Application Guidance - Models 2-4 of Bundled Payments for Care Improvement

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Overview

This document is designed to offer our applicants additional guidance in completing a strong application for the Bundled Payments for Care Improvement (BPCI) initiative. For complete program descriptions, including selection criteria, we recommend that applicants refer to the Request for Application (RFA), our application question documents, frequently asked questions, and other clarification documents and webinars available on our website at: http://innovations.cms.gov/initiatives/bundled-payments/index.html. Unless specified otherwise, the guidance below applies to Models 2-4. Applicants in this document refer to applicants applying as awardees, awardee conveners, or facilitator conveners applying with designated awardees/awardee conveners.

If applicants continue to have further specific questions that are not addressed by the RFA, application question documents, frequently asked questions, and other clarification documents and webinars, please email us directly at: BundledPayments@cms.hhs.gov.

Overall Guidance for Facilitator Convener Applications

Most questions in the Facilitator Convener application are focused on the facilitator convener's over-arching model. The over-arching model refers to the basic framework, including the care improvement interventions, clinical interventions, gainsharing arrangements, and any other proposed interventions, from which the applicant is operating. There may be instances when the approach for a given individual designated awardee/awardee convener will differ from the over-arching approach. For several questions in Sections B, C, and D for Models 2, 3, and 4 applicants will be asked to identify instances in which their overall response may not apply to all designated awardees/awardee conveners encompassed by the proposal. Optional text boxes are provided for these questions and applicants are asked to highlight when significant deviations from the over-arching approach to a given clinical condition are planned or envisioned for specific designated awardees/awardee conveners.

CMS values the role of the facilitator convener in fostering the participation of large numbers of providers, affecting large numbers of beneficiaries in a consistent, organized and efficient manner, and therefore expects proposed care redesign interventions to be substantially consistent across designated awardees/awardee conveners within a facilitator convener application. Again, we recognize that the care redesign interventions may vary by clinical

condition, and not all designated awardees/awardee conveners in a facilitator convener application may be participating in each proposed episode. CMS is interested in understanding the variation among designated awardees/awardee conveners within a facilitator convener application to better understand how those variations support the unique care redesign opportunities at each designated awardee/awardee convener. By understanding these variations, CMS can assess the strengths and weaknesses of individual designated awardees/awardee conveners; assess the ability of the facilitator convener to effectively support its designated awardees/awardee conveners and foster best practices and continual learning; and assess the extent to which inclusion of the applicant in the initiative would contribute to a model design that would yield valid results that could support rapid replication and scaling.

For the purposes of this application, a significant deviation from the overall framework that the applicant proposes is defined as the planned use of a fundamentally different approach or intervention; the absence of a core element of the over-arching response; the application of the over-arching approach to a fundamentally different population; a difference in the timing of an intervention or approach that is expected to impact the timing of results; or other difference the applicant believes is relevant and merits discussion.

CMS is interested in understanding those deviations that represent a fundamental difference in approach and that have the potential to impact the effectiveness of an intervention. Deviations include the use of different metrics, assessment, and measurement tools; a different timetable for key components of a program or for the entire program; significant differences in support requirements; and differences in projected results.

For instances where there are significant deviations that the applicant describes in the application, the applicant should present a strong rationale for this variation. In addition, if these variations present additional operational/implementation challenges, the applicant should discuss how these challenges will be addressed. The applicant should indicate to which designated awardees/awardee conveners these variations apply.

More specific guidance on the information we are requesting related to deviations for specific sections of the application follows. *Questions specific to each designated awardee/awardee convener can be found in the designated awardee/awardee convener sub-proposals that are to be submitted with the main facilitator convener proposal.*

Section A: Organization Information

Question A4 in the Awardee and Awardee Convener applications, A4 in the Designated Awardee/Awardee Convener sub-proposals: ***Please complete a table identifying the Bundled Payment participating organizations the applicant expects to partner with in this application. For each Bundled Payment participating organization, please include name, contact information, a brief description, bed size of the facility if applicable, type of entity, and whether they are planning to participate in a Medicare shared savings program. Please include the national provider identifier (NPI) and tax identification number (TIN) for all organizations. Include the CMS certification number (CCN) for each organization, as applicable. If the organization listed is an institution (acute care hospital, skilled nursing facility, inpatient rehabilitation facility, long term care hospital), the application will not be processed without a valid CCN. For a physician group practice applicant, please complete a table listing all physicians in the practice and their NPI numbers. Please note for each physician whether they are currently a member of the group and whether they were a member of the group at any time during CY 2008 and CY 2009. Include physicians who are not current members but were during those calendar years.***

Please complete the Bundled Payment participating organization table with information about each Bundled Payment participating organization. Please note that physician group practices (PGPs) are not considered Bundled Payment participating organizations and should not be included in this table. Please complete the physician group practice table *only if* the applicant is a physician group practice. Applicants who are not physician group practices do not need to enter any information into this table. Physician group practice applicants should include all physicians in the practice during CY 2008 and CY 2009.

Section B: Model Design

Section B: Episode Definition

Question B1 in the Awardee and Awardee Convener applications, B2 in the Facilitator Convener application: ***Please complete tables for each episode with the following information: the episode name; the rate of discount; a definition of the end of the episode.***

Because CMS is interested in supporting awardees whose model design lends itself to rapid replication and scaling, in later stages of the selection process, CMS may request changes from applicants on specific aspects of their proposals, including episode definitions, to promote certain commonalities among awardees.

In Model 2, applicants are expected to propose a definition of the end of the episode, which must be at least 30 days following discharge from the acute care hospital. In Model 3, applicants are expected to propose a definition of the end of the episode, which must be at least 30 days following the initiation of the episode. In Model 4, the end of the episode of care is 30 days following discharge from the acute care hospital. Applicants do not have the option to propose a different timeframe for the end of the episode of care in Model 4. For Models 2-4, the day of discharge is counted as day 1.

Question B2 in the Awardee and Awardee Convener applications, B3 in the Facilitator Convener application: Please complete tables defining the MS-DRGs the applicant proposes to use to define the episode of care, episode MS-DRG anchors and proposed exclusions for each episode.

Updated 4.26.2012: In Models 2-4, applicants must propose the anchor MS-DRGs used to define the episode of care. Each episode must include all the related MS-DRG severity levels, which we are designating as an MS-DRG family. In Models 2-4, we have stated that applicants must include, at a minimum, the full family of MS-DRGs based on severity. We encourage applicants to include multiple related MS-DRG families in their episode definition. We understand this may lead to scenarios where an applicant is including an MS-DRG in their episode definition for which the applicant or its episode-initiating Bundled Payment participating organizations (BPPOs) had zero cases in 2009 and, therefore, no target price or bundled payment amount can be estimated based on historical claims data. There may also be situation in which only very few cases are available upon which to set a target price. For these scenarios, the application provides an opportunity in Section C for applicants to indicate whether the target price, bundled payment amount, or number of episode cases is not applicable, but applicants should still include these MS-DRGs in their episode definition, despite having few or zero cases, and include as much information as possible about historical payments made even if there is a small sample size.

CMS is seeking broad episode definitions with few proposed exclusions. In Models 2-4, applicants may propose MS-DRGs to exclude readmissions to an acute care hospital from the episode of care. In Models 2-4, readmissions to acute care hospitals may not be excluded by any other criteria. Applicants may propose excluded non-IPPS Part A and Part B services furnished during the post-discharge period by principal ICD-9 diagnosis code. In Model 4, all Part A and Part B services furnished during *included* readmissions are included in the episode of care; all Part A and Part B services furnished during *excluded* readmissions are excluded from the episode of care. Applicants are *not* able to propose additional exclusions by other criteria (such as principal ICD-9 diagnosis codes) in Model 4.

Section B: Model Design – Provider Engagement

In all Models of the BCPI initiative CMS is seeking applications that present strong evidence of physician/practitioner commitment to align incentives through care redesign. In addition, CMS is seeking applications that present strong evidence of other participating providers' commitment. The questions in this section provide a series of opportunities to demonstrate different aspects of physician/practitioner and provider organization engagement.

In the BPCI initiative, CMS uses the terms Bundled Payment participating organization (BPPO), episode-initiating BPPOs, which are a subset of BPPOs, and Bundled Payment physicians/practitioners (BPPP). Please see the application documents for definitions of these terms.

Applicants in this initiative may propose to use gainsharing as a tool to align incentives to redesign care. Some BPPOs and BPPPs may participate in this initiative without participating in gainsharing arrangements. The subset of BPPOs and BPPPs who are participating in gainsharing arrangements are referred to as **Enrolled BPPOs and BPPPs.** Note that the term Bundled Payment physicians/practitioners (BPPPs), and more generally the term "practitioners," may include physicians as well as nonphysician practitioners.

Question B3 in the Awardee and Awardee Convener applications, B2 in the Designated Awardee/Awardee Convener sub-proposal: Please attach letters of agreement from Bundled Payment physicians/practitioners or physician/practitioner representatives who may be separately paid by Medicare for their professional services indicating their willingness to participate in this model, including describing any gainsharing agreements, if applicable. These letters should demonstrate agreement that the applicant shall coordinate any distribution of gains resulting from care improvement under this initiative.

In response to this question, please attach letters from BPPPs or their representatives indicating their endorsement of and engagement in the BPCI initiative. There is no minimum required number of letters. There is no required format for these letters. Applicants may create a form letter if they wish. Applicants may obtain letters from physician or practitioner representatives (e.g., Chief Medical Officer, Chief Nursing Officer) on behalf of multiple physicians or nonphysician practitioners.

If not all BPPPs are or plan to become Enrolled BPPPs (that is, BPPPs who are participating in gainsharing arrangements), please obtain letters from both BPPPs and Enrolled BPPPs. These letters do not need to specify the terms of gainsharing arrangements. These letters themselves are not binding gainsharing arrangement contracts. BPPPs who sign these letters may later opt out of gainsharing arrangements; physicians/practitioners who do not sign letters of agreement

for inclusion in the application may become Enrolled BPPPs (opt in to a gainsharing arrangement) at a later date in accordance with the procedures for becoming an Enrolled BPPP, proposed by the applicant.

Designated awardees/awardee conveners should attach letters from BPPPs in their sub-proposals, not in the Facilitator Convener main application.

Please estimate the proportion of physicians/practitioners (those planning to participate in gainsharing arrangements and those who are not) regularly practicing in all of the care settings that are part of the application, including physicians/practitioners at Bundled Payment participating organizations, who are represented in these letters of agreement.

Question B4 in the Awardee application, B4-B5 in the Awardee Convener application, B3-B4 in the Designated Awardee/Awardee Convener sub-proposals:

- ***Awardees: Please attach letters of agreement from Bundled Payment participating organizations indicating their willingness to participate in this model, including describing any agreements to share gains and/or risk, if applicable.***
- ***Awardee Conveners: Please attach letters of agreement from each of the applicant's episode-initiating Bundled Payment participating organizations indicating their willingness to participate in this initiative. The letters should be executed by individuals who are able to pledge participation on behalf of these organizations. Please attach letters of agreement from Bundled Payment participating organizations indicating their willingness to participate in this model, including describing any agreements to share gains and/or risk, if applicable.***
- ***Designated Awardees/Designated Awardee Conveners: Please attach letters of agreement from Bundled Payment participating organizations indicating their willingness to participate in this model, including describing any agreements to share gains and/or risk, if applicable. For designated awardee conveners, please attach letters of agreement from each of the designated awardee convener's episode-initiating Bundled Payment participating organizations indicating their willingness to participate in this initiative. The letters should be executed by individuals who are able to pledge participation on behalf of these organizations.***

In response to this question, please attach a letter from each BPPO, including episode-initiating BPPOs as applicable, indicating their willingness to participate in this initiative. The letters should be executed by individuals who are able to pledge participation on behalf of these organizations. There is no required format for these letters. Applicants may create a form letter if they wish.

The applicant may propose a gainsharing methodology where not all BPPOs will be Enrolled BPPOs (that is, BPPOs that are participating in gainsharing). Please obtain letters from all BPPOs, whether enrolled in gainsharing arrangements or not. The letters from Enrolled BPPOs should indicate these BPPOs' willingness to participate in gainsharing arrangements. These letters do not need to explain the exact methodology for distributing gains, nor do these letters constitute a formal gainsharing contract.

Question B5 in the Awardee application, B6 in the Awardee Convener application, B5 in the Facilitator Convener application:

- ***Awardees and Awardee Conveners: Please describe the applicant's plan to disclose participation in this initiative to physicians/practitioners practicing at the applicant organization or its Bundled Payment participating organizations.***
- ***Facilitator Conveners: Describe the over-arching plan to disclose designated awardees/awardee conveners' participation in this initiative to physicians/practitioners providing care to beneficiaries who may be eligible. This would include all physicians/practitioners providing care related to the proposed episodes AND all physicians/practitioners on the medical staff or providing care at designated awardees/awardee conveners and their partner Bundled Payment participating organizations.***

This question refers to the applicant's plan to inform physicians/practitioners who are not yet involved in the BPCI initiative (and may not be aware of the BPCI initiative) of the applicant organization's and BPPOs' participation in this initiative. Please note that all eligible beneficiaries must be included in the payment model; it is not possible for a physician/practitioner to "opt out" of participation in the payment model in this initiative. Therefore, it is essential that applicants and their BPPOs have strong plans for informing physicians/practitioners of the applicant organization's involvement in this initiative. The focus of this question is about physician/practitioner notification about the initiative. The question that follows is focused on physician/practitioner endorsement and engagement, which we expect to be a more concerted effort aimed at achieving widespread physician/practitioner participation in care redesign efforts during the course of the initiative.

Question B6 in the Awardee application, B7 in the Awardee Convener application, and B6 in the Facilitator Convener application: Please describe the applicant's plan to obtain widespread endorsement and engagement by physicians/practitioners at the applicant organization and its Bundled Payment participating organizations for this initiative. Describe the applicant's plan to retain Bundled Payment physicians/practitioners and Bundled Payment participating organizations in care redesign activities related to this initiative.

CMS is interested in robust plans to obtain and retain widespread endorsement and engagement by physicians/practitioners at the applicant organization and its BPPOs during the course of this initiative. We expect applicants to have significant physician/practitioner buy-in prior to submitting the application, as evidenced in the letters of agreement submitted in question B3 in the Awardee and Awardee Convener applications and B2 in the Designated Awardee/Awardee Convener sub-proposal. However, CMS expects the applicant to continue obtaining widespread endorsement and engagement from physicians/practitioners, including engagement with physicians/practitioners who are not engaged in BPCI care redesign efforts at the time of application, throughout the performance period of this initiative.

Please also include information on the proportion of total physicians/practitioners affiliated with the applicant and/or its Bundled Payment participating organizations that are salaried/employed by the applicant and/or its BPPOs or independent, the proportion of physicians/practitioners that are represented in the letters of agreement that are salaried/employed or independent, and in what way the plan to obtain and retain widespread endorsement and engagement may differ for employed/salaried vs. independent physicians/practitioners. Facilitator conveners need not indicate the proportion of employed/salaried physicians at each one of its designated awardee/awardee conveners, but rather may estimate the proportion within the entire application.

As discussed in the RFA, the applications, and this document, physicians may participate in this initiative with or without participating in gainsharing arrangements. As part of the plan to obtain and retain endorsement and engagement by physicians/practitioners in the initiative broadly, please also include the number of physicians/practitioners the applicant is currently expecting to participate in gainsharing arrangements across all care settings and how the applicant plans to expand this number during the course of the initiative.

Section B: Model Design – Care Improvement

Question B7 in the Awardee application, B8 in the Awardee Convener application, B7 in the Facilitator Convener application: Please describe the applicant's plan for care redesign in order to achieve Bundled Payments for Care Improvement outcomes. Include specific mechanisms and actions to redesign care processes in the following areas, at a minimum: evidence-based medicine; beneficiary/caregiver engagement; coordination of care; and care transitions.

A central aim of this initiative is to promote better care at lower costs by using episode-based care to support care redesign. In all models, applicants are asked to describe their proposed comprehensive care redesign interventions, including how these proposed care redesign interventions include and respond to beneficiary experiences of care. It is important that applicants clearly articulate their comprehensive care improvement plan here. This question focuses on the plan for care improvement, which may be based off of current or past initiatives. The applicant should provide a clear picture of how participation in this initiative will further the applicant's and its BPPOs' care improvement goals beyond what they have been able to accomplish with past/current initiatives. Later in the application, applicants are asked how gainsharing will support the care improvement strategies detailed here (in the gainsharing section of Section B), how the planned care improvement interventions will result in improved efficiency, cost savings, and/or reduced Medicare spending (in Section C), how evidence from

past experience and research indicates that the planned care improvement interventions will result in improved quality of care (in Section D), experience using care redesign strategies (in Section E), and how the proposed care improvement interventions will relate to current care improvement/redesign efforts (in Section E).

Facilitator convener applicants are asked to describe the over-arching approach to care redesign and assessment of beneficiary/caregiver experience of care. Facilitator conveners are asked to highlight significant deviations from this plan for proposed designated awardees/awardee conveners in the additional text boxes provided in this section. CMS recognizes that facilitator conveners might propose multiple sets of care redesign interventions, especially if they are targeting multiple clinical conditions. Care improvement plans that vary by clinical condition should be addressed in the main response. However, if there is variation in the care improvement plan among the designated awardees/awardee conveners for the same clinical condition, it should be elucidated in the additional text box. That is, for example, Hospital A and Hospital B could both target cardiac procedures, but it is planned for Hospital A to redesign emergency department procedures and Hospital B to target device implants. A strong application would include a discussion that describes this difference in approach.

Section B: Model Design – Gainsharing

Applicants in this initiative may propose to use gainsharing as a tool to align incentives to redesign care. Gainsharing in the BPCI initiative includes distribution of gains accrued due to internal organizational cost savings during the episode of care, as well as distribution of gains received via episode reconciliation payment(s). Because gainsharing is a tool to support care redesign, gainsharing payments must be tied to actual changes in behavior and/or increases in quality. CMS is interested in understanding the proposed methodology that awardees (whether an awardee, awardee convener, designated awardee/awardee convener) will use to track changes in behavior, patterns of care, and quality; the algorithms awardees will use to allocate gainsharing payments; the logistical mechanisms for distributing those gainsharing payments (i.e., which legal entity will be paying whom and how); the contractual relationships governing the distribution of payments (i.e., who will contract with whom); and the entities overseeing these gainsharing arrangements (i.e., what entity determines whether gainsharing requirements have been met and whether gainsharing payments can be made).

In the BPCI initiative, CMS uses the terms Bundled Payment participating organization (BPPO), episode-initiating BPPOs, which are a subset of BPPOs, and Bundled Payment physicians/practitioners (BPPP). Please see the application documents for definitions of these terms.

Awardees who propose and are approved to use gainsharing as a tool in this initiative will establish **gainsharing arrangement contracts** among the entities who will share gains. This may include gainsharing arrangement contracts between the awardee and its BPPPs, between the awardee and its BPPOs, between its BPPOs and *their* BPPPs, and/or among BPPOs. As discussed in the provider engagement section, some BPPOs and BPPPs may participate in this initiative without participating in gainsharing arrangements. The subset of BPPOs and BPPPs who are participating in gainsharing arrangements and are parties to gainsharing arrangement contracts are referred to as **Enrolled BPPOs and BPPPs.** If the Enrolled BPPOs and BPPPs do not meet gainsharing requirements, the Enrolled BPPO or BPPP should not receive gainsharing payments at the time of disbursement. Note that Bundled Payment physicians/practitioners (BPPPs) may include physicians as well as nonphysician practitioners.

Please see the guidance below, broken down by question, for more details on the information to be included in a successful application.

Question B12 in the Awardee application, B13 in the Awardee Convener application, and B14 in the Facilitator Convener application: Please describe the applicant's and its Bundled Payment participating organizations' prior or current experience with any gainsharing or pay-for-performance initiatives, including with Medicare, Medicaid, or commercial purchasers. Please describe at a high level the gainsharing methodology used and how cost savings and quality of care were measured to determine gainsharing payments.

In this question, we ask applicants to describe current or past experience with gainsharing or pay-for-performance initiatives. Please provide a high level description of the initiative(s) and the gainsharing methodology. If the methodology is the same as the one the applicant would like to propose for this initiative, please describe the methodology in depth in the questions that follow; the information in the response to this question should be general.

Question B13 in the Awardee application, B14 in the Awardee Convener application, and B15 in the Facilitator Convener application: Describe the applicant's proposed methodology for sharing gains among Bundled Payment participating organizations and physicians/practitioners, including with whom gains will be shared, the proportion of gains to be shared with Bundled Payment participating organizations and with physicians/practitioners, the mechanism for calculating gains, the timing and periodicity of payment determinations, and the timing and method of distributing gains. Specify the plan to ensure that gainsharing payments to physicians/practitioners do not exceed 50% of the amount normally paid by Medicare to physicians/practitioners for the episodes included in

the initiative. Describe how the allocation of gains will incorporate best practice norms, quality, patient safety, patient experience, and efficiency measures.

In response to this question, applicants should address the following:

1. Methodology for allocating gains
2. Capacity to track internal costs, quality performance, and changes in care that can be attributed to actions taken by BPPOs and/or BPPPs (e.g., HIT capabilities, information sharing between and among awardee, BPPOs, and BPPPs)
3. Contractual relationships
    a. Who are signatories to gainsharing arrangement contracts?
    b. Are BPPPs employed (salaried) or independent? Does this change the signatories of the gainsharing arrangement contracts?

The applicant should describe its methodology to allocate gains to Enrolled BPPPs and BPPOs accrued due to internal organizational cost savings or due to episode reconciliation payment(s) from CMS. A successful description of the applicant's proposed gainsharing methodology will describe the algorithms used to allocate payments to Enrolled BPPPs and BPPOs. This should include the activities in care redesign that will lead to cost savings and the estimated savings that are anticipated to result from the redesign.

If gains are to be shared between the awardee and Enrolled BPPOs, the applicant should describe how gains will be allocated among Enrolled BPPOs (e.g., allocated by type of BPPO, or a different percentage for episode-initiating BPPOs versus other BPPOs). If gains are to be shared with Enrolled BPPPs, the applicant should describe how gains will be allocated among Enrolled BPPPs (e.g., by BPPP type such as physician vs. nonphysician practitioners, by BPPP specialty, by employed/salaried BPPPs s. independent BPPPs). The methodology for allocating gains among BPPPs may vary by the organization with whom the BPPP is contracted. For example, an awardee may have a SNF BPPO. The awardee may allocate gains among its BPPPs according to a different methodology than the SNF BPPO allocates gains among *its* BPPPs. The applicant should describe all of these aspects of the methodology in response to this question.

The applicant should describe how the methodology for allocating gains among Enrolled BPPOs and BPPPs is tied to an incentive system which rewards individual Enrolled BPPOs and BPPPs for performance improvement. Performance improvement may include quality metrics, compliance with care improvement interventions (e.g., discharge planning processes), efficiency, patient experience of care, patient safety, and other criteria within the parameters laid out in the BPCI Request for Applications.

In Model 4, the participating hospital (awardee or episode-initiating BPPO) will receive a single bundled payment for each episode of care as payment in full. The hospital is then responsible for distributing payment to providers as appropriate. Physicians would be paid by the hospital for their professional services, which could be at the same rate as the FFS payment that would otherwise apply, or could be at another rate agreed to between the providers and physicians as proposed by the applicant. Any physician payment in Model 4 that is higher than the Medicare Physician Fee Schedule payment that would otherwise apply, whether that be a hospital's base rate for physician services or the base rate plus incentive payments, is considered gainsharing. Applicants for Model 4 should describe these gainsharing arrangements in accordance with the guidance in this document, the Request for Application, and other BPCI materials.

To successfully use gainsharing payments as a way to incentivize care redesign, the awardee and its BPPOs must have the capacity to track the proposed interventions, corresponding changes in care, corresponding changes in quality, and corresponding changes in internal cost savings attributable to actions taken by the BPPOs and/or BPPPs. The applicant should describe the systems they will use to drive change, track Medicare payments to awardees and BPPOs and changes in internal awardee and BPPO costs, and monitor changes in quality indicators to inform gainsharing decisions. This should include a description of the health information technology (HIT) that allows the awardee and/or BPPO to track these changes. This should also include a description of the information sharing arrangements among awardees and BPPOs that allow an awardee to track this information across settings. The systems used to track changes in payment, cost, and quality across an awardee and its BPPOs should have the capacity to identify the cost savings achieved per beneficiary; identify the providers (BPPOs, BPPP, or non-participating providers) providing care to that beneficiary and the quality of that care; and compare the costs and quality of that care to benchmarks of best practices norms or averages across peer groups.

Lastly, the applicant should describe the gainsharing arrangement contracts. This must include identification of which parties will be signatories to the gainsharing arrangement contracts. For facilitator conveners, please describe the parties to the gainsharing arrangement contracts among all designated awardees and designated awardee conveners. For awardee conveners and designated awardee conveners, this includes a description of whether the gainsharing contracts will be held by a parent company, an individual Medicare provider/supplier on behalf of the whole initiative, multiple individual Medicare providers/suppliers (e.g., individual hospitals or post-acute providers), or another entity that must be described in detail. For all awardee types, the applicant should describe the entity the awardee would contract with in BPPO gainsharing arrangement contracts, for example, parent companies, individual Medicare provider/suppliers, or others, which must be described in detail. For BPPOs that wish to hold

gainsharing arrangement contracts with *their* BPPPs, the applicant should describe the contractual arrangements between the awardee, the BPPO, and the BPPPs in those scenarios. For all awardee types, the applicant should describe whether the BPPP gainsharing arrangement contracts will be with individual physicians, physician group practices, IPAs, or others, which must be described in detail. In the case where the gainsharing arrangement contract would be with physician group practices and IPAs, please describe whether gainsharing participation would be voluntary, what the process would be to contract with new BPPPs or BPPPs outside of the group or IPA, and the parameters in place to ensure that distribution of gainsharing incentive payments are made only to BPPPs that have met the gainsharing requirements. Please indicate which contracts will be with employed/salaried physicians vs. independent physicians. If the signatories of gainsharing arrangement contracts for employed/salaried physicians vs. independent physicians will be different, please describe.

Question B14 in the Awardee application, B15 in the Awardee Convener application, and B16 in the Facilitator Convener application: Please describe how the applicant's proposed gainsharing methodology will support care improvement, and specify proposed safeguards and quality control mechanisms to ensure that medically necessary care is not reduced to achieve savings.

In response to this question, applicants should address the following:

1. What care redesign interventions are gainsharing payments associated with?
2. What entities are overseeing gainsharing arrangements? (e.g., what entities make decisions on who may become an Enrolled BPPO or BPPP, and what entities make decisions on which Enrolled BPPOs and BPPPs have met gainsharing requirements and therefore receive gainsharing incentive payments?)

In this initiative, CMS views gainsharing payments as a tool to align BPPO and BPPP incentives to redesign care towards better outcomes for beneficiaries. Therefore, the applicant should describe how gainsharing will be used as a tool to support the care improvement plan described in the care improvement section in Section B. For example, if the applicant's proposed care improvement intervention involves redesigning care in a specific service line, the proposed gainsharing would most likely involve BPPOs and BPPPs involved in that clinical area. In response to this question, the applicant should specifically reference the care improvement interventions described in the care improvement section in Section B of the application.

Applicants should include a specific description of the entities providing oversight over gainsharing arrangements and the entities making decisions regarding the criteria for who

receives gainsharing incentive payments. For example, this could be the governing board of the awardee, a subcommittee of that board, the governing board of a company that owns the awardee, or a separate board designed to govern this initiative. These are examples and are not an exhaustive list. The entity or entities making determinations regarding the disbursement of gainsharing incentive payments may be the same entities or different entities than the awardee; may be the same entities or different entities than the governing bodies of the awardee and their BPPOs; may be the same entities or different entities than the entities who hold gainsharing arrangement contracts with Enrolled BPPPs or Enrolled BPPOs; and may be the same or different entities than the entities that actually disburse gainsharing payments.

Question B15 in the Awardee application, B16 in the Awardee Convener application, and B17 in the Facilitator Convener application: Describe the eligibility requirements, such as quality thresholds and quality improvement requirements, for physicians/practitioners and Bundled Payment participating organizations to participate in gainsharing. Include a discussion of how a physician/practitioner or Bundled Payment participating organization may become eligible or ineligible to participate in gainsharing.

In response to this question, applicants should address the following:

1. The process, including quality and other criteria, to become an Enrolled BPPO or BPPP
2. The gainsharing requirements, including quality or other criteria, for an Enrolled BPPO or BPPP to receive a gainsharing incentive payment

The applicant should describe the process by which a BPPO or BPPP becomes an Enrolled BPPO or BPPP and is therefore eligible to receive gainsharing incentive payments. This must include quality criteria that the BPPO or BPPP must meet, and may include other criteria (e.g., an applicant may propose that a physician must have had admitting privileges at the awardee or relevant BPPO for a certain number of months prior to becoming an Enrolled BPPP).

The applicant should describe the gainsharing requirements, including quality and any other criteria an Enrolled BPPP or BPPO must meet to receive a gainsharing incentive payment. It is possible that in a given disbursement period, not every Enrolled BPPP and BPPO will actually receive a gainsharing payment if the BPPP or BPPO has not met specified gainsharing requirements.

Section C: Financial Model

Question C1 in the Awardee and the Awardee Convener applications, C1 or C2 in the Designated Awardee/Awardee Convener Sub-Proposal

For Awardee Conveners in Model 3, applicants should provide a target price for each anchor MS-DRG in the episode at the applicant level. In this model (unlike Models 2 and 4), applicants are *not* asked to propose different target prices for each episode-initiating BPPO. Table C1 should be completed for each episode-initiating BPPO and the historical number of episode cases for each anchor MS-DRG should be indicated. Table C2 is populated at the awardee convener level and applicants should propose a single target price for each anchor MS-DRG in the episode that reflects the volume weighted average of the historical episode payments for all episode-initiating BPPOs with the incorporated discount.

Regarding Physician Group Practice (PGP) applicants, we recognize that for PGP applicants, there may be no systematic way to identify every beneficiary who would initiate an episode under the BPCI initiative due to the encryption of the NPI in the claims data provided. If the applicant is a physician group practice applicant and is having trouble constructing a target price or bundled payment amount because of this, we ask the applicant to do its best at estimating a hospital-specific target price that incorporates all physicians in the PGP for each hospital at which a member of the PGP practices. We understand this may result in imprecise proposed target prices or bundled payment amounts. Please describe any concerns about the analysis in the response to the question that asks about limitations to the data used to construct the target price or bundled payment amount, and we will take these inaccuracies into account later in the application and review process.

Updated 5.08.12: Regarding convener applicants, the episode parameters (anchor MS-DRGs, length of episode, discount rate, and excluded services) must be consistent across all providers. For *facilitator conveners*, it is *not* necessary that all designated awardees/designated awardee conveners participate in every proposed episode. For *awardee conveners*, all episode-initiating BPPOs *must* participate in *all* episodes. For example, a Model 2 facilitator convener is working with 30 hospitals and proposes an episode of cardiac care and an episode of orthopedic care. The convener may designate that only 20 of the hospitals will participate in the cardiac episode, whereas all 30 hospitals will participate in the orthopedic episode. For each hospital that participates in the cardiac episode, the episode parameters (anchor MS-DRGs, length of episode, discount rate, and excluded services) must be the same. For each hospital that participates in the orthopedic episode, the episode definition (MS-DRGs included, length of episode, discount rate, and excluded services) must be the same. If a Model 2 awardee

convener is working with 30 episode-initiating BPPOs and proposing both a cardiac episode and an orthopedic episode, all 30 episode-initiating BPPOs must participate in both the cardiac episode and the orthopedic episode.

Regarding Home Health Claims Data in Models 2 and 3, we note that due to the time period of the claims data distributed in conjunction with the BPCI initiative, many of the claims for home health services starting after November 1, 2009, are not in the files. As such, episodes of care constructed for beneficiaries who may have received home health services beginning in November and December of 2009 may not include all relevant home health agency services rendered to those beneficiaries. The failure to include Medicare payment for home health agency services furnished during the episode of care could result in proposed target prices that do not include all services that were historically rendered to beneficiaries. If there is concern that this is a significant problem in constructing episodes for beneficiaries, please only include episodes of care that start on or after 1/1/2009 and end on or before 10/31/2009 when calculating target prices or bundled payment amounts. Please indicate this in the application, in response to the question that asks about limitations to the data used to construct target prices or bundled payment amounts.

Updated 4.26.2012: Regarding beneficiary liability amounts**,** you should provide your proposed target price or bundled payment amount in terms comparable to a Medicare approved amount, without considering any coinsurance or deductibles that may apply. This means that deductibles and coinsurance that were historically applicable to services that are part of the episode you are analyzing should be included in your target price or bundled payment amount proposal.

Updated 4.26.2012: Regarding Model 3 initiation, under Model 3, an episode is initiated by the start of post-acute services for a beneficiary with an awardee or episode-initiating BPPO SNF, IRF, LTCH, or HHA within 30 days of beneficiary discharge from an acute care hospital stay for an agreed-upon anchor MS-DRG, as stated in the applications. **Note that a Model 3 episode is only triggered by initiation of Medicare Part A covered services at the relevant SNF, IRF, LTCH, or HHA, and not by the initiation of any service.**

Updated 5.08.12: Regarding Model 3 initiation following multiple admissions, under *Model 3,* if an eligible beneficiary discharged from any acute care hospital for an included MS-DRG then initiates care with an awardee or episode-initiating SNF, IRF, HHA or LTCH within 30 days of discharge, that beneficiary would initiate a Model 3 episode. At the point of initiation of post-acute services and thus Model 3 initiation in this scenario, if the beneficiary has had two

separate hospital admissions for two different anchor MS-DRGs within the prior 30 days and had no covered Part A services rendered at a SNF, IRF, LTCH, or HHA in the time between the two admissions, the most recent discharge would be the one to trigger the Model 3 episode of care.

Updated 4.26.2012: Regarding inpatient psychiatric facilities, inpatient psychiatric facilities (IPFs) are considered to be acute inpatient facilities in this initiative for purposes of readmissions but not for anchor hospitalization purposes. As such, services that are rendered in an IPF during the post-discharge period of a Model 4 episode are considered readmissions and should be included in target price calculations. If you would like to exclude services that occur in an IPF from your Model 2, 3, or 4 episode, you may do this by including the MS-DRGs you consider unrelated in your list of proposed excluded MS-DRGs. Inpatient stays at IPFs cannot anchor episodes in any model.

Updated 4.26.2012: Clarification of what services constitute a readmission, for the purpose of Model 4 episode construction and MS-DRG based exclusions for Models 2, 3, and 4

Admissions to acute care IPPS hospitals, Maryland hospitals, Critical Access Hospitals, Cancer Hospitals, Children's Hospitals, and Inpatient Psychiatric Facilities are considered readmissions under the Bundled Payments for Care Improvement initiative. Readmissions to these types of facilities will be included in Model 4 unless explicitly excluded as unrelated by MS-DRG. Readmissions to these types of facilities can be excluded from Model 2 and 3 episodes by MS-DRG. *(Only admissions to acute-care IPPS hospitals can anchor episodes in all models).*

Admissions to Inpatient Rehabilitation Facilities, Skilled Nursing Facilities, and Long-Term Care Hospitals are considered post-acute services for purposes of this initiative. They will not be included in Model 4 episodes. They will be included in Model 2 and Model 3 episodes unless explicitly excluded as unrelated by principal ICD-9 diagnosis code.

Updated 4.26.2012: Regarding the time period of the analysis, please use only episodes that both start and end in calendar year 2009 to complete your analysis. In Models 2 and 4, the episode begins at hospital admission. As such, if the admission date is in 2008, the episode does not start and end in calendar year 2009 even if the claim through date is in 2009 and thus the claim appears in the 2009 file. In Model 3, if an anchor admission begins in 2008, the episode can be included as long as post-acute services are initiated (and thus the episode is initiated) in calendar year 2009.

Updated 4.26.2012: Regarding the discount percentage, your discount percent should be applied to the Medicare allowed amount, not to the paid amount.

***Updated 4.26.2012: Regarding use of statistical or actuarial techniques*,** we are aware that small sample sizes may introduce statistical uncertainty into proposed target prices or bundled payment amounts, and we ask that you please do not use statistical or actuarial techniques to adjust your estimates. We will be recreating your proposed target prices or bundled payment amounts and will examine the appropriate statistical techniques to set target prices or bundled payment amounts in a way that ensures no undue risk is being introduced to awardees.

***Updated 5.08.12; updated 4.26.2012: Regarding transfers*,** if an eligible beneficiary is admitted to an awardee or episode-initiating BPPO and then transferred to another acute inpatient hospital, he or she is included in the program if the admission at the awardee or episode-initiating BPPO is for an anchor MS-DRG. In this case, the admission at the hospital to which the beneficiary is transferred may be excluded from the episode if it is considered unrelated based on the MS-DRGs the applicant has proposed as being unrelated and thus excluded readmissions. Additionally, note that the date of transfer is counted as day 1 of the post-discharge period, for purposes of counting the episode length or readmissions period. If an eligible beneficiary is admitted to a non-participating acute inpatient hospital and transferred to an awardee or episode-initiating BPPO hospital, he or she is included in the program if the admission at the awardee or episode-initiating BPPO is for an anchor MS-DRG. In Model 2 and Model 4, the episode of care will begin at admission to the awardee or episode-initiating BPPO if the admission is for an anchor MS-DRG. As such, any Medicare payments made during the initial hospital stay should not be included if the episode is initiated at the hospital which receives the transferred beneficiary.

If an eligible beneficiary initiates an episode by being admitted to an awardee or episode-initiating BPPO for an anchor MS-DRG, and is then transferred to another awardee or episode-initiating BPPO for one of that organization's anchor MS-DRGs, the eligible beneficiary will not initiate an episode at the second hospital but will remain in the episode that was initiated at the first hospital.

If an eligible beneficiary is admitted to a Model 4 awardee or episode-initiating BPPO for an anchor MS-DRG but under Medicare fee-for-service rules the hospital would not receive the entire MS-DRG payment on behalf of that beneficiary (such as due to a shortened stay or transfer), the beneficiary will not initiate a Model 4 episode.

Updated 4.26.2012: Regarding the cell size suppression policy, applications to the Bundled Payments for Care Improvement initiative are not subject to the cell size suppression policy explained in the DUA.

***Questions C3-C4 in the Facilitator Convener main application:* Please describe how the planned care improvement interventions that the applicant proposed in Section B will result in improved efficiency, cost savings, and/or reduced Medicare spending. Please describe any other cost-saving approaches included the over-arching plan, such as the use of formularies, negotiations for implantable device purchases based on clinical standardization , protocols for discharge, etc. Please use the optional additional text box below to highlight significant deviations for individual designated awardees/awardee conveners. The text box should not be used to expand on the over-arching response.**

For facilitator conveners, a complete response to questions C3 and C4 will identify if and how specific outcomes may be expected to differ materially for specific designated awardees/awardee conveners, including expected differences in improved efficiency and cost savings. The applicant should comment on the extent to which any expected differences in outcomes for a specific designated awardee are driven by differences in service mix, population or provider type, whether these differences impose additional support requirements, and the applicant's planned role in providing related support. Applicants should describe the extent to which cost savings approaches for an awardee may deviate from the over-arching plan, particularly in the areas of formularies, implantable devices, clinical standardization, and protocols for discharge.

Section D: Quality of Care and Patient Centeredness

Section D: Quality of Care and Patient Centeredness – Quality Improvement and Quality Assurance *(Questions D1-17 in the Awardee and Awardee Convener applications and D1-14 in the Designated Awardee/Awardee Convener sub-proposal)*

Recently, payers and providers have been experimenting with payment approaches that attempt to align incentives between providers, physicians, and nonphysician practitioners in the Fee-For-Service (FFS) payment system to foster working together to improve clinical quality and efficiency while enhancing the patient experience of care. We believe cooperative engagement by physicians, hospitals, and post-acute providers in this initiative has the potential to significantly improve the efficiency and quality of patient care. Accordingly, in this section of the application, the applicant is provided the opportunity to showcase past experiences in quality improvement, discuss how planned care improvement interventions in its proposal will result in improved quality and patient experience of care, as well as propose specific quality measures that would be directly applicable in monitoring the planned care improvement interventions discussed in Section B. The questions in this section are designed to allow applicants to highlight provider and physician quality improvement experiences, both in Medicare-specific settings as well as non-Medicare-specific (including private sector) quality improvement activities, in order to show that the applicant is ready and able to fulfill the

quality requirements under the BPCI initiative. Applicants should discuss the quality improvement measures that will be reported to CMS and the internal quality assurance efforts that we expect will be used to monitor internal activities and for gainsharing.

Question D1 in the Facilitator Convener application: ***Using evidence from past experience and research, please describe how the planned care improvement interventions described in Section B will result in improved quality and patient experience of care?***

Facilitator convener applicants may use the additional text box to comment on the extent to which designated awardees/awardee conveners can, based on research or past experience, expect more or less favorable results than those generally expected from the care improvement strategies described in Section B.

Question D2 in the Awardee, Awardee Convener, and Facilitator Convener applications: ***Please complete a table proposing measures to assess quality performance, patient functionality, patient and caregiver experience, care coordination and transitions, and patient safety. Include the source and evidence of the reliability of each measure (e.g., endorsed by the National Quality Forum), as well as proposed descriptions of numerators and denominators. If the applicant is proposing multiple episodes, please complete a separate table for each episode.***

Please include a brief narrative description of which individuals would be included in the numerators and denominators for the quality measures proposed in these tables (e.g., all individuals or all FFS Medicare beneficiaries admitted to a facility or receiving a procedure).

Questions D4-6 in the Awardee and the Awardee Convener applications, D2-4 in the Designated Awardee/Awardee Convener Sub-Proposal:

- ***B4. If the applicant or any of its Bundled Payment participating organizations are acute care hospitals, please describe their experience with the Medicare Hospital Inpatient Quality Reporting (Hospital IQR) Program and the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). Include whether all organizations have received full IPPS (since at least FY 2007) and OPPS (since at least CY 2009) annual payment updates for reporting measures, and a description of achievements in quality improvement. Please include past performance with the Hospital IQR program and the HOP QDRP. CMS expects that any applicants and Bundled Payment participating organizations that are acute care hospitals will maintain or improve performance on the measures reported through the Hospital IQR program and the HOP QDRP; decreased performance during the period of this initiative may result in termination.***
- ***B5. Please describe the applicant's (if a Medicare provider/supplier) and its Bundled Payment participating organizations' experience with other mandatory CMS quality measurement and improvement initiatives, such as Nursing Home Compare. Include a description of past***

performance and achievements in quality improvement. CMS expects that the applicant (if a Medicare provider/supplier)and its Bundled Payment participating organizations will maintain or improve their performance on the measures reported in any mandatory CMS quality measurement and improvement initiatives; decreased performance during the period of this initiative may result in termination.

- ***B6. Please describe the applicant's (if a Medicare provider/supplier), its Bundled Payment participating organizations', and Bundled Payment physicians'/practitioners' experience with voluntary Medicare quality measurement and improvement initiatives, including the Physicians Quality Reporting System (PQRS). Include a description of past performance and achievements in quality improvement. Please describe the extent and percentage of physicians/practitioners who are included in these programs. Please include whether physicians not currently participating in PQRS will participate for the duration of the project and discuss plans to encourage physician participation if selected. Physician participation and performance in PQRS should remain steady or improve during this initiative. If participation or performance shows a marked decline, CMS may terminate the agreement.***

CMS will expect awardees and participating physicians and nonphysician practitioners to maintain or improve their aggregate performance on the measures reported through Hospital IQR, Hospital Outpatient Quality Data Reporting Program (HOP QDRP), and the Physician Quality Reporting System (PQRS) for the duration of the program.

Question D9 in the Awardee and the Awardee Convener applications, D5 in the Facilitator Convener application, and D7 in the Designated Awardee/Awardee Convener Sub-Proposal: ***Please describe the applicant's and its Bundled Payment participating organizations' experience with assessment tools, including the Continuity Assessment Record and Evaluation (CARE) tool (or comparable tool). Please describe how such a tool would be used during the initiative.***

We note awardees will be expected to use a tool to evaluate beneficiary condition at discharge from the hospital, as well as periodically throughout the episode including during periods of post-acute care, to ensure quality and document patterns in patient referrals as they relate to patient health status. A strong application will include a description of past experience using such a tool and how the applicant plans to improve beneficiary care and satisfaction.

Designated awardees/awardee conveners are asked to describe their experience using assessment tools in their sub-proposals (question D7). Facilitator convener applicants are asked in question D5 for *their* experience using assessment tools. Please describe whether the facilitator convener will be supporting the designated awardees/awardee conveners in the use of these tools. Facilitator convener applicants are encouraged to use the additional text box to summarize differences in experience with assessment tools as well as how these tools would be used among the designated awardees/awardee conveners.

Question D9-11 in the Facilitator Convener application:

- ***D9: Please describe the over-arching plan for beneficiary protections beyond those components outlined above.***
- ***D10: Please describe the over-arching plan to ensure beneficiary freedom of choice of providers.***
- ***D11: Please describe the over-arching plan for beneficiary notification of participation in this initiative as well as ongoing processes to handle and track beneficiary questions and concerns.***

Deviations from the over-arching plan to protect and engage beneficiaries and to ensure choice should be highlighted along with information regarding if and how these differences may be expected to materially impact beneficiaries.

Question D14 in the Awardee and Awardee Convener applications, D11 in the Designated Awardee/Awardee Convener sub-proposal: Please complete a table describing the certifications and accreditations that the applicant and its Bundled Payment participating organizations have earned.

Please provide the certifications and accreditations for the applicant organization if it is a Medicare provider or supplier and its Bundled Payment participating organizations. Applicants do not need to provide information about physicians or departments.

Question D15 in the Awardee and Awardee Convener applications, D12 in the Designated Awardee/Awardee Convener sub-proposal: Please complete a table describing any sanctions, investigations, probations or corrective action plans that the applicant, its physicians/practitioners and/or Bundled Payment participating organizations are currently undergoing or have undergone in the last three years.

For each issue, please describe the current status and/or resolution, as applicable, including actions the applicant, BPPOs, or BPPPs took in response to the issue.

Please report whether the applicant organization, its physicians/practitioners, and/or Bundled Payment participating organizations have ever been the target of a federal agency, state agency, or accrediting organization investigation (e.g., Department of Justice, Office of Inspector General, State Survey Agencies, The Joint Commission). If so, please describe the investigation and the status.

Updated 5.22.12: Specific guidance on the level of detail to provide is as follows. If you have questions regarding what level of detail to provide in response to this question, please contact

us directly and specify the examining agency (e.g. federal agency, state agency, accrediting organization, etc.)

For hospitals, IRFs, LTCHs, and HHAs accredited under an approved Medicare accreditation program, please describe any serious deficiencies cited by the accrediting organization, such as Requirements for Improvement from the Joint Commission (there is no need to describe supplemental Requirements for Improvement). Please describe any instances in the past three years where your hospital has been denied accreditation or has received conditional accreditation.

For all hospitals, IRFs, LTCHs, HHAs or other providers, whether or not accredited, please report any immediate jeopardy deficiencies or Medicare condition-level deficiencies cited by the State Survey Agency or an accrediting organization in the past three years. For nursing homes, please report deficiencies cited at the G-level or higher. Describe the status of the corresponding corrective action plan associated with these deficiencies.

Section D: Quality of Care and Patient Centeredness – Beneficiary Protections *(Questions D18-21 in the Awardee and the Awardee Convener applications, D9-12 in the Facilitator Convener application)*

Beneficiaries are entitled to seek care from any provider of their choosing. In all models, applicants are asked to describe their beneficiary protections, including protecting the beneficiary's freedom to choose his or her own provider, and the applicant's plan to promote beneficiary engagement and education. A strong application would include a description of the patient notification process, including how it will be implemented and documented.

Question D12 in the Facilitator Convener application*: *Please describe the over-arching plan for beneficiary engagement and education.

Facilitator convener applicants should use the additional text box provided in this question to describe significant deviations in the over-arching plan for beneficiary engagement. For example, variation in the patient mix (e.g., due to differences in clinical condition targeted or differences due to demographic variation of the overall patient population) at the designated awardees/awardee conveners that results in an overall different approach to beneficiary education should be described. Variation in the structure of beneficiary involvement (e.g., Designated Awardee Convener A has a Beneficiary Steering Committee specifically to guide this initiative versus Designated Awardee B has one beneficiary sitting on an existing steering committee for the hospital) is another example of variation that should be described.

Conversely, slight variations in the implementation details of a beneficiary education program (e.g., Designated Awardees A and B are both hosting listening sessions to understand beneficiary concerns but one is hosting weekly listening sessions and the other monthly) is not a substantial variation that would merit description in the application.

Section E: Organizational Capabilities, Prior Experience, and Readiness

Section E: Financial Arrangements

Question E2 in the Awardee application, E3 in the Awardee Convener application, and E3 the Designated Awardee/Awardee Convener sub-proposal: Please describe the financial and logistical mechanisms for distributing any gains resulting from care improvement under this initiative.

Please identify the entity that will distribute gainsharing incentive payments. This may or may not be the awardee itself. This may or may not be the same entities who are signatories of gainsharing arrangement contracts with BPPOs, the awardee, or BPPPs. For example, an awardee convener who receives a reconciliation payment from CMS may disburse funds to BPPPs directly, may disburse funds to BPPOs directly, may disburse funds to only episode-initiating BPPOs directly and those episode-initiating BPPOs may further disburse funds to other BPPOs and BPPPs. This is not a comprehensive list of potential arrangements.