BUNDLED PAYMENTS FOR CARE IMPROVEMENTS-ADVANCED
TODAY’S SPEAKERS

Dr. Jonathan Piccini, MD, MHS
Associate Professor of Medicine
Duke University Medical Center and Duke Clinical Research Institute

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Program Manager, Payment Innovation
Dignity Health

Christine Rutan, CPHQ
National Director, Quality and Health IT
American Heart Association
GOALS OF TODAY’S WEBINAR:

1. Describe the purpose, structure and current status of BPCI Advanced
2. Discuss potential benefits of participating in BPCI Advanced
3. Understand how GWTG can support successful participation
4. Review the BPCI Advanced application process and timelines
BUNDLED PAYMENTS

ECONOMIC CONCEPT

“Bundled clinical episode” payments link hospitalization, post acute care and ambulatory care.

Payments under the bundle are tied to quality and cost.

Participants may earn additional payments, but may owe money if costs higher than expected.

CLINICAL CONCEPT

Shifts emphasis from individual services to a coordinated clinical episode.

Establishes an accountable party to lead and coordinate patient care.

Drives innovation and improvement through focus on quality, outcomes and efficiency.
WHAT IS BCPI ADVANCED?

- BCPI-Advanced is a voluntary model intended to incentivize providers to explore innovative practice models to:
  - Better coordinate care
  - Reduce costs
  - Improve quality of care
- Scope is Medicare FFS beneficiaries
- BCPI-Advanced Qualifies as an Advanced Alternative Payment Model (AAPM). AAPM participation has many potential benefits, including a 5% bonus and exclusion from MIPS
- Participants expected to redesign care delivery, coordinate entire episode of care and reduce costs while maintaining or improving performance on quality measures.
Clinical Episode triggered by an Inpatient Hospital Stay (Anchor Stay)

Clinical Episode attributed to Acute Care Hospital

Care provided under standard fee-for-service payments

At the end of each performance period, quality and cost performance are assessed.
HOW DOES IT WORK?

• Available bundles include 33 inpatient clinical episodes and 4 outpatient clinical episodes starting in Y3, including AMI, HF and Stroke

• Single retrospective payment and risk track with a 90-day episode duration

• Target prices are set using an established formula and provided prior to each model year

• Participants bear financial risk for total cost of care for all Medicare FFS services and items provided during a clinical episode.

• Payment tied to performance on quality measures

• Claims for an inpatient stay (Anchor Stay) or an outpatient procedure (Anchor Procedure) at an acute care hospital trigger clinical episodes.
WHO PARTICIPATES IN BCPI-A?

**Conveners:**
- Bring together downstream episode initiators (EI) to participate
- Facilitate EIs working together to coordinate care
- Bear and allocate financial risk.

**Non-Conveners:**
- EIs that bear financial risk only for themselves and do not have any Downstream EIs.
- Only acute care hospitals and physician group practices may participate as non-conveners.
DIGNITY HEALTH PARTICIPATION IN CMS BUNDLED PAYMENT PROGRAMS

**Hospital**
Including BPCI, BPCI-A, and CJR, bundle programs across **31 different hospitals**

Opportunity to build infrastructure for broader **Population Health** and **Value Based Care** goals

**Care Redesign**
**Collaborative efforts** among hospitals, providers, post-acute facilities, and external partners

Reductions in high acuity post-acute care utilization and **increase in discharges home with home health**

**Financial**
**CMS and hospital savings** earned through the bundled payment programs

**Physician**
Program provides analytic feedback and develops **evidence-based knowledge**

Establishes **competencies** for future models
WHAT’S NEW IN MODEL Y3?

- CMS worked with established registries, including GWTG-Stroke, GWTG-HF and GWTG-CAD, to identify measures that align with each of the specialty clinical episodes.

- In model year 3, participants have the flexibility to elect to report Administrative Quality Measures Set or Alternate Quality Measures Set, which is a combination of claims-based and registry-based measures.

- Alternate measure sets have not been announced yet, so we can’t share which GWTG measures will be reported.

- More information on Model Year 3 measure sets expected to be released before June 24, 2019.
### 33 INPATIENT CLINICAL EPISODES

#### SPINE, BONE, AND JOINT
- Back and neck except spinal fusion
- Spinal fusion (non-cervical)
- Cervical spinal fusion
- Combined anterior posterior spinal fusion
- Fractures of the femur and hip or pelvis
- Hip and femur procedures except major joint
- Lower extremity/humerus procedure except hip, foot, femur
- Major joint replacement of the lower extremity (MJRLE)
- Major joint replacement of the upper extremity
- Double joint replacement of the lower extremity

#### KIDNEY
- Renal failure

#### INFECTIOUS DISEASE
- Cellulitis
- Sepsis
- Urinary tract infection

#### NEUROLOGICAL
- Seizures
  - Stroke
33 INPATIENT CLINICAL EPISODES

CARDIAC
- Transcatheter Aortic Valve Replacement**
- Acute myocardial infarction
- Cardiac arrhythmia
- Cardiac defibrillator
- Cardiac valve
- Pacemaker
- Percutaneous coronary intervention
- Coronary artery bypass graft
- Congestive heart failure

PULMONARY
- Simple pneumonia and respiratory infections
- COPD, bronchitis, asthma

GASTROINTESTINAL
- Bariatric Surgery**
- Inflammatory Bowel Disease**
- Major bowel procedure
- Gastrointestinal hemorrhage
- Gastrointestinal obstruction
- Disorders of the liver excluding malignancy, cirrhosis, alcoholic hepatitis
ITEMS TO CONSIDER:

DATA TO DRIVE DECISIONS ABOUT BUNDLES AND PARTICIPATION

- Financial and clinical data to forecast performance
- Quality Data to understand current performance and improvement opportunities

ALIGNMENT

- What registries do or can you participate in to support reporting
- Who may be participating in your area. BCPI-A site lists participants in excel or you can search via the interactive map: https://innovation.cms.gov/initiatives/bpci-advanced/#overview

APPLY AND DECIDE

- Applicants will receive historical claims data files and preliminary target prices in late September 2019.
- Submitting an application does not obligate hospitals to participate. Applicants will have 2-3 months to review historical data and target prices before committing.
- May terminate participation at any time without penalty after 90 days’ advance written notice.
TIMING AND OPPORTUNITY

• First cohort started on 10/1/2018 and performance period runs through 12/31/2023.

• CMS accepting applications now for cohort 2 (Model year 3).

• Cohort 2 starts on 1/1/2020 and runs through 12/31/2023.

• Application deadline for Cohort 2, Model Y3 is June 24th
WHY PARTICIPATE?

1. CMS is moving towards payment models that reward value instead of volume of care.

2. BPCI Advanced provides an opportunity to prepare for value-based care while participation remains voluntary.

3. Provides resources and support to redesign care and improve coordination across providers
HOW CAN GWTG HELP?

GWTG-Stroke, GWTG-HF and GWTG-CAD are expected to be reporting options

AHA will report quality measure results to CMS

Low burden reporting for registry participants

Suite of tools and resources to help improve processes and maximize effectiveness
HOW CAN GWTG HELP?

Registry participation promotes consistent adherence to the latest scientific treatment guidelines

Real-time reports on guideline-supported metrics allow hospitals to continuously monitor performance and correct course

Ability to drill down to identify outliers

Focus on improving systems of care

Numerous studies demonstrate GWTG’s success in improving patient outcomes
DR. JONATHAN PICCINI, MD, MHS
GWTG Bridges the Gap Between Knowledge and Routine Clinical Practice

AHA Guidelines

- Clinical trial evidence
- National guidelines

Systems

- Implement evidence-based care
- Improve communications
- Ensure compliance

Clinical Practice

- Improve quality of care
- Improve outcomes

Adapted from the American Heart Association.; 2001.
GWTG-STROKE IMPROVES OUTCOMES

- GWTG focuses on care standardization and the consistent application of evidence-based guidelines in all patients.
- The program has shown rapid and sustained improvement year over year in evidence-based stroke care, especially in Achievement measures, which have the strongest process outcome link.
- A study comparing 366 GWTG-Stroke hospitals with non-participating hospitals showed accelerated reductions in 30-day and one year mortality and sustained reductions over 18 months.

FOCUSING ON MEASURES THAT MATTER

• GWTG-Stroke deploys focused improvement programs.
• In 2010, Target: Stroke launched with the goal of doubling the number of eligible patients who receive Alteplase within the 60-minute DTN timeframe.
• 1200 hospitals enrolled and deployed best practice strategies associated with shorter Door-to-needle times.
• Resources, including focused education and sample protocols as well as a recognition program were provided.
• In 2013-14, this goal was reached. Today, 75% of patients are treated within the 60min time

### GWTG-HF MEASURES

<table>
<thead>
<tr>
<th>Achievement</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ACE/ARB or ARNI at discharge</td>
<td>• Aldosterone Antagonist at discharge for patients with HFrEF</td>
</tr>
<tr>
<td>• Evidence-bases specific beta blockers</td>
<td>• Anticoagulation for atrial fibrillation or flutter</td>
</tr>
<tr>
<td>• Measure LV Function</td>
<td>• ARNI at discharge</td>
</tr>
<tr>
<td>• Post-discharge appointment for heart Failure patients</td>
<td>• Hydralazine/nitrate at discharge</td>
</tr>
<tr>
<td></td>
<td>• DVT prophylaxis</td>
</tr>
<tr>
<td></td>
<td>• CRT-D or CRT-P placed or prescribed at discharge</td>
</tr>
<tr>
<td></td>
<td>• ICD counseling or ICD placed or prescribed at discharge</td>
</tr>
<tr>
<td></td>
<td>• Influenza vaccination</td>
</tr>
<tr>
<td></td>
<td>• Pneumococcal vaccination</td>
</tr>
<tr>
<td></td>
<td>• Follow-up visit in 7 days or less</td>
</tr>
</tbody>
</table>
## THE PROCESS OUTCOME LINK

<table>
<thead>
<tr>
<th>Guideline Recommended Therapy</th>
<th>Relative Risk Reduction in Mortality</th>
<th>Number Needed to Treat for Mortality</th>
<th>NNT for Mortality (standardized to 36 months)</th>
<th>Relative Risk Reduction in HF Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI/ARB</td>
<td>17%</td>
<td>22 over 42 months</td>
<td>26</td>
<td>31%</td>
</tr>
<tr>
<td>ARNI</td>
<td>16%</td>
<td>36 over 27 months</td>
<td>27</td>
<td>21%</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>34%</td>
<td>28 over 12 months</td>
<td>9</td>
<td>41%</td>
</tr>
<tr>
<td>Aldosterone Antagonist</td>
<td>30%</td>
<td>9 over 24 months</td>
<td>6</td>
<td>35%</td>
</tr>
<tr>
<td>Hydralazine/Nitrate</td>
<td>43%</td>
<td>25 over 10 months</td>
<td>7</td>
<td>33%</td>
</tr>
<tr>
<td>Ivabradine</td>
<td>10%</td>
<td>100 over 23 months</td>
<td>64</td>
<td>26%</td>
</tr>
<tr>
<td>CRT</td>
<td>36%</td>
<td>12 over 24 months</td>
<td>8</td>
<td>52%</td>
</tr>
<tr>
<td>ICD</td>
<td>23%</td>
<td>14 over 60 months</td>
<td>23</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Guideline Recommended Therapy

<table>
<thead>
<tr>
<th>Guideline Recommended Therapy</th>
<th>HF Patient Population Eligible for Treatment, n*</th>
<th>Current HF Population Eligible and Untreated, n (%</th>
<th>Potential Lives Saved per Year</th>
<th>Potential Lives Saved per Year (Sensitivity Range*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI/ARB</td>
<td>2,459,644</td>
<td>501,767 (20.4)</td>
<td>6516</td>
<td>(3336-11,260)</td>
</tr>
<tr>
<td>Beta-blocker</td>
<td>2,512,560</td>
<td>361,809 (14.4)</td>
<td>12,922</td>
<td>(6616-22,329)</td>
</tr>
<tr>
<td>Aldosterone Antagonist</td>
<td>603,014</td>
<td>385,326 (63.9)</td>
<td>21,407</td>
<td>(10,960-36,991)</td>
</tr>
<tr>
<td>Hydralazine/Nitrate</td>
<td>150,754</td>
<td>139,749 (92.7)</td>
<td>6655</td>
<td>(3407-11,500)</td>
</tr>
<tr>
<td>CRT</td>
<td>326,151</td>
<td>199,604 (61.2)</td>
<td>8317</td>
<td>(4258-14,372)</td>
</tr>
<tr>
<td>ICD</td>
<td>1,725,732</td>
<td>852,512 (49.4)</td>
<td>12,179</td>
<td>(6236-21,045)</td>
</tr>
<tr>
<td>ARNI (replacing ACEI/ARB)</td>
<td>2,287,296</td>
<td>2,287,296 (100)</td>
<td>28,484</td>
<td>(18,230-41,017)</td>
</tr>
</tbody>
</table>

## GW TG-CAD MEASURES

**A FOCUS ON SYSTEMS OF CARE THROUGH AHA’S MISSION: LIFELINE PROGRAM**

<table>
<thead>
<tr>
<th>Receiving Center</th>
<th>Referral Center</th>
<th>NSTEMI-ACS Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary PCI ≤ 90 minutes</td>
<td>• ECG within 10 minutes of Arrival</td>
<td>• Cardiac Rehabilitation Patient Referral from an Inpatient Setting</td>
</tr>
<tr>
<td>• EMS First Medical Contact to Primary PCI ≤ 90 minutes</td>
<td>• Arrival to Thrombolytics in 30 minutes</td>
<td>• ACE-Inhibitor or Angiotensin Receptor Blocker (ARB) for LVSD at Discharge</td>
</tr>
<tr>
<td>• Aspirin at Arrival</td>
<td>• Arrival to PCI Transfer within 45 minutes</td>
<td>• Dual Antiplatelet Therapy Prescribed at Discharge</td>
</tr>
<tr>
<td>• Aspirin at Discharge</td>
<td>• Aspirin at Arrival</td>
<td>• Evaluation of LV Systolic Function</td>
</tr>
<tr>
<td>• Beta-Blocker at Discharge</td>
<td>• Aspirin at Discharge</td>
<td>• Adult Smoking Cessation Advice</td>
</tr>
<tr>
<td>• Statin at Discharge</td>
<td>• Beta-Blocker at Discharge</td>
<td></td>
</tr>
</tbody>
</table>
First Medical Contact-to-Device times (FMC) According to Hospital Implementation of Key Interventions

• Coronary reperfusion can be greatly accelerated by coordinated care between hospitals and EMS

• When a prehospital ECG revealed a STEMI, the cath lab was activated through ED notification without the involvement of cardiology 78% of the time.
CHRISTINE RUTAN, CPHQ
SUBMITTING AN APPLICATION

• **Remember:** Submitting an application does not obligate hospitals to participate in the model.

• Applicants will have 2–3 months to review historical data and preliminary target prices before committing to participate.

• Applications must be submitted through the CMS online portal by 11:59 p.m. ET on Monday, June 24.
STEPS TO APPLY

Read the BPCI Advanced RFA

Review the MY3 Application Resources

Register for the BPCI Advanced Application Portal

Complete your application in the BPCI Advanced Application Portal

Submit the application in the BPCI Advanced Application Portal

Supporting Documents needed:
1) Application template
2) Application Attachment – Participating Organizations Template
3) Application Portal Walkthrough

Make sure to complete ALL sections of the application. CMS will not process incomplete applications.

CMS will review application with errors upon hitting the submit button. If there are errors, you will need to fix the errors before resubmitting. NO applications through email will be accepted.
April 2019

May 2019

June 2019

July 2019

August 2019

Sept 2019

Oct 2019

Nov 2019

Dec 2019

Jan 2020

4/24/2019: CMS releases call for applications for Cohort 3

6/24/2019: Application period ends

Late Sept.: CMS provides historical claims data and preliminary target prices.

Deadline to decide whether to participate. Participation agreements due to CMS.

Model year 3 begins

Remaining deliverables due to CMS
HELPFUL LINKS

• Cohort 2 (Model Year 3) Fact Sheet: https://innovation.cms.gov/Files/fact-sheet/bpciadvanced-my3-modeloverviewfs.pdf

APPLICATION PORTAL:

□ For NEW applicants: https://app1.innovation.cms.gov/bpciadvancedapp
□ Current participants can go to their BPCI account and add MY3

• BPCI Advanced Info: https://innovation.cms.gov/initiatives/bpci-advanced/

• Questions for BPCI Advanced Team, please email BPCIAdvanced@cms.hhs.gov