Bundled Payments for Care Improvement Advanced Application

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

Applicant Type

Period of Performance Start Date

10/01/2018

Participants must use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical 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?

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1. **Organization Details**

Applicant Organization Legal Name

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

Date Established

Street Address

Address Line 2

City

State

Zip Code

(+4)

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

Billing Address

Billing Address Line 2

Billing City

Billing State

Billing Zip Code

Billing (+4)

Organization Information

Organization Type

If Organization Type is “Other”, specify below

Facility Bed Size

TIN

NPI

CCN

Entity Type

If Entity Type is “Other”, specify below

Academic Medical Center

Current/Previous Phase II BPCI Participation

Current/Future Medicare Model or Program Participation (excluding BPCI)

Specify Current/Future Medicare Model or Program

Please list Medicare Model/Program Identifiers Below

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

Email Address

First Name

Last Name

Title/Position

Business Phone Number

Business Phone Extension

Alternative Phone Number

3. **Convener Applicants:** Fill out the Participating Organizations Attachment to provide information on all participating organizations, and then submit this attachment along with this application form.

☐ Not Applicable

4. **Physician Group Practice (PGP) applicants and Convener applicants that have Physician Group Practices as Participating Organizations:** Fill out the PGP Practitioners Attachment to provide information on all physicians who were in your practice at any time during CYs 2013, 2014, 2015, 2016, as well as in which Hospitals you expect to trigger Clinical Episodes, and then submit this attachment along with this application form.

☐ Not Applicable

Organization Information

5. 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.

Practitioner Engagement

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

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

Care Improvement

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.

Care Improvement

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

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

Net Payment Reconciliation Amount (NPRA) Sharing

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

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

3. Describe the applicant's proposed methodology for NPRA Sharing among participating organizations and participating practitioners, including with whom gains will be shared, the proportion of gains to be shared with participating organizations and with participating practitioners, the mechanism for calculating gains, include any quality metrics associated with the sharing of gains. 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.

Net Payment Reconciliation Amount (NPRA) Sharing

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

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

Quality Improvement

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

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

Quality Improvement

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

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

Quality Improvement

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

6. In order to participate in this initiative, the Participant must use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care with patients and other health care professionals. For non-hospital Participants, at least 50% of eligible clinicians in an entity must use the CEHRT definition of certified health IT functions to participate in this initiative. Describe the applicant's and its participating organizations' experience using CEHRT to document and communicate clinical care with patients and other health care professionals, to measure and improve quality of care, to enable care redesign, and to coordinate care across multiple providers.

Quality Improvement

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.

Quality Assurance

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

Quality Assurance

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

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

Quality Assurance

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

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

Quality Assurance

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
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Beneficiary Protections

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

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

Beneficiary Protections

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

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

Financial Arrangements

If the applicant is selected, in addition to accepting the pay-for-performance methodology for quality performance, the applicant must agree to accept some financial risk as part of participating in this initiative. Participants must repay Medicare for expenditures for the episode that are above the episode target price. CMS will also monitor and measure the care provided to beneficiaries by participating and non-participating providers during a Post-Episode 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.

Organizational Capabilities and Readiness

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

Partnerships

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

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

Data Request and Attestation

In order to receive the data used by CMS to calculate the prospectively determined preliminary Target Prices and/or historical Medicare claims data from CMS, 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. Fill out the Data Request and Attestation (DRA) form ensuring each section is addressed. Submit the DRA along with this application form.

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