Bundled Payments for Care Improvement Advanced | BPCI Advanced

Model Year 3

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Bundled Payments for Care Improvement Advanced (BPCI Advanced)

Application Portal Walkthrough

Center for Medicare & Medicaid Innovation (CMS Innovation Center)

Walkthrough Outline

- Portal Registration and Navigation
- Home Page
- Submitting an Application
  - Navigating through each Application Section
  - Submitting a Participating Organizations Attachment
  - Adding a Sanctions/Investigations
  - Completing the Data Request and Attestation (DRA)
  - Submission Certification
- Helpful Hints
- HelpDesk and User Manual

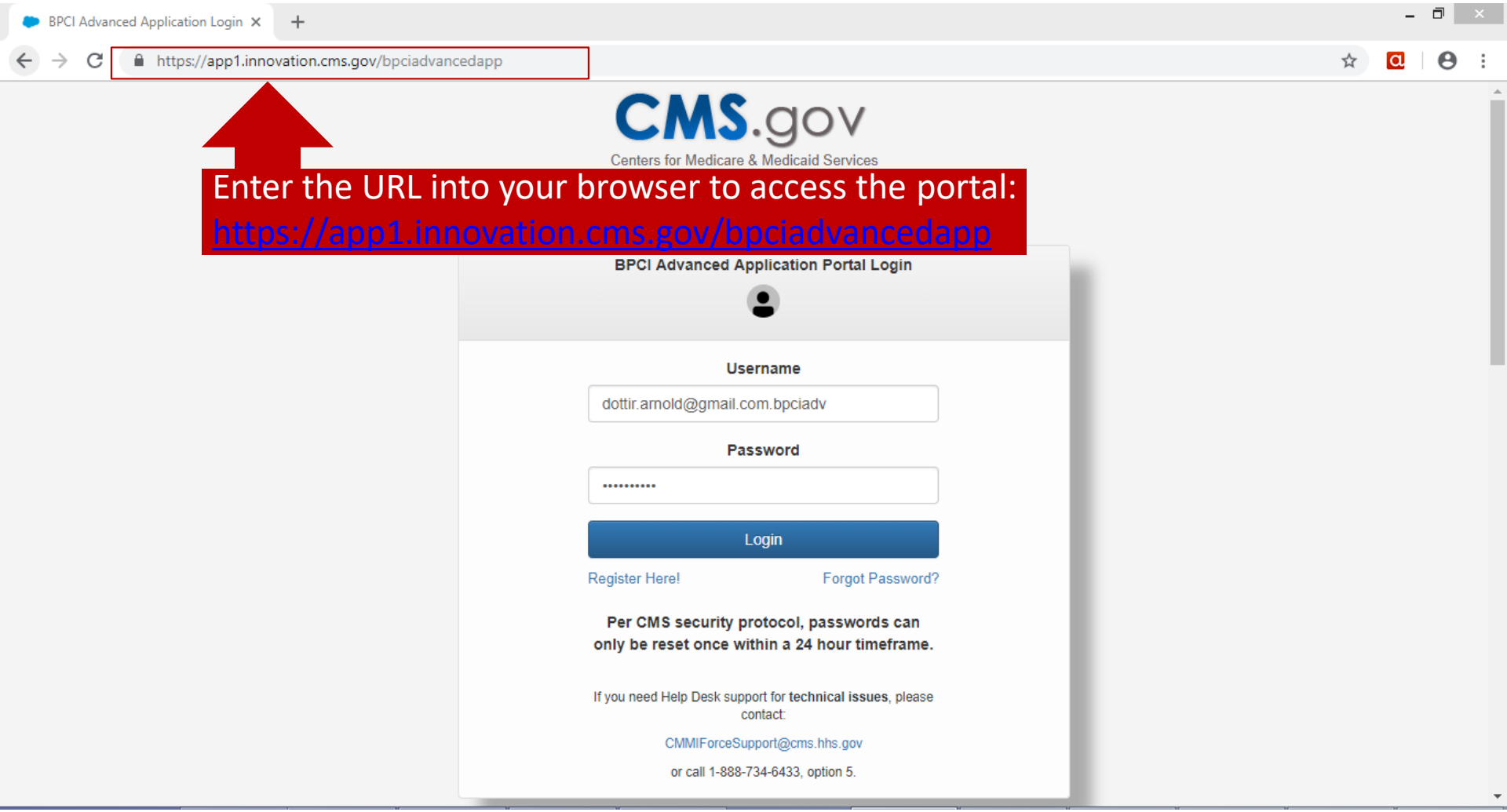
Application Portal Overview

The **BPCI Advanced Application Portal** is an online platform that allows Applicants to:

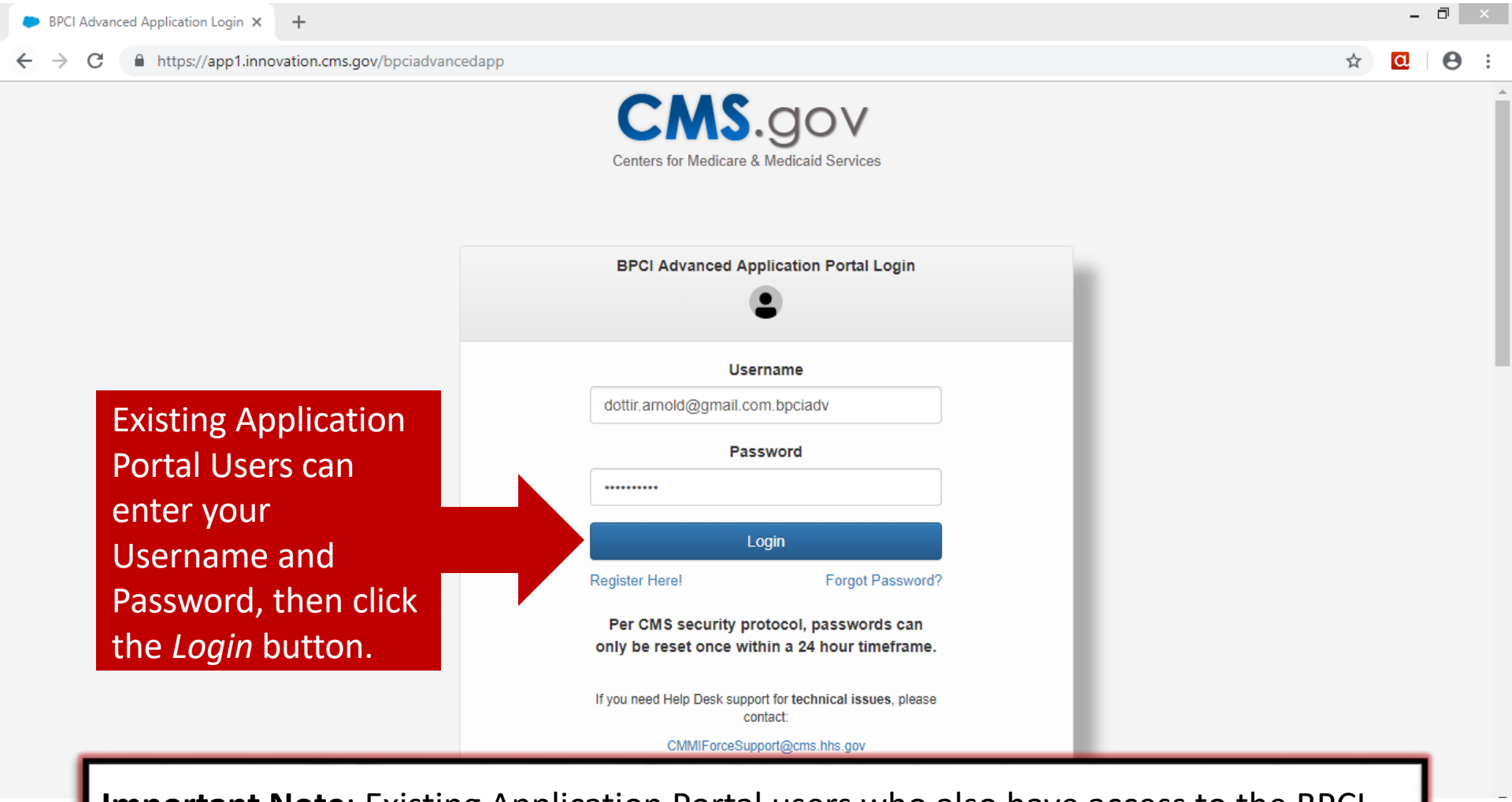
- Apply to the BPCI Advanced model
- Edit or Delete In-Progress Applications
- Clone Submitted Applications
- View and Download Submitted Applications and Data Request and Attestation (DRA) forms.

Registering and Navigating the Portal

Accessing the Portal



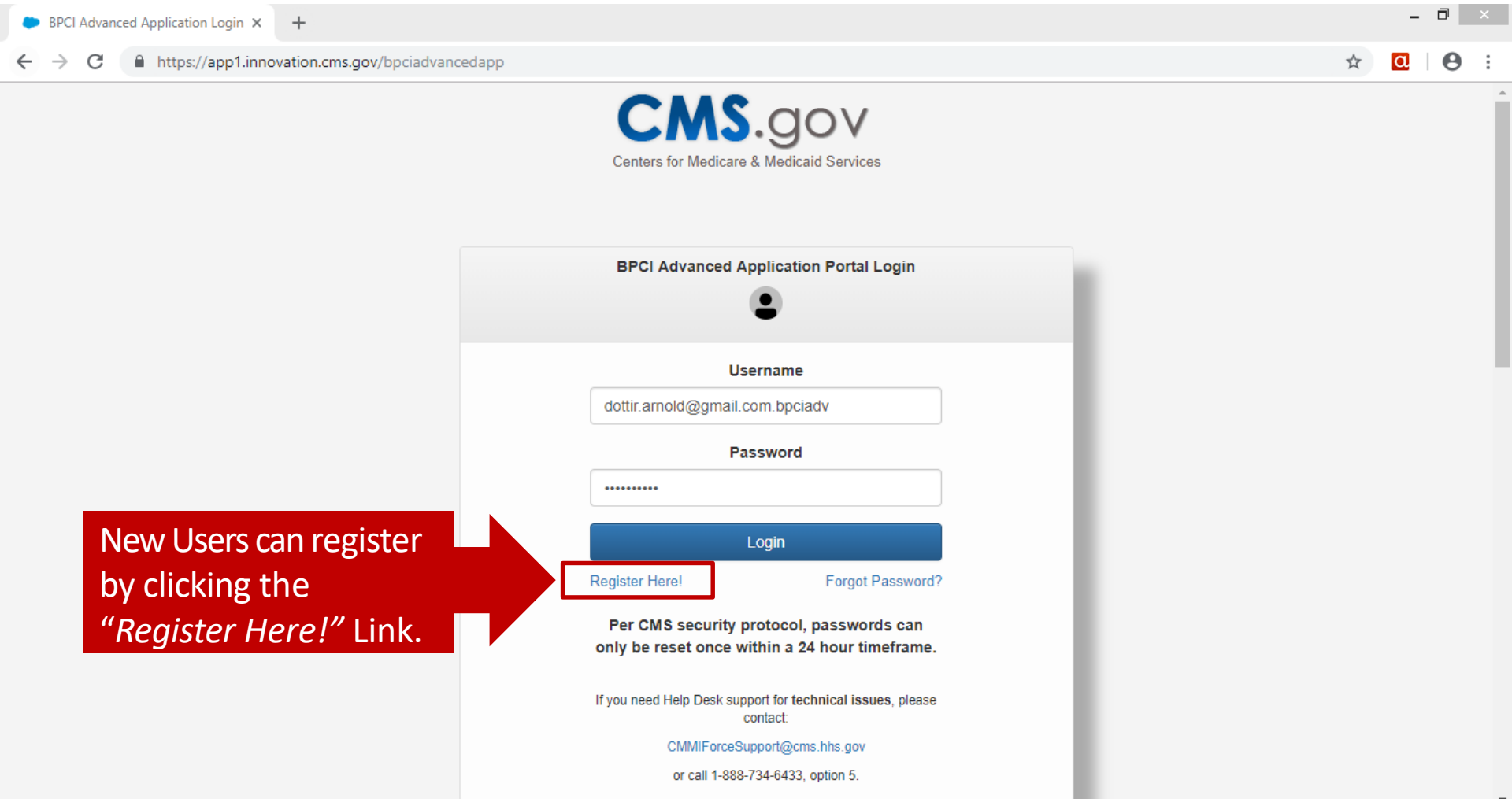
Logging into Portal: Existing Users



Existing Application Portal Users can enter your Username and Password, then click the *Login* button.

Important Note: Existing Application Portal users who also have access to the BPCI Advanced Participant Portal, will use the same Username and Password credentials as the Participant Portal when logging into the Application Portal.

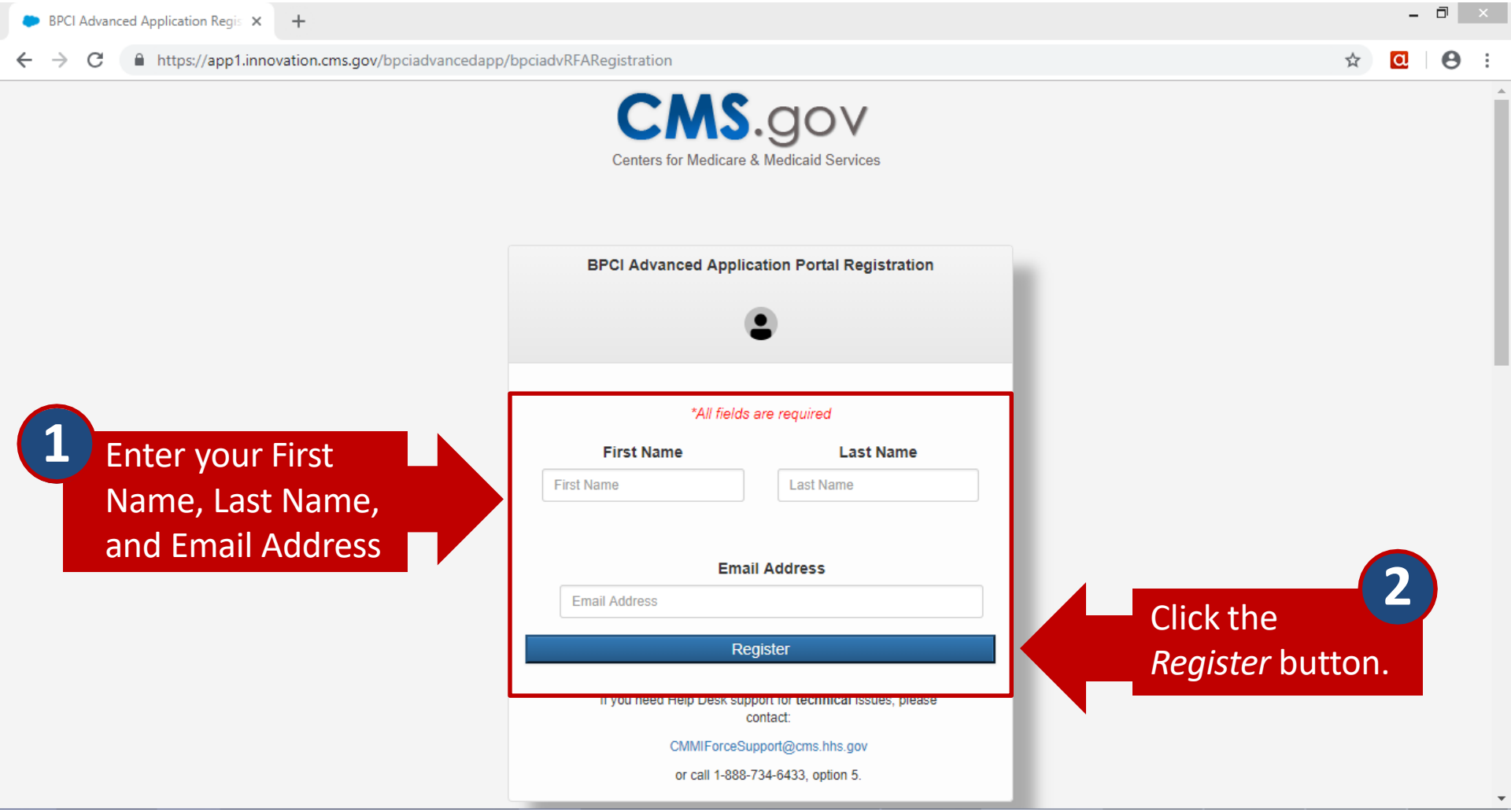
Registering for the Portal: New Users



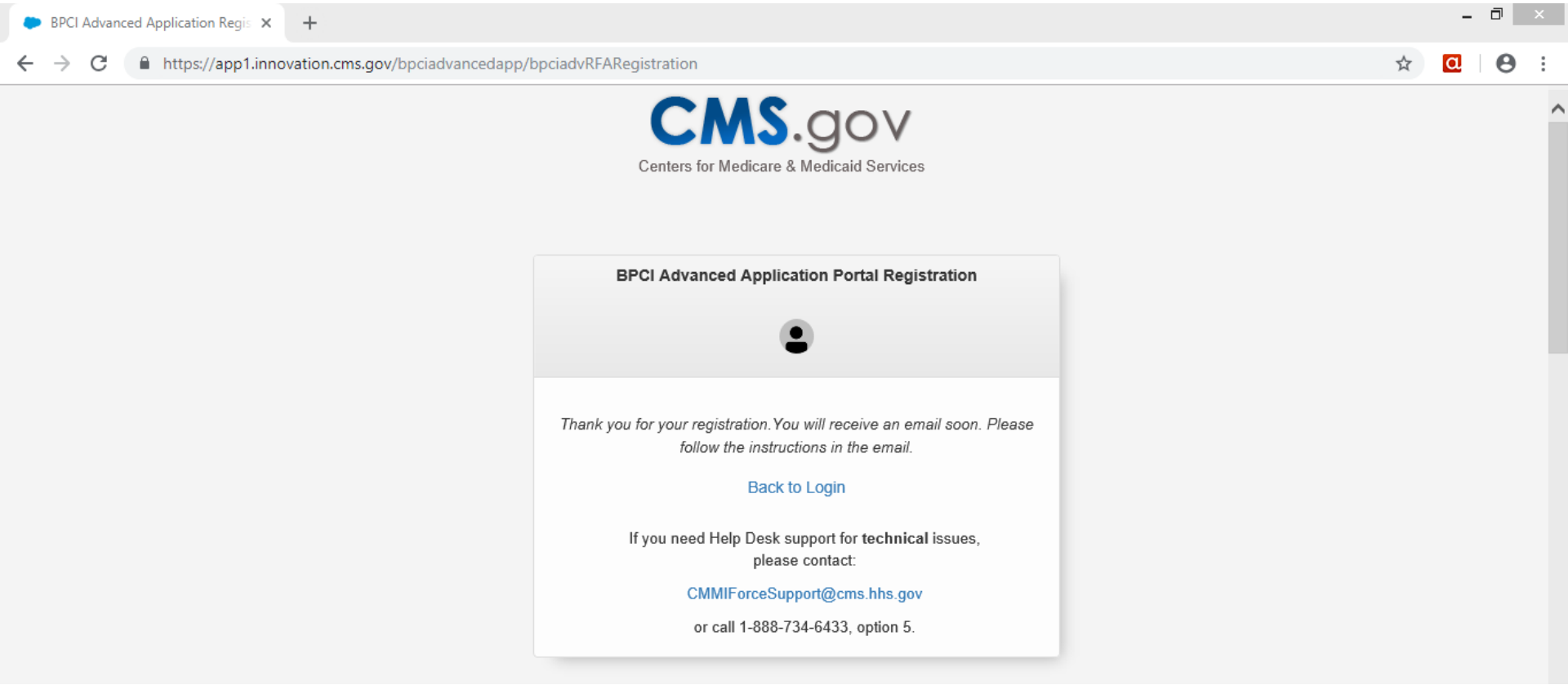
New Users can register by clicking the *"Register Here!"* Link.

Important Note: Users who have access to the BPCI Advanced Participant Portal but have never accessed the Application Portal will need to register before logging in.

Registration Page



Successful Registration Submission

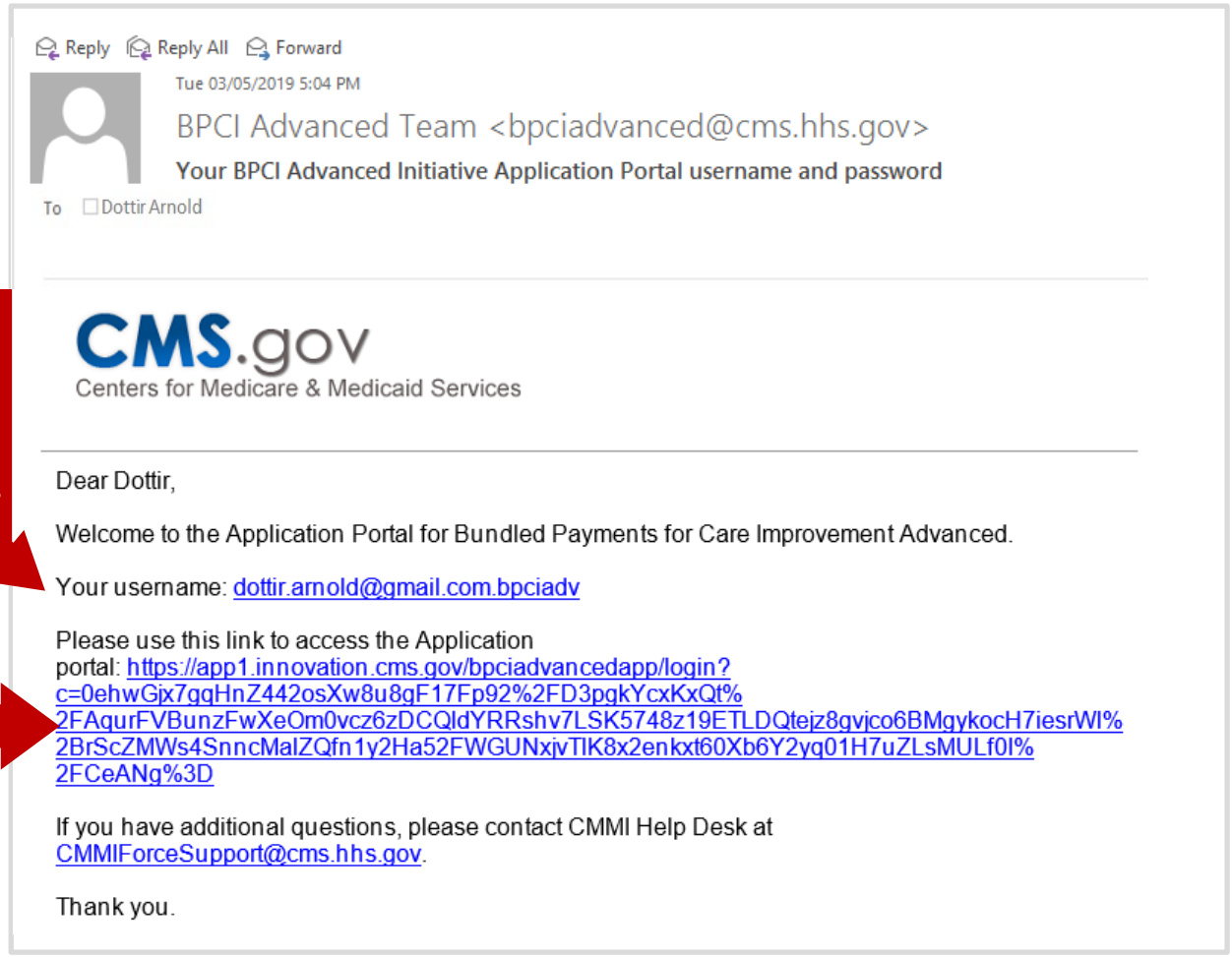


Important Note: Upon registration submission, users new to both the Application Portal and Participant Portal will receive an email with their username and password. Existing Participant Portal users that are new to the Application Portal can now can navigate back to the Login screen and use their Participant Portal credentials to login.

Username and Password Email

Your username will be your email with the *.bpciadv* extension.

Click on this link to set-up your password.



Reply Reply All Forward

Tue 03/05/2019 5:04 PM

BPCI Advanced Team <bpciadvanced@cms.hhs.gov>

Your BPCI Advanced Initiative Application Portal username and password

To Dottir Arnold

CMS.gov
Centers for Medicare & Medicaid Services

Dear Dottir,

Welcome to the Application Portal for Bundled Payments for Care Improvement Advanced.

Your username: dottir.arnold@gmail.com.bpciadv

Please use this link to access the Application portal: https://app1.innovation.cms.gov/bpciadvancedapp/login?c=0ehwGjx7gqHnZ442osXw8u8gF17Fp92%2FD3pgkYcxKxQt%2FAqurFVBunzFwXeOm0vcz6zDCQldYRRshv7LSK5748z19ETLDQtejz8gvjco6BMgykocH7iesrWI%2BrScZMWs4SnncMaIZQfn1y2Ha52FWGUNxjvTlK8x2enkxt60Xb6Y2yq01H7uZLsMULf0I%2FCeANg%3D

If you have additional questions, please contact CMMI Help Desk at CMMIForceSupport@cms.hhs.gov.

Thank you.

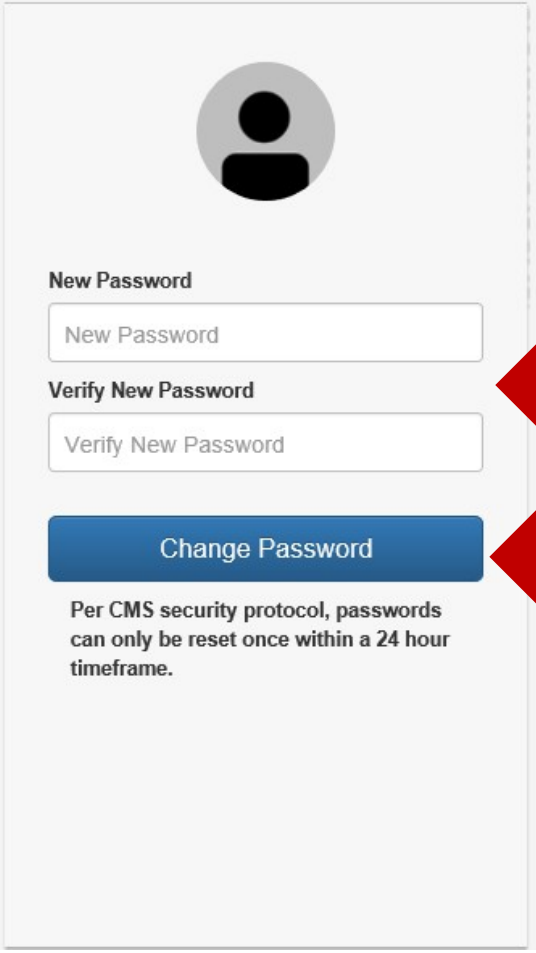
Setting-up Your Password

CMS.gov
Centers for Medicare & Medicaid Services

Password Tips

- ✓ **Passwords must contain:**
  - A minimum of 8 characters
  - A mix of numbers, uppercase and lowercase letters
  - At least one of the following special characters: !#$%_=+<>.
- ✓ **Passwords are case-sensitive**

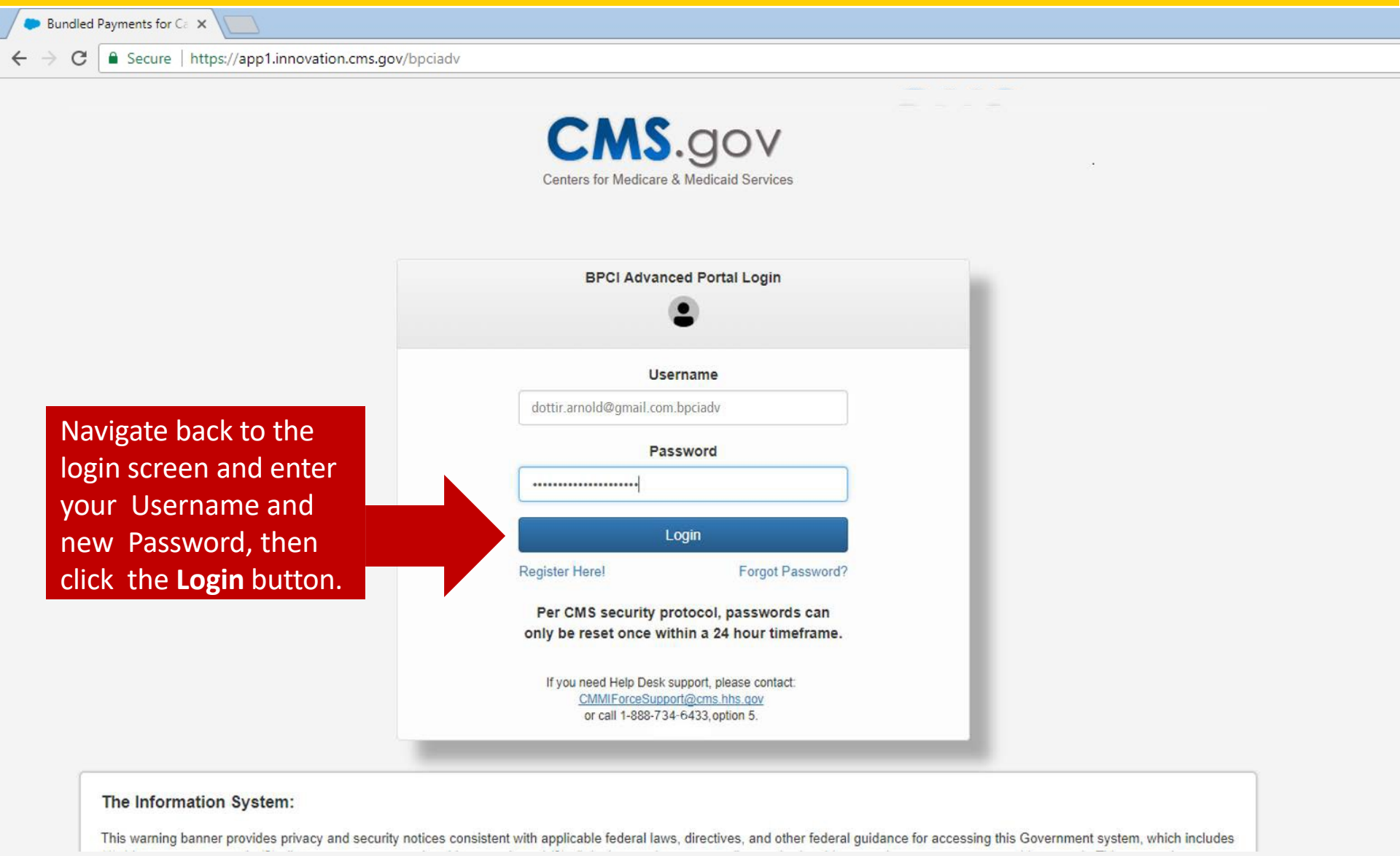
BPCI Advanced Application Portal Change Password



Using the Password Tips, create and verify your *New Password*.

When you finish entering your new password, click the **Change Password** button.

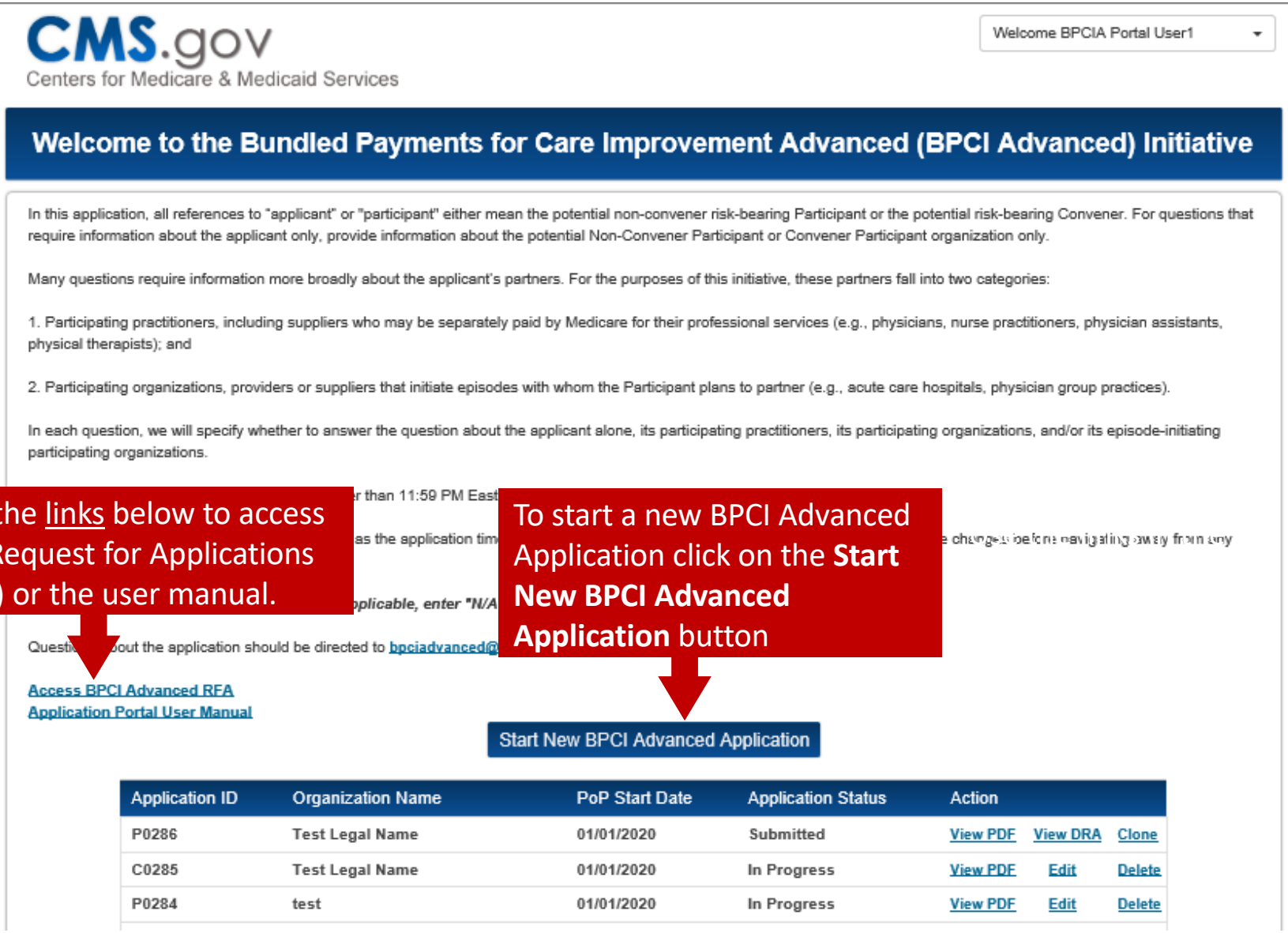
Login



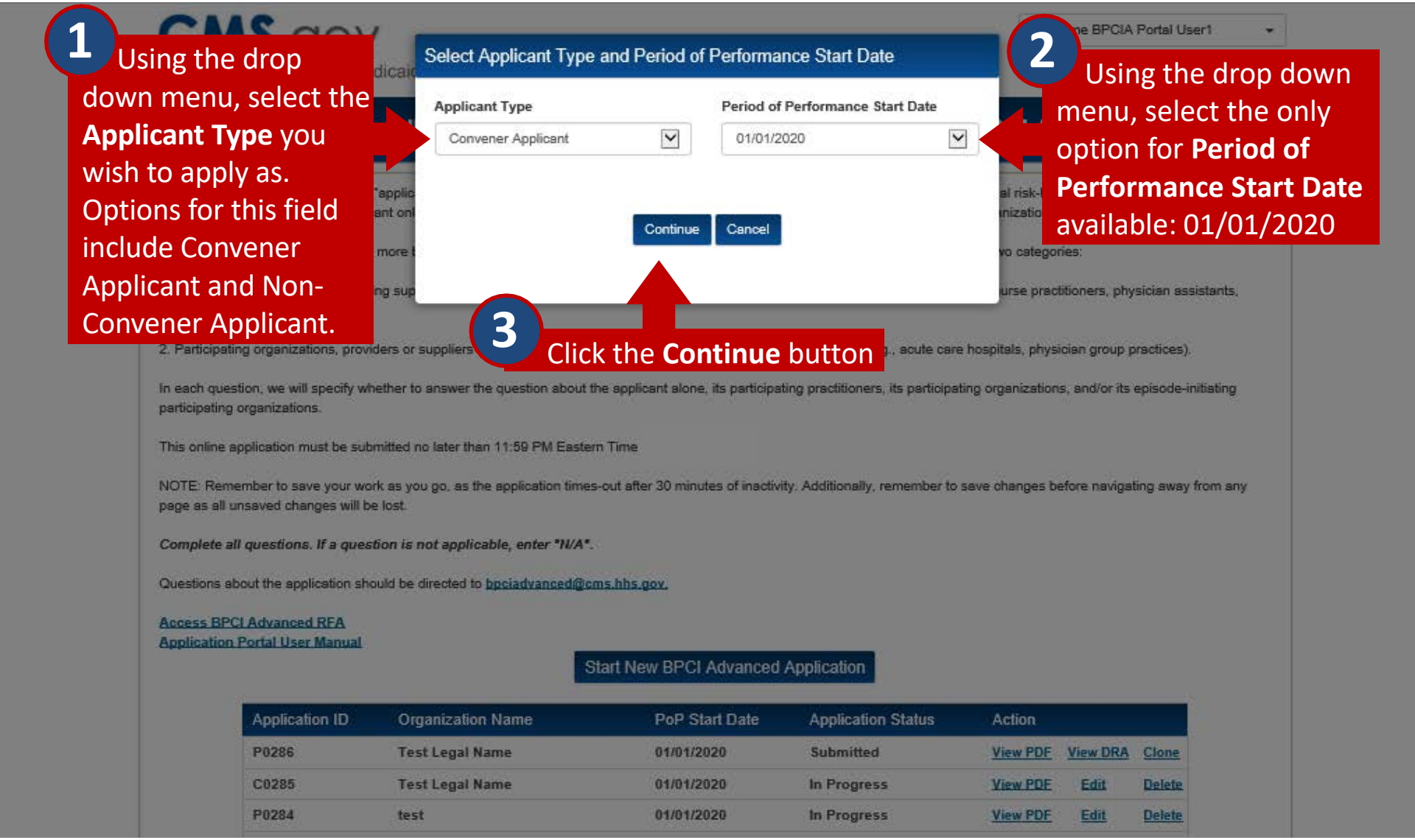
Navigate back to the login screen and enter your Username and new Password, then click the **Login** button.

Application Portal

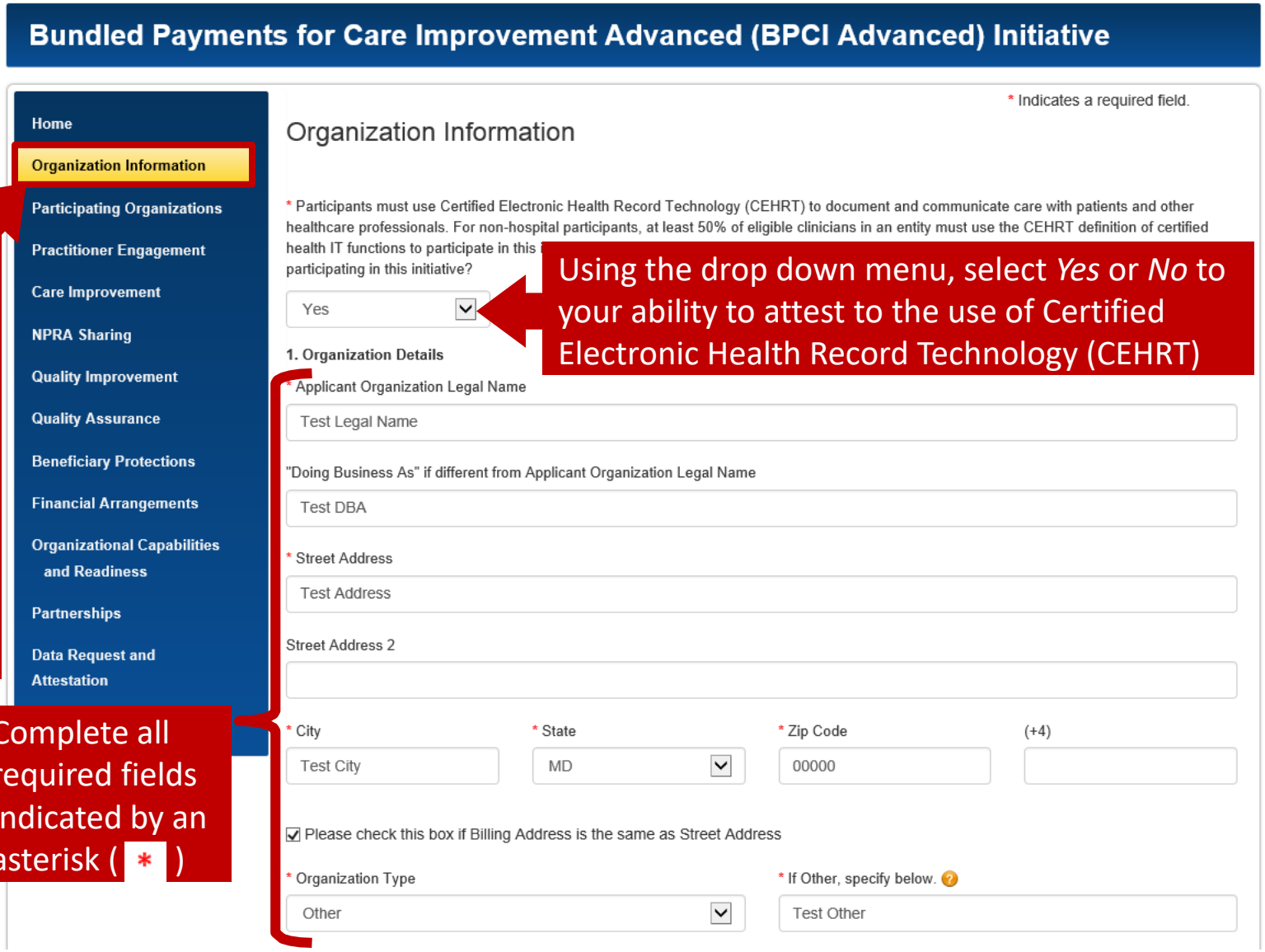
Application Home Page



Starting a New Application



Application: Organization Information Section

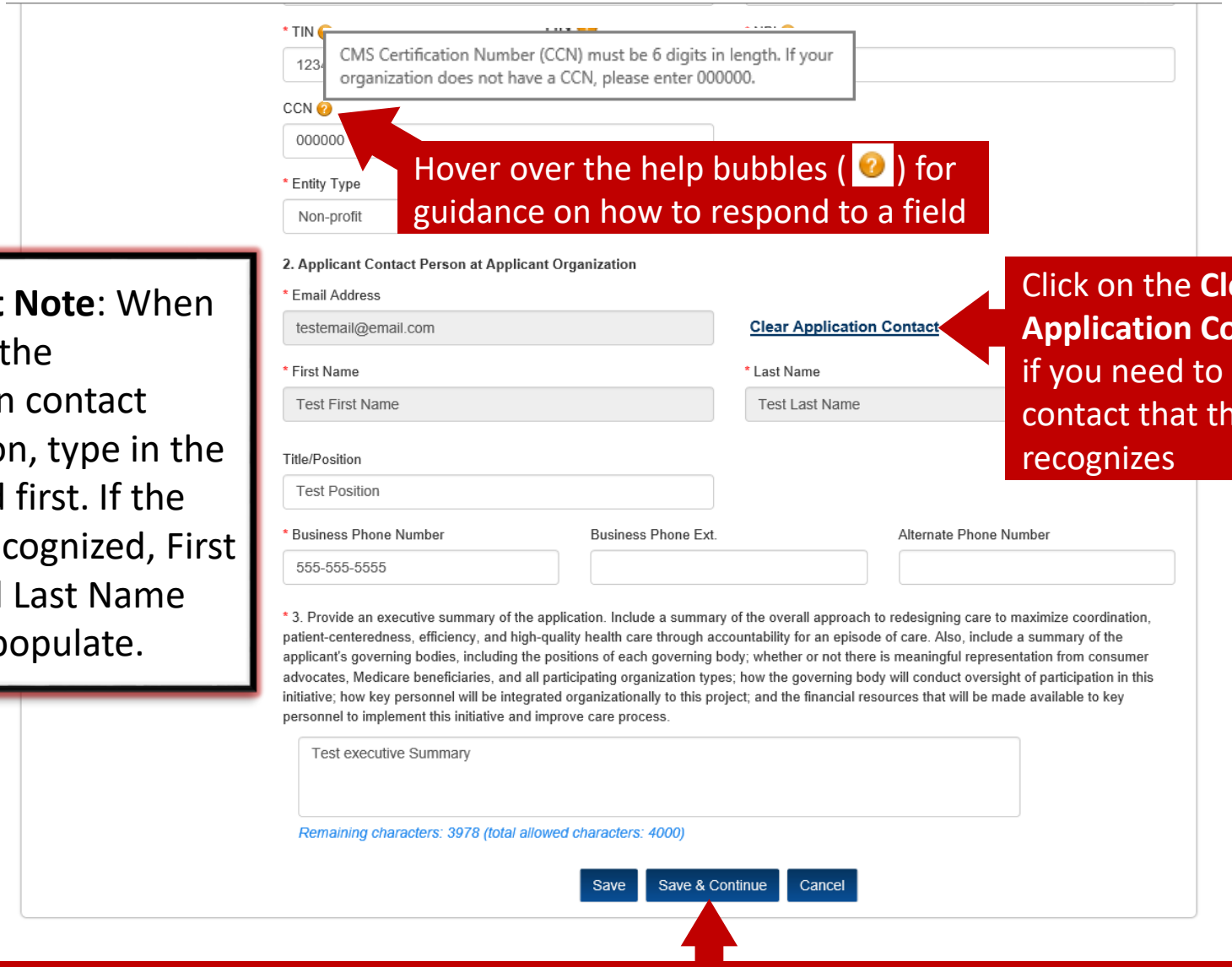


To navigate between application sections, click on the left side navigation tabs. Remember to save your progress before navigating to a different page.

Using the drop down menu, select *Yes* or *No* to your ability to attest to the use of Certified Electronic Health Record Technology (CEHRT)

Complete all required fields indicated by an asterisk (*)

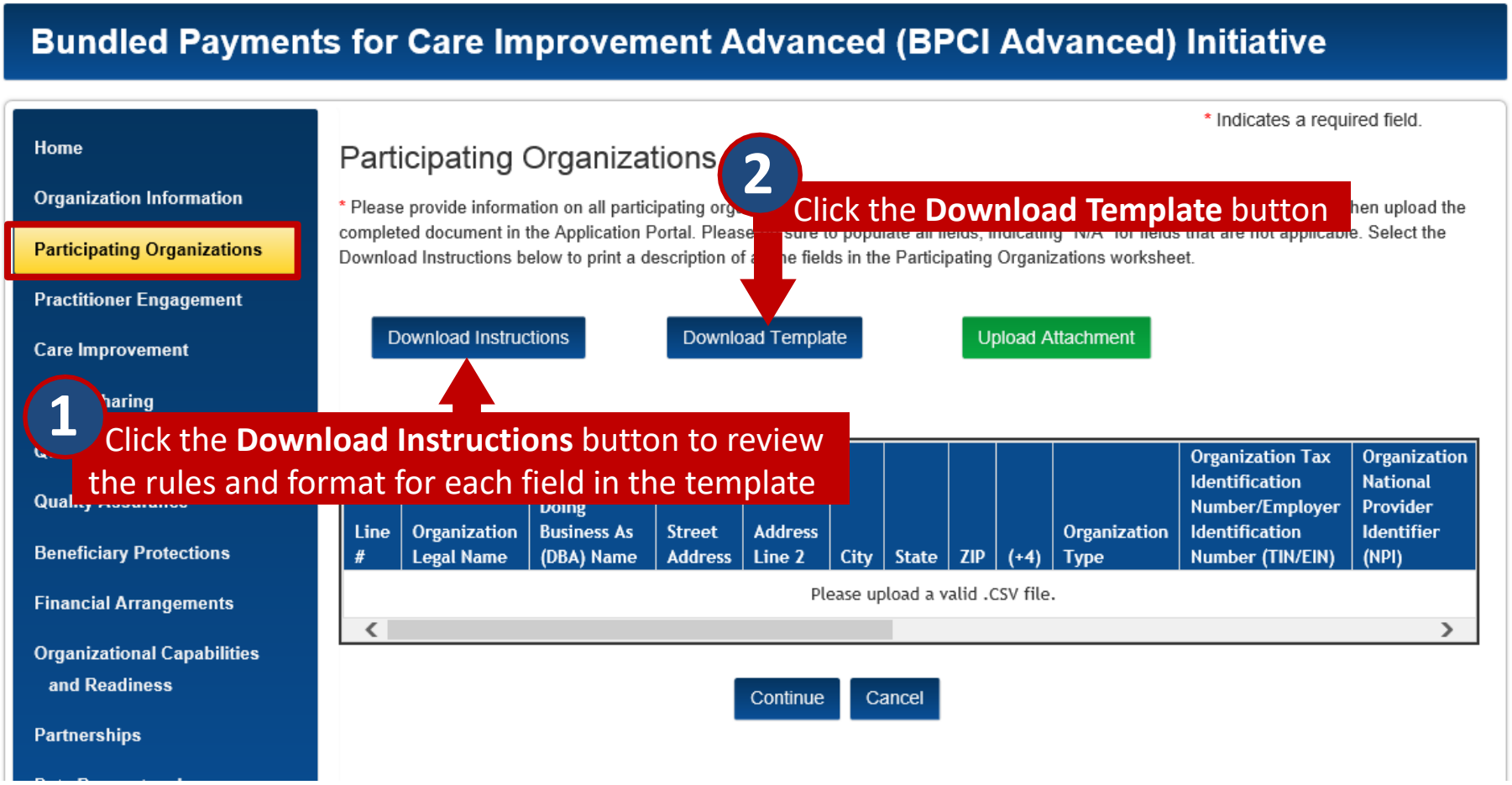
Application: Organization Information Section cont.



Important Note: When providing the application contact information, type in the email field first. If the email is recognized, First Name and Last Name will auto-populate.

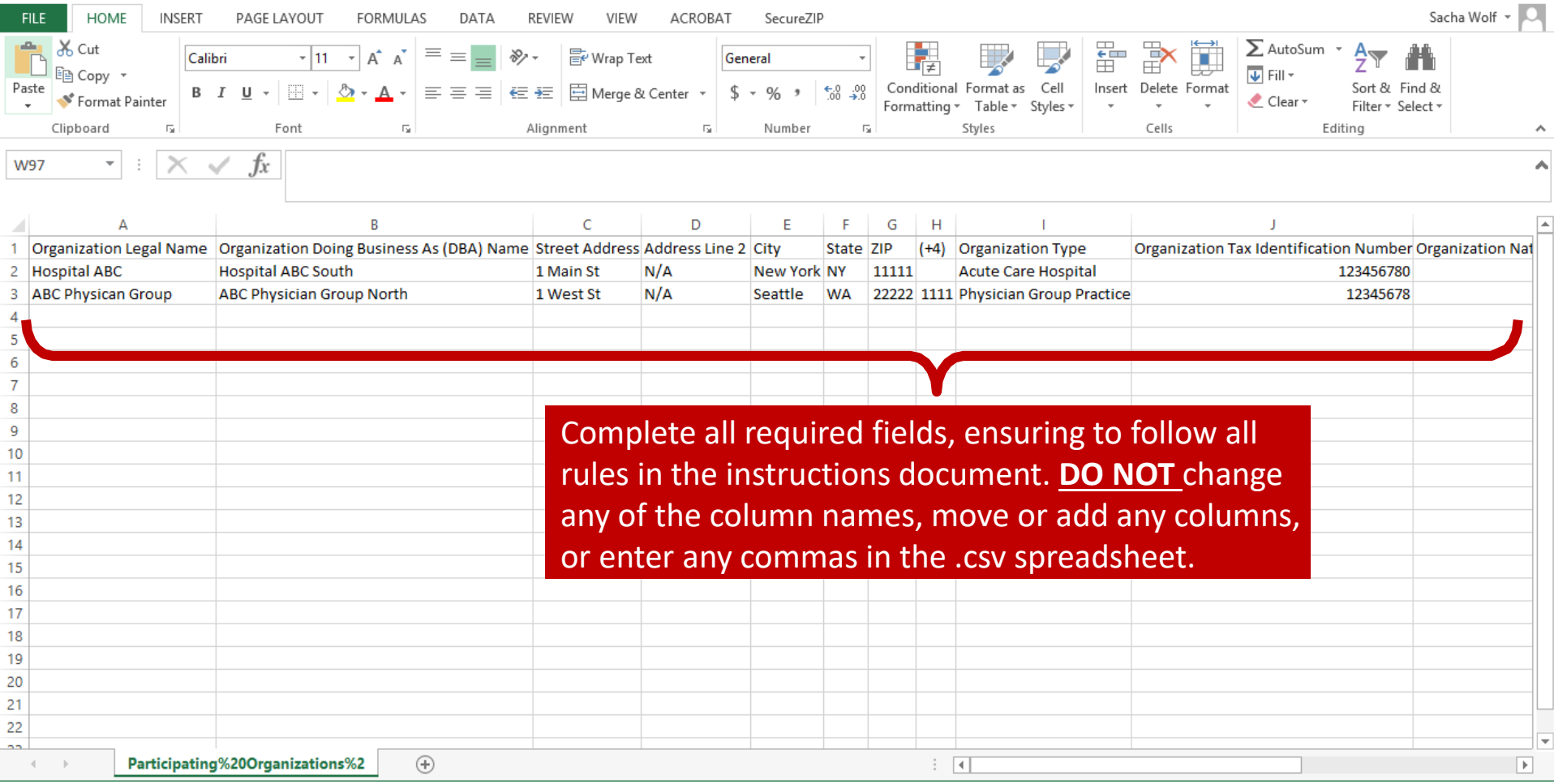
Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: Participating Organizations Section



Important Note: Only Convener Applicants and Non-Convener Applicants who are Physician Group Practices are required to complete a Participating Organizations attachment. Non-Convener Applicants who are Acute Care Hospitals (ACHs) will not have a Participating Organizations attachment section in their online application.

Application: Participating Organizations Template



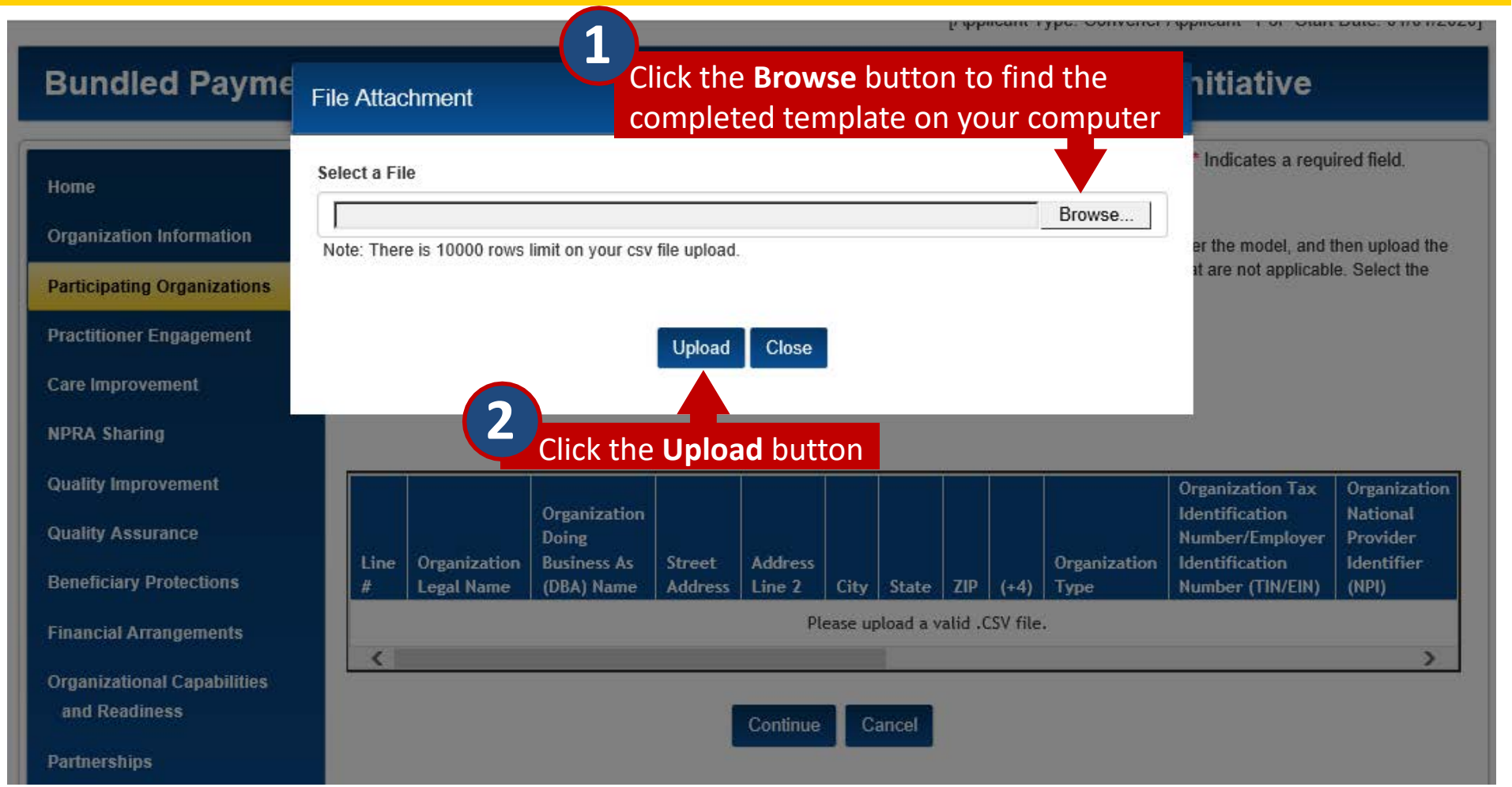
	A	B	C	D	E	F	G	H	I	J	
1	Organization Legal Name	Organization Doing Business As (DBA) Name	Street Address	Address Line 2	City	State	ZIP	(+4)	Organization Type	Organization Tax Identification Number	Organization Nat
2	Hospital ABC	Hospital ABC South	1 Main St	N/A	New York	NY	11111		Acute Care Hospital	123456780	
3	ABC Physican Group	ABC Physician Group North	1 West St	N/A	Seattle	WA	22222	1111	Physician Group Practice	12345678	

Complete all required fields, ensuring to follow all rules in the instructions document. **DO NOT** change any of the column names, move or add any columns, or enter any commas in the .csv spreadsheet.

Important Note: Template must be saved as a .csv file. The application portal will not accept any other file format.

Application: Participating Organizations Section cont.

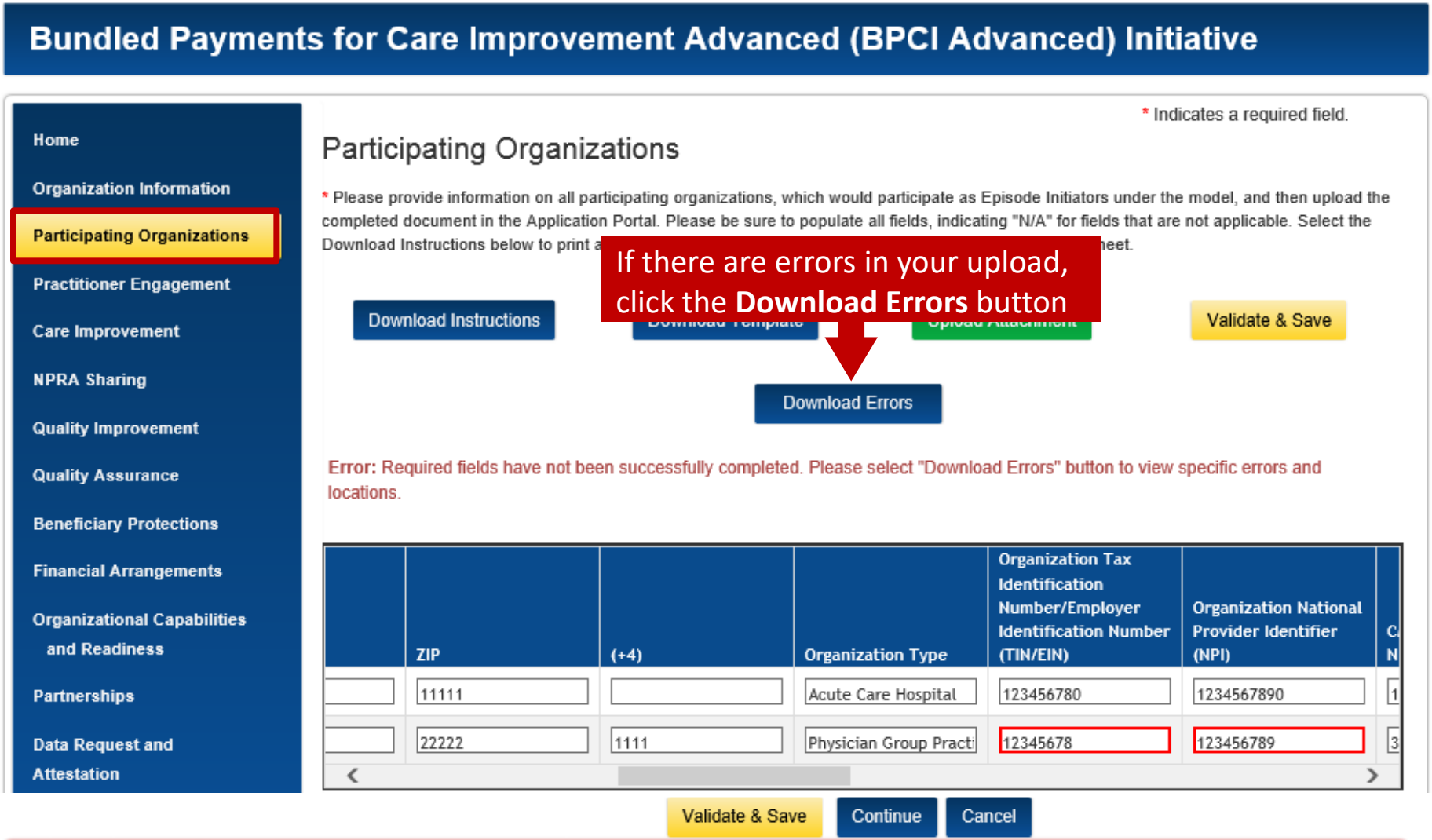
Application: Participating Organizations Section cont.



Application: Participating Organizations Section cont.

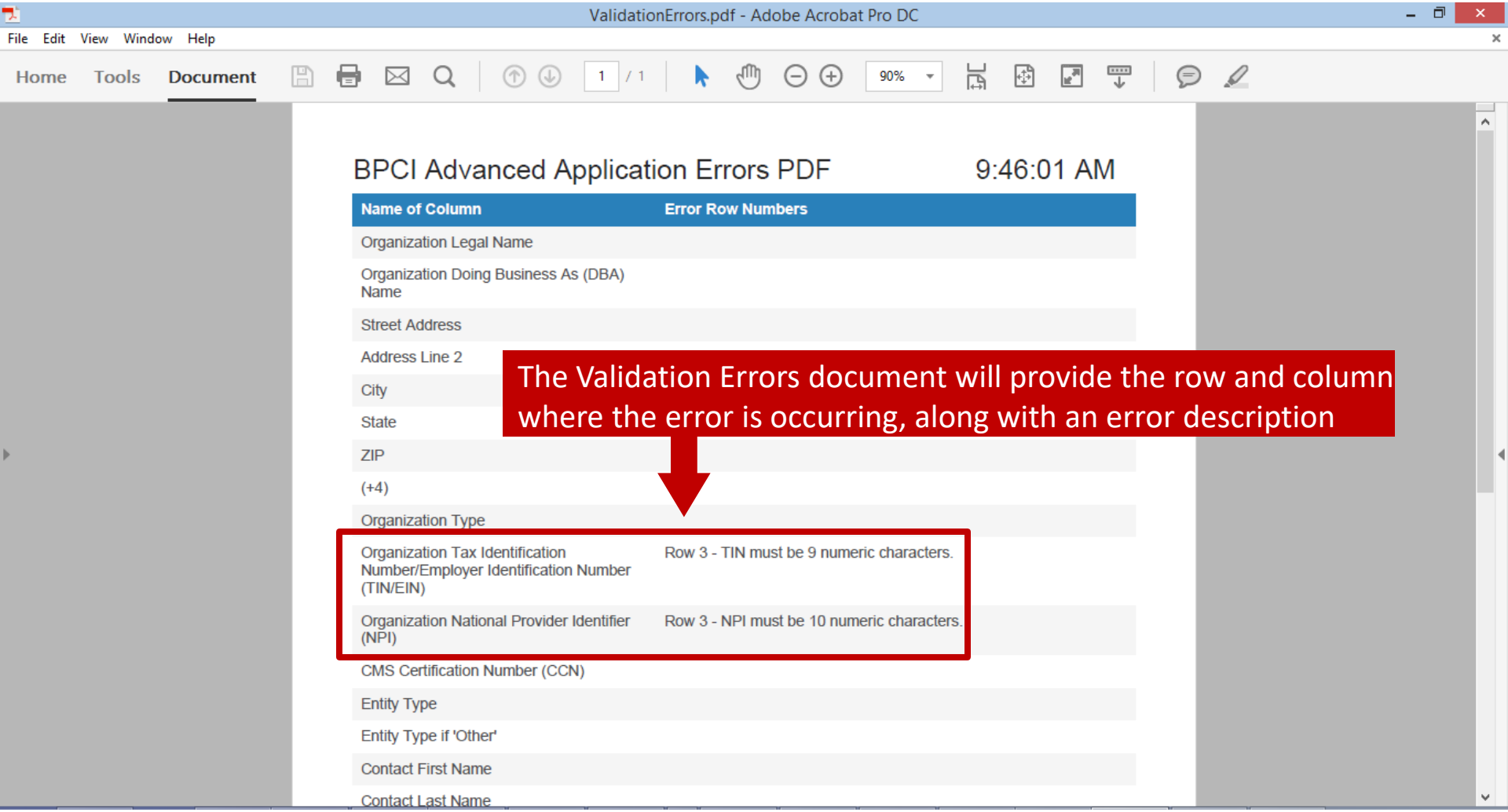
Important Note: The Validate & Save button confirms that data in the Participating Organizations attachment meets all rules and formats outlined in the instructions document.

Application: Participating Organizations Section cont.

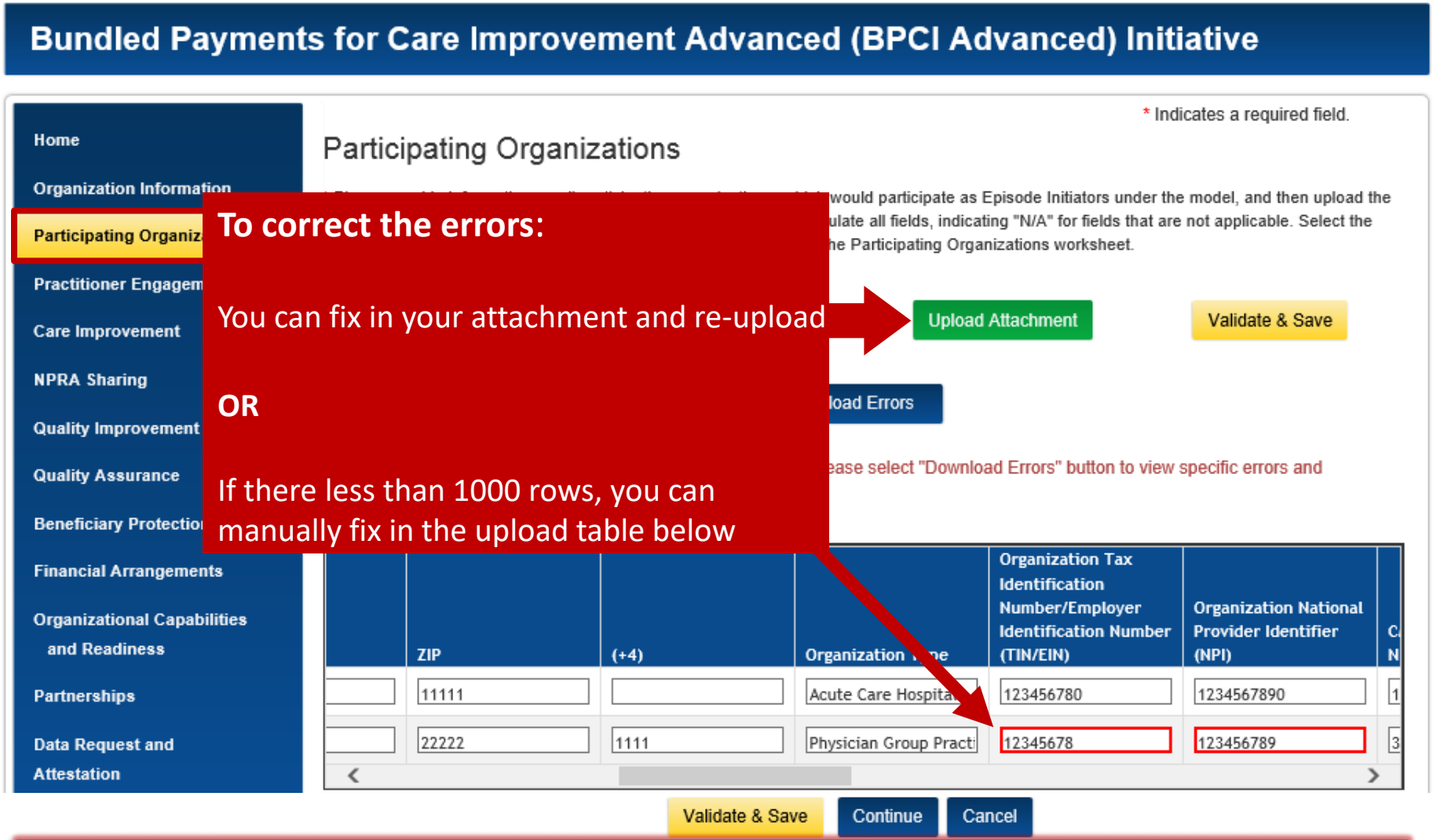


Important Note: If there are no errors in your upload, the Download Errors button will not display. Click on the Continue button to move onto the next application section.

Application: Participating Organizations Validation Errors



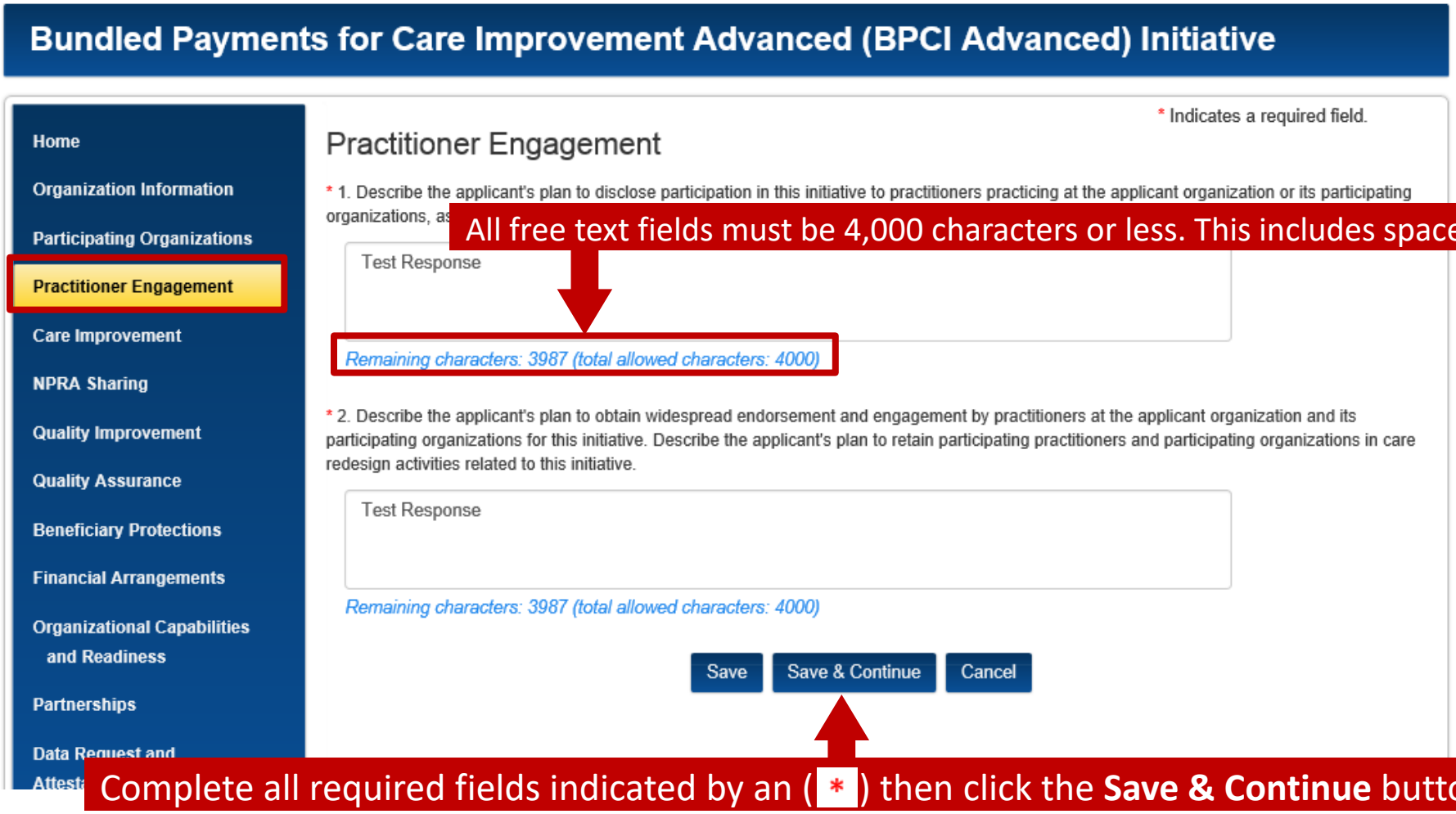
Application: Participating Organizations Section cont.



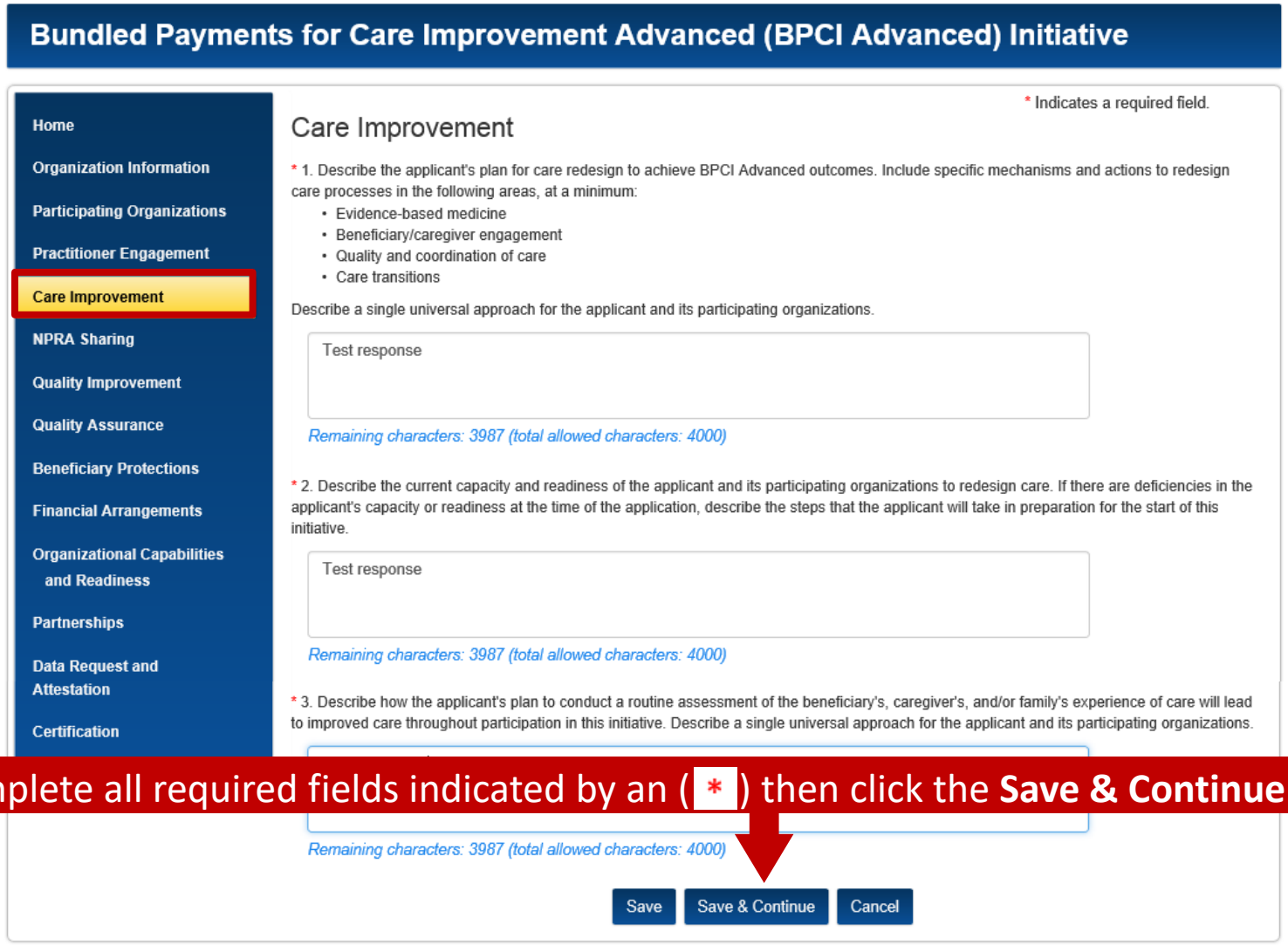
Important Note: After correcting the errors, you will need to click the Validate & Save button to confirm the corrections.

Application: Participating Organizations Section cont.

Application: Practitioner Engagement Section

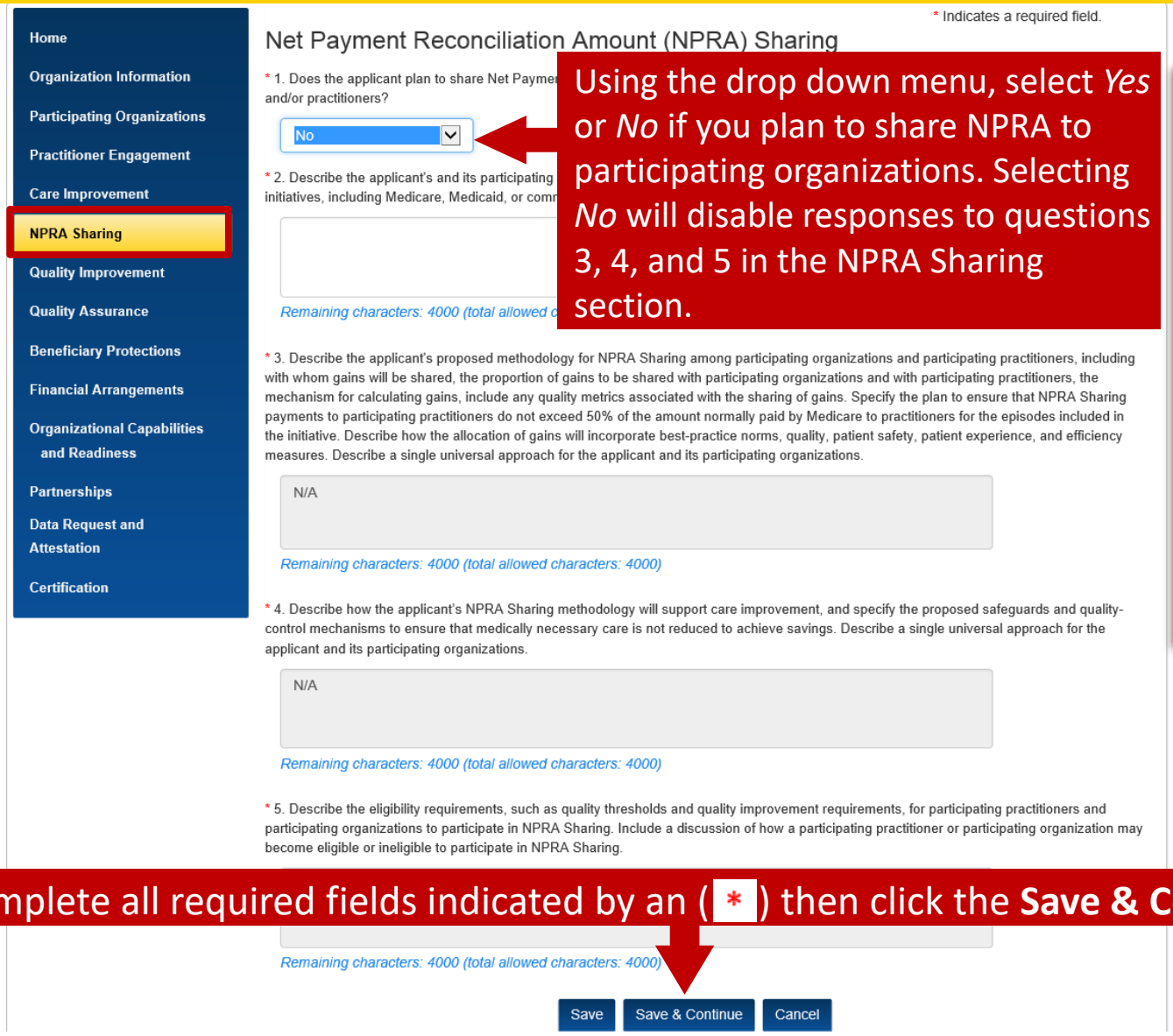


Application: Care Improvement Section



Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: NPRA Sharing Section

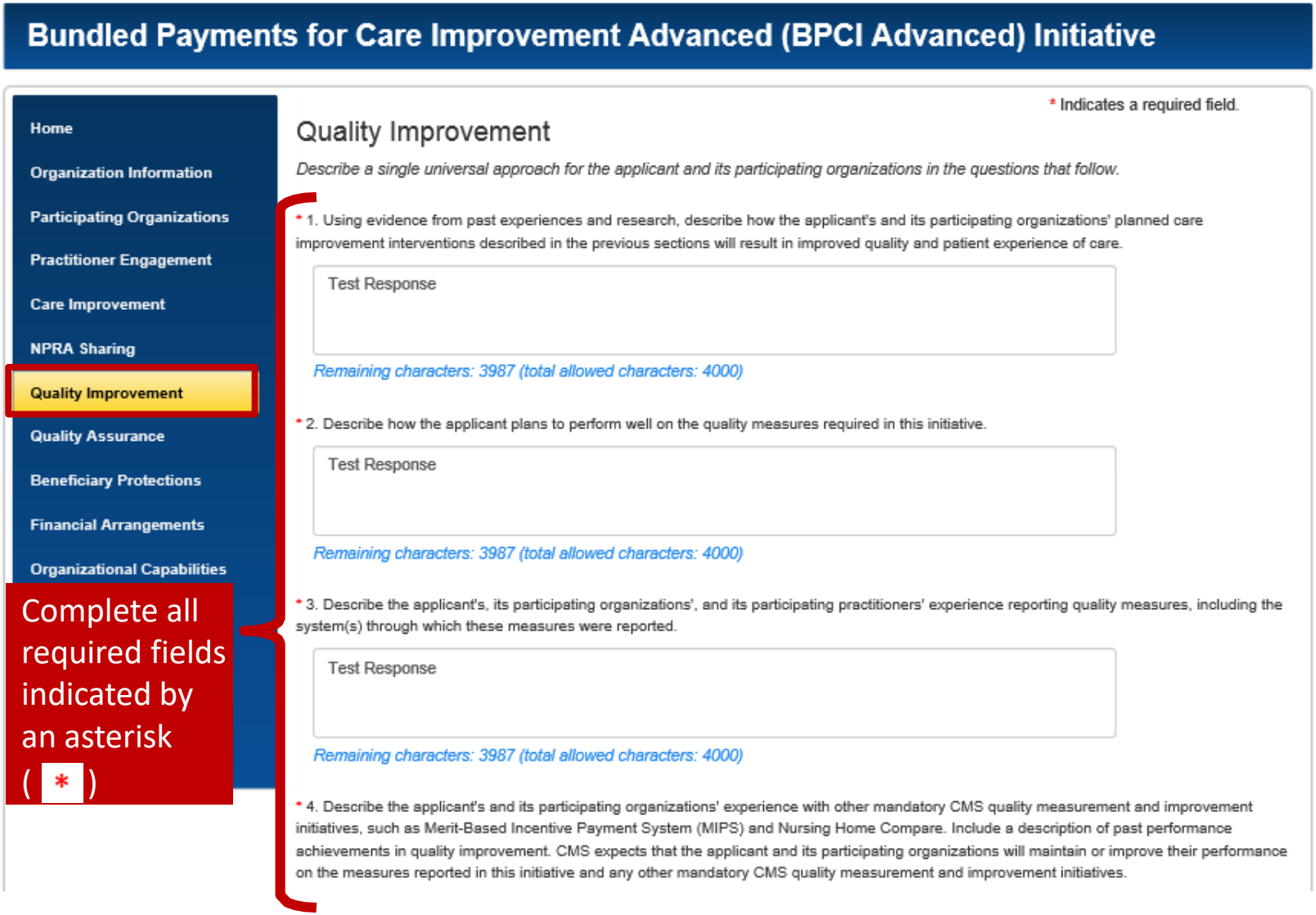


Using the drop down menu, select *Yes* or *No* if you plan to share NPRA to participating organizations. Selecting *No* will disable responses to questions 3, 4, and 5 in the NPRA Sharing section.

Important Note: Your response to the first question in the NPRA Sharing section will not need to be updated if your plan changes after application submission.

Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: Quality Improvement Section



Application: Quality Improvement Section Cont.

* 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

* 6. In order to participate in this initiative, the Participants 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

* 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.

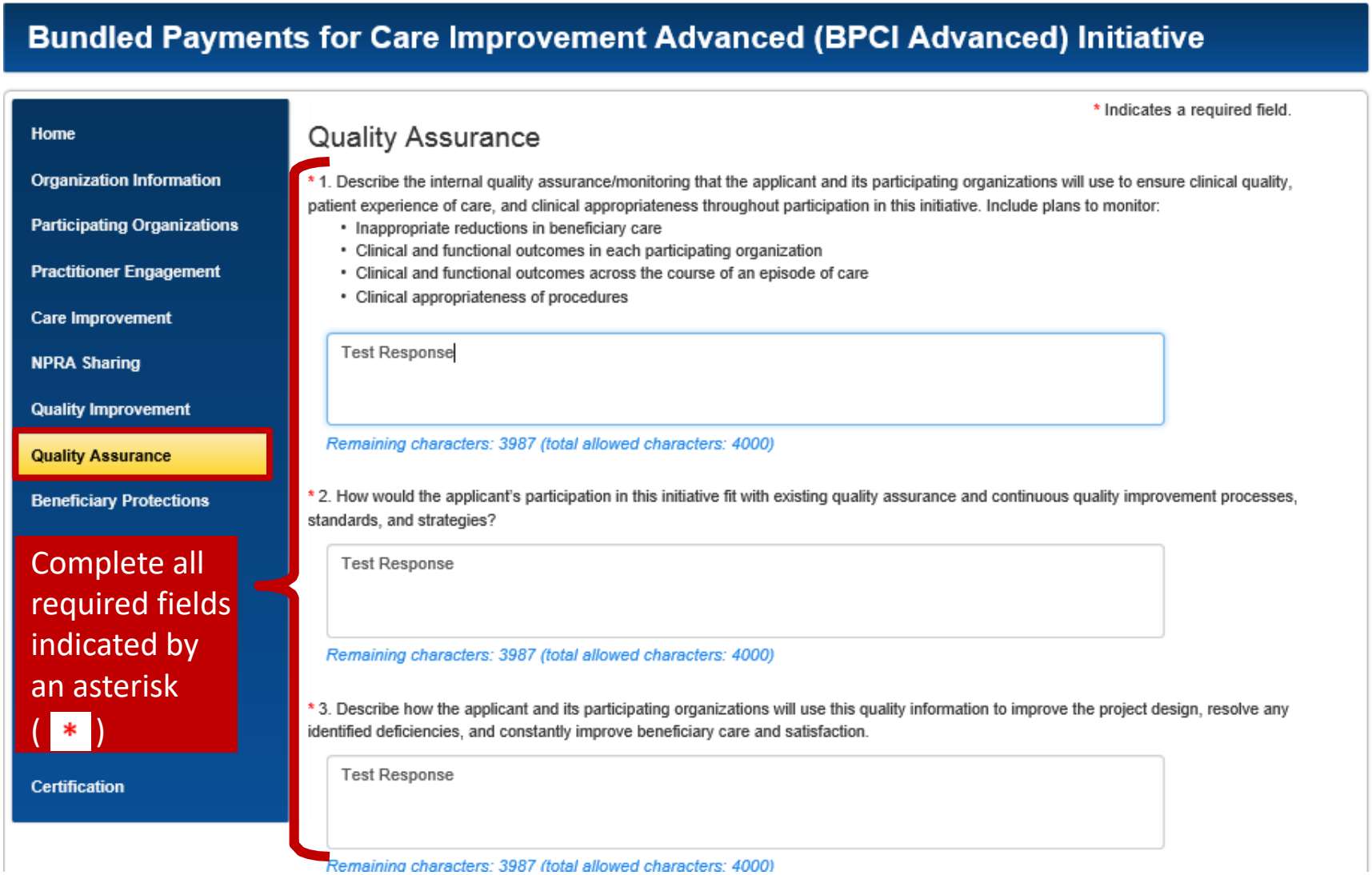
Test Response

Remaining characters: 3987 (total allowed characters: 4000)

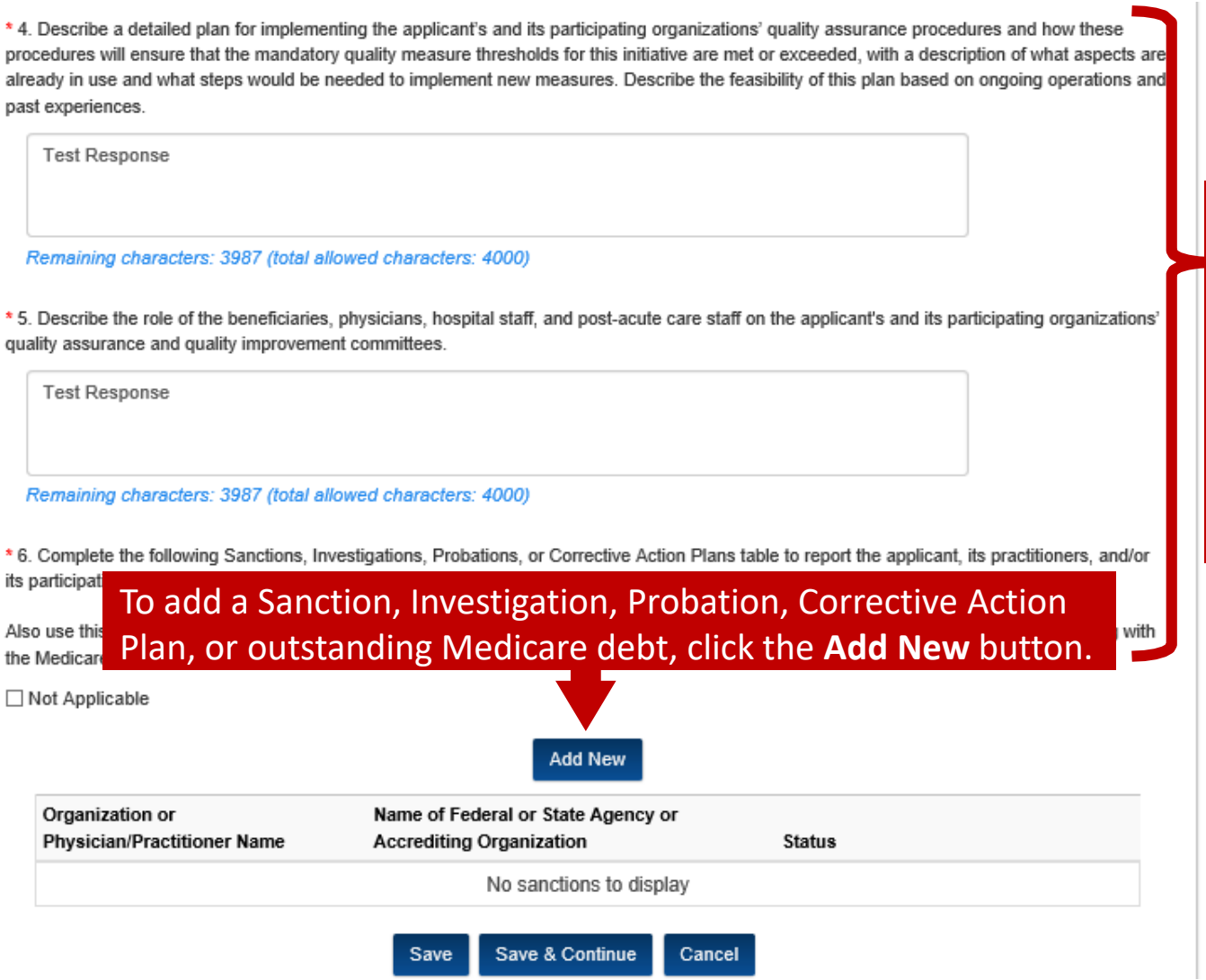
Complete all required fields indicated by an (*) then click the **Save & Continue** button

Save | Save & Continue | Cancel

Application: Quality Assurance Section



Application: Quality Assurance Section cont.

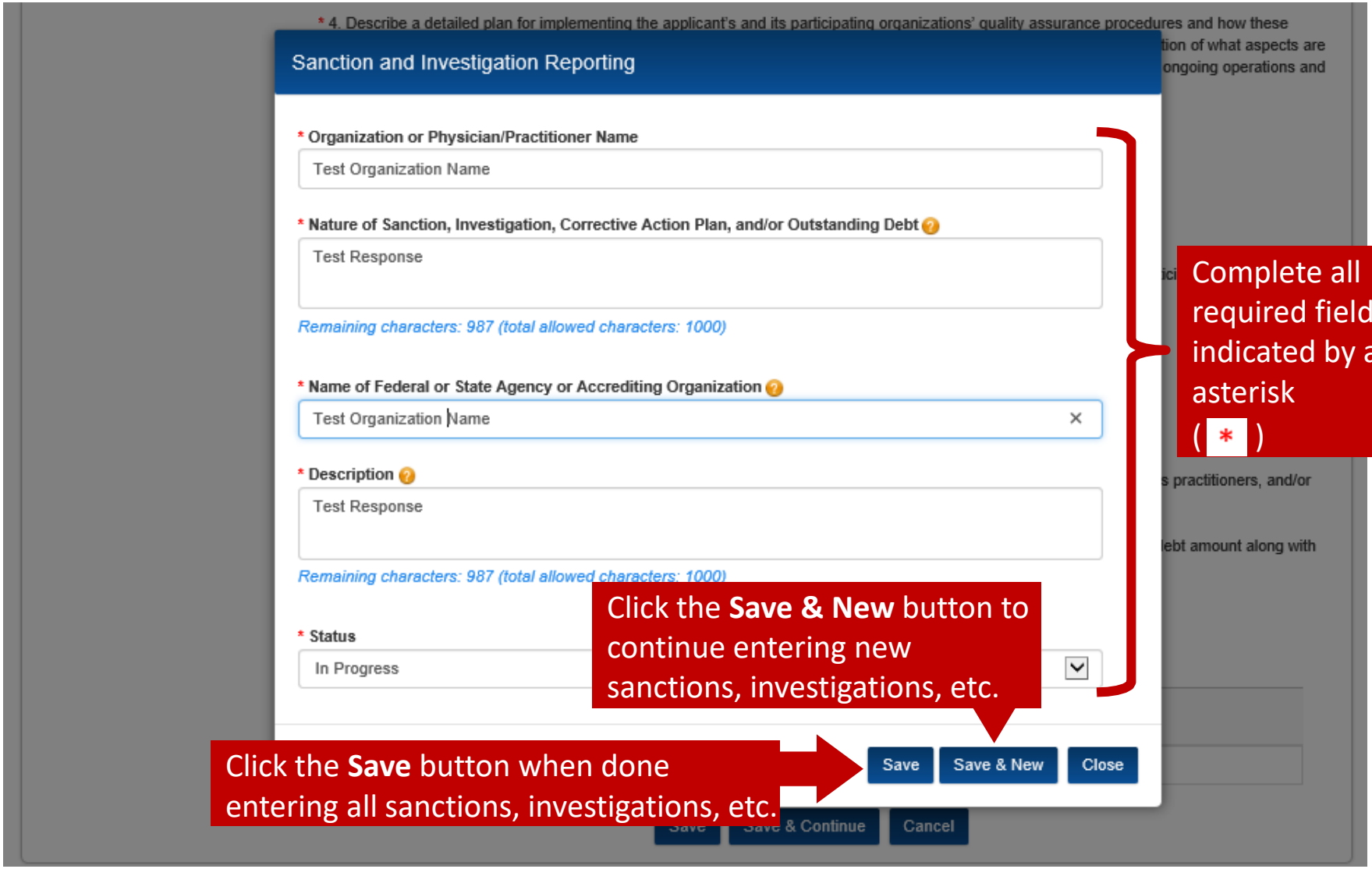


If your organization, its practitioners, and/or participating organizations do not have any Sanctions, Investigations, Probations, Corrective Action Plans, or outstanding Medicare debt, click on the **Not Applicable** checkbox. Then click the **Save & Continue** button.

To add a Sanction, Investigation, Probation, Corrective Action Plan, or outstanding Medicare debt, click the **Add New** button.

Complete all required fields indicated by an asterisk (*)

Application: Quality Assurance Section cont.



Application: Quality Assurance Section cont.

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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

* 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

* 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.

Add New

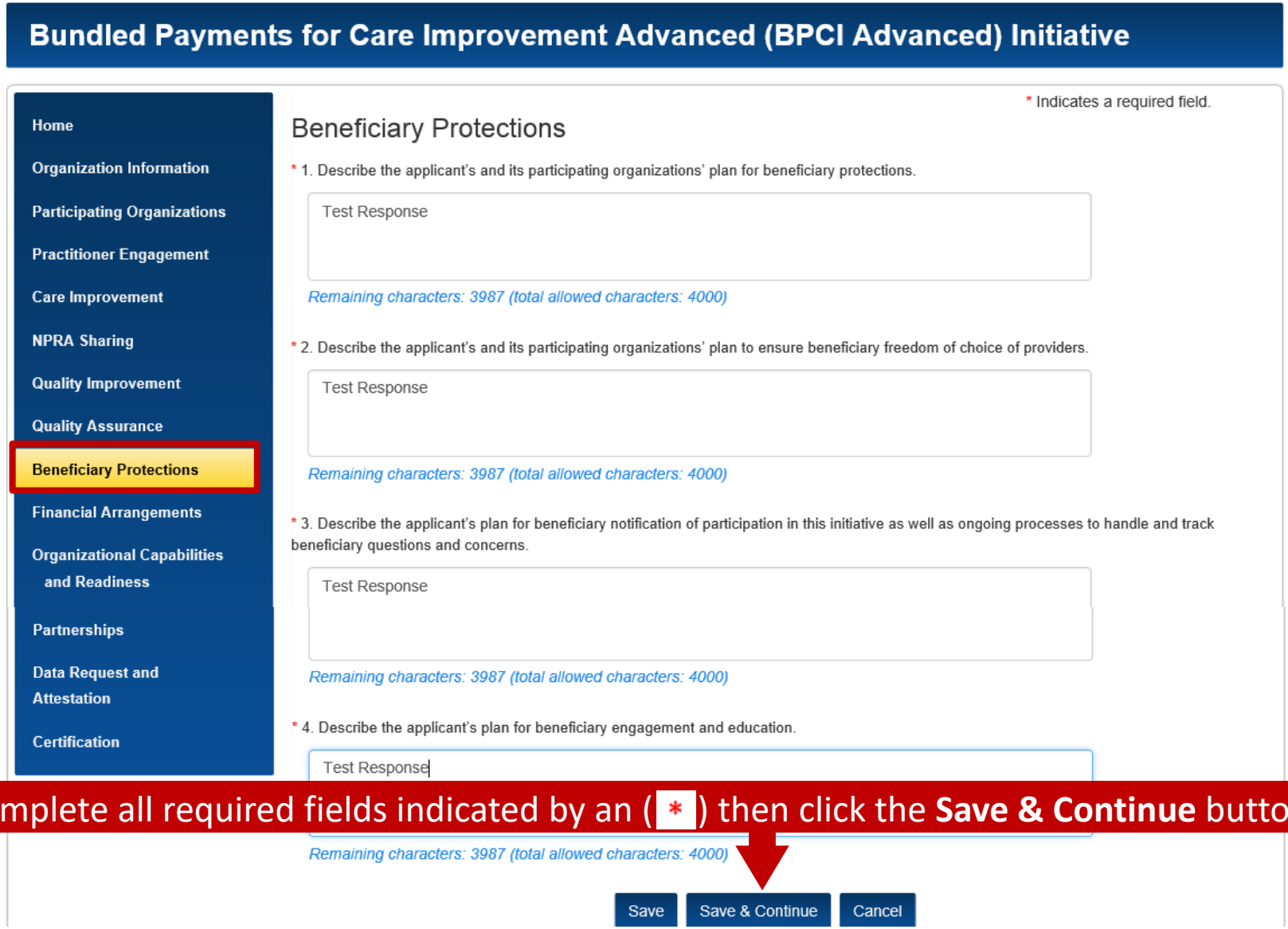
Organization or Physician/Practitioner Name	Name of Federal or State Agency or Accrediting Organization	Status	Action
Test Organization Name	Test Organization Name	In Progress	Edit Delete
Test Organization #2	Test Organization #2	Resolved	Edit Delete

Save | Save & Continue | Cancel

Sanctions, Investigations, Probations, Corrective Action Plans, or outstanding Medicare debt will display in a table

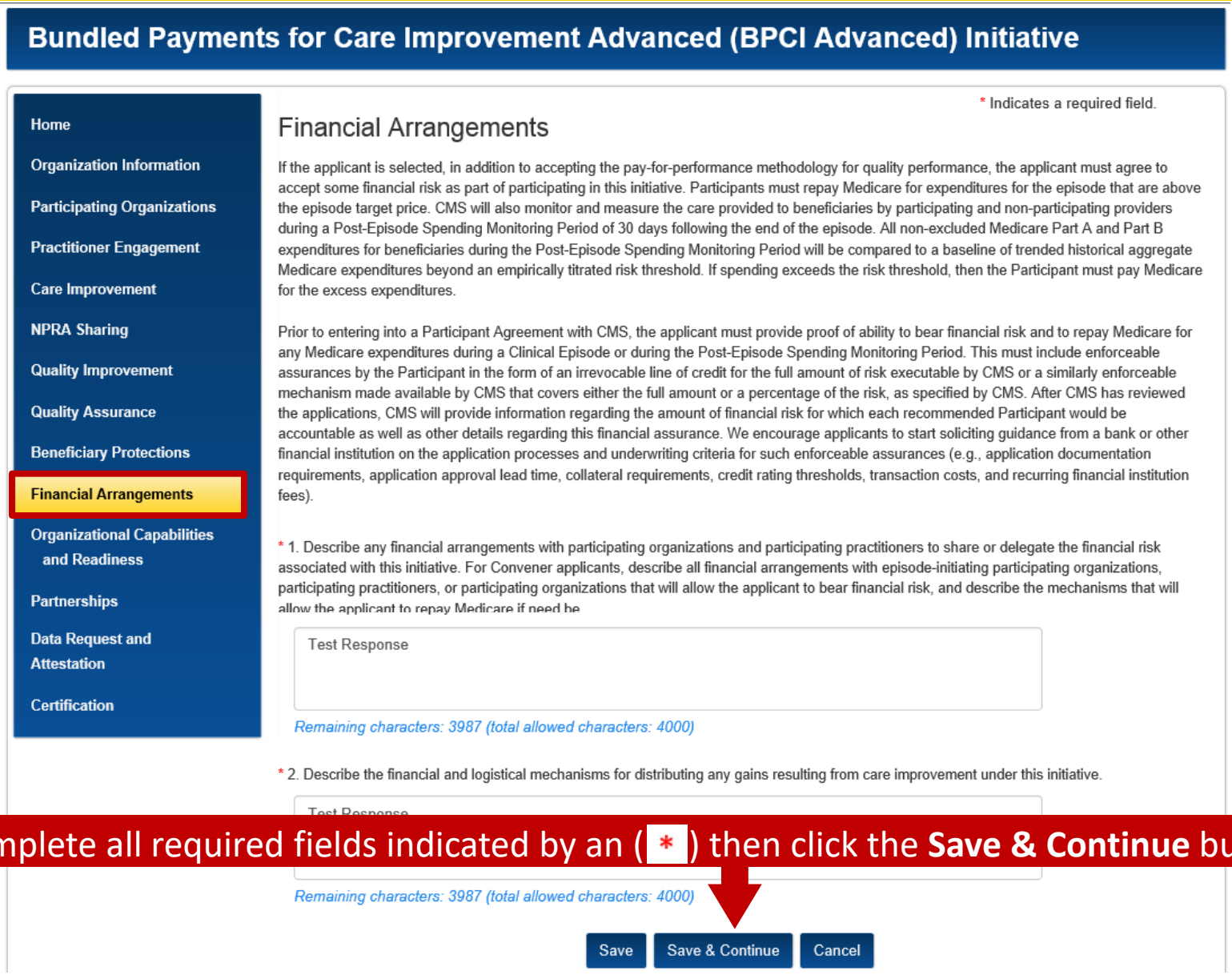
Click the **Save & Continue** button

Application: Beneficiary Protections Section



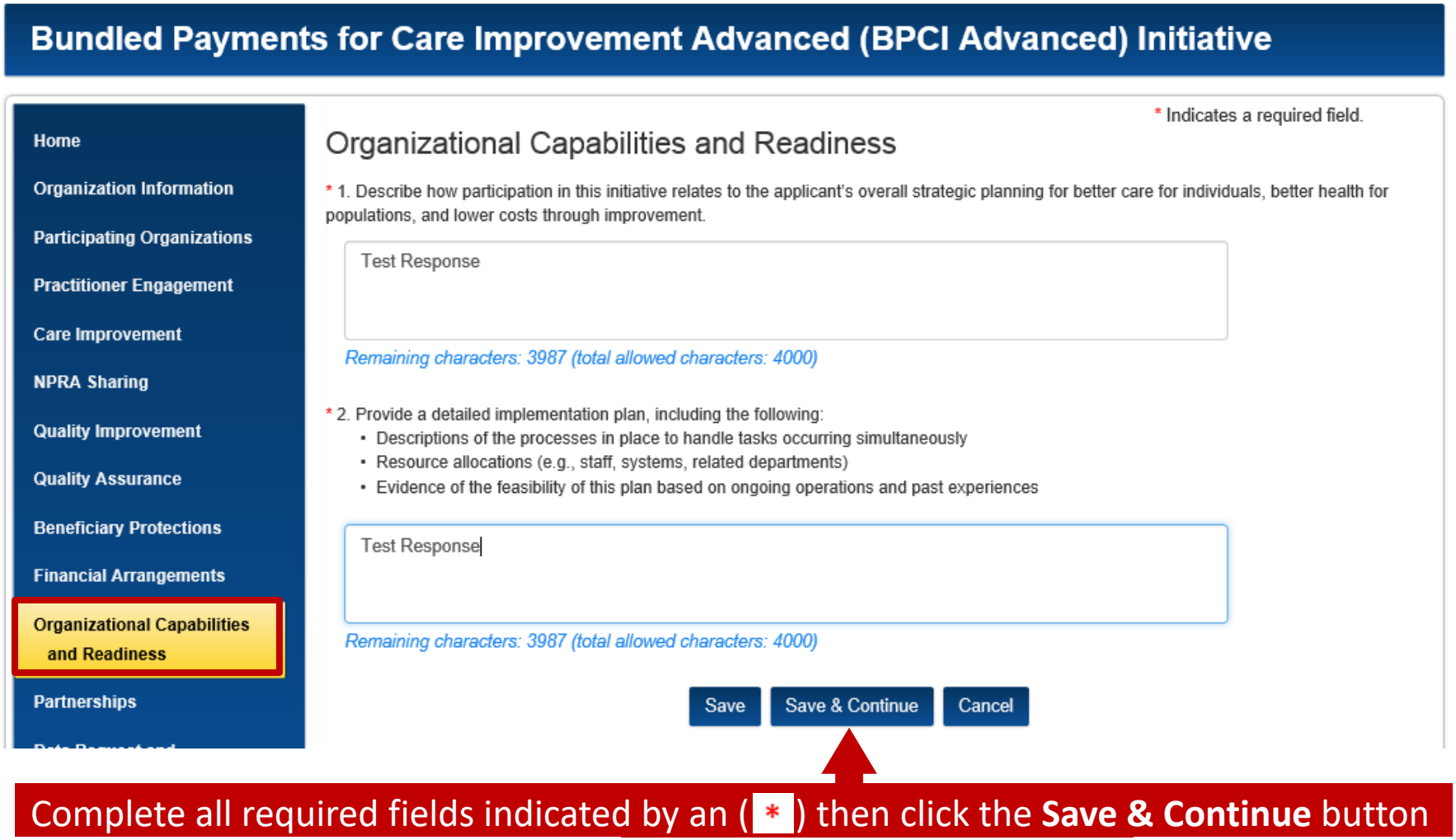
Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: Financial Arrangements Section



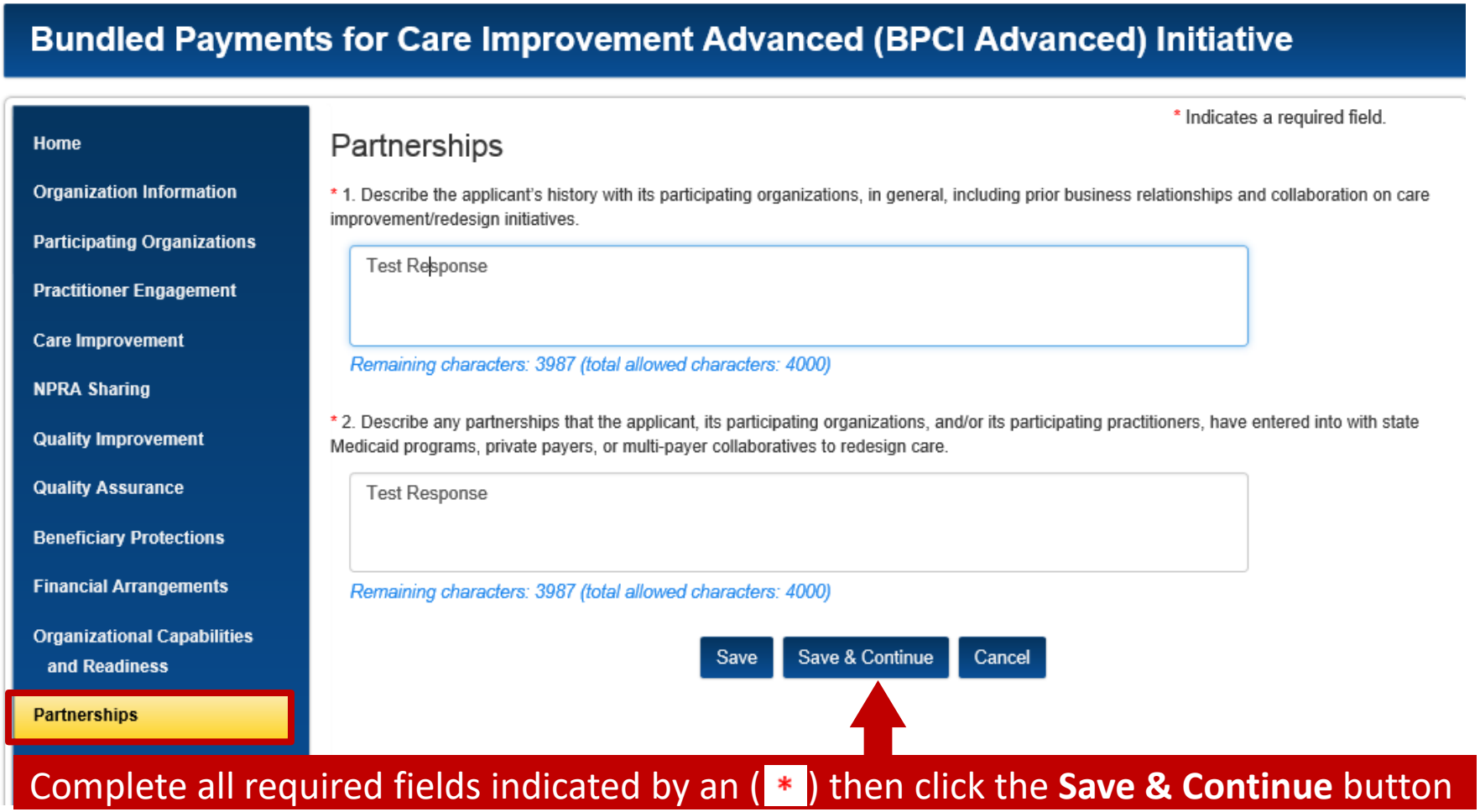
Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: Organizational Capabilities and Readiness Section



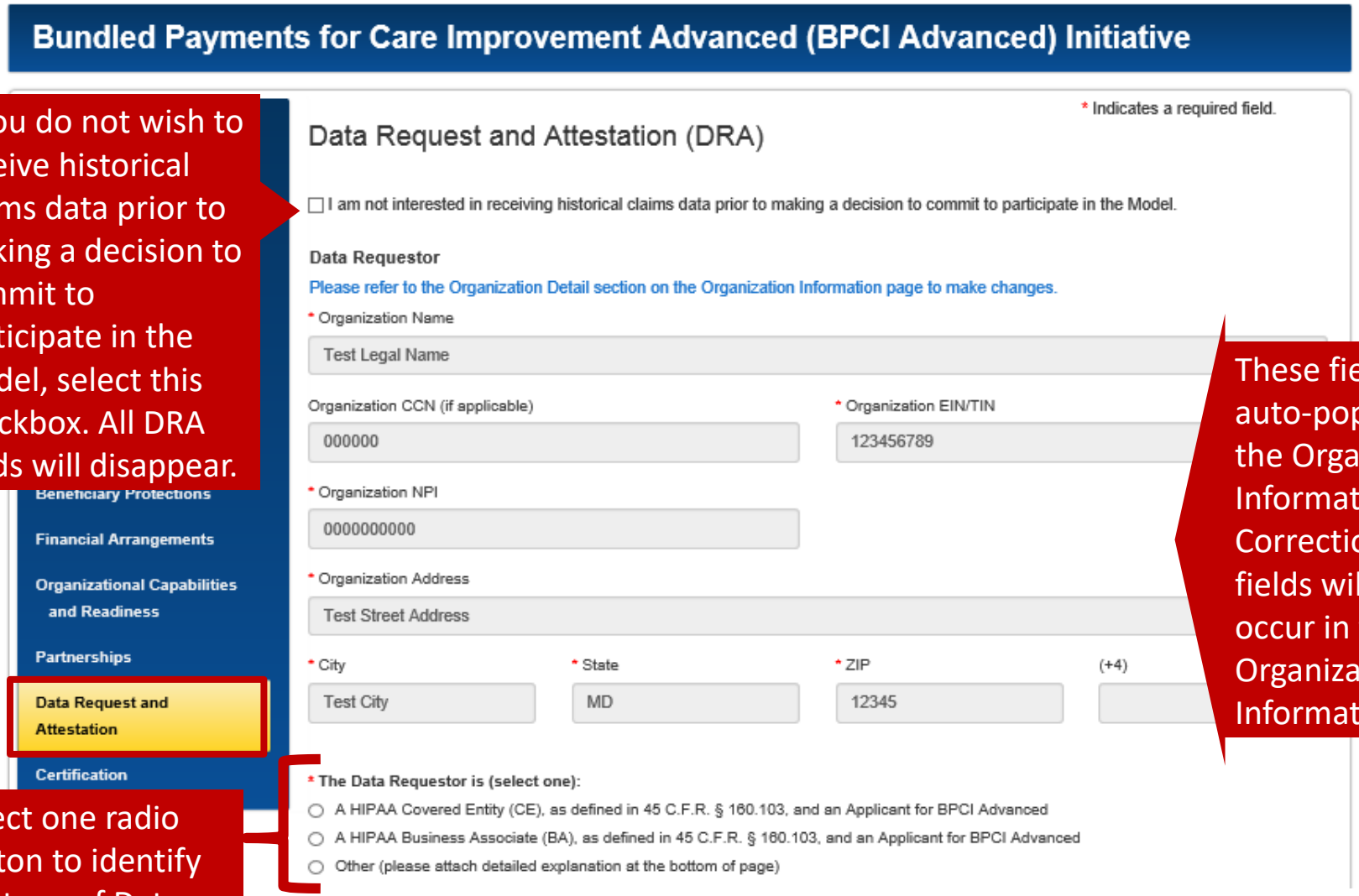
Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: Partnerships Section



Application: Data Request & Attestation Section

Application: Data Request & Attestation (DRA) Section



If you do not wish to receive historical claims data prior to making a decision to commit to participate in the Model, select this checkbox. All DRA fields will disappear.

These fields are auto-populated from the Organization Information Section. Corrections to these fields will have to occur in the Organization Information Section.

Select one radio button to identify the type of Data Requestor

Application: Data Request & Attestation (DRA) Section cont.

Complete all required fields indicated by an asterisk (*)

*** 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 at the bottom of page)

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

☑ 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.

☑ 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.

☐ Other: (Please attach detailed description, including legal justification supporting the desired disclosure at the bottom of page).

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 at the bottom of page)

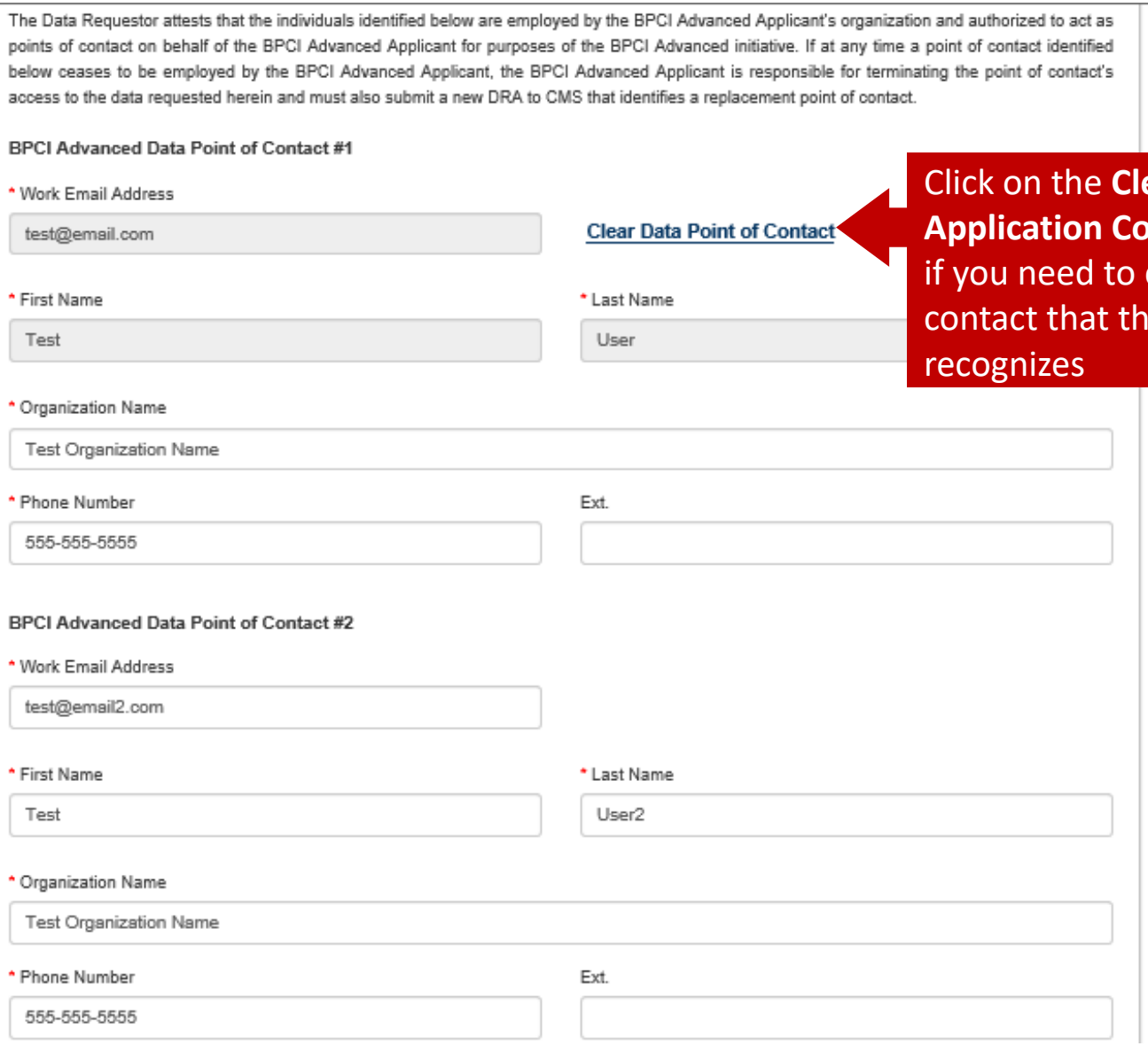
*** The data requested herein is (select one):**

- (•) The "minimum necessary" to carry out the intended purpose as described in 45 C.F.R. § 164.502(b)
- ( ) Other (please attach detailed explanation at the bottom of page)

Application: Data Request & Attestation (DRA) Section cont.

Important Note: When providing a data point of contact information, type in the email field first. If the email is recognized, First Name and Last Name will auto-populate.

Complete all required fields indicated by an asterisk (*)



Click on the **Clear Application Contact** l if you need to change contact that the syste recognizes

Application: Data Request & Attestation (DRA) Section cont.

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 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.

Supporting Documents

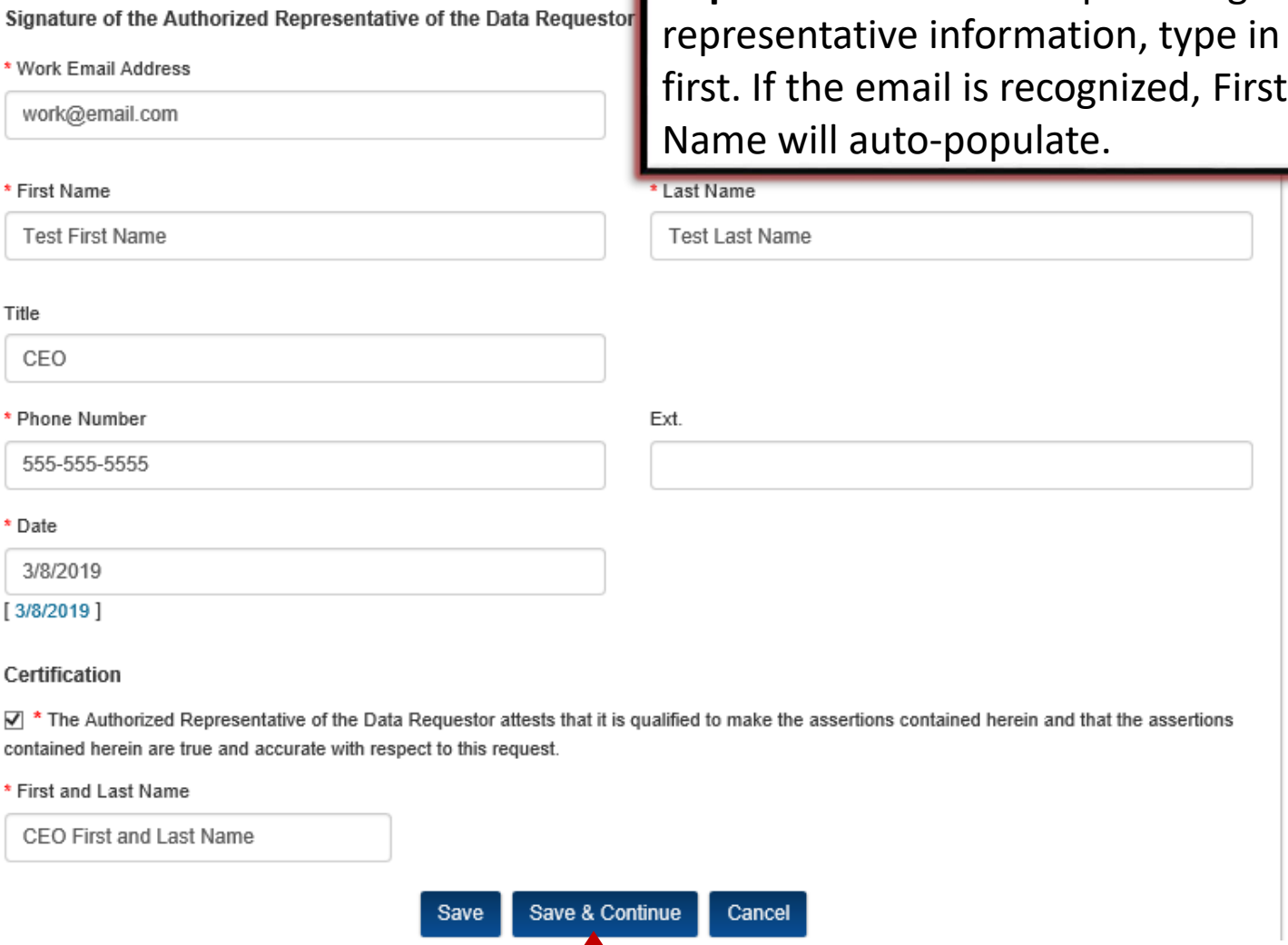
Upload Attachment

File Name	Date	Action
No uploaded documents		

If you selected "Other" to any responses in the previous slides for the DRA, you will be required to upload supporting documents by clicking on the **Upload Attachment** button.

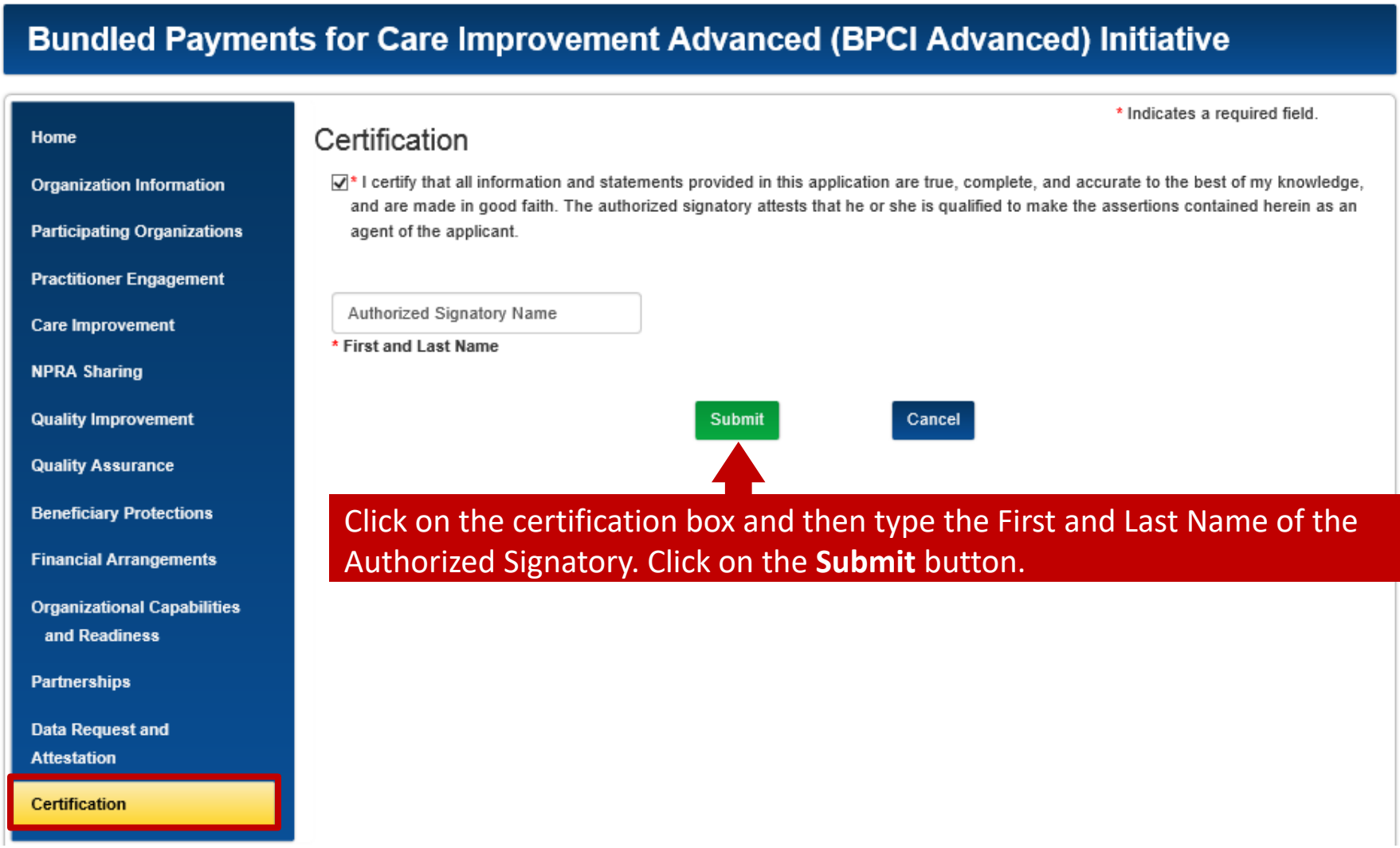
Application: Data Request & Attestation (DRA) Section cont.

Important Note: When providing an authorized representative information, type in the email field first. If the email is recognized, First Name and Last Name will auto-populate.



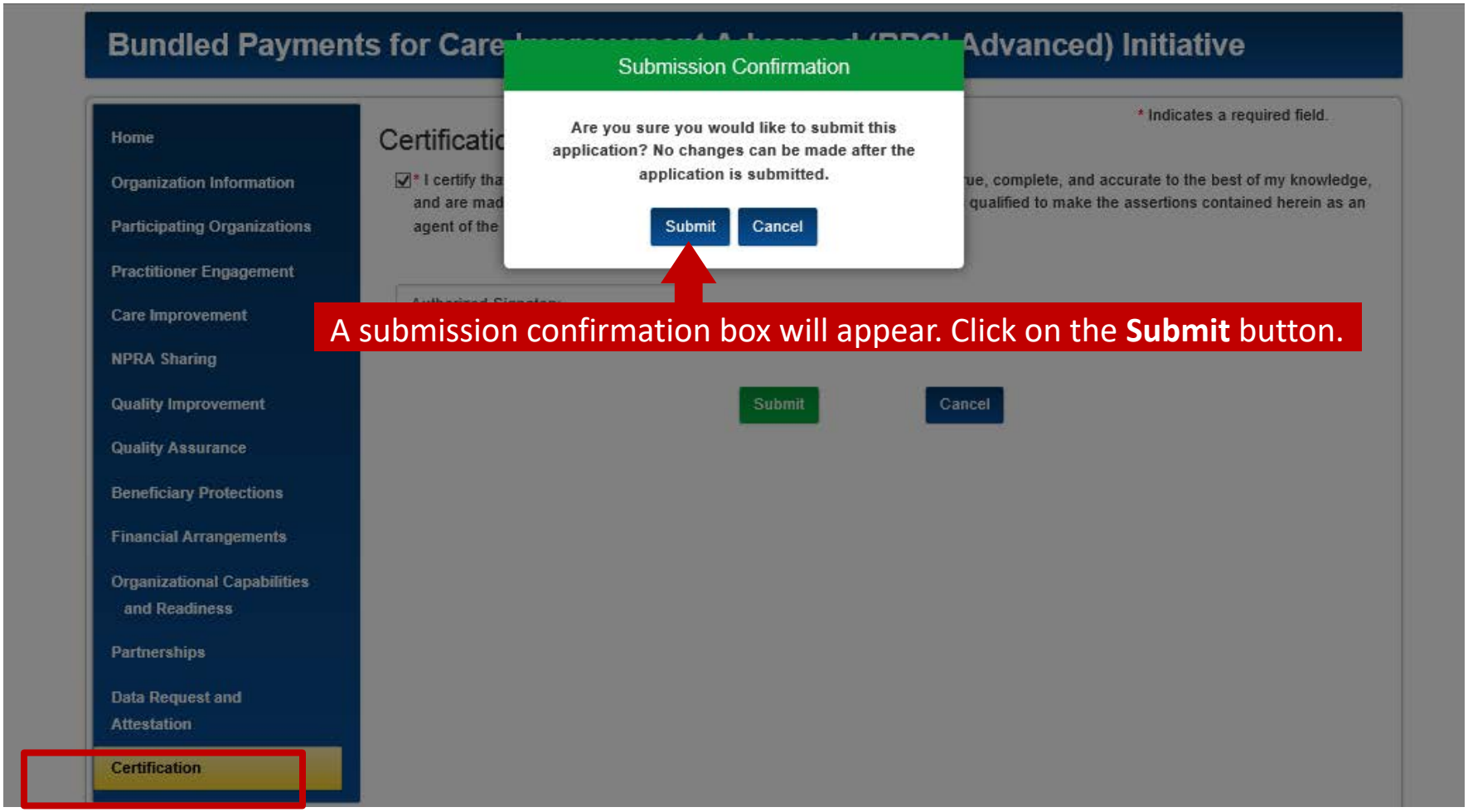
Complete all required fields indicated by an (*) then click the **Save & Continue** button

Application: Certification Section

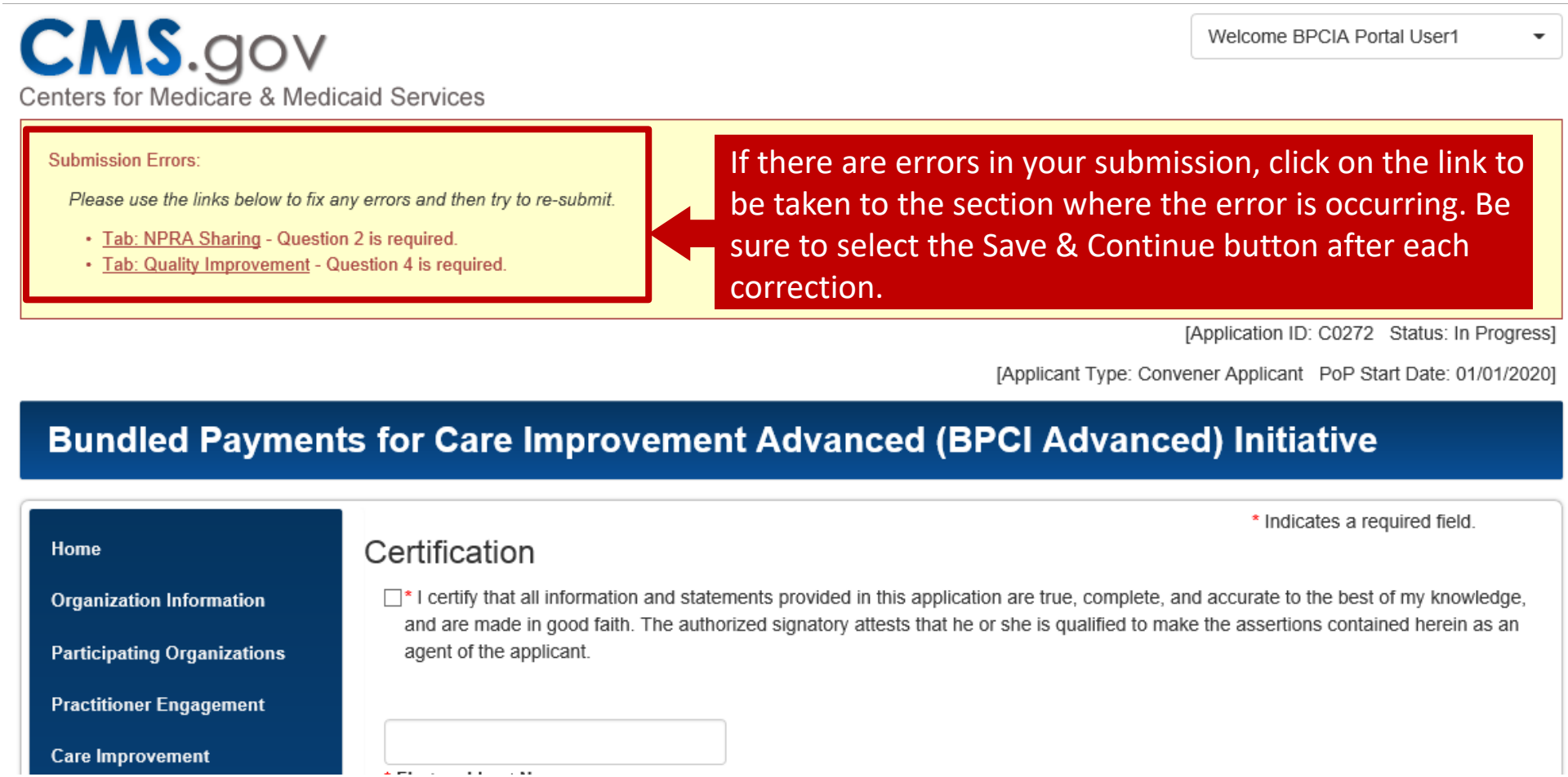


Important Note: The Authorized Signatory name must be at least 5 characters.

Application: Certification Section

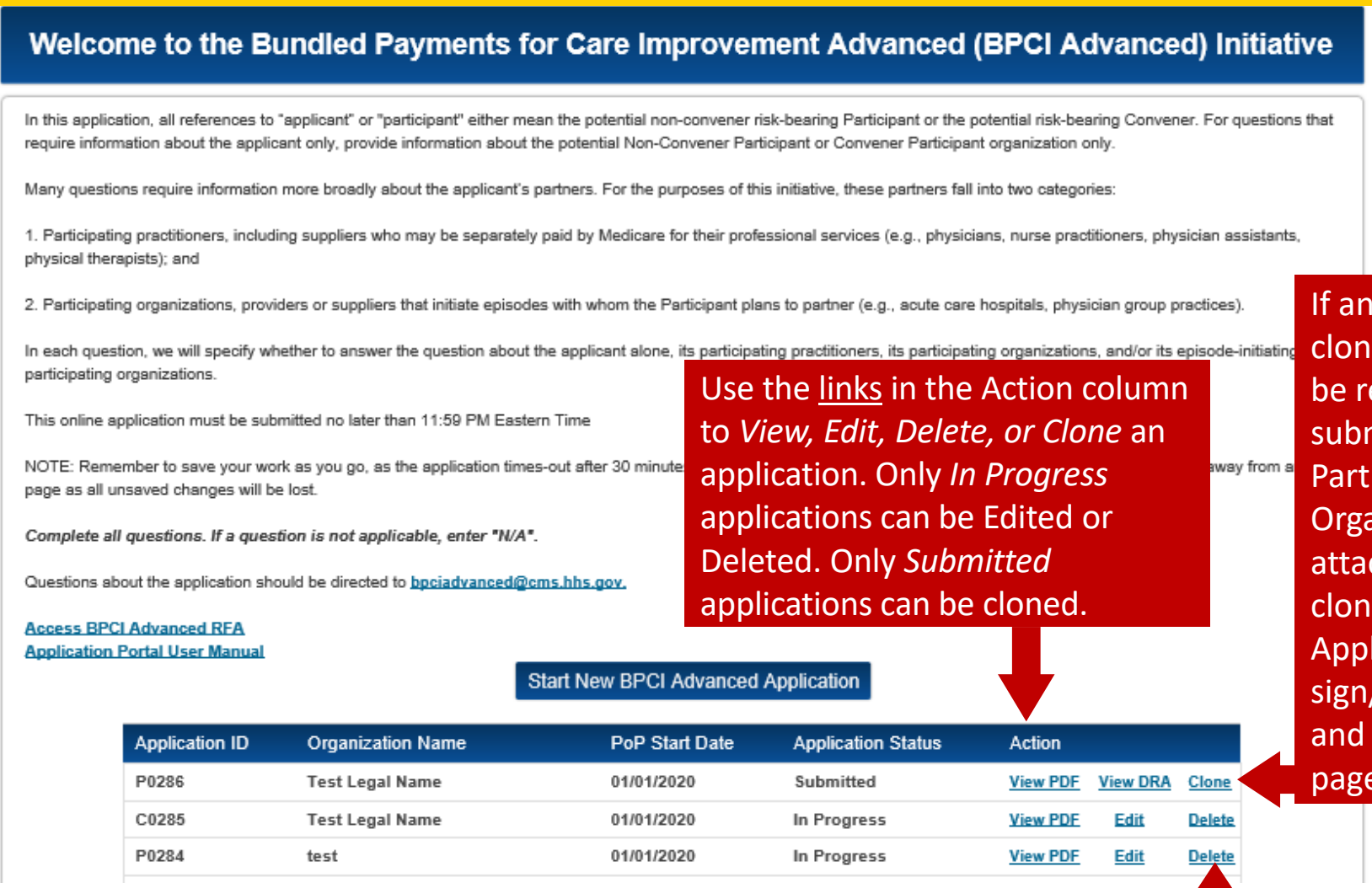


Application: Submission Errors



Important Note: After all errors are corrected, you will be required again to certify and sign the submission.

Submitted, In Progress, and Cloned Applications



Use the links in the Action column to *View, Edit, Delete, or Clone* an application. Only *In Progress* applications can be Edited or Deleted. Only *Submitted* applications can be cloned.

If an application is cloned, you will still be required to submit a Participating Organizations attachment (if cloning a Convener Application), and sign/certify the DRA and the certification page.

If you delete an application, it cannot be retrieved.

Helpful Hints

- CMS will allow Episode Initiators to appear in multiple Convener applications and/or apply as a Participant themselves. However, Episode Initiators that are listed in multiple applications must ensure that at the time of submission of the Participant Profile, by a given Convener Participant or a Non-Convener Participant, that they appear as "Active" in only ONE Participant Profile. Otherwise, that Episode Initiator will be rejected and not be eligible to participate in the Model effective January 1, 2020.

- Ensure all unique identifiers are correct before submitting your application, this includes Tax Identification Numbers, National Provider Identifiers, CMS Certification Numbers, and Legal/DBA Names for your organization and if applicable, organizations listed in the Participating Organizations attachment.

- If you are a Post-Acute Care (PAC) provider, you can only submit a Convener Application. Likewise PAC providers cannot be listed in the Participating Organizations attachment.

- The "paper" application was created as a guide for Applicants. Applications and application attachments will only be accepted when submitted via the BPCI Advanced Application Portal. We will not accept applications or application attachments submitted via mail or email.

- Applications do not need to be completed in one sitting. Remember to save your work as you go, as the application times-out after 30 minutes of inactivity. Additionally, remember to save changes before navigating away from any page as all unsaved changes will be lost.

- Submitting an application does not obligate the applicant to participate in BPCI Advanced. Likewise, submission of an application does not guarantee applicants will be selected by CMS for participation.

HelpDesk / User Manual

- If you have technical difficulties accessing the BPCI Advanced Application Portal please contact the HelpDesk at: CMMIForceSupport@cms.hhs.gov or call 1-888-734-6433, option 5.
- For step-by-step instructions, please refer to the Application Portal User Manual. You will find the link on the home page.
- If you have questions about the BPCI Advanced Model, please contact the BPCI Advanced Team at BPCIAdvanced@cms.hhs.gov