IMPACT OF THE BUNDLED PAYMENTS FOR CARE IMPROVEMENT ADVANCED INITIATIVE

In April 2013, the CMS Innovation Center (CMMI) launched the [Bundled Payments for Care Improvement] (BPCI or BPCI Classic) initiative, which lasted through September 2018. The initiative assessed whether linking payment for all providers that deliver Medicare-covered items and services during an episode of care related to an inpatient hospitalization would reduce Medicare expenditures while maintaining or improving quality of care.

The Centers for Medicare and Medicaid Services' (CMS) model evaluations across the model's six performance years found that BPCI resulted in reduced Medicare fee-for-service (FFS) payments for most clinical episodes evaluated while maintaining the quality of care for beneficiaries. While these results were promising, after considering reconciliation payments to participants, Medicare experienced net losses under the BPCI model.

Bundled payment models play a critical role in the APM ecosystem by engaging specialists on improving quality and reducing costs for specific services or conditions that would be difficult to address through other APM approaches.

CMS used early results from the BPCI model to inform the creation of the Bundled Payment for Care Improvement Advanced (BPCI-A) model. BPCI-A improves upon the BPCI Classic methodology, incorporating changes intended to increase the potential for savings and promote better alignment with the Quality Payment Program. While BPCI Classic was unlikely to qualify for model expansion, it was a successful demonstration in that it provided critical information to inform the development of its successor and all future episode payment models.

Program Differences Between BPCI and BPCI Advanced

CMMI used lessons learned from BPCI to inform the design of the BPCI Advanced (BPCI-A) model. The key program differences between the models include:

1. **AAPM Status:** BPCI-A qualifies as an Advanced APM (AAPM), and therefore participants are eligible for a 5 percent bonus payment.
2. **Greater financial risk:** Up to ten percent of payments are at risk for quality performance under BPCI-A and downside risk is effective immediately; BPCI did not have a risk component based on quality.
3. **Prospective target prices:** BPCI-A target prices are set prospectively, offering model participants greater potential to successfully manage costs.
4. **Longer episode windows:** BPCI-A participants are responsible for 90-day bundles, instead of having the option to choose between 30, 60, or 90-day bundles as in BPCI. Longer episode windows create stronger incentives for care coordination.
5. **Fewer exclusions:** BPCI-A includes all Part A services resulting from anchor stay/procedure and post-acute care services during episodes. This increases the model participants' incentives to focus on the full scope of patient care.

The Centers for Medicare and Medicaid Services' decision to iterate on the BPCI Classic model to design the BPCI Advanced model allowed providers who invested in episode-based models to continue to pursue their care delivery reform efforts.

Early Impact of BPCI Advanced`

The goal of the BPCI-A model is to support health care providers who invest in practice innovation and care redesign to better coordinate care, improve quality of care, and reduce expenditures. The model seeks to encourage clinicians to redesign care delivery by: (1) adopting best practices, (2) reducing differences in standards of care, and (3) providing appropriate services for patients throughout clinical episodes. Since the onset of the BPCI-A model in 2018, CMS has released two evaluation reports covering model years 1, 2 and 3 through January 1, 2020. The first evaluation report reviewed just the first six months of the model which was insufficient time to capture quality or cost impacts of the model.

The second evaluation report found similar conclusions to the BPCI Initiative, with early evidence indicating that participating hospitals reduced Medicare FFS payments for most of the clinical episodes evaluated while maintaining quality of care. However, like the BPCI Initiative, Medicare experienced net losses in the first ten months of BPCI-A after accounting for reconciliation payments. Evaluators expect the model's financial sustainability will improve as a result of significant design changes CMS made beginning in Model Year 4 (2021). The full impact of these changes will be analyzed in future evaluations.

Through Model Year 3, 33 percent of eligible hospitals and over 1,000 physician groups practices (PGPs) participated in BPCI-A. Through the first ten months of the model, roughly 23 percent of the BPCI-A eligible discharges and outpatient procedures were at a BPCI-A hospital or attributed to a BPCI-A PGP and 24 percent of eligible clinicians participated in the model. The reasons participants gave for entering the model included: 1) financial opportunities, 2) the prospect of building on past bundled payment success or gaining experience with bundled payments, and 3) opportunities to invest in care transformation and better collaborate with physicians and hospitals. It was notable that while BPCI-A qualifies as an Advanced APM (AAPM) – benefitting specialties who otherwise have few options to participate in AAPMs – this was not a regularly cited reason for participation. Future evaluations will focus on the impact of the model on payments, utilization and quality of care, Medicare program savings, and beneficiary-reported outcomes.

BPCI-A reflects CMMI's role as a research laboratory willing to iterate and refine bundled payment model concepts from BPCI while allowing organizations to sustain their investments in improving delivery and quality of care. It is equally important to stress the need for CMS to address the limitations of the BPCI evaluation as it continues to evaluate BPCI-A performance. Specifically, CMS should: 1) reevaluate how it counts reconciliation payments in calculations of model savings to avoid penalizing participants due to factors inherent to the model design, and 2) test methodologies for designing control groups that account for the potential spillover effects of bundled payment model care redesign efforts that benefit all patients.

Resource Links

CMS Evaluations: BPCI Model 1

- First Evaluation Report
- Second Evaluation Report

CMS Evaluations: BPCI Models 2, 3, 4

- First Evaluation Report
- Second Evaluation Report
- Third Evaluation Report
- Fourth Evaluation Report
- Fifth Evaluation Report
- Sixth Evaluation Report

CMS Evaluations: BPCI Advanced

- First Evaluation Report
- Second Evaluation Report

Established in 2014, The Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.