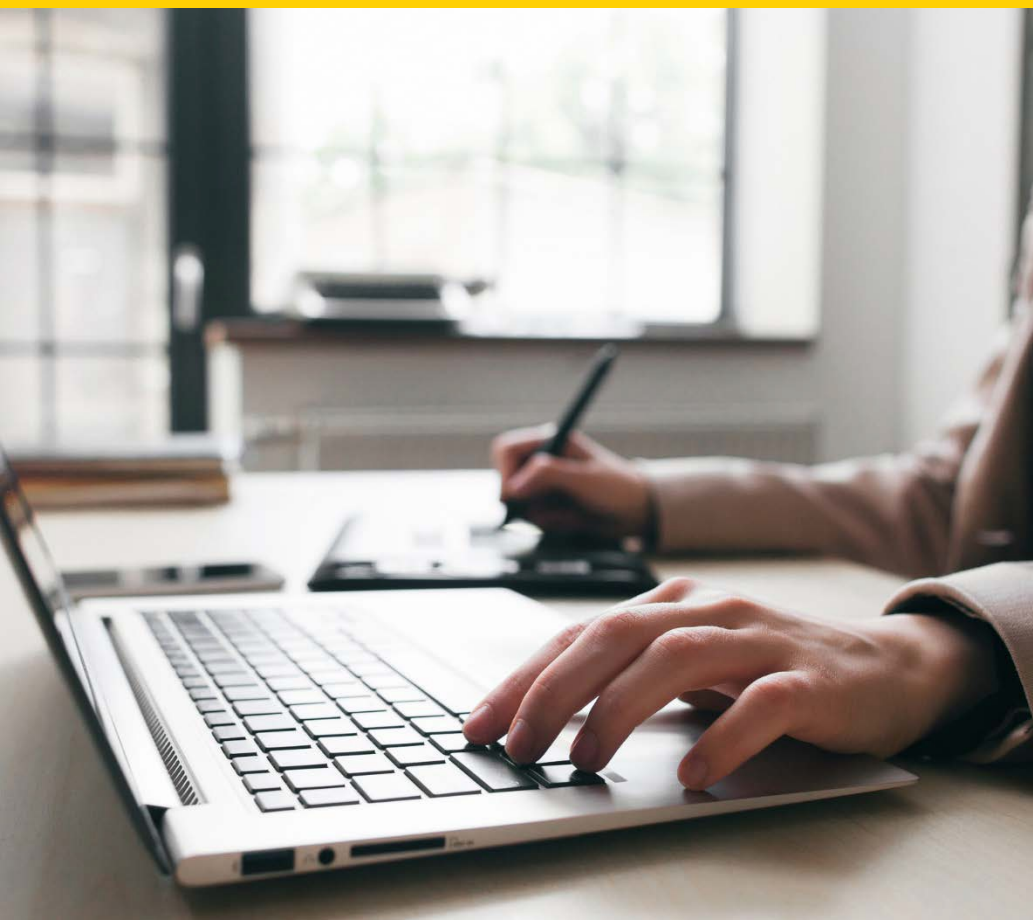


# Bundled Payments for Care Improvement Advanced (BPCI Advanced)



## *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:

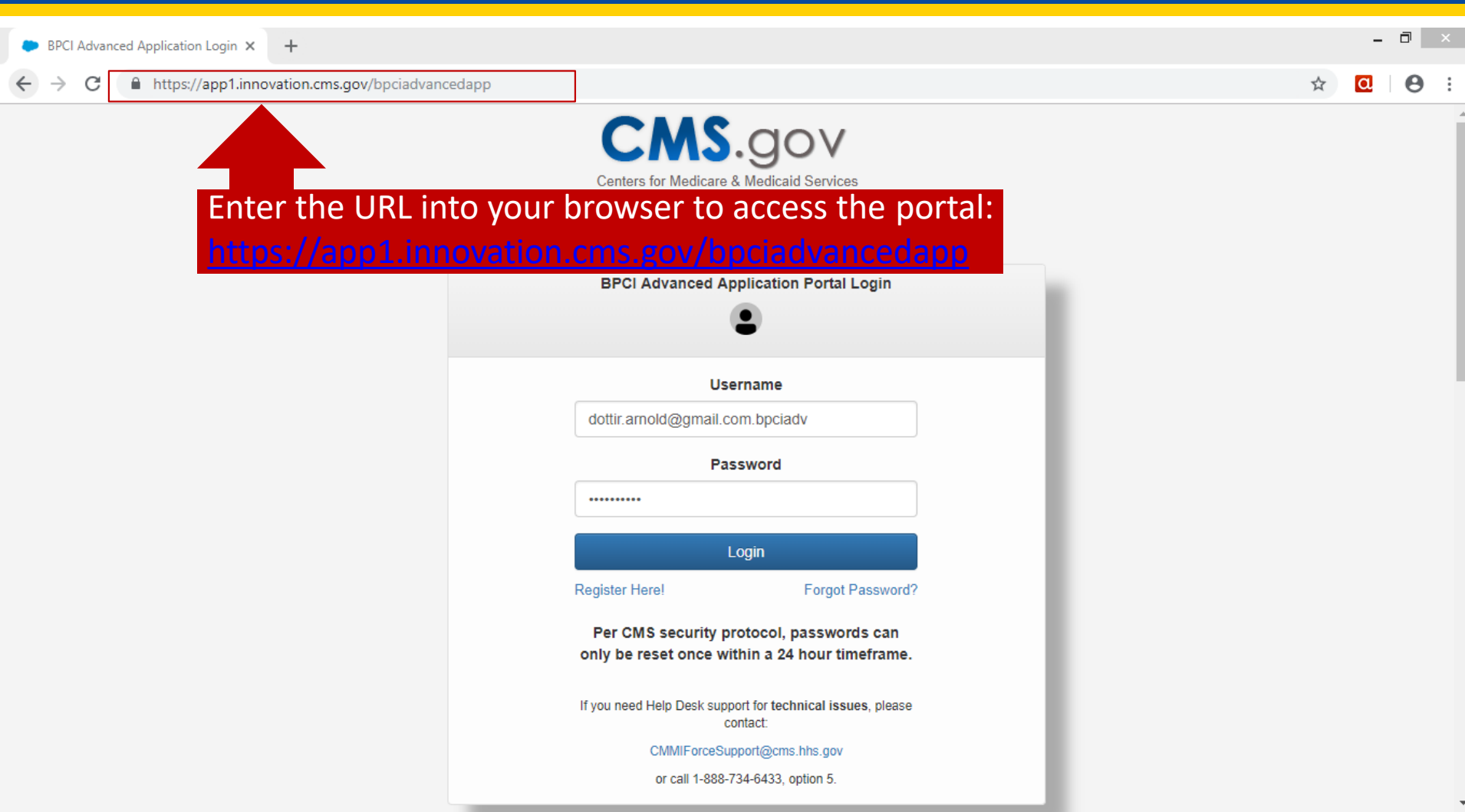
- Apply to the BPCI Advanced model
- Edit or Delete In-Progress Applications
- Clone Submitted Applications
- View and Download Submitted Applications and Data Request and Attestation (DRA) forms.



# Registering and Navigating the Portal



# Accessing the Portal



The screenshot shows a web browser window with the address bar containing the URL <https://app1.innovation.cms.gov/bpciadvancedapp>. A red arrow points from a text box to this URL. The page header displays the CMS.gov logo and the text "Centers for Medicare & Medicaid Services". The main heading is "BPCI Advanced Application Portal Login". Below this is a user icon and a form with the following fields:

- Username**:
- Password**:
- Login**:

Below the form are two links: [Register Here!](#) and [Forgot Password?](#). A security notice states: "Per CMS security protocol, passwords can only be reset once within a 24 hour timeframe." At the bottom, contact information is provided: "If you need Help Desk support for technical issues, please contact: [CMMIForceSupport@cms.hhs.gov](mailto:CMMIForceSupport@cms.hhs.gov) or call 1-888-734-6433, option 5."

# Logging into Portal: Existing Users

The screenshot shows a web browser window with the address bar displaying `https://app1.innovation.cms.gov/bpciadvancedapp`. The page header features the **CMS.gov** logo and the text "Centers for Medicare & Medicaid Services". The main content area is titled "BPCI Advanced Application Portal Login" and includes a user icon. Below the title are two input fields: "Username" with the value `dottir.arnold@gmail.com.bpciadv` and "Password" with masked characters. A blue "Login" button is positioned below the password field. To the left of the "Login" button are links for "Register Here!" and "Forgot Password?". Below these links is a security notice: "Per CMS security protocol, passwords can only be reset once within a 24 hour timeframe." At the bottom, there is a contact instruction: "If you need Help Desk support for technical issues, please contact: CMMIForceSupport@cms.hhs.gov". A red callout box on the left side of the page contains the text: "Existing Application Portal Users can enter your Username and Password, then click the *Login* button." A large red arrow points from this callout box to the "Login" button.

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

BPCI Advanced Application Login x +

← → ↻ https://app1.innovation.cms.gov/bpciadvancedapp ☆ a |

**CMS.gov**  
Centers for Medicare & Medicaid Services

**BPCI Advanced Application Portal Login**



**Username**

dottir.arnold@gmail.com.bpciadv

**Password**

.....

**Login**

[Register Here!](#) [Forgot Password?](#)

Per CMS security protocol, passwords can only be reset once within a 24 hour timeframe.

If you need Help Desk support for technical issues, please contact:

[CMMIForceSupport@cms.hhs.gov](mailto:CMMIForceSupport@cms.hhs.gov)  
or call 1-888-734-6433, option 5.

**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

BPCI Advanced Application Regis x +

← → ↻ https://app1.innovation.cms.gov/bpciadvancedapp/bpciadvRFARegistration ☆ @ |

**CMS.gov**  
Centers for Medicare & Medicaid Services

**BPCI Advanced Application Portal Registration**



*\*All fields are required*

**First Name** **Last Name**

**Email Address**

**Register**

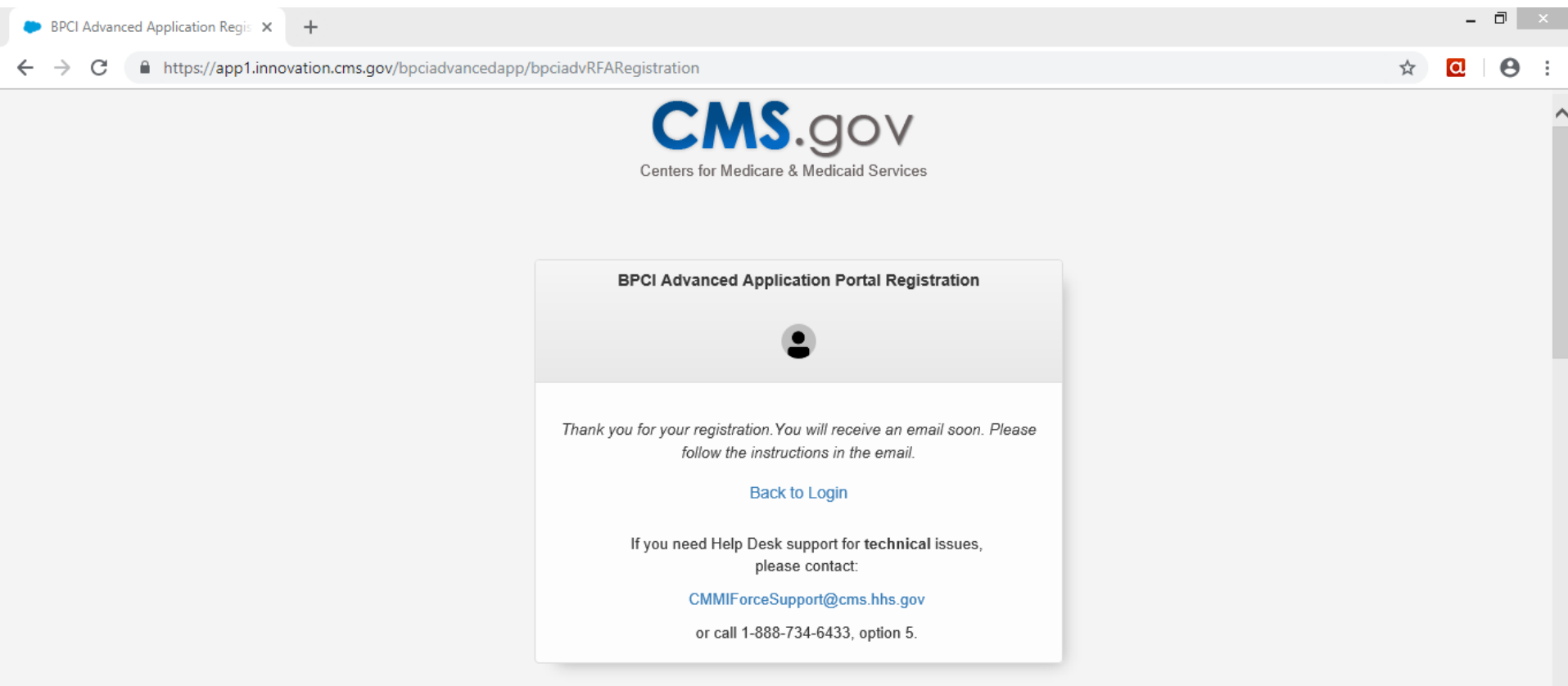
If you need Help Desk support for technical issues, please contact:  
[CMMIForceSupport@cms.hhs.gov](mailto:CMMIForceSupport@cms.hhs.gov)  
or call 1-888-734-6433, option 5.

**1** Enter your First Name, Last Name, and Email Address

**2** Click the Register button.



# 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

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](mailto:dottir.arnold@gmail.com.bpciadv)

Please use this link to access the Application

portal: <https://app1.innovation.cms.gov/bpciadvancedapp/login?c=0ehwGjx7gqHnZ442osXw8u8gF17Fp92%2FD3pgkYcxKxQt%2FAqurFVBunzFwXeOm0vcz6zDCQldYRRshv7LSK5748z19ETLDQteiz8gvjco6BMgykocH7iesrWI%2BrScZMWs4SnnMalZQfn1y2Ha52FWGUNxjvTIK8x2enkxt60Xb6Y2yq01H7uZLSMULf0I%2FCeAnq%3D>

[2FAqurFVBunzFwXeOm0vcz6zDCQldYRRshv7LSK5748z19ETLDQteiz8gvjco6BMgykocH7iesrWI%2BrScZMWs4SnnMalZQfn1y2Ha52FWGUNxjvTIK8x2enkxt60Xb6Y2yq01H7uZLSMULf0I%2FCeAnq%3D](https://app1.innovation.cms.gov/bpciadvancedapp/login?c=0ehwGjx7gqHnZ442osXw8u8gF17Fp92%2FD3pgkYcxKxQt%2FAqurFVBunzFwXeOm0vcz6zDCQldYRRshv7LSK5748z19ETLDQteiz8gvjco6BMgykocH7iesrWI%2BrScZMWs4SnnMalZQfn1y2Ha52FWGUNxjvTIK8x2enkxt60Xb6Y2yq01H7uZLSMULf0I%2FCeAnq%3D)

If you have additional questions, please contact CMMI Help Desk at [CMMIForceSupport@cms.hhs.gov](mailto:CMMIForceSupport@cms.hhs.gov).

Thank you.

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

Click on this link to set-up your password.

# Setting-up Your Password




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



New Password

Verify New Password

[Change Password](#)

Per CMS security protocol, passwords can only be reset once within a 24 hour timeframe.

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

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


# Login

Bundled Payments for Ce X

Secure | <https://app1.innovation.cms.gov/bpciadv>

**CMS.gov**  
Centers for Medicare & Medicaid Services

**BPCI Advanced Portal Login**



**Username**

**Password**

**Login**

[Register Here!](#) [Forgot Password?](#)

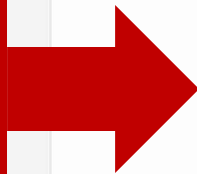
**Per CMS security protocol, passwords can only be reset once within a 24 hour timeframe.**

If you need Help Desk support, please contact:  
[CMMIForceSupport@cms.hhs.gov](mailto:CMMIForceSupport@cms.hhs.gov)  
or call 1-888-734-6433, option 5.

**The Information System:**

This warning banner provides privacy and security notices consistent with applicable federal laws, directives, and other federal guidance for accessing this Government system, which includes

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



# Application Portal



# Application Home Page



Centers for Medicare & Medicaid Services

Welcome BPCIA Portal User1

## Welcome to the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

In this application, all references to "applicant" or "participant" either mean the potential non-convenor risk-bearing Participant or the potential risk-bearing Convenor. For questions that require information about the applicant only, provide information about the potential Non-Convenor Participant or Convenor 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.

Use the links below to access the Request for Applications (RFA) or the user manual.

[Access BPCI Advanced RFA](#)  
[Application Portal User Manual](#)

To start a new BPCI Advanced Application click on the **Start New BPCI Advanced Application** button

[Start New BPCI Advanced Application](#)

Application ID	Organization Name	PoP Start Date	Application Status	Action
P0286	Test Legal Name	01/01/2020	Submitted	<a href="#">View PDF</a> <a href="#">View DRA</a> <a href="#">Clone</a>
C0285	Test Legal Name	01/01/2020	In Progress	<a href="#">View PDF</a> <a href="#">Edit</a> <a href="#">Delete</a>
P0284	test	01/01/2020	In Progress	<a href="#">View PDF</a> <a href="#">Edit</a> <a href="#">Delete</a>

# Starting a New Application

1

Using the drop down menu, select the **Applicant Type** you wish to apply as. Options for this field include Convener Applicant and Non-Convener Applicant.

Select Applicant Type and Period of Performance Start Date

Applicant Type	Period of Performance Start Date
Convener Applicant	01/01/2020

Continue Cancel

2

Using the drop down menu, select the only option for **Period of Performance Start Date** available: 01/01/2020

3

Click the **Continue** button

2. Participating organizations, providers or suppliers

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.

This online application must be submitted no later than 11:59 PM Eastern Time

NOTE: 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.

Complete all questions. If a question is not applicable, enter "N/A".

Questions about the application should be directed to [bpciadvanced@cms.hhs.gov](mailto:bpciadvanced@cms.hhs.gov).

[Access BPCI Advanced RFA Application Portal User Manual](#)

Start New BPCI Advanced Application

Application ID	Organization Name	PoP Start Date	Application Status	Action
P0286	Test Legal Name	01/01/2020	Submitted	<a href="#">View PDF</a> <a href="#">View DRA</a> <a href="#">Clone</a>
C0285	Test Legal Name	01/01/2020	In Progress	<a href="#">View PDF</a> <a href="#">Edit</a> <a href="#">Delete</a>
P0284	test	01/01/2020	In Progress	<a href="#">View PDF</a> <a href="#">Edit</a> <a href="#">Delete</a>



# Application: Organization Information Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

### Organization Information

\* Indicates a required field.

\* 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 participating in this initiative?

Yes

#### 1. Organization Details

\* Applicant Organization Legal Name

Test Legal Name

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

Test DBA

\* Street Address

Test Address

Street Address 2

\* City

Test City

\* State

MD

\* Zip Code

00000

(+4)

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

\* Organization Type

Other

\* If Other, specify below. ?

Test Other

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

Complete all required fields indicated by an asterisk ( \* )


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



# 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.

\* TIN  CMS Certification Number (CCN) must be 6 digits in length. If your organization does not have a CCN, please enter 000000.

CCN  

\* Entity Type

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

\* Email Address  [Clear Application Contact](#)


\* First Name  \* Last Name

Title/Position

\* Business Phone Number  Business Phone Ext.  Alternate Phone Number

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

Remaining characters: 3978 (total allowed characters: 4000)

Hover over the help bubbles (  ) for guidance on how to respond to a field

Click on the **Clear Application Contact** link if you need to change a contact that the system recognizes

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

# Application: Participating Organizations Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

**Participating Organizations**

Practitioner Engagement

Care Improvement

Sharing

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities and Readiness

Partnerships

Participating Organizations

\* Indicates a required field.

\* Please provide information on all participating organizations. Please ensure to populate all fields, indicating "N/A" for fields that are not applicable. Select the Download Instructions below to print a description of the fields in the Participating Organizations worksheet.

Download Instructions

Download Template

Upload Attachment

1 Click the **Download Instructions** button to review the rules and format for each field in the template

2 Click the **Download Template** button

Line #	Organization Legal Name	Doing Business As (DBA) Name	Street Address	Address Line 2	City	State	ZIP	(+4)	Organization Type	Organization Tax Identification Number/Employer Identification Number (TIN/EIN)	Organization National Provider Identifier (NPI)
Please upload a valid .CSV file.											

Continue Cancel

**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

W97

	A	B	C	D	E	F	G	H	I	J	
	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 Physician Group	ABC Physician Group North	1 West St	N/A	Seattle	WA	22222	1111	Physician Group Practice	12345678	
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23											

Participating%20Organizations%2

**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.

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

### Participating Organizations

\* Indicates a required field.

\* Please provide information on all participating organizations. Upload a completed document in the Application Portal. Please be sure to download the Download Instructions below to print a description of all the fields in the Participating Organizations worksheet.

Click the **Upload Attachment** button to upload the completed template

Download Instructions

Download Template

Upload Attachment

Line #	Organization Legal Name	Organization Doing Business As (DBA) Name	Street Address	Address Line 2	City	State	ZIP	(+4)	Organization Type	Organization Tax Identification Number/Employer Identification Number (TIN/EIN)	Organization National Provider Identifier (NPI)
Please upload a valid .CSV file.											

Continue

Cancel

# Application: Participating Organizations Section cont.

## Bundled Payment

### File Attachment

1

Click the **Browse** button to find the completed template on your computer

Select a File

 Browse...

Note: There is 10000 rows limit on your csv file upload.

Upload

Close

2

Click the **Upload** button

Line #	Organization Legal Name	Organization Doing Business As (DBA) Name	Street Address	Address Line 2	City	State	ZIP	(+4)	Organization Type	Organization Tax Identification Number/Employer Identification Number (TIN/EIN)	Organization National Provider Identifier (NPI)
Please upload a valid .CSV file.											

Continue

Cancel

# Application: Participating Organizations Section cont.

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and

### Participating Organizations

\* Indicates a required field.

\* Please provide information on all participating organizations, which would participate in the BPCI Advanced program, on the completed document in the Application Portal. Please be sure to populate all fields, including the Organization Doing Business As (DBA) field. Download Instructions below to print a description of all the fields in the Participating Organizations worksheet.

Click the **Validate & Save** button

Download Instructions

Download Template

Upload Attachment

Validate & Save

Line #	Organization Legal Name	Organization Doing Business As (DBA) Name	Street Address	Address Line 2	City	State
2	Hospital ABC	Hospital ABC South	1 Main St	N/A	New York	NY
3	ABC Physician Group	ABC Physician Group H	1 West St	N/A	Seattle	WA

Validate & Save

Continue

Cancel

**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.

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

### Participating Organizations

\* Indicates a required field.

\* Please provide information on all participating organizations, which would participate as Episode Initiators under the model, and then upload the completed document in the Application Portal. Please be sure to populate all fields, indicating "N/A" for fields that are not applicable. Select the Download Instructions below to print a

Download Instructions

If there are errors in your upload,  
click the **Download Errors** button

Download Errors

Validate & Save

Error: Required fields have not been successfully completed. Please select "Download Errors" button to view specific errors and locations.

	ZIP	(+4)	Organization Type	Organization Tax Identification Number/Employer Identification Number (TIN/EIN)	Organization National Provider Identifier (NPI)	C N
	11111		Acute Care Hospital	123456780	1234567890	1
	22222	1111	Physician Group Practi	12345678	123456789	3

Validate & Save

Continue

Cancel

**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

ValidationErrors.pdf - Adobe Acrobat Pro DC

File Edit View Window Help

Home Tools Document

1 / 1 90%

BPCI Advanced Application Errors PDF 9:46:01 AM

Name of Column	Error Row Numbers
Organization Legal Name	
Organization Doing Business As (DBA) Name	
Street Address	
Address Line 2	
City	
State	
ZIP	
(+4)	
Organization Type	
Organization Tax Identification Number/Employer Identification Number (TIN/EIN)	Row 3 - TIN must be 9 numeric characters.
Organization National Provider Identifier (NPI)	Row 3 - NPI must be 10 numeric characters.
CMS Certification Number (CCN)	
Entity Type	
Entity Type if 'Other'	
Contact First Name	
Contact Last Name	

The Validation Errors document will provide the row and column where the error is occurring, along with an error description



# Application: Participating Organizations Section cont.

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home  
Organization Information  
**Participating Organizations**  
Practitioner Engagement  
Care Improvement  
NPRA Sharing  
Quality Improvement  
Quality Assurance  
Beneficiary Protection  
Financial Arrangements  
Organizational Capabilities and Readiness  
Partnerships  
Data Request and Attestation

\* Indicates a required field.

You would participate as Episode Initiators under the model, and then upload the spreadsheet. You must complete all fields, indicating "N/A" for fields that are not applicable. Select the "Upload" button to upload the Participating Organizations worksheet.

**To correct the errors:**  
You can fix in your attachment and re-upload  
**OR**  
If there less than 1000 rows, you can manually fix in the upload table below

Upload Attachment Validate & Save  
Download Errors  
Please select "Download Errors" button to view specific errors and

ZIP	(+4)	Organization Name	Organization Tax Identification Number/Employer Identification Number (TIN/EIN)	Organization National Provider Identifier (NPI)	C
11111		Acute Care Hospital	123456780	1234567890	1
22222	1111	Physician Group Practi	12345678	123456789	3

Validate & Save Continue Cancel

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

# Application: Participating Organizations Section cont.

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

\* Indicates a required field.

### Participating Organizations

\* Please provide information on all participating organizations, which would participate as Episode Initiators under the model, and then upload the completed document in the Application Portal. Please be sure to populate all fields, indicating "N/A" for fields that are not applicable. Select the Download Instructions below to print a description of all the fields in the Participating Organizations worksheet.

Download Instructions

Download Template

Upload Attachment

Show 10 entries

Search:

Organization Legal Name	Organization Type	TIN	CCN
Hospital ABC	Acute Care Hospital	123456780	123456
ABC Physican Group	Physician Group Practice	012345678	

Showing 1 to 2 of 2 entries

First Previous 1 Next Last

Continue

Cancel

After all errors have been corrected, and the Validate & Save button was re-run, click on the **Continue** button.

# Application: Practitioner Engagement Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and

Attestation

### Practitioner Engagement

\* Indicates a required field.

\* 1. Describe the applicant's plan to disclose participation in this initiative to practitioners practicing at the applicant organization or its participating organizations, as applicable.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

Save

Save & Continue

Cancel

All free text fields must be 4,000 characters or less. This includes spaces.

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

# Application: Care Improvement Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities and Readiness

Partnerships

Data Request and Attestation

Certification

Care Improvement

\* Indicates a required field.

\* 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.

Test response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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.

Test response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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.

Remaining characters: 3987 (total allowed characters: 4000)

Save

Save & Continue

Cancel

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

# Application: NPRA Sharing Section

\* Indicates a required field.

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

**NPRA Sharing**

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

Certification

## Net Payment Reconciliation Amount (NPRA) Sharing

\* 1. Does the applicant plan to share Net Payment Reconciliation Amount (NPRA) with participating organizations and/or practitioners?

No

\* 2. Describe the applicant's and its participating organizations' initiatives, including Medicare, Medicaid, or commercial insurance.

Remaining characters: 4000 (total allowed characters: 4000)

\* 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.

N/A

Remaining characters: 4000 (total allowed characters: 4000)

\* 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.

N/A

Remaining characters: 4000 (total allowed characters: 4000)

\* 5. Describe the eligibility requirements, such as quality thresholds and quality improvement requirements, for participating practitioners and participating organizations to participate in NPRA Sharing. Include a discussion of how a participating practitioner or participating organization may become eligible or ineligible to participate in NPRA Sharing.

Remaining characters: 4000 (total allowed characters: 4000)

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

Save

Save & Continue

Cancel

# Application: Quality Improvement Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities

### Quality Improvement

\* Indicates a required field.

*Describe a single universal approach for the applicant and its participating organizations in the questions that follow.*

- \* 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.

Test Response

*Remaining characters: 3987 (total allowed characters: 4000)*

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

Test Response

*Remaining characters: 3987 (total allowed characters: 4000)*

- \* 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.

Test Response

*Remaining characters: 3987 (total allowed characters: 4000)*

- \* 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.

Complete all  
required fields  
indicated by  
an asterisk

( \* )

# 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

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

*Remaining characters: 3987 (total allowed characters: 4000)*

Save

Save & Continue

Cancel

# Application: Quality Assurance Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

\* Indicates a required field.

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Complete all  
required fields  
indicated by  
an asterisk

( \* )

Certification

### 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

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

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

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)



# Application: Quality Assurance Section cont.

\* 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.

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.

Also use this table to report the Medicare debt.

☐ Not Applicable

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

Add New

Organization or Physician/Practitioner Name	Name of Federal or State Agency or Accrediting Organization	Status
No sanctions to display		

Save

Save & Continue

Cancel

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.

Complete all required fields indicated by an asterisk ( \* )

# Application: Quality Assurance Section cont.

\* 4. Describe a detailed plan for implementing the applicant's and its participating organizations' quality assurance procedures and how these

## Sanction and Investigation Reporting

\* Organization or Physician/Practitioner Name

Test Organization Name

\* Nature of Sanction, Investigation, Corrective Action Plan, and/or Outstanding Debt ?

Test Response

Remaining characters: 987 (total allowed characters: 1000)

\* Name of Federal or State Agency or Accrediting Organization ?

Test Organization Name x

\* Description ?

Test Response

Remaining characters: 987 (total allowed characters: 1000)

\* Status

In Progress

Click the **Save & New** button to continue entering new sanctions, investigations, etc.

Click the **Save** button when done entering all sanctions, investigations, etc.

Save Save & New Close

Save Save & Continue Cancel

Complete all required fields indicated by an asterisk ( \* )

# 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.

Sanctions, Investigations, Probations, Corrective Action Plans, or outstanding Medicare debt will display in a 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	<a href="#">Edit</a> <a href="#">Delete</a>
Test Organization #2	Test Organization #2	Resolved	<a href="#">Edit</a> <a href="#">Delete</a>

Save

Save & Continue

Cancel

Click the **Save & Continue** button

# Application: Beneficiary Protections Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

**Beneficiary Protections**

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

Certification

### Beneficiary Protections

\* Indicates a required field.

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

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

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

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

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

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: Financial Arrangements Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

**Financial Arrangements**

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

Certification

### Financial Arrangements

\* Indicates a required field.

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

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

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

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: Organizational Capabilities and Readiness Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

**Organizational Capabilities  
and Readiness**

Partnerships

Data Requested

\* Indicates a required field.

### 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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

Test Response|

Remaining characters: 3987 (total allowed characters: 4000)

Save

Save & Continue

Cancel

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

# Application: Partnerships Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

### Partnerships

\* Indicates a required field.

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

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

\* 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.

Test Response

Remaining characters: 3987 (total allowed characters: 4000)

Save

Save & Continue

Cancel



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

# Application: Data Request & Attestation Section

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

Welcome BPCIA Portal User1

Status: In Progress]

Start Date: 01/01/2020]

**Bundle**

Home

Organization

Participating

Practitioner

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Privacy

Financial Arrangements

Organizational and Readiness

Partnerships

**Data Request and Attestation**

Certification

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.resdec.org/cms-datafile-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 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. CMS 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.

**Close**

Read the Data Request & Attestation and then click on the **Close** button



# Application: Data Request & Attestation (DRA) Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

### Data Request and Attestation (DRA)

\* Indicates a required field.

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

#### Data Requestor

Please refer to the Organization Detail section on the Organization Information page to make changes.

\* Organization Name

Test Legal Name

Organization CCN (if applicable)

000000

\* Organization EIN/TIN

123456789

\* Organization NPI

0000000000

\* Organization Address

Test Street Address

\* City

Test City

\* State

MD

\* ZIP

12345

(+4)

\* 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 at the bottom of page)

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.

Beneficiary Protections

Financial Arrangements

Organizational Capabilities  
and Readiness

Partnerships

Data Request and  
Attestation

Certification

Select one radio button to identify the type of Data Requestor

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

# 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 ( \* )

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**

\* Work Email Address

test@email.com

\* First Name

Test

\* Last Name

User

\* Organization Name

Test Organization Name

\* Phone Number

555-555-5555

Ext.

[Clear Data Point of Contact](#)

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

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

\* Work Email Address

test@email2.com

\* First Name

Test

\* Last Name

User2

\* Organization Name

Test Organization Name

\* Phone Number

555-555-5555

Ext.

# 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](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.

**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.

Signature of the Authorized Representative of the Data Requestor

\* Work Email Address

work@email.com

\* First Name

Test First Name

**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.

\* Last Name

Test Last Name

Title

CEO

\* Phone Number

555-555-5555

Ext.

\* Date

3/8/2019

[ 3/8/2019 ]

**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

CEO First and Last Name

Save

Save & Continue

Cancel

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

# Application: Certification Section

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

NPRA Sharing

Quality Improvement

Quality Assurance

Beneficiary Protections

Financial Arrangements

Organizational Capabilities and Readiness

Partnerships

Data Request and Attestation

Certification

Certification

\* Indicates a required field.

☒ \* 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 Signatory Name

\* First and Last Name

Submit

Cancel

Click on the certification box and then type the First and Last Name of the Authorized Signatory. Click on the **Submit** button.

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

# Application: Certification Section

**Bundled Payments for Care Improvement (BPCI) Advanced Initiative**

**Submission Confirmation**

Are you sure you would like to submit this application? No changes can be made after the application is submitted.

**\* Indicates a required field.**

☒ I certify that the information provided is true, complete, and accurate to the best of my knowledge, and I am authorized to make the assertions contained herein as an agent of the [Organization Name].

**Navigation Menu:**

- Home
- Organization Information
- Participating Organizations
- Practitioner Engagement
- Care Improvement
- NPRA Sharing
- Quality Improvement
- Quality Assurance
- Beneficiary Protections
- Financial Arrangements
- Organizational Capabilities and Readiness
- Partnerships
- Data Request and Attestation
- Certification**

A submission confirmation box will appear. Click on the **Submit** button.

# Application: Submission Errors



Centers for Medicare & Medicaid Services

Welcome BPCIA Portal User1

## Submission Errors:

Please use the links below to fix any errors and then try to re-submit.

- [Tab: NPRA Sharing](#) - Question 2 is required.
- [Tab: Quality Improvement](#) - Question 4 is required.

If there are errors in your submission, click on the link to be taken to the section where the error is occurring. Be sure to select the Save & Continue button after each correction.

[Application ID: C0272 Status: In Progress]

[Applicant Type: Convener Applicant PoP Start Date: 01/01/2020]

## Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

Home

Organization Information

Participating Organizations

Practitioner Engagement

Care Improvement

### Certification

\* Indicates a required field.

- ☐ \* 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.

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



# Submitted, In Progress, and Cloned Applications

## Welcome to the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Initiative

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.

This online application must be submitted no later than 11:59 PM Eastern Time

NOTE: Remember to save your work as you go, as the application times-out after 30 minutes away from a page as all unsaved changes will be lost.

Complete all questions. If a question is not applicable, enter "N/A".

Questions about the application should be directed to [bpciadvanced@cms.hhs.gov](mailto:bpciadvanced@cms.hhs.gov).

[Access BPCI Advanced RFA](#)  
[Application Portal User Manual](#)

Start New BPCI Advanced Application

Application ID	Organization Name	PoP Start Date	Application Status	Action
P0286	Test Legal Name	01/01/2020	Submitted	<a href="#">View PDF</a> <a href="#">View DRA</a> <a href="#">Clone</a>
C0285	Test Legal Name	01/01/2020	In Progress	<a href="#">View PDF</a> <a href="#">Edit</a> <a href="#">Delete</a>
P0284	test	01/01/2020	In Progress	<a href="#">View PDF</a> <a href="#">Edit</a> <a href="#">Delete</a>

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](mailto: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](mailto:BPCIAdvanced@cms.hhs.gov)

