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Findings at a Glance

Bundled Payments for Care Improvement (BPCI) Initiative, Models 2-4

Final Evaluation: October 2013 through September 2018

MODEL OVERVIEW

The Bundled Payments for Care Improvement (BPCI) initiative tested whether linking payments for providers that furnish Medicare-covered items and services during an episode of care related to an inpatient hospitalization could reduce Medicare expenditures while maintaining or improving quality of care. Model 2 episodes began with a hospital admission and extended for 30, 60, or 90 days after discharge. Model 3 episodes began with the initiation of post-acute care following a hospital admission and extended for 30, 60, or 90 days. Model 4 episodes began with a hospital admission and included readmissions within 30 days after discharge.

The BPCI initiative rewarded participants in Models 2 and 3 financially through reconciliation payments for reducing Medicare payments for an episode of care relative to a target price. When episode payments were higher than the target price, Awardees may have had to make repayments to CMS. However, CMS eliminated repayment responsibility for the early portion of the initiative due to early technical challenges. Model 4 participants were paid a prospectively determined amount, and they, in turn, paid the providers that furnished services included in the episode.

PARTICIPANTS

Participants could join the risk-bearing phase from October 1, 2013 through September 30, 2015, and could stop participating at any time. The average length of participation was 10 quarters.

Percentage of participants that withdrew from BPCI

42% of Model 2 47% of Model 3 91% of Model 4

	# Participants	% of the 1.4 million BPCI Episodes
Model 2	**423** hospitals & **272** PGPs	**88%**
Model 3	**873** SNFs & **117** HHAs	**8%**
Model 4	**23** hospitals	**1%**

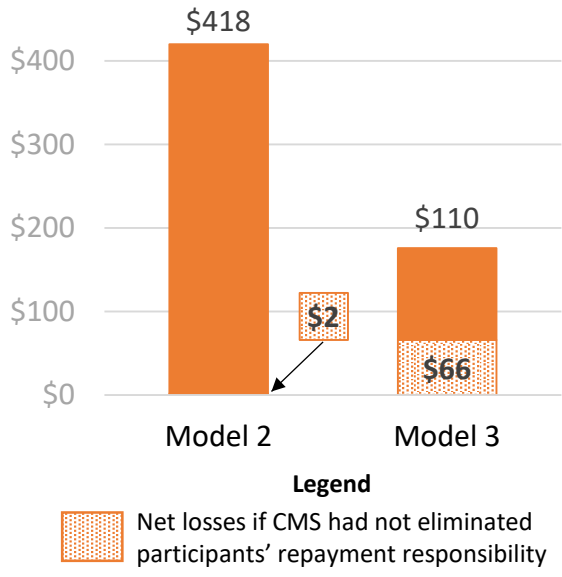
NET MEDICARE LOSSES

Despite reductions in fee-for-service (FFS) payments of $1,193 million for Model 2 and $232 million for Model 3, Medicare experienced net losses of $418 million ($p<0.05$) for Model 2, or $332 per episode, and $110 million ($p<0.05$) for Model 3, or $714 per episode, after accounting for reconciliation payments to participants.

This represents a net loss to Medicare of 1.3% of what payments would have been absent BPCI under Model 2 and 3.1% under Model 3.

The largest contributing factor to these losses was the elimination of participants' repayment responsibility. If CMS had not eliminated repayment responsibility, and assuming model participation remained the same, Model 2 would have resulted in no net losses or savings, and net losses under Model 3 would have been reduced to $66 million ($p<0.05$), or 1.9% of what payments would have been absent BPCI.

Net Medicare Losses (millions)



This document summarizes the evaluation report prepared by an independent contractor. For more information about BPCI and to download the evaluation report, visit https://innovation.cms.gov/initiatives/bundled-payments/

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OVERALL FINDINGS

PAYMENTS & UTILIZATION

Total payments		Changes in total payments were driven by	
Model 2	↓	Hospital episodes: PGP episodes:	Reductions in SNF and IRF payments; increase in HHA payments Reductions in SNF, IRF, HHA, and readmission payments
Model 3	↓	SNF episodes: HHA episodes:	Reduction in SNF payments; increase in HHA payments Small reductions in all Part A & B payments
Model 4	=	Reduction in 30-day readmission payments offset by increase in HHA payments	

QUALITY BPCI generally did not impact the quality of care as measured by unplanned readmissions, emergency department visits, and mortality, or functional status as reported in beneficiary surveys. However, fewer BPCI respondents reported the highest level of satisfaction with care relative to the comparison group. Quality was maintained among populations dually eligible for Medicare and Medicaid, with dementia, or with recent institutional post-acute care use.

SPENDING REDUCTIONS: MODEL BENCHMARKS VS EVALUATION ESTIMATES

Although the model was intended to bring net savings of 2-3%, the evaluation found that BPCI resulted in net losses to Medicare. To understand why, we compared Medicare FFS spending reductions that are calculated with the use of model benchmarks to those estimated by the evaluation. The model benchmarks are based on historical allowed amounts trended forward using a **partially risk-adjusted** retrospective **nation-wide trend**, while the evaluation uses a **fully risk-adjusted** retrospective **comparison group trend**. Spending reductions calculated with the use of model benchmarks were statistically significantly greater than the evaluation estimates for Model 2 hospital, Model 3 SNF, and Model 3 HHA episodes. This implies that the model benchmarks were too high, which led to inflated reconciliation payments. This was particularly problematic for Model 3 SNFs, likely due to very low episode volume per participant and shifts in patient mix, which are difficult to account for in claims-based data.

Reduction in Spending

	Model		Evaluation (95% CI)
Model 2 Hospitals	**6.0%**	>	**3.3%** (2.3% to 4.3%)
Model 2 PGPs	**5.5%**		**4.7%** (3.0% to 6.5%)
Model 3 SNFs	**11.9%**	>	**7.6%** (5.7% to 9.5%)
Model 3 HHAs	**10.2%**	>	**5.8%** (1.6% to 10.1%)

KEY TAKEAWAYS

Consistent with previous reports, the Bundled Payments for Care Improvement (BPCI) initiative independent evaluation found that BPCI resulted in reduced Medicare FFS payments while maintaining the quality of care for Medicare beneficiaries. Despite these encouraging results, and as previously reported, Medicare experienced net losses under Models 2 and 3 after taking into account reconciliation payments to participants. Elimination of the repayment responsibility for the early portion of the Initiative was a major reason for Medicare losses. Had CMS not forgiven the downside risk, Medicare would not have experienced losses (or savings) in Model 2, but would still have experienced losses in Model 3. This underscores the difficulty of setting appropriate benchmarks especially in a model with voluntary participation and exit.

Note: HHA=home health agency. IRF=inpatient rehabilitation facility. PGP=physician group practice. SNF=skilled nursing facility.