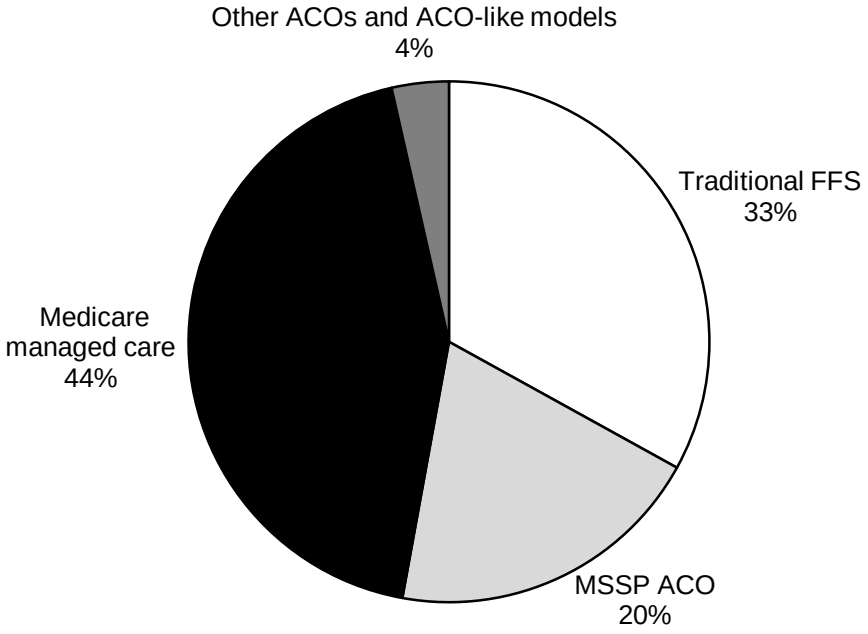
SECTION 5

Alternative payment models

Chart 5-1. Most beneficiaries are in Medicare managed care plans or are assigned to accountable care organizations, 2020

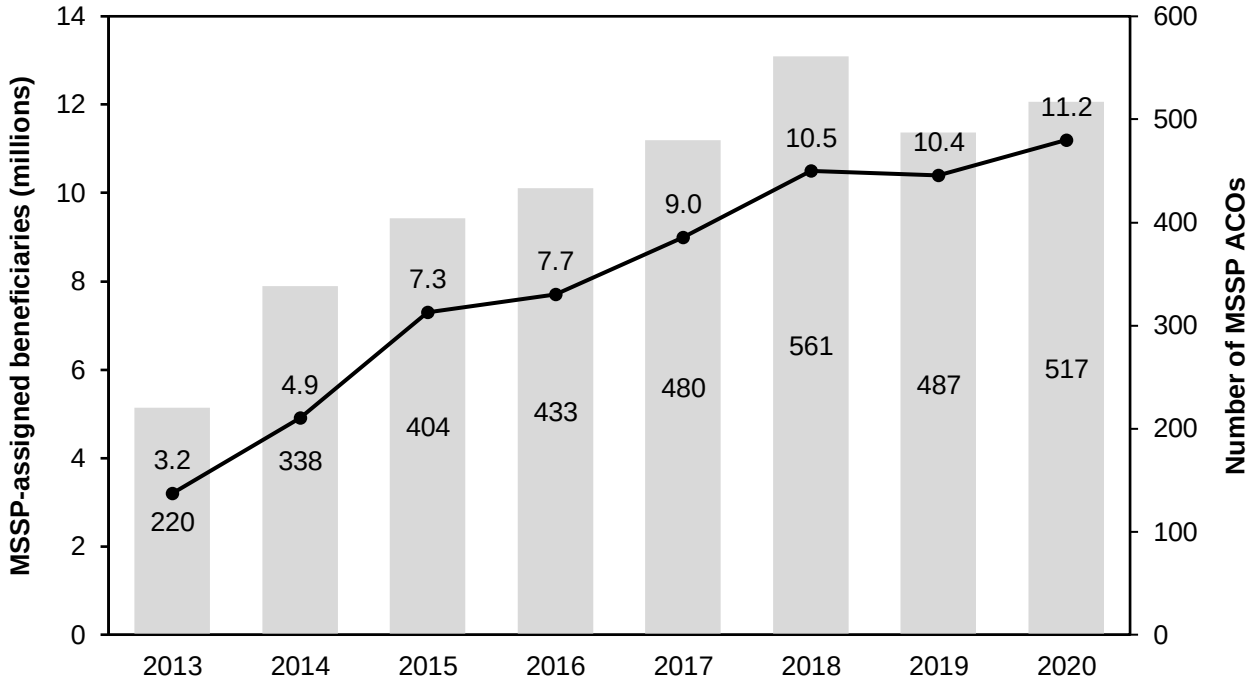


Note: ACO (accountable care organization), FFS (fee-for-service), MSSP (Medicare Shared Savings Program). This chart includes only beneficiaries enrolled in both Part A and Part B in January 2020. Both Part A and Part B coverage is necessary for either Medicare Advantage enrollment or ACO assignment. Percentages in this chart differ from those in Charts 9-5 and 9-10 because the 5.7 million beneficiaries with either only Part A or only Part B coverage are included in those charts. In general, Medicare managed care plans include Medicare Advantage plans as well as cost-reimbursed plans. Other ACOs and ACO-like models include the Next Generation ACO model, the Maryland Total Cost of Care (TCOC) model, the ESRD Seamless Care Organization (ESCO) 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. Percentages do not total 100 because of rounding.

Source: CMS January 2020 enrollment dashboard data, CMS Shared Savings Program January 2020 Fast Facts, CMS ACO Next Generation 2018 performance data and 2019 participant lists, CMS ESCO 2018 report to the Congress, and State of Vermont Green Mountain Care Board 2020 report.

- Among the 56.5 million Medicare beneficiaries with both Part A and Part B coverage in 2020, approximately two-thirds are in Medicare managed care (Medicare Advantage or other private plans) or accountable care organization (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 33 percent of Medicare beneficiaries with both Part A and Part B coverage are now in traditional fee-for-service (FFS) Medicare—a share that has declined in recent years.
- Even among the one-third 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 Comprehensive Primary Care Plus model.

Chart 5-2. The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but more moderately since then

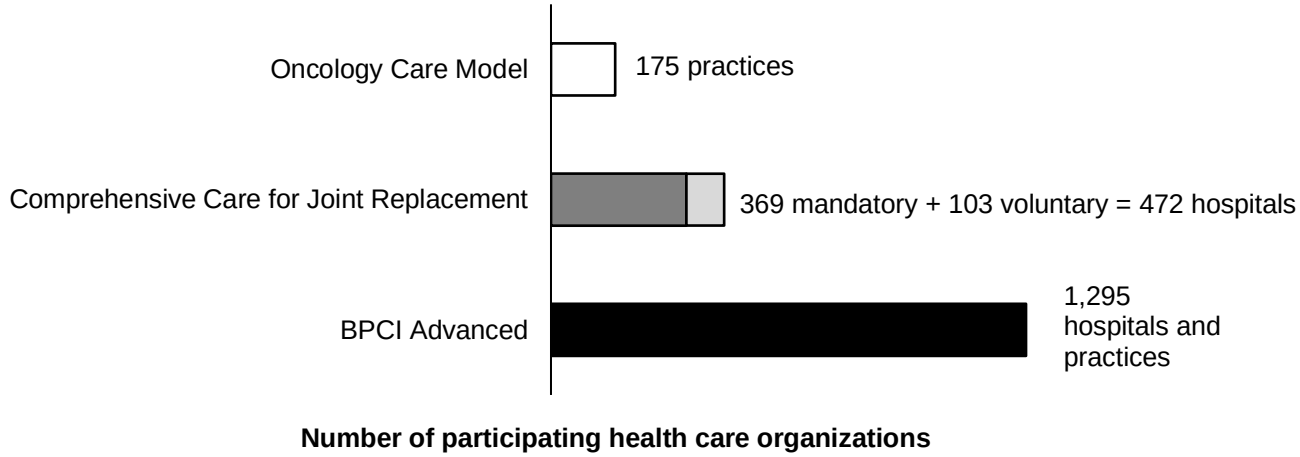


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). Numbers are as of January in each year. In 2019, MSSP ACOs were allowed to join the program in July 2019. Those ACOs and the beneficiaries assigned to them were not in the program as of January 2019 and are therefore not 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.

Source: CMS Shared Savings Program January 2020 Fast Facts.

- The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has grown at a more moderate pace in recent years.
- The number of ACOs peaked in 2018 and then declined between 2018 and 2020.
- From 2018 to 2020, the simultaneous decline in MSSP ACOs but increase in assigned beneficiaries reflects larger assignment per ACO.
- CMS finalized changes to the MSSP program at the end of 2018 that included (1) requiring ACOs to transition toward greater levels of risk and (2) using regional spending as a component of all ACO benchmarks (the spending level used to measure an ACO's financial performance). These changes coincided with some ACOs dropping out of the program and fewer new ACOs joining the program.

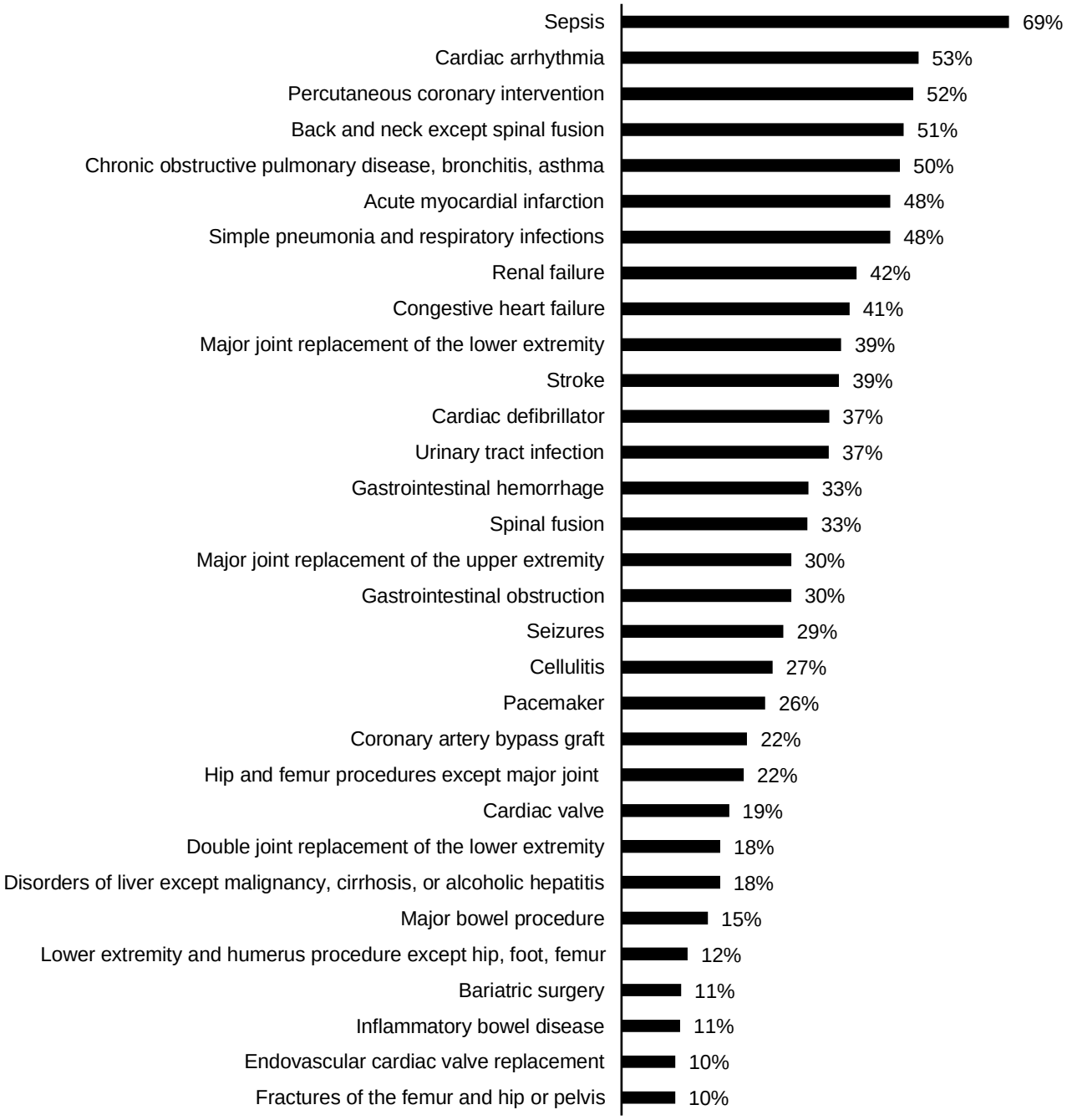
Chart 5-3. Bundled Payments for Care Improvement (BPCI) Advanced is Medicare's largest episode-based payment model, 2020



Sources: CMS's Oncology Care Model website (https://innovation.cms.gov/innovation-models/oncology-care); information on the latest number of Comprehensive Care for Joint Replacement participants: Personal communication from CMS staff, May 1, 2020; information on BPCI Advanced participants: CMS's Where Innovation Is Happening website (https://innovation.cms.gov/innovation-models/map#model=bpci-advanced).

- Medicare fee-for-service (FFS) providers can participate in episode-based payment models.
- Episode-based payment models give health care providers a spending target for most types of care provided during a clinical episode (e.g., 6 months of chemotherapy, 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 (1,295 acute care hospitals and physician group practices participating) is the BPCI Advanced model.
- BPCI Advanced allows hospitals and practices to participate in dozens of clinical episodes, most of which are for inpatient admissions (as opposed to outpatient procedures). The most commonly pursued types of clinical episodes in BPCI Advanced are shown in Chart 5-4.
- About two-thirds of BPCI Advanced participants accept episode-based payments for fewer than six types of clinical episodes at a time. Twenty-two percent accept episode-based payments for only one type of clinical episode (data not shown).

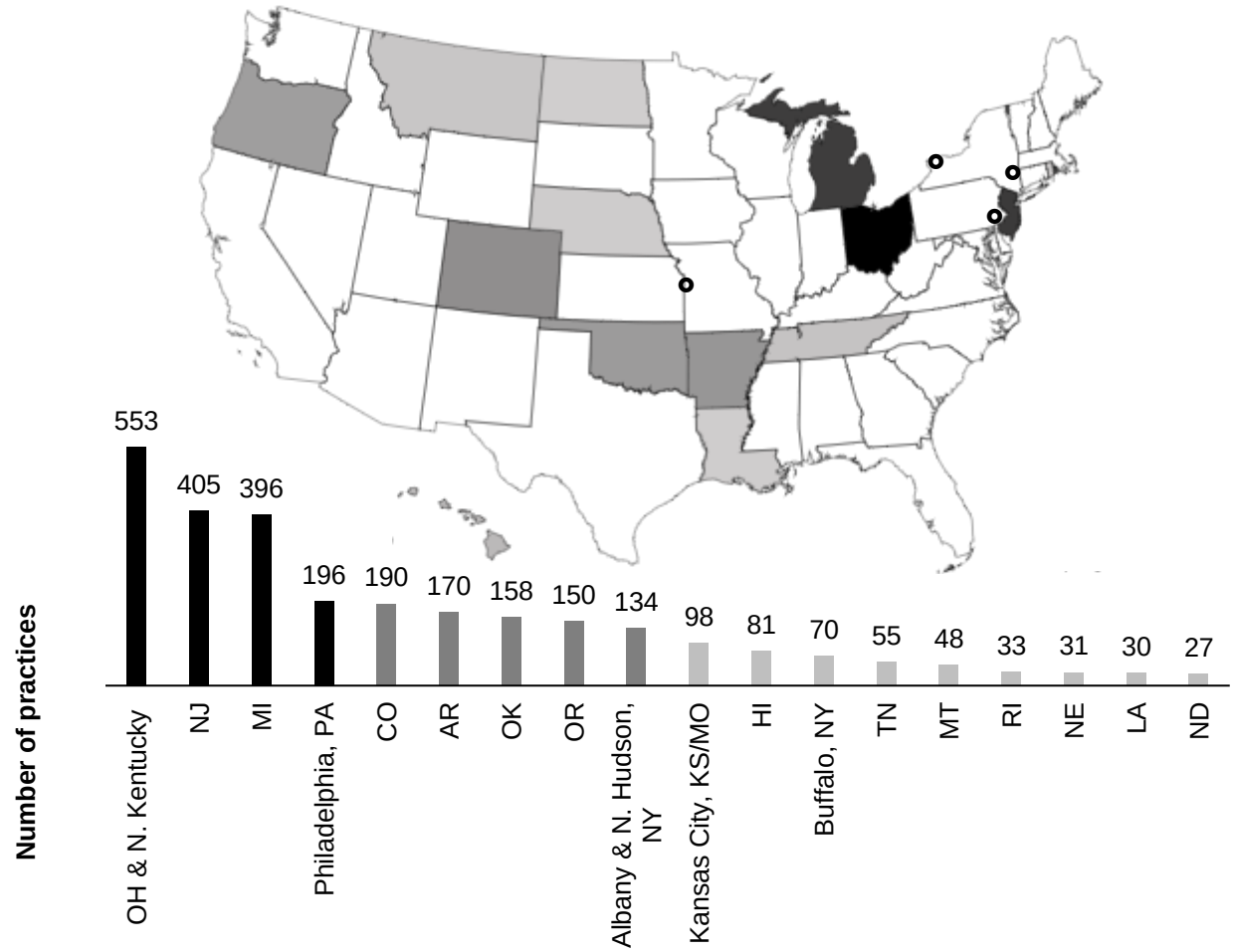
Chart 5-4. Share of BPCI Advanced participants accepting financial responsibility for particular types of clinical episodes, 2020



Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple types of clinical episodes. The denominator is 1,295 BPCI Advanced participants in 2020.

Source: List of clinical episodes each BPCI Advanced participant agreed to take financial responsibility for in Model Year 3 (2020) downloaded from CMS's BPCI Advanced webpage (https://innovation.cms.gov/innovation-models/bpci-advanced).

Chart 5-5. 2,825 practices are testing the Comprehensive Primary Care Plus (CPC+) model, 2020



Note: Comprehensive Primary Care Plus (CPC+) is an advanced alternative payment model that CMS began testing in 2017 in some regions and in 2018 in others. CPC+ is a multipayer model, with some Medicaid and private insurers voluntarily paying similar fees for their enrollees. Alaska (not shown) was not selected as a region eligible to participate in the CPC+ model.

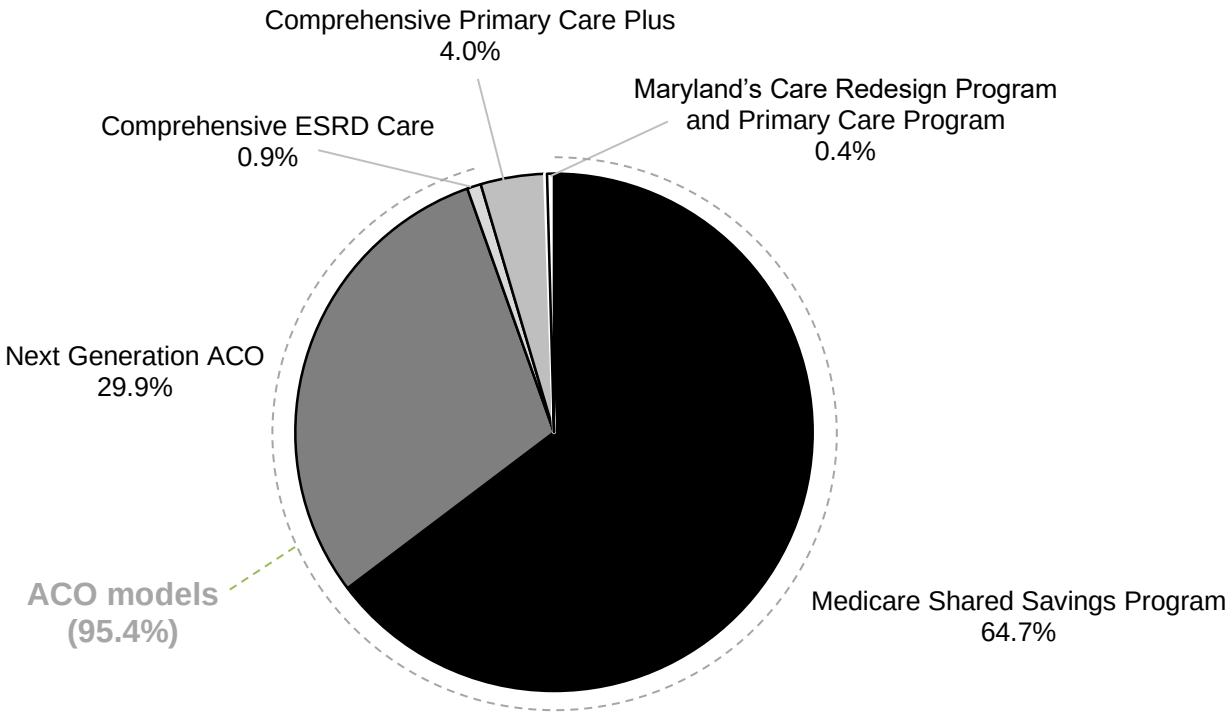
Source: CMS's list of CPC+ practices (https://data.cms.gov/Special-Programs-Initiatives-Speed-Adoption-of-Bes/Comprehensive-Primary-Care-Plus/eevd-hiep).

- CMS's CPC+ is an advanced alternative payment model that aims to strengthen primary care by providing additional, up-front payments to 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, in addition to standard fee-for-service (FFS) payments. Practices can also opt to shift some of their FFS revenue into prospective payments received quarterly.

- CPC+ practices can earn performance bonuses unless they also participate in a Medicare Shared Savings Program (MSSP) accountable care organization (since bonuses are already available through the MSSP). About half the CPC+ practices also participate in the MSSP.

Chart 5-6. About 95 percent of the clinicians who qualified for a 5 percent A–APM bonus in 2020 were in ACO models



Note: A–APM (advanced alternative payment model), ACO (accountable care organization), ESRD (end-stage renal disease). Clinicians' 2018 A–APM participation determines their 2020 bonuses. To qualify for the A–APM bonus, clinicians had to receive 25 percent of their professional services payments or provide 20 percent of their patients with professional services through an A–APM in 2018. 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). In addition to the A–APMs shown above, clinicians had the option of qualifying for the A–APM bonus through participation in the Oncology Care Model (under which no clinicians qualified) or the Bundled Payments for Care Improvement Advanced model (under which one clinician qualified). 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). Percentages do not total 100 because of rounding.

Source: CMS data on clinicians who qualified for the 5 percent bonus in 2020 based on clinicians' 2018 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 2020, about 183,000 clinicians nationwide qualified for the A–APM bonus (based on 2018 A–APM participation). About 95 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.

- Among physicians who qualified for an A–APM bonus in 2020, 62 percent were specialists and 38 percent were primary care physicians.