



Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

Patient Care Models Group

Bundled Payments for Care Improvement Advanced

Request for Applications (RFA)

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Bundled Payments for Care Improvement Advanced Initiative
Request for Application

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I. Background

A. Framework for BPCI Advanced Initiative

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

Section 1115A of the Social Security Act (the Act) authorizes the CMS Center for Medicare and Medicaid Innovation (Innovation Center) to test innovative payment and service delivery models to reduce Medicare, Medicaid, and CHIP expenditures while preserving or enhancing the quality of care furnished to beneficiaries. Through the voluntary initiative, Bundled Payments for Care Improvement Advanced (BPCI Advanced or the “Model”), described in this Request for Applications (RFA), the Innovation Center will test an alternative payment model to incentivize financial accountability, care redesign, data analysis and feedback, provider engagement, and patient engagement through the use of bundled payments, care redesign activities, and accountability for performance on quality measures. This alternative payment model will include a single payment and risk track.

Previous demonstrations and initiatives have shown the promise of bundled payments. For example, in the Medicare Participating Heart Bypass Center demonstration, under which Medicare paid participants a single global rate for specified hospital discharges, Medicare achieved savings without any decrease in the quality of care provided to beneficiaries. The hospitals participating in the demonstration achieved cost efficiencies through streamlined processes leading to fewer re-operations, lower readmissions, and shorter average lengths of stay.¹

In 2013, the Innovation Center began testing the Bundled Payments for Care Improvement (BPCI) initiative. The BPCI initiative was created as a way to link payments across all healthcare providers delivering care during an episode of care. BPCI focuses on generating savings and improving quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge Emergency Department (ED) visits and readmissions. Evaluation results from the BPCI initiative are also informative as to the potential for bundled payments to reduce Medicare expenditures.²

CMS has also begun testing the Comprehensive Care for Joint Replacement (CJR) model, which is an episode payment model that uses bundled payments for clinical episodes focused on lower extremity joint replacements. CMS envisions using bundled payments as a payment lever to improve the efficiency and quality of care for an episode of care in this new model test, BPCI Advanced.

¹ Cromwell J., Dayhoff DA., McCall NT, et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Prepared by Health Economics Research, Inc. 1998.

² Dummit, L., et al. *CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 2 Evaluation & Monitoring Annual Report*. The Lewin Group for the Center for Medicare and Medicaid Services. August 2016. Available at: <https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf>.

Episode payment models provide a single bundled payment to healthcare providers for items and services furnished during an episode of care, while holding these healthcare providers accountable for the cost, quality, and patient outcomes during that episode. Holding healthcare providers jointly accountable for resource management and total costs of care by bundling payment for multiple healthcare providers in multiple care-delivery settings with one lump sum for items and services furnished during a Clinical Episode, improves coordination and creates incentives for healthcare providers to deliver care more efficiently. These bundled payment approaches may therefore spur hospitals, physicians, and other healthcare providers to better coordinate care, improve quality of care, and consider the financial implications of their treatment decisions, and can help align healthcare provider incentives in pursuit of improved quality and reduced spending.

Bundled payment approaches can be administered as either:

1. **Retrospective Bundled Payments:** the usual fee-for-service (FFS) payments are made, and the total FFS payment for the clinical episode is then retrospectively reconciled against a predetermined target price; or
2. **Prospective Bundled Payments:** a negotiated single payment for the clinical episode is paid as a lump sum in lieu of FFS payment.

The BPCI Advanced initiative will use a retrospective bundled payment approach. Specifically, under the BPCI Advanced initiative, payment may be made to Model Participants or Model Participants may owe a payment to CMS after CMS reconciles all non-excluded Medicare FFS expenditures for a Clinical Episode against a Target Price for that Clinical Episode, as those terms are defined in Appendix A of this RFA.

The Target Price will be calculated by applying a discount, referred to as the “CMS Discount,” to the Benchmark Price. During the initial years of the Model, the CMS Discount is 3 percent. However, CMS may make slight adjustments to this amount in future Model Years. The Benchmark Price is, in turn, calculated based on the historical Medicare FFS expenditures for most items and services furnished during the Clinical Episode. Based on the actual Medicare FFS expenditures for that Clinical Episode relative to the Target Price, Participants may either have the opportunity to earn a Net Payment Reconciliation Amount (NPRA), to be paid by CMS, or may owe CMS a Repayment Amount.

B. Objectives of the BPCI Advanced Initiative

BPCI Advanced will have the following objectives in order to achieve the aim of the initiative to improve the quality of care furnished to beneficiaries and reduce costs:

1. **Financial Accountability:** Test a payment model that creates extended financial accountability for the outcomes of improved quality and reduced spending, in the context of acute and chronic episodes of care.
2. **Care Redesign:** Support and encourage Participants, Participating Practitioners, and Episode Initiators who are interested in continuously reengineering care.
3. **Data Analysis and Feedback:** Decrease the cost of a Clinical Episode by eliminating unnecessary or low-value care, increasing care coordination, and fostering quality improvement.

4. Health Care Provider Engagement: Create environments that stimulate rapid development of new evidence-based knowledge – the *Learning System*.
5. Patient and Caregiver Engagement: Increase the likelihood of better health at lower cost through patient education and on-going communication throughout the Clinical Episode.

C. BPCI Advanced Overview

Participants

For purposes of BPCI Advanced, a Participant is defined as an entity that enters into a BPCI Advanced Model Participation Agreement with CMS to participate in the Model. The types of entities eligible to be a Participant are described below. BPCI Advanced will require all Participants to take on downside financial risk from the outset of the Performance Period of the Model.

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

The following eligible entities may participate in BPCI Advanced as either a Non-Convener Participant or as a Convener Participant:

- Medicare-certified Acute Care Hospitals (ACHs), defined as a subsection (d) hospital as defined under section 1886(d)(1)(B) of the Act, and include ACHs where outpatient procedures included in Clinical Episodes are performed in hospital outpatient departments (HOPDs).
 - PPS-Exempt Cancer Hospitals, inpatient psychiatric facilities, Critical Access Hospitals (CAHs), hospitals in Maryland, hospitals participating in the Rural Community Hospital Demonstration, and Participant Rural Hospitals in the Pennsylvania Rural Health Model, are all excluded from the definition of an ACH for purposes of BPCI Advanced because of their unique payment methodologies, and may not participate in the Model in any capacity.
- Physician Group Practices (PGPs).

Medicare-enrolled providers or suppliers – other than ACHs and PGPs – and entities not themselves enrolled in Medicare may participate in BPCI Advanced as a Convener Participant, but not as a Non-Convener Participant.

Both Convener Participants and Non-Convener Participants may enter into agreements with individual downstream physicians and non-physician practitioners (referred to as “Participating Practitioners”) who furnish care during Clinical Episodes under BPCI Advanced. In addition, both Convener Participants and Non-Convener Participants that select to participate in Financial Arrangements may enter into such arrangements with entities that qualify as “NPRA Sharing Partners,” as defined in Appendix A, which

may include a Participating Practitioner, PGP, ACH, an Accountable Care Organization (ACO), or a post-acute care provider (PAC Provider).

CAHs are not subject to the Acute Care Hospital Inpatient Prospective Payment System (IPPS) or Hospital Outpatient Prospective Payment System (OPPS), making it difficult to calculate Target Prices for CAHs and leading to potential double payment by CMS to CAHs (were they to participate in the initiative). Therefore, CAHs, are not eligible to participate in BPCI Advanced in any capacity.

Episode Initiators

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

Participating Practitioners

As noted above, both Non-Convener Participants and Convener Participants may enter into arrangements with downstream practitioners, referred to as Participating Practitioners, who furnish care under this initiative and participate in BPCI Advanced Activities (i.e., care redesign, quality measure reporting, and use of Certified EHR Technology). A Participating Practitioner may be any physician or non-physician practitioner (e.g., nurse practitioner, physician assistant, physical therapist) paid separately by Medicare for their professional services.

Model Population

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

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

Although BPCI Advanced will not allow beneficiaries to opt out of the payment methodology, the initiative will not affect beneficiaries’ freedom to choose their healthcare provider, meaning that

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

BPCI Advanced Model Participation Agreement and Clinical Episode Selection

In order to participate in BPCI Advanced, Applicants that pass the pre-screening process for participation in the initiative, as described in Section I.D. of this RFA, and must both: (1) commit to being held accountable for one or more Clinical Episodes; and (2) enter into a BPCI Advanced Model Participation Agreement with CMS. Participants may be required to sign a new BPCI Advanced Model Participation Agreement with CMS for each Model Year.

Clinical Episodes: At least initially, BPCI Advanced will include 105 Medicare Severity-Diagnosis Related Groups (MS-DRGs), grouped into 29 inpatient Clinical Episode categories, as well as 3 outpatient Clinical Episode categories, each identified by 30 Healthcare Common Procedure Coding System (HCPCS) codes. CMS may elect to add or remove Clinical Episodes from BPCI Advanced on an annual basis, beginning in 2020, which will apply to Participants already participating in the Model, as well as any Participants that join the Model concurrent with such annual updates.

BPCI Advanced Participants must select the Clinical Episodes for which they will commit to be held accountable concurrent with the signing of their BPCI Advanced Model Participation Agreement; Participants may add or drop Clinical Episodes only when expressly permitted to do so by CMS.

For example, Participants selected to participate in BPCI Advanced beginning on October 1, 2018 may not add new Clinical Episodes until January 1, 2020. Participants that begin participating in the Model beginning on October 1, 2018 will not be allowed to drop Clinical Episodes, except upon request by CMS, until January 1, 2020. For each Clinical Episode to which a Participant has committed, all non-excluded Medicare FFS expenditures for items and services furnished during the Clinical Episode will be compared against a Target Price for that Clinical Episode during the semi-annual Reconciliation process.

Participation Agreement: Pursuant to the terms of the BPCI Advanced Model Participation Agreement between each Participant and CMS:

- (1) depending on the results of each semi-annual Reconciliation, during which the actual Medicare FFS expenditures for all Clinical Episodes attributed to the Participant and, for Convener Participants, to the Participant's downstream Episode Initiators are compared to the final Target Price for those Clinical Episodes (and subject to adjustments based on quality performance), either the Participant will receive an NPRA payment from CMS or the Participant must make a payment (the Repayment Amount) to CMS. These calculations are each described in Section II.E of this RFA;

(2) the Participant must assume financial risk for increases in Medicare FFS expenditures during the 30-day Post-Episode Spending Monitoring Period above a specified threshold (described below in Section II.F of this RFA), if applicable;

(3) the Participant must participate in BPCI Advanced Activities, which include implementing care redesign activities (i.e., care delivery enhancements such as reengineered care pathways using evidence-based medicine, standardized care pathways); reporting on all applicable quality measures (described in greater detail in Appendix B of this RFA); using CEHRT in accordance with the BPCI Advanced Model Participation Agreement; attesting to a minimum of four MIPS Improvement Activities; and any other related activities to be specified by CMS;

(4) the Participant must participate in Learning System activity (described in greater detail in Section II.D of this RFA);

(5) the Participant may select to enter into Financial Arrangements, in accordance with the terms of the BPCI Advanced Model Participation Agreement and applicable law, with entities or practitioners that qualify as NPRA Sharing Partners (described in greater detail in Section II.D of this RFA); and

(6) the Participant may select to furnish items and services to BPCI Advanced Beneficiaries pursuant to Payment Policy Waivers (described in greater detail in Section II.K of this RFA), in accordance with the terms of the BPCI Advanced Model Participation Agreement.

The BPCI Advanced Model Participation Agreement will terminate on December 31, 2025, unless sooner terminated in accordance with the terms thereof. See Section I.I of this RFA below for more information on the requirement to execute a restated and amended BPCI Advanced Model Participation Agreement, if offered by CMS, for continued participation in the Model.

D. Application Submission Process

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

This RFA seeks applications from Applicants that intend to build upon the successes of current and previous CMS models, demonstrations, and programs, as well as private-sector initiatives. Specifically, CMS is seeking Applicants with the capacity for care redesign that:

- focuses on quality and meets or exceeds quality measure benchmarks;
- reaches many Medicare beneficiaries;
- offers significant savings to Medicare; and
- may be implemented on aggressive timelines.

Applicants should have experience with cross-provider care improvement efforts of this type and have already begun to redesign care or be prepared to redesign care, be able to enter into a BPCI Advanced

Model Participation Agreement with CMS that includes financial and performance accountability for Clinical Episodes, and be capable of meeting the quality measure reporting requirements under the BPCI Advanced Model Participation Agreement. CMS will offer Applicants the opportunity to request certain data to support informed Clinical Episode selection, ongoing self-evaluation, and quality and process improvement, as described in greater detail below. CMS will also offer Applicants substantial Learning System activity around the components of care redesign and how to access, protect, and use the data offered by CMS to Applicants, as discussed further in Sections II.L and I.D of this RFA, respectively.

The Performance Period of the Model will be from October 1, 2018 to December 31, 2023. We anticipate that BPCI Advanced will have one initial enrollment date, October 1, 2018, with a single subsequent enrollment date, January 1, 2020.

i. Data Request and Attestation Form

BPCI Advanced will include a retrospective bundled payment mechanism that involves semi-annual Reconciliation against Clinical Episode-specific Target Prices. CMS will prospectively provide preliminary Target Prices to Applicants to allow Applicants and Participants to evaluate their ability to improve the cost and quality of care prior to their commitment to be held accountable for a Clinical Episode category under the Model. Applicants also will have the opportunity to request the data used to calculate the prospectively determined preliminary Target Prices that will be provided by CMS to all Applicants and/or other historical Medicare claims data from CMS by submitting a Data Request and Attestation (DRA) form along with their completed application. To request such Medicare claims data from CMS, the Applicant must specify the requested data elements, as well as the time period for which such data are requested. At a minimum, CMS intends to provide the opportunity to request certain summary beneficiary claims data and line-level beneficiary claims data, to be described in greater detail on the DRA form. Applicants must also specify the legal basis that justifies the disclosure of the requested claims data under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, where indicated on the DRA. For example, Applicants may request beneficiary-identifiable data under the BPCI Advanced initiative under the HIPAA Privacy Rule provisions that permit disclosures of protected health information for purposes of the recipient's healthcare operations.³ The application and DRA, as well as further instructions, are available on the Innovation Center website at: <https://innovation.cms.gov/initiatives/bpci-advanced>.

If accepted into the BPCI Advanced initiative, Participants will have the opportunity to submit a different DRA, to be provided by CMS, in order to request similar data during their participation in the Model..

ii. Application Deadline

Applicants that wish to be considered for Model participation beginning October 1, 2018 should submit their completed application, along with their completed DRA, as applicable, via the application portal, which will be accessible from the Innovation Center website, beginning January 11, 2018, at: <https://innovation.cms.gov/initiatives/bpci-advanced>, no later than March 12, 2018, at 11:59 PM EST. Application deadlines for Model participation beginning January 1, 2020 will be posted on the Innovation Center website at: <https://innovation.cms.gov/initiatives/bpci-advanced>. Applications will

³ 45 CFR §164.506(c)(4).

be received and processed on a rolling basis until each application deadline. CMS reserves the right to request additional information from Applicants in order to assess their applications. Application instructions and forms may be accessed at: <https://innovation.cms.gov/initiatives/bpci-advanced>.

iii. Provision of Data

Following the application review process, and in accordance with applicable law, CMS intends to release up to 3 years of historical Medicare claims data for Medicare FFS beneficiaries who would have been included in a Clinical Episode during a baseline period attributed to the Applicant that submitted both a completed application and a completed DRA form requesting such data. The data is intended to enable Applicants to evaluate which Clinical Episodes provide the greatest opportunity for process improvement through quality improvement and care coordination. While beneficiaries will not be able to opt out of having their historical data shared with Applicants, any requests or questions regarding data sharing that Applicants receive should be directed to 1-800-MEDICARE.

iv. Requests to Withdraw a Pending Application or Remove a Proposed Participating Practitioner or Proposed Episode Initiator Included on the Application

Applicants seeking to withdraw an entire application or to remove one or more specific proposed Participating Practitioners or proposed Episode Initiators from an application after it has been submitted on the application portal, but prior to the execution of the BPCI Advanced Model Participation Agreement for Applicants selected to participate in the Model, should submit a written request on the Applicant organization's letterhead, signed by an official authorized to act on behalf of the organization, via email to: BPCIAdvanced@cms.hhs.gov.

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

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

v. Applicant Screening

Participants will apply and be accepted into the BPCI Advanced initiative based on the content of their application and ability to pass multiple levels of program integrity and law enforcement screening. All applications will first be assessed to determine an Applicant's eligibility to participate in this Model. In addition, CMS may deny an application on the basis of information found during a program integrity screen regarding the Applicant, its proposed Episode Initiators and proposed Participating Practitioners, or any other relevant individuals or entities. Applicants must disclose all present or past history of any sanctions or other actions of an accrediting organization or a federal, state, or local governmental agency; investigations including being subject to the filing of a complaint, filing of a criminal charge, being subject to an indictment, or being named as a defendant in a False Claims Act qui tam matter in which the government has intervened, or similar action; probations; corrective action plans; or any

other administrative enforcement actions; each related to the Applicant, its affiliates or any other relevant persons and entities. Applicants must also disclose all debts currently due and owing to CMS by the Applicant, its affiliates, or any other relevant persons or entities.

vi. Exception Process

CMS will consider exception requests to the application criteria outlined in this RFA specific to participation in BPCI Advanced and will reserve the right, in CMS's sole judgment, to admit an Applicant that does not strictly meet such criteria under limited circumstances. In addition, CMS may consider applications submitted by entities that do not meet the application criteria at the time of application, but that are anticipated to qualify by the application deadline for the applicable enrollment date. Applicants seeking an exception should do so in writing by submitting an exception request to: BPCIAdvanced@cms.hhs.gov, describing the specific application criteria for which an exception is sought and why the exception is needed under the Applicant's specific circumstances. Applicants are strongly encouraged to make such requests well in advance of the applicable application deadline.

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

II. Description of Initiative

The BPCI Advanced initiative will help align ACH, physician, and PAC provider payment incentives. BPCI Advanced will do so by inviting Participants to receive payment under bundled payment arrangements that include financial and quality performance accountability for Clinical Episodes. Participants may then select to enter into Financial Arrangements, consistent with the terms of the forthcoming BPCI Advanced Model Participation Agreement and applicable law, to share NPRA payments received from CMS that accrue from furnishing more cost-effective and higher quality care under the Model.

A. Advanced APM Determination

We anticipate that BPCI Advanced will meet the criteria as an Advanced Alternative Payment Model (Advanced APM) as of the first day of the model which we anticipate will be October 1, 2018. However, an eligible clinicians' participation in the Model will not be tracked, for purposes of the Qualifying APM Participant (QP) determination and the five percent APM Incentive Payment, until the Performance Period beginning on January 1, 2019. We anticipate the first "snapshot" date for QP determination for eligible clinicians following the start of BPCI Advanced will be March 31, 2019. For Non-Convener Participants that are ACHs and Convener Participants who do not have any downstream Episode Initiators that are PGPs, eligible clinicians who are NPRA Sharing Partners included on the Financial Arrangements Screening List will be considered affiliated practitioners in the Model for purposes of QP determinations. For any Participant that is a PGP and for Convener Participants with at least one downstream Episode Initiator that is a PGP, each eligible clinician who has reassigned his or her rights to

receive Medicare payment to a PGP Participant and is included on the PGP List will be on the Participation List used for purposes of QP determinations under the Quality Payment Program.

B. MIPS APM Determination

We anticipate that BPCI Advanced will be a Merit-Based Incentive Payment System (MIPS) APM beginning January 1, 2019. Therefore, beginning in 2019, MIPS eligible clinicians who are physicians who have reassigned their rights to receive Medicare payment to a PGP Participant (or a Convener Participant with at least one downstream Episode Initiator that is a PGP) and are included on the PGP list (the Participation List), and who do not become QPs for the year, will be subject to the APM scoring standard under the Quality Payment Program for the applicable MIPS Performance Period. However, NPRA Sharing Partners would not be subject to the APM scoring standard. The APM scoring standard applies only for MIPS APMs to the extent that APM entities include at least one MIPS eligible clinician on a Participation List. Hospitals that are APM Entities in BPCI Advanced would not include at least one MIPS eligible clinician on a Participation List.

C. Retrospective Bundled Payment Mechanism

As stated previously, BPCI Advanced will involve a retrospective bundled payment mechanism that involves semi-annual Reconciliation against prospectively determined Clinical Episode-specific Target Prices subject to adjustment by CMS based on the Participant's actual patient case mix. Under BPCI Advanced, each Clinical Episode is triggered by the submission of a claim to Medicare FFS by an Episode Initiator for an inpatient Anchor Stay or an outpatient Anchor Procedure. Medicare FFS claims for all items and services furnished during that Clinical Episode will continue to be processed under the relevant Medicare payment system rules. However, Medicare FFS expenditures for the Clinical Episode will be subsequently reconciled against the final Target Price for that Clinical Episode.

D. Items and Services Included in the Clinical Episode

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

Inclusions: Each Clinical Episode will include Medicare FFS expenditures for:

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

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

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

- (1) All Part A and Part B services furnished to a BPCI Advanced Beneficiary during certain specified ACH admissions and readmissions (i.e., an admission assigned at discharge to MS-DRGs for organ transplants, major trauma, cancer-related care, ventricular shunts);
- (2) New technology add-on payments under the IPPS;
- (3) Payments for items and services with pass-through payment status under the OPPS; and
- (4) Payment for blood clotting factors to control bleeding for hemophilia patients.

In addition, Medicare FFS expenditures on items and services furnished to Medicare beneficiaries covered under managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); to Medicare beneficiaries eligible on the basis of end-stage renal disease (ESRD); to Medicare beneficiaries for whom Medicare is not the primary payer; and to Medicare beneficiaries who died during the Anchor Stay or Anchor Procedure, as applicable, are also excluded.

Clinical Episode List: CMS will maintain a list of MS-DRGs and HCPCS codes that are included in the Clinical Episode categories, as well as those that are specifically excluded, which CMS plans to update whenever CMS elects to add or remove Clinical Episodes, as described in Section I.C of this RFA.

Episode Attribution: Clinical Episodes will be attributed at the Episode Initiator level. The hierarchy for attribution of a Clinical Episode among different types of Episode Initiators in BPCI Advanced is as follows, in descending order of precedence: (1) the PGP that has the attending physician's National Provider Identifier (NPI) listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) billed under the participating PGP's Tax Identification Number; (2) the PGP that has the operating physician's National Provider Identifier (NPI) listed on the institutional claim (UB-04) and a corresponding carrier claim (Part B claim) during the Anchor Stay or Procedure billed under the participating PGP's Tax Identification Number; and (3) the ACH where services during the Anchor Stay or Anchor Procedure were furnished.

E. Reconciliation

CMS will conduct semi-annual Reconciliation against prospectively determined Clinical Episode-specific Target Prices, adjusted by CMS based on the Participant's actual patient case mix to calculate the final Target Price. If, during the semi-annual Reconciliation process, all non-excluded Medicare FFS expenditures for a Clinical Episode for which the Participant has committed to be held accountable are less than the final Target Price for that Clinical Episode, this results in a Positive Reconciliation Amount. By contrast, if all non-excluded Medicare FFS expenditures for a Clinical Episode are greater than the final Target Price, this results in a Negative Reconciliation Amount. All Positive Reconciliation Amounts

and Negative Reconciliation Amounts will then be netted across all Clinical Episodes attributed to the Episode Initiator to calculate either a Positive Total Reconciliation Amount or a Negative Total Reconciliation Amount.

If this calculation results in a Negative Total Reconciliation Amount, this amount will be adjusted by the Composite Quality Score (CQS) Adjustment Amount, as described in Table 1 below, based on quality performance, resulting in the Adjusted Negative Reconciliation Amount. For Non-Convener Participants, this amount is the Repayment Amount. If this calculation results in a Positive Total Reconciliation Amount, this amount will be adjusted by the CQS Adjustment Amount, based on quality performance, resulting in the Adjusted Positive Total Reconciliation Amount. For Non-Convener Participants, this Adjusted Positive Total Reconciliation Amount is the NPRA. For the first two Model Years, there will be a 10 percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount and the Negative Total Reconciliation Amount. Therefore, an Adjusted Positive Total Reconciliation Amount or an Adjusted Negative Reconciliation Amount will be 90 percent to 100 percent of the Positive Total Reconciliation Amount or Negative Total Reconciliation Amount, respectively. This policy is subject to change in subsequent Model Years.

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

These amounts will be specified in a Reconciliation Report to be provided to the Participant by CMS. If applicable, CMS will pay the NPRA specified in the Reconciliation Report to the Participant, subject to a 20-percent stop-gain provision at the Episode Initiator level. To the extent the Participant selects to participate in Financial Arrangements under BPCI Advanced, the Participant may distribute this NPRA payment to the Participant's NPRA Sharing Partners pursuant to such Financial Arrangements, consistent with the terms of the BPCI Advanced Model Participation Agreement and applicable law. These NPRA shared payments cannot exceed 50 percent of the total Medicare FFS expenditures included in Clinical Episodes attributed to the Participant for which the NPRA was calculated or adjusted.

If applicable, the Participant will owe CMS the Repayment Amount specified in the Reconciliation Report, subject to a 20 percent stop-loss provision at the Episode Initiator Level. To the extent the Participant selects to participate in Financial Arrangements under BPCI Advanced, the Participant may apportion the Repayment Amount among the Participant's NPRA Sharing Partners pursuant to such Financial Arrangements, consistent with the terms of the BPCI Advanced Model Participation Agreement and applicable law. These apportioned payments cannot exceed 50 percent of the total Medicare FFS expenditures included in Clinical Episodes attributed to the Participant for which the Repayment Amount was calculated or adjusted.

F. Post-Episode Spending Monitoring Period

CMS will measure the cost of care furnished during the 30-day Post-Episode Monitoring Period, to ensure the aggregate Medicare FFS expenditures for BPCI Advanced Beneficiaries do not increase due to cost shifting or other reasons. This review will include measuring Medicare FFS expenditures for items and services furnished to BPCI Advanced Beneficiaries by healthcare providers that are not participating in BPCI Advanced. All non-excluded Medicare FFS expenditures for BPCI Advanced Beneficiaries during

the Post-Episode Monitoring Period will be compared to the 99.5% confidence interval of predicted spending for post-discharge days 90-120 under the statistical model used for setting Target Prices. If Medicare FFS expenditures during the Post-Episode Monitoring Period exceed this risk threshold, then the Participant must pay Medicare the difference.

G. Accountability for Quality Performance

As noted above, CMS will adjust any Positive Total Reconciliation Amount or Negative Total Reconciliation Amount based on quality performance on the applicable quality measures. Specifically, CMS will adjust the Positive Total Reconciliation Amount or Negative Total Reconciliation Amount by an Episode Initiator-specific CQS Adjustment Amount, which is based on a continuous function of the CQS, in turn calculated based on the Episode Initiator’s scores on the applicable set of quality measures. Adjusting payment for quality performance helps align resources while ensuring that cost saving strategies do not lower the quality of care for beneficiaries. CMS may incorporate new quality measures, re-evaluate and improve existing quality measures, and adjust the quality measure set and/or CQS calculation methodology on an annual basis during the Performance Period of the Model.

H. Participation in BPCI Advanced Activities

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

Table 1. Summary of the Model

Acute Care Hospital Inpatient Stay or Hospital Outpatient Procedure, plus Post-Acute Care	
Entities eligible to be Participants:	<p>Non-Convener Participants:</p> <ul style="list-style-type: none"> • Acute care hospitals (ACHs). • Physician group practices (PGPs). <p>Convener Participants:</p> <ul style="list-style-type: none"> • Eligible entities that may or may not be Medicare-enrolled providers or suppliers.
<i>Episode definition</i>	
Criteria for beneficiary inclusion in Clinical Episode:	<ul style="list-style-type: none"> • Medicare FFS beneficiary who receives inpatient care during an Anchor Stay (identified by a qualifying MS-DRG) or outpatient care during an Anchor Procedure (identified by a HCPCS code) billed to Medicare FFS by an Episode Initiator.
Clinical Episode trigger:	<ul style="list-style-type: none"> • Inpatient claim from an ACH with a qualifying MS-DRG; or • Hospital outpatient claim from an ACH with a qualifying HCPCS code.
End of episode:	<ul style="list-style-type: none"> • 90 days following discharge from the Anchor Stay or completion of the Anchor Procedure.

Acute Care Hospital Inpatient Stay or Hospital Outpatient Procedure, plus Post-Acute Care	
Types of services included in Clinical Episode (unless specifically excluded) :	<ul style="list-style-type: none"> • Physicians' services. • Inpatient or outpatient hospital services that comprise the Anchor Stay or Anchor Procedure, respectively. • Other hospital outpatient services. • Inpatient hospital readmission services. • Long term care hospital (LTCH) services. • Inpatient rehabilitation facility (IRF) services. • Skilled nursing facility (SNF) services. • Home health agency (HHA) services. • Clinical laboratory services. • Durable medical equipment. • Part B drugs. • Hospice services.
Payment from CMS for Clinical Episodes (if any):	<ul style="list-style-type: none"> • Medicare FFS payment with retrospective Reconciliation based on comparing actual non-excluded Medicare FFS expenditures to the final Target Price. The final Target Price calculation is described in Sections I and II.E of this RFA. • Any Positive Total Reconciliation Amount is then adjusted based on quality performance to calculate the Adjusted Positive Total Reconciliation Amount. For Non-Convener Participants, this Adjusted Positive Reconciliation Amount is the NPRA paid to the Non-Convener Participant by CMS. For Convener Participants, all Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts are netted across the Convener Participant's Episode Initiators; if the result of this calculation is positive, this amount is the NPRA paid to the Convener Participant by CMS.
Expected discount provided to Medicare (CMS Discount):	<ul style="list-style-type: none"> • Discount percentage applied to the Benchmark Price to calculate the Target Price. • Initially 3 percent, but may be subject to change by CMS in future Model Years.
Reconciliation, spending calculation, disbursement, and post-episode monitoring period:	<ul style="list-style-type: none"> • <u>Clinical Episode reconciliation:</u> • If, during the semi-annual Reconciliation process, all non-excluded Medicare FFS expenditures for a Clinical Episode for which the Participant has committed to be held accountable are less than the final Target Price for that Clinical Episode, this results in a Positive Reconciliation Amount. By contrast, if all non-excluded Medicare FFS expenditures for the Clinical Episode are greater than the final Target Price, this results in a Negative Reconciliation Amount. • All Positive Reconciliation Amounts and Negative Reconciliation Amounts will be netted across all Clinical

Acute Care Hospital Inpatient Stay or Hospital Outpatient Procedure, plus Post-Acute Care	
	<p>Episodes attributed to the Episode Initiator. If this results in a negative amount, this is the Negative Total Reconciliation Amount.</p> <ul style="list-style-type: none"> Any Negative Total Reconciliation Amount will then be adjusted based on quality performance to calculate the Adjusted Negative Reconciliation Amount. For Non-Convener Participants, this Adjusted Negative Total Reconciliation Amount is the Repayment Amount. For Convener Participants, all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts are netted across all of the Participant's Episode Initiators. If this results in a negative amount, this is the Repayment Amount owed by the Convener Participant to CMS. If this results in a positive amount, CMS will issue the NPRA to the Convener Participant. Reconciliation payments will be subject to a 20 percent stop-loss and stop-gain limit at the Episode Initiator level. <u>Post-Episode Monitoring</u>: Any Medicare FFS expenditures for items and services furnished to a BPCI Advanced Beneficiary during the 30-day Post-Episode Monitoring Period that exceeds the 99.5% confidence interval of predicted spending for post-discharge days 90-120 under the statistical model used for setting Target Prices, must be paid by the Participant to Medicare.
Post-Episode Spending Monitoring Period:	<ul style="list-style-type: none"> 30 days following the end of the Clinical Episode.
Financial Arrangements and Payment Policy Waivers	<ul style="list-style-type: none"> The Participant may elect to participate in Financial Arrangements under BPCI Advanced. The BPCI Advanced Model Participation Agreement will outline the criteria for permissible Financial Arrangements, which are intended to encourage healthcare provider engagement through the distribution of NPRA payments to NPRA Sharing Partners. Participants will have the opportunity to choose to furnish services to BPCI Advanced Beneficiaries pursuant to Payment Policy Waivers, including the 3-Day SNF Rule, Telehealth, and Post-Discharge Home Visit Payment Policy Waivers, which involve conditional waivers of certain Medicare payment rules.
Quality measures:	<ul style="list-style-type: none"> Payment will be linked to quality using a pay-for-performance methodology. A quality score will be calculated for each quality measure at the Clinical Episode level, if applicable. These scores will be

Acute Care Hospital Inpatient Stay or Hospital Outpatient Procedure, plus Post-Acute Care	
	<p>scaled across all Clinical Episodes attributed to a given Episode Initiator, weighted based on Clinical Episode volume, and summed to calculate an Episode Initiator-specific Composite Quality Score (CQS).</p> <ul style="list-style-type: none"> • Includes both process and outcome measures, with outcome measures weighted more than process measures for purposes of the pay-for-performance methodology. • A CQS Adjustment Amount will be applied to the Positive Total Reconciliation Amount, if any, or the Negative Total Reconciliation Amount, if any, resulting in the Adjusted Positive Total Reconciliation Amount or the Adjusted Negative Total Reconciliation Amount, respectively, which either becomes a Non-Convener Participant’s NPRA or Repayment Amount, or is used to determine the Convener Participant’s NPRA or Repayment Amount. For the first two Model Years, there will be a 10-percent cap on the amount by which the CQS can adjust the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount. This policy is subject to change in subsequent Model Years.

I. Term of BPCI Advanced Model Participation Agreement

We anticipate that the Performance Period of the Model for BCPI Advanced will begin on October 1, 2018. However, there will be one other opportunity for Participants to join the Model. Therefore, the start date for a given Participant’s BPCI Advanced Model Participation Agreement will depend on that Participant’s enrollment date. For example, the start date in the Model will be October 1, 2018 for a Participant that executes a BPCI Advanced Model Participation Agreement with CMS and enrolls in BPCI Advanced during the enrollment period with a start date of October 1, 2018.

In order for Participants to continue participation in BPCI Advanced they will need to sign a restated and amended version of the BPCI Advanced Model Participation Agreement, if offered by CMS. For example, if CMS offers a restated and amended version of the BPCI Advanced Model Participation Agreement with an effective date of January 1, 2020, Participants with an executed BPCI Advanced Model Participation Agreement with CMS with a start date of October 1, 2018, will be required to execute the restated and amended BPCI Advanced Model Participation Agreement in order to continue participating in the Model beyond December 31, 2019.

We anticipate that the Performance Period of the Model for BPCI Advanced will end on December 31, 2023. BPCI Advanced Model Participation Agreements with all Participants will extend beyond this date until after the final semi-annual Reconciliation, unless sooner terminated in accordance with its terms.

J. Budget Impact

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

As described above, BPCI Advanced will involve retrospective Reconciliation of Medicare FFS expenditures on items and services included in each Clinical Episode against a Target Price for that Clinical Episode. Such Target Prices will be calculated by applying the CMS Discount to the Benchmark Price. The applicable Target Price for each Clinical Episode will be based on the Episode Initiator that triggered the Clinical Episode. Each Episode Initiator that is an ACH will receive its own Target Price for each Clinical Episode, while each Clinical Episode triggered by an Episode Initiator that is a PGP will be assigned a Target Price specific to the ACH where the services during the Anchor Stay or Procedure were furnished by physicians billing those Part B services for the Anchor Stay or Procedure to the PGP's TIN, subject to certain PGP-specific adjustments. This allows for more granularity in estimating the true costs of Clinical Episodes, which will vary based on the ACH where the Anchor Stay or Anchor Procedure occurred, and avoids the potentially significant discrepancy between the preliminary Target Price and final Target Price inherent in calculating these prices based on data from a frequently-evolving group of physicians (as opposed to the more stable nature of an ACH). A preliminary Target Price will be determined prospectively, with a final Target Price set retrospectively at the time of Reconciliation by making adjustments to the preliminary Target Price based on actual patient case-mix. BPCI Advanced will also limit risk to Participants through a risk track that applies Winsorization at the 1st/99th percentile of total standardized allowed amounts within the Clinical Episode during each baseline calendar year and of national Medicare FFS spending on each MS-DRG and HCPCS code to account for random variation. Further details regarding this methodology will be provided to Applicants prior to executing a BPCI Advanced Model Participation Agreement with CMS.

K. Waivers

i. Fraud and Abuse Waivers

The authority for this initiative is section 1115A of the Act. Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII, and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and 1934 (other than subsections (b)(1)(A) and (c)(5) of such subsection) of the Act as may be necessary solely for purposes of testing models described in section 1115A(b). For purposes of this Model and consistent with this standard, the Secretary may consider exercising such waiver authority with respect to the fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act as may be necessary to develop and implement the BPCI Advanced model, pursuant to section 1115A(b). Waivers are not being issued in this document; waivers, if any, would be set forth in separately issued documentation. Thus, notwithstanding any other provision of this RFA, individuals and entities must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver or waivers issued specifically for BPCI Advanced pursuant to section 1115A(d)(1). Any such waiver would apply solely to BPCI Advanced and could differ in scope and design from waivers granted for other programs or models.

ii. Payment Policy Waivers

Separate from any fraud and abuse waivers, CMS intends to offer conditional waivers of certain Medicare payment rules, referred to as Payment Policy Waivers, as necessary to test whether flexibility and coverage of additional services will lower costs, improve quality, facilitate the delivery of care in new settings, and better engage beneficiaries in their care. These Payment Policy Waivers relate to the 3-Day SNF Rule, telehealth, and post-discharge home visit services.

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

For purposes of this 3-Day SNF Rule Payment Policy Waiver, a Qualified SNF is a SNF, as defined under section 1861(j) of the Act, that: (1) has an overall rating of three or more stars in the Nursing Home Five-Star Quality Rating System for SNFs on the CMS Nursing Home Compare Website for at least 7 of the 12 preceding months; and (2) is identified on the list of SNFs eligible to be Qualified SNFs posted on the CMS website, as determined by CMS based on the most recent rolling 12 months of SNF star rating data available that includes the date of the beneficiary's admission to the SNF. CMS will post the list of SNFs that CMS determines are eligible to be Qualified SNFs on a quarterly basis to: <https://innovation.cms.gov/initiatives/bpci-advanced>.

Second, for purposes of the Telehealth Payment Policy Waiver, CMS intends to offer a conditional waiver of the otherwise applicable geographic area requirements for Medicare coverage of telehealth services under section 1834(m) of the Act, when these services are furnished to BPCI Advanced Beneficiaries during a BPCI Advanced Clinical Episode, so long as the services are furnished in accordance with the remaining provisions of section 1834(m), and all other applicable Medicare coverage and payment criteria have been met.

Third, for purposes of the Post-Discharge Home Visits Payment Policy Waiver, CMS intends to allow for "incident to" services furnished in a beneficiary's home in the period following discharge from the Anchor Stay or completion of the Anchor Procedure to be furnished by "auxiliary personnel" under the general supervision of the physician or other practitioner, as opposed to direct supervision, through a conditional waiver of the direct supervision requirement for "incident to" services under 42 C.F.R.

§ 410.26(b)(5), so long as the services are furnished in accordance with the conditions of the BPCI Advanced Model Participation Agreement and all other Medicare coverage and payment criteria, including the remaining provisions of 42 C.F.R. § 410.26(b), have been met.

L. Learning System Activities

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

iii. Learning System Activities for Applicants

Through Learning System activity, CMS will provide support to Applicants as they prepare to redesign care and enter into BPCI Advanced Model Participation Agreements with CMS that impose financial and quality performance accountability for Clinical Episodes and, at the option of the Participant, to enter into Financial Arrangements in accordance with the BPCI Advanced Model Participation Agreement. Applicant Learning System activity may include the creation and dissemination of resource documents by CMS or CMS's contractors on suggested means of care redesign in the context of bundled payments (including recommended data and/or system capabilities, promising practices around protocols for evidence-based medicine, etc.); learning sessions geared specifically towards Applicants; and hypothetical case studies. These will provide an opportunity to introduce key concepts to Applicants and their proposed Participating Practitioners and proposed Episode Initiators; create a vigorous learning community; engage individuals from across the Applicant organization; and initiate action planning by Applicants and their proposed Participating Practitioners and proposed Episode Initiators. Applicants are encouraged, but not required, to participate in Learning System activities.

iv. Learning System Activities for Participants

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

Potential Learning System activities for this initiative include learning sessions; topic-specific webinars; group-specific virtual collaborations; semi-annual hypothetical "live case" visits between Participants; regular site visits by CMS and CMS contractors to Participants, Episode Initiators, and Participating Practitioners by request or at CMS' discretion; showing interim results with structured qualitative inquiry; and hypothetical case studies for formal sharing based on site visits, which include identifying,

acknowledging and studying high performers, variation in performance as well as lessons learned from performance-improvement efforts. For a discussion of the activities that are expected to comprise the Learning System, see the Learning System Strategy and Structure in Appendix C of this RFA. Applicants will be expected to describe how they plan to participate in the Learning System in their application to participate in BPCI Advanced.

M. Model Monitoring

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

All Participants will be required to comply fully with CMS' and its contractor(s)' requests for monitoring of the BPCI Advanced initiative, including without limitation: providing data related to providers and suppliers, beneficiaries, BPCI Advanced Activities, Financial Arrangements, and Payment Policy Waivers; being available for site visits by CMS staff and its contractors at the Participant's facilities, in accordance with the terms of the BPCI Advanced Model Participation Agreement, and not interfering with site visits at its Participating Practitioners' and Episode Initiators' facilities; requiring its Episode Initiators and Participating Practitioners to be available for site visits at their respective facilities by CMS staff and its contractors; and participating in surveys and interviews. Participants will be expected to provide CMS and its contractor(s) with ongoing monitoring information by tracking and reporting various measures of performance improvement efforts and operational metrics, including data on Participant expenditure reductions, NPRA payments received from CMS and NPRA Shared Payments made to NPRA Sharing Partners, clinical quality, and patient experience of care. Such data may include, but are not limited to, system-level measures of complication, mortality, and readmission rates, as well as measures of process improvement.

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

CMS may send a Participant a warning letter; terminate the Participant's BPCI Advanced Model Participation Agreement; require the Participant to terminate arrangements with one or more downstream Episode Initiators, Participating Practitioners, or others; require Participants to implement a corrective action plan (CAP); and/or take other corrective action where it is determined—through monitoring or otherwise—that a Participant, or other providers and suppliers participating in the Model pursuant to an agreement with the Participant, are not in compliance with the Model's requirements. Any CAP implemented for purposes of BPCI Advanced must require the Participant to propose a plan for

achieving compliance and allow CMS to determine whether such changes were made. Failure to comply with the requirements of the CAP, or with the BPCI Advanced Model Participation Agreement itself, may result in termination of the Participant's BPCI Advanced Model Participation Agreement or referral to law enforcement, or both, if necessary.

N. Beneficiary Protections

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

First, although BPCI Advanced will not allow beneficiaries to opt out of the payment methodology, as described above, the initiative will not affect beneficiaries' freedom to choose their healthcare provider, meaning that beneficiaries may elect to see a provider or supplier of their choosing, including a provider or supplier that does not participate in BPCI Advanced. Specifically, under the terms of the BPCI Advanced Model Participation Agreement, Participants may not restrict beneficiary choice of providers or suppliers, and Participants must also place this responsibility onto their downstream Episode Initiators and Participating Practitioners.

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

Third, Participants must also notify beneficiaries of the Participants' participation in this initiative and require their downstream Episode Initiators and Participating Practitioners to do the same. CMS will provide Participants with a template notification letter to share with BPCI Advanced Beneficiaries, which highlights the beneficiary's right to choose their healthcare provider and explains the goals and objectives of the initiative. This template notification letter will also inform beneficiaries that they may be contacted by CMS or CMS's contractors to provide information for the evaluation and monitoring of the initiative. However, beneficiaries will be specifically advised that refusal to participate in the evaluation or monitoring, as well as refusal to respond to requests for information will not affect their Medicare benefits or provision of care in any way. Participants may not make changes to any portion of this template notification letter, except where indicated in the template.

Participants must inform beneficiaries about the initiative prior to, or as soon as possible following, the submission of a claim for the Anchor Stay or Anchor Procedure that triggers a Clinical Episode, as applicable, by sending the beneficiary a copy of the template notification letter provided by CMS. Participants must also agree to notify beneficiaries of their participation in the initiative through any additional mechanisms specified by CMS.

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

O. Termination of BPCI Advanced Model Participation Agreements

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

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

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

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

P. Evaluation

CMS will contract with an independent evaluator to conduct the Model evaluation pursuant to section 1115A(b)(4) of the Act. All Participants will be required to cooperate with the independent evaluator to track and provide any and all relevant data, as may be needed for the Model evaluation, and must require their Participating Practitioners and Episode Initiators to do the same. These data may include, but are not limited to, data pertaining to: clinical quality performance, patient functional status, utilization, and finances. CMS will seek to align measures in these areas and those related to ensuring a positive patient/caregiver experience of care, care coordination/transitions, and patient safety with measures used for other programs and initiatives, such as MIPS, the Hospital Inpatient Quality Reporting (IQR) program and other hospital quality initiatives, and quality standards under the Medicare Shared Savings Program (Shared Savings Program) and other ACO initiatives.⁴

III. Conditions of Model Participation

A. Eligible Applicants

An Applicant may be any entity eligible to participate in BPCI Advanced as a Convener Participant or as a Non-Convener Participant, as discussed in section I.C and Table 1 of this RFA.

CMS is not placing limitations on Applicants based on geographic region (e.g., Applicants are not limited to a specific MAC jurisdiction), geographic type (e.g., urban, rural), or facility size. Current and past participants of the Bundled Payments for Care Improvement (BPCI) initiative, as well as Participants in other current and past CMS Innovation Center models and Medicare demonstrations—including participants in the Medicare ACE Demonstration, Medicare Hospital Gainsharing, and Physician Hospital Collaboration Demonstration—are eligible to apply. Applications received from current and past Participants of the BPCI initiative will be subject to the same application submission and review processes, as well as selection criteria, as are applications received from Applicants that did not participate in BPCI. For discussion of the application submission, review, and selection processes, see section IV, below. CMS's general policies for addressing overlap with other CMS initiatives are described in section III.B, below. If Applicants are selected, Participant-specific issues pertaining to overlapping participation in other CMS initiatives (e.g., related to transition timing) will be addressed by CMS, in CMS's sole discretion, as necessary.

All applications must identify a single entity that seeks to participate in BPCI Advanced as a Participant—either as a Non-Convener Participant or as a Convener Participant—that will accept and bear financial responsibility to Medicare under BPCI Advanced. With the exception of Convener Participants that are not themselves enrolled in Medicare as a provider or supplier, a condition of continuing participation in BPCI Advanced is that the Participant continues to offer its services as a Medicare provider or supplier. All applications must also identify, in a form and manner to be specified by CMS, each of the proposed Participating Practitioners and, to the extent that the Participant is a Convener Participant, all proposed Episode Initiators and demonstrate the necessary partnerships between the designated Participant and

⁴ For more information about quality performance standards related to Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program, please see 42 C.F.R. part 425, subpart F. The quality measures used in the Shared Savings Program are updated annually through rulemaking. See, e.g., CY 2017 Physician Fee Schedule Final Rule, 81 Fed. Reg. 80,170, 80,484-89 (Nov. 15, 2016).

each of these individuals and organizations, if applicable. Note that Applicants selected to participate in BPCI Advanced beginning on October 1, 2018 will not be allowed to add Episode Initiators that were not included on the Participants application. After October 1, 2018, Participants will not be allowed to add or drop Episode Initiators until January 1, 2020, unless requested by CMS.

Applicants must include information regarding their ability to bear financial risk and to repay Medicare for any Medicare FFS spending during a Clinical Episode in excess of the Target Price, as well as any excess Medicare expenditures identified during the Post-Episode Monitoring Period. This must include enforceable assurances of each Participant's ability to repay Medicare. This assurance could take the form of an irrevocable letter of credit for the full amount of risk undertaken, or it could take the form of any similarly enforceable mechanism that covers either the full amount or a percentage of the risk, as specified by CMS.

An application to participate in BPCI Advanced as a Convener Participant must also provide information regarding current or anticipated financial arrangements with Episode Initiators that would allow the Convener Participant to bear risk, and the mechanisms that would enable the Convener Participant to make payments to its NPRA Sharing Partners, if any, and to Medicare.

B. Participation in Other CMS Quality Initiatives

Participants, Episode Initiators, and Participating Practitioners must continue to participate in all applicable CMS quality reporting initiatives for the duration of the Model. Applications should indicate historical participation in the Physician Quality Reporting System (PQRS) by proposed Participating Practitioners, as well as an indication that proposed Participating Practitioners not currently participating in the PQRS will participate for the duration of the Model. As applicable, participating healthcare providers are also expected to maintain or improve their performance on the measures reported through MIPS, Hospital IQR, Hospital Outpatient Quality Data Reporting Program (HOP QDRP), PQRS, and any other CMS quality improvement program for the duration of this initiative; decreased performance during the period of this initiative may result in termination of the BPCI Advanced Model Participation Agreement, or other appropriate remedial action, by CMS.

C. Overlap with Other CMS Initiatives

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

With regard to beneficiary overlap with ACOs, BPCI Advanced payment methodologies will exclude Clinical Episodes for BPCI Advanced Beneficiaries aligned to: (1) a Next Generation ACO; (2) Vermont All-payer ACO (3); an ESRD Seamless Care Organization; or (4) a Shared Savings Program ACO participating under Track 3. CMS will not, however, exclude Clinical Episodes for BPCI Advanced Beneficiaries aligned to a Shared Savings Program ACO participating under Tracks 1, 1+, and 2. Although a prospective assignment methodology is used to assign beneficiaries to ACOs participating in both Track 1+ and Track 3 of the Shared Savings Program, CMS makes the distinction between the two tracks in the BPCI Advanced payment methodology due to the level of risk in Track 1+, as compared to Track 3, which makes it more akin to Tracks 1 and 2 than Track 3.

Applicants selected to participate in BPCI Advanced that are also participating in any Innovation Center model implemented via regulation (e.g., the Comprehensive Care for Joint Replacement (CJR)), will not be permitted to participate in BPCI Advanced for the episodes included in those models. For example, while a hospital participating in CJR would generally be able to participate in the BPCI Advanced initiative, this hospital would not be able to select Clinical Episodes for the orthopedic bundle or Major Joint Replacement of the Lower Extremity (MJRLE) Clinical Episodes for purposes of BPCI Advanced.

Applicants currently participating in the Oncology Care Model (OCM) are eligible to apply to participate in BPCI Advanced. BPCI Advanced will run concurrently with OCM. This means that BPCI Advanced Clinical Episodes do not take precedence over OCM Episodes and vice versa. Rather, CMS will adjust OCM performance-based payments to account for NPRA payments under BPCI Advanced based on the proportion of the BPCI Advanced Clinical Episode that overlaps with the OCM Episode. CMS may apply this same rule for overlap with any potential future ambulatory episode payment models.

IV. Application Submission, Review Process, and Selection Criteria

Please see Section I.D. of this RFA for further information regarding the application submission process itself. Applications and further instructions are available at: <https://innovation.cms.gov/initiatives/bpci-advanced>.

CMS will assess all applications for eligibility and conduct screening activities to ensure that Non-Convener Applicants, proposed Participating Practitioners, and proposed Episode Initiators are eligible to receive Medicare payments (including, but not limited to, checking for excluded providers and suppliers). Each complete application will be reviewed by individuals at CMS with expertise in the areas of Medicare payment policy, care improvement, and care coordination based on the Application Review Guidelines listed in Table 2, below. Applications will also be shared with contractors bidding for CMS' BPCI Advanced evaluation contract and/or BPCI Advanced monitoring contract, and with the evaluation and/or monitoring contractors, once selected. Such contractors will be required to sign a non-disclosure agreement prohibiting re-disclosure of any information provided by Applicants under this RFA.

CMS will establish guidelines for reviewers and will prioritize applications based on the following components:

- Model Design;
- Cost Reduction;

- Quality of Care and Patient Centeredness; and
- Organizational Capabilities, Prior Experience, and Readiness.

Table 2. Application Review Guidelines.

Model Design
Criteria:
<ul style="list-style-type: none"> • Level of engagement and participation <ul style="list-style-type: none"> ➢ CMS is seeking applications that present strong evidence of proposed Participating Practitioner and Episode Initiator commitment to participate in an episode payment model that aims to align incentives. • Care Improvement <ul style="list-style-type: none"> ➢ CMS is seeking applications that present detailed plans to achieve improved care outcomes, including: <ul style="list-style-type: none"> ▪ Aspects of care that will be redesigned and plans for improving care quality. ▪ Capacity and readiness to improve care quality. ▪ Plans to assess beneficiary, caregiver, and/or family experience of care. • Financial Arrangements Design <ul style="list-style-type: none"> ➢ For those Applicants interested in pursuing Financial Arrangements under BPCI Advanced, CMS is seeking applications that provide a thoughtful methodology for Financial Arrangements, including sufficient safeguards and quality-control mechanisms. ➢ CMS is seeking applications that describe a methodology for Financial Arrangements that is transparent, replicable, scalable, and will successfully align healthcare provider incentives to improve care quality and improve cost effectiveness.
Information to be Included in Application:
<ul style="list-style-type: none"> • Identification of entity to be designated as Participant (either Convener Participant or Non-Convener Participant) • Identification of proposed Participating Practitioners and, for Convener Participants, proposed Episode Initiators <ul style="list-style-type: none"> ➢ Description of plans for disclosing participation in this initiative to potential downstream participants. ➢ Description of plans to obtain and retain widespread engagement by Participating Practitioners and, for Convener Participants, Episode Initiators in this initiative, including plans for executing the necessary agreements with these individuals and entities. • Care Improvement <ul style="list-style-type: none"> ➢ Description of the aspects of care that will be redesigned, plans for how such care will be redesigned to improve care quality, and capacity and readiness to improve care quality, including the following: <ul style="list-style-type: none"> ▪ Evidence-based medicine (e.g., through the establishment and implementation of evidence-based guidelines at the organizational or institutional level).

- Beneficiary/caregiver engagement (e.g., any shared decision-making processes or tools with which the patient can assess the merits of various treatment options in the context of his or her unique needs, preferences, values, and priorities, methods for fostering "health literacy" in patients and their families, routine assessments of beneficiary/caregiver experience of care, etc.).
 - Coordination of care and care transitions (e.g., sharing of electronic records across providers, telehealth, remote patient monitoring or other enabling technologies, care plans, medication reconciliation, registries, case conferences, standard protocols, provision of patient self-management tools and education, etc.).
- For Applicants interested in the potential to include Financial Arrangements in their care redesign:
 - Description of the nature of the relationship and existing or future agreements between the Applicant and its proposed NPRA Sharing Partners
 - Prior experience with comparable financial arrangements or pay-for-performance initiatives, including with non-Medicare payers
 - Specific plans and methodology for Financial Arrangements under BPCI Advanced, including:
 - Proportion of NPRA payments to be shared with NPRA Sharing Partners
 - Description of how NPRA Shared Payment amounts will be calculated
 - The timing and periodicity of NPRA Shared Payment determinations and the timing and method for distributing payments to NPRA Sharing Partners
 - Description of how the allocation of NPRA Shared Payments incorporates quality, patient safety, and internal efficiency measures, as well as eligibility requirements (e.g., quality thresholds) for participation in Financial Arrangements
 - Plans to ensure NPRA Shared Payments do not exceed 50 percent of the amount normally paid by Medicare FFS to physicians/practitioners for the Clinical Episodes for which the NPRA was calculated or adjusted
 - Financial Arrangement-specific quality control mechanisms
 - Description of how Financial Arrangements will support care improvement and redesign, including quality control mechanisms and safeguards to ensure that medically necessary care is not reduced in an effort to reduce Medicare FFS expenditures

Comments:

- Participants may not make cash payments to beneficiaries
- Competition in the healthcare marketplace promotes quality of care for Medicare beneficiaries and protects access to a variety of providers. These benefits to Medicare patients would be reduced or eliminated if CMS facilitated the creation of healthcare provider agreements among healthcare providers that reduce competition, including arrangements for Financial Arrangements described in this RFA. Nothing in this RFA shall be construed to modify, impair, or supersede the applicability of any of the antitrust laws.

Cost Reduction

Criteria:

- Overall reductions in Medicare FFS expenditures
- Anticipated actions that will result in lower Medicare FFS spending
 - CMS is seeking applications that demonstrate how the planned care improvement interventions described above will result in improved efficiency, cost savings, and/or reduced Medicare FFS spending

Information to be Included in Application:
<ul style="list-style-type: none"> • Actions that will result in increased efficiency and reduced spending <ul style="list-style-type: none"> ➢ Discussion of how care improvement and redesign efforts will result in improved efficiency, cost savings, and/or reduced Medicare FFS spending ➢ Description of other planned cost-saving approaches
Quality of Care and Patient Centeredness
Criteria:
<ul style="list-style-type: none"> • Proposed mechanisms to improve quality and patient experience of care <ul style="list-style-type: none"> ➢ CMS is seeking applications that demonstrate how redesigned care, including coordination of care across care settings, will lead to improved quality and patient experience of care. ➢ CMS is seeking applications that demonstrate how the Applicant will meet the Model requirement to use Certified Electronic Health Record Technology (CEHRT) to document and communicate clinical care with patients and other healthcare professionals, how the Applicant will use Health Information Technology (HIT) to enable quality measurement, reporting and feedback, and how the Applicant will use Electronic Health Records (EHRs) as a part of care redesign across treating healthcare providers to ensure coordination of care across settings. ➢ CMS may look favorably on applications that incorporate tools to collect information and assess patient functional status into the application. ➢ Proposed mechanisms to maintain or improve performance on the quality reporting requirements ➢ CMS is seeking applications that describe how the Applicant will meet quality reporting requirements as specified in this RFA, including both those required under the Model as well as under other applicable CMS quality improvement initiatives. CMS may look favorably on applications that indicate meaningful participation in MIPS or PQRS by proposed Participating Practitioners, and/or that indicate that proposed Participating Practitioners not currently participating will participate for the duration of the Model. ➢ CMS may also look favorably on applications that indicate mechanisms to address quality measures beyond those required for participation in the initiative. Specifically, CMS is seeking applications that propose a comprehensive, meaningful, evidence-based, and credible set of quality measures to track quality and ensure that quality does not decrease during this initiative in the domains of quality performance, patient functionality, patient and caregiver experience, care coordination and transitions, and patient safety. • Quality assurance and continuous quality improvement <ul style="list-style-type: none"> ➢ CMS is seeking applications that have a comprehensive plan for ensuring that measures of quality outcomes will be used to continuously improve care redesign and care provided. • Beneficiary protections <ul style="list-style-type: none"> ➢ CMS is seeking applications that include comprehensive plans for beneficiary protection, including plans around freedom of choice of healthcare providers, beneficiary notification, and beneficiary engagement and education.
Information to be Included in Application:
<ul style="list-style-type: none"> • Quality improvement <ul style="list-style-type: none"> ➢ Detailed discussion of how care improvement and redesign will improve care quality and patient experience of care.

- Description of measures, beyond the quality measures required for participation in the Model, the Applicant plans to use in order to assess quality performance, patient functionality, patient and caregiver experience, care coordination and transitions, and patient safety, source of measure, reliability of measure (e.g., National Quality Forum-endorsed), and descriptions of numerators and denominators. Description of experience, participation, and results from mandatory and voluntary CMS quality improvement programs or measurement systems, including intended Participating Practitioners' participation in MIPS and PQRS.
- Description of experience, participation, and results from other HHS and/or private-sector care improvement, quality improvement, and care coordination activities.
- Internal quality assurance and continuous quality improvement processes
 - Description of internal quality assurance and improvement processes, including how participation in this initiative would fit within existing quality assurance and improvement strategies.
 - Description of plans for internal monitoring of clinical and functional outcomes.
 - Description of plans for continuous quality improvement.
 - Description of the role of beneficiaries, physicians, hospital staff, and post-acute care staff on quality improvement committee(s).
 - Results from relevant quality assurance studies.
- Beneficiary Protections
 - Description of proposed beneficiary protections.
 - Evidence that beneficiaries will have complete freedom of choice of providers and suppliers, including PAC providers.
 - Description of the beneficiary notification process, including how it will be implemented and documented.
 - Description of proposed plan for beneficiary engagement and education.

Organizational Capabilities, Prior Experience, and Readiness

Criteria:

- Financial Risk and Financial Arrangements
 - CMS is seeking applications that demonstrate an ability to bear 100 percent financial risk, up to the 99th percent of national Medicare FFS expenditures on items and services included in a Clinical Episode and subject to the 20 percent stop-loss provision at the Episode Initiator level.
 - CMS is seeking applications that include transparent, detailed plans on how NPRA Shared Payments will be distributed to NPRA Sharing Partners.
- Commitment and credentials of Applicant executives and governance bodies
 - CMS is seeking applications that include strong support from the Applicant's leadership and are aligned with the Applicant's overall vision and mission.
 - CMS will look favorably on applications that include governance bodies with meaningful representation from consumer advocates, patients, and all participating healthcare provider types.
- Success and readiness to participate

- CMS is seeking applications that demonstrate prior success coordinating care across healthcare providers, although evidence of readiness to launch participation in the Model will carry more weight.
 - Applicants must attest to their use of CEHRT, as well as the use of CEHRT by their Participating Practitioners and Episode Initiators, to document and communicate clinical care with patients and other healthcare professionals, in accordance with the Advanced APM criterion under the Quality Payment Program.
 - CMS is seeking applications that have a comprehensive and credible implementation plan, including a timeline.
- Partnerships
 - CMS will look favorably on applications that demonstrate partnership with State Medicaid programs, private payers, or multi-payer collaborations to redesign care.
 - Applications from potential Convener Participants that foster the participation of large numbers of healthcare providers, affecting large numbers of beneficiaries in an organized and efficient manner, may also be considered favorably.

Information to be Included in Application:

- Financial Risk and Financial Arrangements:
 - Letter of commitment from designated Participant attesting to ability to bear the financial risk associated with this initiative.
 - Description of any Financial Arrangements
 - Description of the Financial Arrangements and logistical mechanisms for distributing NPRA Shared Payments among NPRA Sharing Partners. Note these Financial Arrangements must meet the applicable requirements described in this RFA and the forthcoming BPCI Advanced Model Participation Agreement, and must comply with applicable law.
 - Percentage of revenues from Medicare FFS, Medicare Advantage, Medicaid, commercial health plans, self-pay patients, and any other sources.
- History and prior experience:
 - For applicants applying to be Convener Participants, description of prior business relationships with proposed Episode Initiators.
 - Description of prior experience with care improvement across care settings and experience in achieving medical expenditure targets in such arrangements.
 - Description of how this initiative will relate to other care redesign efforts the Applicant is undertaking, if any. These include all Medicare and Medicaid (including any other CMS Innovation Center initiatives), as well as private-sector ACO, medical home, or bundled payment pilots, as well as any other relevant initiatives.
 - Identification of partnerships with other payers that utilize the same (or similar) payment and care redesign mechanisms as proposed for payment under BPCI Advanced.
 - Description of experience with process-improvement efforts, such as Six Sigma®, Lean Enterprise®, etc.
- Readiness and partnerships:
 - Description of governing body that will oversee the Applicant's participation in the Model and how that body will conduct oversight related to participation in the Model.

- Detailed implementation plan, including milestones, how tasks will be sequenced, and in what timeframe; the management control and coordination tools that will be used to ensure the timely and successful conduct of Model participation; descriptions of the processes in place to handle tasks occurring simultaneously; resource allocations (e.g., staff, systems, related departments); designation of the tasks to be performed by an employee, subcontractor, or consultant; and evidence of the feasibility of this plan based on the Applicant's ongoing operations and past experience.
- Description of availability and access to systems and facilities, including staff, consultants, computer systems and technical equipment, types of IT vendors/software, if applicable, and discussion of whether participation in an episode payment model will require additional hardware and software beyond current infrastructure.
- Convener Participants
 - All applications to be Convener Participants must include:
 - Description of the nature of the relationships between proposed Episode Initiators and the Convener Participant, including any proposed Financial Arrangements
 - Description of prior experience the Convener Participant and the proposed Episode Initiators have working together

Comments:

- Applicants may be current or past Awardees in the BPCI initiative, or Participants in Medicare ACE Demonstration, the Medicare Hospital Gainsharing Demonstration, and/or the Physician Hospital Collaboration Demonstration. Participation in other initiatives (whether current or prior) should be disclosed in the application.

Appendix A: Glossary

Accountable Care Organization (ACO) – An ACO is a legal entity that is recognized and authorized under applicable law, identified by a Taxpayer Identification Number, and formed by one or more ACO participants. For the purposes of this initiative, an ACO includes a participant in the Shared Savings Program, Next Generation ACO Model, or other Medicare-specific ACO-related initiatives administered by CMS.

Acute Care Hospital (ACH) – A Medicare-enrolled subsection (d) hospital, as defined in Section 1886(d)(1)(B) of the Act, to include ACHs where outpatient procedures are performed in hospital outpatient departments (HOPDs). PPS-Exempt Cancer Hospitals, inpatient psychiatric facilities, CAHs, hospitals and Maryland, hospitals participating in the Rural Community Hospital demonstration, and Participant Rural Hospitals in the Pennsylvania Rural Health Model, are excluded from the definition of an ACH for purposes of BPCI Advanced.

Adjusted Negative Total Reconciliation Amount – The product of applying the CQS Adjustment Amount to the Negative Total Reconciliation Amount. The Adjusted Negative Total Reconciliation Amount, if any, either becomes the Non-Convener Participant’s Repayment Amount or, for Convener Participants, is netted against all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts across the Convener Participant’s downstream Episode Initiators, resulting in either the Repayment Amount or NPRA, as applicable.

Adjusted Positive Total Reconciliation Amount – The product of applying the CQS Adjustment Amount to the Positive Total Reconciliation Amount. The Adjusted Positive Total Reconciliation Amount, if any, either becomes the Non-Convener Participant’s NPRA or, for Convener Participants, is netted against all Adjusted Positive Total Reconciliation Amounts and all Adjusted Negative Total Reconciliation Amounts across the Convener Participant’s downstream Episode Initiators, resulting in either the Repayment Amount or NPRA, as applicable.

Anchor Procedure – A hospital outpatient procedure performed in a Hospital Outpatient Department identified by a qualifying HCPCS code for which an Episode Initiator submits a claim to Medicare FFS, which in turn triggers a Clinical Episode.

Anchor Stay – An inpatient stay at an ACH assigned to a qualifying MS-DRG code for which an Episode Initiator submits a claim to Medicare FFS, which in turn triggers a Clinical Episode.

Benchmark Price - A metric used by CMS, together with the CMS Discount, to calculate an Episode Initiator-specific Target Price for each Clinical Episode. The Benchmark Price is calculated based on a combination of historical Medicare FFS spending, adjusted to reflect the Episode Initiator’s efficiency relative to its peers over time, along with adjustments for patient characteristics and regional spending trends.

BPCI Advanced Activities – Activities related to the overall care of BPCI Advanced Beneficiaries during a Clinical Episode, which include: furnishing direct patient care to BPCI Advanced Beneficiaries pursuant to a Care Redesign Plan; reporting on quality measures; using CEHRT in accordance with the BPCI Advanced

Model Participation Agreement; attesting to a minimum of four MIPS Improvement Activities; and any other related activities to be specified by CMS.

BPCI Advanced Beneficiary – A Medicare beneficiary entitled to benefits under Part A and enrolled under Part B on whose behalf an Episode Initiator submits a claim to Medicare FFS for an Anchor Stay or Anchor Procedure associated with a Clinical Episode for which a Participant has committed to be held accountable. The term BPCI Advanced Beneficiary specifically excludes: (1) Medicare beneficiaries covered under United Mine Workers or managed care plans (e.g., Medicare Advantage, Health Care Prepayment Plans, or cost-based health maintenance organizations); (2) beneficiaries eligible for Medicare on the basis of end-stage renal disease (ESRD); (3) Medicare beneficiaries for whom Medicare is not the primary payer; and (4) Medicare beneficiaries who die during the Anchor Stay or Anchor Procedure.

BPCI Advanced Entity – An entity that administers the Participant’s Financial Arrangements pursuant to a BPCI Advanced Entity Agreement. To be eligible to serve as a BPCI Advanced Entity, an entity must: (1) be identified as a BPCI Advanced Entity on the CMS-approved Financial Arrangement Screening List; (2) be legally authorized to distribute NPRA Shared Payments to and receive Shared Repayment Amounts from each NPRA Sharing Partner; and (3) be legally authorized to receive funds distributed from the BPCI Advanced Savings Pool and retain them solely for Administrative Services actually furnished by the BPCI Advanced Entity. A BPCI Entity may not be a Medicare-enrolled provider or supplier.

BPCI Advanced Savings Pool – A collection of funds maintained by a Participant, or a BPCI Advanced Entity on the Participant’s behalf, that consists solely of: (1) contributions by NPRA Sharing Partners of the NPRA Sharing Partners’ own Internal Cost Savings and Shared Repayment Amounts; and (2) contributions by the Participant of NPRA payments received by the Participant from CMS. Funds maintained in the BPCI Advanced Savings Pool may be distributed pursuant to the BPCI Advanced Model Participation Agreement as either NPRA Shared Payments to NPRA Sharing Partners or as payment for Administrative Services actually furnished by a BPCI Advanced Entity.

Bundled Payment / Bundling – A predetermined payment amount for all items and services (including physician, hospital, and other healthcare provider services) furnished during an episode of care. In BPCI Advanced, this is paid retrospectively. In contrast to fee-for-service payment, the bundled payment amount covers items and services furnished by multiple healthcare providers in multiple care delivery settings during the episode of care. This also differs from capitation or global payment, in that the bundled payment is a single payment only for the specified episode with some exclusions, rather than a payment for all care furnished to a patient during a specified time period, without exclusions.

Clinical Episode – The defined period of time triggered by the submission of a claim for an Anchor Stay or Anchor Procedure by an Episode Initiator, during which all Medicare FFS expenditures for all non-excluded items and services furnished to a BPCI Advanced Beneficiary are bundled together as a unit for purposes of calculating the Target Price and for purposes of Reconciliation.

CMS Discount – A set percentage by which CMS reduces the Benchmark Price in order to calculate the Target Price.

Convener Participant – A Participant that brings together multiple downstream Episode Initiators to participate in BPCI Advanced, facilitate coordination among them, and bears full financial risk to CMS under the Model. A Convener Participant may be an entity that is either a Medicare-enrolled provider or supplier or an entity that is not enrolled in Medicare. Entities other than ACHs and PGPs (e.g., PAC providers) may participate in BPCI Advanced as Convener Participants but not as Non-Convener Participants.

CQS -- Composite Quality Score.

CQS Adjustment Amount – The adjustment applied during the Reconciliation process to the Positive Total Reconciliation Amount, if any, or the Negative Total Reconciliation Amount, if any, to calculate the Adjusted Positive Total Reconciliation Amount or Adjusted Negative Total Reconciliation Amount, respectively, for each Episode Initiator.

Episode Initiator – An ACH or PGP that participates in BPCI Advanced as either: (1) a Participant; or (2) pursuant to an Agreement with a Convener Participant under which such downstream Episode Initiator agrees to participate in BPCI Advanced and comply with all of the applicable requirements of the BPCI Advanced Model Participation Agreement. An Episode Initiator can trigger a Clinical Episode under BPCI Advanced.

Financial Arrangements – Either an NPRA Sharing Agreement or a Partner Distribution Agreement.

Learning System – A healthcare system designed to generate and apply the best evidence for the collaborative healthcare choices of each patient together with his or her healthcare provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in healthcare.

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

MIPS Improvement Activities – Activity to improve clinical practice or care delivery and included on the MIPS Improvement Activities list on the Quality Payment Program website.

Model Year – A full or partial calendar year during the Performance Period of the Model. The first Model Year of BPCI Advanced begins on October 1, 2018 and ends on December 31, 2018. The second and subsequent Model Years of BPCI Advanced will begin on January 1 and end on December 31 of the applicable calendar year. The final Model Year of BPCI Advanced will begin on January 1, 2023 and end on December 31, 2023.

Negative Reconciliation Amount -- If applicable, the amount by which all non-excluded Medicare FFS expenditures for a Clinical Episode exceeds the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to an Episode Initiator, together with all Positive Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

Negative Total Reconciliation Amount – If applicable, the negative sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator. CMS will adjust the Negative Total Reconciliation Amount by an Episode-Initiator-specific CQS Adjustment Amount to calculate the Adjusted Negative Total Reconciliation Amount.

Net Payment Reconciliation Amount (NPRA) – If applicable, the amount paid to a Participant by CMS, if the summed total of Adjusted Negative Total Reconciliation Amounts and Adjusted Positive Total Reconciliation Amounts for the Participant and, for Convener Participants, all of a Participant’s Episode Initiators is positive, as specified in the Reconciliation Report deemed to be final pursuant to the BPCI Advanced Model Participation Agreement.

Non-Convener Participant – A Participant that is not a Convener Participant because the Participant does not bear risk on behalf of multiple downstream Episode Initiators to participate in BPCI Advanced. A Non-Convener Participant must itself be an Episode Initiator.

NPRA Shared Payment - Any payment made by the Participant from the BPCI Advanced Savings Pool to an NPRA Sharing Partner pursuant to an NPRA Sharing Agreement.

NPRA Sharing Agreement – The written agreement that exists between the Participant and an NPRA Sharing Partner, formalizing their NPRA sharing arrangement that satisfies the applicable requirements of the BPCI Advanced Model Participation Agreement. Pursuant to such NPRA Sharing Agreement the Participant may permissibly: (1) share NPRA received by the Participant from CMS with NPRA Sharing Partners; and/or (2) apportion a Repayment Amount owed to CMS by the Participant among such NPRA Sharing Partners.

NPRA Sharing Group Practice Practitioner – A physician or non-physician practitioner who is employed by an NPRA Sharing Partner that is a PGP and who: (1) is participating in BPCI Advanced Activities; (2) is identified as an NPRA Sharing Group Practice Practitioner on the Financial Arrangement Screening List; and (3) has entered into a written Partner Distribution Agreement that satisfies all of the applicable requirements of the BPCI Advanced Model Participation Agreement.

NPRA Sharing Partner - A Participating Practitioner, clinician who is employed by an ACH Participant or Episode Initiator, ACH, PGP, ACO, or PAC provider that: (1) is participating in BPCI Advanced Activities; (2) is identified as an NPRA Sharing Partner on the Financial Arrangement Screening List; and (3) has entered into a written NPRA Sharing Agreement that satisfies all of the applicable requirements of the BPCI Advanced Model Participation Agreement.

Participant – An entity that enters into a BPCI Advanced Model Participation Agreement with CMS to participate in the BPCI Advanced initiative. A Participant may only be a Convener Participant or a Non-Convener Participant.

Participating Practitioner – A Medicare-enrolled physician or non-physician practitioner (e.g., nurse practitioner, physician assistant, or physical therapist) who: (1) is participating in BPCI Advanced Activities and (2) has entered into an agreement with the Participant that satisfies all of the applicable requirements of the BPCI Advanced Model Participation Agreement.

Partner Distribution Agreement – A written agreement between a NPRA Sharing Partner PGP and an NPRA Sharing Group Practice Practitioner, formalizing their partner distribution arrangement that satisfies the applicable requirements of the BPCI Advanced Model Participation Agreement. Pursuant to such Partner Distribution Agreement, PGP NPRA Sharing Partners may permissibly: (1) share a Partner Distribution Payment with the NPRA Sharing Group Practice Practitioner; and/or (2) apportion a Shared Repayment Amount owed by the NPRA Sharing Partner to the Participant to such NPRA Sharing Group Practice Practitioner.

Performance Period—The defined period of time during which Clinical Episodes may be triggered under BPCI Advanced.

Performance Period of the Model – The period of time that begins on the first day of the first Performance Period of BPCI Advanced (October 1, 2018) and extends until the final day of the final Performance Period of BPCI Advanced (December 31, 2023).

Physician Group Practices (PGPs)—Medicare-enrolled physician group practices.

Positive Reconciliation Amount – If applicable, the amount by which all non-excluded Medicare FFS expenditures for a Clinical Episode is less than the final Target Price for that Clinical Episode. This amount is summed across all Clinical Episodes attributed to the Episode Initiator, together with all Negative Reconciliation Amounts for such Clinical Episodes, to determine either the Positive Total Reconciliation Amount or the Negative Total Reconciliation Amount, as applicable, for that Episode Initiator.

Positive Total Reconciliation Amount -- If applicable, the positive sum of all Negative Reconciliation Amounts and all Positive Reconciliation Amounts for all Clinical Episodes attributed to an Episode Initiator. CMS will adjust the Positive Total Reconciliation Amount by an Episode-Initiator-specific CQS Adjustment Amount to calculate the Adjusted Positive Total Reconciliation Amount.

Post-Episode Spending Calculation – The financial analysis performed by CMS to determine whether aggregate Medicare FFS expenditures on items and services furnished to BPCI Advanced Beneficiaries during the Post-Episode Spending Monitoring Period exceeds the 99.5% confidence interval of predicted spending for post-discharge days 90-120 under the statistical model used for setting Target Prices , due to cost shifting or other reasons.

Post-Episode Spending Monitoring Period – The period of 30 days after the end of a Clinical Episode during which Medicare FFS spending for items and services furnished to BPCI Advanced Beneficiaries is monitored by CMS for purposes of conducting the Post-Episode Spending Calculation.

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

Reconciliation Report –The report issued by CMS to the Participant following each Performance Period that specifies whether the Participant is eligible to receive an NPRA payment from CMS or is required to pay a Repayment Amount to CMS.

Repayment Amount – If applicable, the amount that must be paid to CMS by a Participant if the summed total of all Adjusted Negative Total Reconciliation Amounts and all Adjusted Positive Total Reconciliation Amounts for the Participant (in the case of a Non-Convener Participant) or for the Participant and all of the Participant’s Episode Initiators (in the case of a Convener Participant) is negative, as specified in the Reconciliation Report deemed to be final in accordance with the BPCI Advanced Model Participation Agreement.

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

Start Date – The first day of the first Performance Period after a Participant begins participating in the Model.

Target Price – The Benchmark Price multiplied by one minus the CMS Discount.

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

Appendix B: BPCI Advanced Quality Measures

The highlighted measures in Table B1 below are claims-based measures for which reporting is required for Participants (and their downstream Episode Initiators) whose participation in the Model begins on October 1, 2018 (the “Required Quality Measures List”) for the first two Model Years (2018 and 2019). These claims-based measures will be collected by CMS directly. The remaining measures are additional measures that may be included in the Required Quality Measures List for Model Year 3 (2020). Beginning on January 1, 2020, Participants will be held accountable for, and must report on all of the applicable measures on this Required Quality Measures List. Each Participant, either on behalf of itself or its downstream providers and suppliers, will be required to report on all applicable non-claims based quality measures no later than February 20 of the year immediately following the Model Year in which the quality measures were applicable. For example, by February 20, 2021, Participants must report on all applicable quality measures for all of 2020.

The Required Quality Measures List may be updated by CMS on an annual basis. In future Model Years, CMS may allow Participants to report on various additional quality measures on a voluntary basis.

Table B1.

Quality Measure Name
Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
All-cause Hospital Readmission Measure (NQF #1789)
CAHPS for Clinicians (NQF #0005)
CAHPS for Hospitals (NQF #0006)
CAHPS Home Health Care (NQF #0166)
Advanced Care Plan (NQF #0326)
Hypertension: Improvement in Blood Pressure (CMS #373)
Drug Regimen Review with Follow-up (CMS #2849)
Surgical Site Infection (SSI) (NQF #0299)
Unplanned Reoperation within the 30 Day Postoperative Period (CMS #1966)
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)
AHRQ Patient Safety Indicators (PSI)

In addition to the above quality measures, CMS intends to assess additional quality measures for purposes of benchmarking to determine whether these quality measures should be incorporated into the Required Quality Measures List in future Model Years. These quality measures may include measures that are either claims-based or that otherwise impose minimal additional reporting burden on Participants. For example, they may include quality improvement and patient safety measures reported via registry to applicable specialist societies by an Episode Initiator or Participating Practitioner.

Participants may have the opportunity to request data to analyze their performance on these measures, if available, by way of the Participant DRA. However, these measures are for benchmarking purposes to assess the potential for including them on the Required Quality Measures List and will not be used to adjust payments under the Model, unless CMS adds them later to the Required Quality Measures List. Participants will receive notice of revisions to the Required Quality Measures List in accordance with BPCI Advanced Model Participation Agreement.

Appendix C: Learning System Strategy and Structure

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

- (1) Drivers of Model Success:** The Learning System will use a data-driven, evidence-based framework for the initiative, which articulates the aims and key drivers for success. The primary drivers of the Model are: (1) Financial Accountability; (2) Care Redesign; (3) Data Analysis and Feedback; (4) Health Care Provider Engagement; and (5) Patient and Caregiver Engagement. These drivers represent the hypothesis of what will work to achieve the aims of the Model based on current shared theories of “cause and effect” in the initiative – i.e., what changes and interventions are expected to lead to the desired effects and outcomes. The current drivers for BPCI Advanced will be improved over time, as clinical and operational evidence and lessons learned emerge throughout the initiative.
- (2) Technical Assistance:** The Technical Assistance function will address programmatic and policy questions raised by the Participants in order to communicate critical information to help Participants understand the initiative and what is required for successful participation. Technical Assistance communications may take the form of webinars, implementation guides, pre-recorded videos, FAQs, etc. In a related vein, the BPCI Advanced Connect Site, described below, will serve as a platform for Technical Assistance communications with Participants, on topics ranging from the details of managing participation in the Model, to operational requirements, and to the new features of the initiative (e.g., quality measurement and reporting).
- (3) Use of Data for Improvement:** In keeping with the aims and drivers of the initiative, data will be collected on an initial set of quality measures. Additional data from CMS and other sources will also be leveraged by the initiative, including claims for the Clinical Episodes, baseline pricing data, and the creation of Participant feedback reports. In turn, the various data sets will be used to support the work of the BPCI Advanced model team and Participants in pursuing improved performance. Of particular note, data that has been de-identified in accordance with HIPAA standards will be used in direct support of Participant Action Groups (see subsequent discussion below).
- (4) Assessment and Feedback:** This Learning System function will involve performing an ongoing needs assessment for Participants in the initiative, while relaying insights back concerning the organizational capabilities required to achieve success. In general, needs assessments will involve the identification of Participants’ priorities and capabilities, as well as change concepts and tactics, problem areas, barriers, performance opportunities, and needs. Related data will be solicited during interviews and focus groups, to provide detailed information that can inform changes and/or improvements to the Learning System and thus provide Participants better Model support. Assessment and feedback activity may also be used to develop an innovation toolkit and/or other supporting materials that capture change concepts.

- (5) **Measuring Model Performance toward Aims:** Building on the use of data, this Learning System function will leverage aggregate de-identified data to provide feedback to the BPCI Advanced model team and Model Participants on relevant performance metrics. The Learning System Dashboard will enable assessment of progress toward Learning System aims and initiative aims from an improvement perspective, while providing actionable data on overall and specific performance trends.
- (6) **Tools and Methods to Capture Improvement and Innovation:** Building on the assessment and feedback function of the Learning System, CMS will provide supporting materials to Participants to capture and disseminate strategies and tactics that increase the likelihood of success. Related materials for BPCI Advanced may include: evidence-based, Clinical Episode-specific resources for care redesign; peer-reviewed articles, controlled studies and academic literature that support promising practices to achieve the initiative aims; articulation of core models for care delivery and operations; and successful strategies and innovation techniques for dissemination. These resources and tools will periodically be revised and updated, based on knowledge gained in the initiative.
- (7) Other Tools and Methods that may be leveraged by the Learning System include spotlight stories, case studies, and similar written and video materials, designed to spotlight exemplar practices and approaches to meeting initiative aims. These spotlights/case studies may be Clinical Episode-specific and/ or based on emerging strategies for success. Such spotlights/case studies will provide key insights and lessons learned from other Participants, and the opportunity to demonstrate the application of a theory or concept in the real world by model Participants. Any such spotlights/case studies may take the form of Best Practice Business Process Flows, Clinical Protocols, Data Sheets, Staffing Mix and Job Description documentation, etc. In general, Tools and Methods for Capturing Improvement and Innovation will be shared via the Connect site, and made available for Participants to access at their convenience.
- (8) **Learning Communities:** The Learning System for BPCI Advanced will create Learning Communities to facilitate peer-to-peer exchange of the most promising practices, while helping to motivate Participants. Learning Communities for the Initiative may be Clinical Episode-specific or initiative-wide in scope, as appropriate and needed by the Participants. In context, CMS anticipates maintaining and deploying strong expertise in high-leverage strategies and tactics for the initiative, in support of and embedded within the Learning Communities. Each Learning Community will engage in the following types of events and activities:
- **All-Participant Events.** These broadly targeted events will focus on supporting the aims of, and success across, the entire initiative. The All-Participants events will also serve as opportunities for CMS and the Learning System team to disseminate important programmatic information and to interact with model Participants.
 - **Affinity Groups.** These are groups of Participants that share a key characteristic (e.g., similar interests, issues, and/or aims) and who elect to join and offer support to each other. Depending on need, a group may convene multiple times to collaborate and help identify opportunities for success.
 - **Participant Action Groups.** Action Groups involve Participants who join together to

accomplish a specific task or solve a common problem. The objective of such groups is to identify and implement a change to respond to the task or problem. An Action Group may convene multiple times over a specific period to discuss, test, and debrief on activities associated with its task.

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