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

Samantha Ross, MPH
Program Manager, Payment Innovation
Dignity Health

Christine Rutan, CPHQ
National Director, Quality and Health IT
American Heart Association

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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

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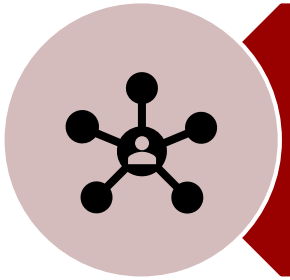
BUNDLED PAYMENTS

ECONOMIC CONCEPT

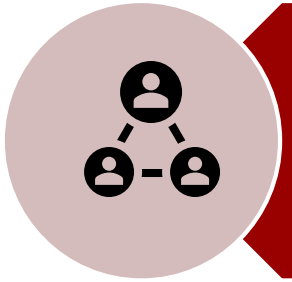


"Bundled clinical episode" payments link hospitalization, post acute care and ambulatory care

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

BUNDLED PAYMENTS FOR CARE IMPROVEMENT-ADVANCED (BCPI-ADVANCED)

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.

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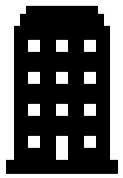
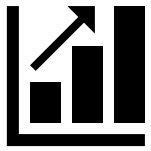
BCPI-ADVANCED AT A GLANCE

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.

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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.

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WHO PARTICIPATES IN BCPI-A?

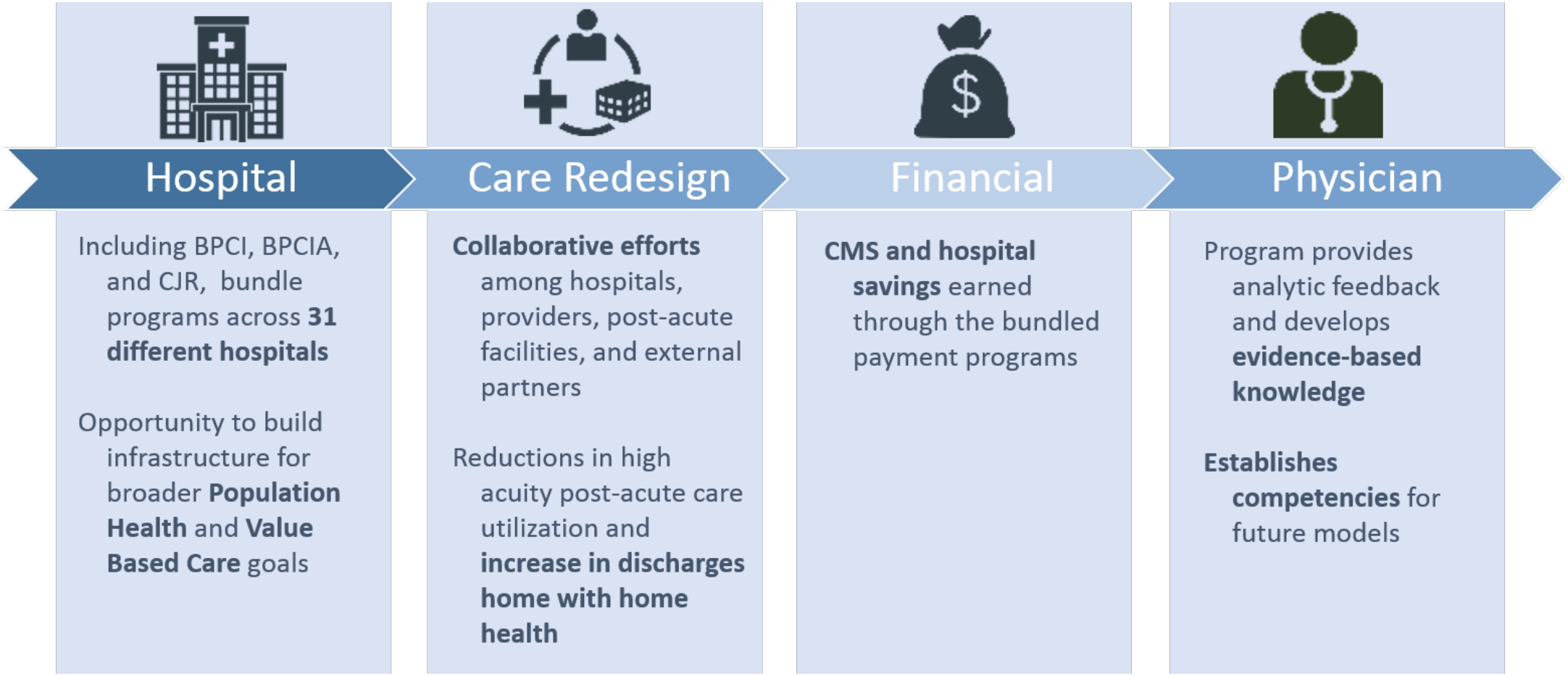
Conveners:

- 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



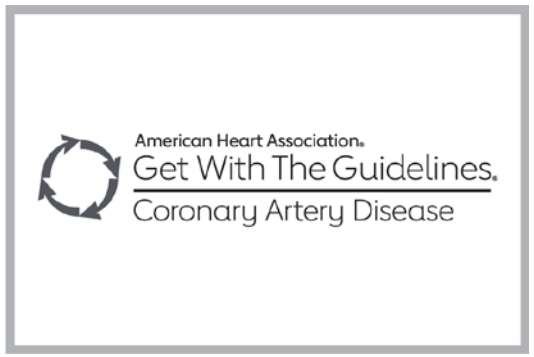
WHAT'S NEW IN MODEL Y3?

Y1&2

Administrative Quality Measures sets ONLY

Y3

Option to use registries for Quality Reporting



- 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.

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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

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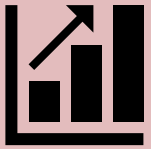
HOW CAN GWTG HELP?

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

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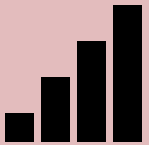
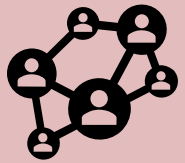
HOW CAN GWTG HELP?

Registry participation promotes consistent adherence to the latest scientific treatment guidelines

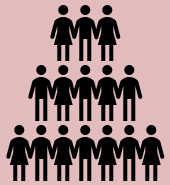


Real-time reports on guideline-supported metrics allow hospitals to continuously monitor performance and correct course

Ability to drill down to identify outliers



Focus on improving systems of care



Numerous studies demonstrate GWTG's success in improving patient outcomes

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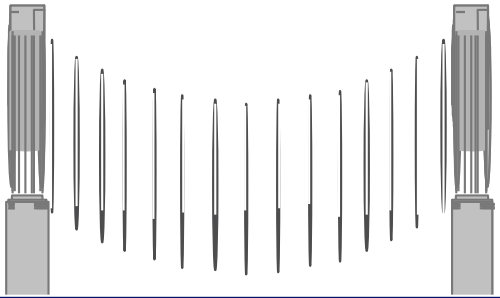
DR. JONATHAN PICCINI, MD, MHS

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.

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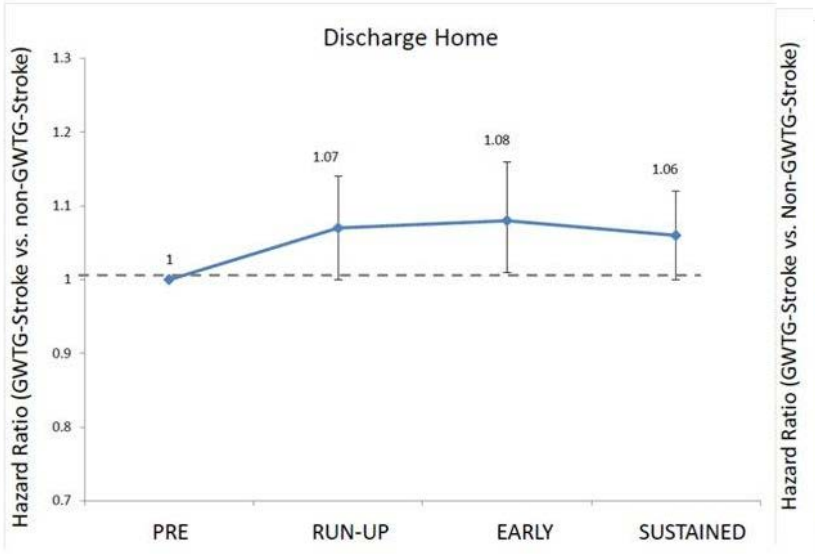
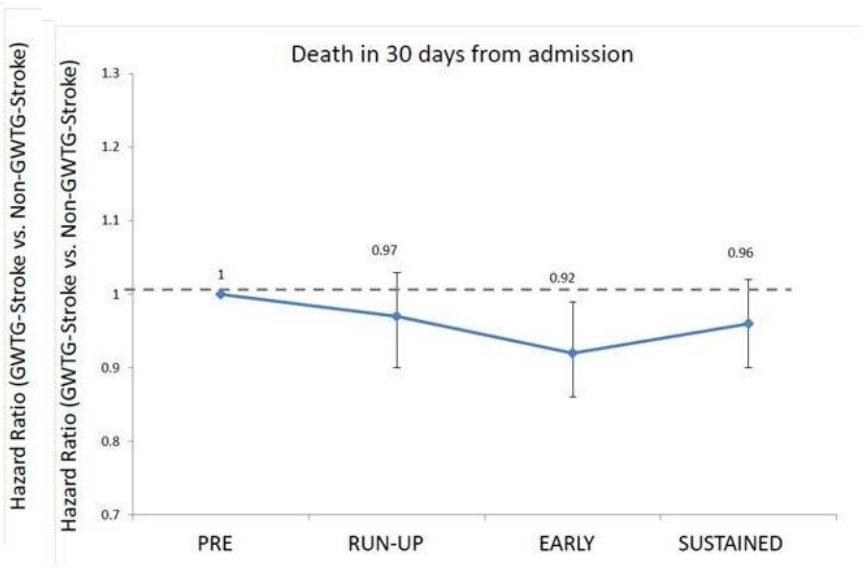
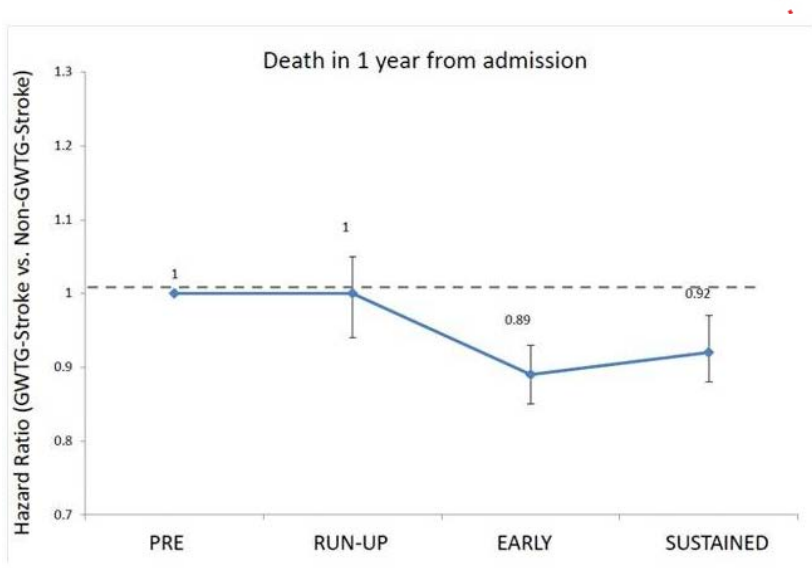
GWTG-STROKE IMPROVES OUTCOMES

- 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.







Song S, Fonarow GC, Olson DM, et al. Association of Get With The Guidelines-Stroke Program Participation and Clinical Outcomes for Medicare Beneficiaries With Ischemic Stroke. *Stroke*. 2016;47(5):1294–1302. doi:10.1161/STROKEAHA.115.011874

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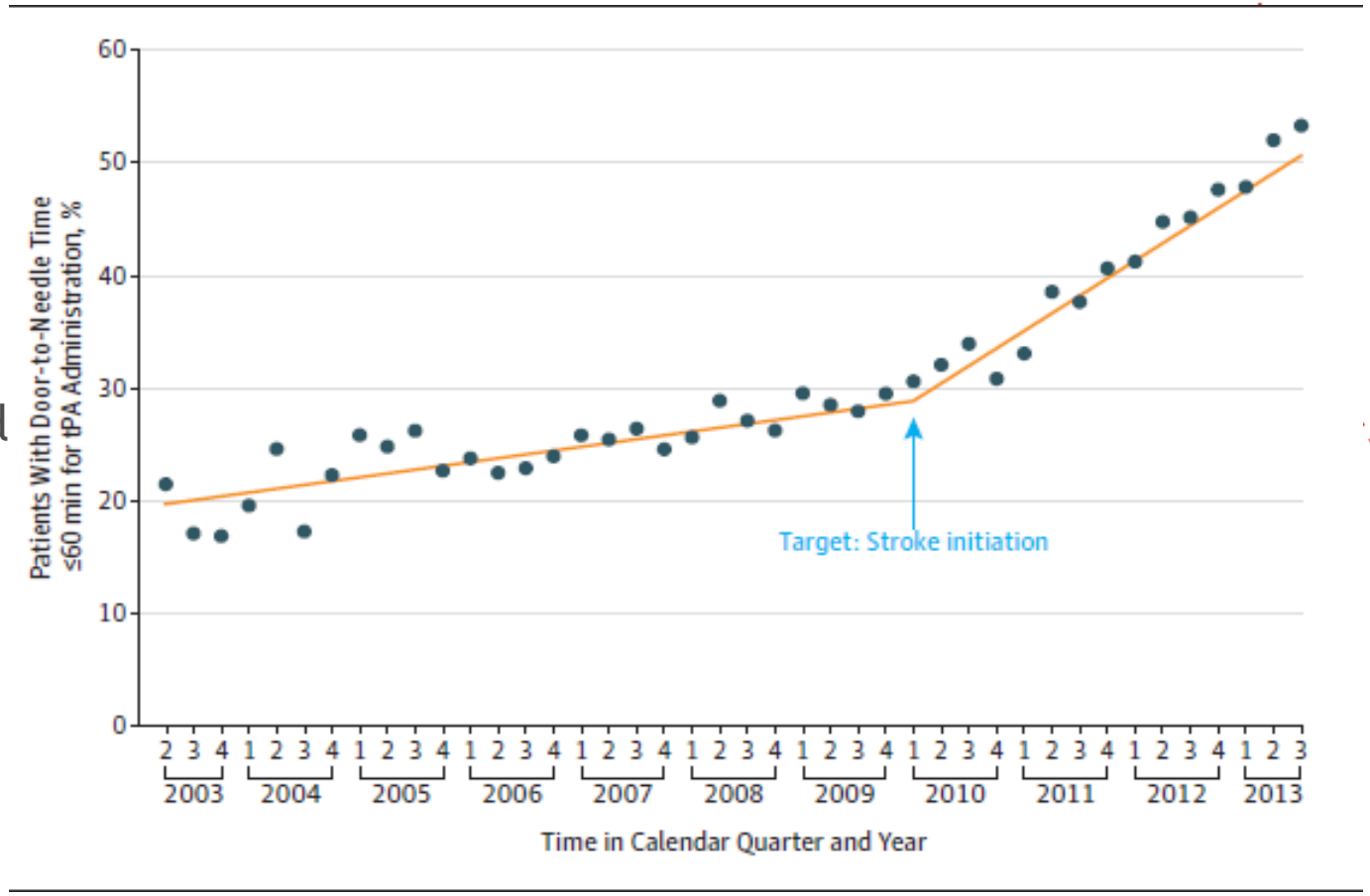
FOCUSING ON MEASURES THAT MATTER

- 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



Fonarow GC, Zhao X, Smith EE, et al. Door-to-Needle Times for Tissue Plasminogen Activator Administration and Clinical Outcomes in Acute Ischemic Stroke Before and After a Quality Improvement Initiative. *JAMA.* 2014;311(16):1632–1640. doi:10.1001/jama.2014.3203

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GWTG-HF MEASURES

Achievement

- ACE/ARB or ARNI at discharge
- Evidence-bases specific beta blockers
- Measure LV Function
- Post-discharge appointment for heart Failure patients

Quality

- Aldosterone Antagonist at discharge for patients with HFrEF
- Anticoagulation for atrial fibrillation or flutter
- ARNI at discharge
- Hydralazine/nitrate at discharge
- DVT prophylaxis
- CRT-D or CRT-P placed or prescribed at discharge
- ICD counseling or ICD placed or prescribed at discharge
- Influenza vaccination
- Pneumococcal vaccination
- Follow-up visit in 7 days or less

THE PROCESS OUTCOME LINK

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

Updated from Fonarow GC, et al. Am Heart J 2011;161:1024-1030.

THE PROCESS OUTCOME LINK

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

Updated from Fonarow GC, et al. Am Heart J 2011;161:1024-1030. and JAMA Cardiology 2016

GWTG-CAD MEASURES

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

Receiving Center

- Primary PCI ≤ 90 minutes
- EMS First Medical Contact to Primary PCI ≤ 90 minutes
- Aspirin at Arrival
- Aspirin at Discharge
- Beta-Blocker at Discharge
- Statin at Discharge
- Adult Smoking Cessation Advice
- Arrival at First Facility to Primary PCI ≤ 120 minutes

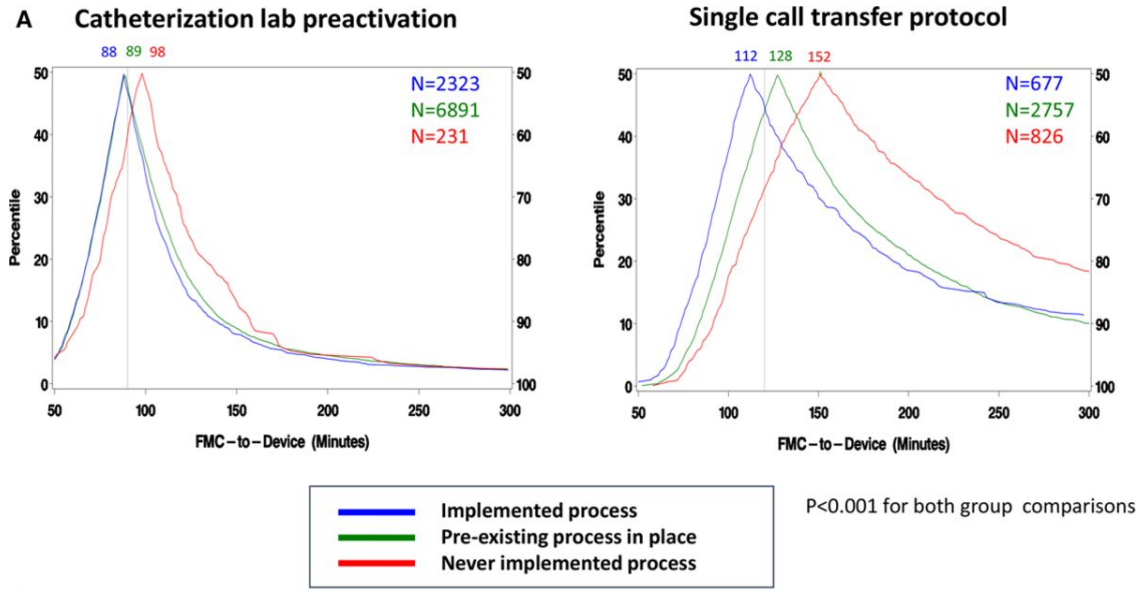
Referral Center

- ECG within 10 minutes of Arrival
- Arrival to Thrombolytics in 30 minutes
- Arrival to PCI Transfer within 45 minutes
- Aspirin at Arrival
- Aspirin at Discharge
- Beta-Blocker at Discharge
- Statin at Discharge
- Adult Smoking Cessation Advice

NSTEMI-ACS Measures

- Cardiac Rehabilitation Patient Referral from an Inpatient Setting
- ACE-Inhibitor or Angiotensin Receptor Blocker (ARB) for LVSD at Discharge
- Dual Antiplatelet Therapy Prescribed at Discharge
- Evaluation of LV Systolic Function
- Adult Smoking Cessation Advice

First Medical Contact-to-Device times (FMC) According to Hospital Implementation of Key Interventions



Christopher B. Fordyce et al. Circ Cardiovasc Interv. 2017;10:e004061

Mission: Lifeline 5 Year Paper

Systems of Care for ST-Segment–Elevation Myocardial Infarction: A Report From the American Heart Association's *Mission: Lifeline*

James G. Jollis, MD; Christopher B. Granger, MD; Timothy D. Henry, MD; Elliott M. Antman, MD; Peter B. Berger, MD; Peter H. Moyer, MD, MPH; Franklin D. Pratt, MD; Ivan C. Rokos, MD; Anna R. Acuña; Mayme Lou Roettig, RN, MSN; Alice K. Jacobs, MD

- 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.

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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

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.

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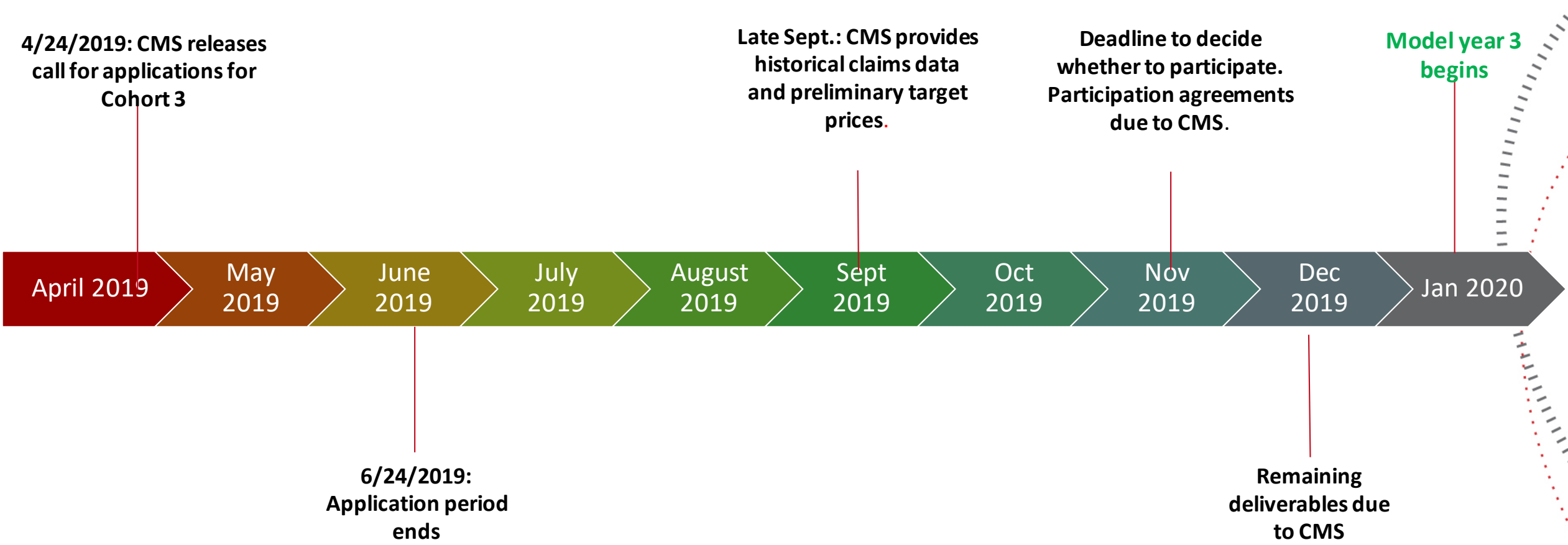
TIMELINE


4/24/2019: CMS releases call for applications for Cohort 3
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
April 2019
May 2019
June 2019
July 2019
August 2019
Sept 2019
Oct 2019
Nov 2019
Dec 2019
Jan 2020
6/24/2019: Application period ends
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

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