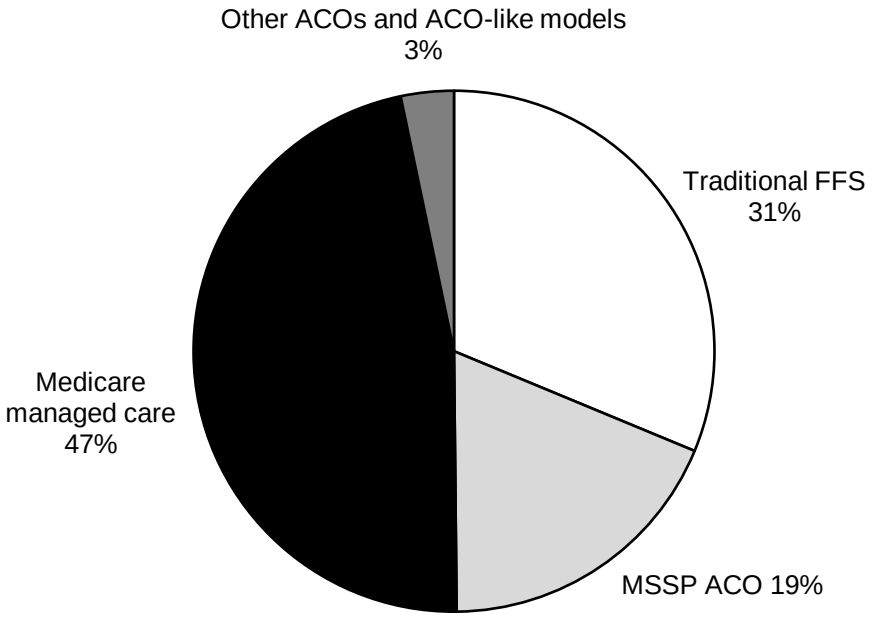
SECTION 5

Alternative payment models

Chart 5-1. Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2021

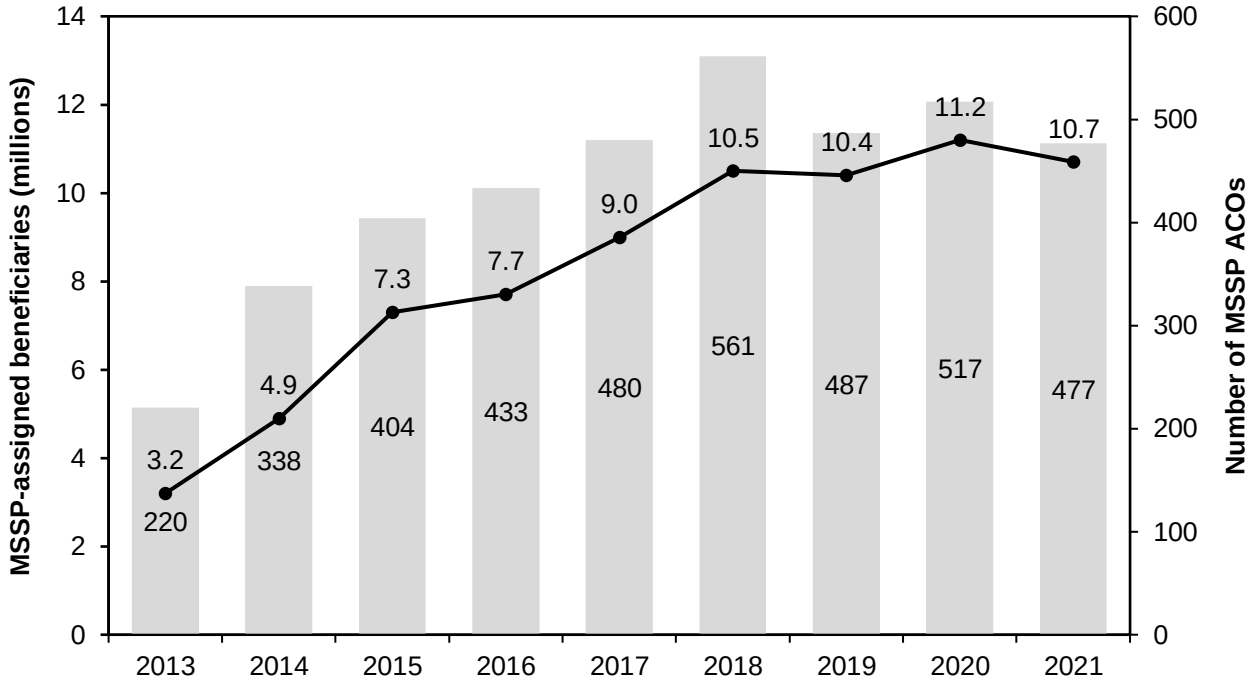


Note: ACO (accountable care organization), FFS (fee-for-service), MSSP (Medicare Shared Savings Program). This chart includes only beneficiaries enrolled in both Part A and Part B in January 2021. Both Part A and Part B coverage is necessary for either Medicare Advantage enrollment or ACO assignment. In general, Medicare managed care plans include Medicare Advantage plans as well as cost-reimbursed plans. Other ACOs and ACO-like models include the Next Generation ACO 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 2021 enrollment dashboard data, CMS Shared Savings Program January 2021 Fast Facts, CMS ACO Next Generation 2019 performance data and 2020 participant lists, and State of Vermont Green Mountain Care Board 2020 report.

- Among the 57.6 million Medicare beneficiaries with both Part A and Part B coverage in 2021, approximately two-thirds 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 31 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 Comprehensive Primary Care Plus model.

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

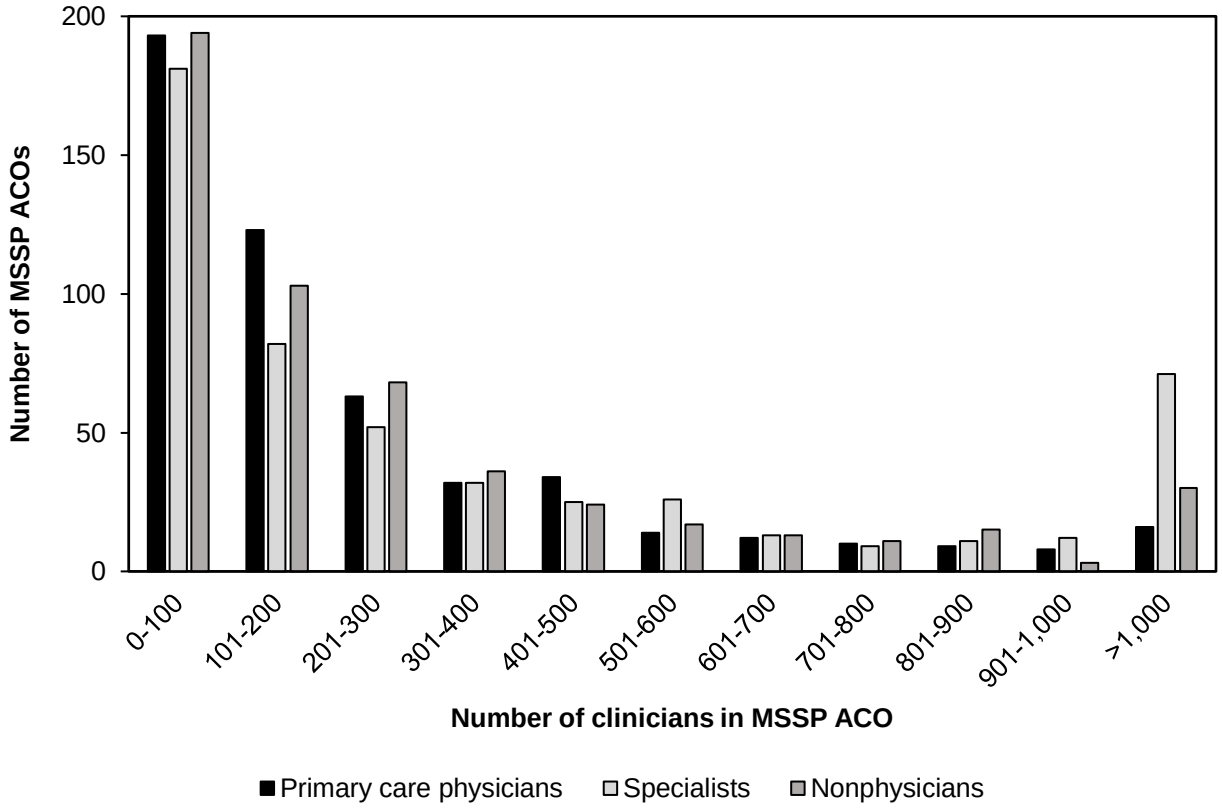


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). Numbers are as of January in each year. In 2019, MSSP ACOs were allowed to join the program in July 2019. Those ACOs and the beneficiaries assigned to them were not in the program as of January 2019 and are therefore not 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. 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 2021 Fast Facts.

- The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has leveled off in recent years.
- The number of ACOs peaked in 2018 and then declined between 2018 and 2021, in part due to CMS restricting new ACOs from entering MSSP in 2021 because of the coronavirus pandemic.
- While the number of ACOs and assigned beneficiaries has leveled off in recent years, the number of beneficiaries per ACO continues to increase (data not shown).
- 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 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 the program.

Chart 5-3. Distribution of clinicians participating in the Medicare Shared Savings Program, by type of provider, 2019

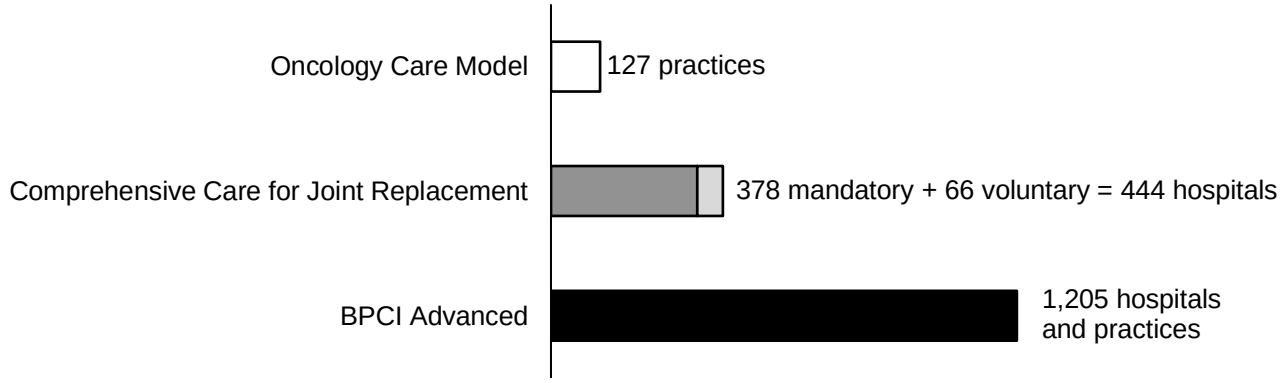


Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). As of December 2019, there were 514 MSSP ACOs. "Nonphysician" clinicians include nurse practitioners, physician assistants, and clinical nurse specialists.

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

- MSSP ACOs usually have a combination of primary care physicians, specialists, and nonphysician practitioners. On average, MSSP ACOs have about 260 primary care physicians, 480 specialists, and 300 nonphysician practitioners (data not shown).
- Nearly 200 MSSP ACOs have 100 or fewer primary care physicians, specialists, or nonphysician practitioners. Sixty-seven ACOs have 100 or fewer total clinicians (data not shown).
- Sixteen ACOs have more than 1,000 primary care physicians, and 71 ACOs have more than 1,000 specialists; 157 ACOs have more than 1,000 total clinicians (data not shown).

Chart 5-4. Bundled Payments for Care Improvement Advanced is Medicare's largest episode-based payment model, 2021

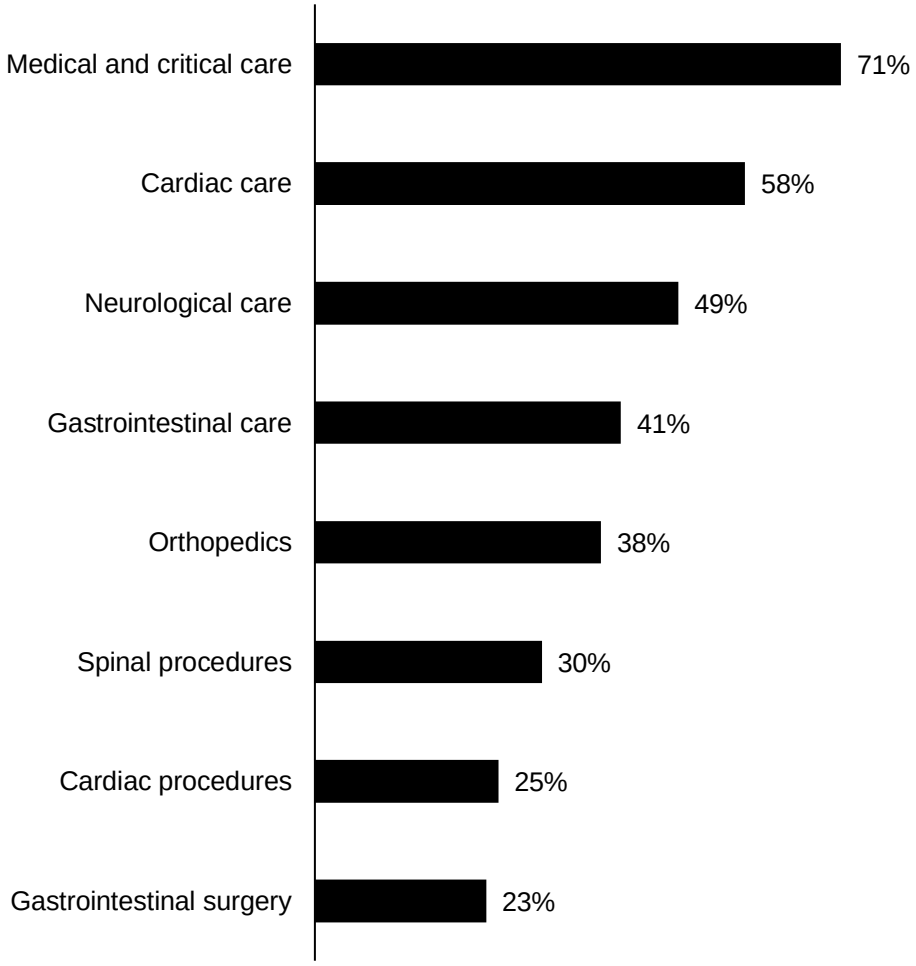


Note: BPCI (Bundled Payments for Care Improvement).

Source: CMS's Oncology Care Model website (https://innovation.cms.gov/innovation-models/oncology-care); Comprehensive Care for Joint Replacement website (https://innovation.cms.gov/innovation-models/cjr); 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., 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 (1,205 acute care hospitals and physician group practices participating) is the BPCI Advanced model.

Chart 5-5. Share of BPCI Advanced participants accepting financial responsibility for each clinical episode group, 2021



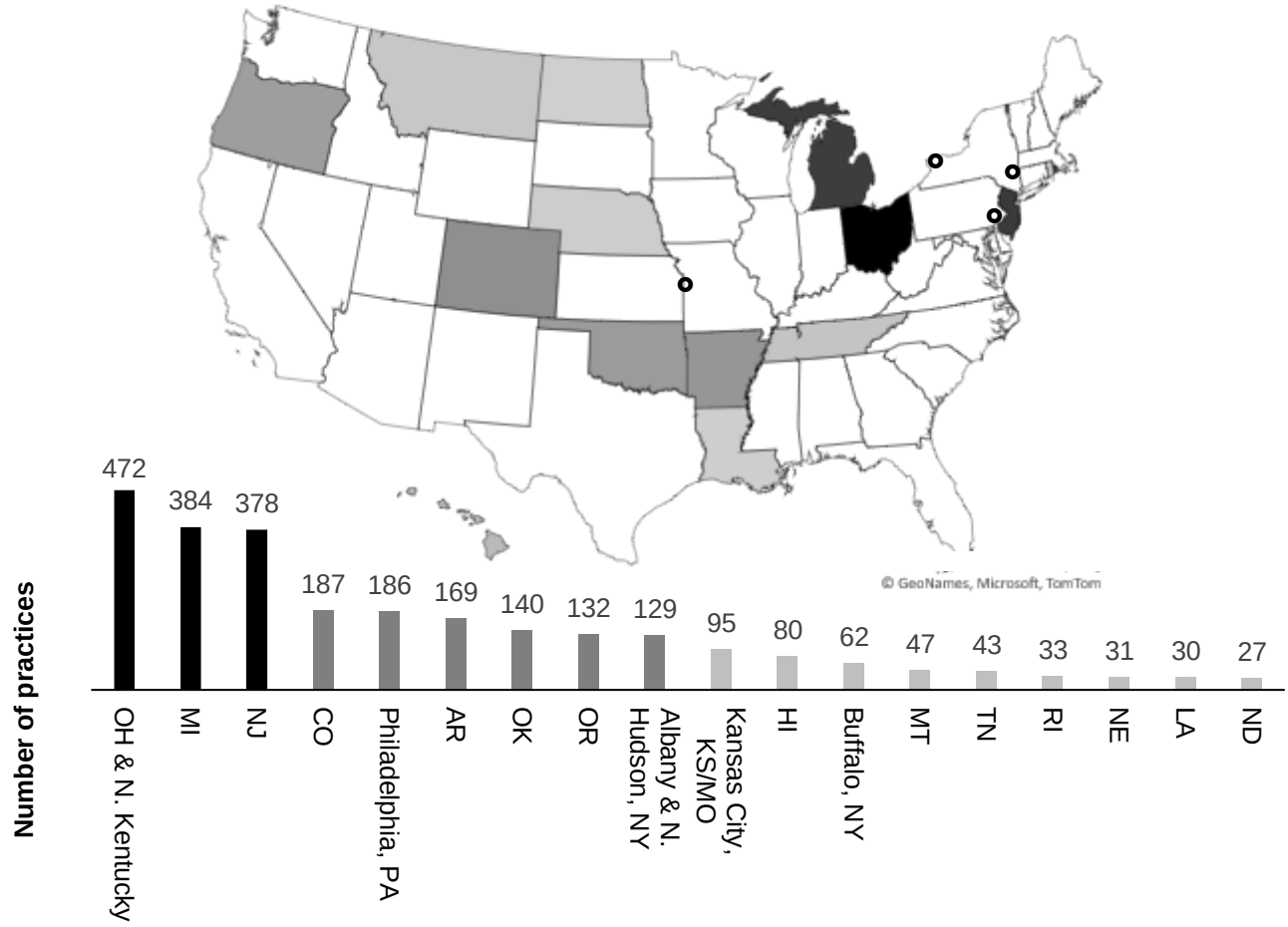
Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple clinical-episode service-line groups. The denominator is 1,205 BPCI Advanced episode initiators in 2021.

Source: List of clinical episodes each BPCI Advanced participant agreed to take financial responsibility for in Model Year 4 (2021) downloaded from CMS's BPCI Advanced webpage (https://innovation.cms.gov/innovation-models/bpci-advanced).

- BPCI Advanced allows hospitals and practices to initiate dozens of clinical episodes, most of which are for inpatient admissions (as opposed to outpatient procedures). Starting in Model Year 4 (2021), episodes under the model 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).

- About two-thirds of BPCI Advanced participants accept episode-based payments for fewer than four clinical-episode service-line groups. Twenty-nine percent accept episode-based payments for only one clinical-episode service-line group (data not shown).

Chart 5-6. 2,625 practices are testing the Comprehensive Primary Care Plus model, 2021



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.

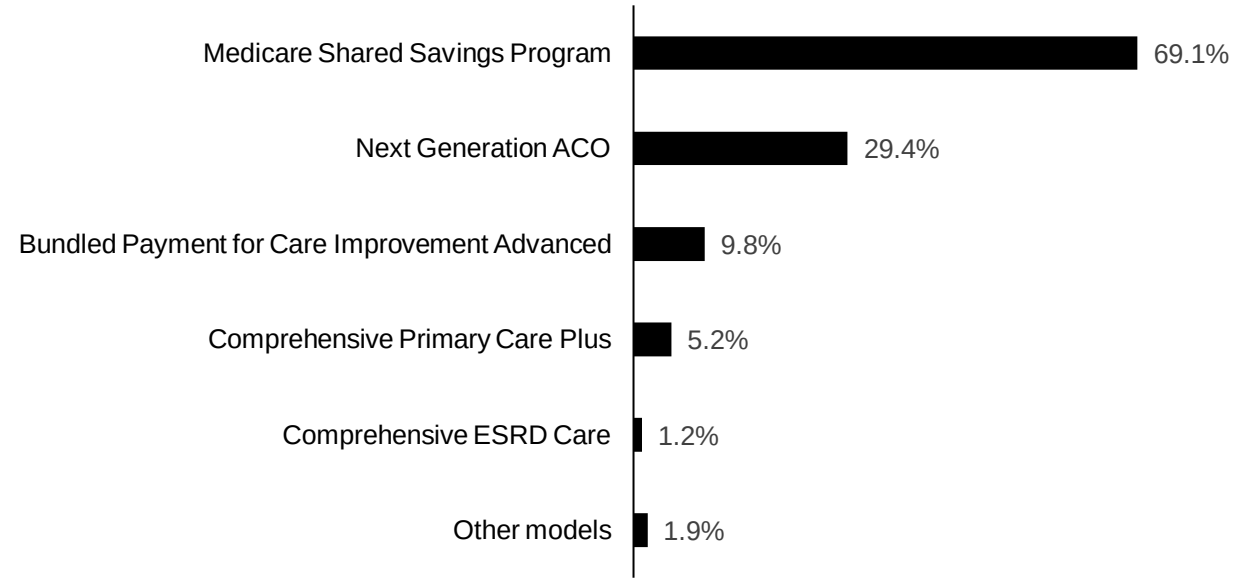
Source: CMS's list of CPC+ practices (https://data.cms.gov/Special-Programs-Initiatives-Speed-Adoption-of-Bes/Comprehensive-Primary-Care-Plus/eevd-hiep).

- 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 5-7. About 70 percent of the clinicians who qualified for a 5 percent A–APM bonus in 2021 were in the Medicare Shared Savings Program



Note: A–APM (advanced alternative payment model), ACO (accountable care organization), ESRD (end-stage renal disease). Clinicians' 2019 A–APM participation determines their 2021 bonuses. Clinicians can participate in more than one A–APM simultaneously. To qualify for the A–APM bonus in 2021, 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 2019. 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, Vermont ACO model, and Oncology Care 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 2021 based on clinicians' 2019 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 2021, nearly 195,000 clinicians nationwide qualified for the A–APM bonus (based on 2019 A–APM participation). About 96 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 2021, 39 percent were specialists, 26 percent were primary care physicians, and 35 percent were nonphysician practitioners (data not shown).