



Executive Summary

Final Evaluation Report

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model was a voluntary model that tested whether holding participants accountable for the cost and quality of an episode of care reduced Medicare expenditures while improving or maintaining quality of care. The Center for Medicare and Medicaid Innovation, within the Centers for Medicare & Medicaid Services (CMS), launched BPCI Advanced in October 2018, and it continued for 8 model years, through December 2025.

BPCI Advanced episodes of care started with a hospitalization or surgical procedure initiated by a participating hospital or physician group practice (PGP) and spanned 90 days after discharge. Financial accountability for episodes of care relative to a target price encouraged physicians and hospitals to work with providers across care settings to improve care transitions and support successful recoveries. Participants chose to be held accountable for service line groups encompassing select clinical episodes, including acute medical conditions (such as sepsis and stroke) and surgical procedures (such as coronary artery bypass graft).

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 examined the model's impact on health care expenditures, patient outcomes, and health system transformation. The final evaluation report considers the model's impact across time, focusing on results from the final 4 model years.

Model overview

- **Timeline:** Oct. 2018–Dec. 2025
- **Design:** Voluntary episode-based payment model in which participants were financially accountable for the cost and quality of health care services during an episode of care
- **Goals:** Reduce Medicare spending while maintaining or improving quality of care
- **Participants:** Hospitals, PGPs, and other entities such as health systems or value-based care consultants serving as “conveners”
- **Patients:** Original Medicare beneficiaries with an inpatient stay or outpatient procedure for select acute conditions and surgeries
- **Episode of care:** Anchor stay or anchor surgical procedure plus 90 days after discharge
- **Clinical episodes and clinical episode service line groups (CESLGs):** Select medical conditions and surgical procedures or service lines for which participants opted to be held accountable
- **Financial accountability:** Participants earned a reconciliation payment if episode spending was below a target price or owed a repayment to CMS if episode spending exceeded the target price, after adjusting for quality

Impact of the BPCI Advanced Model

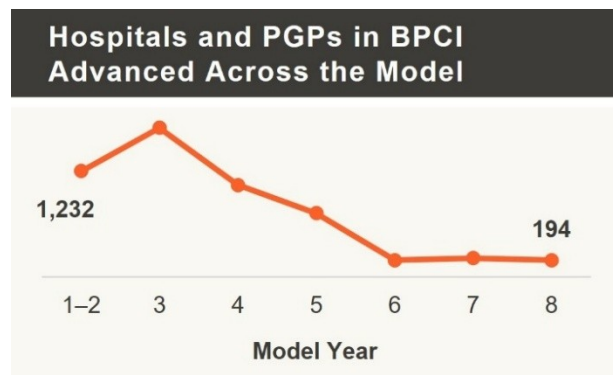
- **Reduced Medicare spending** by encouraging more efficient use of post-acute care
- **Maintained quality of care** for several key outcomes, with room for improvement in shared decision-making related to post-discharge care
- **Motivated participants to redesign care** to improve care coordination and avoid readmissions by, for example, investing in care management staff and standardizing care protocols

BPCI Advanced engaged more than 1,100 hospitals and 800 PGPs in value-based care across the model's performance period.

The BPCI Advanced Model had a broad reach, attracting hundreds of hospitals and PGPs throughout its performance period. Many participants joined BPCI Advanced because they anticipated financial gain or wanted experience with bundled payments in the event that CMS enacted a future mandatory bundled payment model.

The number of hospitals and PGPs in the model peaked in Model Year 3 (2020), but participation declined substantially in the years that followed. Over the course of the model, most hospitals and PGPs received support, such as data analytics or case management support, from conveners or consultants.

Despite the fluctuations in participation, BPCI Advanced engaged a substantial share of eligible hospitals, clinicians, and patients. The model reached nearly 1 in 3 eligible hospitals and clinicians at its peak in Model Year 3. In Model Year 4 (2021), when hospitals and PGPs became accountable for clinical episode groupings (CESLGs) rather than individual clinical episodes, the model reached nearly 1 in 5 eligible patients. Across all 8 model years, BPCI Advanced engaged 1.8 million patients in value-based care.



BPCI Advanced led to about \$800 million in estimated net savings to Medicare during its 8 model years.

Across model years, BPCI Advanced generated about \$800 million in estimated net savings to Medicare by achieving total episode expenditure reductions that exceeded net reconciliation payments from CMS to participants. Savings were greatest (\$915.8 million) in Model Years 4 through 6 (2021–2023), following model design changes. In Model Year 4, CMS adjusted the target pricing methodology to account for retrospective peer group and national trends, standardized rules that defined how overlapping episodes were treated in the baseline and performance periods, and required that hospitals and PGPs participate in all clinical episodes in broader service line groups, reducing opportunities for selective participation in clinical episodes that were most profitable. These updates limited the substantial payments made to participants in earlier model years and overall helped generate model savings to Medicare starting in Model Year 4. Surgical episodes consistently generated net savings across model years; for medical episodes, the model resulted in net losses in Model Years 1–3 and net savings in Model Year 4 and beyond.

Components of Medicare Program Savings

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: Due to rounding, the sum of the values in the reduction in expenditures and net reconciliation payment rows may not correspond to the total in the net savings or losses row. DiD = difference-in-differences; MY = model year. ^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. *Indicates that the range based on the DiD estimate's 90% confidence interval does not include \$0.

Participants lowered episode expenditures in each model year, primarily by reducing discharges to post-acute care (PAC) facilities.

Many BPCI Advanced participants achieved reductions in episode expenditures relative to the comparison group by redesigning care in response to the model. Participants reviewed CMS data to identify areas to reduce spending and understand how their utilization patterns compared with their peers. Participants described taking a “why not home?” approach to discharge planning, which encouraged staff to consider whether patients could adequately recover at home

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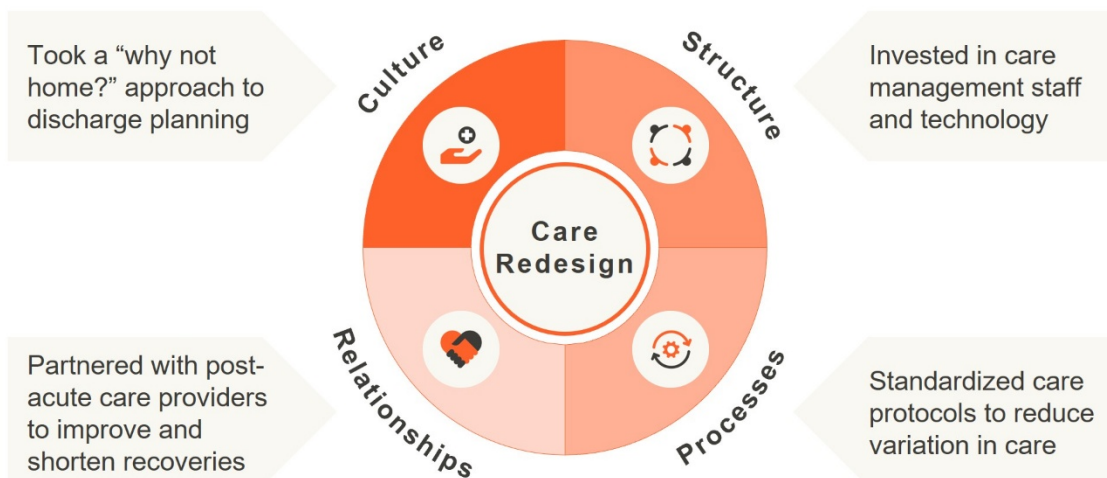
The BPCI Advanced data helped us realize we were overutilizers of [skilled nursing facilities] compared to others and below benchmarks in sending people home. This has incentivized us to change our practices.

– BPCI Advanced Hospital

instead of at a skilled nursing facility or inpatient rehabilitation facility. If discharge to a PAC facility was necessary, participants used preferred networks of PAC providers and collaborated with these partners to help patients recover and reduce length of facility stays. Another common care redesign strategy was to have care navigators monitor patients in the post-discharge period to address patient needs in recovery and avoid preventable hospital readmissions.

These efforts led to decreased expenditures relative to the comparison group. Corresponding payment reductions ranged from \$743 per episode in Model Years 1 and 2 to more than \$1,000 per episode in Model Years 3 through 8. Participants achieved greater per-episode payment reductions for surgical episodes compared with medical episodes. Participants reported that they had more opportunities to contain costs for elective surgical procedures—including the chance to optimize patient health before surgery and set patient and family expectations about discharge and recovery—than they did for urgent medical episodes.

Examples of Participant Care Redesign Under BPCI Advanced



Most participants were able to reduce episode expenditures and earn reconciliation payments.

The BPCI Advanced Model was designed to influence participants' behavior by holding them accountable for episode expenditures and quality of care. Over the course of the model, most BPCI Advanced participants reduced episode expenditures and earned reconciliation payments. Reconciliation payments from CMS to participants were greater in Model Years 1 through 3, before updates to the model design.

The model's pricing methodology resulted in higher target prices for participants with higher historical spending and those in peer groups with higher spending, including safety-net hospitals. While participation declined in later model years as it became harder to earn reconciliation payments, some participants continued to find opportunities to reduce expenditures and avoid repayments to CMS. Only 3% of Medicare savings came from participant repayments in Model Years 4 through 6.

Participants generally maintained quality of care, as reflected in readmission rates, mortality rates, and patient-reported functional status.

In addition to reducing spending, another key goal of BPCI Advanced was to maintain or improve the quality of patient care. Across the model, we found that participants maintained quality of care in terms of readmission and mortality rates, despite significant reductions in PAC facility use. Additionally, most BPCI Advanced and comparison patients reported maintaining or improving functional status after their hospitalization or procedure. However, in the last survey wave, on a core measure of functional status—bathing, dressing, using the toilet, or eating—a smaller share of BPCI Advanced patients with medical episodes reported maintaining or improving status than the comparison group. This result may reflect that changes in care delivery were not optimal for all

patients, but this finding was not consistent over time and could reflect differences between BPCI Advanced and comparison participants in the model's final 2 years.

BPCI Advanced participants reported a range of efforts to deliver better care to their patients, including the creation of standardized protocols for specific clinical conditions to reduce complications and facilitate recoveries. Some participants also referred patients to PAC facilities that specialized in recovery from joint replacement or other surgeries and clinical conditions.

Care navigators ensured that patients had the equipment, medications, and follow-up appointments needed for a successful recovery. Providers reported that care improvements made in response to BPCI Advanced benefited all patients, regardless of payer.

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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

Most BPCI Advanced patients had positive care experiences, but there was room for improvement in shared decision-making on post-discharge care.

Over the course of the model, most BPCI Advanced patients who responded to our patient survey reported positive care experiences, but some patients were less likely to agree that staff took their preferences into account for post-discharge care. Model participants and clinical experts were not surprised by this finding, given that patients may expect to recover in a PAC facility. Many participants described having to reset patient and family expectations about discharge destination.

When asked what went well during their hospital stay or procedure, most BPCI Advanced patients reported positive experiences with their care, including good experiences with care coordination and interactions with hospital staff. However, some patients described challenges with recovering at home because they lived alone and needed 24-7 assistance.

BPCI Advanced Patient Experiences: What Went Well With Your Care?

Examples

- Felt Well Prepared for Surgery
- Appreciated Follow-Up Calls After Discharge
- Experienced Better Transitions of Care

Positive

Examples

- Disagreed With Discharge Destination
- Felt Unprepared or Lacked the Resources or Support to Recover at Home

Negative



Note: Exhibit shows the sentiment assigned to open-ended survey question responses for BPCI Advanced patients. Responses with no themes (8.7%) are not shown. Sentiment breakdown was similar for comparison patients.

The Transforming Episode Accountability Model (TEAM) will continue to test whether episode-based payment models can reduce Medicare spending while maintaining quality of care.

The BPCI Advanced Model, along with the Comprehensive Care for Joint Replacement (CJR) Model, informed the design of CMS' latest episode-based payment model, TEAM.¹ Under TEAM, hospitals in selected areas must participate, with financial accountability for the cost and quality of episodes of care for five high-volume surgical procedures. While the BPCI Advanced Model provided evidence that voluntary participants could reduce Medicare spending for medical and surgical clinical episodes, selective attrition over time also showed the limitations of voluntary models in terms of generalizable results and long-term sustainability. TEAM's mandatory, randomized design will inform future decisions about expanding the use of bundled payments in Original Medicare.

¹ For more information, see the CMS Innovation Center TEAM web page: <https://www.cms.gov/priorities/innovation/innovation-models/team-model>

About this document

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Interested in learning more?

In addition to this summary, the following resources are available to learn more about findings from the BPCI Advanced evaluation:

- [Findings at a Glance](#) | 2 pages
Concise visual summary of key findings
- [Technical Report](#) | 37 pages
Deep dive into evaluation findings
- [Appendices](#) | 150 pages
Detailed methods and results tables