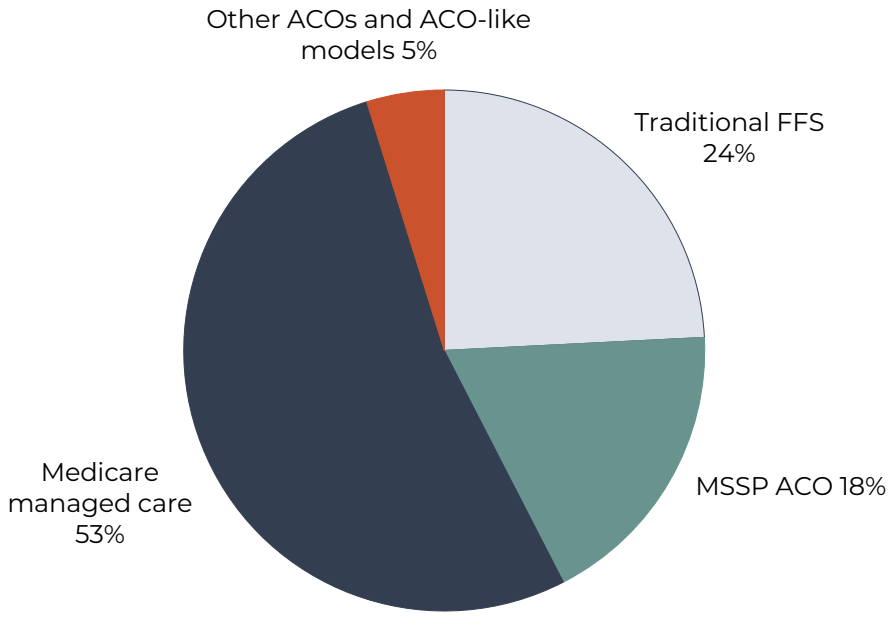
SECTION

5

Alternative payment models

Chart 5-1 Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2023



Note: ACO (accountable care organization), FFS (fee-for-service), MSSP (Medicare Shared Savings Program). This chart includes only beneficiaries enrolled in both Part A and Part B in January 2023. Both Part A and Part B coverage is necessary for either Medicare Advantage enrollment or ACO assignment. In general, Medicare managed care plans include Medicare Advantage plans as well as cost-reimbursed plans and Medicare–Medicaid demonstration plans. "Other ACOs and ACO-like models" include the ACO Realizing Equity, Access and Community Health (REACH) Model, the Maryland Total Cost of Care (TCOC) Model, and the Vermont All-Payer ACO. In the Maryland TCOC Model, all FFS beneficiaries are assigned to a hospital, and each hospital is responsible for all Part A and Part B spending for all Medicare beneficiaries in its market. This system creates ACO-like incentives for the hospital and qualifies physicians affiliated with those hospitals for the Medicare Access and CHIP Reauthorization Act (MACRA) bonus payments for participation in eligible alternative payment models.

Source: CMS January 2023 enrollment data, CMS Shared Savings Program January 2023 Fast Facts, CMS ACO REACH 2023 Fast Facts, and State of Vermont Green Mountain Care Board 2023 total cost of care annual report.

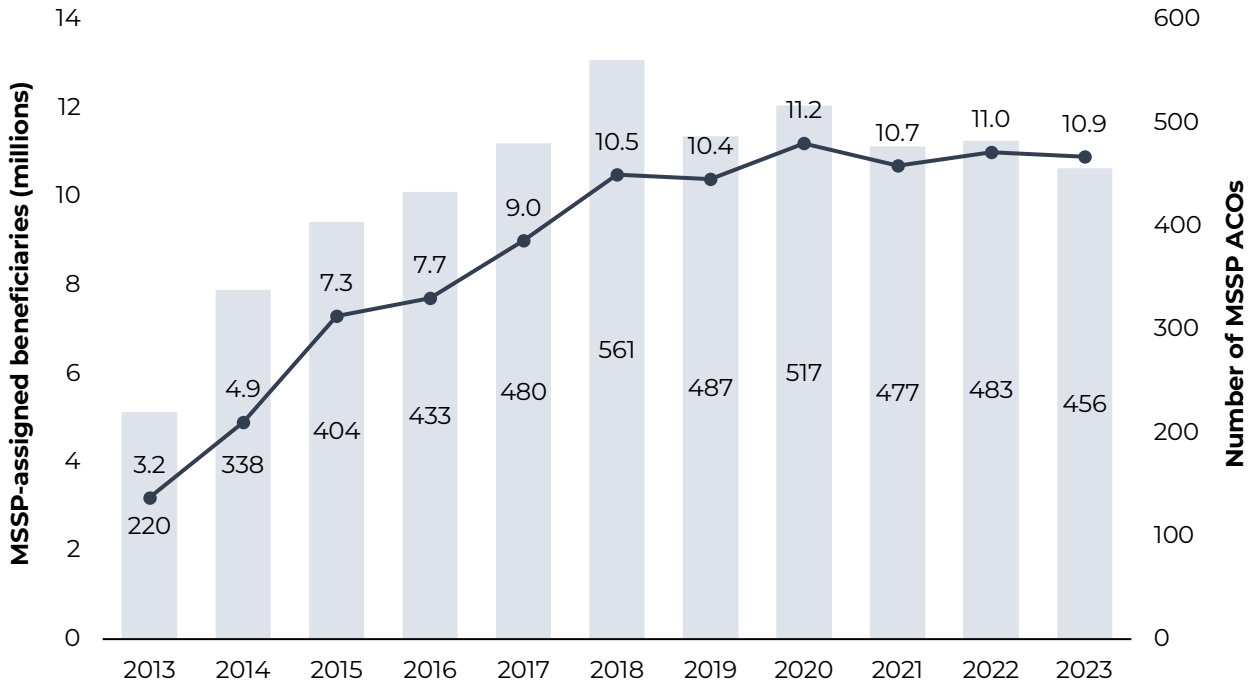
> Among the 59.8 million Medicare beneficiaries with both Part A and Part B coverage in 2023, approximately three-fourths (76 percent) are in Medicare managed care (Medicare Advantage or other private plans) or ACO models.

> The Medicare Shared Savings Program—a permanent ACO model established through the Affordable Care Act of 2010—accounts for most of the beneficiaries assigned to ACO or ACO-like payment models.

> Only 24 percent of Medicare beneficiaries with both Part A and Part B coverage are now in traditional FFS Medicare—a share that has declined in recent years.

> Even among the share of beneficiaries in traditional FFS, some beneficiaries may be assigned to other alternative payments models such as the Bundled Payments for Care Improvement Advanced Model or the Primary Care First Model.

Chart 5-2 The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 and then leveled off



Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). Numbers are as of January in each year. In 2019, MSSP ACOs were allowed to join the program in July. Those ACOs and the beneficiaries assigned to them were therefore not in the program as of January 2019 and so are not included in the 2019 counts on this chart. As of July 2019, there were 518 MSSP ACOs and 10.9 million beneficiaries assigned to them (data not shown). In 2021, new MSSP ACOs were not allowed to join the program due to the coronavirus pandemic, though ACOs were still allowed to exit the program.

Source: CMS Shared Savings Program January 2023 Fast Facts.

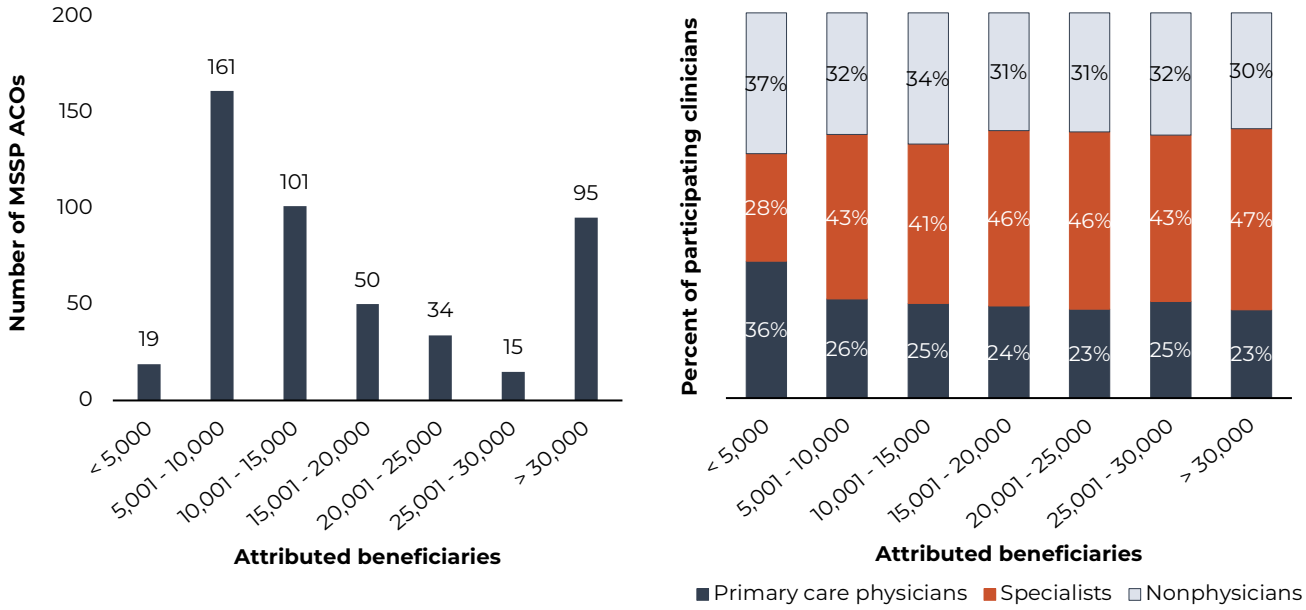
> The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has leveled off in recent years. In 2023, 18 percent of beneficiaries enrolled in both Part A and Part B were assigned to an MSSP ACO (see Chart 5-1).

> The number of ACOs peaked at 561 in 2018 and then declined to 487 in 2019. In 2023, the number of ACOs declined to 456—the lowest level since 2016.

> CMS finalized changes to MSSP at the end of 2018 that included (1) requiring ACOs to transition toward greater levels of financial risk and (2) using regional spending as a component of all ACO benchmarks (the spending levels used to measure an ACO's financial performance). These changes coincided with some ACOs dropping out of the program and fewer new ACOs joining.

> While the number of assigned beneficiaries has leveled off in recent years, the number of beneficiaries per ACO continues to increase (data not shown).

Chart 5-3 Distribution of ACOs and types of providers participating in MSSP, by number of attributed beneficiaries, 2021



Note: ACO (accountable care organization), MSSP (Medicare Shared Savings Program). As of January 2021, there were 477 MSSP ACOs, but the chart includes only the 475 ACOs that did not drop out of the program prior to July 2021. "Nonphysician" clinicians include nurse practitioners, physician assistants, and clinical nurse specialists.

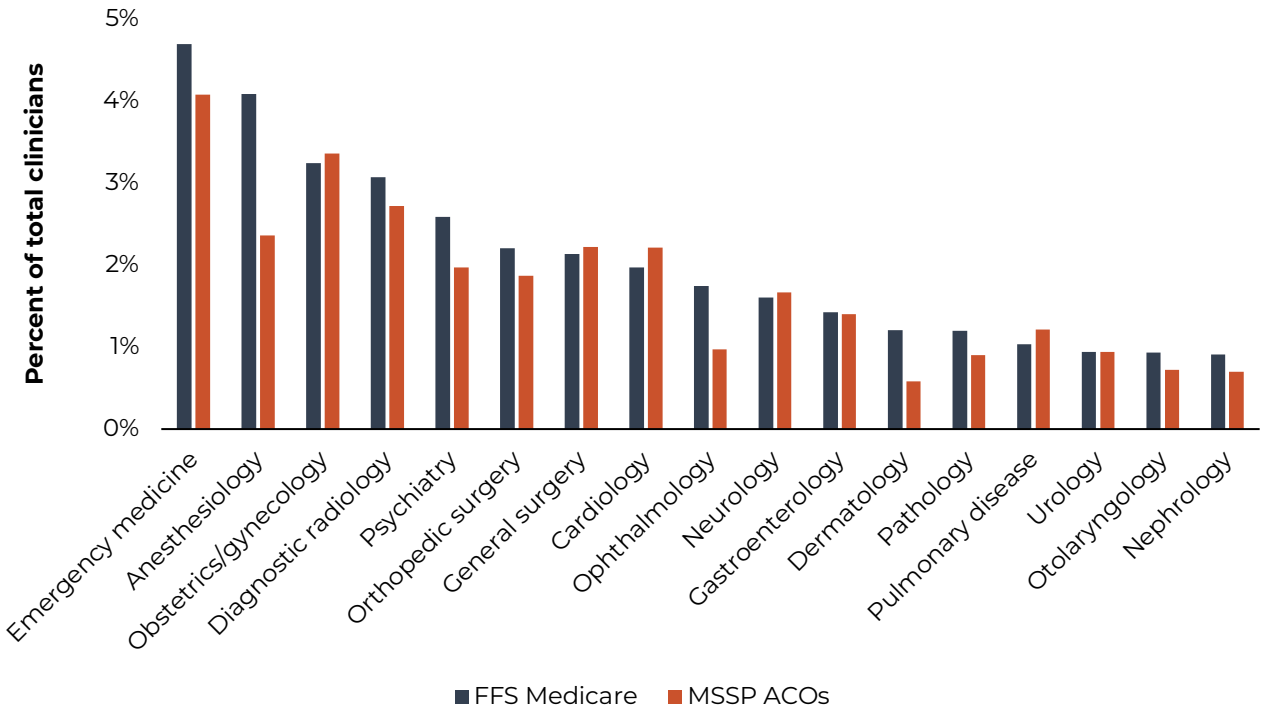
Source: Shared Savings Program Accountable Care Organizations public use files from CMS.

> Of 475 MSSP ACOs, more than half (59 percent) have 15,000 or fewer attributed beneficiaries. Twenty percent of MSSP ACOs have 30,000 or more attributed beneficiaries.

> MSSP ACOs usually have a combination of primary care physicians, specialists, and nonphysician practitioners; the mix of these practitioners is relatively similar across size categories. On average, 24 percent of clinicians participating in an MSSP ACO are primary care physicians, while 45 percent are specialists and 31 percent are nonphysician practitioners (data not shown).

> Primary care physicians comprise at least half of all participating clinicians in 51 (11 percent) MSSP ACOs, while specialists comprise more than half of all clinicians in 86 (18 percent) of MSSP ACOs (data not shown).

Chart 5-4 Participation by select specialists in MSSP ACOs, 2021



Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), FFS (fee-for-service). The "FFS Medicare" category includes all physicians who treated at least one FFS beneficiary, including those who participate in an MSSP ACO. "Total clinicians" includes all physicians, nurse practitioners, physician assistants, and clinical nurse specialists. This chart focuses on non–primary care physician specialties.

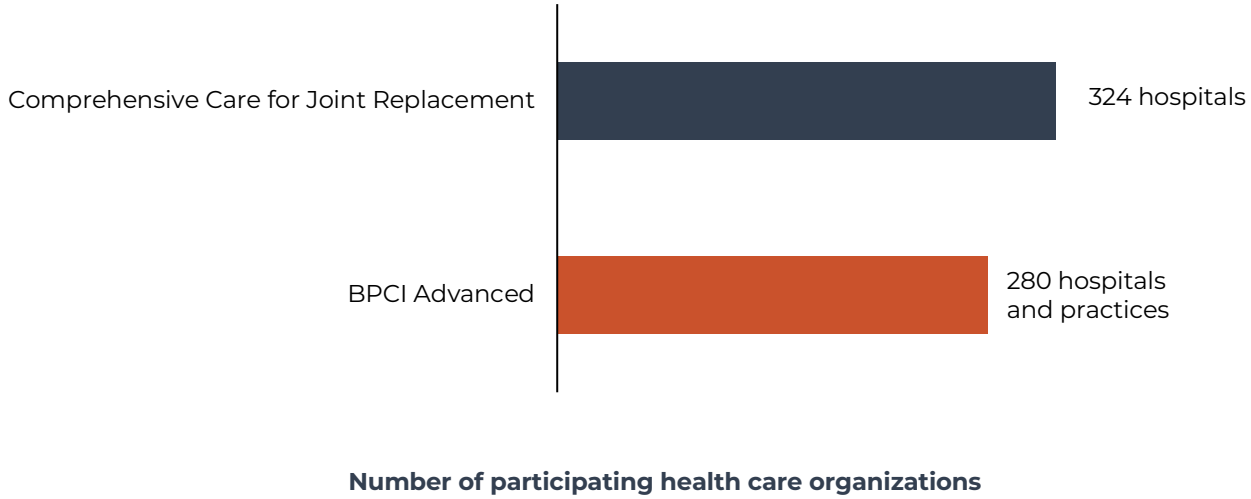
Source: Shared Savings Program Accountable Care Organizations public use files and research identifiable files from CMS; Carrier Standard Analytic File for 100 percent of Medicare beneficiaries from CMS.

> ACOs by design are oriented around primary care, but specialists can and do participate in these models. Most MSSP ACOs have a mix of physicians among various clinical specialties.

> Specialists' participation in ACOs relative to their share of all clinicians varies by specialty. For most specialties, the portion of physicians who participate in MSSP ACOs is similar to the portion of that specialty who participate in all of FFS Medicare.

> Among some specialties, the portion of ACO participants is higher or lower than FFS Medicare as a whole. For example, cardiologists comprise about 2 percent of all clinicians participating in FFS Medicare, but a larger share of clinicians participating in ACOs. By contrast, specialties such as anesthesiology, ophthalmology, and dermatology are underrepresented in ACOs relative to their share of all FFS clinicians.

Chart 5-5 Comprehensive Care for Joint Replacement is Medicare's largest episode-based payment model, 2023



Note: BPCI (Bundled Payments for Care Improvement).

Source: Comprehensive Care for Joint Replacement website (https://innovation.cms.gov/innovation-models/cjr); information on BPCI Advanced participants is from CMS's Where Innovation Is Happening website (https://innovation.cms.gov/innovation-models/bpci-advanced).

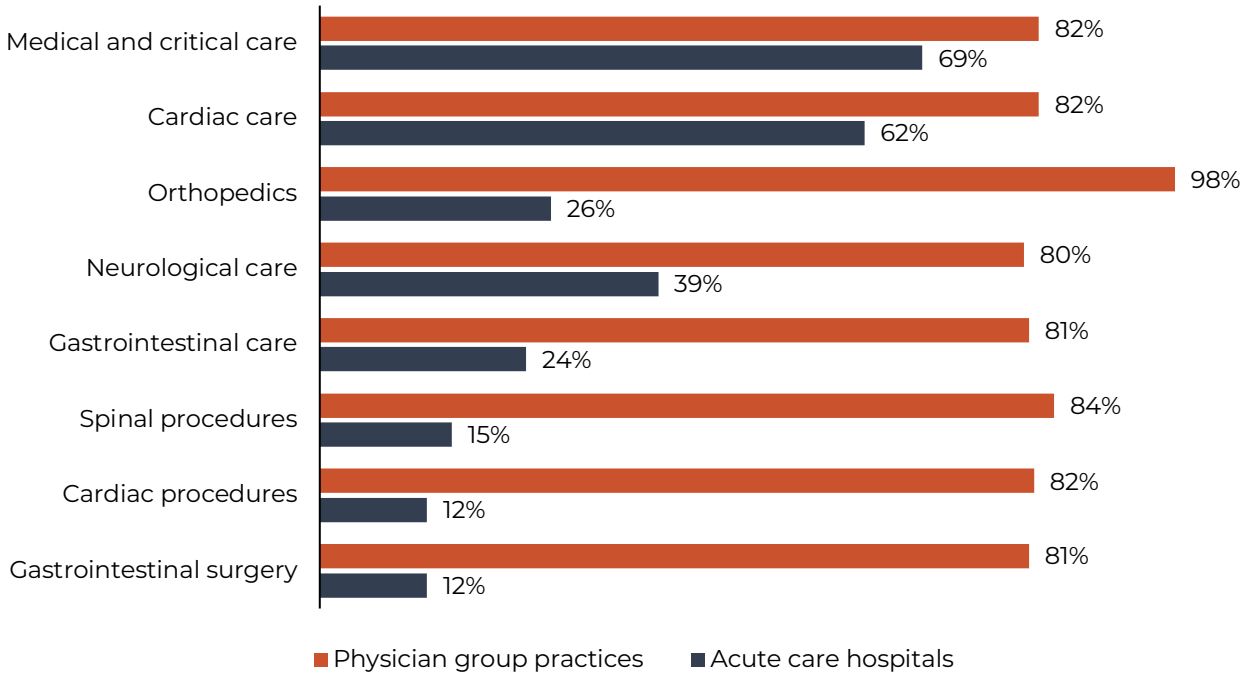
> Episode-based payment models give health care providers a spending target for most types of care provided during a clinical episode (e.g., six months of chemotherapy or an inpatient admission or outpatient procedure plus most other care provided in the subsequent 90 days). If total spending is less than the target, Medicare pays providers a bonus; if total spending is more than the target, Medicare recoups money from providers.

> Within FFS Medicare, the episode-based payment model with broadest participation is the Comprehensive Care for Joint Replacement Model, with 324 participating hospitals.

> Participation in the BPCI Advanced Model shrank from 831 acute care hospitals and physician group practices in 2022 to 280 in 2023. Challenges faced by providers during the coronavirus pandemic and rule changes that can make it more difficult to achieve shared savings have been cited as factors in the sharp decline in participation in the voluntary BPCI Advanced model.

> Another episode-based payment model, the Oncology Care Model, began in 2016 and ended in 2022. The voluntary model established spending targets for certain cancer treatment episodes involving chemotherapy. Preliminary assessments of the model indicate that it did not generate net savings to the Medicare program and did not significantly change measures of quality.

Chart 5-6 Share of BPCI Advanced episode initiators accepting responsibility for each clinical episode group, 2023



Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple clinical-episode service-line groups. The denominators for each group are 174 physician group practice and 106 acute care hospital episode initiators in 2023.

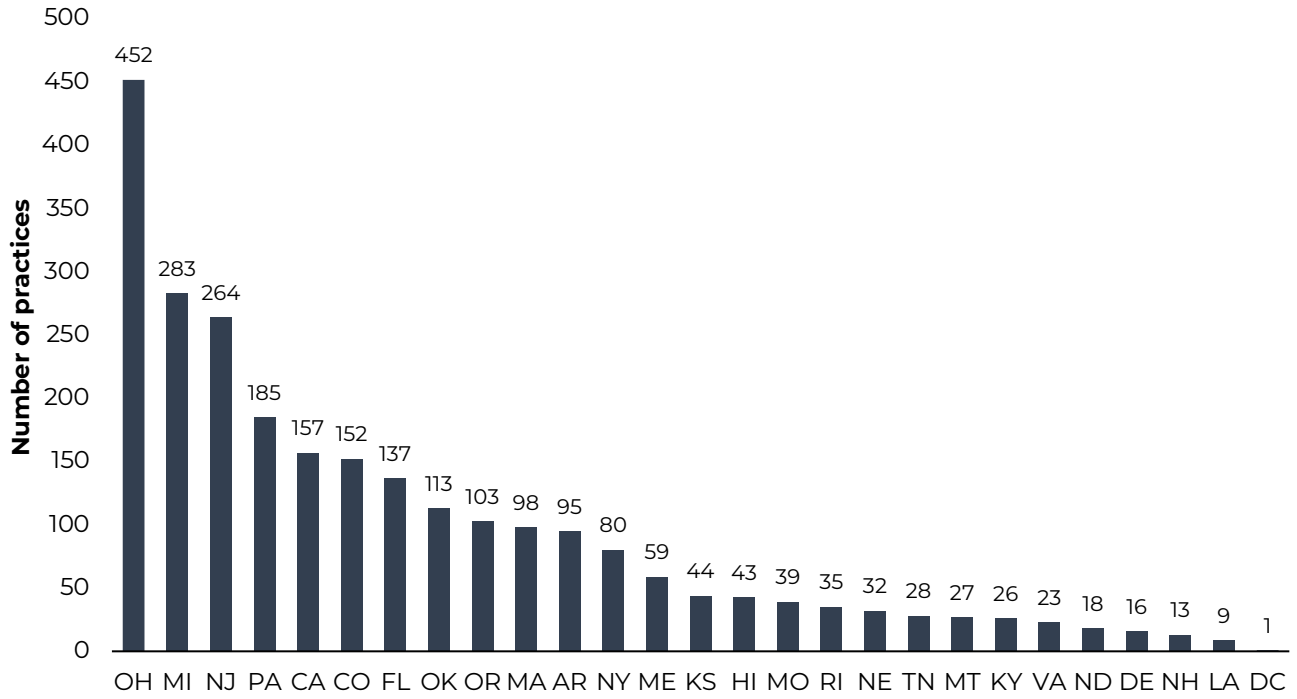
Source: List of clinical-episode service-line groups each BPCI Advanced participating episode initiator agreed to take financial responsibility for in Model Year 6 (2023) downloaded from CMS's BPCI Advanced webpage (https://innovation.cms.gov/innovation-models/bpci-advanced).

> BPCI Advanced covers dozens of types of inpatient and outpatient clinical episodes, which are aggregated into eight clinical-episode service-line groups (e.g., the cardiac care group includes acute myocardial infarction, cardiac arrhythmia, and congestive heart failure). Participating hospitals and physician practices select the service-line groups for which they will be financially responsible under the model.

> More than 80 percent of physician practices initiate episodes in all of the service-line groups. Among participating hospitals, there is much more variation. Nearly 70 percent of hospitals initiate episodes within the medical and critical care service-line group, while only 12 percent of hospitals opt to initiate episodes under the gastrointestinal surgery service-line group.

> Just over 50 percent of all BPCI Advanced episode initiators accept episode-based payments for more than four of the eight clinical-episode service-line groups. Eighteen percent accept episode-based payments for only one clinical-episode service-line group (data not shown).

Chart 5-7 Almost 2,500 practices are testing the Primary Care First model, 2023



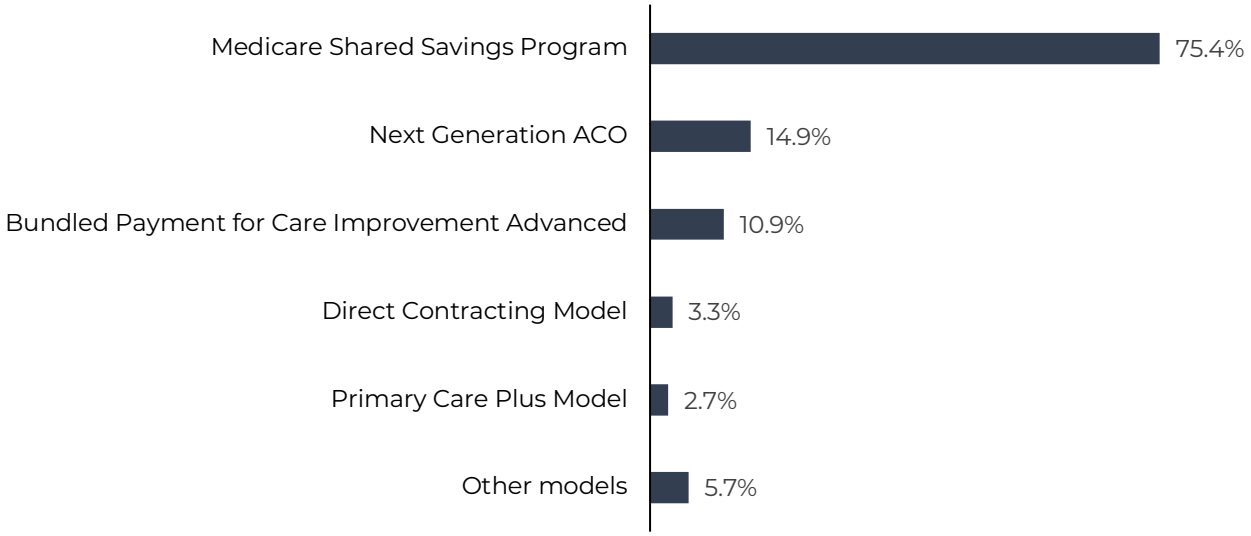
Note: Primary Care First is an advanced alternative payment model that CMS began testing with the first cohort in 2021 and the second cohort in 2022. Primary Care First is a multipayer model, with some Medicaid and private insurers voluntarily paying similar fees for their enrollees.

Source: CMS's list of Primary Care First practices (https://innovation.cms.gov/innovation-models/primary-care-first-model-options).

> CMS's Primary Care First is an advanced alternative payment model that has about 2,500 participating practices in 26 states and the District of Columbia. The model aims to strengthen primary care by testing alternative ways of paying participating providers of primary care services. These payments are intended to support enhanced, coordinated care management and assist with care delivery transformation.

> Participating practices receive a risk-adjusted per beneficiary per month care management fee, plus a flat primary care visit fee instead of fee-for-service payments for certain primary care services. These payments are subject to adjustments determined by each practice's performance on specified quality and utilization measures.

Chart 5-8 About 75 percent of the clinicians who qualified for a 5 percent A–APM bonus in 2023 were in the Medicare Shared Savings Program



Note: A–APM (advanced alternative payment model), ACO (accountable care organization). Clinicians' 2021 A–APM participation determines their 2023 bonuses. Shares do not sum to 100 percent because clinicians can participate in more than one A–APM simultaneously. To qualify for the A–APM bonus in 2023, clinicians had to receive 50 percent of their professional services payments or provide 35 percent of their patients with professional services through an A–APM in 2021. The A–APM bonus is equal to 5 percent of a clinician's professional services payments from Medicare (not including cost sharing paid by beneficiaries). "Other models" includes the Maryland Total Cost of Care Model, Comprehensive Care for Joint Replacement Model, Comprehensive ESRD (End-Stage Renal Disease) Care Model, Primary Care First Model, and Vermont ACO model. For the payment models shown, only those model tracks that require clinicians to take on some financial risk qualify as A–APMs (e.g., physicians participating in Track 1 of the Medicare Shared Savings Program did not qualify for A–APM bonuses because Track 1 involved no financial risk for participants).

Source: CMS data on clinicians who qualified for the 5 percent bonus in 2023 based on clinicians' 2021 model participation.

> The payment models that CMS has designated as A–APMs place health care providers at some financial risk for Medicare spending while expecting them to meet quality goals for a defined patient population. Clinicians who participate in A–APMs qualify for bonuses equal to 5 percent of their professional services payments from Medicare. These bonus payments are available from 2019 to 2024. In 2025, A–APM bonuses for qualifying clinicians will equal 3.5 percent of professional service payments.

> In 2023, nearly 271,000 clinicians nationwide qualified for the A–APM bonus (based on 2021 A–APM participation) out of about 1.3 million who billed the Medicare physician fee schedule. About 90 percent of these clinicians participated in ACOs, which give clinicians an opportunity to earn shared savings payments from Medicare if they lower health care spending while meeting care quality standards (data not shown).

> Among clinicians who qualified for an A–APM bonus in 2022, 37 percent were specialists, 24 percent were primary care physicians, and 39 percent were nonphysician practitioners such as nurse practitioners or physician assistants (data not shown).