Bundled Payments for Care Improvement (BPCI) Advanced

Selected Results 4th Evaluation Report Webinar

Webinar Transcript

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Mira Friedlander: Perfect. Today's event will be recorded, but we wanted to highlight a few of the Zoom features in the platform before taking off today's event. Next slide. We recommend allowing pop-ups to ensure the full webinar functionality to make sure that you can access the polls and all of the surveys and chats, et cetera. Please note that all attendees have been muted. The chat function is enabled, so make sure that if you are sending a chat to drop down and click to, "Everyone," that way it doesn't just go to the host and panelists. If you're having any trouble during the event, feel free to chat the host and panelists and we will help you out. Then if you need to use closed captioning, please select the live transcript option at the bottom of your screen. Next slide. So again, I am Mira Friedlander and I work with the Deloitte team supporting the BPCI Advanced Learning System. I'm super excited today that we have two of our CMS team members with us today, so I'll pass it over to Daver first to introduce himself.

Daver Kahvecioglu: Hi everyone, this is Daver Kahvecioglu. I have been at the CMS Innovation Center (CMMI) over the last nine years and also the time have been leading evaluations of several CMMI's bundled payment models, and to Ellen.

Ellen Lukens: Thank you, Daver. Good afternoon everyone and welcome to today's event. I'm Ellen Lukens, and I'm the Deputy Director for Policy at the CMS Innovation Center and we're very happy that you're taking the time to join us today as we discuss the 4th annual BPCI Advanced Evaluation report. As a reminder for all new and returning attendees, the purpose of this evaluation webinar is really to share key findings from the BPCI Advanced Model 4th annual evaluation report. The model evaluation process, as you probably all know, is really a core component of the Innovation Center's work. Not only does it support our long-term decision making around the future of our models, but it also helps us support current Participants by enhancing Models that are in progress. So some of the changes that CMS has recently implemented for the BPCI Advanced Model were informed actually by evaluation results such as reducing the CMS discount from 3% to 2% for medical episodes to improve the pricing methodology and support providers engagement in value-based care.

So the report that Daver Kahvecioglu and the team will be discussing today covers results, trends, and insights from Model Years 3 and 4, which are 2020 and 2021, which were also the years impacted by the COVID-19 public health emergency. As you know, the COVID-19 public health emergency had widespread effects on the healthcare system and on patients receiving care during this time. This evaluation report and future reports will take into consideration the effects of COVID-19 as we assess the impact BPCI Advanced has had on quality and cost of care. As many of you know, the CMS Innovation Center released a strategy in 2021, which articulated our vision and five key pillars, which were to drive accountable care, advance health equity, support innovation, address affordability, and partner to achieve system transformation. This evaluation report informs our broader strategic work and we're hopeful that by leveraging the lessons learned from evaluation efforts, we will continue to move the needle in the right direction.

We are thrilled to be extending participation in the BPCI Advanced Model for the next two years and we'll be continuing this evaluation process throughout the extension period to confirm that the changes we've made support the ongoing success of our participant partners as we work toward our shared goals. The BPCI Advanced Model extension also contributes to the Innovation Center's larger specialty care strategy, specifically the element for maintaining momentum on acute episode payment models. For those of you that are interested in learning more about our specialty care strategy, you can find that on our public website where we have a blog post as well as a report. Extending the BPCI Advanced Model, we'll continue to drive essential care delivery changes and transform how patients transition between hospitals and post-acute care providers.

Additionally, during the BPCI Advanced Model extension, the Innovation Center will pursue the development of a potential mandatory episode payment model designed to build on the lessons learned from BPCI, BPCI Advanced, and CJR. For those of you who are continuing participation in BPCI Advanced, thank you for your ongoing support efforts and partnership. We couldn't do it without you. For those of you who have applied in our considering participation, thank you for taking the first step in joining us on this ongoing journey toward improving the healthcare system for developing high quality, affordable, and person-centered care. We look forward to seeing you all at future events and are grateful for your time today. With that, I will turn it back over to Mira.

Mira Friedlander: I got it.

Ellen Lukens: Okay, great.

Mira Friedlander: Thank you, Ellen. I know she said a lot. So again, thank you Ellen for sharing all of that with us today. We will walk through a lot of what she shared, so if you felt like you missed it or want to unpack it a little bit more, we have some time in the presentation today, but we'll go to the agenda. So next slide. Okay, perfect. So today, we will start with reviewing the structure of the model for Model Year 3 and any changes that occurred from Model Year 3 to Model Year 4 to start level setting on what the evaluation report was looking at. Then we'll also be able to discuss some high-level findings of the evaluation analysis that impact things like the fee for service payments, post-acute care, and readmission rates.

We have some new health equity findings that we're excited to talk through around the Model's reach underserved populations and how that we might be able to use this information as a new opportunity for participants. We'll close out with question and answer and some closing remarks, but feel free to ask questions throughout the event. We'll try to get to them as we're going and the conversation is flowing. We're really hoping that this is a little bit more of a fireside chat. That's why Daver and I are at a bonfire at the beach today. So, we're hoping that you guys can join in the conversation, put in your chats and as much as we're hoping to share insights with you all from the evaluation report, we're really hoping that you can share what you're hearing and feeling as Participants back with us as well.

So that being said, now that we are familiar with the facilitators and the lay of the land for today, we'd like to get to know who we have on the line with us a bit more. So we will launch a short poll to see who we have with us in the call today. You're also welcome to share your name, organization and role or anything in the chat so we can really see who's on the line and start connecting with each other. You can close out the poll. Okay, so it looks like we have a good amount of current Participants, a few who are current applicants and a few who were previous Participants but not currently in the model. Daver, any thoughts around who we have on the line with us today?

Daver Kahvecioglu: It's interesting that we have Participants who in the past take part in some model, payment model and very few Participants who have never participated in a payment model.

Mira Friedlander: Everyone has participated in some aspect or let's say we just have a few comments then. So we will move forward and I see the chats rolling in, so a lot of familiar names from the learning events and thank you all again for joining us. So as we are currently in Model Year 6, the evaluation results are reviewing the evaluation from Model Year 3, so it feels like a little bit of a blast from the past. There were significant changes from Model Year 3 to Model Year 4 in model design and pricing methodology. So to help frame up what the evaluation team was looking at or evaluating. Daver, can you talk a bit more about the changes that occurred from Model Year 3 to Model Year 4?

Daver Kahvecioglu: Sure. As Mira mentioned, there were significant changes from Model Year 3 to Model Year 4. I almost considered Model Year 4 and beyond a different model in a sense given how significant changes were. So just to remind participants, the webinar that the evaluation report that we're presenting today is about 2020, but there have been some big changes, so I'll mention only a few of those here. There are more changes that happened. One of the key changes was the pricing methodology was adjusted to include or incorporate a realized trend adjustment, a retrospective trend adjustment, that turned out to be an important component given the evaluation results indicated that model was not going to be sustainable financially. So some changes had to be made and this was a key change.

Another key change was Participants were now allowed to choose from the clinical episode service line groups as a whole. In the past, they used to be able to pick and choose individual clinical episodes, but in 2021 and onwards they could come in with a group of clinical episodes that helps spread the Model to a wider beneficiary group. One other change that I'll mention is the overlap methodology. In the past it used to be that the Model did not allow certain overlaps only in the intervention period, but did allow in the baseline period and evaluation showed that that might create some pricing issues and that's also one of the things the Model team here addressed.

Mira Friedlander: Okay. Daver, that all makes sense. It sounds like there were some changes that occurred due to the evaluation results and that the model team is able to be receptive and iterate on the model based on some findings. Can you speak to any changes that occurred after Model Year 4 as a result of the evaluation results as well?

Daver Kahvecioglu: As Ellen mentioned in her remarks, one of the key changes that happened after Model Year 4 more recent, I believe in Model Year 6 was that the discount factor was reduced from 3% to 2% and that was also informed by the evaluation finding that it seemed it's more challenging to reduce costs for medical episodes possibly given the kind of patients that are in medical episodes with many acute conditions or chronic conditions. Whereas there might be more opportunity for further cost deduction in surgical episodes. In recognition of that difficulty, CMS reduced the discount factor to 2% for medical episodes.

Mira Friedlander: Okay, awesome. Thank you for that, Daver. Now that we know a little bit about where we are in the evaluation sample, we'll move forward to talk a little bit about how the evaluation is organized, what clinical episodes we're looking at and how the episode initiators are grouped together, organized. Do you want to talk through this a bit?

Daver Kahvecioglu: Yeah, so the information on the left side of the slide actually underscores that this model is in a sense 68 different model tests because there are 34 clinical episodes in Model Year 3 and each of these clinical episodes could be initiated by two different provider types, hospitals or physician group practices. So they're in total 68 different tests that we are evaluating. On the top right you see the breakdown of the types of clinical episodes. 15 of them are medical episodes like stroke, urinary tract infection, renal failure, and 19 of them were surgical episodes. Some outpatient episodes like cardiac defibrillator and some inpatient episodes, like spinal fusion. A total of 34. Given that there are two different episode initiator types, you have a total of 68 possible tests that evaluation could be addressing.

Mira Friedlander: That's a lot of different distinct tests and things that the evaluation team can evaluate. About how many of the clinical episodes were evaluated and what did that sample look like?

Daver Kahvecioglu: You can move to the next slide here. Of the 68 that I mentioned, we were able to evaluate 34 of the combinations which you see in the slide. Even though 34 sounds like only half, that 34 actually represents vast majority of the model, 92% of all episodes are represented in the evaluation results and that's because the sample sizes were much larger for these clinical episodes. That's the reason we were able to evaluate because we need statistical significance and for episodes or critical episodes with small sample size, we just couldn't evaluate given the small sample size, but we were able to evaluate vast majority of the model volume. As you can see the breakdown here, we evaluated 10 medical clinical episodes under hospitals and 12 under physician group practices (PGPs) and seven surgical clinical episodes under hospitals and five under PGPs.

Mira Friedlander: Okay. So I know you stated that there was a little bit of a challenge with the sample size. Was there anything around contamination of the sample or differences there?

Daver Kahvecioglu: I think a key challenge maybe been increasing challenge has been contamination in the sense that there is so much participation in bundle payment model and not only hospitals participate but physician group practices as well. So we had to really carefully measure possible contamination. So there could be hospitals for example, the physician group practices are participating and those hospitals we normally don't want to use as a comparison group because the innovation is happening in those hospitals as well. Comparing against those hospitals that has some model presence would depress evaluation results. So we took I would say intense care to try to identify such contamination and maybe a better word to use would be spread of the model. The Model's impact and reach is beyond the specific clinical episodes we evaluate and we took great care to make sure that that does not bias the results in some way.

Mira Friedlander: Okay, good to note, Daver, that's really helpful. Now that we know a little bit about what the evaluation tests looked like, what was looked at, can we talk a little bit about what model enrollment and clinical episodes looked like during Model Year 3? So let's move to the next slide to see what our Participant role looked like at the time.

Daver Kahvecioglu: As you can see on the slide, there have been about 1500 Episode Initiators (EIs). That's a combination of hospitals and physician group practices. That's a pretty good number. There have been 350,000 clinical episode initiated in 2020. 74% of these episodes were medical. You can see the breakdown on the bottom left, medical clinical episodes were more likely to be initiated by hospitals. 910 hospitals initiated medical clinical episodes and there were 245 PGPs initiating medical

clinical episodes. The situation was more balanced on the surgical clinical episode side, more or less half/half, there were 473 hospitals initiating surgical clinical episodes and almost 400 PGPs initiating clinical episodes. As you can see on the right, that's the clinical episode breakdown. Most of the volume belonged to medical clinical episodes. Actually more than half of the entire model volume were medical episodes initiated by hospitals. 21% was initiated by PGPs as medical clinical episodes and 10% and 16% are the surgical clinical episodes initiated by hospitals. Then PGPs.

Mira Friedlander: What do you think is causing that breakdown, Daver, with the lower volume of surgical episodes compared to medical?

Daver Kahvecioglu: Typically, we have seen larger volume of medical clinical episodes but not to this extent. The reason in this case is the COVID-19 pandemic. Because of the pandemic patients avoided, beneficiaries avoided going to hospitals, especially for elective surgical episodes. So that's the reason why the drop in the percent of surgical episodes is relatively large. I believe it used to be 6% larger in the past year in 2019, whereas it's only 26% surgical in 2020.

Mira Friedlander: That makes a lot of sense. I was planning on touching on COVID, so you kind of got there perfectly. Were there any other ways that COVID had an influence on any of the evaluation results that your team saw?

Daver Kahvecioglu: COVID-19 impacted the entire industry significantly and we were not sure what to expect in terms of evaluation results because one key mechanism this payment model has utilized is, if possible, avoiding institutional care, institutional post-acute care. That has been the main mechanism, but COVID-19 pandemic also had the same effect. One would think because beneficiaries wanted to avoid institutions as much as possible given the pandemic. So we were not sure how the results would be impacted, but I think in the next few slides we'll get to it, but it's somewhat surprisingly results have been pretty stable despite the pandemic.

Mira Friedlander: So it seems like you said COVID impacted everyone and not just the BPCI Advanced Participants. We'll see that a little bit differently compared to the comparison group as well. If anyone in the audience has insights on how COVID was impacted or how COVID impacted your participation around BPCI Advanced, feel free to put that in the chat. Otherwise, we are going to move on to talk a little bit about the high level results. So right before we get into the results, Daver, can you remind me what the goal of our pricing methodology is? How does that work? What are we hoping for in the outcomes of that?

Daver Kahvecioglu: So the way the Model was designed, the financial component of the Model was such that it would save Medicare 3% of what the cost would've been if the Model did not exist. So the Model Participants based on the pricing methodology was supposed to lower cost by at least 3% and if they lowered costs more than 3%, let's say 5%, then the 2% differential would be paid them as reconciliation payments in sort of like a bonus. However, if they were able to lower costs less than 3%, let's say 1%, then they would have to pay back CMS the 2%. So that was the risk, both sided risk and the goal was to save 3%, but it all assumes that the pricing, the benchmarking was done correctly, which it wasn't, hence the reasons for the change in pricing for 2021. So that's, I would say, the financial background and obviously the model was also designed to improve quality of care beneficiary outcomes as well. But this slide that we are looking at now is just looking at things from the cost perspective.

Mira Friedlander: So for the cost perspective then, how effective has the Model been in lowering costs and does it depend on clinical episode or episode initiator type or how does that impact or what patterns are there?

Daver Kahvecioglu: I think the biggest pattern would be that over time repeatedly, the Model and its predecessor Model demonstrated that the bundled payment Model can lower costs for episode pretty much all of the episodes. So be continued to see the same pattern of lower episode costs. That's, I would say, maybe a key observation. Another one is almost all bundles saw a decrease. So the Model did have an impact on costs. One other pattern that we have seen is there have been larger reductions in the cost for surgical episodes compared to medical episodes. As I mentioned earlier, it may be more challenging to lower costs for medical episodes given the type of patients that are serviced in those episodes. Whereas in surgical episodes, most of these episodes are elective and there might be more opportunities and that finding has been consistent over time as well leading to a lower discount factor actually in Model Year 6.

Mira Friedlander: Okay. So based on these graphs that we're looking at, the orange line is the BPCI Advanced Participants, and the blue is the comparison group. So what is the gray line? What would happen if there is no BPCI Advanced or can you talk a little bit more about that since the comparison group and the BPCI Advanced Participants have different baselines?

Daver Kahvecioglu: The gray line actually is the crux of the evaluation. I would say the most important maybe methodological construct that is the counterfactual, which means it's our best estimate of what would've happened if the Model did not exist. But the orange line starts from $34,000 for surgical episodes. So that has been the average cost for the surgical episodes in the baseline. Just to remind people, the baseline is about five years long in the evaluation from 2013 through 2017, but that has been the average surgical cost for an episode average over the five years for Participants and then that went down to 28,000. Now, we have a comparison group which the evaluation identifies by similar looking hospitals, the similar looking patient mix in similar geographic locations, try to identify these hospitals as similar as possible so that there are benchmark and these hospitals that we identified had a little bit lower starting baseline costs 30,642 and you can see that comparison hospitals, which were not subject to this model or were not in this Model, they also lowered episode costs. I would say substantially it's about 3%.

So then we use this reduction about 3% and say that if the Model did not exist, Participants would've experienced a similar decline which would then put them in about $30,000 like the right point of the gray line from 31,000. That's the starting cost to 30,000. If the model did not exist, then our estimates show that parts would've reduced the cost by $1,000, but actually they reduced the cost by much more than $1,000, about $3,000. The difference is what we call so the causal effect of the model, which comes to about $1,800 or about 6%. So we say the Model's impact on surgical clinical episode have been to lower costs by 6%. Note that 6% is much larger than 3%. So if the pricing was done correctly, that means participants would've received the additional 3% as reconciliation payments. So that's the story for the surgical costs.

Mira Friedlander: Okay. So then seeing that surgical was going down across the board, BPCI Advanced Participants accelerated the cost performance, but medical episodes did go up for the comparison grouping cost. So BPCI Advanced Participants did have some success in lowering payments there. Based on that and knowing that the costs are declining overall for surgical and medical episodes, where is that cost reduction potentially coming from?

Daver Kahvecioglu: Yes, maybe I want to highlight what you just said because it's quite interesting to me. The pattern was a bit different from medical clinical episodes. If BPCI Advanced did not exists, you can see the gray line, we would've thought that cost would have gone up to about $27,000 per episode, but yet because of the Model, the cost stayed stable instead of rising. So the Model participant did not see lower costs, but they maintained costs as opposed to increasing costs. That's why we were able to measure the impact, which is about $800 per episode or about 3%. So they were able to lower costs just at the discount level, which means if the pricing was accurate, there will be all average zero reconciliation payments or repayments. Now going back to your question, I think it's in the next slide. So what's behind, how did the Participants achieve these cost reductions? Something must have been reduced and maybe next slide we can advance.

One of the main things that we have seen Participants do, and this has been very consistent over time, is Participants reduced discharges to institutional post-acute care settings. Both hospitals and PGPs lowered the percent of discharges to institutional post-acute care such as skilled nursing facilities and instead they discharge patients to home or with home health or without home health. That's been a key driver of the cost reduction. Another driver is even the beneficiaries that were discharged to a skilled nursing facility, their length of stay on average, shortened. Hospital Episode Initiators (EIs) shortened the length of stay at skilled nursing facilities (SNFs) for both medical and surgical episodes. Whereas PGPs lowered length of stay at skilled nursing facilities only for surgical clinical episodes.

I would say those were the two major drivers of the declines. Then there's another driver for the PGPs not hospitals is PGPs not only reduced institutional post care use but they also reduced home health payments and quite significantly it's about $332 per episodes whereas hospitals had no impact on home health agency payments. In the past we have seen sometimes hospitals increase home health use maybe as a substitute for skilled nursing facility, but this year's evaluation results did not show any impacts on home health use.

Mira Friedlander: Okay, thank you for that, Daver. So overall, CMMI's goals are to lower costs and increase quality of care. I know that we're talking about lowering costs and where some of that might have come from. Can you speak to what the Evaluation Team found related to quality being impacted by the model? Was it impacted, was it not? What results do we see there?

Daver Kahvecioglu: Obviously it's really critical to look at quality. We have started with the cost and what we have seen as in the past also very consistent is that in general, quality of care has not been impacted neither favorably or unfavorably. So all those cost deductions were achieved without hurting quality of care. That's the main story and it hasn't changed since the evaluation started years ago. One of the metrics that we look at when it comes to quality of care is unplanned readmission rates. I know this is not a perfect quality measure, but it's something that relates to quality and is available for everyone in the claims' data. So that makes it a good candidate for one of our outcome measures. As you can see on the left and on the right, on left for surgical critical episodes on the right for medical critical episodes.

In this case, I'm not going to get into the comparison group or counterfactuals because everything is on top of each other. What these pictures are telling us is that there have been reductions in readmission rates over time across the entire healthcare system and we say best Participants' experience just as much reductions as everybody else, which means the impact has been zero, neither favorable nor favorable. So this is only one of the measures that we look at for quality. We also look at beneficiary survey. We have a beneficiary survey. This we actually couldn't do in 2020 because of the pandemic, but if you look at the prior survey results, they're also consistent with defining that quality of care have been maintained despite significant reductions in utilization.

Mira Friedlander: So with this, we're looking at the BPCI Advanced group versus the comparison group and the counterfactual. Like you said, they're all pretty aligned. Was there other ways to slice and dice the data? Was there anything we saw between the differences in physician group practices versus hospitals and how they deliver care to this impact?

Daver Kahvecioglu: There was one group in this year's evaluation, there was one group that appeared to have lowered re-admission rates beyond what similar entities have been doing. That is initial group practices for medical episodes. I can't remember the exact number now, but the impact has been about 0.8 percentage point. So that means physician group practices for the year 2020 were able to lower readmission rates almost one percentage point more than the comparison groups identifying an impact. They have not seen any other statistical significant impact, but for that particular group we do see. But I wanted to point out that over the years, one group, another at times may show up as significant effects but typically it hasn't been maintained. So this is just one data point. I also want to mention that this is the year where the COVID pandemic was happening, so it makes it a little bit more challenging to interpret results even though as I mentioned earlier, our results have been very consistent and that was somewhat surprising to us given the pandemic, we haven't really seen a big change in the patterns despite the pandemic.

Mira Friedlander: Okay. Daver, we have a few questions so I'm going to pop to those if that's okay. Did the analysis stratify the readmissions by time period? For example, was there a difference in seven day or 30-day or the 90-day rate is tough to impact as those readmissions are frequently less related to the index day?

Daver Kahvecioglu: In this evaluation we only focus on 90 days. In the past evaluation of the predecessor model, we did look at 30 and 90 days and what I remember is that there wasn't much difference back then. For BPCI Advanced, we have been focusing on 90 days and that's because the episode length is 90 days and we had economized on the kind of outcomes number of outcomes. So we didn't look at 30 day readmission rates. But my experience has been, at least based on the predecessor model, is that the reductions were consistent. Maybe reductions may have been happening within the first 30 days, but it's been maintained over the 90 days.

Mira Friedlander: Okay. Then I know I asked you about breaking up the difference between hospitals and PGPs and you talked a little bit about that, but did they look comparable to the non-Participants or the comparison group?

Daver Kahvecioglu: Well, the picture that we see on the slide, if I understand the question correctly, the comparison group experienced similar declines as the intervention group and that's the reason we couldn't identify unfavorable effects and that there have been no effects.

Mira Friedlander: Perfect. So thank you for those questions, James and Alexander. This has been really helpful to have you break down the high-level evaluation results, Daver, and we can move forward a little bit. I know we have some health equity components that we are hoping to get to. So the BPCI Advanced Model was implemented in October of 2018, which predated CMMI strategy refresh, which Ellen touched on a little bit. The strategy refresh had a large focus on health equity, while health equity is still very important to CMMI, we're excited that the Evaluation team had some availability to look at some different analyses and determine how the models reached to underserved populations look and

what we are able to share. So I'm going to pass it over to you, Daver, to share what the Evaluation Team noticed related to hospitalizations and health equity.

Daver Kahvecioglu: As Mira said, health equity was not the focus of this Model in 2020, but we were able to look into the issues or started looking into the issues and we will keep doing that in the future. Maybe here I'm sharing I would say the most interesting finding when you think about maybe the finding isn't as surprising, but it was surprising to us at first, and that's the finding that the Model has relatively large access to other certain populations through its medical episodes. The Model was able to reach to Black and African American beneficiaries as well as dual eligible beneficiaries at relatively high rates for medical episodes. Whereas the reverse was true for surgical episodes, the reach of the Model was less, relatively less.

The graph on the right, the first bar, 9.3% is the proportion of Black or African American beneficiaries in the general fee for service population. But the proportion of those beneficiaries in medical episodes is larger 10.5%, whereas it's lower 4.8% for surgical episodes. So from here we can conclude that medical episodes have high reach to Black or African American beneficiaries and the story is even stronger for dual eligible beneficiaries. As you see on the right, 17.6% of the general fee for service Medicare population is dual eligible, but the proportion is more than a quarter for medical episodes under the model. The model has quite larger reach to these beneficiaries and less reach in surgical episodes.

Mira Friedlander: I think that's really interesting, Daver, and for our participants on the line, this is something new, but was this something that you and your organization were aware of when you've been reflecting on your own data? Is this a new opportunity that you see? Then, Daver, what type of opportunity does this provide to Model Participants to impact health equity specifically around the medical episodes?

Daver Kahvecioglu: I think in general, we know that historically underserved populations are harder to reach. But in this case, these medical episodes that Participants have, in a sense have a captive audience. These beneficiaries have been hospitalized, they have been staying in the hospitals that are associated with the model in a sense a captive audience. The opportunity is that this hard to reach population is right there and hopefully there could be ways to maybe connect them to healthcare system, maybe through primary care which they may be lacking. The Episode Initiators (EIs) might serve as a catalyst to connect these beneficiaries to the healthcare services that they may have been under utilizing.

Mira Friedlander: Okay. For the audience, are these again trends that you're seeing in your organization or as you said, Daver, there's a captive audience with these beneficiaries, so there's the ability to impact their care in different ways. Are there different organization types that might be better suited to be successful in serving or caring for these populations or how does it vary by Participant type?

Daver Kahvecioglu: I was looking at the chat.

Mira Friedlander: Okay, I will -

Daver Kahvecioglu: I got distracted.

Mira Friedlander: No, that's perfect. We can hop to David's question a little bit. So how do we know that the equity results are not representative of the prevalence of medical episodes and perhaps poorly

managed in the non-White populations that the surgical clinical episodes result in reflective of implicit bias and offering surgical interventions? Can I take a stab and see if I'm tracking? Is it because the comparison of the fee for service population is different? So we're seeing that while that might be true overall within the model, it's different and that's what we're seeing in the dark blue bar.

Daver Kahvecioglu: Yes. The comparison group is constructed to reflect similar hospitals, similar physical practices and similar patient mix. So these results, I would say, are not biased, but maybe what the real question is, do we believe these reflect, like surgical episodes having much less representation of historical underserved population? Is that a reflection of the systemic bias? I would say likely so, but the way that we did the analysis can't measure to what extent, but I would say it's much more likely than not that contributes to the smaller green bar to the right. In a sense, the way that I have been personally thinking maybe as an economist is surgical episodes in some sense, especially the planned episodes are somewhat desired, they're done to improve the conditions, so they're desirable.

Then what we see is historical underserved populations and much lesser weight of these hospitalizations that are in a sense desired. On the other hand, medical episodes are not the episodes that you just want to go to the hospital, you end up in the hospital. There are health needs of patients, maybe unmet needs, congestive heart failure, renal failure, a number of bad things happen to the patient and ends up in a hospital. It is not planned. For these cases we see a higher representation, sort of unwanted hospitalization. Just personally, that's how I interpret it. For these hospitalizations, the rate is higher whereas for desired hospitalization rate is lower, much more much likely. This is reflecting systemic bias, but it's not something that we are able to measure.

Mira Friedlander: Okay. David, feel free to chat and if that answers, if you have follow up questions. So what I'm hearing is it's a little bit of both, but also knowing that there might be the bias, we still do have this, like you said, Daver, a captive audience around the medical beneficiaries within the Model. So there is an opportunity to enhance their care further. So can you speak to what that opportunity could be or that seems a little unique, right? To have this specific population that we could impact a little bit further.

Daver Kahvecioglu: I think like I mentioned before, opportunity here, regardless of how these patients arrive at the hospital, the Episode Initiators in their hospitals have a much higher rate of underserved populations than typical. I think that's where the opportunity lies given the connection to these patients staying in those hospitals, there's opportunity to improve their healthcare environment beyond what they receive in the hospital.

Mira Friedlander: Awesome, thank you for that, Daver. We will move forward. We've had some great discussion so far and I know we've only had a few questions but we're going to move to our Q&A portion, so we have a few more questions that we can talk through. But to start us off, Daver, we've heard that there are some preliminary results from the 2021 beneficiary survey that might indicate dual eligible beneficiaries reporting worse functional outcomes than the comparison group. Again, I know you talked about this a little bit of it's just one data point and it's very preliminary, but what do you think is happening and can you explain what that insight means a little bit further?

Daver Kahvecioglu: So just to be clear, this finding that we just mentioned is not in the report that was posted. It's going to be in the next report, but it's like a preview is we have started looking into how equity issues we have been now analyzing impacts by these health equity subgroups. All of these subgroups is dual eligible. So let me compare, as I said, we have a robust beneficiary survey which we

resumed in 2021. When we looked at the results, we saw that dual eligible beneficiaries in the Model that are served by the hospitals or physician group practices that are in the Model on average, their self-reported functional outcomes have been less than those beneficiaries in the comparison group that are in comparable hospitals or served by comparable PGPs and comparable beneficiaries. So there seems to be this impact, unfavorable impact of maybe reduction in functional status about 90 days after discharge. So that's the finding that we have.

So as Mira said, this is only one data point in time. We are looking at other metrics like readmission rates, cost, and utilization metrics to see how the results may relate. We will also continue estimating the impacts on these subgroups in the coming years as well. When we see a pattern continuing, then it's more of a concern, but at this point it's just a data point that is of interest. We wanted to point that out given the emphasis on health equity, and you wondered if this may resonate with Participants in some way in terms of how the Model may be impacting dual eligible beneficiaries, that's the reason you wanted to bring up.

Mira Friedlander: I kind of jumped ahead I guess by talking about the 2021 beneficiary survey. Without giving any context, I know you shared earlier that we couldn't do a 2020 beneficiary survey due to COVID. Can you talk a little bit more about just what is included in the beneficiary survey? What's looked at and how does the evaluation team use that information?

Daver Kahvecioglu: Yes. So the beneficiary survey is conducted about 90 days after discharge and it covers a number of domains, all staff reports, obviously, one of the domains is care experience. We asked the beneficiary's experience and experience and satisfaction with care that was received during and after hospital stay through 90 days. The other domain is self-reported function outcomes, like activities of daily living. I believe there are eight questions or metrics regarding patient experience and seven regarding patient report functional outcomes.

So those two domains, we asked the same questions to a comparison group that is matched and these beneficiaries come from hospitals that are similar to intervention hospitals and come from the practices that are similar to the participating PGPs. We make adjustments as best as possible to make them comparable. So when we compare the rates or the beneficiaries in the bundle of payment model to those in the comparisons to date, and it's important to mention to date, it has been a pretty consistent finding that there was no findings. The bundled payment model has not impacted staff reported functional outcomes. But this is the first time we are seeing a change from that pattern against seven, eight years of evaluation. That's why I said it's just one data point, but an interesting one.

Mira Friedlander: Okay. So knowing that, last year we talked a little bit about some Model Year 2 beneficiary survey results. So this initial result we're talking about will be in the Model Year 4 evaluation report coming up next year, correct?

Daver Kahvecioglu: Yes.

Mira Friedlander: Okay.

Daver Kahvecioglu: Approximately a year from the release of this report, you should expect the release of the next report roughly.

Mira Friedlander: Cool. I don't see any other questions in the chat, but feel free to put them in. Like Daver said, we have the evaluation report for Model Year 3 available. So that is on the CMS website

along with the findings at a glance, so you don't have time to go through the a hundred or so pages report that Daver's team put together, there's the at a glance findings, but we will keep moving us forward. If there's any other questions, I know we're wrapping up a little early, but happy to answer any, I think this has been really helpful and really appreciative of you, Daver, breaking down this information and helping it be more digestible and understand what's going on across the Model and how it impacts participants and beneficiaries and what trends are we seeing and what we are predicting to see in the future. So really thank you, Daver, for you and your time.

For all of the Participants who joined us today, we really value your feedback and input, especially as we continue to develop additional learning activities for you, either within the Model currently or as additional or upcoming applicants and Participants in the Model. We'd love to learn more about what you're looking for from the Learning System. So again, thank you for joining us and taking the time to discuss and debrief that all with us.

Please take the survey, there will be a link in the chat. Then also one sent in the post event email. Materials for the webinar will be available on the website and on *CMMI Connect* in the next few weeks. Again, if you're looking for additional resources, check them out on the CMS website. You can also find them linked in the resources here. Then if you have any additional questions, feel free to send them to the Learning System inbox. Again, thank you for taking your time out of your busy day and again. Thank you, Daver, to you and your team, all your hard work putting this together.

Daver Kahvecioglu: It was a pleasure.

Mira Friedlander: Awesome. Thank you all for joining us today.