Performance Pathway (APP) for the applicable MIPS Performance Period. Hospitals that are APM Entities in BPCI Advanced would not include at least one MIPS-eligible clinician on a Participation List.

VIII. CMS Payment Policy Waivers, Financial Arrangements, and Beneficiary Incentives

A. CMS Payment Policy Waivers

Separate from any fraud and abuse waivers, CMS offers conditional waivers of certain Medicare payment rules, referred to as Payment Policy Waivers, to test whether flexibility and coverage of additional services will lower costs, improve quality, facilitate the delivery of care in new settings, and better engage beneficiaries in their care. The CMS Payment Policy Waivers relate to the 3-Day SNF Rule, Telehealth, and Post-Discharge Home Visit services.

1. 3-Day SNF Rule Payment Policy Waiver

CMS offers a conditional waiver of the requirement that a Medicare beneficiary has a prior inpatient hospital stay of not less than 3 consecutive days in order to be eligible for Medicare coverage of inpatient SNF services. Specifically, under the 3-Day SNF Rule Payment Policy Waiver, if the Participant provides services according to the waiver, Medicare Part A will cover post-hospital extended care services furnished to BPCI Advanced Beneficiaries who are discharged after an Anchor Stay of fewer than 3 days, as long as: (1) the beneficiary is discharged to a Qualified SNF (defined below); (2) the beneficiary satisfies the definition of a BPCI Advanced Beneficiary (as defined in Appendix A) at the time of discharge from the Anchor Stay; (3) at the time of such discharge, the beneficiary's diagnosis (as determined by the ICD-10 codes included on the hospital claim) corresponds to an MS-DRG that is included in a Clinical Episode to which the Participant has committed to be held accountable under BPCI Advanced; and (4) all other coverage requirements for such services are met. In the event the 3-Day SNF Rule Waiver is not used in accordance with these conditions with respect to SNF services, CMS will make no payments to the Qualified SNF for such services, the Participant must ensure that the Qualified SNF does not charge the BPCI Advanced Beneficiary for the expenses incurred for such services (and returns any applicable cost-sharing amounts already paid), and the Participant may be liable for the cost of the uncovered SNF stay, subject to the exceptions and applicable conditions further outlined in the BPCI Advanced Participation Agreement.

For purposes of this 3-Day SNF Rule Payment Policy Waiver, a Qualified SNF is a SNF, as defined under Section 1861(j) of the Act, that: (1) has an overall rating of three or more stars in the Nursing Home Five-

Star Quality Rating System for SNFs on the CMS Nursing Home Compare Website for at least 7 of the 12 preceding months; and (2) is identified on the list of SNFs eligible to be Qualified SNFs posted on the CMS website, as determined by CMS based on the most recent rolling 12 months of SNF star rating data available that includes the date of the beneficiary's admission to the SNF. CMS will post the list of SNFs that CMS determines are eligible to be Qualified SNFs on a quarterly basis to the Model's website: https://innovation.cms.gov/initiatives/bpci-advanced.

2. Telehealth Waiver Payment Policy Waiver

CMS offers a conditional waiver of the otherwise applicable geographic area and setting for Telehealth originating site requirements for Medicare coverage of Telehealth services under Section 1834(m) of the Act, when these services are furnished to BPCI Advanced Beneficiaries during a BPCI Advanced Clinical Episode in the BPCI Advanced Beneficiary's home or place of residence, so long as the services are furnished in accordance with the remaining provisions of Section 1834(m), and all other applicable Medicare coverage and payment criteria have been met.

3. Post-Discharge Home Visit Payment Policy Waiver

CMS allows for "incident to" services furnished in a beneficiary's home in the period following discharge from the Anchor Stay or completion of the Anchor Procedure to be furnished by "auxiliary personnel" under the general supervision of the physician or other practitioner, as opposed to direct supervision, through a conditional waiver of the direct supervision requirement for "incident to" services under 42 C.F.R. § 410.26(b)(5), so long as the services are furnished in accordance with the conditions of the BPCI Advanced Model Participation Agreement and all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b), have been met.

B. Fraud and Abuse Waivers

The authority for this initiative is Section 1115A of the Act. Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII, and of Sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such subsection) of the Act as may be necessary solely for purposes of testing models described in Section 1115A(b). For purposes of this Model and consistent with this standard, the Secretary has exercised such waiver authority with respect to the fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act as may be necessary to develop and implement the BPCI Advanced model, pursuant to Section 1115A(b). The Notice of Waivers of Certain Fraud and Abuse Laws in Connection with the Bundled Payments for Care Improvement Advanced Model ("Notice of Waivers") can be found here: https://www.cms.gov/files/document/notice-amended-waivers-certain-fraud-and-abuse-laws-connection-bundled-payments-care-improvement.pdf. These fraud and abuse waivers apply solely to BPCI Advanced and differ in scope and design from fraud and abuse waivers granted for other programs or models. Notwithstanding any other provision of this RFA, individuals and entities must comply with all applicable fraud and abuse laws and regulations, except as explicitly provided in the Notice of Waivers issued specifically for BPCI Advanced pursuant to section 1115A(d)(1).

Participants may select to enter into certain financial arrangements or to furnish beneficiary engagement incentives, consistent with the terms of the BPCI Advanced Model Participation Agreement for Model Year 7 (2024) or the Amended and Restated BPCI Advanced Model Participation Agreement for Model Year 7 (2024), as applicable, the Fraud and Abuse Waivers available for this Model and applicable law.

This Notice is composed of two parts. Part I sets forth the four Fraud and Abuse waivers established for the BPCI Advanced Model and the specific conditions that must be met to qualify for each waiver. The four waivers protect specific financial arrangements or beneficiary incentives that are part of the BPCI Advanced Model and are described in the Bundled Payments for Care Improvement Advanced Participation Agreement, as amended from time to time (Participation Agreement), and in the applicable waiver. Each waiver protects only arrangements that meet all of the listed conditions and applies only with respect to the specific laws cited in the waiver. Part II consists of commentary explaining the waiver requirements set forth in Part I as well as general limitations.

1. Beneficiary Incentives

Under the BPCI Advanced Model, a Participant may elect to furnish in-kind items and services to BPCI Advanced Beneficiaries during the Agreement Performance Period. These may be covered under the Beneficiary Engagement Incentives Provided to BPCI Advanced Beneficiaries (BEI Waiver), provided all waiver conditions are met.

Under the Participation Agreement, there must be a reasonable connection between the items and services provided to the BPCI Advanced Beneficiary and the medical care provided to the BPCI Advanced Beneficiary. In addition, to receive waiver protection, the items and services furnished must be preventive care items or services or advance a clinical goal for the BPCI Advanced Beneficiary, including adherence to a treatment regime, adherence to a drug regimen, adherence to a follow-up care plan, or management of a chronic disease or condition.

IX. Data Sharing by CMS

Following the application review process, and in accordance with applicable law, CMS intends to release up to three years of historical (baseline period) Medicare claims data for Medicare FFS beneficiaries who would have been included in a Clinical Episode during a baseline period attributed to the Applicant that submitted a completed application and a completed DRA form requesting such data. The data are intended to enable Applicants to evaluate which CESLGs provide the greatest opportunity for process improvement through quality improvement and care coordination.

Applicants may anticipate receiving historical Medicare claims data and preliminary Target Prices for all Clinical Episode Service Line Groups after the BPCI Advanced Application Portal closes and CMS has performed a screening of their application and DRA form. If the Applicant does not sign a BPCI Advanced Participation Agreement and transition to Participant status by the first Performance Period in Model Year 7, then all beneficiary-identifiable data received from CMS must be destroyed unless the retention of such data is required by law. Further information on the protection and destruction of CMS data will be addressed in the DRA.

While beneficiaries will not be able to opt out of having their historical data shared with Applicants, any requests or questions regarding data sharing that Applicants receive should be directed to 1-800-MEDICARE.

X. CMS Monitoring

CMS will measure and monitor care throughout the BPCI Advanced Model to ensure that Model objectives are met in redesigning care, achieving quality measure thresholds and patient experience-of-care standards, and demonstrating improved care coordination.

A. Participants Requirements

All Participants will be required to comply fully with CMS' and its contractor(s)' requests for monitoring of the BPCI Advanced Model, including without limitation:

1. Providing data related to providers and suppliers, beneficiaries, BPCI Advanced Activities, Financial Arrangements, and Payment Policy Waivers; being available for site visits by CMS staff and its contractors at the Participant's facilities, per the terms of the BPCI Advanced Model Participation Agreement, and not interfering with site visits at its Participating Practitioners' and Episode Initiators' facilities;
2. Requiring its Episode Initiators and Participating Practitioners to be available for site visits at their respective facilities by CMS staff and its contractors, and participating in surveys and interviews.
3. Providing CMS and its contractor(s) with ongoing monitoring information by tracking and reporting various measures of performance improvement efforts and operational metrics, including data on Participant expenditure reductions, NPRA payments received from CMS, and NPRA Shared Payments made to NPRA Sharing Partners and Partner Distribution Payments made to NPRA Sharing Group Practice Practitioners by NPRA Sharing Partners, clinical quality, and patient experience of care. Such data may include but are not limited to, system-level measures of complication, mortality, and readmission rates, as well as measures of process improvement.

B. Beneficiary Protections

Participants may not restrict beneficiary access to medically necessary care. To safeguard against reductions in such care, CMS will routinely monitor and analyze data on service utilization and may review utilization and referral patterns. CMS will also conduct medical record audits, tracking of patient complaints and appeals, and monitoring of patient outcome measures, to assess improvement, deterioration, and/or any deficiencies in the quality of care under the Model. Participants' performance will be assessed against their own historical performance, as well as against a comparison group. To the extent that such monitoring reveals restrictions in access to medically necessary care, CMS may terminate a Participant's BPCI Advanced Model Participation Agreement, and may also require the Participant to terminate arrangements with Episode Initiators, Participating Practitioners, and others, as appropriate.

CMS anticipates that beneficiaries who receive care from BPCI Advanced Participants, Episode Initiators, and Participating Practitioners may benefit from increased communication and coordination among their treating healthcare providers, improved hospital discharge and facility transfer planning, fewer re-operations, fewer avoidable readmissions, more appropriate post-acute care, higher quality of care throughout the Clinical Episode, and shorter average lengths of stay in the ACH and PAC facilities. BPCI Advanced will also include certain beneficiary protections.

First, although BPCI Advanced will not allow beneficiaries to opt out of the payment methodology, as previously described, the Model will not limit beneficiaries' freedom to choose their healthcare provider, meaning that beneficiaries may elect to see a provider or supplier of their choosing, including a

provider or supplier that does not participate in the BPCI Advanced Model. Specifically, under the terms of the BPCI Advanced Model Participation Agreement, Participants may not restrict the beneficiary choice of providers or suppliers, and Participants must also place this responsibility onto their downstream Episode Initiators and Participating Practitioners.

Second, the beneficiary's Medicare benefits will remain the same as if the provider or supplier providing the care was not participating in the Model, unless the Participant meets the conditions for and selects to furnish services according to one or more of the Payment Policy Waivers, in which case the beneficiary may have access to additional benefits as a result of seeing a provider or supplier participating in the Model. In addition, the beneficiary's out-of-pocket costs for care furnished under the Model will not be affected.

Third, Participants must also notify beneficiaries of the Participants' participation in this initiative and require their downstream Episode Initiators and Participating Practitioners to do the same. CMS will provide Participants with a template of the Beneficiary Notification Letter that must be provided to BPCI Advanced Beneficiaries, which highlights the beneficiary's right to choose their healthcare provider and explains the goals and objectives of the Model. The Beneficiary Notification Letter will also inform beneficiaries that they may be contacted by CMS or CMS's contractors to provide information for the evaluation and monitoring of the Model. However, beneficiaries will be specifically advised that refusal to participate in the evaluation or monitoring, as well as refusal to respond to requests for information will not affect their Medicare benefits or provision of care in any way. Participants may not make changes to any portion of the template provided by CMS which has a section to insert the name of the Participant or Episode Initiator providing the services. Participants must provide beneficiaries with a copy of the Beneficiary Notification Letter prior to discharge from the Anchor Stay, or prior to the completion of the Anchor Procedure, as applicable.

Applicants must include information about their plan regarding beneficiary notification in their application. Applicants will also be expected to provide information about how they will ensure beneficiaries have complete freedom of choice of healthcare providers, including PAC providers.

XI. Evaluation

CMS has contracted with an independent evaluator to conduct the Model evaluation pursuant to Section 1115A(b)(4) of the Act. All Participants will be required to cooperate with the independent evaluator by being available for site visits at the Participant's facilities, per the terms of the BPCI Advanced Model Participation Agreement, and not interfering with site visits at its Participating Practitioners' and Episode Initiators' facilities; by requiring its Episode Initiators and Participating Practitioners to be available for site visits at their respective facilities by the independent evaluator; and by participating in surveys and interviews. Participants are also required to provide any and all relevant data, as may be needed for the Model evaluation, and must require their Participating Practitioners and Episode Initiators to do the same. These data may include but are not limited to, data described in the Model Monitoring Section.

XII. Learning System Activities

A Learning System is a structured approach to sharing, integrating, and actively applying quality improvement concepts, tactics, and lessons learned, all in support of the aims of an alternative payment model. The Learning System under BPCI Advanced will provide support to Applicants as they prepare to redesign care and bear financial risk under the Model and assist Participants in lowering the cost of care and maintaining or improving the quality of care for Medicare beneficiaries.

Learning System Activities for Applicants

Through Learning System activities, CMS will provide support to Applicants as they prepare to redesign care and enter into BPCI Advanced Model Participation Agreements with CMS that impose financial and quality performance accountability for Clinical Episodes and, at the option of the Participant, to enter into Financial Arrangements per the terms of the BPCI Advanced Model Participation Agreement.

Applicant Learning System activities may include the creation and dissemination of resource documents by CMS or CMS's contractors on suggested means of care redesign in the context of bundled payments (including recommended data and/or system capabilities, promising practices around protocols for evidence-based medicine, etc.); learning sessions geared specifically towards Applicants; and hypothetical case studies. These will provide an opportunity to introduce key concepts to Applicants and their proposed Participating Practitioners and proposed Episode Initiators; create a vigorous learning community; engage individuals from across the Applicant organization, and initiate action planning by Applicants and their proposed Participating Practitioners and proposed Episode Initiators. Applicants are encouraged, but not required, to participate in Learning System activities.

Learning System Activities for Participants

Participants will be required, under the terms of the BPCI Advanced Model Participation Agreement, to actively participate in and shape Learning System activities as a condition of participation in BPCI Advanced. The Learning System will facilitate peer learning and information sharing about how best to achieve quick and effective performance improvement. Because CMS and others have been considering and testing bundled payments for over two decades, there are a wide variety of experiences available to share. The Learning System will allow Participants to glean promising practices from their peers and to further develop their own programs throughout the term of their BPCI Advanced Model Participation Agreement. The Innovation Center will undertake various approaches to group learning and exchange, helping Participants to effectively share their experiences, track their progress, and rapidly adopt new ways of achieving improvements in care quality, as well as reductions in Medicare FFS expenditures.

Potential Learning System activities for the BPCI Advanced Model include learning sessions; topic-specific webinars; group-specific virtual collaborations; semi-annual hypothetical "live case" visits between Participants; regular site visits by CMS and CMS contractors to Participants, Episode Initiators, and Participating Practitioners by request or at CMS' discretion; showing interim results with the structured qualitative inquiry; and hypothetical case studies for formal sharing based on-site visits, which include identifying, acknowledging and studying high performers, variation in performance as well as lessons learned from performance-improvement efforts. For a discussion of the activities that are expected to comprise the Learning System, see the Learning System Strategy and Structure in Appendix C of this RFA. Applicants will be expected to describe how they plan to participate in the Learning System in their application to participate in BPCI Advanced.

Appendix A: Glossary

Accountable Care Organization (ACO) – An ACO is a legal entity that is recognized and authorized under applicable law, identified by a Taxpayer Identification Number, and formed by one or more ACO participant(s). For the purposes of this initiative, an ACO includes a participant in the Shared Savings Program, ACO Realizing Equity, Access, and Community Health (REACH) Model, Kidney Care Choice (KCC) model, Vermont All-Payer ACO Model, or other currently active Medicare-specific ACO-related initiatives administered by CMS.

"**Acute Care Hospital**" or "**ACH**" means a Medicare-enrolled "sub-Section (d) hospital" as defined in Section 1886(d)(1)(B) of the Act, including ACHs where outpatient procedures are performed in hospital outpatient departments (HOPDs). PPS-exempt cancer hospitals, inpatient psychiatric facilities, critical access hospitals (CAHs), hospitals in Maryland, hospitals participating in the Rural Community Hospital Demonstration, and Rural Hospitals participating in the Pennsylvania Rural Health Model, are excluded from the definition of an ACH for purposes of BPCI Advanced.

"**Adjusted Negative Total Reconciliation Amount**" means, if applicable, the Negative Total Reconciliation Amount as adjusted by the CQS Adjustment Amount, which either becomes the Repayment Amount to the extent the Participant is a Non-Convener Participant or, if the Participant is a Convener Participant, is netted against all other Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Convener Participant (if applicable) and the Convener Participant's Downstream Episode Initiators, resulting in either the Repayment Amount or the NPRA.

"**Adjusted Positive Total Reconciliation Amount**" means, if applicable, the Positive Total Reconciliation Amount as adjusted by the CQS Adjustment Amount, which either becomes the NPRA to the extent the Participant is a Non-Convener Participant or, if the Participant is a Convener Participant, is netted against all other Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts for the Convener Participant (if applicable) and the Convener Participant's Downstream Episode Initiators, resulting in either the Repayment Amount or the NPRA.

"**Administrative Services**" means services furnished by a BPCI Advanced Entity pursuant to a BPCI Advanced Entity Agreement that is directly related to the administration of the Participant's Financial Arrangements.

"**Aggregate FFS Payment**" or "**AFP**" means the total dollar amount of Medicare FFS expenditures for items and services included in a Clinical Episode excluding all Medicare FFS expenditures for items and services specifically excluded from a Clinical Episode

"**Anchor Procedure**" means a hospital outpatient procedure performed in a hospital outpatient department of an ACH identified by a HCPCS code specified on the Clinical Episode List, and maintained on the BPCI Advanced webpage, for which an Episode Initiator submits a claim to Medicare FFS. The first day of an Anchor Procedure initiates a Clinical Episode.

"**Anchor Stay**" means an inpatient stay at an ACH assigned to an MS-DRG specified on the Clinical Episode List, and maintained on the BPCI Advanced webpage, for which an Episode Initiator submits a claim to Medicare FFS. The first day of the Anchor Stay initiates a Clinical Episode.

Baseline Periods Used to Create Benchmark Prices
In BPCI Advanced, the baseline periods shift forward every Model Year.
For Model Years 1 and 2, the baseline period includes all Anchor Stays/Anchor Procedures ending between January 1, 2013, and December 31, 2016
For Model Year 3, the baseline period is between October 1, 2014, and September 30, 2018
For Model Year 4, the baseline period is between October 1, 2015, and September 30, 2019
For Model Year 5, the baseline period is between October 1, 2016, and September 30, 2020
For Model Year 6, the baseline period is between October 1, 2017, and September 30, 2021
For Model Year 7 we anticipate the baseline period will be between October 1, 2018, and September 30, 2022

"**Benchmark Price**" means a metric used by CMS, together with the CMS Discount, to calculate an Episode Initiator-specific Target Price for each Clinical Episode.

"**BPCI Advanced Activities**" means activities related to the overall care of BPCI Advanced Beneficiaries during a Clinical Episode, which include: furnishing direct patient care to BPCI Advanced Beneficiaries in a manner that reduces cost or improves quality; engaging in Care Redesign; performing quality measures; using CEHRT; performing a minimum of four MIPS Improvement Activities; and any other related activities specified by CMS.

"**BPCI Advanced Beneficiary**" means a Medicare beneficiary entitled to benefits under Part A and enrolled in Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for an Anchor Stay or Anchor Procedure. The term BPCI Advanced Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of an end-stage renal disease (ESRD) diagnosis; (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure. A BPCI Advanced Beneficiary must meet this definition for the full duration of the Clinical Episode.

"**BPCI Advanced Entity**" means an entity other than the Participant that administers the participant's Financial Arrangements pursuant to a BPCI Advanced Entity Agreement.

"**BPCI Advanced Savings Pool**" means a collection of funds maintained in the name of the Participant by either the Participant or a BPCI Advanced Entity on the Participant's behalf, that consists solely of (1) contributions by NPRA Sharing Partners of the NPRA Sharing Partners' own Internal Cost Savings and Shared Repayment Amounts; (2) contributions by the Participant of NPRA received by the Participant from CMS; and (3) in the case of a Non-Convener Participant, contributions of its own Internal Cost Savings. Funds maintained in the BPCI Advanced Savings Pool may be distributed as either NPRA Shared Payments or as payment for Administrative Services furnished by a BPCI Advanced Entity,

"**Care Redesign**" means the specific planned interventions and changes to the Participant's, its Downstream Episode Initiators', Participating Practitioners', NPRA Sharing Partners', or NPRA Sharing Group Practice Practitioners' current healthcare delivery system and set forth with particularity in the Participant's Care Redesign Plan.

"**Care Redesign Plan**" means the Participant's plan for Care Redesign which is a required deliverable for Model Participants, prior to the start of each Model Year.,

"**CCN**" means a CMS Certification Number.

"**Certified Electronic Health Record Technology**" or "**CEHRT**" means CEHRT as defined in 42 C.F.R. § 414.1305, as may be amended from time to time.

"**Change of Control**" means any of the following: (1) the acquisition by any "person" (as such term is used in Sections 13(d) and 14(d) of the Securities Exchange Act of 1934) of beneficial ownership (within the meaning of Rule 13d-3 promulgated under the Securities Exchange Act of 1934), directly or indirectly, of voting securities of an entity representing more than 50 percent of the entity's outstanding voting securities or rights to acquire such securities; (2) the acquisition of an entity by any other individual or entity; (3) any merger, division, or expansion of an entity (including satellite offices); or (4) the sale, lease, exchange or other transfer (in one transaction or a series of transactions) of all or substantially all of the assets of an entity, or an agreement for the sale or liquidation of the entity.

"**Clinical Episode**" means the period of time initiated on the first day of an Anchor Stay or an Anchor Procedure, during which all Medicare FFS expenditures for all non-excluded items and services furnished to a BPCI Advanced Beneficiary are bundled together as a unit for purposes of calculating the Target Price and for purposes of Reconciliation. Clinical Episodes may be initiated only during the Agreement Performance Period.

"**Clinical Episode Service Line Group**" means the grouping of Clinical Episodes, identified in the Clinical Episode Service Line Group List defined in Article 5.1, for which the Participant commits to be held accountable in its Participant Profile.

"**CMS Discount**" means a set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price.

"**Convener Participant**" means an entity that enters into a BPCI Advanced participation agreement with CMS to participate in the BPCI Advanced model and that brings together at least one Downstream Episode Initiator to participate in BPCI Advanced, facilitates coordination among Downstream Episode Initiators (if more than one), and bears full financial risk to CMS under the Model. A Convener Participant may be either an entity that is a Medicare-enrolled provider or supplier or an entity that is not enrolled in Medicare. Entities other than ACHs and PGPs (e.g., PAC Providers) may participate in BPCI Advanced as Convener Participants, but not as Non-Convener Participants. ACHs and PGPs may participate in BPCI Advanced as either Convener Participants or as Non-Convener Participants.

"**Covered Services**" means the scope of healthcare benefits described in Sections 1812 and 1832 of the Act for which payment is available under Part A or Part B of Title XVIII of the Act.

"**COVID-19 Clinical Episode**" means a Clinical Episode that ends on or before December 31, 2021, where the items and services are furnished to a BPCI Advanced Beneficiary who receives a COVID-19 diagnosis, as specified by the codes identified in the Clinical Episode Construction Specifications, at any time during the Clinical Episode.

"**CQS**" means Composite Quality Score.

"**CQS Adjustment Amount**" means the adjustment applied during the Reconciliation process to the Positive Total Reconciliation Amount, if any, or the Negative Total Reconciliation Amount, if any, in order to calculate the Adjusted Positive Total Reconciliation Amount or Adjusted Negative Total Reconciliation Amount, as applicable.

"**Days**" means calendar days unless otherwise specified.

"**Downstream Episode Initiator**" means an ACH or PGP that is identified on the Participant Profile and that participates in BPCI Advanced pursuant to an agreement with the Participant, to the extent the Participant is a Convener Participant, under which such Downstream Episode Initiator agrees to participate in BPCI Advanced and which requires the Downstream Episode Initiator to comply with all of the applicable terms and conditions of the BPCI Advanced Participation Agreement.

"**Eligible Clinician**" means "**eligible clinician**" as defined in 42 C.F.R. § 414.1305, as may be amended from time to time.

"**Episode Initiator**" means any ACH or a PGP that participates in BPCI Advanced as either: (1) the Participant; or (2) a Downstream Episode Initiator. Any Episode Initiator identified on the Participant Profile can trigger Clinical Episodes under BPCI Advanced.

"**Excess Spending Amount**" means the dollar amount specific to the Post-Episode Spending Calculation by which the Medicare FFS expenditures on items and services furnished to a BPCI Advanced Beneficiary during the Post-Episode Monitoring Period exceeds a benchmark beyond a risk threshold.

"**Federal Government**" means the federal executive, legislative, and judicial branches of the United States of America.

"**Financial Arrangement**" means an NPRA Sharing Arrangement, a Partner Distribution Arrangement, or both.

"**Financial Arrangement List**" means the list that, identifies the BPCI Advanced Entity and all individuals and entities that are parties to a Financial Arrangement with the Participant or with a PGP NPRA Sharing Partner.

"**Internal Cost Savings**" means, for each NPRA Sharing Partner and Non-Convener Participant, the measurable, actual, and verifiable cost savings realized by the NPRA Sharing Partner or the Non-Convener Participant, as applicable, resulting from Care Redesign undertaken by the NPRA Sharing Partner (or by either the NPRA Sharing Partner or the Non-Convener Participant, in the case of Internal Cost Savings contributions made by a Participant) in connection with furnishing items and services to BPCI Advanced Beneficiaries within the Clinical Episodes for which the Participant has committed to be held accountable in the Participant Profile. Internal Cost Savings do not include savings realized by a Convener Participant or any individual or entity that is not an NPRA Sharing Partner or savings realized on COVID-19 Clinical Episodes.

“**Medically Necessary**” means reasonable and necessary as determined in accordance with Section 1862(a) of the Act.

“**Medicare Fee-for-Service**” or “**Medicare FFS**” means Medicare Part A and Part B. The term Medicare FFS does not include Medicare Part C (Medicare Advantage) or Medicare Part D.

“**MIPS Improvement Activity**” means an activity to improve clinical practice or care delivery and is included on the MIPS Improvement Activities list on the Quality Payment Program website at https://Quality Payment Program.cms.gov/mips/improvement-activities

“**Model Year**” means a full or partial calendar year during which Clinical Episodes may initiate. Notwithstanding the duration of the Agreement Performance Period, BPCI Advanced includes the following six (8) Model Years:
Model Year 1: October 1, 2018, through December 31, 2018
Model Year 2: January 1, 2019, through December 31, 2019
Model Year 3: January 1, 2020, through December 31, 2020
Model Year 4: January 1, 2021, through December 31, 2021
Model Year 5: January 1, 2022, through December 31, 2022
Model Year 6: January 1, 2023, through December 31, 2023
Model Year 7: January 1, 2024, through December 31, 2024
Model Year 8: January 1, 2025, through December 31, 2025

The BPCI Advanced Model has been extended for an additional two calendar years and now will conclude at 11:59 PM EST on December 31, 2025.

“**NPI**” means National Provider Identifier.

“**Negative Reconciliation Amount**” means, if applicable, the amount by which the AFP for a Clinical Episode exceeds the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to an Episode Initiator, with the exception of COVID-19 Clinical Episodes, together with all Positive Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

“**Negative Total Reconciliation Amount**” means, if applicable, the negative sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator, with the exception of COVID-19 Clinical Episodes. CMS adjusts the Negative Total Reconciliation Amount by the CQS Adjustment Amount to calculate the Adjusted Negative Total Reconciliation Amount.

“**Net Payment Reconciliation Amount**” or “**NPRA**” means, if applicable, the amount paid to the Participant by CMS if the sum of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Participant (if the Participant is an Episode Initiator) and/or for all of the Participant’s Downstream Episode Initiators (if the Participant is a Convener Participant) is positive, as specified in the Reconciliation Report deemed to be final).

“**Non-Convener Participant**” means either an ACH or a PGP that enters into a BPCI Advanced Participation Agreement with CMS to participate in the BPCI Advanced initiative but is not a Convener Participant because it does not bear financial risk on behalf of Downstream Episode Initiators.

“**NPRA Shared Payment**” means any payment made by the Participant, or the BPCI Advanced Entity on the Participant’s behalf, from the BPCI Advanced Savings Pool to an NPRA Sharing Partner pursuant to an NPRA Sharing Arrangement.

“**NPRA Sharing Arrangement**” means an arrangement between the Participant and an NPRA Sharing Partner pursuant to which: (1) the NPRA Sharing Partner may contribute Internal Cost Savings and Shared Repayment Amounts to the BPCI Advanced Savings Pool; and (2) the Participant may: (a) make contributions to, as applicable, and payments to the NPRA Sharing Partner from, the BPCI Advanced Savings Pool, and (b) apportion some or all of a Repayment Amount owed to CMS by the Participant to such NPRA Sharing Partner.

“**NPRA Sharing Group Practice Practitioner**” means a Medicare-enrolled physician or non-physician practitioner who is: (1) identified by an individual NPI; (2) has reassigned his or her right to receive Medicare payment to the TIN of a PGP NPRA Sharing Partner; (3) is participating in BPCI Advanced Activities; (4) is identified as an NPRA Sharing Group Practice Practitioner on the Financial Arrangement List; and (5) has entered into a Partner Distribution Arrangement.

“**NPRA Sharing Partner**” means a Participating Practitioner, a PGP, an ACH, an ACO, or a PAC Provider that is not the Participant and is: (1) participating in BPCI Advanced Activities; (2) identified as an NPRA Sharing Partner on the Financial Arrangement List; and (3) has entered into a written NPRA Sharing Arrangement.

“**Participant Profile**” means the document submitted to CMS, which includes: (1) a list indicating each Clinical Episode Service Line Group for which the Participant commits to be held accountable and the corresponding Clinical Episodes; (2) to the extent the Participant is a Convener Participant, a list of the Participant’s Downstream Episode Initiators and whether or not each Downstream Episode Initiator has entered into an SRS Reduction Agreement with CMS; (3) a list indicating the quality measures set for which the Participant commits to be held accountable for each Clinical Episode in each Clinical Episode Service Line Group identified on the Participant Profile; (4) the Participant’s intention to: (i) engage in Financial Arrangements ; (ii) offer beneficiary incentives ; or (iii) furnish services to BPCI Advanced Beneficiaries pursuant to one or more of the Payment Policy Waivers described in; and (5) an attestation that the Participant intends to complete the four MIPS Improvement Activities..

“**Participating Practitioner**” means an Eligible Clinician who: (1) is identified by an individual NPI; (2) is Medicare enrolled and has reassigned his or her right to receive Medicare payment to the TIN of the Participant or a Downstream Episode Initiator, if the Participant or such Downstream Episode Initiator is a PGP; (3) is participating in BPCI Advanced Activities; (4) has a written agreement with the Participant that requires the individual to comply with all applicable terms and conditions of this Agreement; and (5) is identified on the BPCI Advanced QPP List.

“**Partner Distribution Arrangement**” means an arrangement between a PGP NPRA Sharing Partner and an NPRA Sharing Group Practice Practitioner pursuant to which the PGP NPRA Sharing Partner may: (1) share a Partner Distribution Payment with the NPRA Sharing Group Practice Practitioner, and (2)

apportion some or all of a Shared Repayment Amount owed by the PGP NPRA Sharing Partner to the Participant to such NPRA Sharing Group Practice Practitioner.

"**Partner Distribution Payment**" means the portion of an NPRA Shared Payment paid by a PGP NPRA Sharing Partner to an NPRA Sharing Group Practice Practitioner pursuant to a Partner Distribution Arrangement.

"**Payment Policy Waiver**" means the following additional benefits the Participant chooses to make available to BPCI Advanced Beneficiaries in order to support high-value services and allow the Participant to more effectively manage the care of BPCI Advanced Beneficiaries: (1) 3-Day SNF Rule Payment Policy Waiver (2) Post-Discharge Home Visits Payment Policy Waiver; and (3) Telehealth Payment Policy Waiver.

"**Performance Period**" means the defined period of time during the Agreement Performance Period during which Clinical Episodes may initiate. Notwithstanding the duration of the Agreement Performance Period, the BPCI Advanced Model includes the following ten (10) Performance Periods:
Performance Period 1: October 1, 2018, through June 30, 2019
Performance Period 2: July 1, 2019, through December 31, 2019
Performance Period 3: January 1, 2020, through June 30, 2020
Performance Period 4: July 1, 2020, through December 31, 2020
Performance Period 5: January 1, 2021, through June 30, 2021
Performance Period 6: July 1, 2021, through December 31, 2021
Performance Period 7: January 1, 2022, through June 30, 2022
Performance Period 8: July 1, 2022, through December 31, 2022
Performance Period 9: January 1, 2023, through June 30, 2023
Performance Period 10: July 1, 2023, through December 31, 2023
Performance Period 11: January 1, 2024, through June 30, 2024
Performance Period 12: July 1, 2024, through December 31, 2024
Performance Period 13: January 1, 2025, through June 30, 2025
Performance Period 14: July 1, 2025, through December 31, 2025

"**PGP**" means a Medicare-enrolled physician group practice.

"**PGP NPRA Sharing Partner**" means an NPRA Sharing Partner that is a PGP.

"**Positive Reconciliation Amount**" means, if applicable, the amount by which the AFP for a Clinical Episode is less than the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to the Episode Initiator, together with all Negative Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

"**Positive Total Reconciliation Amount**" means, if applicable, the positive sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator. CMS adjusts the Positive Total Reconciliation Amount by the CQS Adjustment Amount to calculate the Adjusted Positive Total Reconciliation Amount.

"**Post-Acute Care Provider**" or "**PAC Provider**" means a Medicare-certified Skilled Nursing Facility (SNF), Long-term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF), or Home Health Agency (HHA).

"**Post-Episode Spending Calculation**" means the financial analysis performed by CMS after each Performance Period to determine whether aggregate Medicare FFS spending on items and services furnished to BPCI Advanced Beneficiaries during the Post-Episode Monitoring Period exceeds a baseline of trended historical aggregate Medicare FFS payment beyond an empirically titrated risk threshold due to cost shifting or other reasons.

"**Post-Episode Spending Calculation Report**" means the report issued by CMS to the Participant following each Performance Period, which specifies whether the Participant will owe an Excess Spending Amount to CMS, "**Post-Episode Monitoring Period**" means the period of 30 Days after the end of a Clinical Episode during which Medicare FFS spending for items and services furnished to BPCI Advanced Beneficiaries is monitored by CMS for purposes of conducting the Post-Episode Spending Calculation.

"**Program Integrity Screening**" means a review of an individual's or entity's program integrity history, which may include a review of Medicare or Medicaid, or any combination of the two, program exclusions or other sanctions, current or prior law enforcement investigations or administrative actions, affiliations with individuals or entities that have a history of program integrity issues, or other information pertaining to the trustworthiness of the individual or entity.

"Quality Payment Program (QPP) List" means a list that includes two separate tabs that are used to develop the Participation List and Affiliated Practitioner List as defined in 42 C.F.R. § 414.1305, as may be amended from time to time, for purposes of the Quality Payment Program as set forth in 42 C.F.R. Part 414 Subpart O for the BPCI Advanced Model.

"**Reconciliation**" means the semi-annual process of comparing the aggregate Medicare FFS expenditures for all non-excluded items and services included in a Clinical Episode attributed to the Participant against the final Target Price for that Clinical Episode to determine whether the Participant is eligible to receive an NPRA payment from CMS, or is required to pay a Repayment Amount to CMS.

"**Reconciliation Report**" means the report issued by CMS to the Participant following each Performance Period that specifies whether the Participant is eligible to receive an NPRA payment from CMS, or is required to pay a Repayment Amount to CMS the Reconciliation Report also includes the Post-Episode Spending Calculations, as applicable.

"**Repayment Amount**" means, if applicable, the amount that must be paid to CMS by the Participant if the sum of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Participant (in the case of a Non-Convener Participant) or for the Participant and all of the Participant's Downstream Episode Initiators (in the case of a Convener Participant) is negative, as specified in the Reconciliation Report deemed to be final The Repayment Amount must be paid by the Participant to CMS.

"**Shared Repayment Amount**" means the portion of the Repayment Amount owed by the Participant to CMS that is paid by an NPRA Sharing Partner to the Participant pursuant to an NPRA Sharing Arrangement. Such Shared Repayment Amount may be apportioned by a PGP NPRA Sharing Partner among NPRA Sharing Group Practice Practitioners pursuant to a Partner Distribution Arrangement.

"**Target Price**" means the Benchmark Price multiplied by one minus the applicable CMS Discount. The Target Price is prospectively provided as the preliminary Target Price, updated in accordance with Appendix A of this Agreement, and is subject to adjustments for actual patient case mix used to calculate the final Target Price.

"**TIN**" means a federal taxpayer identification number, which in some cases may be a Social Security Number.

"**Winsorization**" means a statistical method that limits the effects of extreme values or outliers by using the national distribution of Medicare FFS expenditures on non-excluded items and services furnished to a BPCI Advanced Beneficiary during a Clinical Episode.

Appendix B: BPCI Advanced Quality Measures

For quality measure reporting in Model Year 7, Participants have the flexibility to choose either the Administrative Quality Measures Set or the Alternate Quality Measures Set. The Administrative Quality Measures Set includes exclusively claims-based measures directly collected by CMS. The Alternate Quality Measures Set includes a combination of claims-based and registry-based measures. The Alternate Quality Measures Set, which was implemented in Model Year 4, was developed after CMS gathered information on various established registries to identify a tailored set of quality measures that align with each of the specialty-specific Clinical Episodes in the Model.

Applicants may review the Model Year 6 Quality Measure Sets on the BPCI Advanced Quality Measures webpage to get a sense of the types of quality measures used in the Model.

All Participants, whether they select measures from the Administrative Quality Measures Set or the Alternate Quality Measures Set would be accountable, for purposes of the CQS, for up to three claims-based quality measures that apply to all Clinical Episodes in the Model. Included in these quality measure sets will be Clinical Episode-specific measures and Participants will not be responsible for more than five measures for each Clinical Episode in total. To reduce the Participant burden, the Alternate Quality Measures Set contains measures that may be collected through established clinical registries, to take advantage of long-standing investments in procedure and condition-focused registries and balance the Participant burden with clinical relevancy and timeliness of data feedback.

Participants may be required to commit to either the Administrative Quality Measures Set or the Alternate Quality Measures Set in advance of participation in Model Year 7, which begins on January 1, 2024. The established CQS calculation methodology will apply to both measure sets, including CMS' ability to monitor compliance and assess its impact with regard to cost and quality. The Administrative Quality Measures and Alternate Quality Measures Sets will be made available on the BPCI Advanced website.

Participants will be held accountable for and must report on all of the applicable measures on either the Administrative Quality Measures Set or the Alternate Quality Measures Set. Each Participant, either on behalf of itself or its downstream Episode Initiators, will be required to report on all applicable non-claims-based quality measures early in the calendar year immediately following the Model Year in which the quality measures were applicable. For example, early in 2023, Participants must report on all applicable quality measures for Model Year 5 (January 1, 2022, through December 31, 2022). We anticipate sharing the deadline and reporting requirements for BPCI Advanced quality measure reporting during the application period. In future Model Years, CMS may allow Participants to report on various additional quality measures on a required or voluntary basis.

CMS may determine whether additional quality measures should be incorporated into the Administrative Quality Measures Set or the Alternate Quality Measures Set in future Model Years and the quality measures may be updated by CMS on an annual basis. These quality measures may include measures that are either claims-based or that otherwise impose minimal additional reporting burden on Participants. For example, they may include quality improvement and patient safety measures reported via registry to applicable specialist societies by an Episode Initiator or Participating Practitioner.

Participants will receive notice of revisions to the Administrative Quality Measures Set and Alternate Quality Measures Set in accordance with the BPCI Advanced Model Participation Agreement.

Appendix C: Learning System Strategy and Structure

The following are several broad categories of activities that are expected to comprise the Learning System:

(1) Drivers of Model Success: The Learning System will use a data-driven, evidence-based framework for the initiative, which articulates the aims and key drivers for success. The Learning System will also work to produce content that aligns with the vision and goals of Innovation Center's Strategy Refresh. The primary drivers of the Model are (1) Financial Accountability; (2) Care Redesign; (3) Data Analysis and Feedback; (4) Health Care Provider Engagement; and (5) Patient and Caregiver Engagement. These drivers represent the hypothesis of what will work to achieve the aims of the Model based on current shared theories of "cause and effect" in the initiative – i.e., what changes and interventions are expected to lead to the desired effects and outcomes. The current drivers for BPCI Advanced will be improved over time, as clinical and operational evidence and lessons learned to emerge throughout the initiative.

(2) Technical Assistance: The Technical Assistance function will address programmatic and policy questions raised by the Participants in order to communicate critical information to help Participants understand the initiative and what is required for successful participation. Technical Assistance communications may take the form of webinars, implementation guides, pre-recorded videos, FAQs, etc. In a related vein, the BPCI Advanced Connect Site, described below, will serve as a platform for Technical Assistance communications with Participants, on topics ranging from the details of managing participation in the Model to operational requirements, and the new features of the initiative (e.g., quality measurement and reporting).

(3) Use of Data for Improvement: In keeping with the aims and drivers of the initiative, data will be collected on an initial set of quality measures. Additional data from CMS and other sources will also be leveraged by the initiative, including claims data for the Clinical Episodes, baseline pricing data, and the creation of Participant feedback reports. In turn, the various data sets will be used to support the work of the BPCI Advanced model team and Participants in pursuing improved performance. Of particular note, data that has been de-identified in accordance with HIPAA standards will be used in direct support of Participant Action Groups (see subsequent discussion below).

(4) Assessment and Feedback: This Learning System function will involve performing an ongoing needs assessment for Participants in the Model while relaying insights back concerning the organizational capabilities required to achieve success. In general, needs assessments will involve the identification of Participants' priorities and capabilities, as well as change concepts and tactics, problem areas, barriers, performance opportunities, and needs. Related data will be solicited during interviews and focus groups, to provide detailed information that can inform changes and/or improvements to the Learning System and thus provide Participants with better Model support. Assessment and feedback activity may also be used to develop an "innovation toolkit" and/or other supporting materials that capture change concepts.

(5) Measuring Model Performance toward Aims: Building on the use of data, this Learning System function will leverage aggregate de-identified data to provide feedback to the BPCI Advanced model team and Model Participants on relevant performance metrics. The Learning System Dashboard will enable assessment of progress toward Learning System aims and initiative aims from an improvement perspective while providing actionable data on overall and specific performance trends.

- **Tools and Methods to Capture Improvement and Innovation:** Building on the assessment and feedback function of the Learning System, CMS will provide supporting materials to Participants to capture and disseminate strategies and tactics that increase the likelihood of success. Related materials for BPCI Advanced may include evidence-based, Clinical Episode-specific resources for care redesign; peer-reviewed articles, controlled studies, and academic literature that support promising practices to achieve the initiative aims; articulation of core models for care delivery and operations; and successful strategies and innovative techniques for dissemination. These resources and tools will periodically be revised and updated, based on knowledge gained in the initiative.

(6) Other Tools and Methods that may be leveraged by the Learning System include spotlight stories, case studies, and similar written and video materials, designed to spotlight exemplary practices and approaches to meeting initiative aims. These spotlights/case studies may be Clinical Episode-specific and/or based on emerging strategies for success. Such spotlights/case studies will provide key insights and lessons learned from other Participants, and the opportunity to demonstrate the application of a theory or concept in the real world by model Participants. Any such spotlights/case studies may take the form of Best Practice Business Process Flows, Clinical Protocols, Data Sheets, Staffing Mix, Job Description documentation, etc. In general, Tools and Methods for Capturing Improvement and Innovation will be shared via the Connect Site and made available for Participants to access at their convenience.

(7) Learning Communities: The Learning System for BPCI Advanced will create Learning Communities to facilitate the peer-to-peer exchange of the most promising practices while helping to motivate Participants. Learning Communities for the Initiative may be Clinical Episode-specific or initiative-wide in scope, as appropriate and needed by the Participants. In context, CMS anticipates maintaining and deploying strong expertise in high-leverage strategies and tactics for the initiative, in support of and embedded within the Learning Communities. Each Learning Community will engage in the following types of events and activities:

All-Participant Events. These broadly targeted events will focus on supporting the aims of, and success across, the entire initiative. The All-Participants events will also serve as opportunities for CMS and the Learning System team to disseminate important programmatic and operational information and to interact with model Participants.

- **Affinity Groups.** These are groups of Participants that share a key characteristic (e.g., similar interests, issues, and/or aims) and who elect to join and offer support to each other. Depending on the need, a group may convene multiple times to collaborate and help identify opportunities for success.
- **Participant Action Groups.** Action Groups involve Participants who join together to accomplish a specific task or solve a common problem. The objective of such groups is to identify and implement a change to respond to the task or problem. An Action Group may convene multiple

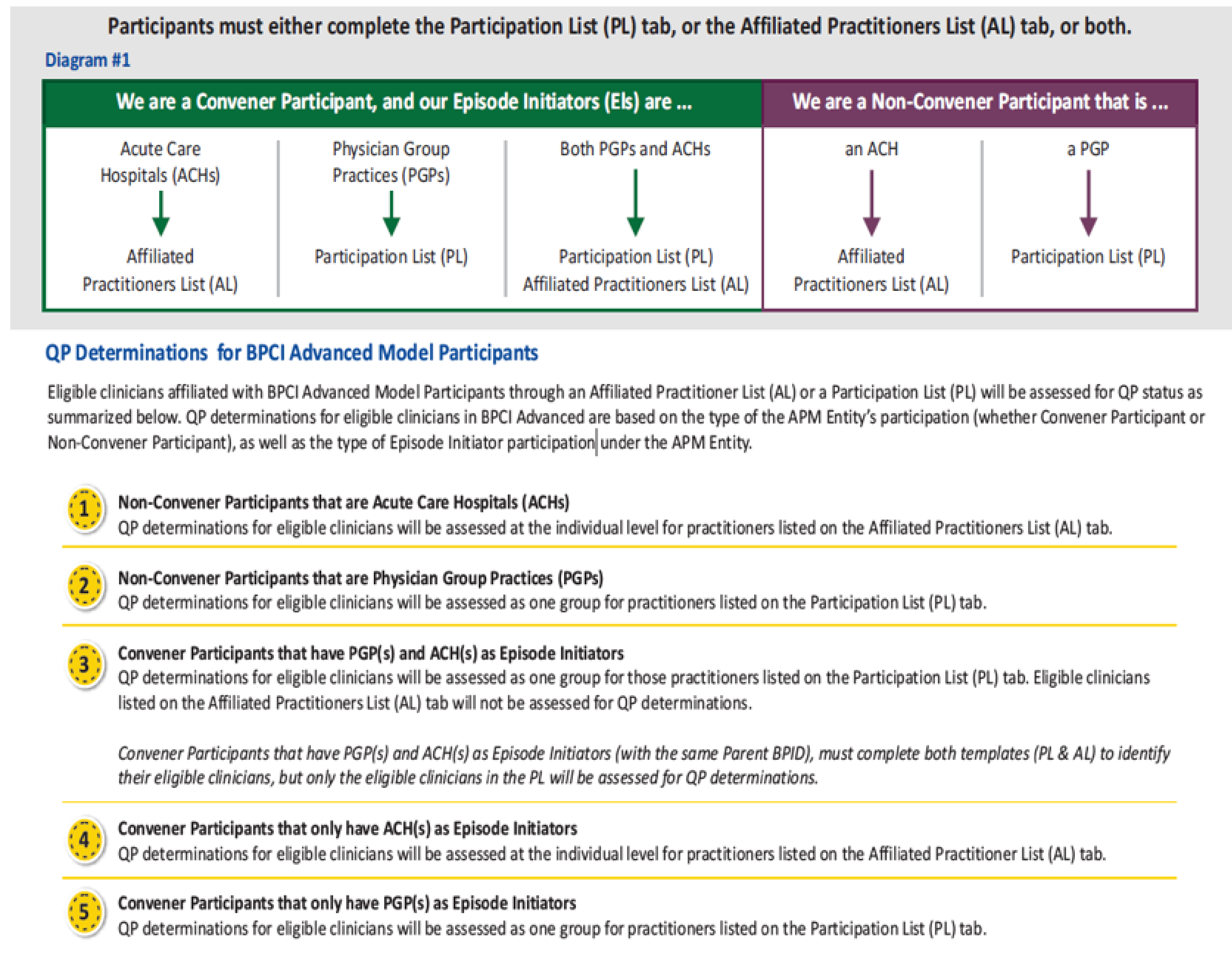
times over a specific period to discuss, test, and debrief on activities associated with its task.

- **Knowledge Management**. A Learning Community engages in Knowledge Management through activities such as literature or environmental scans (to stay well-informed of public commentary on the Model); the conduct of studies related to best practices and implementation, (e.g. developments in alternative payment models, Medicare payment policies, quality measure reporting, existing and emerging trends, etc.); and informing Participants so they may design their own planning activities. Knowledge Management also includes maintaining awareness of external learning communities that relate to the initiative, but that originate from outside sources, such as professional associations or for-profit entities. Knowledge Management activity will draw from a multitude of information sources, including journal articles, publicly released research reports, other literature, and blogs from relevant agencies/associations, media, etc.
- **Connect Site.** Supporting several of the enumerated functions of the Learning Systems, the BPCI Advanced Connect Site will be used to facilitate peer-to-peer learning and collaboration, communication with and feedback to Participants, and knowledge management. Related activities may also include promoting Participant engagement and collaboration, marketing upcoming learning activities, updating the Connect Site's calendar, etc. The Connect Site will facilitate the spread of improvement and adoption strategies through the use of forums, a library, discussion groups, training, listservs, a calendar of events, announcements, and additional related content.

Appendix D: BPCI Advanced Clinical Episode Service Line Group List

CESLG	Clinical Episode	Setting	Type
Cardiac Care	Acute myocardial infarction	Inpatient	Medical
Cardiac Care	Cardiac arrhythmia	Inpatient	Medical
Cardiac Care	Congestive heart failure	Inpatient	Medical
Cardiac Procedures	Cardiac defibrillator	Inpatient	Surgical
Cardiac Procedures	Cardiac defibrillator	Outpatient	Surgical
Cardiac Procedures	Cardiac valve	Inpatient	Surgical
Cardiac Procedures	Coronary artery bypass graft	Inpatient	Surgical
Cardiac Procedures	Endovascular cardiac valve replacement	Inpatient	Surgical
Cardiac Procedures	Pacemaker	Inpatient	Surgical
Cardiac Procedures	Percutaneous coronary intervention	Inpatient	Surgical
Cardiac Procedures	Percutaneous coronary intervention	Outpatient	Surgical
Gastrointestinal Care	Disorders of the liver except malignancy, cirrhosis, or alcoholic hepatitis	Inpatient	Medical
Gastrointestinal Care	Gastrointestinal hemorrhage	Inpatient	Medical
Gastrointestinal Care	Gastrointestinal obstruction	Inpatient	Medical
Gastrointestinal Care	Inflammatory bowel disease	Inpatient	Medical
Gastrointestinal Surgery	Bariatric surgery	Inpatient	Surgical
Gastrointestinal Surgery	Major bowel procedure	Inpatient	Surgical
Medical & Critical Care	Cellulitis	Inpatient	Medical
Medical & Critical Care	Chronic obstructive pulmonary disease, bronchitis, asthma	Inpatient	Medical
Medical & Critical Care	Renal failure	Inpatient	Medical
Medical & Critical Care	Sepsis	Inpatient	Medical
Medical & Critical Care	Simple pneumonia and respiratory infections	Inpatient	Medical
Medical & Critical Care	Urinary tract infection	Inpatient	Medical
Neurological Care	Seizures	Inpatient	Medical
Neurological Care	Stroke	Inpatient	Medical
Orthopedics	Double joint replacement of the lower extremity	Inpatient	Surgical
Orthopedics	Fractures of the femur and hip or pelvis	Inpatient	Medical
Orthopedics	Hip & femur procedures except major joint	Inpatient	Surgical
Orthopedics	Lower extremity and Humerus procedure except hip, foot, femur	Inpatient	Surgical
Orthopedics	Major joint replacement of the lower extremity	Inpatient/Outpatient	Surgical
Orthopedics	Major joint replacement of the upper extremity	Inpatient/Outpatient	Surgical
Spinal Procedures	Back & neck except spinal fusion	Inpatient	Surgical
Spinal Procedures	Back & neck except spinal fusion	Outpatient	Surgical
Spinal Procedures	Spinal Fusion	Inpatient	Surgical

Appendix E: CMS QPP Determinations for Eligible Clinicians reported in the BPCI Advanced QPP Lists



Participants must either complete the Participation List (PL) tab, or the Affiliated Practitioners List (AL) tab, or both.

Diagram #1

We are a Convener Participant, and our Episode Initiators (EIs) are ...			We are a Non-Convener Participant that is ...	
Acute Care Hospitals (ACHs) → Affiliated Practitioners List (AL)	Physician Group Practices (PGPs) → Participation List (PL)	Both PGPs and ACHs → Participation List (PL) Affiliated Practitioners List (AL)	an ACH → Affiliated Practitioners List (AL)	a PGP → Participation List (PL)

QP Determinations for BPCI Advanced Model Participants

Eligible clinicians affiliated with BPCI Advanced Model Participants through an Affiliated Practitioner List (AL) or a Participation List (PL) will be assessed for QP status as summarized below. QP determinations for eligible clinicians in BPCI Advanced are based on the type of the APM Entity's participation (whether Convener Participant or Non-Convener Participant), as well as the type of Episode Initiator participation under the APM Entity.

1. **Non-Convener Participants that are Acute Care Hospitals (ACHs)**
   QP determinations for eligible clinicians will be assessed at the individual level for practitioners listed on the Affiliated Practitioners List (AL) tab.

2. **Non-Convener Participants that are Physician Group Practices (PGPs)**
   QP determinations for eligible clinicians will be assessed as one group for practitioners listed on the Participation List (PL) tab.

3. **Convener Participants that have PGP(s) and ACH(s) as Episode Initiators**
   QP determinations for eligible clinicians will be assessed as one group for those practitioners listed on the Participation List (PL) tab. Eligible clinicians listed on the Affiliated Practitioners List (AL) tab will not be assessed for QP determinations.

   Convener Participants that have PGP(s) and ACH(s) as Episode Initiators (with the same Parent BPID), must complete both templates (PL & AL) to identify their eligible clinicians, but only the eligible clinicians in the PL will be assessed for QP determinations.

4. **Convener Participants that only have ACH(s) as Episode Initiators**
   QP determinations for eligible clinicians will be assessed at the individual level for practitioners listed on the Affiliated Practitioner List (AL) tab.

5. **Convener Participants that only have PGP(s) as Episode Initiators**
   QP determinations for eligible clinicians will be assessed as one group for practitioners listed on the Participation List (PL) tab.