

---

# **Bundled Payments for Care Improvement Advanced**

## **Application - MY3**

---

In this application, all references to “applicant” or “participant” either mean the potential non-convener risk-bearing Participant or the potential risk-bearing Convener. For questions that require information about the applicant only, provide information about the potential Non-Convener Participant or Convener Participant organization only.

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

1. Participating practitioners, including suppliers who may be separately paid by Medicare for their professional services (e.g., physicians, nurse practitioners, physician assistants, physical therapists); and
2. Participating organizations, providers or suppliers that initiate episodes with whom the Participant plans to partner (e.g., acute care hospitals, physician group practices).

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

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

## Organization Information

**TEMPLATE**

*Do not submit as official application*

Applicant Type

Period of Performance Start Date

Participants must use Certified Electronic Health Record Technology (CEHRT) to document and communicate care with patients and other healthcare professionals. For non-hospital participants, at least 50% of eligible clinicians in an entity must use the CEHRT definition of certified health IT functions to participate in this initiative. Will you be able to attest to the use of CEHRT as described at the time that you would begin participating in this initiative?\*

### 1. Organization Details

Applicant Organization Legal Name

“Doing Business As” if Different from Applicant Organization Legal Name

Street Address

Address Line 2

City

State

Zip Code

(+4)

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

Billing Address

Billing Address Line 2

Billing City

Billing State

Billing Zip Code

Billing (+4)

**\* This requirement has been updated per the 2019 Quality Payment Program rule. For this attestation response, you must meet the current eligible clinician requirement of 75%.**

## 2. Applicant Contact Person at Applicant Organization

Email Address

First Name

Last Name

Title/Position

Business Phone Number

## Business Phone Extension

Alternative Phone Number

**Organization Information***Do not submit as official application*

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

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

**Non-Convener Applicants who are Physician Group Practices (PGPs):** Please 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.



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

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

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

## Net Payment Reconciliation Amount (NPRA) Sharing

**TEMPLATE**

*Do not submit as official application*

1. Does the applicant plan to share NPRA between or among the applicant, its participating organizations, and/or practitioners?
2. Describe the applicant's and its participating organization's prior or current experience with any NPRA Sharing or pay-for-performance initiatives, including Medicare, Medicaid, or commercial purchasers.
3. Describe the applicant's proposed methodology for NPRA Sharing among participating organizations and participating practitioners, including with whom gains will be shared, the proportion of gains to be shared with participating organizations and with participating practitioners, the mechanism for calculating gains, include any quality metrics associated with the sharing of gains. Specify the plan to ensure that NPRA Sharing payments to participating practitioners do not exceed 50% of the amount normally paid by Medicare to practitioners for the episodes included in the initiative\*. Describe how the allocation of gains will incorporate best-practice norms, quality, patient safety, patient experience, and efficiency measures. Describe a single universal approach for the applicant and its participating organizations.

---

\* In your response, you may omit reference to the handling of a cap to NPRA Sharing.



**TEMPLATE**

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

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

- 11

12

## Quality Improvement

**TEMPLATE**

*Do not submit as official application*

---

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

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



- 16



## Quality Assurance

**TEMPLATE**

*Do not submit as official application*

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

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

Not Applicable

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

## Beneficiary Protections

**TEMPLATE**

***Do not submit as official application***

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

## Beneficiary Protections

**TEMPLATE**

*Do not submit as official application*

---

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

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

## Financial Arrangements

*Do not submit as official application*

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

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

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

**Financial Arrangements**

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

**Organizational Capabilities and Readiness**

---

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

2. Provide a detailed implementation plan, including the following:
  - Descriptions of the processes in place to handle tasks occurring simultaneously
  - Resource allocations (e.g. staff, systems, related departments)
  - Evidence of the feasibility of this plan based on ongoing operations and past experiences



**Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model**  
**Applicant Data Request and Attestation Form**

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

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

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

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

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

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

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



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

**Data Requestor:**

Organization Name

Organization CCN (if applicable)

Organization EIN/TIN

Organization NPI

Organization Address

Organization City

State

ZIP

**The Data Requestor is (select one):**

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

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

Other (please attach detailed explanation)

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

Its own use

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

Other (please attach detailed explanation)

**The Data Requestor requests (select all that apply):**

**1. Aggregate Historical Claims Data:** That CMS provide the Data Requestor with the data described above as “summary data” for the final 3 years of the initial 4 year historical baseline period from 2013-2016 (or 3 years of data under a subsequent baseline period over the course of the model depending on the Applicant’s requested start date) for the Medicare beneficiaries who would have been included in a Clinical Episode attributed to the BPCI Advanced Applicant under the BPCI Advanced initiative using the methodology described in the BPCI Advanced Technical Specifications that will be provided.

**2. Raw Historical Claims Data:** That CMS provide the Data Requestor with the data described above as “beneficiary line-level claims” for the final 3 years of the initial 4 year historical baseline period from 2013-2016 (or 3 years of data under a subsequent baseline period over the course of the model depending on the Applicant’s requested start date) for the Medicare beneficiaries who would have been included in a Clinical Episode attributed to the Applicant under the BPCI Advanced initiative using the methodology described in the BPCI Advanced Technical Specifications that will be provided.

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

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

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

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

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

Other (please attach detailed explanation)

**The data requested herein is (select one):**

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

Other (please attach detailed explanation)

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

**BPCI Advanced Data Point of Contact #1:**

Name	Title
Organization Name	
Phone Number	Extension
Work Email Address	

**BPCI Advanced Data Point of Contact #2:**

Name	Title
Organization Name	
Phone Number	Extension
Work Email Address	

The Data Requestor asserts that the BPCI Advanced Applicant will be solely responsible for approving and granting any disclosure of BPCI Advanced data to “business associates,” as that term is used in 45 C.F.R. §§ 164.502(e), 164.504(e), 164.532(d) and (e), of the BPCI Advanced Applicant.

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

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

**Disposition of CMS BPCI Advanced Data files:**

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

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

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

Work Email Address:

First Name

Last Name

Title

Phone Number

Extension

Date

**Certification**

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

**First and Last Name**

**Certification**

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

Authorized CEO/Senior Executive  
Applicant Organization

Date