Care Wars: The BPCI Force Awakens
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Bundled Payments for Care Improvement (BPCI)

Per CMS: The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care.
### Shift in Payment Methodology

<table>
<thead>
<tr>
<th>Category 1 Fee for Service</th>
<th>Category 2 Fee for Service Link to Quality</th>
<th>Category 3 Alternative Payment Model Built on FFS Architecture</th>
<th>Category 4 Population-based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments based on volume – no link to quality</td>
<td>A portion of payments vary by quality or efficiency of care delivery</td>
<td>Some payment linked to population management or episode; triggered by delivery of services; shared savings or 2 sided risk</td>
<td>Payment for population management; not linked to volume; pay care of person for long period of time (&gt; a year)</td>
</tr>
<tr>
<td>• Hospital Value Based Purchasing</td>
<td>• Bundled Payments • ACOs</td>
<td>• Eligible Pioneer ACOs years 3-5</td>
<td></td>
</tr>
<tr>
<td>• MD Value Modifier</td>
<td>• Medical Homes • Comp Primary Care • Medicare Medicaid Financial Alignment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Readmissions Penalties</td>
<td>• Hospital Acquired Conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital Acquired Conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Chart Courtesy of Remedy Partners – The Episodes of Care Company*

Bundled Payments for Care Improvement
4 Models

- **BPCI Model 1**: Retrospective Acute Care Hospital Stay Only
- **BPCI Model 2**: Retrospective Acute & Post Acute Care Episode
- **BPCI Model 3**: Retrospective Post Acute Care Only
- **BPCI Model 4**: Prospective Acute Care Hospital Stay Only
What are bundled payments?

Single fixed payment amounts designed to pay all the providers involved for coordinating and covering an episode of care

• Hospitals
• Physicians
• Physical therapy
• Readmissions

The bundled payment approach is leading to:

• Better coordinated care
• Improved efficiencies
• Simplification of processes and billing
• Savings

Gain vs. Risk

Bundled payments offer the potential for gain as well as risk for loss.

Betting on:

- Delivering the same (or better) care at less cost
- Cooperation from all stakeholders
- Smooth coordination

Is your hospital or health system already participating in bundles or will you be participating in the next 6 months?

Choose Yes, No or I don’t know
Types of Awardees

A BPCI participant is a Facilitator Convener if it will not bear risk, but would like to facilitate other organizations (called Designated Awardees and Designated Awardees Convener) that take risk for redesigning care under an episode payment model.
Description of Roles in BPCI:

- **Submission Type**
  - **Risk-Bearing**
    - Single Awardee (Episode Initiator)
    - Awardee Convener
    - Episode Initiator
    - Designated Awardee (Episode Initiator) This entity takes risk under the facilitator convener.
  - **Non-Risk-Bearing**
    - Facilitator Convener
    - Designated Awardee Convener This entity takes risk under the facilitator convener.
BPCI Fast Facts

The Bundled Payments for Care Improvement (BPCI) Initiative

≈181 DRGs collapsed into 48 Clinical Episodes

Includes Part A & B (Model 2 and 3)

30, 60, or 90 day episodes

Funds Flow: FFS directly to providers (reconciled retrospectively)
BPCI Fast Facts

- **Base Pricing:** Based on provider's average Part A & B payments (7/09 – 6/12) less 2 or 3% discount
- **Gainsharing Waiver:** Organizing entities ("Conveners") share savings with other providers
- **Conveners work with Episode Initiators**
- **Very large scale 3+ year demonstration in 50 states**
If your organization is already participating in BPCI, are you primarily participating in?:

A. Medical bundles
B. Surgical bundles
C. Both
Medicare Acute and Post-Acute Care Payments for 30-Day Episodes That Began with a Hospitalization, 2008.

Hospitalists and Emergency Physicians Have Increasing Influence in the Value-Focused Healthcare Economy

Quality & Access

Cost

Productivity Frontier
1. Operational Excellence
2. Optimal Care Coordination

Concept from Michael Porter, author of Competitive Strategies
Retrieved on April 26, 2016 from http://maaw.info/ArticleSummaries/ArtSumPorter96.htm
Episode Cost Breakdown

Spending Distribution within 90-Day Bundles  Average Spend per Bundle:  
$29,991

Source: Remedy Partners

“Manageable Post-Acute Costs” represent 39% or $11,700 of bundle
Continuum of Care

Pre-discharge Visits
Planned Clinician Visits
24/7 Unplanned Care
Telephone Support
# Post Acute Care Settings

## FIGURE 1  Post-Acute Care Settings

<table>
<thead>
<tr>
<th>Least Intensive</th>
<th>Most Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Agencies (HHAs)</strong></td>
<td><strong>Nursing Facilities (NFs) and Skilled Nursing Facilities (SNFs)</strong></td>
</tr>
<tr>
<td>Nursing, medical, and rehabilitative care delivered to the home-bound. Nearly two-thirds of home health episodes are not preceded by a hospitalization or other post-acute stay.</td>
<td>Non-acute and non-intensive nursing, medical, and rehabilitative care. Also serve long-term residents, which Medicare does not cover. Medicaid is the largest payor of NFs.</td>
</tr>
</tbody>
</table>

### Number of Medicare-Certified Providers, 2013

<table>
<thead>
<tr>
<th>Agencies</th>
<th>SNFs</th>
<th>IRFs</th>
<th>LTCHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12,613</td>
<td>15,163</td>
<td>1,161</td>
<td>432</td>
</tr>
</tbody>
</table>

### Utilization Rates among Medicare Fee-for-Service Beneficiaries, 2013

<table>
<thead>
<tr>
<th>Users</th>
<th>Cases</th>
<th>Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4 million</td>
<td>373,000</td>
<td>124,000</td>
</tr>
</tbody>
</table>

### Medicare PAC Spending Variation, by Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mean</th>
<th>25th percentile</th>
<th>75th percentile</th>
<th>Ratio of 75th to 25th percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary bypass w cardiac catheterization</td>
<td>$5,286</td>
<td>$1,864</td>
<td>$6,913</td>
<td>3.7</td>
</tr>
<tr>
<td>Major small &amp; large bowel procedures</td>
<td>$6,100</td>
<td>$2,110</td>
<td>$8,804</td>
<td>4.2</td>
</tr>
<tr>
<td>Major joint replacement</td>
<td>$8,152</td>
<td>$3,890</td>
<td>$11,484</td>
<td>3.0</td>
</tr>
<tr>
<td>Stroke</td>
<td>$13,914</td>
<td>$5,936</td>
<td>$19,371</td>
<td>3.3</td>
</tr>
<tr>
<td>Simple pneumonia &amp; pleurisy</td>
<td>$7,039</td>
<td>$2,351</td>
<td>$10,785</td>
<td>4.6</td>
</tr>
<tr>
<td>Heart failure &amp; shock</td>
<td>$5,997</td>
<td>$2,034</td>
<td>$9,331</td>
<td>4.6</td>
</tr>
<tr>
<td>Fractures of hip &amp; pelvis</td>
<td>$11,688</td>
<td>$8,213</td>
<td>$14,427</td>
<td>1.8</td>
</tr>
<tr>
<td>Kidney &amp; urinary tract infections</td>
<td>$8,040</td>
<td>$3,335</td>
<td>$11,963</td>
<td>3.6</td>
</tr>
<tr>
<td>Hip &amp; knee procedures except major joint replacement</td>
<td>$13,608</td>
<td>$10,526</td>
<td>$16,498</td>
<td>1.6</td>
</tr>
<tr>
<td>Septicemia or severe sepsis w/o MV 96+ hours</td>
<td>$8,282</td>
<td>$3,344</td>
<td>$11,744</td>
<td>3.5</td>
</tr>
</tbody>
</table>

**Average of 10 conditions** 3.2

Source: MedPAC, Medicare Post-Acute Care Reforms, Testimony before the Subcommittee on Health, House Ways and Means Committee, June 14, 2013, Table 2.
Cost Varies Due to 1st Site of Care

Cost by D/C Site of Care

- Home: $22K
- Home Health: $21K
- SNF: $46K
- IRF: $48K
- LTACH: $78K
- Other: $31K

Time Period Oct 2013 – March 2014 (Claims Version 093014) – All Remedy Partners Phase I Providers (600+)
Aligned to Share One Payment

- Physicians
- Pharmacy
- LTAC / SNF
- Home Health

Pre-discharge Visits
Planned Clinician Visits
24/7 Unplanned Care
Telephone Support
On a scale of 1 to 5 with 5 being Always Aligned and 1 being Not at All Aligned, how would you rate your degree of alignment with the physicians re: bundled services?
Why change?
Patients Discharged Earlier (Sicker)

ALOS in Days by Age Group Trends from 1970-2010

“HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule…”

<table>
<thead>
<tr>
<th>All Medicare FFS (Categories 1-4)</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Linked to quality (Categories 2-4)</td>
<td>85%</td>
</tr>
<tr>
<td>Alternative payment models (Categories 3-4)</td>
<td>50%</td>
</tr>
</tbody>
</table>

Gaps in Care

Lack of follow-up with PCP leads to readmissions

*The New England Journal of Medicine* - Special Article
Rehospitalizations among Patients in the Medicare Fee-for-Service Program
Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

“Almost one fifth (19.6%) of the 11,855,702 Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days”

“In the case of 50.2% of the patients who were rehospitalized within 30 days after a medical discharge to the community, there was no bill for a visit to a physician’s office between the time of discharge and rehospitalization.”

Based on Medicare claims data from 2003–2004
BPCI – Likely to Grow in Size

US healthcare spend through bundled payments

Source: CMS, Kaiser Family Foundation, industry participants, lit search, AHA, AIS
Cost Variation Across & Within Episodes

TOTAL COST VARIES ACROSS EPISODES...

...AND COSTS VARY WIDELY WITHIN EACH EPISODE

- **Cellulitis**
- **Stroke**
- **CHF**
- **Sepsis**

- **DME**
- **Part B**
- **OP**
- **Readmits**
- **HHA**
- **SNF**
- **IRF**
- **LTCH**
- **Anchor**

*Note: Inpatient Medicare cost by episode. Source: CMS (LHS); Evolution health data for MIH (RHS).*
Spending Shifts

**MedPac** - Spending in PAC has more than doubled from 2001-2013 ($27 billion to $59 billion)

**IOM** - CMS spent $28 billion on skilled-nursing care in 2013, up from $13.6 million in 2001

BPCI Opportunity

Home, Home, Home

The biggest area of waste → SNF utilization
• 20-25% of episode costs, with significant variation

The biggest adverse outcome → Readmissions
• 12% of all episode costs

Sample 90-Day Medicare Spending Breakdown
The light at the end of the tunnel may be an oncoming train.
ALOS for Hip Replacement

Average length of stay among inpatients aged 45 and over with total hip replacement: United States, 2000–2010

Includes only four listed procedures in this analysis.

Making Bundling Mandatory

We all should have seen this coming.

Because CJR is the continuation of a trend towards value-based care that has accelerated over time and CMS has very publicly committed to pushing it forward.

CMS has been leading the charge (followed by commercial payers) in shifting risk to providers and making payments based on quality and outcomes as opposed to volume.
Making Bundling Mandatory

DRG system shifted some risk to the hospital

- Payed a fixed amount (hospital wins or loses)

New in bundled payment - includes a period of post-acute care

Making Bundling Mandatory

Two bundled payment programs leading up to CJR

Acute Care Episode (ACE) – 2009
- Cardiovascular and orthopedic episodes

CMS launched BPCI – 2013
- Voluntary national program
Making Bundling Mandatory

Choose from 48 episodes of care

Choose between a 30 and 90 day post-acute period

Permitted to take the economic risk on the episode of care
CJR is Mandatory

CJR is a direct offshoot of these prior programs

• Based on BPCI Model 2
• Limited to the Total Joint Replacement episode of care
• Mandatory
• Hospital put at risk by CMS

If you are participating in surgical bundles are they:

A. Orthopedic Bundles
B. Other Surgical Procedure Bundles
Mandatory for Hospitals – Not Patients

Maybe I will. Maybe I won’t.
Patient Engagement - Hospital A

HOSPITAL A

Visits

September  October  November  December  January  February

Outreach  Engaged  Cancelled

0  3  12  9  8  17  19  15  15  7  4  17  22  22  22  22
Patient Engagement - Hospital B

HOSPITAL B

Visits

<table>
<thead>
<tr>
<th>Month</th>
<th>Outreach</th>
<th>Engaged</th>
<th>Cancelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>6</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>October</td>
<td>61</td>
<td>27</td>
<td>34</td>
</tr>
<tr>
<td>November</td>
<td>56</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>December</td>
<td>75</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>January</td>
<td>53</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>February</td>
<td>69</td>
<td>35</td>
<td>32</td>
</tr>
</tbody>
</table>
Patient Engagement - Hospital C

![Graph showing patient engagement trends at Hospital C.](image-url)
Where is all this going?

CMS announced 1/16/15:
By 2016, 30% of payments through ACOs and Bundles

Up to 50% of all payments by 2018

The Health Care Transformation Task Force
• Shift 75% of their business to contracts with incentives for quality and lower-cost by 2020
A Glimpse of the Future

CMS goals make risk shifting programs mandatory

Will not stop at the 50%

It is critical to:
- Understand your costs
- Collect and analyze your claims data
- Redesign and coordinate care across all providers
- Design incentives for alignment
What Does it Take to Succeed?

Proactive mapping of patient progress across the episode timeframe; identify deviations

Integration of unaffiliated post-acute providers

Continual communication with patients and family/caregivers

Provider communication training to ensure effective patient engagement in post-acute care and recovery
What Does it Take to Succeed?

Managing expectations for recovery; home discharge support as appropriate

Development of orders for early ambulation—collaborative ambulation program with nursing and physical therapy

Adherence to best practices for care transitions, such as thorough medication reconciliation
New Business Imperative: Care Process Redesign

In order to achieve success, we have to “redesign care”

This includes clinical and non-clinical care process

We decided to take a process-oriented “project management” approach

We decided to involve and engage all stakeholders
What Do Our Hospitalists Have to Do?

Documentation excellence:
- DRG distribution and impact

Think more carefully about discharge level of care and discharge destination:
- CARL tool, etc.

Care Coordination:
- TCC RNs, APPs

Readmission reduction:
- partner with home health, PCP and SNFists:
  - narrow network

Consider palliative care when appropriate
Focus: improving the value of post-acute care by optimizing post-acute spending—driven mostly by SNF costs—and minimizing avoidable readmissions.

Stakeholders must work together:
- Control costs.
- Maximize patient outcomes.

Must engage the patient in self-management post-discharge.

Effective health coaching.

Participate in monitoring and managing health-related social factors.
BPCI Card

BCPI DRG Codes

Sepsis: 870, 871, 872
Cellulitis: 602, 603
UTI: 689, 690
Renal Failure: 682, 683, 684
Syncope: 312
COPD: 190, 191, 192, 202, 203
Other Respiratory: 186-189; 204-208
CHF: 291, 292, 293
AMI: 280, 281, 282
Simple Pneumonia & Respiratory Infections: 177-179; 193-195
GI Disorders: 391, 392
GI Hemorrhage: 377-379
BPCI Wristband
THANK YOU!

QUESTIONS?
Additional Resources

- Kaiser: Payment and Delivery System Reform in Medicare A PRIMER ON MEDICAL HOMES, ACCOUNTABLE CARE ORGANIZATIONS, AND BUNLED PAYMENTS


- AHA: Moving Towards Bundled Payment http://www.aha.org/content/13/13jan-bundlingissbrief.pdf

- CMS: Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System


- Becker’s Hospital Review: CJR — Why you should have seen it coming and where is this all going? http://www.beckershospitalreview.com/hospital-physician-relationships/cjr-why-you-should-have-seen-it-coming-and-where-is-this-all-going.html

- The Advisory Board Company: 'Bring it on': Why one hospital says it's fired up for mandatory bundles
  https://www.advisory.com/daily-briefing/2015/09/28/fired-up-for-mandatory-bundles