CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Transformation Spotlight

Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model

Insights From the First 5 Years

MODEL OVERVIEW

The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model tests whether holding participants financially accountable for the cost and quality of health care services during an episode can reduce Medicare spending while maintaining or improving quality of care.

Episodes begin with a hospital stay or an outpatient procedure initiated by a participating hospital or physician group practice (PGP) and end 90 days after discharge.

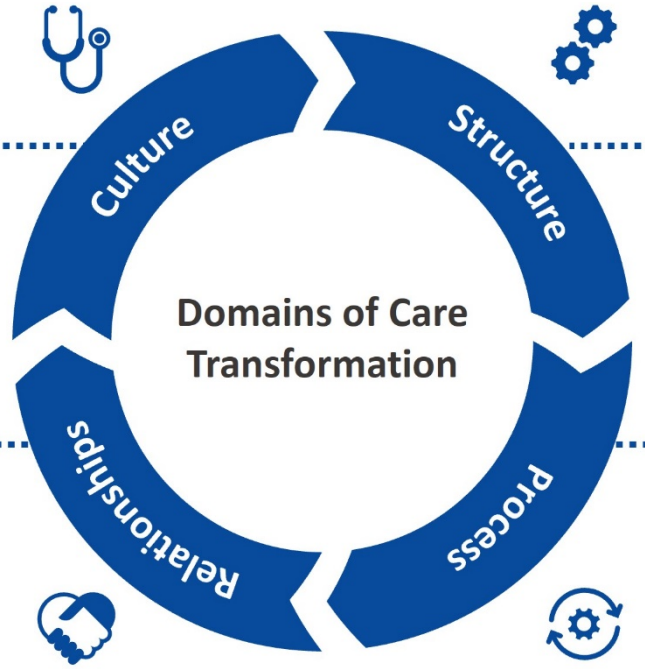
Model participants can earn a reconciliation payment if episode payments are below their target price, or they may be required to repay Medicare if episode payments are above their target price, after considering the quality of their care. This payment approach encourages participants to coordinate care across all providers involved in the episode.

PARTICIPANT CARE TRANSFORMATION UNDER BPCI ADVANCED

Hospitals and PGPs have transformed care under BPCI Advanced in four domains:

Culture. Reshaped patient and provider expectations about appropriate discharge destinations and enhanced provider awareness of costs, utilization, and quality of care in the acute and post-acute care (PAC) settings.

Structure. Invested in technology and care management tools and staff.



Relationships. Formed new partnerships between inpatient providers and PAC facilities.

Process. Reviewed data, standardized care pathways, identified and mitigated medical and social risk factors, monitored patients after discharge, and connected patients to primary care providers.

TRANSFORMING CARE THROUGH PRIMARY CARE CONNECTIONS

Many BPCI Advanced participants said they increased efforts to connect patients with primary care providers (PCPs) after hospitalization to ensure a successful recovery and reduce the chance of readmission.

By encouraging primary care connections, the model could help the Centers for Medicare & Medicaid Services increase the number of patients in accountable care relationships.

Example: Links to Primary Care

Before participating in BPCI Advanced, one hospital simply told patients to follow up with their PCP to arrange for home health care. Since joining the model, the hospital communicates directly with the patient's PCP and works with the PCP to set up home health services on the patient's behalf.

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KEY CARE TRANSFORMATION STRATEGIES

Care Transformation PATIENT JOURNEY

BPCI Advanced has accelerated care transformation by:

- Giving providers actionable **performance data**
- Changing expectations around **discharge destination**
- Encouraging **partnerships** between providers in the acute and post-acute settings

Patient Identification and Risk Assessment

Participants conduct risk assessments to identify the medical and social risk factors for their BPCI Advanced patients. They connect patients with social workers or other community resources so patients can recover at home if possible or address issues that might lead to an unplanned readmission.

Data Review

The data provided by the Centers for Medicare & Medicaid Services (CMS) help participants understand how their performance differs from peers, find areas to reduce spending, and identify qualified PAC providers with which to partner. Many participants use conveners or consultants to help analyze the data.

Improved Care Coordination

Participants have hired or repurposed staff to be care navigators and monitor patients during the 90-day post-discharge period. Care navigators address concerns that could lead to unplanned hospital readmissions and coordinate follow-up appointments with PCPs and specialists.

Changes in Discharge Destination

BPCI Advanced has contributed to changes to discharge planning and coordination between providers across care settings. The model has shifted provider and patient expectations about discharge destinations and led to a "Why Not Home" approach to discharge decision-making.

Coordination With Post-Acute Care Providers

Participants have formed new relationships with PAC providers to help coordinate care after discharge. They create preferred networks of PAC providers, including skilled nursing facilities and home health agencies, and protocols for PAC partners with length of stay and care expectations.

Spillover Effects

Many hospitals and PGPs reported that they apply some care redesign activities to all patients, resulting in broader care transformation beyond just those patients under the model.

> *"Anything that we're doing in the BPCI Advanced program,* ***we're influencing care for all patients****. We're taking this as a step forward in that value-based journey."*
>
> *– BPCI Advanced Hospital*

This document summarizes some of the findings in an evaluation report prepared by an independent contractor. Data come from 179 phone interviews and 43 site visits with BPCI Advanced participants. To learn more about the BPCI Advanced Model and to download the evaluation reports, visit https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced