Bundled Payments for Care Improvement Advanced (BPCI Advanced) Conceptual Overview Webcast Transcript

Hello and welcome to today's webcast which will present a conceptual overview of Bundled Payments for Care Improvement Advanced. I'm Steve Farmer and I'm a practicing cardiologist who also works for the CMS Innovation Center, also called CMMI.

I'm pleased to present today's webcast which will provide a conceptual overview of our newest payment model called Bundled Payments for Care Improvement Advanced or BPCI Advanced for short. This presentation is the first in the series and is intended as an introduction to the model with clinicians as the primary audience.

After this webinar, additional detailed resources are available for those who are interested in learning more. This webcast will take approximately 30 minutes. After introducing the CMS Innovation Center, I will walk you through the BPCI Advanced model concept drawing on my own clinical experience for illustration. I will review the nuts and bolts of the model and talk about why you should participate. Lastly, I will review the ways in which CMMI partners with participants to help them succeed in the model.

Let's get started. I'd like to begin by telling you about the CMS Innovation Center which congress established within the Center for Medicare and Medicaid Services or CMS. The CMS Innovation Center tests new service and delivery models that are designed to maintain or reduce cost while preserving or enhancing quality. Since its establishment, the Innovation Center has been a powerful driver of change within CMS while also providing crucial national leadership in the transition away from fee-for-service and towards value-based payment.

Our models are animated by several guiding principles. Most important among them is the promotion of patient centered care, but they also include the preservation of provider choice and incentives, the fostering of the patient choice and market competition, the facilitation of peer-to-peer learning and the administration of transparent model designs and evaluations. On this last point, all of our models are scrutinized through detailed multidisciplinary evaluations that help us better understand what is working and what needs to be changed.

CMMI models experiment with new ways of paying for and delivering healthcare, and they are evaluated against one of the three criteria for success. Our models are successful if they increase quality without any effect on cost, if they have no effect on quality but decrease cost, or ideally, if they both increase quality and decrease cost. If any of these three outcomes are demonstrated, the Health and Human Services Secretary may expand models to the broader Medicare population.

BPCI Advanced is the CMS Innovation Center's newest model and the first to be announced by the new administration. It tests a different approach to paying for healthcare. At its essence, the new model reconceives care as bundled clinical episodes that link physician, hospital and post-acute care payments. These clinical episodes are assessed for the quality and cost of care provided and participants may earn additional payments above and beyond fee-for-service if things go well, but they may also owe money back if they don't.

In the next section, I'll use a clinical vignette to illustrate some common problems patients encounter in the traditional fee-for-service payment model, and I'll show how BPCI Advanced can improve care for the patient's we serve. I also hope the model will provide a more satisfying experience for clinicians. BPCI Advanced tests 29 inpatient and three outpatient clinical episodes, but I'm a cardiologist so let's use an example of a patient with acute heart failure.

In the vignette, I'll begin with the fee-for-service payment model and then illustrate how bundled clinical episodes are different. While this vignette is simulated, I frequently experience similar challenges in my own practice and I think you'll recognize them as well. In the traditional fee-for-service payment model, patients often experience fragmented care. With each clinician managing their own scope of practice, patients often find the system challenging to navigate and gaps and errors are frequent.

For example, clinicians often treat patients with incomplete information and patients frequently receive conflicting advice. Just as important, with the clinicians all acting independently, none of them truly has either control or accountability for the cost or outcomes of care. In our vignette, our patient's name is Edna. She came to the emergency department with shortness of breath and was admitted by a hospitalist with a heart failure exacerbation. She has both a primary care provider and a cardiologist who she sees regularly for her existing conditions.

Both physicians have their own certified electronic health record systems, but there is limited if any, data sharing between them. In addition, neither the PCP nor the cardiologist has an EHR that communicates with the hospital. Without a shared EHR, the hospitalist does not have access to the patient's full medical history or testing results at least initially and sometimes ever.

In fact, what often happens is that neither the PCP nor the cardiologist are even aware of the admission. Gaps in timely communication may result in duplicative testing, unnecessary care and medication errors, not to mention patient and clinician frustration. Incomplete knowledge of what's happening with our patients may also undermine our ability as clinicians to be aware of and to address systematic gaps in care. Edna assumed that the hospital was in touch with her PCP and cardiologist. Edna has a fairly typical heart failure hospitalization.

During her admission, the hospitalist orders an echocardiogram to assess her heart function. Heart failure treatments also often result in multiple medication adjustments. During her diuresis, Edna's kidney function temporarily gets worse, she develops high potassium levels, and her ACE inhibitor is held. After lying in bed for five days during her hospital stay, she is frail and a physical therapist recommends that she go to a short-term nursing facility to get stronger.

As with any care transition, her transfer from a hospital to a SNF introduces even more clinicians into her care and they result in miscommunication and errors. For Edna, she will now see an entirely new and unfamiliar clinical team. The SNF received Edna's current medication list in a discharge summary; however, the SNF clinical team is primarily focused on getting Edna stronger and does not specialize in heart failure.

They are unfamiliar with planned medication adjustments and lab testing and overlooked that she needs a low sodium diet. Edna herself is not following her normal routine and is not keeping track of her daily weight. She has also deconditioned from her hospitalization and has difficulty assessing the significance of her shortness of breath and fatigue. Several weeks pass before she finally gets home and is able to

visit her PCP. Edna was confused that the SNF team seemed unconcerned about giving her a regular diet and why her medications were changed.

Fortunately, her PCP received her hospital discharge summary. Even so, the summary provides only a brief synopsis of her hospitalization and her discharge medication list. Her discharge kidney function and weight are not documented and her echo report and other testing results are not attached. With the information she has available, the PCP is uncertain why Edna's medications were changed and if and when they should be resumed. She refers Edna back to the cardiologist who she's been seeing for years.

At this point, Edna's care has been primarily managed by a hospitalist with the patient's PCP. Her cardiologist was never notified of her admission and received no records even after the PCP saw her. Instead of spending time exploring the reason for the hospitalization in the first place and finding solutions, she is left to piece together what happened in the hospital on the spot with the patient in the room and during a return visit scheduled for just a few minutes.

As many of you know, this scenario is both common and inefficient. It is also very frustrating for both the patient and the cardiologist. Edna's Lasix dose is doubled, her renal function has changed, and she reports decreased stamina. The reason for stopping her ACE inhibitor is also unclear. To sort things out, she requests records from the hospital, repeats an echocardiogram and orders additional blood tests.

Only when these results are available—sometimes after a long delay—does Edna's ACE inhibitor finally get restarted. The cardiologist is left either scheduling a second return visit or trying to coordinate her care over the phone when her results are finally available. Edna was frustrated that her cardiologist was unaware of her hospitalization and seemed to disagree with her treatment plan.

During her heart failure exacerbation, Edna engaged with an emergency physician, a hospitalist, the SNF clinical team, her PCP and her cardiologist. Care coordination was imperfect with very real consequences for her care and her long-term health. The hospitalist treated her with an incomplete medical history, the SNF team overlooked her dietary requirements and did not intervene when she developed recurrent signs of early heart failure. Her hospital course was incompletely communicated to her PCP and was not communicated at all to her cardiologist.

Her family was never engaged as her advocate. Edna herself had the frustrating experience of working with a large number of new clinicians who she didn't know well. Often, they didn't introduce themselves or clarify their roles, and they repeated the same questions again and again. Additionally, each clinician expressed different opinions and recommendations. Together these hazards resulted in suboptimal care, care delays, and duplicative testing. Edna was left confused by apparently conflicting advice, and as a result, her confidence in the care plan and her motivation to adhere with it were undermined. Her ability to follow complex medical regimen was also undermined by multiple medication adjustments that were not well explained.

Bundled clinical episodes represent a shift in how we typically think about care. Care is designed around the patient's overall need instead of being viewed from the vantage point of where services are delivered. In our vignette for example, instead of our hospitalist focusing on inpatient care and letting the PCP know what happened through a discharge summary, she now needs to anticipate and coordinate Edna's care over the next 90 days.

Many of the hazards Edna experienced could have been avoided, but the fee-for-service payment model was not designed to address them. The clinical episode approach better reflects how patients experience care. BPCI Advanced shifts the emphasis from a series of individual services toward a cohesive, bundled clinical episode. While care continues to be delivered on a fee-for-service basis, an accountable party, in this case the hospitalist, takes responsibility for coordinating the full episode. Bundled clinical episodes are evaluated based on both the quality and cost of care.

How might things have gone differently in the clinical episode? The hospitalist could connect with Edna's PCP as soon as possible to alert her about the admission to better understand Edna's medical history and to identify other clinicians who need to be involved. Patient engagement is crucial. A clear care plan could be reviewed and agreed with both Edna and her family or caregiver before discharge. The patient and her family can help raise the alarm when things are getting off track.

The hospitalist could work with the SNF to establish a heart failure protocol so that Edna receives the correct diet and is monitored for worsening heart failure. If her weight rises more than an agreed amount, the SNF could request a consultation. The discharge summary could be structured in anticipation of the PCP and cardiologists' information needs and could more clearly communicate the plan to resume Edna's ACE inhibitor after discharge. Copies of the discharge summary including a clear post discharge plan and pertinent testing results could be sent to both her PCP and her cardiologist to maximize the value of any testing performed and to prevent duplication. We have seen all of these strategies work well in other CMMI models.

Now that we have explored a clinical example, let's review BPCI Advanced in more detail. BPCI Advanced was developed based on extensive experience with commercial and public payer models including the Acute Care Episode, Oncology Care Model, Comprehensive Care for Joint Replacement, and Bundled Payments for Care Improvement Models. Insights from all of these models are incorporated into BPCI Advanced. The Innovation Center has also engaged extensively with stakeholders who participate in prior models, from patients, to clinicians, to hospitals and post-acute care facilities.

Two core concerns raised by participants in the original BPCI model were that stable target prices be provided in advance so that participants could gauge their performance, and two, that performance assessment account for both patient and provider characteristics. BPCI Advanced addresses both of these concerns. BPCI Advanced is different than the existing BPCI model in important ways. BPCI Advanced has a single track with streamlined design. All episodes are 90 days and all episode costs are capped at a 99th percentile.

We have focused on a smaller number of clinical episodes in the initial year, and BPCI Advanced will have both inpatient and outpatient episodes. Preliminary target prices will be provided in advance with adjustment after the fact only for the complexity of patients actually treated. Payments will now be tied to performance on quality measures. Clinicians are critical to the model's success and BPCI Advanced includes a greater emphasis on physician engagement and learning. That's emphasis is evident in the new attribution rules for clinical episodes. Finally, the model is designed as an Advanced APM under the Quality Payment Program.

Who leads clinical episodes? Clinical episodes may be led either by Physician Group Practices or by acute care hospitals in collaboration with clinicians. BPCI Advanced is designed so that physician group practices and acute care hospitals can participate on their own, however, they may also work with a Convener. In technical terms, a Convener is a Medicare-enrolled provider or supplier or an entity that is

not enrolled in Medicare. Conveners bring together multiple Physician Group Practices and/or acute care hospitals, and may offer several advantages.

For example, Conveners may facilitate participation by smaller Physician Group Practices or acute care hospitals. They may assist with analytic feedback and with operational and logistical support. Perhaps most importantly, they bear financial risk to CMS under the model, though they may apportion, some of that risk to practices or hospitals. In the initial period, there are 29 inpatient clinical episodes that cover a range of cardiac, gastroenterology, and pulmonary conditions. These episodes may be medical, interventional or surgical.

Also included are spine, bone and joint, nephrology, medical infectious and neurological episodes. The inpatient episodes are identified through diagnostic related groups which also account for complexity. BPCI Advanced will have three outpatient clinical episodes in the initial period as well. These include cardiac stenting, ICD implantation and surgical decompression of the spinal cord and/or nerve roots. More inpatient and outpatient episodes may be added in the future.

The clinical community has expressed concern that there are relatively few Advanced APMs available to specialists. BPCI Advanced adds an important opportunity for a range of specialists who otherwise have limited options. In all, these inpatient and outpatient clinical episodes are typically managed by hospital medicine and 11 specialties, both medical and surgical.

How does the model actually work? There are four major steps. Clinical episodes are first triggered by either an inpatient stay called an anchor stay, or an outpatient procedure called an anchor procedure. Clinical episodes are then attributed to an episode initiator—either a Physician Group Practice or an acute care hospital that manages and holds responsibility for them. Care is then provided under standard fee-for-service payments as they are now at the end of each six-month performance period. Quality and cost performance are assessed for each episode initiator for all of the clinical episodes they participated in.

Clinical episodes begin with an anchor stay or anchor procedure and continue towards the next 90 days. For hospitals, the 90-day period begins on the day of discharge. For outpatient procedures, the 90-day period begins on the day of the procedure. BPCI Advanced is a total cost of care model with limited exceptions. In other words, most services are included in the target price including hospital, physician, laboratory, durable medical equipment, hospice, and post-acute care services.

The list of excluded services is very limited, these include blood clotting factors for hemophilia patients, new technology add-on payments, and services with pass-through payment status under the hospital outpatient prospective payment system. In addition, there are a limited number of hospital exclusions as well. For example, hospital or physician cost incurred as a result of admissions for trauma, transplant and cancer treatments are also excluded.

The hospital's benchmark price is intended to compare apples to apples and account for three central factors. Firstly, the price accounts for the complexity of the patient served otherwise called case-mix adjustment. Secondly, the price accounts for hospital spending relative to the hospital's peer group over time. For example, academic medical centers are compared to academic medical centers, community hospitals are compared with community hospitals. Thirdly, the price accounts for the hospital's own historic cost.

PGP benchmark prices are set differently from hospital benchmark prices for several reasons. Physicians may have distinctive practice profiles that result from multiple influences including care philosophy, training and experience and contextual factors like an urban versus rural setting. Most physicians also have limited perspective on their quality and cost profiles relative to their peers.

Those joining the model may be receiving the feedback for the very first time and will need time to assess their practices and adapt. Therefore, the model anchors PGP prices based on the hospitals where episodes occur but adjust the hospital price based on a PGPs historical cost. This approach allows PGPs to refine practices over time and we hope it will allow more practices to participate.

Eligible clinicians that meet specific criteria may become qualified APM participants under the quality payment program and receive the 5% APM payment incentive. For ACH participants, clinicians are individually assessed. For PGP participants, clinicians are assessed as a group. Notably, there are different rules for Physician Group Practices that work with Conveners.

As an Advanced APM, BPCI Advanced must meet three core requirements. This include the use of a certified electronic health record to communicate with patients and healthcare professionals, the linkage of payment with quality performance, and the incorporation or meaningful financial risk. On this latter point, in addition to standard fee-for-service payments, episode initiators are eligible to receive as much as 20% of the target price if things go well, but they may also owe as much as 20% of the target price if they don't.

The current administration has championed patients over paperwork. To reduce clinician burden, all quality measures will be claims-based through 2020. That said, we are particularly interested in feedback from the clinical community on how to incorporate quality measures in the future. Additional measures may be added with varying reporting mechanisms at some point later. For example, in some instances, participants may submit quality measures through a registry in future years which would allow greater breadth of clinically pertinent measures to be reported, and would also allow participants to get feedback more quickly and frequently than is possible through administrative claims.

In the initial performance period, all clinical episodes will be assessed against the hospital-wide, all-cause, unplanned readmissions measure as well as the documentation of an advanced directive. The remaining measures listed here may apply to specific clinical episodes, for example, the hospital 30-day all-cause, risk-standardized mortality rate following CABG will only apply to the CABG clinical episodes. Measure performance within clinical episodes will be compared to other participants in the same clinical episode.

Every patient is different and unusual patient cases exist which may be beyond the control of clinicians. The risk that unusual cases can distort performance in the model is greatest at low volume, and so BPCI Advanced requires a minimum volume of clinical episodes to join. B

PCI Advanced participants will not be on your own. The CMS Innovation Center will partner with you.

The health system is complex and improvement requires us working together. The Innovation Center works closely with model participants to help them succeed. In the model, providers care for patients on the front line and engage in continuous quality improvement. The Innovation Center provides feedback on cost and quality performance, establishes payment mechanisms that support improved care processes, and incorporates rewards for clinicians that deliver better value.

The Innovation Center also offers learning systems to augment our models. These serve three broad functions. Firstly, they identify and package new knowledge and best practices. Secondly, they leverage data and participant input to guide change and improvement. Thirdly, they build learning communities and networks to disseminate successful strategies. The Innovation Center has a track record of partnering with participants to achieve effective, efficient and high-quality care through bundled payments.

Our learning systems catalyze improvement through three channels. Participants learn from CMS, participants learn from each other, and CMS learns from participants. These systems are designed to both help you succeed and to help us refine our model concepts. Successful participants in the existing BPCI model have used a number of strategies to avoid the hazards Edna experienced in the fee-for-service scenario. These strategies fall under six domains including patient education, care navigation, care protocol, data and dashboards, multidisciplinary steering committees, and post-acute care provider networks.

For more details on these strategies, tune in for the forthcoming webinar titled “Operationalizing BPCI Advanced.”

Why should you participate? We've all experienced the pitfalls I've outlined in our brief vignette—some of us both as patients and as clinicians. If successful, the model will result in a streamlined, coordinated care episodes that improve outcomes and decrease cost while improving the patient experience. Within the model, participants are able to make care changes not normally allowable under standard fee-for-service billing rules. For example, patients must normally be admitted to the hospital for three days before they are eligible for a SNF stay. Those rules may be waived under this model.

As most of you are well aware, the world is changing quickly and value is fast becoming a critical skill as we move away from the fee-for-service payment method and towards a value-based payment. BPCI Advanced offers an opportunity to reconceive how care is delivered. Participants may begin with a segment of their clinical practice to gain experience and develop needed infrastructure before making broader practice changes. As an additional enticement, BPCI Advanced qualifies as an Advanced APM under the Quality Payment Program.

As I bring the webinar to a close, I'd like to return to our patient Edna because she is the central concern of the work we do together. This model is designed to provide a more seamless, streamlined patient experience that avoids complications and results in better outcomes. Through a greater focus on patient engagement and care coordination, the model also intends to improve the patient experience by more clearly setting expectations for the care episode and by providing more consistent messaging across providers.

In summary, BPCI Advanced aims to catalyze health system transformation by better linking its disparate parts. It does so by establishing a point person with responsibility for the entirety of the clinical episodes. Episodes are assessed based on both quality and cost, and participants may receive additional payments beyond fee-for-service if things go well, but may owe money back if they don't. We hope that you will consider partnering with us for the benefit of our patients.

What now? As I mentioned at the beginning, this conceptual overview presents the vision for BPCI Advanced and details have been tailored for simplicity and clarity. There's more to learn and CMMI

offers extensive resources to bring you up to speed. We have a range of learning resources available to you. There are webcasts, print resources, frequently asked questions, web-based resources, and we will answer your emails as well. This slide summarizes where you can go for help.

There are several key dates to keep in mind. Most crucially, you must apply before March 12, 2018. That is very soon, but your application does not yet commit you to the model. Instead, it gives you access to resources and data so that you may make an informed decision before the final commitment deadline this August. Thank you for joining our webcast today. We look forward to working with you on this model.