

Bundled Payments for Care Improvement Advanced Model

Final Evaluation Report



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Table of Contents

I.	Introduction	1
	A. Evaluation Research Questions.....	1
	B. The BPCI Advanced Model.....	2
	C. Overview of the Evaluation	8
II.	Expenditures and Savings.....	10
	A. Medicare Program Savings.....	11
	B. Episode Expenditures	13
	C. Reconciliation Payments and Target Pricing	22
	D. Summary	25
III.	Quality	27
	A. Mortality.....	28
	B. Readmissions.....	28
	C. Patient-Reported Functional Status	30
	D. Patient-Reported Care Experience and Satisfaction	32
	E. Summary	34
IV.	Conclusion.....	36

List of Exhibits

Exhibit 1:	BPCI Advanced Spanned Three Distinct Periods Across 8 Model Years.....	2
Exhibit 2:	CMS Designed the BPCI Advanced Model to Reduce Medicare Expenditures While Maintaining Quality of Care.....	3
Exhibit 3:	Over the 8 Model Years, More Than 1,100 Hospitals and 800 PGPs Participated in BPCI Advanced.....	4
Exhibit 4:	Hospitals Were More Likely to Select Medical Clinical Episodes, While PGPs Were More Likely to Select Surgical Clinical Episodes.....	6
Exhibit 5:	The BPCI Advanced Model Led to About \$800 Million in Net Medicare Program Savings Across Model Years.....	12
Exhibit 6:	BPCI Advanced Began Generating Net Savings to Medicare in Model Year 4 (2021) Due to Payment Methodology Updates That Resulted in Lower Net Reconciliation Payments to Participants.....	13
Exhibit 7:	Reductions in Episode Expenditures Were Greater for Surgical Than for Medical Episodes Across Model Years.....	15
Exhibit 8:	BPCI Advanced Led to a 5 Percentage Point Reduction in the Percentage of Surgical Patients Discharged to a PAC Facility Relative to the Comparison Group, Model Years 4–6 (2021–2023)	16
Exhibit 9:	BPCI Advanced Was Associated With 3 Fewer Days in SNFs for Patients With SNF Stays Relative to the Comparison Group, Model Years 4–6 (2021–2023).....	18
Exhibit 10:	On Average, BPCI Advanced Reduced SNF Expenditures by About \$500 per Episode Across Model Years Relative to the Comparison Group	19
Exhibit 11:	BPCI Advanced Led to Reductions in IRF Payments Relative to the Comparison Group That Increased Over Time	20
Exhibit 12:	Model Design Changes in Model Year 4 (2021) Led to a More Balanced Distribution of Participants That Earned and Owed Reconciliation Payments.....	23
Exhibit 13:	BPCI Advanced and Comparison Patients Had Similar Readmission Rates, Which Were Higher for Medical Than for Surgical Episodes, Model Years 4–6 (2021–2023)	29
Exhibit 14:	BPCI Advanced Patients Reported Less Favorable Changes in Functional Status Relative to the Comparison Group in Model Years 7–8 (2024–2025)	31
Exhibit 15:	As in Past Years, in Model Years 7–8 (2024–2025), Most BPCI Advanced Patients Reported Positive Care Experiences, but They Reported Less Favorable Care Experiences Than Comparison Patients on 2 of 10 Measures.....	32
Exhibit 16:	Most BPCI Advanced Respondents Expressed Positive Sentiments When Asked What Went Well With Their Care in Model Years 7–8 (2024–2025), With a Small Share Describing Negative Care Experiences.....	34

List of Appendices

Appendix A: Glossary of Terms and Acronyms	A-1
Appendix B: Clinical Episode Definitions.....	B-1
Appendix C: Methods	C-1
Appendix D: Patient Survey – Instrument.....	D-1
Appendix E: Supplemental Statistics on Comparison Groups	E-1
Appendix F: Participant Characteristics	F-1
Appendix G: Supplemental Sample Characteristics.....	G-1
Appendix H: Expenditure and Utilization Outcomes – Results	H-1
Appendix I: Medicare Program Savings – Results.....	I-1
Appendix J: Participant Reconciliation – Results.....	J-1
Appendix K: Claims-Based Quality Outcomes – Results.....	K-1
Appendix L: Patient Survey – Results.....	L-1

I. Introduction

Medicare beneficiaries who are hospitalized or receive outpatient procedures can experience fragmented or uncoordinated care after discharge. Various factors make it challenging for hospitals and clinicians to support a patient's recovery, including a lack of established communication channels between acute and post-acute care (PAC) providers and limited visibility into patient data across the care continuum. Hospitals and physicians may have a desire to address these issues but might not have the resources, support, or data needed to do so.

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model was a voluntary Advanced Alternative Payment Model (APM) that tested whether holding participants financially accountable for the cost and quality of an episode of care could reduce Medicare expenditures while improving or maintaining quality of care. BPCI Advanced episodes of care started with a hospitalization or outpatient surgical procedure and spanned 90 days following discharge. Accountability for an entire episode of care encouraged hospitals and physicians to work with providers across care settings to improve care transitions for patients, support successful recoveries, and reduce unnecessary PAC use. The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) launched BPCI Advanced in October 2018, and it continued for 8 model years, through December 2025.

CMS contracted with The Lewin Group and Lewin's partners, Abt Global Inc., General Dynamics Information Technology (GDIT), and Telligen, to conduct an independent evaluation of the BPCI Advanced Model. The evaluation's goal was to examine the model's impact on health care expenditures, patient outcomes, and health system transformation. Past reports have included the model's impact on expenditures and quality through Model Year 5 (2022) and patient-reported functional status and care experiences through Model Year 6 (2023) (**Appendix A**).

This final evaluation report presents new findings on impact estimates for Model Years 4 through 6 (2021–2023), following major model design updates, and for the model extension period (Model Years 7 and 8, 2024–2025), when new participants could join. It includes qualitative findings from Model Years 6 and 7 and results from the final patient survey in Model Years 7 and 8. We include key findings from prior model years to show how results changed or remained consistent over time.

A. Evaluation Research Questions

The BPCI Advanced evaluation answered the following primary research questions:

- What was the impact of BPCI Advanced on expenditures and Medicare program savings?
- What was the model's impact on quality of care?
- What was the model's impact on care transformation?

We hypothesized that participants would generate savings to Medicare by decreasing use of institutional PAC facilities and discharging more patients directly home with supports (for example,

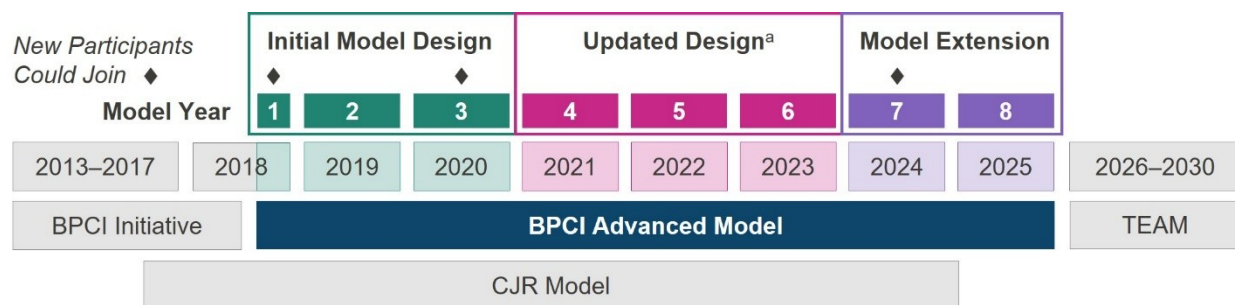
home health) when appropriate. We also anticipated that participants would implement care redesign strategies to improve care transitions and better prepare patients for discharge and recovery. We tested these hypotheses using a mixed-methods analysis of claims, model data, interviews and site visits, and a patient survey.

B. The BPCI Advanced Model

The BPCI Advanced Model began October 1, 2018 (Model Year 1)¹ and ended December 31, 2025 (Model Year 8) (Exhibit 1). This report presents results for three periods: the early years of the model (**initial model design**, Model Years 1–3), the years following major changes to the model's design (**updated design**, Model Years 4–6), and the 2 years that CMS added to the model's original performance period, when new participants could join and existing participants could select different clinical episodes (**model extension**, Model Years 7–8).²

BPCI Advanced was one of several CMS episode-based payment models. For the BPCI Advanced Model's design, CMS drew on lessons learned from the Bundled Payments for Care Improvement (BPCI) Initiative.³ BPCI Advanced overlapped with the Comprehensive Care for Joint Replacement (CJR) Model, an episode-based payment model focused on knee and hip replacements.⁴ Both BPCI Advanced and CJR informed the design of the Transforming Episode Accountability Model (TEAM), a mandatory episode-based payment model that started in January 2026.⁵ Exhibit 2 and the sections that follow identify key features of the BPCI Advanced Model, including participant types, episode types, and target prices and reconciliation.

Exhibit 1: BPCI Advanced Spanned Three Distinct Periods Across 8 Model Years



Note: Participants could withdraw from the model at any time with 90-day advance written notice. CJR = Comprehensive Care for Joint Replacement (April 1, 2016–December 31, 2024); TEAM = Transforming Episode Accountability Model (January 1, 2026–December 31, 2030). ^a Model design changes in Model Year 4 included the shift from clinical episodes to clinical episode service line groups. Major updates to the pricing methodology occurred in Model Year 4, with additional updates in Model Year 6.

Source: CMS model web pages: <https://www.cms.gov/priorities/innovation/models>

¹ Model Year 1 was only 1 quarter of the year (October 1, 2018–December 31, 2018).

² New participants could join the model in Model Years 1, 3, and 7 (2018, 2020, and 2024). Hospitals and physician group practices could change their clinical episode selections in Model Years 1, 3, 4, and 7.

³ See the CMS BPCI Initiative web page: <https://innovation.cms.gov/innovation-models/bundled-payments>

⁴ See the CMS CJR Model web page: <https://www.cms.gov/priorities/innovation/innovation-models/cjr>

⁵ See the CMS TEAM web page: <https://www.cms.gov/priorities/innovation/innovation-models/team-model>

Exhibit 2: CMS Designed the BPCI Advanced Model to Reduce Medicare Expenditures While Maintaining Quality of Care

Participants



Participant Types

- Hospitals and physician group practices (PGPs) could join the model on their own or under a convener, which included health systems, value-based care consultants, Accountable Care Organizations, clinically integrated networks, PGP-led organizations, and health plans.
- Conveners shared or bore financial risk on behalf of hospitals and PGPs and could provide support to help them succeed, such as data analysis or case management.



Model Entry and Exit

- Participants could join the model in Model Years 1, 3, and 7 (2018, 2020, and 2024) and could withdraw from the model at any time with 90-day advance written notice.
- In each entry year, and in Model Year 4 (2021), participating hospitals and PGPs could change their clinical episode or clinical episode service line group (CESLG) selections.

BPCI Advanced Episodes



Episodes of Care

- Episodes of care were initiated by an anchor hospital stay or hospital outpatient procedure for selected acute medical conditions and surgeries.
- Episodes of care included all Original Medicare items and services furnished during the anchor stay or procedure through 90 days after discharge, with some exclusions.



Clinical Episodes and Service Line Groups

- In early model years, participants selected one or more clinical episodes for which they would be held accountable. Starting in Model Year 4, participants chose one or more of eight groupings of clinical episodes referred to as CESLGs.

Medical CESLGs (clinical episode example):

Cardiac care (example: heart failure)

Gastrointestinal care (example: obstruction)

Neurological care (example: stroke)

Medical and critical care (example: sepsis)

Surgical CESLGs (clinical episode example):

Cardiac procedures (example: coronary bypass)

Gastrointestinal surgery (example: bowel surgery)

Spinal procedures (example: spinal fusion)

Orthopedics (example: knee/hip replacement)

Target Prices and Reconciliation

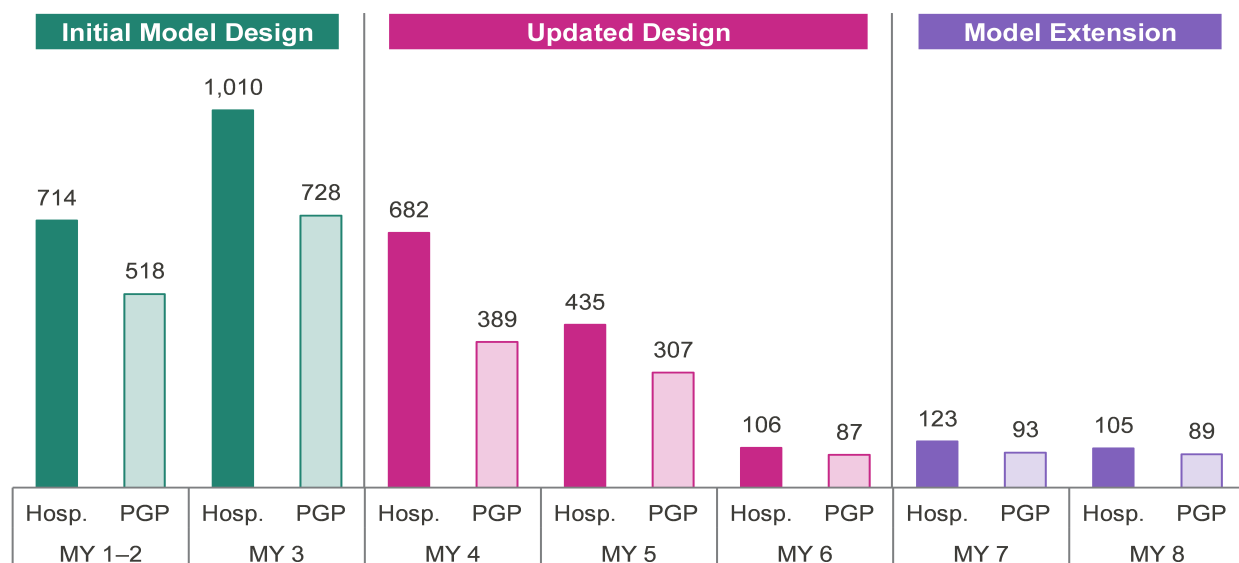


- Participants were paid under the fee-for-service payment system as usual and were subject to a reconciliation process for their selected clinical episodes or CESLGs:
 - CMS set a benchmark price based on historical payments for hospitals and their peers in a baseline period, which shifted forward each year. CMS adjusted the benchmark price for patient case mix and peer group spending trends (including a retrospective adjustment to account for realized peer group spending trends starting in Model Year 4).
 - Target prices incorporated a 3% discount from the benchmark price. (CMS lowered the discount for medical episodes to 2% starting in Model Year 6.)
 - A participant earned a reconciliation payment from CMS if episode payments were below the target price or owed a repayment to CMS if payments exceeded the target price.
 - CMS adjusted reconciliation payments for quality and applied stop-loss/gain limits.

Participants

A substantial share of eligible hospitals and clinicians around the country participated in BPCI Advanced across the model years, helping the model reach millions of patients (**Appendix F**). The number of hospitals and physician group practices (PGPs) participating in BPCI Advanced peaked in Model Year 3 and then decreased over time (Exhibit 3).⁶ Overall, 1 in 3 eligible hospitals participated in the model, as well as 1 in 4 eligible clinicians, providing care during approximately 2.5 million hospital stays and procedures for 1.8 million patients. Across all model years, most BPCI Advanced hospitals (80.9%) and PGPs (76.7%) participated under a convener, which bore or shared financial risk and often offered services that supported hospital and PGP success in the model (**Appendix F**).

Exhibit 3: Over the 8 Model Years, More Than 1,100 Hospitals and 800 PGPs Participated in BPCI Advanced



Note: We counted hospitals and PGPs as BPCI Advanced participants if they had a participation agreement with CMS or were included as a downstream episode initiator on a participation agreement between a convener and CMS. PGPs were included only if they had at least one BPCI Advanced eligible discharge or procedure attributed to their Taxpayer Identification Number between January 1, 2013, and December 31, 2025. Hosp. = hospital; MY = model year; PGP = physician group practice.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures beginning on or after January 1, 2013, and ending on or before December 31, 2023, and the CMS BPCI Advanced Database as of December 31, 2025.

BPCI Advanced increased the reach of value-based care to Medicare patients. More than half of BPCI Advanced episodes of care were for patients who were not engaged in a Medicare

⁶ Some PGPs enrolled in the model had no attributed episodes and were deemed inactive. For evaluation purposes, we counted PGPs only if they actively participated in the model, having at least one BPCI Advanced episode during either the baseline or intervention period.

Accountable Care Organization (ACO)⁷ and could benefit from the care coordination strategies that BPCI Advanced hospitals and PGPs employed. Although BPCI Advanced reached a substantial share of hospitals, PGPs, and patients, because it was a voluntary model with two-sided risk, there was attrition. Participants in Model Years 7 and 8 tended to differ from those in earlier years of the model. For instance, compared with hospitals in earlier years, a greater share of those participating in Model Year 7 were for-profit hospitals, were safety-net hospitals, and had lower patient quality ratings on the Hospital Consumer Assessment of Healthcare Providers and Systems survey (**Appendix F**).

Clinical Episodes and CESLGs

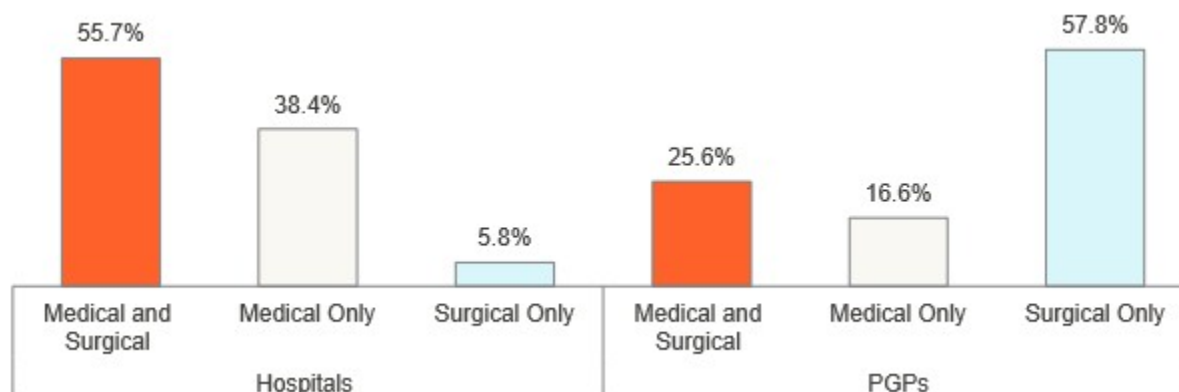
Hospitals and PGPs selected the clinical episodes (Model Years 1–3) or clinical episode service line groups (CESLGs) (starting in Model Year 4) in which they would participate. During site visits, we learned that participants made clinical episode selection decisions by reviewing historical data on patient volume, episode spending, and PAC utilization and identifying the clinical episodes that provided the best opportunity to reduce spending and receive reconciliation payments from CMS. Participants also considered the level of clinician engagement in each clinical episode and their organization's expertise in treating certain conditions, such as Joint Commission certification in stroke or cardiac care.

Hospitals more often selected medical clinical episodes and CESLGs, whereas PGPs were more likely to select surgical clinical episodes and CESLGs (Exhibit 4). The most common medical clinical episodes that hospitals selected were sepsis and simple pneumonia (in the *medical and critical care* CESLG), followed by congestive heart failure (in the *cardiac care* CESLG), all of which are frequent reasons for hospital admission.⁸ Many participants wanted to ensure that they would have adequate volume in their selected clinical episodes to mitigate the risk of costly outlier episodes. Some hospitals avoided selecting surgical CESLGs if a PGP within their hospital was also participating in the model because those episodes would be attributed to the PGP. Many PGPs specialized in orthopedics or cardiac procedures and thus selected those particular surgical CESLGs. The most frequently selected surgical clinical episodes for PGPs were in the *orthopedics* CESLG, specifically knee and hip replacements (**Appendix F**).

⁷ For detailed results, refer to prior evaluation reports and appendices available on the BPCI Advanced Model web page: <https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>

⁸ McDermott, K. W., & Roemer, M. (2021). *Most frequent principal diagnoses for inpatient stays in U.S. hospitals, 2018*. HCUP Statistical Brief #277. Agency for Healthcare Research and Quality. <https://hcup-us.ahrq.gov/reports/statbriefs/sb277-Top-Reasons-Hospital-Stays-2018.jsp>

Exhibit 4: Hospitals Were More Likely to Select Medical Clinical Episodes, While PGPs Were More Likely to Select Surgical Clinical Episodes



Note: Data are limited to participants that had at least one discharge or procedure in medical or surgical clinical episodes and CESLGs for the model year to ensure participants engaged in their chosen clinical episode(s) or CESLG(s). CESLG = clinical episode service line group; PGP = physician group practice.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures beginning on or after October 1, 2018, and ending on or before December 31, 2025 (Model Years 1–8), and the CMS BPCI Advanced Database as of December 31, 2025.

The transition to CESLGs in Model Year 4 broadened the clinical episode mix by requiring participants to be accountable for groupings of related clinical episodes. During site visits, participants noted that this shift helped engage more physicians and specialists and encouraged broader adoption of care redesign strategies across a service line. However, many participants reported that the switch to CESLGs forced their organizations to take on financial risk for clinical episodes for which they could not achieve financial gains, corresponding to a decrease in participation after Model Year 4.

Transition to CESLGs Spread Care Redesign to More Patients

One BPCI Advanced participant described that being responsible for all clinical episodes within the *cardiac care* CESLG helped spread care redesign activities beyond a single diagnosis-related group and improved care management practices for all cardiac patients.

With new participant entry and model attrition, the percentage of hospitals and PGPs participating in various clinical episodes and CESLGs changed over time. From Model Years 1 and 2 to Model Year 8, the percentage of hospitals participating in surgical clinical episodes decreased (from 57.6% to 41.3%) and the percentage of PGPs participating in medical clinical episodes decreased (from 35.9% to 25.6%), while hospital medical (more than 90%) and PGP surgical (more than 80%) clinical episode participation remained high (**Appendix F**). With these shifts, the clinical episode and CESLG mix of patients treated under the model changed over time as well.

Target Prices and Reconciliation

Under the BPCI Advanced Model, participants were accountable for reducing the cost of an episode of care below a target price. During the reconciliation process, CMS determined whether participants earned an additional payment (by keeping episode spending under the target price) or owed a repayment (by exceeding the target price).

Target Pricing

CMS calculated target prices separately for each hospital and clinical episode.⁹ CMS started by determining a *benchmark* price for each hospital and clinical episode combination using hospitals' historical spending patterns in a baseline period.¹⁰ The baseline period shifted forward each year so that in later model years, the baseline period included performance periods when participants may have already reduced spending. CMS calculated the target price by subtracting a *discount* from the benchmark. This discount was intended to result in savings to Medicare. For Model Years 1 through 5, the CMS discount was 3% for both medical and surgical episodes. Starting in Model Year 6, CMS reduced the discount to 2% for medical episodes and maintained the 3% discount for surgical episodes.

Hospitals and PGPs received preliminary target prices, which helped them decide whether to enter or exit the model and select clinical episodes or CESLGs. Preliminary target prices included an adjustment for baseline patient case mix to account for variation in payments due to patient complexity and medical needs. They also included an adjustment for historical spending among similar hospitals ("peer group") and a prospective peer group trend adjustment to account for predicted changes in average payments between the baseline and intervention periods. During the reconciliation process, CMS calculated final target prices, adjusting for patient case mix during the performance period. Starting in Model Year 4, final target prices also reflected retrospective peer group and national trends based on observed, versus expected, spending.¹¹ These methods helped standardize episode pricing across participants with different cost structures and patient populations, supporting a more equitable and comparable basis for participation.

Given participant attrition following the Model Year 4 updates, CMS made additional changes in Model Year 6 to keep hospitals and PGPs engaged in value-based care. These changes included lowering the discount from 3% to 2% for medical episodes and reducing the peer group trend factor adjustment cap.¹²

Reconciliation Process

Model participants received Medicare fee-for-service (FFS) payments for providing Medicare-covered items and services as they had prior to model participation. For each 6-month BPCI Advanced performance period, CMS compared Medicare payments during the performance period with the target price for each of a participant's clinical episodes. When the episode

⁹ For PGPs, the target price was based on the target price of the hospital where the hospitalization or procedure occurred.

¹⁰ Note that the baseline period that CMS used in target pricing differs from the baseline period that the evaluation used to determine model impacts.

¹¹ Centers for Medicare & Medicaid Services. (2022). *Target price specifications Model Year 4*. <https://www.cms.gov/priorities/innovation/media/document/bpciadvanced-targetprice-specs-my4-v4>

¹² Starting in Model Year 6, CMS also included patients with a COVID-19 diagnosis in participants' episode volume. For details on COVID-19 episode policies in Model Years 3 through 5, see the fourth and fifth evaluation reports and appendices, available on the BPCI Advanced Model web page: <https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>

payments for a participant aggregated across all clinical episodes—and aggregated across all downstream hospitals or PGPs if the participant was a convener—were below its target price, the participant received a payment in the form of a Net Payment Reconciliation Amount (NPRA) from CMS; we refer to NPRA in this report as *reconciliation payments* from CMS to participants. When the aggregated episode payments were above the target price, the participant owed a *repayment amount* to CMS. Reconciliation payments were summed across participants to obtain the *net reconciliation payment* either received by CMS from participants or owed to participants by CMS in a given performance period. We used this information in the evaluation to calculate Medicare program savings.

CMS adjusted the reconciliation payments for quality and stop-loss or stop-gain limits. The BPCI Advanced Model qualified as an Advanced APM under the Quality Payment Program in part because CMS factored participant performance on quality measures into the determination of reconciliation payments through the Composite Quality Score (CQS).¹³ The CQS in BPCI Advanced aggregated a participant's performance on a set of quality measures specific to each clinical episode, as well as broad measures, such as unplanned readmissions and advance care planning. CMS used the CQS to adjust the reconciliation payment by up to 10%. After accounting for the CQS, CMS applied stop-loss and stop-gain limits, which restricted reconciliation payments to 20% of the participant's aggregate target price for a performance period. These limits reduced losses for participants but also restricted excessive financial gains, which may have otherwise incentivized hospitals and PGPs to stint on care to achieve higher payments in the model.

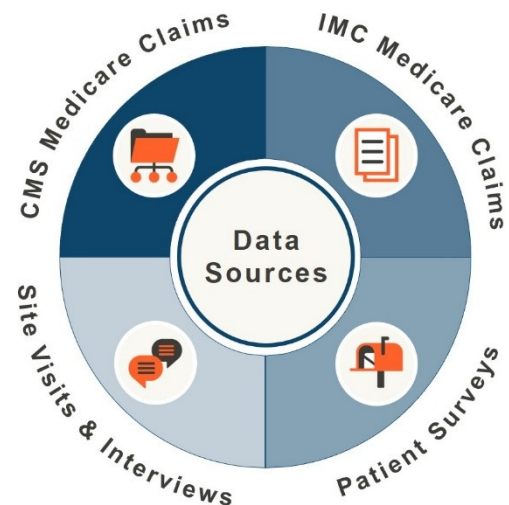
C. Overview of the Evaluation

The BPCI Advanced evaluation integrated multiple primary and secondary data sources, including Medicare claims and enrollment data, information collected from key informant interviews and site visits, and a survey of BPCI Advanced and comparison patients.

The evaluation employed a difference-in-differences (DiD) approach to estimate the model's impact on payment and quality outcomes and, in most years, used a matched comparison group to represent what would have happened if the model had never existed. A key methodological consideration is that for Model Years 7 and 8, we relied on claims data provided by the BPCI Advanced Implementation and Monitoring Contractor (IMC). The IMC data, generated as part of implementation activities, had a more limited set of variables than the custom analytic files we developed for the evaluation of prior model years, but using these data allowed us to more efficiently build the analytic file to evaluate Model Year 7 and 8 episodes. Given data limitations and for efficiency, we also relied on a national comparison group rather than a matched comparison group for the Model Year 7 and 8 analyses. We conducted a

¹³ The Advanced APM designation of the BPCI Advanced Model may have helped incentivize model participation because participating clinicians could qualify as a "Qualifying APM Participant" (QP) if they met certain Medicare patient and payment thresholds. QPs are exempt from Merit-based Incentive Payment System reporting requirements under the Quality Payment Program and are eligible for incentive payments (through 2024) or a higher Physician Fee Schedule update (2024 and beyond). For more information, see <https://qpp.cms.gov/apms/overview>.

sensitivity analysis that quantified the potential bias in our estimates due to the difference in the data source and comparison group between Model Years 7 and 8 and prior periods (**Appendix C**). Although we are confident in the direction of our estimates (that is, a relative reduction in payments), we found that using a national comparison group based on data derived for model implementation overestimated reductions in expenditures associated with the model. This would also lead to overestimates of Medicare program savings. Because of the differences in the evaluation methodology for Model Years 7 and 8, and because of major model changes in Model Year 4, we present results separately for the *initial model design* period (Model Years 1–3), the *updated design* period (Model Years 4–6), and the *model extension* period (Model Years 7–8).



We evaluated the model's impact on all patients as well as separately for patients with medical versus surgical episodes because of their distinct clinical pathways. For example, surgical episodes often include planned procedures where participants can prepare the patient ahead of time for surgery and recovery, making it easier to control costs and avoid discharges to PAC facilities. In contrast, medical episodes are often emergent and do not allow time to prepare patients or to set expectations before the hospitalization.

We provide detailed methods, data descriptions, and information on sensitivity analyses in **Appendix C** and in the relevant chapters that follow.¹⁴

¹⁴ Additional information supporting this report is available in the appendices, which include a glossary and clinical episode definitions (**Appendix A** and **B**), detailed methods (**Appendix C**), and supplemental results, sample characteristics, and data collection instruments corresponding to the analyses conducted for the evaluation (**Appendix D** through **L**).

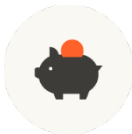
II. Expenditures and Savings

CMS designed the BPCI Advanced Model to lower Medicare expenditures while maintaining or improving quality of care. By holding participants financially accountable for the overall cost and quality of a patient's episode of care, the model encouraged stronger care coordination across providers from all health care settings.

In this chapter, we summarize net Medicare program savings over the 8 model years and break down net savings into two components: (1) reductions in CMS expenditures for episodes of care and (2) net reconciliation payments related to participating in the model. We describe how participants redesigned care to reduce Medicare expenditures. We also discuss how much participants earned or lost during the model and their experience with the BPCI Advanced pricing methodology.

Key Findings

Medicare Savings



BPCI Advanced achieved net savings to Medicare when reductions in episode payments exceeded net reconciliation payments to participants. BPCI Advanced generated net savings in Model Year 4 and onward, and these savings surpassed losses that occurred in prior model years.

Expenditure Reductions



Participants reduced Medicare FFS payments in each model year relative to the comparison group, primarily by decreasing use of and length of stay in PAC facilities during the 90-day post-discharge period. Per-episode payment reductions were greater for surgical episodes than for medical episodes.

Reconciliation Payments and Target Pricing



Most BPCI Advanced participants reduced episode spending and earned reconciliation payments. Hospitals with historically higher spending and those in peer groups with higher spending generally had higher target prices. This may have incentivized the entry of high-cost participants, including safety-net hospitals, into the model, extending value-based care to more high-need patients.

Care Redesign to Reduce Spending and Earn Reconciliation Payments



Participants lowered expenditures by reducing discharges to PAC facilities when possible or shortening PAC facility stays when this care was necessary. During site visits, many participants described taking a “why not home?” approach to discharge decision-making that encouraged participants to send patients home to recover instead of to an institutional PAC facility. In addition, participants formed preferred networks with high-quality PAC providers to shorten length of stay in those facilities, which also contributed to lower Medicare expenditures.

A. Medicare Program Savings

To achieve Medicare savings, the reductions in Medicare expenditures had to be greater than net reconciliation payments to participants or accompanied by net repayments from participants to CMS.

Total Savings

Overall, BPCI Advanced led to about \$800 million in net Medicare program savings across all model years. In Model Years 1 through 3, the model incurred net losses, as net reconciliation payments to participants exceeded the total reduction in episode expenditures. Model design changes implemented in Model Year 4 resulted in net savings for the rest of the model's tenure, and these savings exceeded the losses in earlier years. CMS achieved estimated net savings of \$915.8 million (90% confidence interval [CI] based on DiD estimate: \$745.1 million, \$1,086.5 million) in Model Years 4 through 6 and \$85.8 million (90% CI: \$61.0 million, \$110.6 million) in Model Years 7 and 8, surpassing the estimated net losses of \$65.7 million (90% CI: –152.0 million, 20.5 million) in Model Years 1 and 2 and \$113.7 million (90% CI: –\$207.4 million, –\$20.1 million) in Model Year 3 (Exhibit 5).

Methods Overview

Medicare Program Savings

We calculated total reductions in episode expenditures by extrapolating the model's impact on the average episode payment to all evaluated BPCI Advanced clinical episodes. Medicare program savings are equal to this amount plus the net of repayments from participants to CMS and reconciliation payments from CMS to participants. See **Appendix C** for details on methods and **Appendix I** for more information on Medicare program savings.

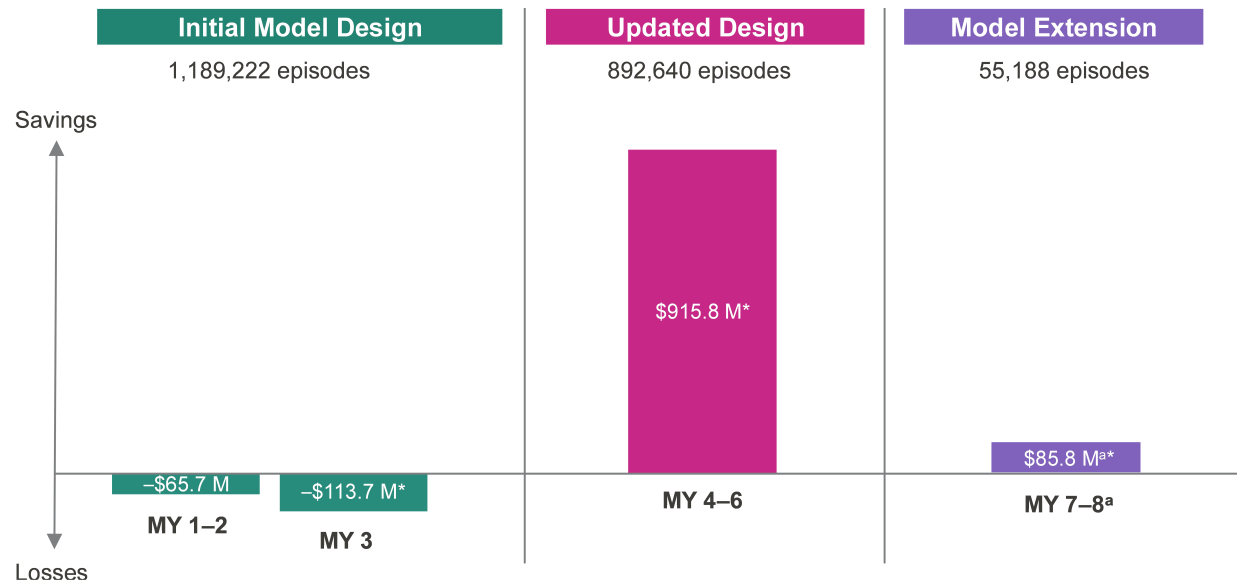
The total savings estimates reflect broad participation in BPCI Advanced among hospitals and PGPs. The smaller savings estimate in Model Years 7 and 8 compared with estimated savings in Model Years 4 through 6 reflects the lower participation in the last years of the model.

The shift to savings beginning in Model Year 4 followed key model design changes. First, CMS introduced retrospective trend adjustments to calculate the final target prices used in the reconciliation process. These adjustments accounted for actual spending trends across peer groups from the baseline through the performance period. Second, CMS aligned episode overlap definitions for the baseline and performance periods so that a readmission that occurred during a patient's ongoing episode (that is, an overlapping episode) was excluded during both periods.¹⁵ This update created consistency across time in episode construction and improved target price accuracy. Third, CMS required participants to select CESLGs rather than individual clinical

¹⁵ There were certain exceptions to the episode overlap rules. See the *Pricing Methodology Frequently Asked Questions* for more information:
<https://www.cms.gov/files/document/bpcia-model-pricing-meth-faq-my7.pdf>

episodes, encouraging broader accountability and reducing opportunities for selective participation in only the most profitable clinical episodes.¹⁶

Exhibit 5: The BPCI Advanced Model Led to About \$800 Million in Net Medicare Program Savings Across Model Years



Note: We calculated the net savings to Medicare as the estimated reduction in episode expenditures from CMS plus net reconciliation payments. See **Appendix C** for details of the DiD methodology, outcome definitions, and additional information on methods. See **Appendix I** for detailed results of Medicare savings. DiD = difference-in-differences; M = million; MY = model year; PGP = physician group practice. ^a Model Year 7–8 results are likely overestimated because of our reliance on national episode data constructed for model implementation rather than the customized data and matched comparison group used to evaluate prior model years; see **Appendix H** for results of sensitivity analyses. * Indicates that the range based on the DiD estimate's 90% confidence interval does not include \$0.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and comparison hospitals or PGPs, as well as CMS reconciliation data from the same period. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

Components of Savings

Most savings to Medicare came from large and consistent reductions in episode expenditures, rather than net reconciliation payments made from participants to CMS. In Model Years 4 through 6, after CMS updated the model design, \$886.9 million of the \$915.8 million in savings resulted from episode expenditure reductions, while \$28.9 million was from net reconciliation payments from participants to CMS. In early model years, net reconciliation payments from CMS to participants exceeded episode expenditure reductions, resulting in net losses to Medicare (Exhibit 6).

¹⁶ See the *Model Year 4 BPCI Advanced Model Overview Fact Sheet* for more details on model design changes:

<https://www.cms.gov/priorities/innovation/media/document/bcpi-model-overview-fact-sheet-my4>

Patterns of savings differed for medical and surgical episodes. Surgical episodes consistently achieved net savings to Medicare because episode expenditure reductions exceeded net reconciliation payments in every model year. Savings from medical episodes, which made up about 75% of the sample evaluated, were more variable. Prior to Model Year 4, net reconciliation payments from CMS to participants were greater than expenditure reductions for medical episodes, but starting in Model Year 4, net reconciliation payments were small relative to expenditure reductions. This shift suggests model design changes that CMS made in Model Year 4 affected target prices for medical episodes more than target prices for surgical episodes. More information is available in **Appendix I**.

Exhibit 6: BPCI Advanced Began Generating Net Savings to Medicare in Model Year 4 (2021) Due to Payment Methodology Updates That Resulted in Lower Net Reconciliation Payments to Participants

Medicare Program Savings Calculation		Initial Model Design		Updated Design	Model Extension
		MY 1–2	MY 3	MY 4–6	MY 7–8 ^a
	Reduction in Expenditures	\$550.7 M	\$514.1 M	\$886.9 M	\$85.6 M
+	Net Reconciliation Payments	–\$616.5 M	–\$627.8 M	\$28.9 M	\$0.2 M
=	Net Savings or Losses	–\$65.7 M	–\$113.7 M*	\$915.8 M*	\$85.8 M*

Note: The estimated reductions in episode expenditures from CMS are based on DiD models of standardized Medicare paid amounts that were adjusted as described in **Appendix I**. We calculated the savings to Medicare as the estimated reduction in episode expenditures plus net reconciliation payments. See **Appendix C** for details of the DiD methodology, reconciliation adjustment methodology, outcome definitions, and additional information on methods. DiD = difference-in-differences; M = million; MY = model year; PGP = physician group practice. ^a Model Year 7–8 results are likely overestimated because of our reliance on national episode data constructed for model implementation rather than the customized data and matched comparison group used to evaluate prior model years; see **Appendix H** for results of sensitivity analyses. *Indicates that the range based on the DiD estimate's 90% confidence interval does not include \$0.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and comparison hospitals or PGPs, as well as CMS reconciliation data from the same period. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

B. Episode Expenditures

In this section, we describe how BPCI Advanced affected episode spending—through changes in institutional PAC use. These findings are bolstered by insights from participant interviews about how hospitals and PGPs redesigned care to manage costs in response to BPCI Advanced incentives.

Total Expenditures

In all model years, we found that the model reduced spending relative to the comparison group. BPCI Advanced led to a decrease of \$743 (90% CI: –\$860, –\$626) per episode on average in

Model Years 1 and 2 and about \$1,000 per episode in Model Years 3 through 6 (**Appendix H**).¹⁷ In Model Years 4 through 6, this estimate corresponded to a 3.8% reduction from the BPCI Advanced baseline mean. The estimated impact was greater in Model Years 7 and 8, but our checks indicated that Model Year 7 and 8 results were sensitive to our reliance on national episode data constructed for model implementation rather than the customized data and matched comparison group used to evaluate prior model years. The approach used in Model Years 7 and 8 resulted in an overestimated effect by 13.6% (**Appendix C**). There also may have been selection bias related to the decision to participate in the final model years. More information on the limitations and sensitivity checks for the Model Year 7 and 8 analyses is available in **Appendix C**.

Methods Overview

Difference-in-Differences (DiD)

We estimated the model's impact on episode payments through a DiD approach using Medicare claims and enrollment data for BPCI Advanced and comparison group hospitals and PGPs. A strength of our methodological approach through Model Year 6 was the construction of matched comparison groups, which considered multiple model entry points, selection of clinical episodes, and contamination from exposure to the model. In Model Years 7 and 8, we used a national comparison group and conducted a series of sensitivity checks to assess whether the results were robust (**Appendix C**). These checks suggest that the impact estimates from Model Years 7 and 8 are overestimated by 13.6%.

BPCI Advanced led to a greater reduction in episode expenditures for surgical episodes than for medical episodes relative to the comparison group (Exhibit 7). For example, in Model Years 4 through 6, the model reduced payments for surgical episodes by \$1,835 (90% CI: –\$2,199, –\$1,471) compared with \$756 (90% CI: –\$923, –\$588) for medical episodes. These estimates corresponded to a 5.9% and 2.9% reduction from the baseline means, respectively. Participants said that reducing spending was easier for elective surgical episodes than for unplanned medical episodes because they could better prepare patients for surgery and mitigate risk factors to avoid surgical complications. They could also delay elective surgeries for patients with substantial risk factors, such as high body mass index or A1c scores. Participants noted they could often avoid PAC use altogether for patients with elective surgical episodes who were mobilized soon after surgery and had adequate support at home, contributing to lower Medicare expenditures.

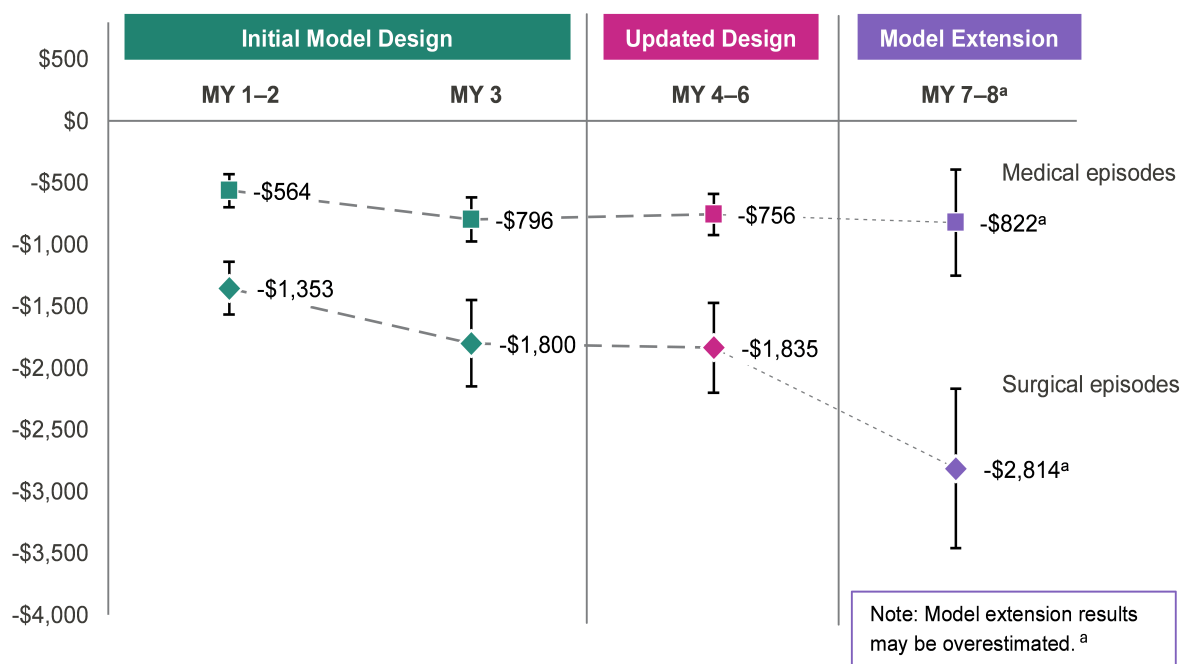
To assess the drivers of episode expenditure reductions, we measured the model's impact on PAC use during the 90-day post-discharge period, including discharges to PAC facilities and days at skilled nursing facilities (SNFs); we also measured impacts on PAC spending by assessing SNF, inpatient rehabilitation facility (IRF), and home health payments. Hospitals and PGPs discharged BPCI Advanced patients to an IRF or SNF depending on their clinical needs and ability to tolerate therapy. IRFs are generally recommended for patients who have experienced strokes, traumatic brain injuries, spinal cord injuries, or complex orthopedic surgeries and require

¹⁷ For detailed results from previous model years, refer to prior evaluation reports and appendices available on the BPCI Advanced Model web page:

<https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>

multidisciplinary care. In general, IRFs provide more intensive therapy than SNFs do, offering 3 hours of therapy a day, while SNF rehabilitation is typically less intense.

Exhibit 7: Reductions in Episode Expenditures Were Greater for Surgical Than for Medical Episodes Across Model Years



Note: The estimates in this exhibit are the results of DiD models. The DiD estimates represent the relative change in dollars. The dark gray lines indicate the 90% CI of the DiD estimate. See **Appendix C** for details of the DiD methodology, parallel trends, outcome definitions, and additional information on methods. See **Appendix H** for detailed results. CI = confidence interval; DiD = difference-in-differences; MY = model year; PGP = physician group practice. ^a Model Year 7–8 results are likely overestimated because of our reliance on national episode data constructed for model implementation rather than the customized data and matched comparison group used to evaluate prior model years; see **Appendix H** for results of sensitivity analyses.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and comparison hospitals or PGPs. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

PAC Use and Spending

PAC facility use, including institutional care in IRFs and SNFs, generally represented a major cost driver within an episode of care and was the primary focus of participants' care redesign strategies. This section examines how BPCI Advanced influenced IRF and SNF use and spending, as well as home health spending.¹⁸

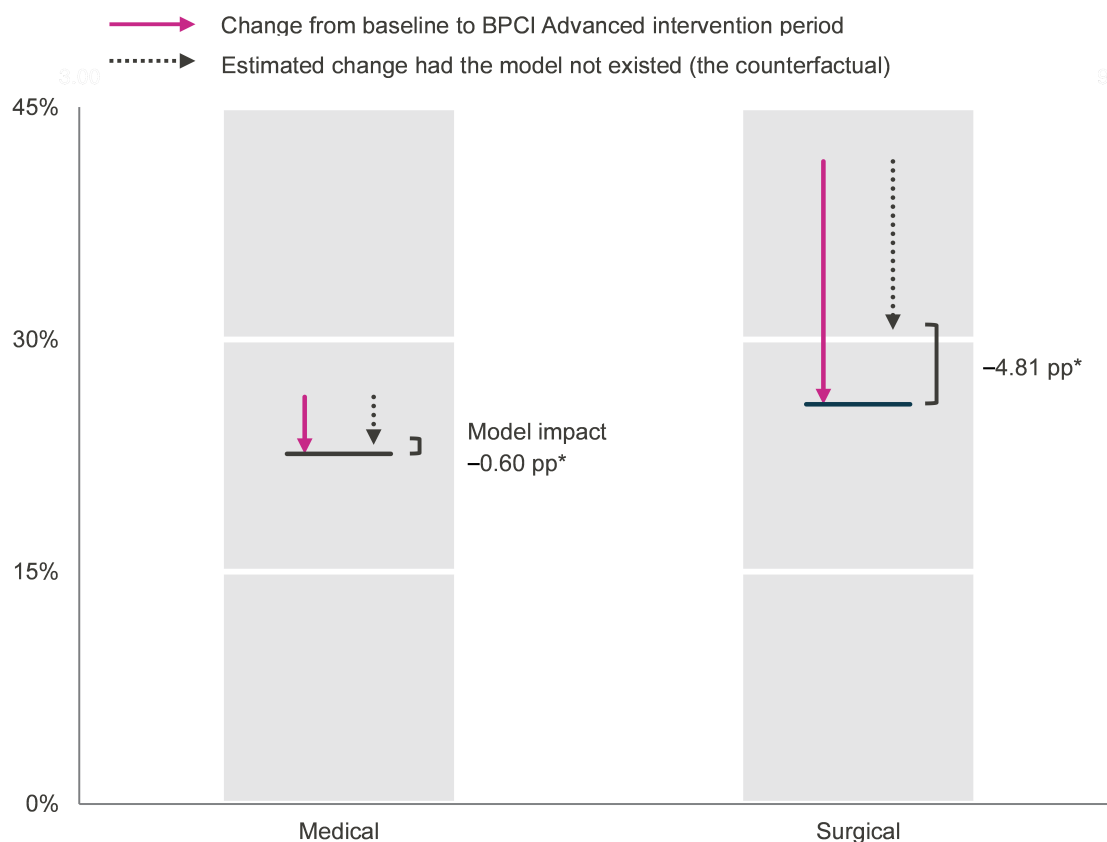
Discharges to PAC Facilities

Participants primarily reduced spending by lowering use of institutional PAC facilities, including IRFs and SNFs. Overall, the model led to a decrease of 1.45 percentage points (pp)

¹⁸ We also evaluated impacts on readmission payments. See **Appendix H** for results.

(90% CI: –2.01 pp, –0.90 pp) in patients discharged to an institutional PAC facility in Model Years 4 through 6 (**Appendix H**). Estimates were similar for other model years.¹⁹ The decrease occurred across both medical and surgical episodes, with a larger effect for surgical episodes (Exhibit 8). From baseline to Model Years 4 through 6, both the BPCI Advanced and comparison group experienced declines, but BPCI Advanced decreased PAC facility discharges by nearly 5 pp more than the comparison group (DiD: –4.81 pp; 90% CI: –6.51 pp, –3.10 pp), from 41.5% to 25.8% (compared with the counterfactual decrease to 30.6%).

Exhibit 8: BPCI Advanced Led to a 5 Percentage Point Reduction in the Percentage of Surgical Patients Discharged to a PAC Facility Relative to the Comparison Group, Model Years 4–6 (2021–2023)



Note: The estimates in this exhibit are the results of DiD models. The DiD estimates represent the relative change in pp. See **Appendix C** for details of the DiD methodology, parallel trends, outcome definitions, and additional information on methods. See **Appendix H** for detailed results. DiD = difference-in-differences; PAC = post-acute care; PGP = physician group practice; pp = percentage point. * $p \leq 0.10$.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and matched comparison hospitals or PGPs. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

¹⁹ For detailed results from previous model years, refer to prior evaluation reports and appendices available on the BPCI Advanced Model web page:

<https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>.

Interviews with participants indicated that the most common strategy for reducing Medicare spending was avoiding discharges to PAC facilities when medically appropriate. CMS provided participants with data on their historical episode spending, and many participants learned from these data that they were overutilizing institutional post-acute care compared with their peers.

“The BPCI Advanced data helped us realize we were overutilizers of [skilled nursing facilities] compared to others and below benchmarks in sending people home. This has incentivized us to change our practices.”

– BPCI Advanced hospital

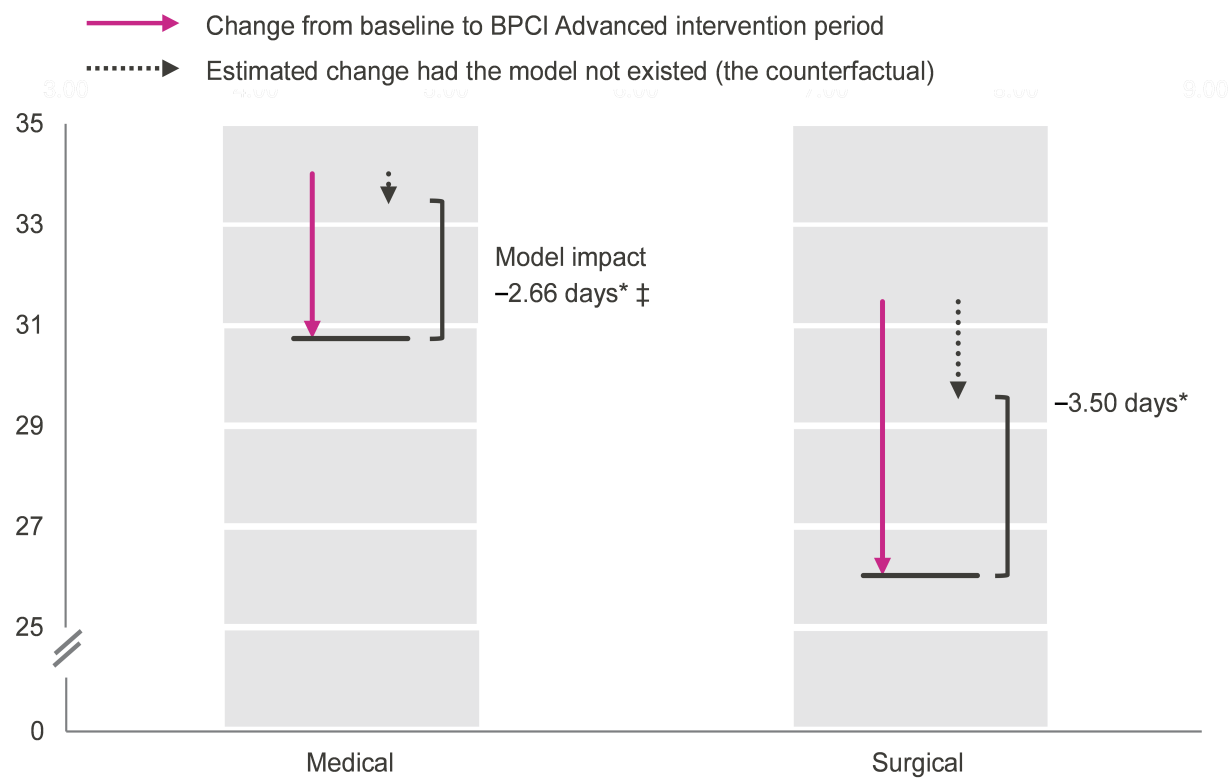
To reduce unnecessary PAC use, many BPCI Advanced participants implemented a “why not home?” approach to discharge decision-making, encouraging providers and discharge planners to consider whether the patient could recover at home instead of in a PAC facility. This strategy required a shift in mindset because many providers automatically discharged patients with Medicare to PAC facilities. BPCI Advanced participants shared that growing evidence suggests that home recoveries can be optimal because patients return to their activities of daily living sooner and recover faster with fewer complications. This culture shift required more conversations with patients and caregivers on why they should not expect to go to a SNF or IRF and the benefits of home recovery. Some BPCI Advanced participants reported using clinical decision-making tools that predicted risk and functional status to determine which patients could recover at home and which patients needed to go to a PAC facility. Participants also enhanced screenings for medical and social risk factors that could impede a safe home recovery, and they connected patients with community resource organizations to address nonmedical needs, such as food insecurity or lack of access to transportation, to support successful recoveries and avoid hospital readmissions.

Length of Stay at PAC Facilities

Not all patients could return directly home after a hospital stay, especially if they were frail or the surgery was emergent. Among patients with SNF care in the post-discharge period, BPCI Advanced patients stayed at SNFs for fewer days than comparison patients in Model Years 4 through 6 (DiD: –2.66 days for medical episodes; 90% CI: –3.06, –2.27,²⁰ DiD: –3.50 for surgical episodes; 90% CI: –4.20, –2.81) (Exhibit 9). BPCI Advanced participants formed networks of high-quality PAC facilities to which they would send their patients in exchange for cooperation with model aims, including shortened length of stay. Participants also used care navigators to monitor patient recovery inside SNFs. In some instances, providers visited the PAC facility and performed rounds on BPCI Advanced patients to identify and address obstacles preventing discharge.

²⁰ This result failed our parallel trends test. A failure of the parallel trends test indicates that BPCI Advanced and matched comparison hospitals and PGPs did not have the same trends for that outcome in the baseline period. This may mean that the impact estimate partially reflects a continuation of preexisting trends and does not solely reflect the impact of BPCI Advanced.

Exhibit 9: BPCI Advanced Was Associated With 3 Fewer Days in SNFs for Patients With SNF Stays Relative to the Comparison Group, Model Years 4–6 (2021–2023)



Note: The estimates in this exhibit are the results of DiD models. The DiD estimates represent the relative change in the length of stay. See **Appendix C** for details of the DiD methodology, parallel trends, outcome definitions, and additional information on methods. See **Appendix H** for detailed results. DiD = difference-in-differences; PGP = physician group practice; pp = percentage point; SNF = skilled nursing facility. * $p \leq 0.10$. ‡ We rejected the null hypothesis that BPCI Advanced and matched comparison hospitals and PGPs had parallel trends for this outcome in the baseline period (with 90% confidence). This may indicate the impact estimate partially reflects a continuation of preexisting trends and does not solely reflect the impact of the BPCI Advanced Model.

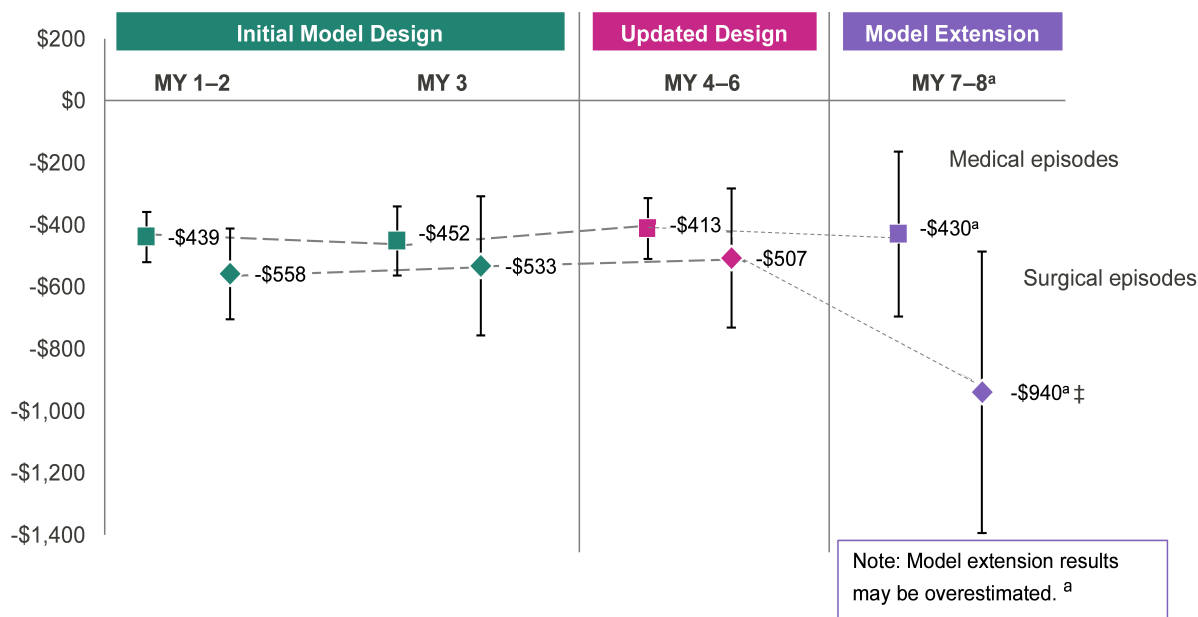
Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and matched comparison hospitals or PGPs. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

PAC Facility Expenditures

In all years, the model led to reductions in per-episode SNF and IRF payments relative to the comparison group because participants discharged fewer patients to PAC facilities and shortened SNF stays (Exhibits 10 and 11). The reduction in SNF payments was generally consistent across years and episode types, at about \$500 per episode. BPCI Advanced resulted in a reduction in SNF payments of \$413 to \$452 per medical episode and \$507 to \$558 per surgical episode

(excluding surgical episodes in Model Years 7–8, for which the impact is likely overestimated and failed our parallel trends test).^{21, 22}

Exhibit 10: On Average, BPCI Advanced Reduced SNF Expenditures by About \$500 per Episode Across Model Years Relative to the Comparison Group



Note: The estimates in this exhibit are the results of DiD models. The DiD estimates represent the relative change in dollars. The dark gray lines indicate the 90% CI of the DiD estimate. See **Appendix C** for details of the DiD methodology, parallel trends, outcome definitions, and additional information on methods. See **Appendix H** for detailed results. CI = confidence interval; DiD = difference-in-differences; MY = model year; PGP = physician group practice; SNF = skilled nursing facility. ^a Model Year 7–8 results are likely overestimated because of our reliance on national episode data constructed for model implementation rather than the customized data and matched comparison group used to evaluate prior model years; see **Appendix H** for results of sensitivity analyses. [‡] We rejected the null hypothesis that BPCI Advanced and the comparison group had parallel trends for this outcome in the baseline period (with 90% confidence). This may indicate the impact estimate partially reflects a continuation of preexisting trends and does not solely reflect the impact of the BPCI Advanced Model.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and comparison hospitals or PGPs, as well as CMS reconciliation data from the same period. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

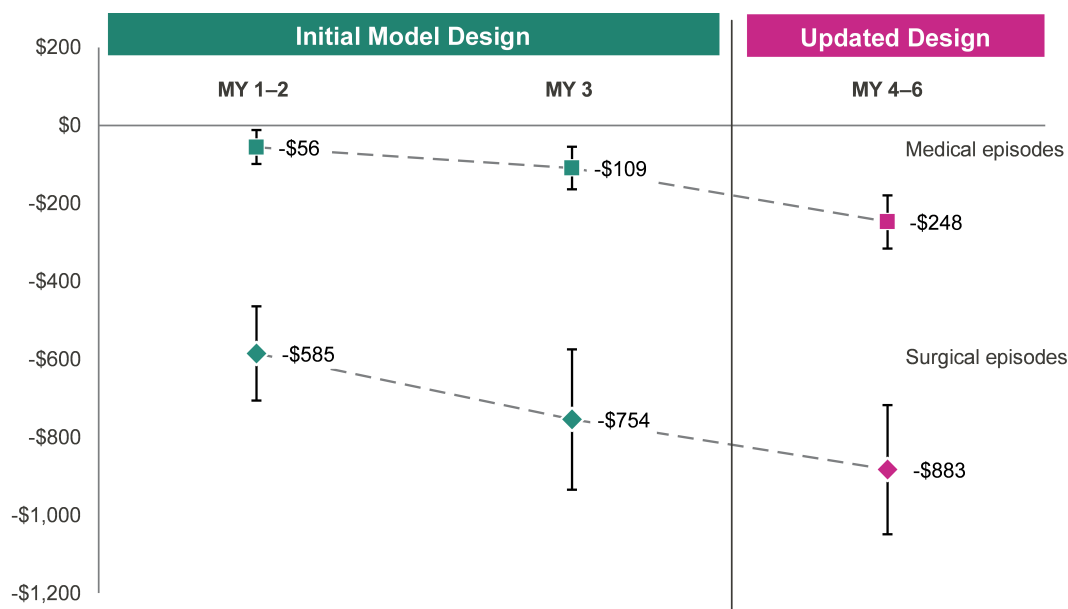
²¹ For detailed results from previous model years, refer to prior evaluation reports and appendices available on the BPCI Advanced Model web page:

<https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>

²² A failure of the parallel trends test indicates that BPCI Advanced and matched comparison hospitals and PGPs did not have the same trends for that outcome in the baseline period. This may mean that the impact estimate partially reflects a continuation of preexisting trends and does not solely reflect the impact of BPCI Advanced.

SNFs typically provide less acute, longer-term rehabilitation, whereas IRFs typically provide higher-acuity, shorter-term recovery care for specific conditions.^{23, 24} Thus, we might expect differences in patterns of care between these facilities and potentially differences in model impacts. While the impact of BPCI Advanced on SNF payment reductions was similar across time and episode type, IRF payment reductions due to the model increased over time and were greater for surgical than for medical episodes (Exhibit 11). The average reduction in IRF payments due to the model per medical episode was \$56 (90% CI: –\$99, –\$13) in Model Years 1 and 2 and increased to \$248 (90% CI: –\$316, –\$179) in Model Years 4 through 6. For surgical episodes, the reduction in IRF payments was \$585 (CI: –\$706, –\$465) in Model Years 1 and 2 and \$883 (90% CI: –\$1,049, –\$717) in Model Years 4 through 6. IRF payments were unavailable as a separate measure in the data used for Model Years 7 and 8.

Exhibit 11: BPCI Advanced Led to Reductions in IRF Payments Relative to the Comparison Group That Increased Over Time



Note: The estimates in this exhibit are the results of DiD models. The DiD estimates represent the relative change in dollars. The dark gray lines indicate the 90% CI of the DiD estimate. See **Appendix C** for details of the DiD methodology, parallel trends, outcome definitions, and additional information on methods. See **Appendix H** for detailed results. CI = confidence interval; DiD = difference-in-differences; IRF = inpatient rehabilitation facility; MY = model year; PGP = physician group practice.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the baseline and intervention periods for BPCI Advanced hospitals or PGPs and matched comparison hospitals or PGPs, as well as CMS reconciliation data from the same period. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

²³ Center for Medicare Advocacy. (2018). *CMS clarifies 3-hour "rule" should not preclude Medicare-covered inpatient rehabilitation hospital care*. <https://medicareadvocacy.org/cms-clarifies-3-hour-rule-should-not-preclude-medicare-covered-inpatient-rehabilitation-hospital-care/>

²⁴ Alcusky, M., Ulbricht, C. M., & Lapane, K. L. (2018). Postacute care setting, facility characteristics, and poststroke outcomes: A systematic review. *Archives of Physical Medicine and Rehabilitation*, 99(6), 1124–1140.e9. <https://doi.org/10.1016/j.apmr.2017.09.005>

An increase in IRF payments among the comparison group drove the model's impact on IRF payments in Model Years 4 through 6, as payments remained stable for BPCI Advanced episodes. This increase for the comparison group may have been related to changes in Medicare IRF policies. For IRFs to receive payment from CMS, at least 60% of an IRF's patients must require rehabilitation services for 1 of 13 specific conditions, and patients generally must receive 15 hours of therapy per week. During the COVID-19 public health emergency (January 2020–May 2023), these and other IRF requirements were waived, which may have led hospitals to send more patients to IRFs when SNF availability was limited. BPCI Advanced participants, however, had incentives to limit shifting patients to IRFs due to the high cost.

Although some BPCI Advanced participants focused on reducing costly IRF stays, some hospitals that owned an IRF had competing financial incentives to maintain a daily census in their IRF, which made it more challenging to reduce IRF utilization. One participant noted that its health system was the largest provider of IRF beds in the state, and this conflicting incentive limited the participant's ability to reduce PAC expenditures. Other participants indicated that anticipated IRF utilization was a factor in their model participation and CESLG selection decisions. One participant reported that it did not select the *neurological care* CESLG because its hospital often discharged patients who experienced a stroke to its IRF, and the participant did not foresee being able to reduce IRF utilization and achieve financial success in the model.

Home Health Expenditures

Patients who are discharged directly home instead of to a SNF or IRF may qualify for Medicare coverage of home health services to facilitate a smooth recovery. Home health care following hospitalization can include wound care, physical therapy, or support with activities such as walking, bathing, and eating. While these services can help patients successfully recover at home, they also contribute to Medicare expenditures during the episode of care. During site visits, participants described efforts to decrease unnecessary utilization of home health care by monitoring the number of home health visits. BPCI Advanced led to a decrease in home health payments for surgical episodes of \$160 (90% CI: –\$287, –\$33) in Model Years 4 through 6 and \$393 (90% CI: –\$563, –\$222) in Model Years 7 and 8 (**Appendix H**). The model did not have an impact on home health payments for medical episodes, which could be because patients with medical episodes were often more medically complex than patients with surgical episodes and sometimes had multiple comorbidities. While discharge to an institutional PAC facility may not be necessary after medical episodes, home health care services may be substituted to ensure a successful home recovery. Participants also explained during site visits that many hospitals that selected medical episodes owned home health agencies and had a financial incentive to refer patients to their agency; these conflicting incentives made it difficult to reduce home health utilization.

C. Reconciliation Payments and Target Pricing

BPCI Advanced participants reported joining the model because they perceived financial opportunity and because they wanted to gain experience with bundled payment models in anticipation of a future mandatory model. However, not all participants earned reconciliation payments, and some participants benefited more than others from the pricing mechanism under the model. This section describes the magnitude and distribution of reconciliation payments over time and how they were related to target pricing.

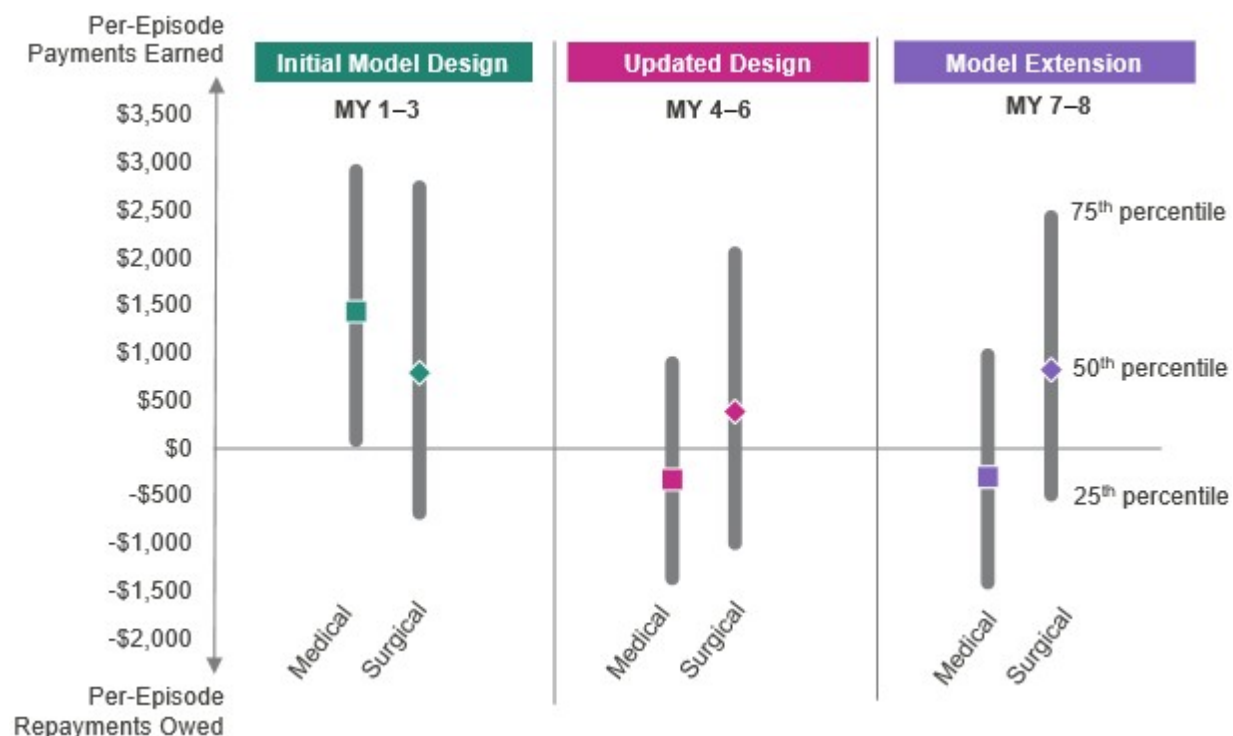
Reconciliation Payments

In the first 3 model years, most participants earned reconciliation payments: The median amount a participant earned in reconciliation payments was nearly \$200,000 across both medical and surgical episodes, with 25% of participants owing repayments to CMS and 25% earning more than \$850,000 in reconciliation payments (**Appendix J**).²⁵ Reconciliation payments differed for medical and surgical episodes, with participants earning larger reconciliation payments per episode for medical than for surgical episodes. In Model Years 1 through 3, the median amount a participant earned in reconciliation payments was about \$1,400 per medical episode and about \$800 per surgical episode (Exhibit 12).

This pattern shifted in Model Years 4 through 6 to a more balanced distribution of participants that earned or owed reconciliation amounts due to changes to the pricing methodology, which included the use of retrospective trend adjustments to final target prices and alignment of episode overlap rules between the baseline and performance periods. The median reconciliation amount was just over \$4,000 in repayments owed to CMS during this period. The pattern also shifted for medical and surgical episodes. In Model Years 4 through 6, the median reconciliation amount was about \$300 owed in repayments for medical episodes and about \$400 earned in reconciliation payments for surgical episodes. In Model Years 7 and 8, the medians remained about the same for medical episodes but increased to more than \$800 earned for surgical episodes. Hospitals' reconciliation payments typically corresponded to 2% or less of their operating profits or losses.

²⁵ In this report, we refer to amounts that participants received from CMS in the form of reconciliation payments and repayment amounts that participants owed to CMS collectively as *reconciliation payments*. We refer to aggregate reconciliation payments summed across participants and received by or owed to CMS as *net reconciliation payments*.

Exhibit 12: Model Design Changes in Model Year 4 (2021) Led to a More Balanced Distribution of Participants That Earned and Owed Reconciliation Payments



Note: The dark gray bars represent the interquartile range for each period. **Appendix C** describes adjustments made to reconciliation payments and additional methods. See **Appendix J** for more detailed results. MY = model year; PGP = physician group practice.

Source: CMS reconciliation data for anchor stays or procedures during the intervention periods for BPCI Advanced hospitals or PGPs and matched comparison hospitals or PGPs.

Several aspects of the BPCI Advanced pricing mechanism affected participants' final reconciliation payment amounts. Participants had to reduce spending by at least 3% of the benchmark price (and by 2% for medical episodes starting in Model Year 6) to earn a reconciliation payment. Some participants (about 15%) had episode expenditures that fell below their benchmark prices, but because they did not reach the discounted amount, they still had to make repayments to CMS.

Additionally, the CQS adjustment affected the final reconciliation payment by up to 10%. Better performance on quality measures decreased the amount that participants owed to CMS (if they made repayments), and worse performance lowered the amount that participants received from CMS (if they earned reconciliation payments). The CQS can range from 0 to 100 and is based on a ranking of peers across multiple quality measures. The average quality score over the course of the model was roughly 55, indicating that BPCI Advanced participants scored slightly better than the median. To put the CQS adjustment in context, for a participant that owed CMS \$500 per episode, ranking at the 5th percentile of scores would decrease its repayments by \$13 per episode, while ranking at the 95th percentile of scores would decrease its repayments by \$41 per episode. Thus, major differences in quality performance did not necessarily lead to substantial differences in financial liability.

Finally, after the CQS adjustment, CMS applied stop-loss and stop-gain limits, restricting each participant's reconciliation payments to no more than 20% of their target price in a given performance period. Over their entire time in the model, 31.8% of participants hit the stop-gain limit and 25.2% hit the stop-loss limit at least once. In Model Years 1 through 3, the stop-gain limits reduced CMS payments that would otherwise have been paid to participants by \$28.5 million, whereas stop-loss limits reduced the financial liability of participants that would have otherwise owed CMS by \$13.0 million in repayments. After changes to the target pricing methodology, these amounts were substantially smaller, and the impact of the stop-gain limit was less than that of the stop-loss limit. In Model Year 4, the stop-gain limit reduced financial liability for CMS by \$3.1 million, whereas the stop-loss limit reduced liability for participants by \$6.9 million (**Appendix J**). This pattern continued in later model years.

Target Pricing

The BPCI Advanced Model's financial incentives were based on the difference between a hospital or PGP's actual episode spending and its target price. Consequently, the model's target pricing mechanism was an important determinant of participant financial success in the model. In BPCI Advanced, CMS computed target prices at the hospital level, based on a given hospital's historical spending, subject to certain adjustments; PGP target prices were based on the target prices of the hospitals at which they practiced. CMS adjusted target prices for patient case mix, historical spending of similar hospitals (referred to as the "peer group"), and spending trends of the peer group. Under this type of pricing mechanism, participants with higher historical spending tended to have higher target prices and had the potential to receive higher reconciliation payments by improving efficiency or performing better than their peer group.

The BPCI Advanced pricing methodology was designed to account for factors outside the hospital's control, such as serving a large proportion of high-need patients. For instance, safety-net hospitals are usually high-cost providers because they serve a high proportion of patients with complex needs. This higher baseline spending and more complex patient mix led to higher peer group and case-mix adjustments for BPCI Advanced safety-net hospitals compared with non-safety-net hospitals.

As a result, target prices were higher on average for safety-net hospitals than for non-safety-net hospitals. Safety-net hospitals received larger reconciliation payments from CMS than non-safety-net hospitals did in Model Years 1 through 3, but both types of hospitals were less financially

What Is a Safety-Net Hospital?

Safety-net hospitals treat a higher proportion of patients who are likely to experience risk factors such as housing instability, social isolation, and higher rates of complex comorbidities. We defined *safety-net hospitals* as hospitals that served a large share of patients who were dually eligible for Medicare and Medicaid or who were eligible for the Medicare Part D Low-Income Subsidy (LIS) (see [footnote 26](#) on the following page).

successful in later model years after model design changes (**Appendix J**).²⁶ Although participation in APMs can be challenging for safety-net hospitals, BPCI Advanced provided an opportunity for these hospitals to expand value-based care to a high-need population and receive financial rewards for cost reductions and improvements in quality of care.

While the pricing mechanism led to higher target prices for historically high-spend participants, it resulted in lower target prices for others. We interviewed participants in Model Year 7 to better understand their experience with the BPCI Advanced pricing methodology. Hospitals and PGPs with prior experience in bundled payment models, such as the BPCI Initiative and CJR, as well as ACOs, reported having already taken steps to limit PAC expenditures and lower unnecessary costs prior to joining BPCI Advanced. Some of these hospitals and PGPs struggled to identify further efficiencies and areas to reduce spending during the model performance period. Because the baseline for target prices moved forward every year, some participants reported feeling penalized for successfully lowering spending in early years of the model. When participants felt that they could no longer come under the target price, many terminated participations in the model to avoid owing repayments to CMS.

Although most participants that we interviewed reported that it was challenging to reduce spending below the target price year after year, many said there were still opportunities to decrease spending, especially in medical clinical episodes. Some participants that had previously exited the model rejoined in Model Year 7 specifically because they saw financial opportunity in medical clinical episodes. Participants that selected surgical clinical episodes more often reported experiencing declining target prices, especially for elective surgeries. They reported that the year-over-year reduction in target prices was compounded by losing volume due to model overlap policies that removed episodes for patients aligned to ACO REACH as well as the loss of episodes for healthier patients to ambulatory surgical centers.

“You're fighting against yourself, right? Because eventually, you're going to drive yourself out of the program if you become too efficient.”

– BPCI Advanced PGP

D. Summary

BPCI Advanced resulted in substantial savings to Medicare after design changes in Model Year 4 (2021). Most savings to Medicare came from large decreases in episode expenditures achieved by reducing discharges to or shortening length of stay in PAC facilities. Many participants adopted a “why not home?” discharge mentality and reduced length of stay in PAC facilities by forming preferred networks of PAC providers and working with these providers to monitor patient recoveries and remove obstacles to discharge.

²⁶ In our analyses, hospital safety-net status was based on the share of patients who were dually eligible or eligible for the Part D LIS exceeding the 75th percentile across all Medicare facilities in 2021 (30.0% dually eligible patients, 30.1% of patients eligible for the LIS). This approach differs from how the model determined safety-net status for target prices/risk adjustment, which was based on the share of inpatient stays for patients who were full or partially dually eligible exceeding 60%.

Model impacts varied between medical and surgical episodes. BPCI Advanced participants achieved greater spending reductions in surgical episodes than in medical episodes. Participants explained that it was easier to control costs and reduce spending for surgical episodes because many of these episodes were elective, allowing the participant to prepare patients for episodes beforehand, optimize their health before the procedure, and reduce the chance of unplanned hospital readmissions. Participants could avoid discharges to PAC facilities more easily for patients with surgical episodes, and IRF payments declined by a larger amount for patients with surgical compared with medical episodes. Hospital ownership of IRFs was an important factor for participants in deciding whether to enter the model and in which CESLGs to participate.

The model's pricing methodology resulted in higher target prices for hospitals with higher historical spending and those in peer groups with higher spending, incentivizing high-spend hospitals, including safety-net hospitals, to join the model and spread care redesign to more patients. Some participants that had successfully lowered expenditures and achieved efficiencies felt it was too challenging to reduce costs year after year and exited the model to avoid owing a repayment to CMS. While there was significant attrition in later years of the model, the remaining participants continued to reduce episode expenditures and achieved net savings to Medicare.

III. Quality

In addition to examining savings and expenditures, we evaluated impacts on key quality measures, including patient-reported outcomes, to determine whether the BPCI Advanced Model achieved its goal of maintaining or improving quality of care. We used claims data to assess changes in hospital readmission and mortality rates during the episode. We selected these measures to ensure the model was not decreasing the quality of patient care because of incentives to lower Medicare spending and avoid institutional PAC use. The evaluation team also surveyed patients in both the model and a comparison group to understand how BPCI Advanced affected change in functional status as well as patient care experience and overall satisfaction with care.

Key Findings



Mortality and Readmissions

BPCI Advanced did not result in increased mortality or hospital readmission rates despite large reductions in PAC facility use, suggesting that participants maintained quality of care for these outcomes.



Patient-Reported Functional Status

Over the course of the model, BPCI Advanced and comparison patients reported similar changes in functional status after their hospitalization or procedure, except in Model Years 7 and 8, when BPCI Advanced patients with medical episodes reported less favorable changes.



Patient-Reported Care Experience and Satisfaction

Most BPCI Advanced patients reported favorable care experiences and satisfaction with care, although over the course of the model, BPCI Advanced patients were consistently less likely than comparison patients to report that staff took their discharge preferences into account. Some BPCI Advanced patients reported not having the caregiver support or other resources to recover successfully at home.

Care Redesign to Improve Quality



Participants reported that the model supported quality improvements by providing cost and quality data that informed care redesign activities. Many participants used these data to form preferred PAC provider networks with high-quality providers that had low readmission rates or specialized in recoveries after certain procedures and conditions. Other participants provided their PAC partners with care protocols to follow to enhance patient recoveries and avoid readmissions. Participants reported that all patients, regardless of payer, benefited from these higher-quality PAC facilities.

A. Mortality

If participants skimmed on care or did not provide needed services to patients in the post-acute period, the likelihood of serious complications could increase, resulting in preventable deaths. Over the course of the model, the evaluation found no impact of BPCI Advanced on mortality rates during the anchor stay and the 90-day post-discharge period (**Appendix K**). During site visits, participants emphasized that they did not anticipate any changes to mortality due to BPCI Advanced because patients would continue to receive appropriate medical care and services regardless of attribution to the model, and any patients who needed care at a PAC facility would still be sent to those facilities. These data support our finding of no impact (positive or negative) of the model on mortality rates.

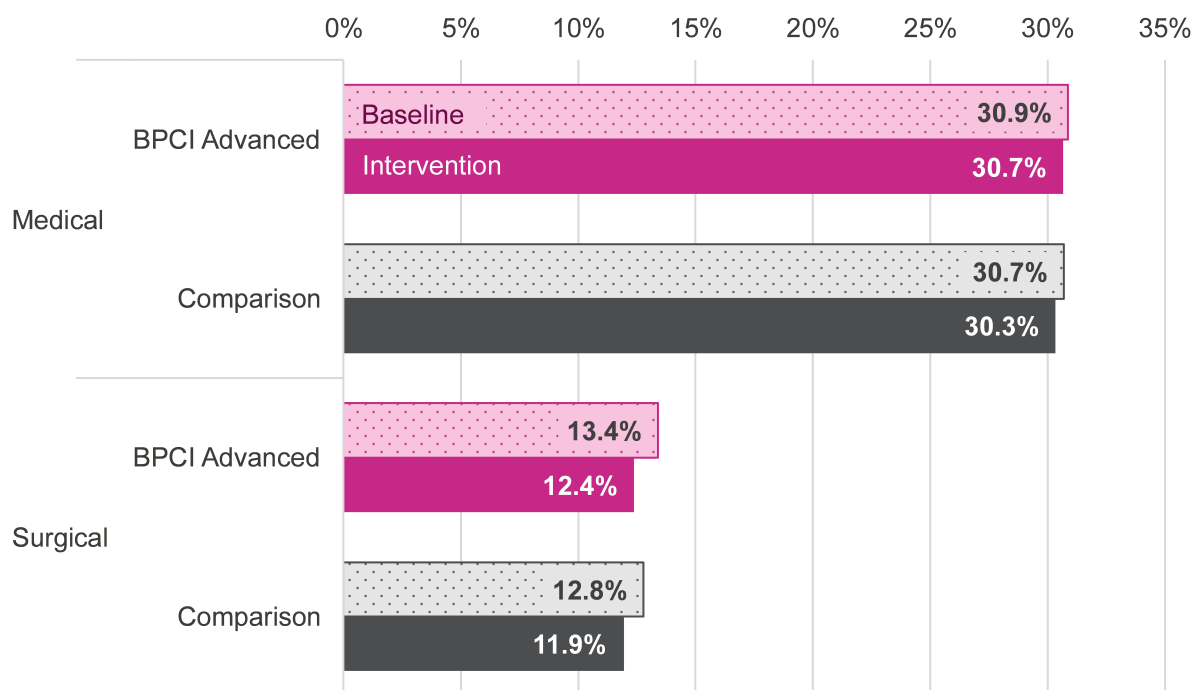
B. Readmissions

Reducing institutional PAC use and sending more patients home for recovery could lead to adverse health events requiring hospital readmission. Generally, over time, we did not find consistent impacts of the model on readmission rates, despite the reduction in institutional PAC utilization and increase in home recoveries, suggesting that participants maintained quality of care for patients served by the model.²⁷

Readmission rates for both BPCI Advanced and the comparison group were higher for medical episodes and lower for surgical episodes. For example, in Model Years 4 through 6, the readmission rate among BPCI Advanced episodes was 30.7% for medical episodes and 12.4% for surgical episodes (Exhibit 13 and **Appendix K**). The readmission rate declined slightly from the baseline period to Model Years 4 through 6 for BPCI Advanced episodes and the comparison group, and the difference in declines between the two groups was not statistically significant. The finding that readmission rates declined only marginally from the baseline to the intervention period, despite strong model incentives in the BPCI Advanced group, suggests the difficulty in improving this quality measure, particularly for patients with severe medical conditions. In interviews, participants noted it was very challenging to curb readmissions following medical episodes, especially for heart failure, sepsis, pneumonia, and urinary tract infection. Given these challenges, the fact that readmissions did not increase, despite substantial reductions in PAC facility use, underscores the model's success in maintaining quality of care.

²⁷ For these analyses, we examined all hospital readmissions. However, we also evaluated the impact of BPCI Advanced on unplanned readmissions, which is a more restricted measure and therefore may be more sensitive to changes in quality of care. The impact on unplanned readmissions in Model Years 4 through 6 was similarly small in magnitude and not statistically significant. See **Appendix K** for these results.

Exhibit 13: BPCI Advanced and Comparison Patients Had Similar Readmission Rates, Which Were Higher for Medical Than for Surgical Episodes, Model Years 4–6 (2021–2023)



Note: Bars represent the risk-adjusted percentage of episodes with a readmission in the 90-day post-discharge period that were attributed to BPCI Advanced participants and comparison providers in medical and surgical episodes. DiD estimates were not statistically significant for medical or surgical episodes. See **Appendix K** for more detailed results. DiD = difference-in-differences; PGP = physician group practice.

Source: The BPCI Advanced evaluation team's analysis of Medicare claims and enrollment data for episodes with anchor stays or procedures during the Model Year 4–6 intervention period for BPCI Advanced and matched comparison hospitals or PGPs. See **Appendix A** for details on baseline and intervention periods across model year evaluations.

We interviewed model participants to better understand strategies and challenges to reducing readmissions. We learned that participants found it easier to reduce readmissions for surgical episodes because they could prepare patients for elective surgeries ahead of time. For example, many offered presurgical knee or hip classes and prehabilitation to build strength and ensure successful operations and recoveries. Participants reported that reducing readmissions for patients with medical episodes was more difficult because patients cannot be prepared ahead of time for the hospitalization, and there is limited time during the hospital stay to identify and address medical and social factors that may put patients at greater risk for readmission. Further, patients in unplanned episodes often have comorbidities or complex chronic medical conditions that make managing their care in the post-discharge period more unpredictable.

A common strategy that model participants reported using for both elective and emergent episodes was to create standardized protocols to reduce complications and variations in care. Another common strategy to reduce readmissions was to hire or repurpose staff to be care navigators and monitor patients in the 90-day post-discharge period to address any needs that could result in a readmission. Participants also established preferred networks of PAC providers,

including SNFs, IRFs, and home health agencies, and sent these providers instructions on how to care for patients during their recovery to ensure PAC staff were not unnecessarily sending patients back to the hospital. Participants described conducting readmission reviews with preferred PAC partners to understand how readmissions happened and how to reduce them in the future. Many participants underscored that quality improvements made in response to the BPCI Advanced Model benefited all patients, regardless of payer.

BPCI Advanced Care Redesign Benefited All Patients

Many participants reported applying BPCI Advanced care redesign to all patients, regardless of payer. Examples included the use of standardized protocols for individual service lines and the establishment of preferred PAC networks with high-quality providers.

“Now every patient in the hospital will have access to a higher quality network of PAC providers. It’s a huge spillover.”

– BPCI Advanced convener participant

C. Patient-Reported Functional Status

Functional status reflects patients’ ability to perform daily activities, such as bathing, dressing, and eating, and to successfully recover from hospitalizations or procedures. Functional status could decline if participants avoided referrals to PAC institutions for patients requiring institutional care or did not provide patients with adequate support after discharge. Alternatively, functional status could improve if patients were mobilized soon after surgery and received needed outpatient or at-home therapy during recovery.

Site visits and interviews with participants indicated that they actively worked to facilitate a quicker recovery. Common strategies included mobilizing patients within hours after surgery to accelerate recovery and engaging physical and occupational therapists earlier in the care episode to help inform discharge decisions. When participants discharged patients to PAC facilities, some reported giving SNFs clinically tailored care instructions to support recovery and prevent readmissions.

Over the course of the model, most BPCI Advanced patients reported they maintained or improved their functional status after their hospitalization or procedure, with small differences relative to comparison patients. However, in Model Years 7 and 8, BPCI Advanced patients reported less favorable changes in bathing, dressing, using the toilet, and eating—a core measure of functional status

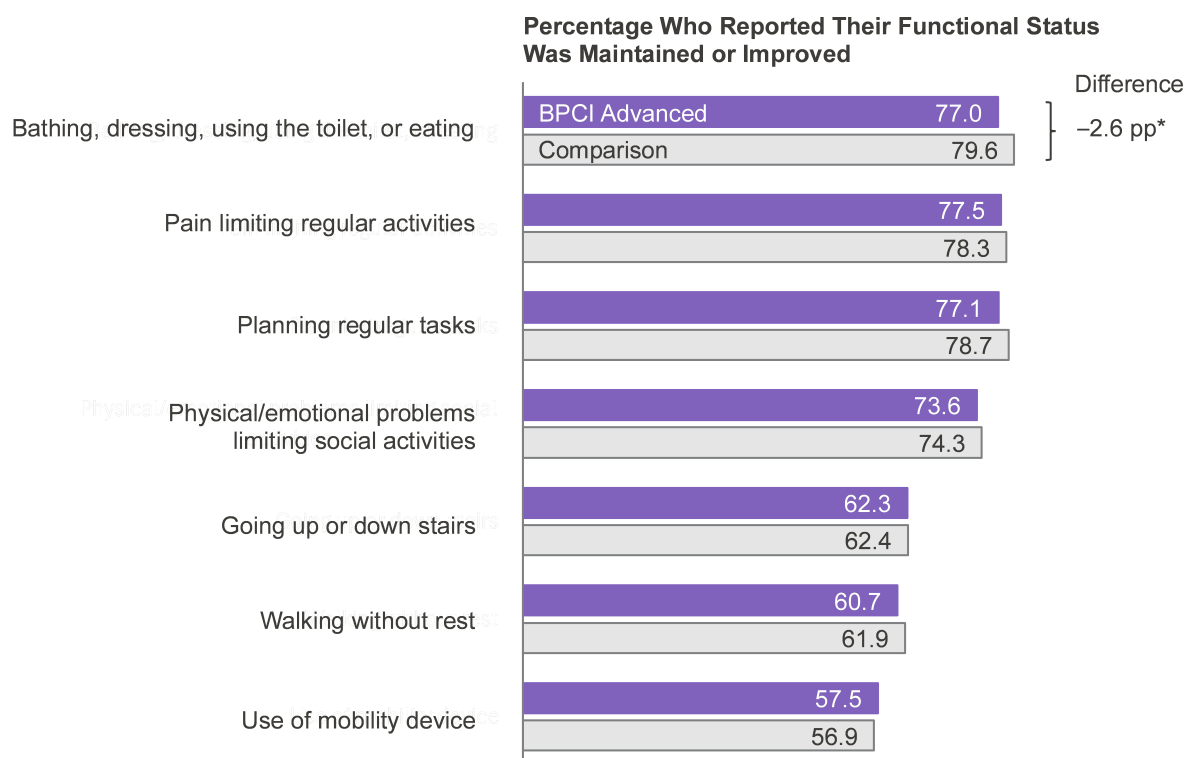
Methods Overview

Patient Survey

To understand the model’s impact on patient functional status, care experience, and satisfaction with care, the evaluation team surveyed patients receiving care under the model and a matched comparison group of patients with the same clinical episodes. Patients completed the survey about 3 months after discharge. The survey asked patients to recall their functional status before hospitalization and at the time of the survey, and the evaluation team assessed whether their functional status improved, was maintained, or declined. The survey also asked patients whether they agreed or disagreed with statements related to their care experience and satisfaction. For the analysis of responses, we used nonresponse and sampling weights and included risk adjustment for a broad set of patient and episode characteristics. More information on the survey methods is in **Appendix C**.

(Exhibit 14). Based on the magnitude of the observed difference, about 3 in 100 additional BPCI Advanced patients reported less favorable change on this measure than comparison patients. Although only one functional status measure was statistically significant on its own, when we aggregated results across all seven functional status measures using a joint significance test, the difference between BPCI Advanced and comparison patients was statistically significant for medical episodes (**Appendix L**). This finding may reflect that changes in care delivery in response to the BPCI Advanced Model were not optimal for all patients. This result was not consistent over time and could also reflect differences in participant and patient mix between the BPCI Advanced and comparison group in the model's final 2 years.

Exhibit 14: BPCI Advanced Patients Reported Less Favorable Changes in Functional Status Relative to the Comparison Group in Model Years 7–8 (2024–2025)



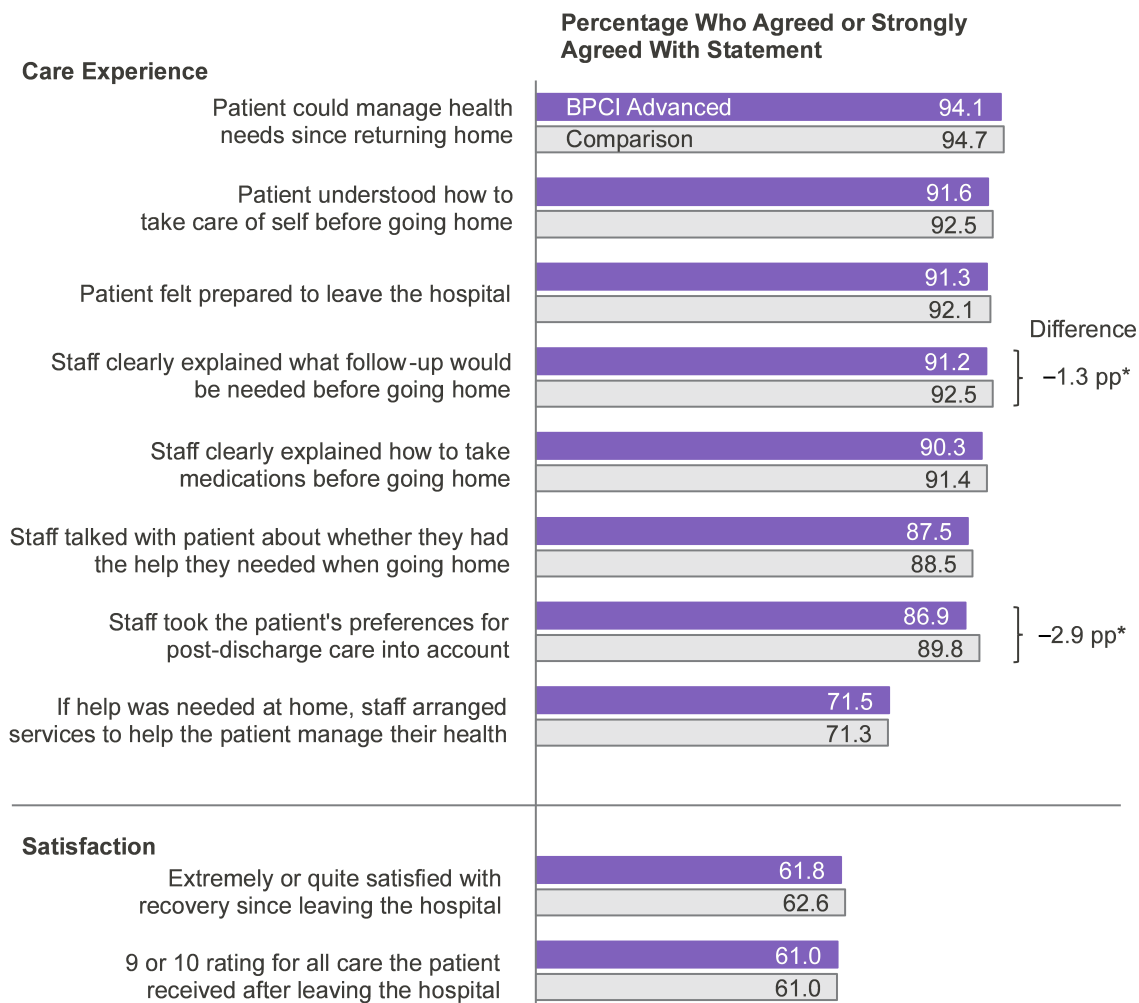
Note: The estimates in this exhibit are the result of a cross-sectional, risk-adjusted multinomial logistic regression model for trinary indicators. All responses were weighted for nonresponse and sampling design. The percentages in each bar represent the proportion of respondents who indicated that their functional status improved (or stayed the same if already in the highest category) or was maintained (above the lowest level of function). The p-values for statistically significant functional status results signify differences in the proportion of patients indicating one of three categories: improvement in (or maintained highest function), decline in (or maintained lowest function), or stayed the same. See **Appendix L** for more detailed results. pp = percentage point. * $p \leq 0.10$.

Source: The BPCI Advanced evaluation team's analysis of survey responses paired with Medicare claims and enrollment data for episodes with anchor stays or procedures that occurred between April 2024 and January 2025.

D. Patient-Reported Care Experience and Satisfaction

Over the course of the model, most patients reported positive care experiences, with small differences in outcomes between BPCI Advanced and comparison respondents (see Exhibit 15 for Model Year 7–8 results).

Exhibit 15: As in Past Years, in Model Years 7–8 (2024–2025), Most BPCI Advanced Patients Reported Positive Care Experiences, but They Reported Less Favorable Care Experiences Than Comparison Patients on 2 of 10 Measures



Note: The estimates in this exhibit are the result of a cross-sectional, risk-adjusted logistic regression model for binary indicators. All responses were weighted for nonresponse and sampling design. The percentages in each bar for care experience represent the proportion of respondents who agreed or strongly agreed with the statement. See **Appendix L** for more detailed results. pp = percentage point. * $p \leq 0.10$.

Source: The BPCI Advanced evaluation team's analysis of survey responses paired with Medicare claims and enrollment data for episodes with anchor stays or procedures that occurred between April 2024 and January 2025.

One of the most consistent findings in multiple survey waves has been that a small proportion of BPCI Advanced patients were less likely than comparison patients to report that staff took their

preferences into account when considering their post-discharge care. When asked about this result during site visits, participants were not surprised by the finding; some patients expect to recover at a rehabilitation facility, even if that level of care is not medically necessary. Additionally, family members may prefer that patients recover in a facility to reduce burden on caregivers. Many participants described having to reset patient and family expectations about the location of their recovery as they discharged more patients home. We asked four practicing physicians in our advisory committee who are experts in the medical conditions and surgical procedures included in BPCI Advanced to review and interpret these survey results.²⁸ Clinical experts did not find the patient survey results to be clinically concerning or surprising given patients' expectations to recover at a facility and the emphasis on discharge directly home by model participants.

In response to findings from the previous survey waves, the final wave of the BPCI Advanced patient survey included an open-ended question asking respondents to describe their overall care experience during their hospitalization or outpatient procedure and 90-day recovery period. In general, BPCI Advanced and comparison respondents discussed similar topics and expressed mostly positive sentiments, describing being well prepared for surgery, appreciating follow-up calls after discharge, and experiencing better transitions of care (Exhibit 16).

Methods Overview

Open-Ended Survey Question

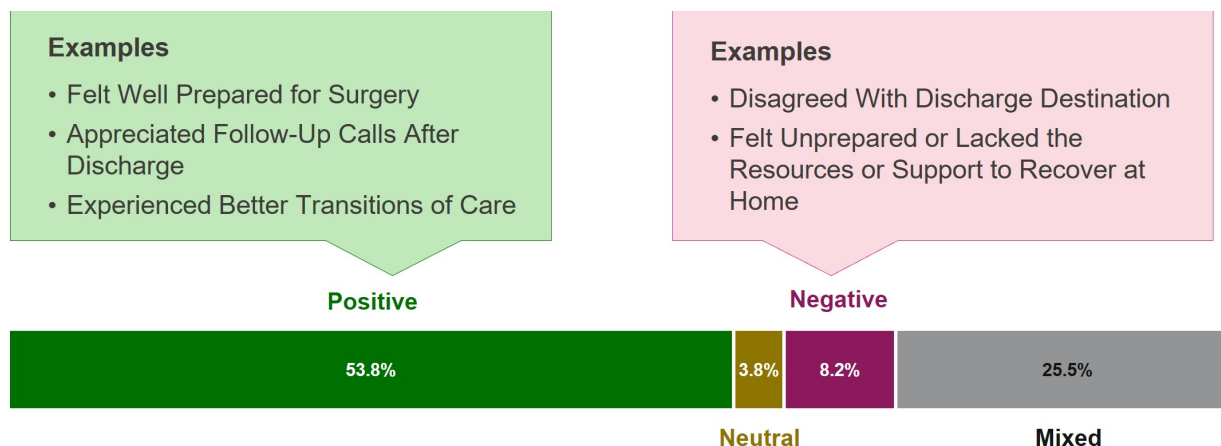
In addition to closed-ended questions, the Model Year 7 and 8 patient survey included an open-ended question that asked what went well with the care received since the patient went to the hospital. The evaluation team used generative artificial intelligence (AI) to conduct thematic and sentiment analyses of responses to the open-ended question. More information on methods is available in **Appendix C**, and additional results are available in **Appendix I**.

The analysis of open-ended responses isolated to those expressing negative sentiment identified three major themes: Patients did not agree with their discharge destination, they did not feel prepared for discharge or home recovery, and they did not have caregiver support or appropriate resources at home. Some BPCI Advanced patients expressed wanting to recover at an IRF after their hospitalization and being disappointed that they were not given that option because they needed more support at home. Although BPCI Advanced participants reported working to set patient expectations about the appropriate next site of care, not all patients believed their home was the most appropriate place to recover. Some patients said they did not have the resources or caregiver support needed to recover successfully at home. Additionally, some patients did not feel prepared to go home because they did not have a chance to discuss their medical condition or recovery plan with their doctor. While BPCI Advanced participants reported connecting patients with physical therapy and home health care after discharge, some patients reported needing additional support during their recovery that exceeded what these providers deliver. Additional support included services such as aides who could provide 24-7 care or support with cooking, cleaning, and laundry. Some patients reported paying out of pocket for private nurses or caregivers to assist them during their recovery. Although we found similar themes for BPCI Advanced and comparison group patients, these findings provide insight into how BPCI Advanced

²⁸ See **Appendix C** for additional information regarding the clinical expert network.

patients experienced being discharged home for recovery, which is incentivized under the model. The closed- and open-ended survey findings suggest that there is room for improvement under bundled payment models in patient communication and shared decision-making, particularly related to discharge destination decisions and how patient needs will be met in the post-acute period.

Exhibit 16: Most BPCI Advanced Respondents Expressed Positive Sentiments When Asked What Went Well With Their Care in Model Years 7–8 (2024–2025), With a Small Share Describing Negative Care Experiences



Note: The values in this exhibit represent the percentage of open-ended survey responses from BPCI Advanced patients who expressed overall positive, neutral, negative, or mixed sentiments concerning their care. We calculated the overall sentiment of each response by aggregating the sentiments for each response. There were 10,886 survey responses total, including 5,374 from BPCI Advanced patients. This exhibit does not include the 470 BPCI Advanced responses that were not assigned a thematic concept. The response rate for the open-ended survey question was 77.5% among all survey respondents and 78.2% among BPCI Advanced respondents. Comparison group results were similar, with 52.8% positive, 3.9% neutral, 7.8% negative, and 25.5% mixed sentiment responses. There were 551 comparison group responses not assigned a thematic concept.

Source: The BPCI Advanced evaluation team's analysis of open-ended survey responses paired with Medicare claims and enrollment data for episodes with anchor stays or procedures that occurred between April 2024 and January 2025.

E. Summary

The evaluation team analyzed four quality-of-care measures: mortality rates, readmission rates, patient-reported functional status, and patient-reported care experience and satisfaction. Over the course of the model, we did not find evidence of consistent impacts on mortality rates, hospital readmission rates, or patient-reported functional status, except in Model Years 7 and 8, when BPCI Advanced patients with medical episodes reported less favorable changes in functional status. These results suggest that the model encouraged participants to reduce unnecessary PAC utilization and Medicare expenditures without compromising the quality of patient care.

While most BPCI Advanced patients reported positive care experiences and satisfaction under the model, a small percentage consistently reported feeling like staff did not take their preferences for post-discharge care into account. An analysis of responses to an open-ended survey question

illuminated the reasons that patients' preferences may have differed from the care they received during the post-discharge period. Some patients reported not feeling adequately prepared for home recovery and not having caregiver support during their recovery. There is opportunity for improvement in these areas to ensure that patients in bundled payment models feel supported in their recovery.

IV. Conclusion

Over the course of the model, BPCI Advanced achieved its goal of reducing spending and achieving Medicare savings while maintaining quality of care. While the model initially incurred net losses to Medicare in its first 3 years, changes to the pricing methodology in Model Year 4 led to net savings that surpassed the early model losses. Despite attrition in later years of the model, participants that remained in BPCI Advanced in Model Years 7 and 8 continued to reduce expenditures, resulting in net savings to Medicare.

Reductions in Medicare spending came largely from decreases in institutional PAC use during the post-discharge period. Many hospitals and PGPs reduced institutional PAC use by adopting a “why not home?” approach to discharge planning and educating staff about appropriate referrals to IRFs, SNFs, and home health agencies. Participants that selected surgical clinical episodes took steps to optimize patient health before elective surgeries and educate patients and caregivers on the care plan and recovery process to minimize the chance of costly unplanned readmissions and institutional PAC use. For participants that selected medical clinical episodes, when it was not possible to optimize patient health before their hospitalization, care redesign was focused on the acute and post-acute periods. For example, acute care providers standardized care protocols to reduce variations in care and avoid complications. For the post-acute period, participants used CMS data to understand which providers in their markets offered the best quality of care and formed preferred PAC networks. Hospitals and PGPs worked with their PAC partners to improve recovery for patients and reduce length of stay, which helped lower episode expenditures.

BPCI Advanced target pricing was based on hospital-level historical spending and the hospital’s peer group spending. Thus, participants with higher historical spending and those in peer groups with higher spending generally had higher target prices than other participants. This pricing methodology incentivized certain participants, such as those with high historical costs, to enter the model and expand value-based care to their patient populations. However, some efficient participants felt the model’s pricing methodology penalized them for their success in reducing costs early in the model and felt pressure to continually reduce spending year after year. Hospitals and PGPs felt the impact of decreasing target prices particularly for elective surgeries and as participants lost episode volume to certain types of Medicare ACOs where overlap was not allowed and to ambulatory surgical centers.

Participants maintained quality of care despite reductions in episode spending and institutional PAC use. We did not find consistent impacts on mortality and readmission rates under the model, indicating that participants were able to reduce Medicare spending and institutional PAC utilization without harming quality of care. Generally, we did not see an impact on patient-reported functional status over the course of the model, except in Model Years 7 and 8, when BPCI Advanced patients with medical episodes reported less favorable changes than the comparison group. This finding could reflect that changes in care delivery under the model were not optimal for all patients

or could reflect differences in participant and patient mix between the BPCI Advanced and comparison group in the model's final 2 years.

The evaluation found room for improvement in shared decision-making related to post-discharge care. Most BPCI Advanced patients reported positive care experiences and satisfaction; however, BPCI Advanced patients were slightly less likely than comparison patients to report feeling that staff took their discharge preferences into account. Analyses of data collected from an open-ended survey question indicated that some patients who were sent home to recover did not feel they had adequate resources to do so. While not every patient agreed with their discharge destination, our data indicated that most patients successfully recovered at home and reported a positive care experience.

BPCI Advanced drew participation from organizations that anticipated financial gain, while participants that anticipated financial losses could exit the model at any time, as long as they provided 90-day notice to CMS. This selective participation and attrition can make it difficult to produce generalizable results about whether bundled payments can work in all hospital types and markets. To understand whether bundled payments can work more broadly, including in rural areas, CMS designed a new mandatory episode-based payment model, TEAM, which began in January 2026 and focuses on five surgical clinical episodes: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures. With TEAM, CMS will test whether hospitals with diverse characteristics in a wide range of markets can reduce expenditures and maintain or improve quality of care under a regional pricing methodology, where hospital target prices are based on average spending by other hospitals in the same geographic region. CMS also announced the nationwide expansion of bundled payments for lower extremity joint replacement episodes under the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model, based on strong evidence that the original CJR Model led to cost savings and maintained quality of care. As CMS expands bundled payment models in Original Medicare under CJR-X and tests additional clinical episodes and model designs under TEAM, lessons learned from the BPCI Advanced Model will continue to inform the direction of future bundled payment policy.