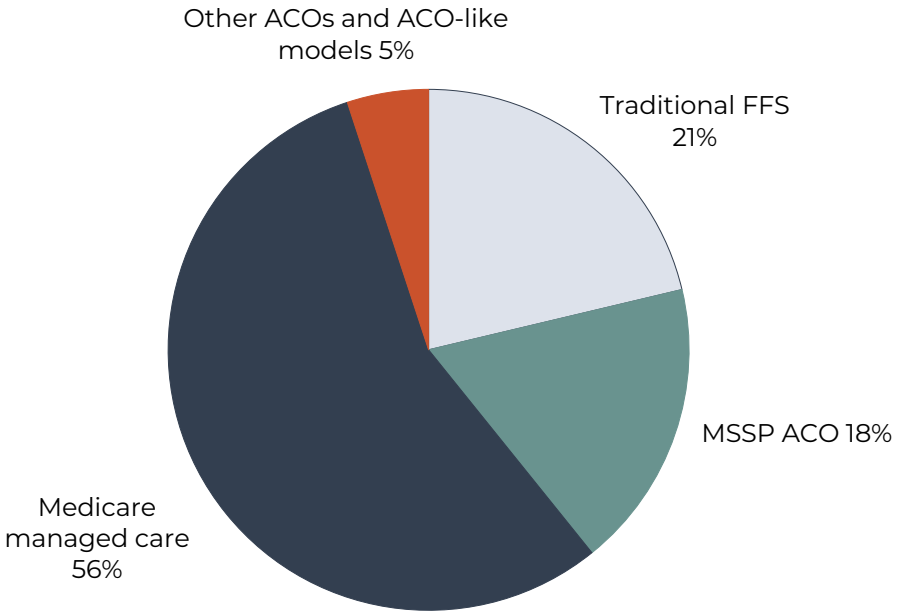
SECTION

5

Alternative payment models

Chart 5-1 Most Medicare beneficiaries are in managed care plans or are assigned to accountable care organizations, 2025



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 2025. 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" includes 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 of 2015 (MACRA) bonus payments for participation in eligible alternative payment models.

Source: CMS January 2025 enrollment data, CMS Shared Savings Program January 2025 Fast Facts, CMS ACO REACH 2025 Fast Facts, and State of Vermont Green Mountain Care Board 2023 Medicare ACO settlement.

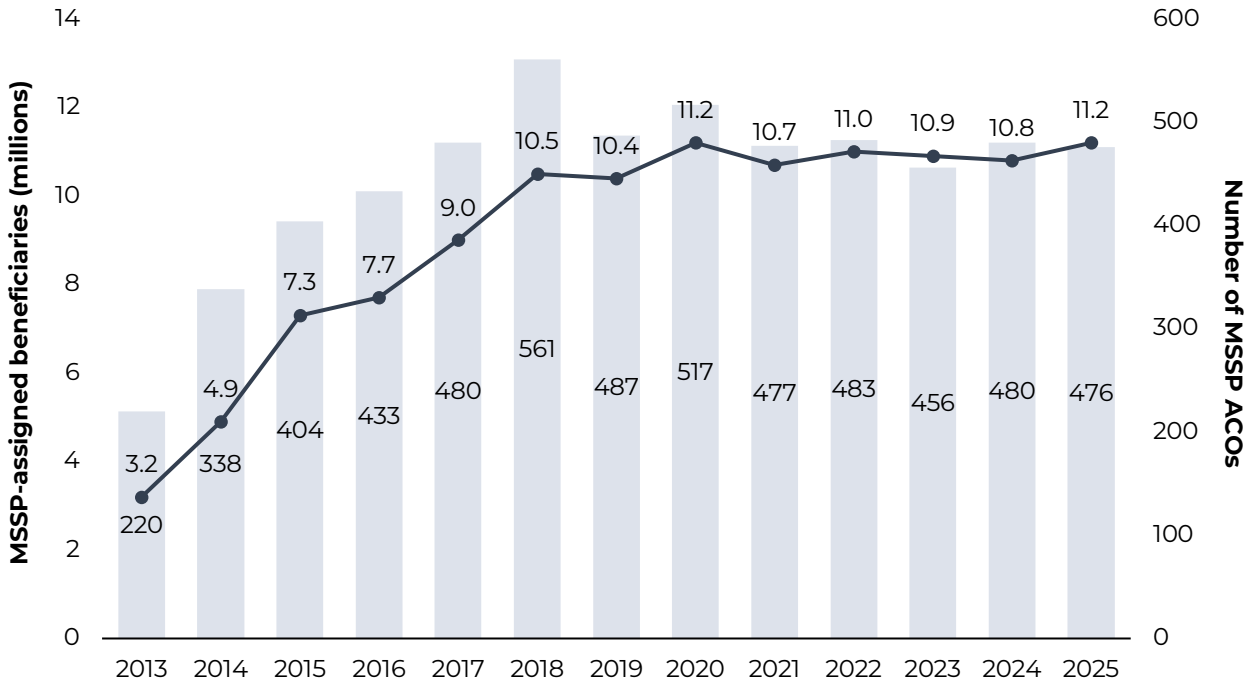
> Among the 62.5 million Medicare beneficiaries with both Part A and Part B coverage in 2025, more than three-fourths (79 percent) are in Medicare managed care (Medicare Advantage or other private plans) or ACO models.

> The MSSP, a permanent ACO model established through the Affordable Care Act of 2010 (ACA), accounts for most of the beneficiaries assigned to ACO or ACO-like payment models.

> Only 21 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 FFS Medicare, some beneficiaries may be assigned to other alternative payments models such as the Bundled Payments for Care Improvement Advanced 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 2025 Fast Facts.

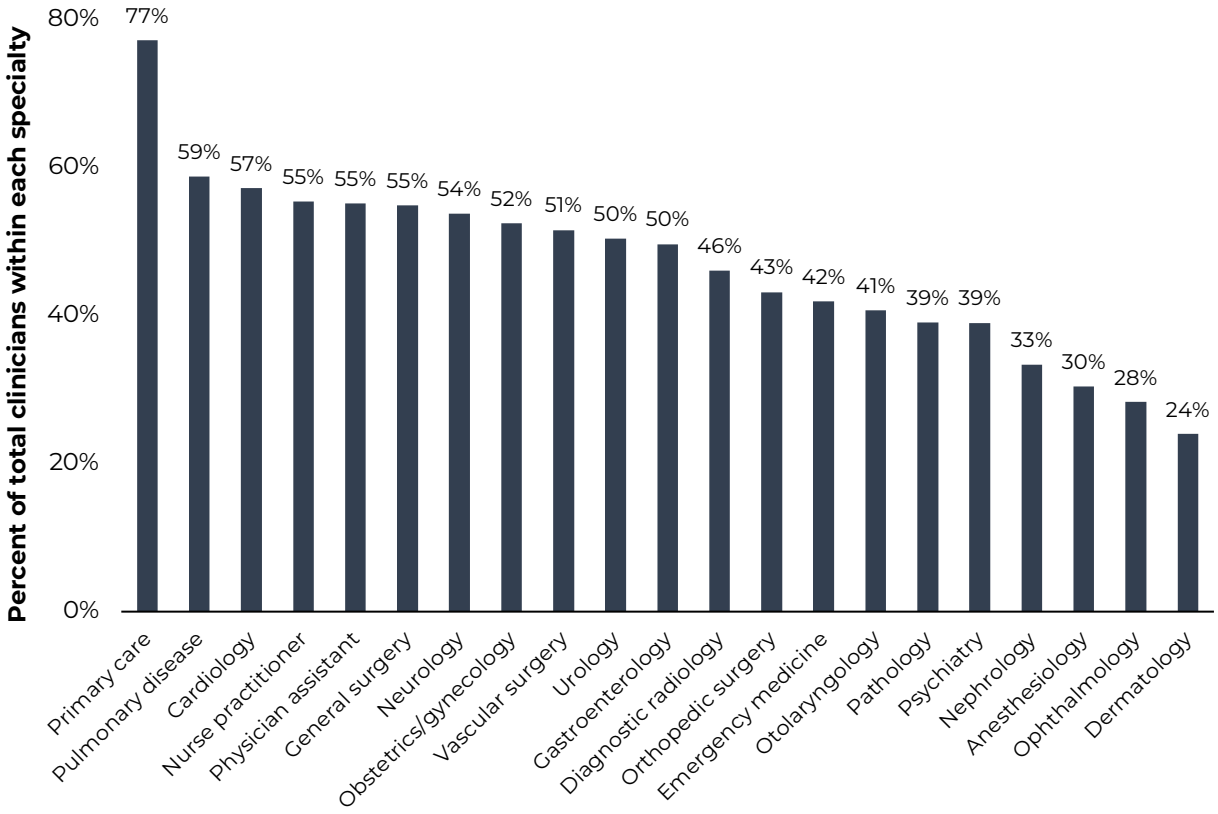
> The number of beneficiaries assigned to MSSP ACOs grew rapidly through 2018 but has leveled off in recent years. In 2025, 18 percent of beneficiaries enrolled in both Part A and Part B were assigned to an MSSP ACO (see Chart 5-1).

> The number of ACOs peaked at 561 in 2018 and then declined to 487 in January 2019. In 2025, there were 476 ACOs—a slight decrease relative to 2024.

> At the end of 2018, CMS finalized changes to the MSSP 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.

> In 2025, the number of assigned beneficiaries (11.2 million) is similar to the amount in 2020.

Chart 5-3 Clinician participation in MSSP ACOs among select specialties, 2022



Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). "Total clinicians" includes all clinicians from each specialty who treated at least one Medicare fee-for-service beneficiary in 2022, including those who participated in an MSSP ACO. "Primary care" includes physicians who specialize in internal medicine, family medicine, geriatric medicine, and pediatric medicine.

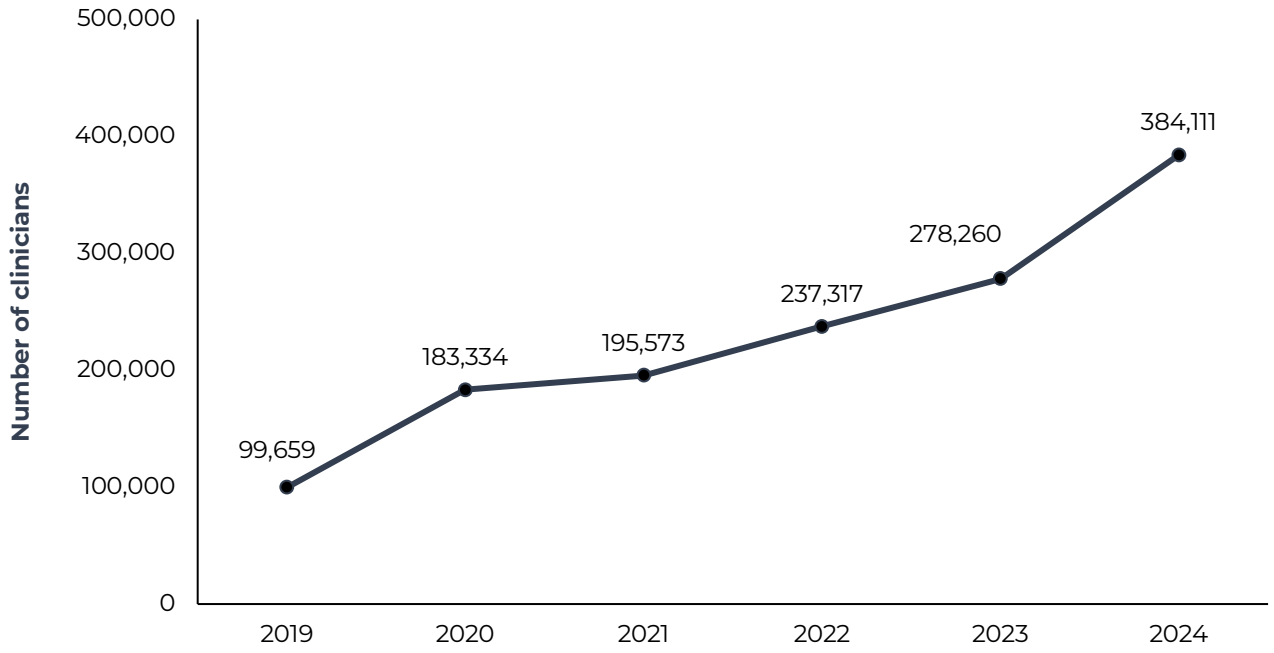
Source: Shared Savings Program Accountable Care Organizations public use files and research identifiable files from CMS; Carrier Standard Analytic File for 100 percent of Medicare beneficiaries from CMS.

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

> Among all primary care physicians who billed fee-for-service (FFS) Medicare in 2022, 77 percent participated in an MSSP ACO.

> Among other specialties, participation in ACOs as a share of all clinicians within the specialty varies greatly. For example, 59 percent of all pulmonologists participating in FFS Medicare in 2022 also participated in an ACO. By contrast, less than 30 percent of ophthalmologists and dermatologists participated in an MSSP ACO.

Chart 5-4 An increasing number of clinicians qualified for the A–APM participation bonus, 2019–2024



Note: A–APM (advanced alternative payment model). Numbers have been rounded to the nearest thousand. Figure shows the number of clinicians who qualified for the A–APM participation bonus in a given year (based on their A–APM participation two years prior), which may be higher than the number who actually received the bonus (e.g., due to retirement).

Source: MedPAC analysis of CMS data identifying the national provider identifiers of clinicians who qualified for the A–APM participation bonus linked to 100 percent of fee schedule claims.

> The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established bonus payments for clinicians who participate in A–APMs. A–APMs are models that require participating providers to take on a more-than-nominal amount of financial risk, tie bonuses to quality measures, and require the use of electronic health records that have been certified by the federal government. Clinicians are eligible to receive a participation bonus worth 5 percent of their Medicare payments for fee schedule services from 2019 through 2024, a bonus worth 3.5 percent of these payments in 2025, and a bonus worth 1.88 percent in 2026.

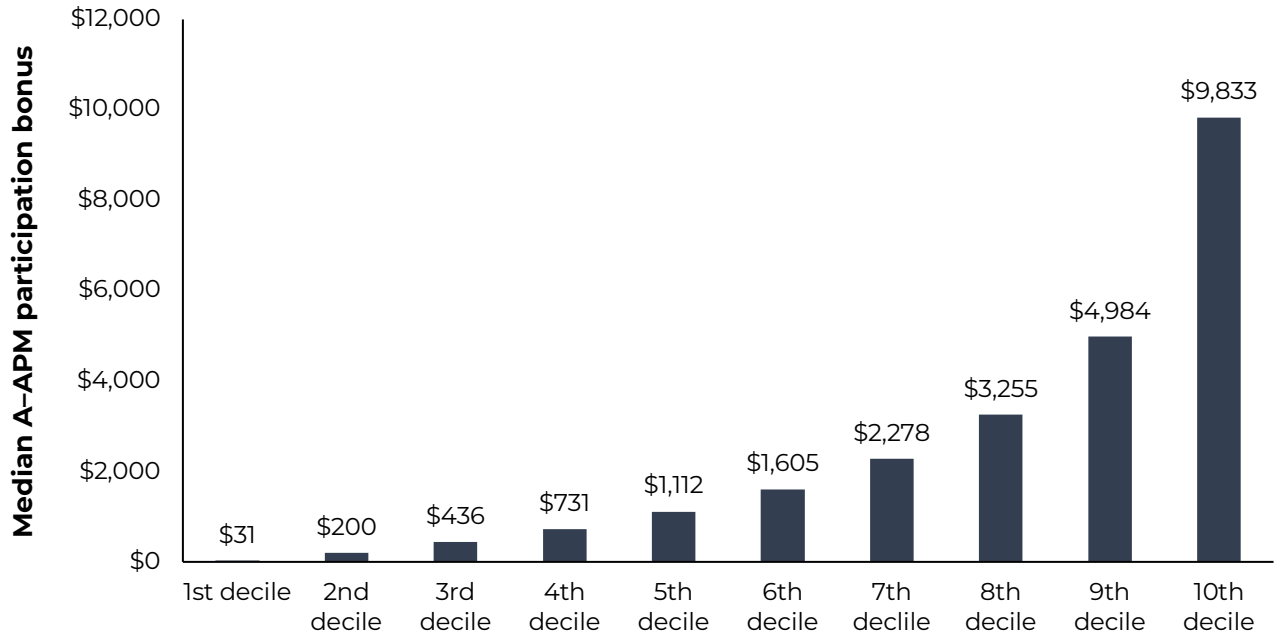
> Bonus payments are paid two years after the year in which a clinician participates in an A–APM.

> To qualify for the bonus payment in most of the years shown above, at least 50 percent of a clinician's FFS Medicare or multipayer payments had to be associated with an A–APM or at least 35 percent of a clinician's FFS Medicare or multipayer patients had to be participating in an A–APM.

> The number of clinicians who qualified for the A–APM participation bonus has increased steadily since it first became available in 2019 but has remained a minority of all clinicians. About one in three clinicians who billed the physician fee schedule received the bonus in 2024.

> We estimate that 34,000 clinicians participated in A–APMs in the 2024 payment year but did not qualify for the A–APM participation bonus due to an insufficient share of their payments or patients being in A–APMs (data not shown). Another 116,000 clinicians were in alternative payment models that did not meet MACRA's criteria to be considered an A–APM (e.g., they did not require clinicians to take on a sufficient degree of financial risk), so they were not eligible for MACRA's participation bonus.

Chart 5-5 The size of A–APM participation bonuses varied widely, 2023



Note: A–APM (advanced alternative payment model). Figure shows MedPAC's estimates of the median bonus amount at different deciles in the 2023 payment year. Bonuses were calculated based on A–APM participation from two years prior (2021) and Medicare payments from one year prior (2022). Bonuses totaled $607 million in our analysis, which is lower than the $644 million that CMS reported paying out in 2023 (Centers for Medicare & Medicaid Services 2023). Our estimates are slight underestimates of bonus sizes primarily because, when calculating bonuses, we did not include supplemental service payments that clinicians receive through A–APMs (e.g., capitated care-management fees).

Source: MedPAC analysis of CMS data identifying the national provider identifiers of clinicians who qualified for the A–APM participation bonus linked to 100 percent of physician fee schedule claims.

> The size of A–APM participation bonuses varies based on a clinician's total annual fee-for-service (FFS) Medicare payments for physician fee schedule services. By our estimates, the median size of all bonus payments in 2023 (when it was 5 percent of a clinician's fee schedule payments) was $1,287 (data not shown).

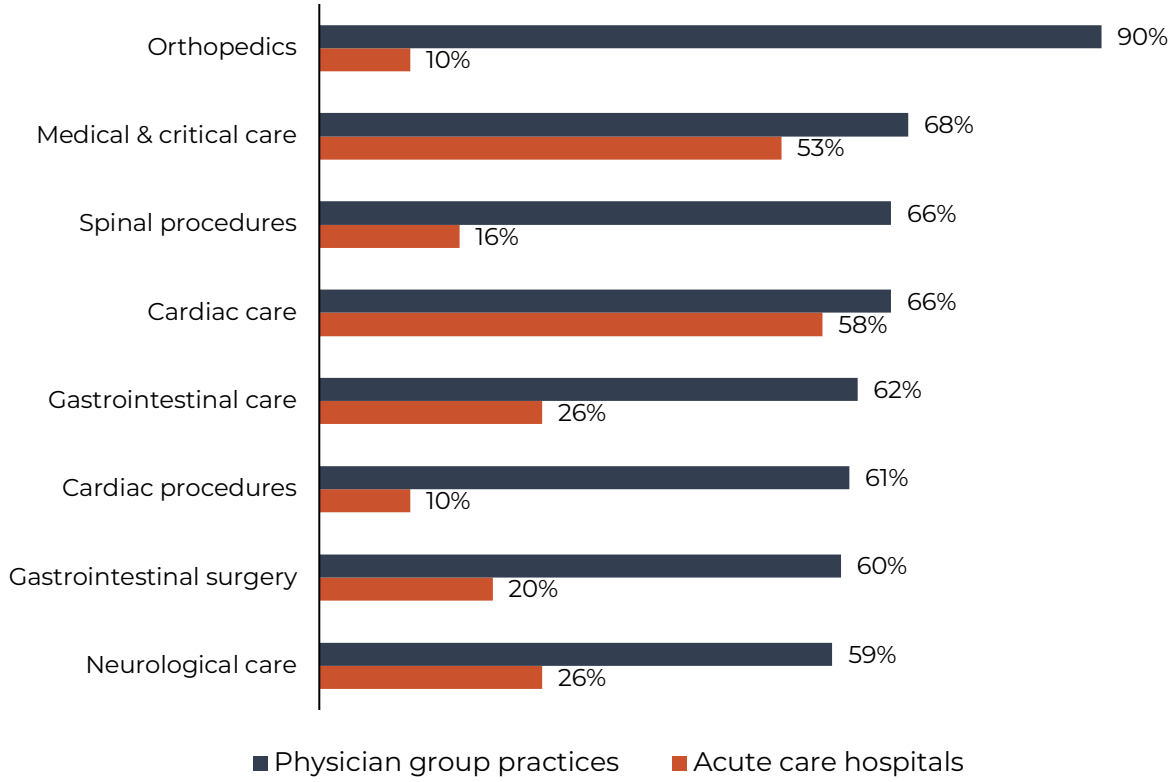
> Among the 10 percent of clinicians who received the smallest bonus, the median bonus was $31; among the 10 percent of clinicians who received the largest bonus, the median bonus was $9,833.

> Because of "incident to" billing rules, which allow physicians to bill for services furnished by advanced practice registered nurses (APRNs) and physician assistants (PAs), bonuses paid to a single physician may be partly based on services performed by these other types of clinicians.

> Specialists received larger A–APM participation bonuses than primary care physicians, APRNs and PAs, and other clinicians in 2023 because specialists tend to generate more annual FFS Medicare payments than other types of clinicians (not shown).

> All clinicians in advanced payment models are also eligible for payments available through these models (e.g., shared savings payments), which are not shown here.

Chart 5-6 Share of BPCI Advanced episode initiators accepting responsibility for each clinical-episode group, 2025



Note: BPCI (Bundled Payments for Care Improvement). BPCI Advanced participants can accept episode-based payments for multiple clinical-episode service-line groups. Some participants work with other acute care hospitals or physician group practices to initiate and manage episodes. The denominators for each group are 105 episode initiators among physician group practices and 103 episode initiators among acute care hospitals in 2025.

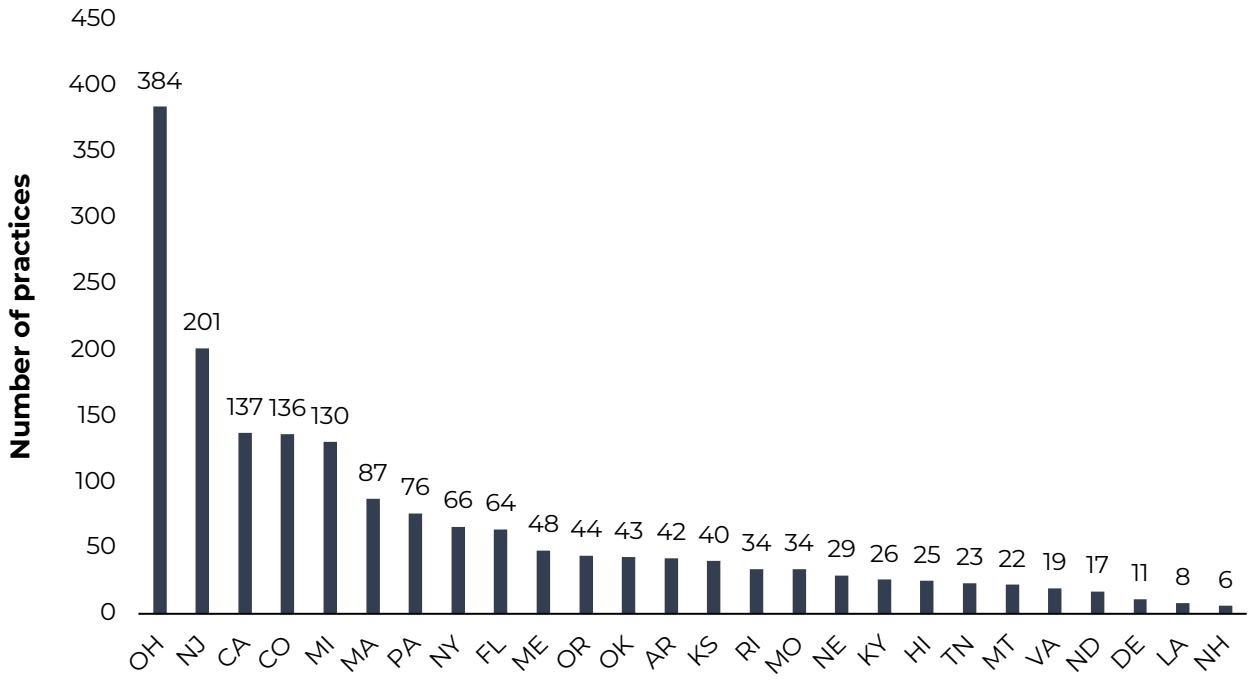
Source: List of clinical-episode service-line groups that each BPCI Advanced participating episode initiator agreed to take financial responsibility for in Model Year 8 (2025), downloaded from CMS's BPCI Advanced webpage (https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced).

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

> Among the 105 physician practices that initiate episodes in the model, 90 percent initiate episodes in the orthopedics service-line group, while 59 percent initiated episodes in the neurology care service line. Among participating hospitals, there is more variation. Of the 103 acute care hospitals that initiate episodes, 58 percent initiated episodes in the cardiac care service line, but only 10 percent initiated episodes in the orthopedics and cardiac procedure groups.

> Almost 60 percent of physician practices in the model initiate episodes in all eight service-line groups in 2025, which is substantially less than the 80 percent of practices that initiated episodes in all service-line groups in 2023 (data not shown). In 2025, no acute care hospitals initiated episodes in all eight service-line groups, and 90 percent initiated episodes in fewer than four service-line groups (data not shown).

Chart 5-7 About 1,750 practices in 26 states are testing the Primary Care First Model, 2025



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 as of March 2025 (https://innovation.cms.gov/innovation-models/primary-care-first-model-options).

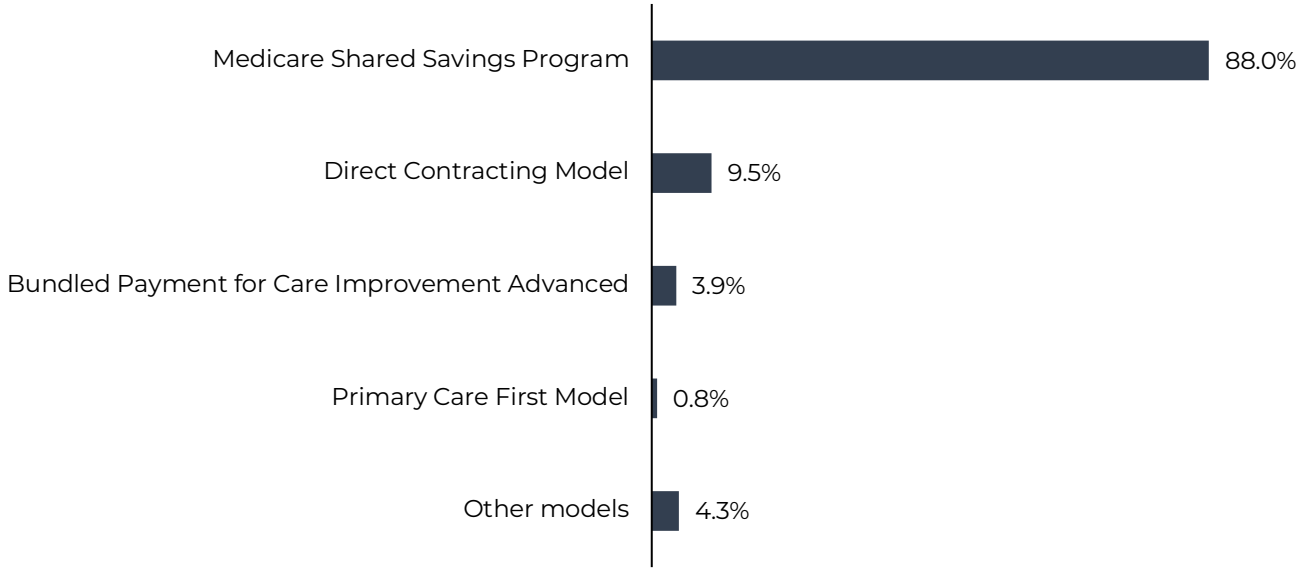
> CMS's Primary Care First is an advanced alternative payment model that has just over 1,750 participating practices in 26 states in 2025 (its final year). Substantially fewer practices participated in the model in 2025 than 2024, when participation was about 2,200 (data not shown).

> 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.

> Participants are highly concentrated in just a few states. Roughly 40 percent of practices in Primary Care First are located in three states (Ohio, New Jersey, and California), while 10 percent of participants are in 10 states (Nebraska, Kentucky, Hawaii, Tennessee, Montana, Virginia, North Dakota, Delaware, Louisiana, and New Hampshire).

Chart 5-8 Almost 90 percent of the clinicians who qualified for a 5 percent A–APM bonus in 2024 were in the Medicare Shared Savings Program



Note: A–APM (advanced alternative payment model). Clinicians' 2022 A–APM participation determined their 2024 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 2024, clinicians had to receive 50 percent of their payments for professional services or provide 35 percent of their patients with professional services through an A–APM in 2022. The A–APM bonus is equal to 5 percent of the payments a clinician receives for their 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, Kidney Care Choices Model, Oncology Care Model, and Vermont Accountable Care Organization 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 2024 are based on clinicians' 2022 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. Those 5 percent bonus payments have been available from 2019 to 2024. A–APM bonuses for qualifying clinicians will equal 3.5 percent of professional service payments in 2025 and 1.88 percent in 2026.

> In 2024, nearly 384,000 clinicians nationwide qualified for the A–APM bonus (based on 2022 A–APM participation) out of about 1.3 million who billed the Medicare physician fee schedule (data not shown). More than 95 percent of clinicians who qualified for an A–APM bonus participated in at least one of the ACO initiatives administered by CMS, which gives 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 2024, 37 percent were specialists, 23 percent were primary care physicians, and 40 percent were nonphysician practitioners such as nurse practitioners or physician assistants (data not shown).