

Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

Model Years 1 & 2 (October 2018 through December 2019)

Findings at a Glance

MODEL OVERVIEW

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model, launched on October 1, 2018, tests whether linking payments for an episode of care can reduce Medicare expenditures while maintaining or improving quality of care. BPCI Advanced participants are financially accountable for the cost and quality of health care services during an episode, which begins with a hospitalization or an outpatient procedure and ends 90 days after discharge or the procedure. At the end of each performance period, episode payments are compared to the hospital or physician group practice (PGP) episode initiator's (EI) risk-adjusted target price. Participants can earn a reconciliation payment if episode payments are below their target price and participants repay Medicare if episode payments are above their target price, after considering the quality of their care. Thus, participants have incentives to coordinate care across all providers involved in the episode.

PARTICIPANTS AND SAMPLE

PARTICIPANTS

Participants in Model Years 1 & 2 (October 2018 through December 2019) had to enter the model at its start (October 1st, 2018). They could withdraw at any time with advance notice.

Model Years 1 & 2

334 participants | 715 hospital EIs | 580 PGP EIs

SAMPLE

Participants chose from 32 clinical episodes (CEs). The evaluation included CEs with sufficient volume. These CEs accounted for 91% of all episodes in the first two Model Years.

Number of CEs Evaluated, Model Years 1 & 2

EI Type	Medical	Surgical
Hospital	10	3
PGP	11	7

OVERALL FINDINGS

PAYMENTS

BPCI Advanced reduced episode payments by 2.2% of the BPCI Advanced baseline mean for medical episodes (or \$564 per episode) and 4.5% for surgical episodes (or \$1,353 per episode). Reductions in episode payments were driven by changes in post-acute care (PAC) use.* Results were similar when calculated by EI type, as both hospital and PGP EIs reduced payments in both episode categories.

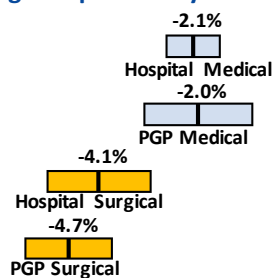
QUALITY

BPCI Advanced reduced readmissions for surgical episodes during the 90 days following a discharge or procedure by 4.1% of the BPCI Advanced mean.* Estimates were similar by EI type, though only the PGP estimate was statistically significant. Neither EI type reduced readmissions for medical CEs. There was little to no impact on mortality overall or by medical and surgical groupings.

UTILIZATION

Both EI types reduced institutional PAC use by discharging a smaller share of episodes to these settings, though reductions were smaller for hospital CEs. Hospital EIs also reduced the number of days in skilled nursing facilities (SNFs) for both medical and surgical CEs, whereas reductions in SNF days for PGP EIs were concentrated in surgical CEs. Hospitals may have achieved reductions in institutional PAC use by increasing home health (HH) use, as HH payments increased for most hospital CEs.

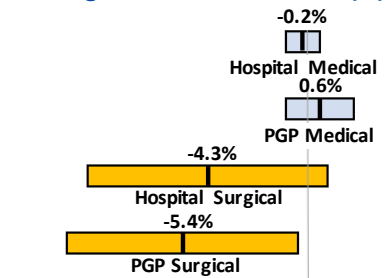
Change in Episode Payments (%)



As a proportion of the BPCI Advanced baseline average
Bars indicate the 90% confidence intervals

* Individual estimates for the two EI types may not average to the pooled estimate for a given CE type as the sets of estimates are derived from different regressions.

Change in Readmission Rate (%)



Changes in Post-Acute Care Use by EI Type

Outcome	Hospital EIs	PGP EIs
Discharged to Institutional PAC	↓	↓
Days in SNF [§]	↓	↓‡
HH Payments	↑	↓

[§] Among episodes discharged to SNF

[‡] Reductions concentrated in surgical CEs

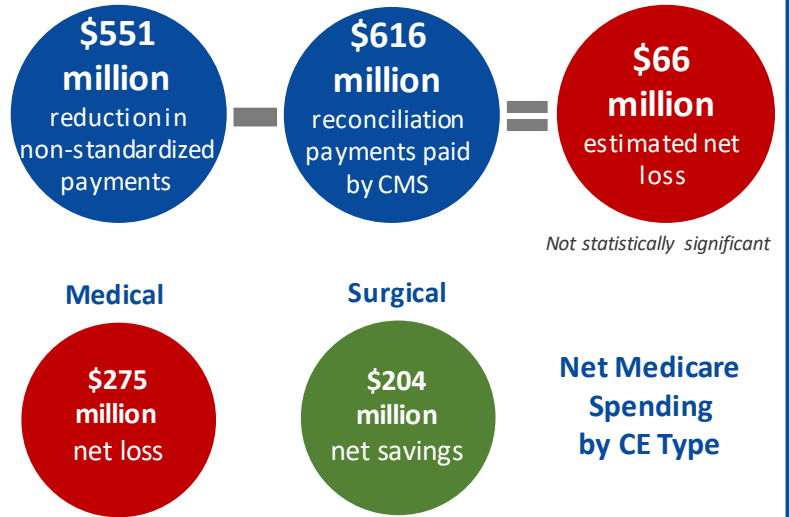
MEDICARE SAVINGS FOR MODEL YEARS 1 & 2

NET MEDICARE SPENDING

Though hospitals and PGPs EIs reduced episode payments, after accounting for reconciliation payments made to participants, Medicare experienced a small net loss of \$65.7 million, or 0.4% of what Medicare payments would have been absent the model for Model Years 1 & 2. The estimated loss was not statistically significantly different from zero.

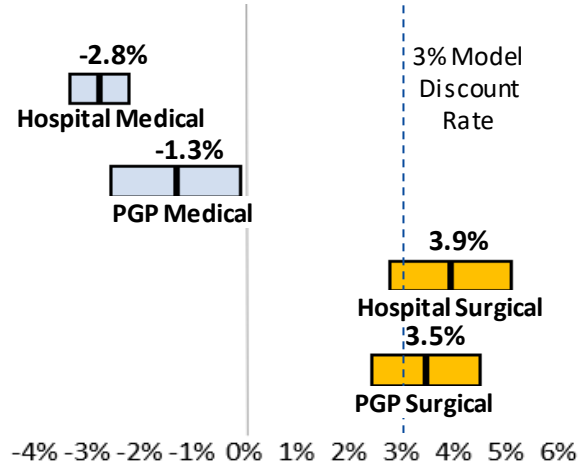
BPCI Advanced generally resulted in estimated net losses for medical CEs and estimated net savings for surgical CEs. Target prices in the BPCI Advanced Model were designed to achieve 3% net savings compared to what Medicare payments would have been absent the model. For both hospitals and PGPs, evidence suggests target prices were too high for most medical CEs but were more accurate for surgical CEs.

Net Medicare Spending, Entire Model



Note: The estimates by CE type do not sum to the \$66 million net loss above, as the estimates are derived from different regressions.

Net Medicare Savings (%), By EI and CE Type



As a proportion of what Medicare payments would have been absent the model. Bars indicate the range based on the 90% confidence interval.



Medical

For medical CEs, BPCI Advanced resulted in an estimated loss of \$275.0 million, or 2.2% of what Medicare would have spent absent the model. When estimated by EI type, the model increased Medicare spending on hospital medical episodes by 2.8% and PGP medical episodes by 1.3%. By individual CE, the largest net losses were in congestive heart failure and sepsis.



Surgical

For surgical CEs, BPCI Advanced resulted in an estimated net savings of \$204.4 million, or 3.6% of what payments would have been absent the model. When estimated by EI type, the model reduced Medicare spending on surgical clinical episodes by 3.9% for hospital EIs and 3.5% for PGP EIs. Orthopedic procedures accounted for three quarters of surgical episodes.

KEY TAKEAWAYS

Hospitals and PGPs participating in the BPCI Advanced Model reduced Medicare fee-for-service payments primarily by reducing post-acute care use. Evidence from the independent evaluation indicates that for surgical episodes overall, BPCI Advanced achieved net savings to Medicare and possibly improved quality of care, driven mostly by orthopedic procedures. Savings from surgical episodes, however, were fully offset by losses from medical episodes. Evidence indicates that, generally, target prices were too high for medical episodes but were more accurate for surgical episodes. CMS made significant design changes starting in Model Year 4 (2021) to improve the model's target pricing, which will be analyzed in future evaluation reports.