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Advising the Congress on Medicare issues

Considering the participation bonus for clinicians in advanced alternative payment models

Rachel Burton, Luis Serna, Pamina Mejia

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Presentation roadmap

1. Advanced alternative payment models
2. Has the bonus influenced participation in A-APMs?
3. New policies may alter the A-APM landscape
4. Discussion

Advanced alternative payment models

Alternative payment models try to counteract the physician fee schedule's volume incentives

- Physician fee schedule creates incentives to increase volume
- APMs try to counteract this incentive by offering additional payments:
  - For example, "shared savings" if clinicians keep patients' spending below a target amount while meeting quality targets
- Clinicians in an APM can also incur a financial loss if:
  - They owe a penalty due to poor performance (e.g., "shared losses")
  - They make infrastructure investments (e.g., hire new care coordinators) but then fail to qualify for a performance bonus

Note: APM (alternative payment model).

Most alternative payment models have generated promising results but not net savings

- Clinicians in APMs often change the mix and/or quantity of services they deliver
  - APM entities usually maintain or improve performance on quality measures
- APMs often generate *gross* savings, but usually fail to produce *net* savings once new payments in APMs are included
- Estimates of the net spending effects of APMs do not include:
  - Spending impacts on MA
    - When a model causes FFS spending to increase, it increases the FFS spending benchmarks that MA plans bid against, which ends up raising MA spending
  - Spending on the A–APM participation bonus ($3.3 billion to date)
    - Estimates of savings would be more accurate if spending on this bonus were included

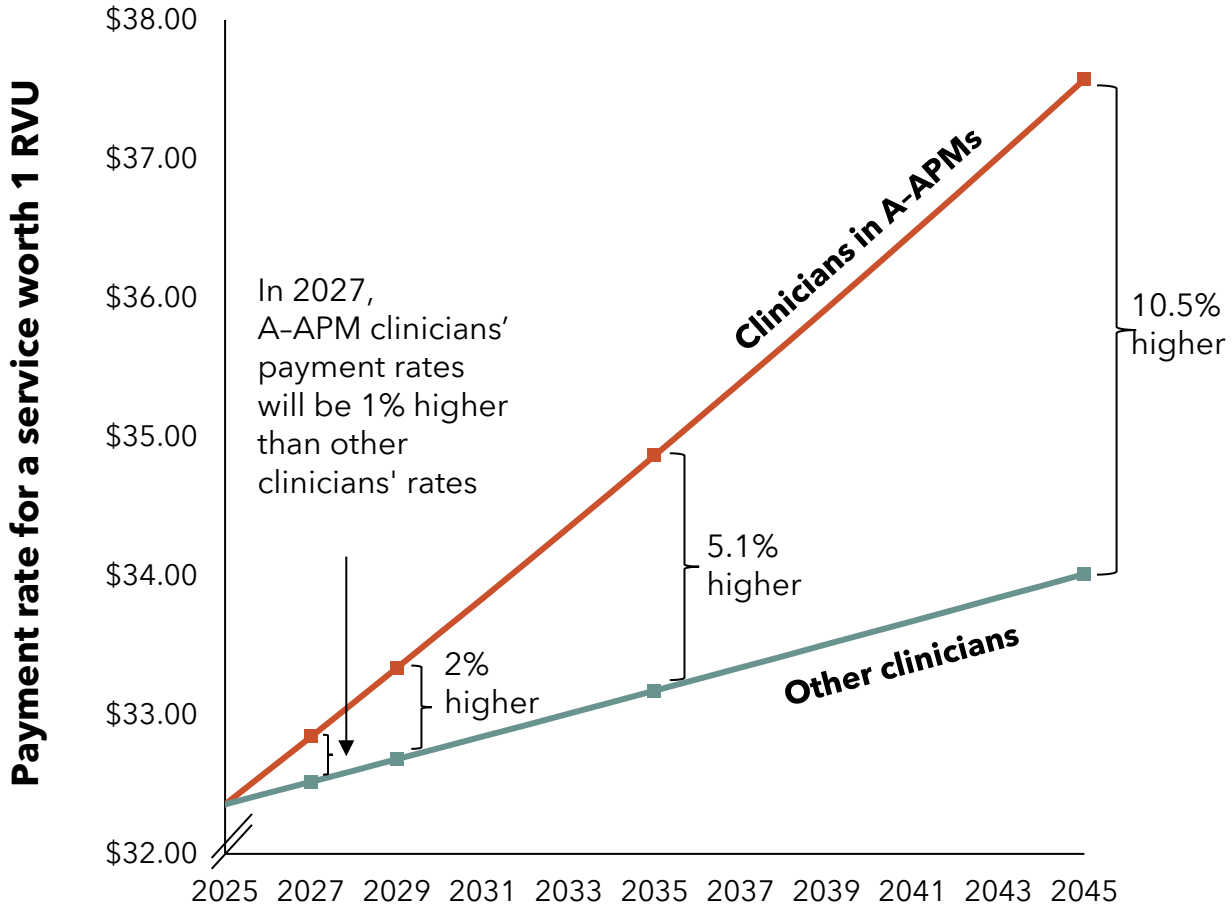
Note: APM (alternative payment model), MA (Medicare Advantage), FFS (fee-for-service).
Source: Congressional Budget Office. (2023). *Federal budgetary effects of the activities of the Center for Medicare & Medicaid Innovation*; Medicare Payment Advisory Commission. (2021). Streamlining CMS's portfolio of alternative payment models. *Report to the Congress: Medicare and the Health Care Delivery System*; Smith, B. (2021). CMS Innovation Center at 10 years: Progress and lessons learned. *New England Journal of Medicine*.

MACRA currently incentivizes A–APM participation through a participation bonus and exemption from MIPS

- Clinicians in "advanced" APMs (A–APMs) are eligible to receive a participation bonus worth:
  - 5% of their fee schedule payments in 2019–2024
  - 3.5% in 2025
  - 1.88% in 2026
- Exempt from MIPS adjustments to payment rates
  - Size of adjustments (+/–) is based on performance on MIPS measures
  - Highest MIPS adjustment has usually (+2%) been less than A–APM bonus (+5%)
  - CMS paid out $500M more in positive adjustments than it collected in negative adjustments in 2019–2024; adjustments will be budget neutral starting in 2025

Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A–APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System). The A–APM participation bonus is calculated as a share of Medicare payments for physician fee schedule services, Method II critical access hospital payments, and A–APM supplemental service payments. Payments that are excluded from this calculation are payments for services furnished in rural health clinics or federally qualified health centers, health professional shortage area bonuses, A–APM financial risk payments, A–APM cash-flow mechanism payments, and beneficiaries' cost-sharing liability.

Starting in 2026, MACRA incentivizes A–APM participation through higher fee schedule payment rates



- Differential updates for clinicians in A–APMs vs. others (0.75% vs. 0.25%) will produce incentives to participate in A–APMs that grow over time:
  - 2020s: Very small incentive
  - 2040s: Very large incentive

Note: MACRA (Medicare Access and CHIP Reauthorization Act of 2015), A–APM (advanced alternative payment model), RVU (relative value unit). Graph does not show expiration of 2% sequester.

Source: MedPAC analysis of current law.

Payment incentives should work in harmony to promote efficient, high-quality care

- Payment incentives in A–APMs, MIPS, fee schedule, and so forth, should all send consistent signals encouraging efficient, high-quality care
- To date, A–APM participation has been incentivized by payments in A–APMs themselves, the participation bonus, and low MIPS adjustments for non-A–APM participants
- Given the impending expiration of the participation bonus, the Commission has discussed (in June 2024) extending the bonus
- Objective: To avoid creating an incentive for clinicians to prefer MIPS over A–APMs

Note: MIPS (Merit-based Incentive Payment System), A–APM (advanced alternative payment model).
Source: Medicare Payment Advisory Commission. (2024). *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

If the bonus is extended, it could be restructured—which could solve some problems but introduce others

Approach 1

Calculate the bonus as a share of a clinician's A–APM payments and eliminate the requirement that a certain share of a clinician's payments or patients be attributed to them through A–APMs

- ✓ Would expand the availability of the bonus to all clinicians in A–APMs (especially specialists in episode-based payment models)
- ✘ Would reduce the size of the bonus for current recipients
- ✘ Would be more difficult to determine how A–APM participation bonus compares with MIPS (would no longer both be calculated as a share of a clinician's physician fee schedule payments)

Note: A–APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).
Source: Medicare Payment Advisory Commission. (2024). Approaches for updating clinician payments and incentivizing participation in alternative payments models. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

If the bonus is extended, it could be restructured—which could solve some problems but introduce others

Approach 2

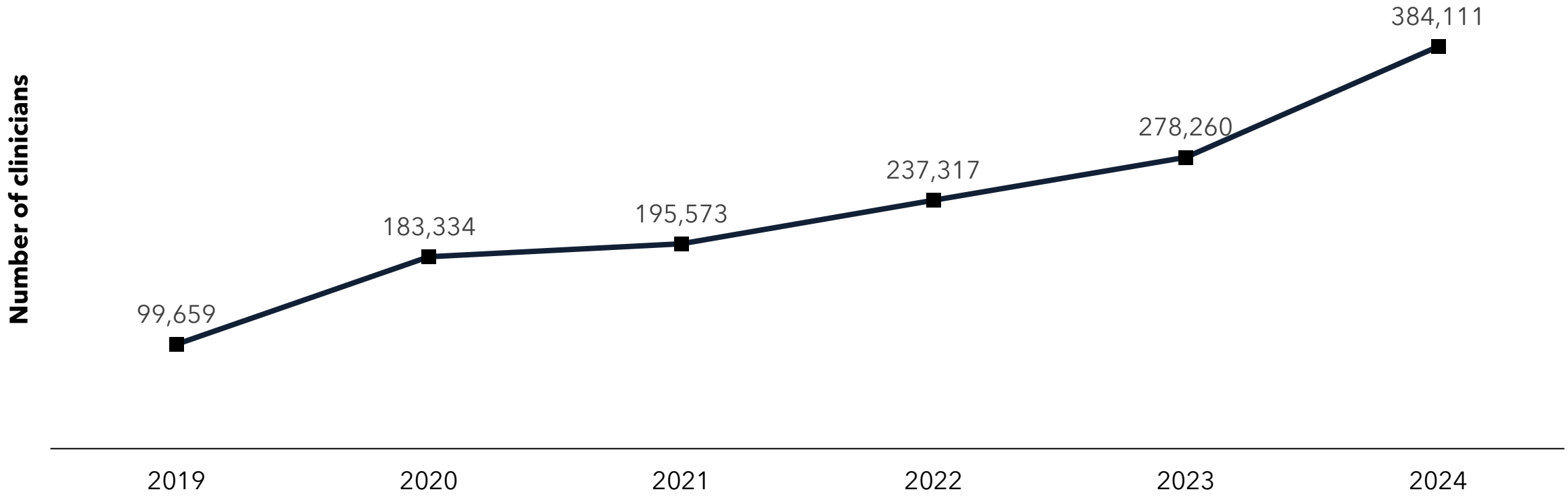
Calculate the bonus as a flat (risk-adjusted) payment for each beneficiary attributed to a clinician through an A–APM and eliminate the requirement that a certain share of a clinician's payments or patients be attributed to them through A–APMs

- ✓ Would remove the bonus's volume incentive
- ✗ Would result in most specialists losing access to the bonus
- ✗ Would be more difficult to determine how A–APM participation bonus compares with MIPS (would no longer both be calculated as a share of a clinician's physician fee schedule payments)

Note: A–APM (advanced alternative payment model), MIPS (Merit-based Incentive Payment System).
Source: "Considering approaches for updating the Medicare physician fee schedule," session at MedPAC's April 2024 meeting.

Has the bonus influenced participation in A-APMs?

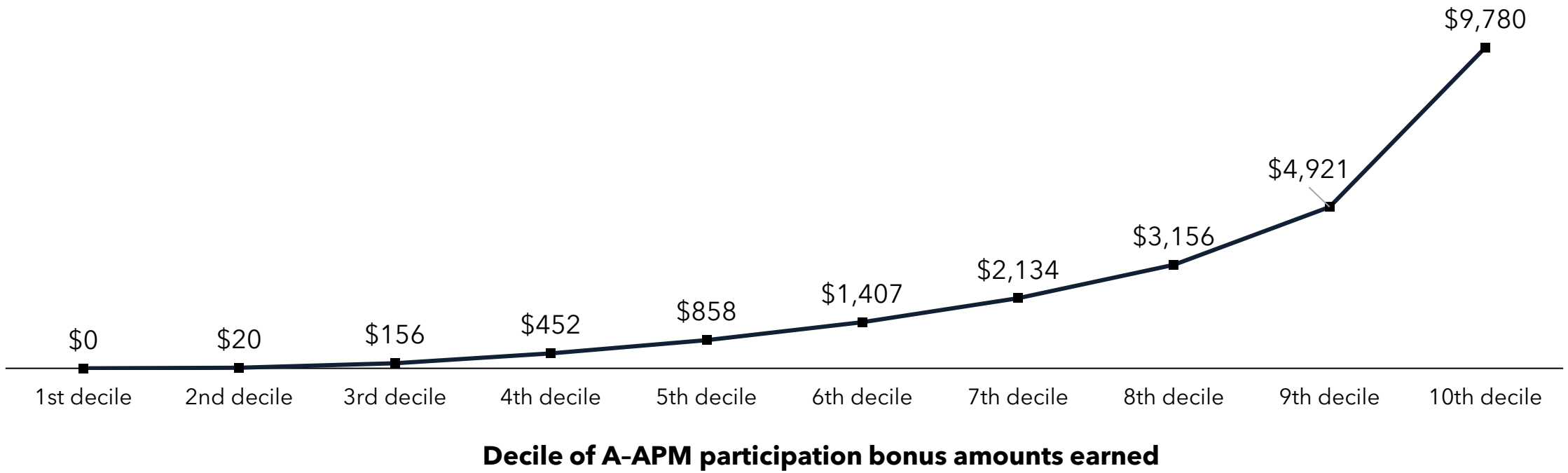
An increasing number of clinicians have qualified for the A–APM participation bonus over time



Note: A–APM (advanced alternative payment model). Figure reflects the number of clinicians who qualified for the bonus in a given year based on their A–APM participation 2 years prior. As a point of reference, 1.1 million clinicians billed Medicare for more than 15 fee-for-service beneficiaries in 2022. In all years shown, the bonus was worth 5% of a clinician's Medicare fee schedule payments.

Source: MedPAC analysis of CMS data identifying actual A–APM participation bonus amounts earned.

For many clinicians, the A–APM participation bonus is worth a relatively small amount, 2022



Note: A–APM (advanced alternative payment model). Figure shows the median bonus amount earned at different deciles in the 2022 payment year (reflecting A–APM participation in 2020). A bonus worth $0 indicates that a clinician generated no Medicare payments in 2021, which was the year used to calculate 2022 bonuses. Although some bonus amounts appear large in this figure, we caution that larger bonuses may reflect physicians who submitted claims on behalf of themselves plus other clinicians, such as advanced practice registered nurses and physician assistants who provide services "incident to" the physician's services. These bonuses may be shared among multiple clinicians.

Source: MedPAC analysis of CMS data identifying actual A–APM participation bonus amounts earned.

The A-APM participation bonus is larger than estimated payments for most clinicians in MSSP

Note: A–APM (advanced alternative payment model), MSSP (Medicare Shared Savings Program). "Shared savings" refers to shared savings paid by CMS to an accountable care organization (ACO) that were then distributed to a participating clinician after the ACO deducted administrative costs and profit. We assume primary care physicians receive much larger shared savings payments from their ACOs than other types of clinicians. Analysis is restricted to clinicians in bonus-eligible tracks of MSSP (i.e., that involve more than a nominal amount of financial risk). MSSP is the A–APM that 88% of A–APM bonus recipients are in.

Source: MedPAC analysis of actual A–APM participation bonuses earned in 2024 combined with MSSP shared savings data from 2022.

In MSSP, the A-APM bonus is larger than estimated shared savings for most non-primary care physicians

Primary care physicians

A-APM bonus > shared savings

The bonus may not be the main factor influencing primary care physicians' A-APM participation decisions . . .

All other types of clinicians

A-APM bonus > shared savings

. . . but it may be influencing other types of clinicians' A-APM participation decisions

Note: MSSP (Medicare Shared Savings Program), A-APM (advanced alternative payment model). "Shared savings" refers to shared savings paid by CMS to an accountable care organization (ACO) that were then distributed to a participating clinician after the ACO deducted administrative costs and profit. We assume primary care physicians receive much larger shared savings payments from their ACOs than other types of clinicians. Analysis is restricted to clinicians in bonus-eligible tracks of MSSP (i.e., that involve more than a nominal amount of financial risk). MSSP is the A-APM that 88% of A-APM bonus recipients are in.

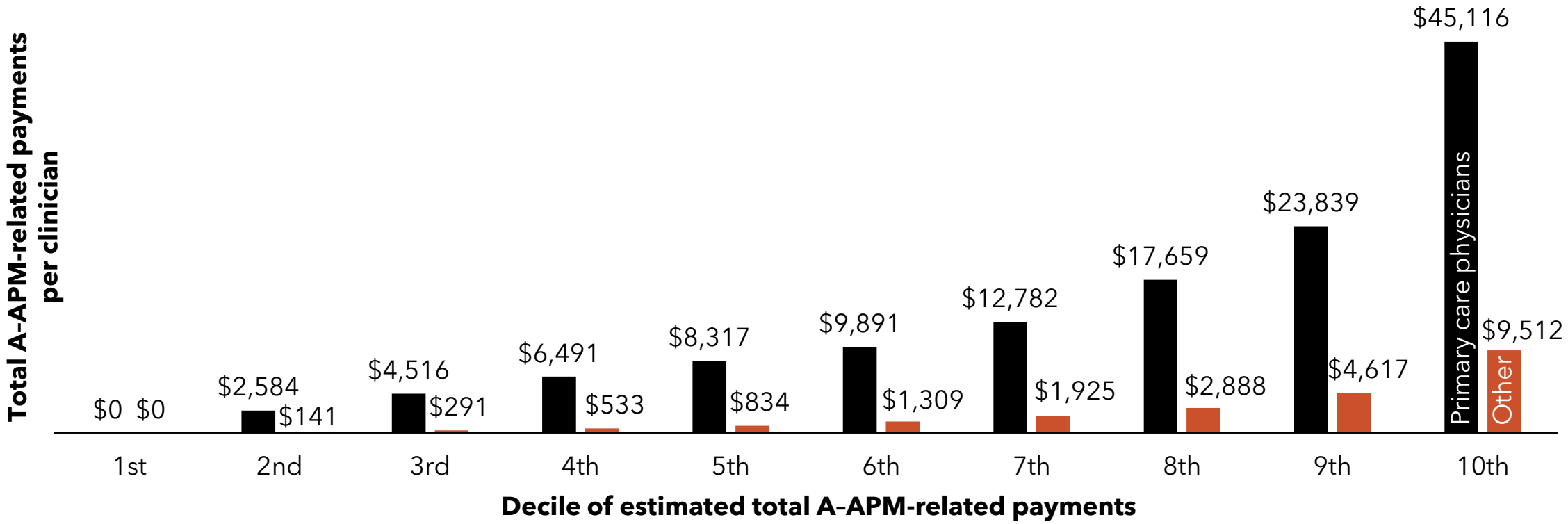
Source: MedPAC analysis of actual A-APM participation bonuses earned in 2024 combined with MSSP shared savings data from 2022.

Lower bonuses would have been larger than many MSSP clinicians' estimated shared savings payments

Note: MSSP (Medicare Shared Savings Program), A–APM (advanced alternative payment model). "Shared savings" refers to our estimate of the shared savings paid by CMS to an accountable care organization (ACO) that were then distributed to a participating clinician, after the ACO deducted administrative costs and profit. We assume primary care physicians receive much larger shared savings payments from their ACOs than other types of clinicians. Analysis is restricted to clinicians in bonus-eligible tracks of MSSP (i.e., that involve more than a nominal amount of financial risk). MSSP is the A–APM that 88% of A–APM bonus recipients are in.

Source: MedPAC analysis of actual A–APM participation bonuses earned in 2024 combined with MSSP shared savings data from 2022.

Total estimated A-APM incentive payments are relatively small for non-primary care physicians



Note: A-APM (advanced alternative payment model). "A-APM-related payments" refers to the shared savings we estimate were paid from an ACO to a clinician plus the clinician's A-APM participation bonus.

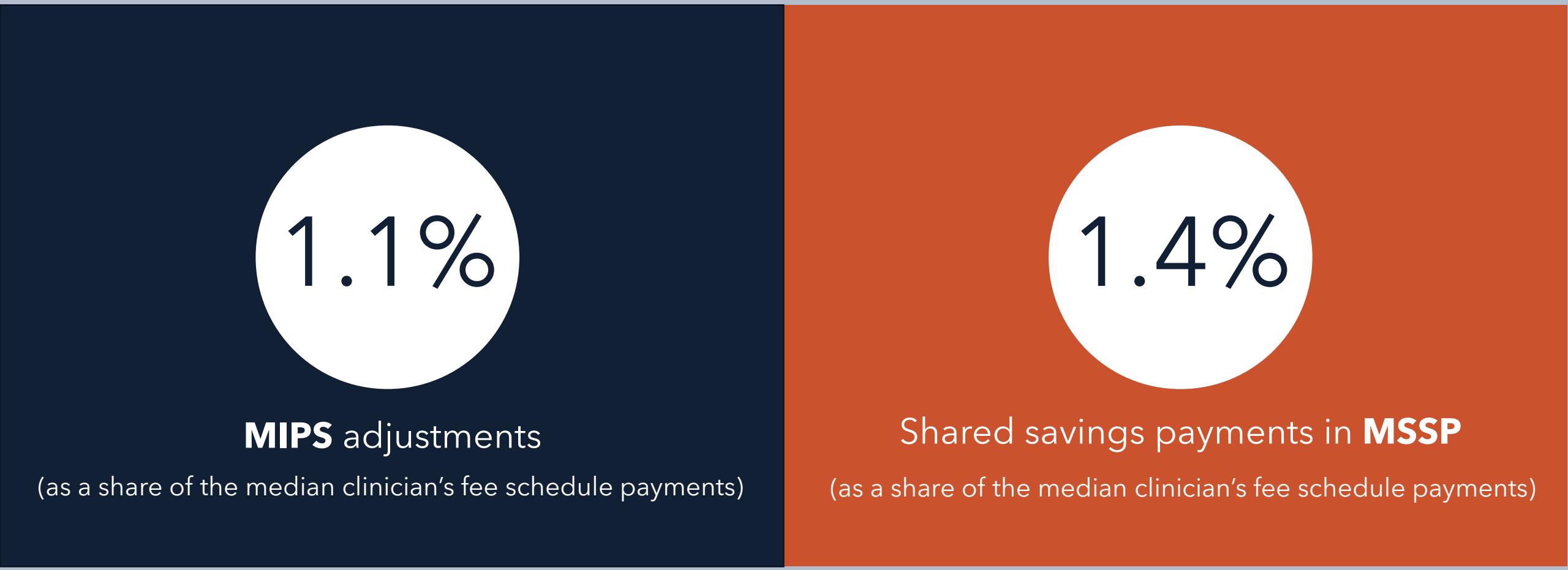
Source: MedPAC analysis of actual A-APM participation bonuses earned in 2024 combined with MSSP shared savings data from 2022.

In focus groups, clinicians participating in ACOs described reasons for joining

- To obtain additional revenue and positive outcomes
- To ensure they continued to receive referrals from primary care providers who had joined an ACO
- To access data analytics on their patients, such as which patients are due for a visit
- To learn how to succeed in a value-based contract, which they viewed as "the future of health care"

Note: ACO (accountable care organization).
Source: MedPAC-sponsored focus groups of clinicians conducted by NORC at the University of Chicago in 2023 and 2024.

MSSP yields higher payments for clinicians than MIPS, even without the A–APM participation bonus



Note: MSSP (Medicare Shared Savings Program), MIPS (Merit-based Incentive Payment System), A–APM (advanced alternative payment model). Analysis restricted to clinicians in bonus-eligible tracks of MSSP. We imputed MIPS scores for clinicians who qualified for the A–APM participation bonus by assigning them the MIPS score awarded to other clinicians in their ACO since MIPS scores can be calculated at the ACO level. We show estimated MIPS adjustments for 2024 (a year with unusually high MIPS adjustments, up to 8.26%) and estimated shared savings payments for 2022 (the most recent data available).

Source: MedPAC analysis of MIPS payment adjustments, A–APM participation bonuses, MSSP participant lists, and MSSP financial performance data.

The A–APM participation bonus does not help clinicians who lack access to an A–APM

- Most A–APMs are available only in certain areas of the U.S. and are geared toward a handful of specialties
- MSSP is available nationwide, but MSSP ACOs now have an incentive to recruit clinicians with low risk-adjusted spending per beneficiary relative to their region
  - In 2023, among ACOs in bonus-eligible MSSP tracks, 90% had risk-adjusted spending that was low for their region
- Clinicians with high risk-adjusted spending per beneficiary likely have difficulty finding an MSSP ACO willing to include them

Note: A–APM (advanced alternative payment model), MSSP (Medicare Shared Savings Program), ACO (accountable care organization). An MSSP ACO's spending benchmark (against which its financial performance is assessed) includes a blend of its past historical spending and the average historical spending in its region. If an ACO is made up entirely of clinicians who treat beneficiaries with below-average risk-adjusted spending, and the ACO does nothing to reduce the spending trajectory of these beneficiaries, the ACO will likely nevertheless qualify for shared savings payments. Thus, ACOs have a strong financial incentive to seek out clinicians with below-average risk-adjusted spending per beneficiary in their area and avoid clinicians with higher-than-average spending.

New policies may alter the A-APM landscape

MIPS adjustments are now projected to be low in the next few years

- CMS has frozen the MIPS performance threshold through payment year 2029
  - Will minimize the number of clinicians who receive negative adjustments
  - Will minimize the size of the highest positive adjustment
- As a result, we now estimate that in the late 2020s, the top MIPS adjustment will be around 2.25% (similar to past years)
- Implication: If the A–APM participation bonus is extended, it would not need to be very large to ensure A–APM-related payments (e.g., shared savings + bonus) are larger than the top MIPS adjustment
- Note: There is high uncertainty around the 2.25% estimate due to MIPS's many moving parts

Note: MIPS (Merit-based Incentive Payment System), A–APM (advanced alternative payment model).

Many specialists may soon be required to participate in an A–APM

- CMS has launched a new episode-based payment model (TEAM), mandatory in a fifth of all towns and cities (2026–2030)
- CMS is contemplating a mandatory A–APM for all specialists in ambulatory settings (possibly as early as 2026)
  - Would phase in specialties over time
  - Would incentivize partnering with clinicians in other A–APMs (PCPs in ACOs)
  - Could obviate the need for the bonus
  - Note: It is unclear when the model will launch, how many specialties will be required to participate initially, and so forth

Note: A–APM (advanced alternative payment model), TEAM (Transforming Episode Accountability Model), PCP (primary care provider), ACO (accountable care organization).

Overall takeaways from these findings and developments

- Considerable uncertainty about:
  - Whether the bonus has influenced participation in A–APMs
  - What programs and policies will be in place in the late 2020s
- Extending the bonus for a few years could guard against attrition in A–APMs; a reassessment of the bonus could be undertaken later
- However, if the number of clinicians in A–APMs continues to grow in 2025 (despite the bonus declining in size), there may be less need for the bonus

Note: A–APM (advanced alternative payment model).

Discussion

Discussion

- Questions for commissioners:
  - Questions about analyses?
  - Feedback on material?

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