Bipartisan Policy Center

The Need for Medicare Part B Physician Payment Reform

Issue Brief #1 of 3

Building on over a decade of policy expertise—including work on Medicare sustainability, chronic care, and health care system improvements—the Bipartisan Policy Center is releasing a three-part series on improving access to high-quality health care in traditional Medicare and restraining long-term Medicare spending by reforming Part B physician payment.

Nearly a decade ago, Congress sought to transform traditional Medicare's physician payments from a volume-based, fee-for-service (FFS) system to a value-based one.[a,b] With overwhelming bipartisan support, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to create incentives for clinicians to shift into value-based payment models (also known as alternative payment models, or APMs) that tie payment to the quality of care provided.

The act's objective was to replace a fee-for-service system that was dually incentivizing excessive service volume and imposing deep, unsustainable payment rate cuts to clinicians. In its place, MACRA attempted to establish a Part B physician payment system that would better align the interests of clinicians, patients, and the Medicare program to ensure high-quality, patient-centered care while constraining excessive cost growth.

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a "Physician payment" includes other eligible clinicians who bill for Part B-covered professional services.

b Under a fee-for-service payment system, clinicians are reimbursed based on the type and number of services rendered.

Unfortunately, MACRA has largely failed to meet its policy goals. Although federal policymakers have made some progress in restructuring Medicare reimbursement for Part B-covered professional services to encourage higher-value care in traditional Medicare, further reforms are needed.

Greater adoption of the most promising alternative payment models—including population-based payments and other models that reward clinicians for taking on significant financial risk—is necessary to improve access to care and quality, as well as to realize long-term cost savings (described below in Patient-First Care: Promising Population-Based Payment Models).[c,1] Despite MACRA's intent to drive participation in alternative payment models, fee-for-service remains the predominant payment model.

Fee-for-service, however, is inherently misaligned with policymakers' efforts to encourage high-quality care at lower cost to Medicare. Moreover, it rewards clinicians for delivering a high volume of expensive services regardless of their value to the patient. As most physicians (78%) are now employed by hospitals/ health systems or corporate entities, this incentive to furnish more services is potentially amplified.[2]

In contrast, alternative payment models seek to hold clinicians accountable for delivering high-quality care while providing them with greater flexibility to render high-value services that can reduce the total cost of care. These services include consulting with other clinicians, coordinating care across providers, responding to communications from patients, educating patients on their health conditions or health risk factors, and addressing health-related social needs.

Under the current system, clinicians have far greater incentives to participate in fee-for-service than in alternative payment models, which typically require initial investments and changes to clinical and administrative processes before clinicians can experience greater flexibility in delivering care and earn financial rewards. MACRA also created excessive quality reporting burdens on clinicians, further adding to the attractiveness of fee-for-service.

Examining the processes for valuing Medicare's physician fee schedule services is an important part of broader efforts to transform Part B payments to clinicians, as many alternative payment models are still based on a fee-for-service reimbursement structure and are thus affected by physicians' fee schedule rates. As currently structured, MACRA's formula consistently yields unworkable cuts to physicians' payments, forcing Congress to intervene each year since 2021.

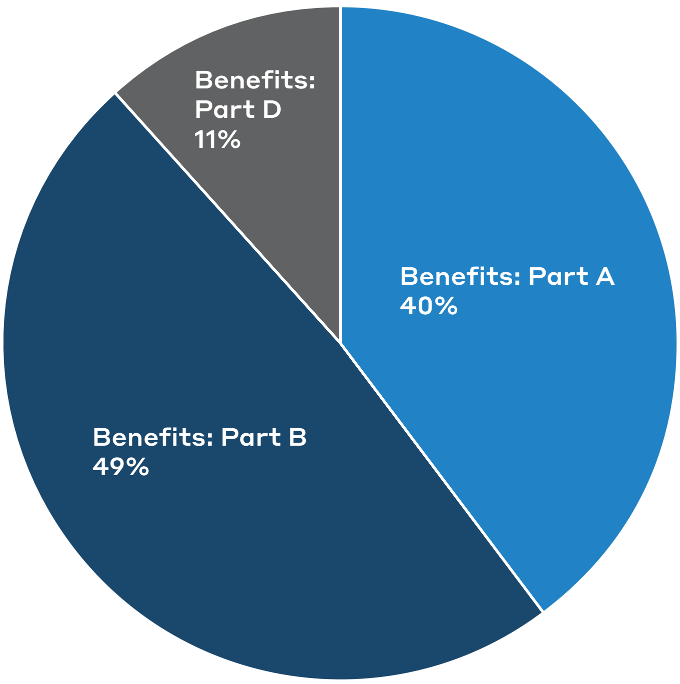
As described below, MACRA's scheduled, fixed updates to fee schedule payment rates, combined with the rising cost of providing health services, often trigger payment cuts because of current law requirements that any changes to the rates be budget

c Population-based payments are prospective (typically risk-adjusted) payments to clinicians that cover health care services and activities for a defined population over a specified time period (e.g., per member, per month). These payments typically replace all or some portion of standard fee schedule payments (i.e., through full or global capitation, partial capitation, or capitation-like payments).

neutral.[d,3,4] Despite Congress's annual interventions, clinicians' costs are projected to continue exceeding the growth in fee schedule payment rates through 2033.[5] This patchwork approach, however, is unsustainable from a fiscal and policy perspective, because the yearly temporary fixes require both an annual increase in federal spending relative to the baseline and potential budgetary offsets.

Without change, according to Congressional Budget Office projections, Medicare Part B benefits spending—which includes not only physicians' services but also other services and supplies, such as outpatient hospital services, laboratory services, some home health services, durable medical equipment, and physician-administered drugs—will increase about 9% annually from $500 billion in 2023 to $1.17 trillion in 2034.[6] Medicare Part B accounted for nearly half (about 49%) of total Medicare benefit spending in 2023, making it the largest share of spending among Medicare Parts A, B, and D.[7] See Figure 1. Part B spending alone has increased nearly 80% since 2011, far outpacing growth in both Parts A and D spending and inflation over the same period.[e,8,9,10,11]

Figure 1: Medicare Mandatory Benefit Outlays, 2023



Note: Part A and Part B both include mandatory outlays to Medicare Part C/Medicare Advantage to cover Part A and Part B benefits.
Source: Congressional Budget Office, "Baseline Projections," June 2024. Available at: https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf.

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d Physician fee schedule payment rates are generally based on the resources needed to furnish the service. For each service, CMS establishes relative value units (RVUs)—for work (i.e., time and intensity), practice expense (PE), and malpractice (MP)—which are each adjusted for geographic cost variations. A conversion factor (CF) is used to convert these relative values into payment rates. Payment rates are further adjusted by certain modifiers or other adjustments established in law. The CF is typically reduced when budget neutrality is triggered, resulting in payment cuts.

e Part A covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health. Part D covers prescription drugs.

Rising costs are also increasing the financial burden for beneficiaries. The standard monthly premium for Part B increased nearly 6% annually from $105 in 2015 to $185 in 2025, while the annual deductible increased at roughly the same rate from $147 to $257 over the same period.[12,13]

There is little evidence that this spending has produced meaningful improvements in care quality or patient outcomes for traditional Medicare's 33.4 million beneficiaries.[14] In fact, clinician shortages continue to limit patients' access to care—including primary care, behavioral health, direct care, and care in rural or underserved areas. Payment challenges are contributing to the problem.[15,16,17,18] In addition, the number of Medicare beneficiaries and the services they require, along with the intensity of their care, are all growing. These alarming trends underscore the urgent need for bipartisan policy reforms to optimize care access and value in traditional Medicare.

As concerns about the physician payment system mount, both Republicans and Democrats have signaled their commitment to further reform. Congress and the Trump administration now have an opportunity to make impactful changes and achieve the goals set nearly 10 years ago.

To support policymakers' efforts, this issue brief outlines the relevant legislative history of physician payment reforms, the current legislative and regulatory landscape, and the challenges and opportunities that federal policymakers are expected to address. It also highlights the need to accelerate clinicians' participation in the most promising alternative payment models.

BPC's second and third issue briefs will identify key barriers to accelerating clinicians' participation in APMs and outline bipartisan federal policy reforms to enhance their participation. Some of these reforms will likely require federal investment up-front if they are to succeed in shifting clinicians into sustainable, alternative payment models that reward them for delivering high quality care at lower cost to Medicare. They might also require some positive reduced cost-sharing incentives to encourage Medicare beneficiaries to participate more exclusively in these models. Federal policymakers should offset any federal costs associated with these payment reforms to achieve budget neutrality.

LEGISLATIVE HISTORY

Federal policymakers have long grappled with how best to value and pay for Part B-covered professional services in a way that supports access to care and is fiscally responsible. Before MACRA, a statutory formula known as the Sustainable Growth Rate (SGR) determined annual updates to the payment rate under Medicare's physician fee schedule. This flawed formula limited the fee schedule's spending growth based on such factors as per capita gross domestic product. Escalating annual cuts to physicians' payments followed, forcing Congress to make an annual "doc fix" that ensured payment rates remained adequate to preserve beneficiaries' access to care.

Accordingly, MACRA replaced the problematic SGR formula with statutorily set annual updates to Medicare's physician fee schedule payment rates. The law also consolidated several payment and performance programs into a new Quality Payment Program (QPP), which financially incentivizes clinicians to deliver high-quality care through alternative payment models. Eligible Part B clinicians must participate in one of the QPP's two pathways: (1) the Merit-based Incentive Payment System program (MIPS) or (2) Advanced APMs. Although Medicare law requires that both pathways tie payments to quality of care in different ways, MIPS requires less accountability for care quality and costs compared to the Advanced APM pathway, which requires clinician participants to take on significant financial risk.

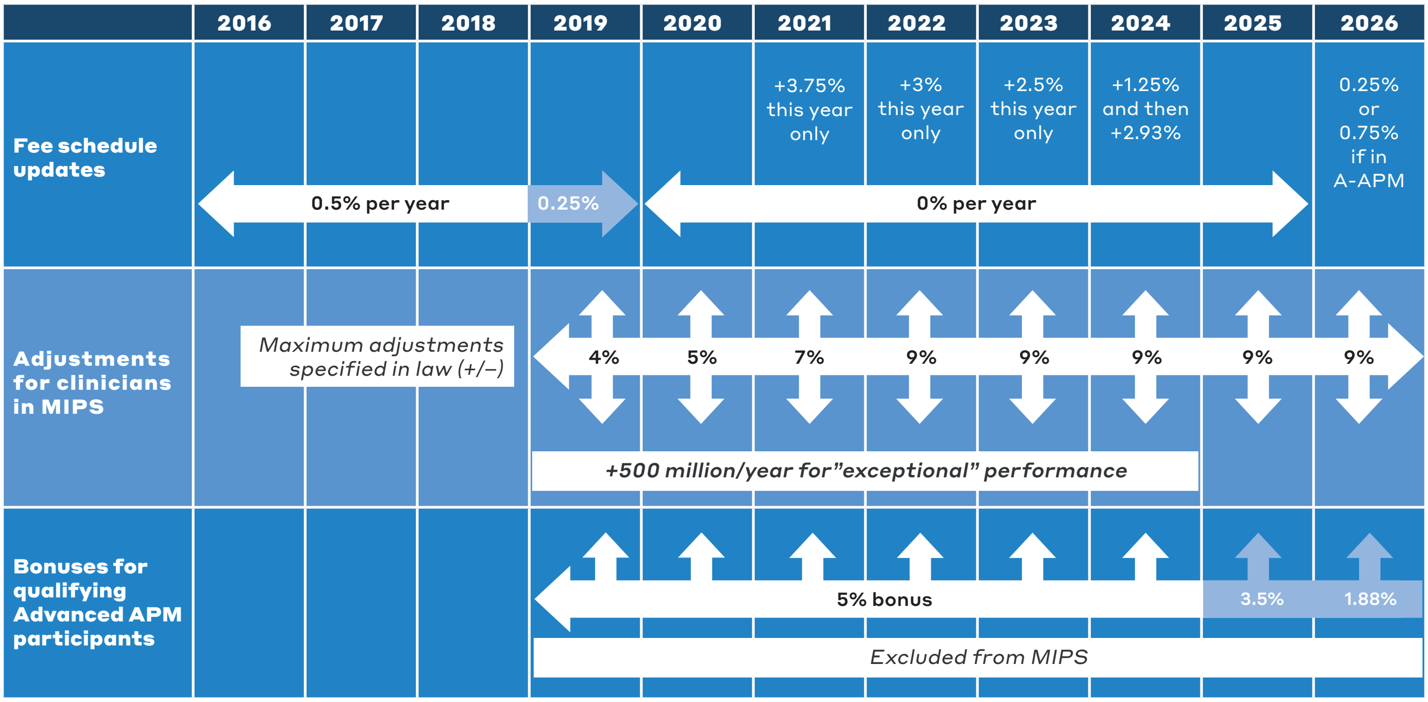
Through the physician fee schedule payment rate updates and QPP, MACRA attempted to financially *disincentivize* clinicians from remaining in models with little to no accountability, including traditional fee-for-service and MIPS. MACRA initially provided all clinicians with a 0.5% increase in the fee schedule rates from 2015–2019, but no annual increases in the rates from 2020–2025. It also established lower rate updates for clinicians remaining in traditional FFS or MIPS in later years.[f] Beginning in 2026, these clinicians will receive only a 0.25% rate increase; qualifying Advanced APM participants will get triple that (0.75%).[19]

As discussed above, Congress has temporarily increased the payment rate update each year since 2021 to offset cuts resulting from the budget neutrality requirement. This requirement was triggered by increases to certain billing codes and a new add-on payment.[20] Some stakeholders, including clinicians and the Medicare Payment Advisory Commission (MedPAC), have raised concerns about MACRA's fixed updates to the fee schedule rates, given practices' rising costs and the need for annual congressional intervention.[21]

MACRA also incentivized Advanced APM participation by providing a bonus payment of 5% of a qualifying clinician's Medicare payments for fee schedule services. Congress has since extended this bonus—although at reduced levels—through 2026.[22] See Figure 2.

f Congress passed subsequent legislation that reduced the payment rate update to 0.25% in 2019.

Figure 2: Medicare Physician Fee Schedule Updates, MIPS Adjustments, and Advanced APM Bonuses Under Current Law



Note: Changes to MACRA's original provisions are shown in light blue. In 2024, rates were updated by 1.25 percent through March 8, 2024, and then are updated by 2.93 percent from March 9, 2024, through December 31, 2024. MIPS adjustments to payment rates can be positive, neutral, or negative. The highest MIPS adjustment actually paid out so far has been lower than the maximum possible under law (+1.9 percent in 2019, +1.7 percent in 2020, +1.8 percent in 2021, +1.9 percent in 2022, and +2.3 percent in 2023). The Advanced APM participation bonus is not available after 2026. MIPS adjustments and the Advanced APM participation bonus apply for only one year at a time and are not built into subsequent years' payment rates. Since the fee schedule updates for 2021 through 2024 apply for one year only and in most years decline in size from one year to the next, they have generally had the effect of slowly lowering the fee schedule's conversion factor. The conversion factor needed to be lowered to offset a large increase to the payment rates for a widely used set of billing codes for office/outpatient evaluation and management visits, which took effect in 2021.
Source: MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," June 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf.

Qualifying Advanced APM participants receive their bonus payment two years after the performance year. This means that performance year 2022 was the last year in which participants could earn the full 5% Advanced APM bonus payment, which expired in 2024.[23] Similarly, performance year 2024 was the last year to earn the 1.88% bonus, which will be paid in 2026. Clinicians who participate in an Advanced APM in 2025 or later cannot earn a participation bonus payment under current law.

The declining bonus payment under MACRA for qualifying Advanced APM participants—and its expiration—weakens a key financial incentive for participation in this model. This could result in clinicians exiting or not entering Advanced APMs, despite their greater potential to improve care quality and control costs compared with MIPS and traditional FFS.

CONGRESSIONAL ACTION EXPECTED

Reforming Medicare's physician fee schedule to ensure sustainable, accurate payment and appropriate incentives for participating in Advanced APMs will likely be a central focus of MACRA reform discussions in Congress in 2025 and beyond. As such, identifying strategies to address these and other issues in a way that enhances the program and maintains fiscal responsibility will be essential to advancing bipartisan policy solutions.

Congressional Republicans and Democrats have expressed concerns about the shortcomings of the current system and shown considerable interest in bipartisan efforts to increase the adoption of Advanced APMs. Over the past year, congressional committees with jurisdiction over Medicare have held hearings highlighting the need for reforming Medicare Part B physician payment.[24,25,26] Additionally, a bipartisan group of senators—Marsha Blackburn (R-TN), John Thune (R-SD), John Barrasso (R-WY), Debbie Stabenow (D-MI), Mark Warner (D-VA), and Catherine Cortez Masto (D-NV)—formed a working group to advance long-term reforms to the fee schedule and further updates to MACRA.[27]

Other bipartisan efforts include a white paper released by Senate Finance Committee Chairman Mike Crapo (R-ID) and ranking member Ron Wyden (D-OR) to lay the groundwork for accelerating Part B physician payment reform through legislative and regulatory policy changes. Sens. Sheldon Whitehouse (D-RI) and Bill Cassidy, M.D. (R-LA) introduced the Pay PCPs Act of 2024 and issues a request for information to address primary care access and payment challenges in Part B.[28,29]

Sens. Whitehouse, Barrasso, Cassidy, Blackburn, Thune, Peter Welch (D-VT), and Thom Tillis (R-NC), also introduced a bipartisan bill, the Value in Health Care Act of 2023 (S.3503/H.R.5013), to encourage participation in Advanced APMs and a specific type of alternative payment model known as Accountable Care Organizations (ACOs).[30] See Figure 3.[31] Rep. Darin LaHood (R-IL) introduced a companion bill in the House with 13 Democratic and nine Republican co-sponsors.[32] Provisions include extending the Advanced APM participation bonus by two years, reforming the bonus thresholds, and removing barriers to ACO participation.[33]

In October 2024, Reps. Mariannette Miller-Meeks, M.D. (R-IA) and Jimmy Panetta (D-CA), along with more than 230 Democratic and Republican representatives, signed a letter urging House leadership to find a permanent solution to MACRA's imminent, annual cut to clinicians' reimbursement.[34] Relatedly, the House GOP Doctors Caucus co-chairs—Reps. Brad Wenstrup, D.P.M. (R-OH), Michael Burgess, M.D. (R-TX), and Greg Murphy, M.D. (R-NC)—released a discussion draft of legislation to reform the fee schedule. The proposal includes updating the budget neutrality threshold, reconciling pricing adjustments, and requiring timely updates to direct practice expenses.[35]

Figure 3: Accountable Care Organizations

- ACOs are groups of providers who deliver coordinated, high-quality care and take on financial risk for the ability to share in the savings they achieve for the Medicare program.
- Some ACOs qualify as Advanced APMs, and clinicians can participate in ACOs through the Medicare Shared Savings Program (MSSP) or certain demonstration models under the CMS Innovation Center.

In December 2024, a continuing resolution (H.R.10445) reflecting bipartisan agreement did not advance through Congress, but it notably included a one-year extension of the Advanced APM bonus payment at 3.53%, an extension of the quality payment eligibility thresholds, and a 2.5% temporary payment increase under the fee schedule.[36]

In January 2025, Rep. Vern Buchanan (R-FL), vice chairman of the House Ways and Means Committee and chair of the Health Subcommittee, introduced the bipartisan Healthcare Efficiency Through Flexibility Act. Co-sponsored by Reps. Panetta and Dan Crenshaw (R-TX), the bill addresses digital reporting among accountable care organizations.[37] Additionally, Rep. Greg Murphy, M.D. (R-NC), reintroduced the bipartisan Medicare Patient Access and Practice Stabilization Act with nine Republican and 12 Democratic co-sponsors to address cuts to Medicare clinicians' reimbursement.[38]

Recent administrations have prioritized participation in alternative payment models, and the Trump administration has an opportunity to further improve and advance these models as part of its effort to end the chronic disease epidemic.

The Centers for Medicare and Medicaid Services (CMS) Innovation Center set a goal to have all traditional Medicare beneficiaries in accountable care arrangements by 2030.[39] The agency has encouraged participation in these payment models by conducting new and continuing payment demonstrations, as well as reforms to the Medicare Shared Savings Program (MSSP). These efforts have increased the number of ACOs and expanded the capacity of smaller practices to participate in accountable care organizations.[40,41] In 2024, nearly half of traditional Medicare beneficiaries (13.7 million) were aligned to an ACO under the MSSP or a demonstration.[g,42]

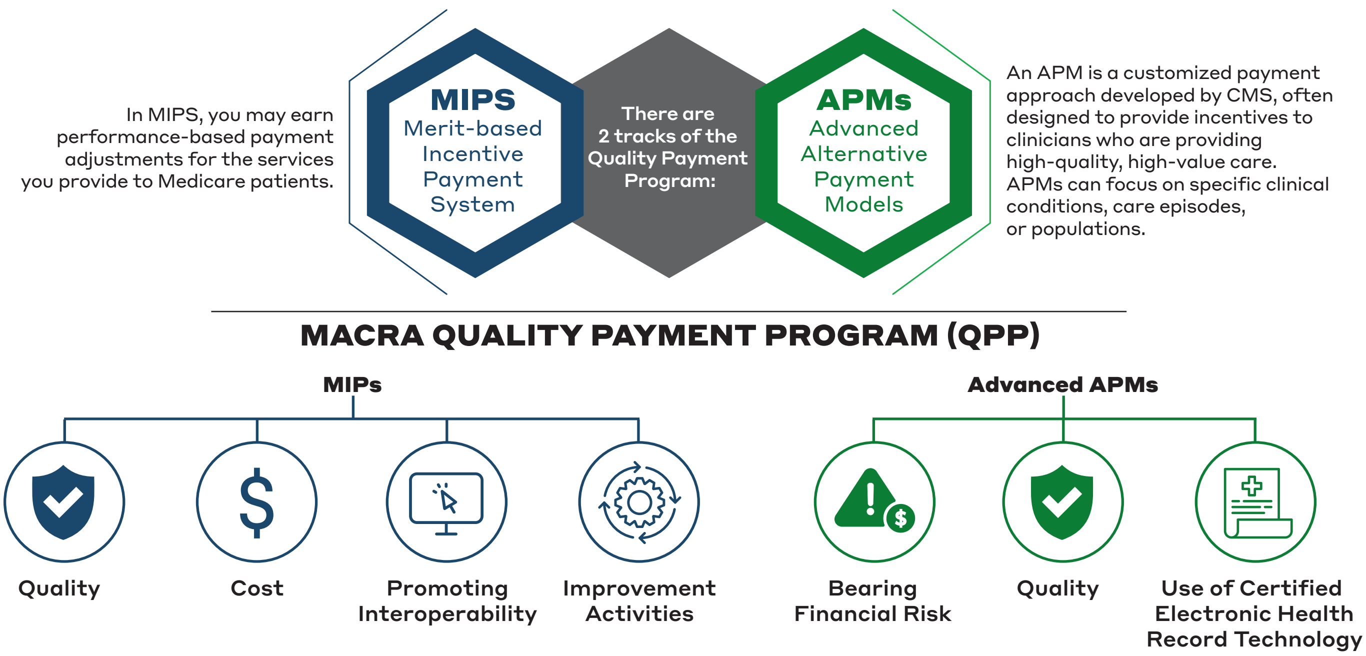
g Beneficiaries are generally aligned to ACOs through claims or voluntary alignment. CMS's ACO models are part of traditional Medicare, and beneficiaries aligned to ACOs have freedom of choice of traditional Medicare providers and suppliers. They are not required to receive services from the ACO.

HOW MEDICARE PART B PHYSICIAN PAYMENT WORKS

Medicare generally pays physicians and other eligible clinicians for Part B-covered professional services based on the Medicare physician fee schedule, with several factors modifying or adjusting payments.[43,44] MACRA's Quality Payment Program is one such factor.[45] ACOs under the Medicare Shared Savings Program and accountable care demonstrations under the CMS Innovation Center are alternative payment models that generally align with the QPP. These models can help clinicians satisfy QPP requirements to qualify for financial incentives for high-quality care.

As noted above, all eligible clinicians billing for Medicare Part B-covered professional services must participate in one of the QPP's two pathways: (1) MIPS or (2) Advanced APMs. Clinicians may be exempt from QPP participation if they are newly enrolled in Medicare or do not exceed the annual Medicare low-volume threshold criteria.[h,46,47] In practical terms, about half of all Medicare Part B providers are exempt from participation.[48]

Figure 4: Quality Performance Determines Clinicians' Payments under the QPP's MIPS and Advanced APM Pathways



Note: In lieu of bearing significant financial risk, an Advanced APM can be a medical home model.
Source: CMS Quality Payment Program, "Quality Payment Program Overview." Adapted from: https://qpp.cms.gov/about/qpp-overview. American Academy of Professional Coders, "What Is MACRA?" Adapted from: https://www.aapc.com/resources/what-is-macra.

h Clinicians are exempt for low volume if they do not meet the minimum: (1) billing amount for Part B covered professional services, (2) number of Part B patients who receive covered professional services, or (3) number of covered professional services to Part B patients. In 2024, the low volume threshold was more than $90,000 in billed Part B professional services, 200 Part B patients, and 200 Part B covered professional services.

MIPS

The Merit-Based Incentive Payment System program rewards or penalizes clinicians based on their performance on measures they select in four areas: (1) quality, (2) cost, (3) interoperability (such as patient engagement and electronic health record use), and (4) improvement activities.[49] Clinicians' fee-for-service payments are adjusted up or down by statutorily defined percentages based on their performance in these areas. In 2024, MIPS payments can be adjusted to -9% and +9%.[50]

MIPS payments must be budget neutral, however. Congress appropriated $500 million annually for payment years 2019–2024 for exceptional performance, temporarily bolstering positive payment adjustments in MIPS and narrowing the financial incentive gap between MIPS and Advanced APMs.[51] Notably, payments have not reached the statutory maximum of +9% due to relatively low performance thresholds set by CMS. As a result, fewer clinicians receive negative payment adjustments, which fund the positive payment adjustments available under this budget-neutral program.[52] Policymakers looking to encourage clinicians' participation in Advanced APMs or other population-based payment models must consider how MIPS payment adjustments—both in statute and in implementation—affect the financial appeal of these models.

Despite the program's goal of supporting high-value care, research indicates that MIPS has not improved the quality of care or reduced spending.[53] Critics have noted the significant administrative burden under the quality measure reporting structure and excessive choice in selecting quality measures—clinicians can choose measures they expect to perform well on or report on measures as a group under one tax identification number, which limit the meaningfulness of MIPS data and its comparability across clinicians. In response, CMS will phase out "traditional" MIPS and replace it with a new MIPS Value Pathways (MVPs) in a future year.[54,55] The new MVPs aim to address these challenges by requiring clinicians to report on a subset of quality measures and activities based on specialty or medical condition.[56] CMS introduced MVPs in 2023 and made participation voluntary through performance year 2027. It has not announced when reporting will become mandatory.[57]

Advanced APMs

The second quality payment pathway offers incentive payments to clinicians participating in Advanced APMs, such as an MSSP ACO or a CMS Innovation Center accountable care demonstration model.[i,58,59]

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[i] MSSP's BASIC Track Level E and the ENHANCED Track are Advanced APMs in performance year 2025.

Models must meet certain criteria to be an Advanced APM.[j,60] One requirement is that participants must bear significant financial risk and accountability for care, distinguishing these models from the Merit-Based Incentive Payment System program.[61] Assuming financial risk encourages clinicians to reduce costs by delivering more holistic primary and preventive care, better managing chronic diseases, and reducing unnecessary services. Research shows that certain Advanced APMs are associated with federal savings (described below in Patient-First Care: Promising Population-Based Payment Models).[62]

To achieve Qualifying APM Participant status, which is required to receive a bonus payment, clinicians must have seen at least 35% of their Medicare patients through the Advanced APM or have received at least half of their Part B payments through the model in 2024.[63] The vast majority (88%) of clinicians who received this bonus in 2024 (for performance year 2022) were in the MSSP's BASIC Track Level E or ENHANCED Track, while others participated in the CMS Innovation Center's Direct Contracting Model, Bundled Payment for Care Improvement Advanced Model, Primary Care First Model, or other models.[64] CMS has identified these demonstration models as Advanced APMs eligible for Qualifying APM Participant status.[65]

PATIENT-FIRST CARE: PROMISING POPULATION-BASED PAYMENT MODELS

The early success of certain population-based payment models suggests that policymakers desiring to support care quality while better controlling Part B spending should consider reforms to expand these models. Almost 30 different payment model options operate under Part B, each affecting care quality and Medicare spending in unique ways.[66,67] Available data should inform federal efforts to accelerate clinicians' participation in the most promising models.[68] Some population-based payment models, particularly ACOs, have demonstrated early success in generating gross or net savings to Medicare, improving health outcomes, and increasing patients' and providers' satisfaction.[69]

For example, evidence suggests that Medicare Shared Savings Program ACOs have demonstrated at least some modest savings, with physician-led ACOs showing the greatest success.[70,71] However, challenges in estimating what Medicare would have spent absent the MSSP ACO make it difficult to accurately evaluate savings associated with these models; estimates of savings vary widely as a result.[72,73]

[j] The criteria for Advanced APM participation include the following: (1) use certified electronic health record technology, (2) base clinician payment for covered professional services on quality measures comparable to those used in the MIPS quality performance category (including one outcome measure), and (3) either be a medical home model expanded under CMS Innovation Center authority or require participants to bear significant financial risk.

Separately, the CMS Innovation Center's Pioneer ACO Model achieved gross and net savings in an evaluation of its first two years, while the Next Generation ACO Model achieved gross savings in its first three years.[74] Between 2015 and 2018, the ACO Investment Model—which provided new and existing ACOs with up-front funding for infrastructure and staffing—resulted in more than 2% net Medicare savings on average each year, as well as gross savings.[75] The model also reduced hospital readmissions and emergency department visits.[76]

Current law allows the Health and Human Services (HHS) secretary to expand or make permanent a CMS Innovation Center demonstration only if it meets certain criteria. However, few models have met the standard for care quality, reducing or not increasing spending, and benefits access.[k,77] To date, the HHS secretary has certified only four models for expansion, including the Pioneer ACO Model, which was incorporated into Medicare's permanent ACO program, the MSSP.[78]

Consumer groups and other stakeholders emphasize the value of accountable care organizations for patients, citing their ability to facilitate care coordination for those with chronic conditions and complex needs.[79,80,81] Notably, in January 2025, the CMS Innovation Center implemented a new ACO Primary Care Flex Model within the MSSP.[82] This model supports enhanced coordination between primary care and specialty providers, an important feature with the potential to reduce low-value care and support the model's effectiveness.[83,84]

CHALLENGES AND NEXT STEPS

Despite modest annual increases in Advanced APM participation, total participation remains low compared with MIPS, and key challenges threaten current participation levels and might limit growth. Among the 1.3 million clinicians billing the fee schedule, 624,209 clinicians participated in MIPS in performance year 2022, while only 386,263 clinicians participated in Advanced APMs during that same period.[85,86] Because many clinicians satisfy Advanced APM requirements by participating in Medicare ACOs, addressing barriers to participation in these models can inform broader efforts to encourage participation in other population-based payment models. Moreover, a Congressional Budget Office report from April 2024 found that weak incentives to reduce spending, inadequate resources for participation, and the ability to easily exit the program based on anticipated financial gains or losses can limit both participation in Medicare ACOs and savings.[87]

[k] For expansion, the model must be expected (1) to either reduce spending without reducing care quality, or to improve care quality without increasing spending; (2) to result in reduced (or no increase) in net spending if expanded, as certified by CMS's chief actuary; and (3) to not deny or limit beneficiaries' benefits if expanded.

Figure 5: Clinician Participation in MIPS and Advanced APMs (Performance Year 2022)

MIPS (clinicians)	Advanced APMs (clinicians)
624,209	386,263

Note: Data on MIPS clinicians represents total clinicians who received a MIPS payment adjustment. Data on Advanced APM clinicians represents total clinicians who achieved Qualifying APM Participant status.
Source: Adapted from CMS Quality Payment Program, "Participation and Performance Data." Available at: https://qpp.cms.gov/resources/performance-data.

Building on these findings, BPC's next issue brief will further examine the challenges limiting the uptake and growth of Advanced APMs and other population-based payment models. These challenges include misaligned financial incentives that do not effectively encourage Advanced APM participation over MIPS; inadequately structured participation thresholds for the Advanced APM bonus payment and its expiration; significant administrative burden; and a lack of transparent, evidence-based processes for appropriately valuing physician fee schedule services.

Improving access to high-quality care and constraining spending growth in Part B will be extremely difficult without first addressing these existing barriers. To enhance clinicians' adoption of promising Advanced APMs and other population-based payment models, policymakers must address these barriers by pursuing bipartisan reforms. Some reforms will likely require up-front federal investment if clinicians are to transition to sustainable, alternative payment models. Policymakers should prioritize reforms that offset these costs and ensure that overall changes are budget neutral.

BPC's second and third issue briefs will provide more detail on these challenges and propose actionable federal policy reforms.

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Health Program

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Disclaimer

Endnotes

1 For relevant background on alternative payment models, see "Common Alternative Payment Model (APM) Approaches: Reference Guide," prepared by the Office of Health Policy of the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services and by NORC at the University of Chicago, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/aspe-files/207901/common-apms-reference-guide-2021.pdf.

2 Physicians Advocacy Institute, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023," prepared by Avalere, April 2024. Available at: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d.

3 MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," June 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf.

4 Omnibus Budget Reconciliation Act of 1989, H.R. 3299, 101st Cong., 1989. Available at: https://www.congress.gov/bill/101st-congress/house-bill/3299/text. See also Section 1848(c)(2)(B)(ii)(II) of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1848.htm.

5 MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," June 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf.

6 Congressional Budget Office, "Baseline Projections Medicare," June 2024. Available at: https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf.

7 Ibid.

8 Juliette Cubanski and Tricia Neuman, "What to Know about Medicare Spending and Financing," *KFF*, January 19, 2023. Available at: https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-spending-and-financing/#:~:text=In%202021%2C%20Medicare%20benefit%20payments,(48%25%20in%202021).

9 Paul Wynn, "Medicare Part B: Costs and Coverage," *U.S. News & World Report*, April 10, 2024. Available at: https://health.usnews.com/medicare/articles/what-is-medicare-part-b - :~:text=Medicare%20Part%20B%20covers%20two%20types%20of%20services%3A,for%20cardiovascular%20disease%2C%20diabetes%2C%20depression%20and%20certain%20cancers.

10 Congressional Budget Office, "March 2012 Medicare Baseline," March 13, 2012. Available at: https://www.cbo.gov/sites/default/files/recurringdata/51302-2012-03-medicare.pdf.

11 Congressional Budget Office, "Baseline Projections: Medicare," May 2022. Available at: https://www.cbo.gov/system/files/2022-05/51302-2022-05-medicare.pdf. See also Committee for a Responsible Federal Budget, "Analysis of the 2023 Medicare Trustees' Report," April 3, 2023. Available at: https://www.crfb.org/papers/analysis-2023-medicare-trustees-report.

12 Centers for Medicare & Medicaid Services, "Medicare Program; Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2015," October 10, 2014. Available at: https://www.federalregister.gov/documents/2014/10/10/2014-24248/medicare-program-medicare-part-b-monthly-actuarial-rates-premium-rate-and-annual-deductible.

13 Centers for Medicare & Medicaid Services, "2025 Medicare Parts A & B Premiums and Deductibles," November 8, 2024. Available at: https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles.

14 Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes," The Commonwealth Fund, January 31, 2021. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022.

15 Bipartisan Policy Center, "Charting the Course: Transforming Primary Care for Tomorrow," Event Summary, June 2024. Available at: https://bipartisanpolicy.org/event/charting-the-course-transforming-primary-care-for-tomorrow/.

16 Tara Hartnett, Gabriel Loud, et al., "Strengthening the Integrated Care Workforce," Bipartisan Policy Center, December 2023. Available at: https://bipartisanpolicy.org/report/strengthening-the-integrated-care-workforce/.

17 Lisa Harootunian, Kamryn Perry, et al., "Addressing the Direct Care Workforce Shortage," Bipartisan Policy Center, December 2023. Available at: https://bipartisanpolicy.org/report/addressing-the-direct-care-workforce-shortage/.

18 Kendall Strong, Michele Gazda, et al., "Achieving Behavioral Health Care Integration in Rural America," Bipartisan Policy Center, May 2023. Available at: https://bipartisanpolicy.org/report/behavioral-health-rural-integration/.

19 Medicare Access and CHIP Reauthorization Act of 2015, H.R. 2, 114th Cong., 2015. Available at: https://www.congress.gov/bill/114th-congress/house-bill/2/text.

20 Centers for Medicare & Medicaid Services, "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021," December 1, 2020. Available at: https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1.

21 MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," June 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf.

22 42 U.S.C. § 1395l(z)(1)(a). Available at: https://uscode.house.gov/view.xhtml?req=(title:42%20section:1395l%20edition:prelim).

23 Quality Payment Program, "Advanced APMs Overview., Centers for Medicare & Medicaid Services. Available at: https://qpp.cms.gov/apms/advanced-apms. See also 42 CFR § 414.1450. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-O/section-414.1450.

24 U.S. Senate Committee on Finance, "Full Committee Hearing: Bolstering Chronic Care through Medicare Physician Payment," April 11, 2024. Available at: https://www.finance.senate.gov/hearings/bolstering-chronic-care-through-medicare-physician-payment.

25 U.S. Senate Committee on the Budget, "Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care," May 8, 2024. Available at: https://www.budget.senate.gov/hearings/reducing-paperwork-cutting-costs-alleviating-administrative-burdens-in-health-care.

26 U.S. House Committee on Ways & Means, "Health Subcommittee Hearing on Improving Value-Based Care for Patients and Providers," June 26, 2024. Available at: https://waysandmeans.house.gov/event/health-subcommittee-hearing-on-improving-value-based-care-for-patients-and-providers/.

27 Sen. Marsha Blackburn, "Blackburn, Thune, Barrasso, Stabenow, Warner, Cortez Masto Announce Formation of Medicare Payment Reform Working Group," February 9, 2024. Available at: https://www.blackburn.senate.gov/2024/2/blackburn-thune-barrasso-stabenow-warner-cortez-masto-announce-formation-of-medicare-payment-reform-working-group.

28 U.S. Senate Committee on Finance, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B," May 17, 2024. Available at: https://www.finance.senate.gov/imo/media/doc/051723_phys_payment_cc_white_paper.pdf.

29 Sen. Sheldon Whitehouse, "Whitehouse and Cassidy Introduce Legislation, Release RFI on Primary Care Provider Payment Reform," May 15, 2024. Available at: https://www.whitehouse.senate.gov/news/release/whitehouse-and-cassidy-introduce-legislation-release-rfi-on-primary-care-provider-payment-reform/#:~:text=The%20Pay%20PCPs%20Act%20would,other%20big%20cost%20drivers%20%E2%80%94%20and.

30 Value in Health Care Act of 2023, S. 3503, 118th Cong., 2023. Available at: https://www.congress.gov/bill/118th-congress/senate-bill/3503.

31 Centers for Medicare & Medicaid Services, "Accountable Care Organizations (ACOs): General Information." Available at: https://www.cms.gov/priorities/innovation/innovation-models/aco. See also Section 1899 of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1899.htm. And see Quality Payment Program, "Alternative Payment Models in the Quality Payment Program as of December 2022," Centers for Medicare & Medicaid Services. Available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2180/2022%20and%202023%20Comprehensive%20List%20of%20APMs.pdf.

32 Value in Health Care Act of 2023, H.R. 5013, 118th Cong., 2023. Available at: https://www.congress.gov/bill/118th-congress/house-bill/5013.

33 Ibid.

34 Rep. Mariannette Miller-Meeks, "Miller-Meeks Leads 232 House Members to Address Doc Cuts Before 2025," Press Release, October 15, 2024. Available at: https://millermeeks.house.gov/media/press-releases/miller-meeks-leads-232-house-members-address-doc-cuts-2025. See also "Letter to House Speaker Mike Johnson (R-LA) and House Minority Leader Hakeem Jeffries (D-NY)," October 11, 2024. Available at: https://millermeeks.house.gov/sites/evo-subsites/millermeeks.house.gov/files/evo-media-document/Doc%20Letter.pdf.

35 GOP Doctors Caucus, "GOP Doctors Caucus Co-Chairs Release Draft Reforms to the Medicare Physician Fee Schedule," October 11, 2023. Available at: https://osma.org/aws/OSMA/asset_manager/get_file/868644?ver=0.

36 Further Continuing Appropriations and Disaster Relief Supplemental Appropriations Act, 2025, H.R.10445, 118th Cong., 2024. Available at: https://www.congress.gov/bill/118th-congress/house-bill/10445/text.

37 Rep. Vern Buchanan, "Buchanan Leads Bill to Improve Healthcare Reporting," Press Release, January 21, 2025. Available at: https://buchanan.house.gov/2025/1/buchanan-leads-bill-to-improve-healthcare-reporting.

38 To amend title XVIII of the Social Security Act to increase support for physicians and other practitioners in adjusting to Medicare payment changes, H.R.879, 119th Cong., 2025. Available at: https://www.congress.gov/bill/119th-congress/house-bill/879/text?s=1&r=1.

39 Center for Medicare and Medicaid Innovation, "Innovation Center Strategy Refresh," Centers for Medicare & Medicaid Services, 2021. Available at: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.

40 Liz Fowler, Purva Rawal, et al., "The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care," Centers for Medicare & Medicaid Services, November 7, 2022. Available at: https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care#:~:text=In%202021%2C%20the%20Centers%20for%20Medicare%20%26%20Medicaid,Medicare%20and%20Medicaid%20Innovation%E2%80%99s%20%28Innovation%20Center%29%20strategic%20refresh.

41 Centers for Medicare & Medicaid Servies, "Participation Continues to Grow in CMS' Accountable Care Organization Initiatives in 2024," January 29, 2024. Available at: https://www.cms.gov/newsroom/press-releases/participation-continues-grow-cms-accountable-care-organization-initiatives-2024.

42 Ibid.

43 Eligible clinician types include physicians (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry), osteopathic practitioners, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, registered dietitians or nutrition professionals, clinical social workers, and certified nurse midwives. See Centers for Medicare & Medicaid Services, "MIPS Eligible Clinician Types." Available at: https://qpp.cms.gov/mips/how-eligibility-is-determined.

44 For details on payment modifiers and adjustments, see MedPAC, "Physician and Other Health Professional Payment System," October 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_Physician_FINAL_SEC.pdf.

45 For further details on payment modifiers and adjustments, see MedPAC, "Physician and Other Health Professional Payment System," November 2021. Available at: https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_physician_final_sec.pdf.

46 American Medical Association, "Medicare Basics series: Merit-based Incentive Payment System (MIPS)," October 9, 2023. Available at: https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-basics-series-merit-based-incentive-payment-system - :~:text=All%20physicians%20in%20the%20United%20States%20must%20participate,first%20year%20of%20participating%20in%20the%20Medicare%20program.

47 Quality Payment Program, "How MIPS Eligibility is Determined Intro," Centers for Medicare & Medicaid Services, 2024. Available at: https://qpp.cms.gov/mips/how-eligibility-is-determined.

48 U.S. Government Accountability Office, "MEDICARE Provider Performance and Experiences under the Merit-based Incentive Payment System," October 2021. Available at: https://www.gao.gov/assets/gao-22-104667.pdf.

49 Quality Payment Program, "Traditional MIPS Overview," Centers for Medicare & Medicaid Services. Available at: https://qpp.cms.gov/mips/traditional-mips.

50 Section 1848(q)(6)(B) of the Social Security Act. https://www.ssa.gov/OP_Home/ssact/title18/1848.htm.

51 Section 1848(q)(6)(F)(iv)(I) of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1848.htm.

52 MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System," June 2024. Available at: https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf.

53 Zack Cooper, Elizabeth Jurinka, et al., "Review of the Expert and Academic Literature Assessing Impact of Medicare Access and CHIP Reauthorization Act of 2015," Yale Tobin Center for Economic Policy, April 13, 2023. Available at: https://tobin.yale.edu/sites/default/files/2023-06/20230413_MACRA%20Literature%20Review_0.pdf.

54 Quality Payment Program, "Learn about the MVP Reporting Option," Centers for Medicare & Medicaid Services. Available at: https://qpp.cms.gov/mips/mvps/learn-about-mvp-reporting-option.

55 Quality Payment Program, "MIPS Value Pathways (MVPs)," Centers for Medicare & Medicaid Services. Available at: https://qpp.cms.gov/mips/mips-value-pathways.

56 Quality Payment Program, "Learn about the MVP Reporting Option," Centers for Medicare & Medicaid Services, October 2024. Available at: https://qpp.cms.gov/mips/mvps/learn-about-mvp-reporting-option.

57 Quality Payment Program, "MIPS Value Pathways (MVPs)," Centers for Medicare & Medicaid Services. Available at: https://qpp.cms.gov/mips/mips-value-pathways.

58 Centers for Medicare & Medicaid Services, "The Quality Payment Program," October 25, 2016. Available at: https://www.cms.gov/newsroom/fact-sheets/quality-payment-program.

59 For a list of alternative payment models that CMS operated as of November 2022 and for a description of which are an Advanced APM, see Centers for Medicare & Medicaid Services, "Alternative Payment Models in the Quality Payment Program as of December 2022." Available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2180/2022%20and%202023%20Comprehensive%20List%20of%20APMs.pdf.

60 42 CFR § 414.1415. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-O/section-414.1415.

61 Quality Payment Program, "Advanced Alternative Payment Models (APMs)," Centers for Medicare & Medicaid Services. Available at: https://qpp.cms.gov/apms/advanced-apms.

62 Zack Cooper, Elizabeth Jurinka, et al., "Review of the Expert and Academic Literature Assessing Impact of Medicare Access and CHIP Reauthorization Act of 2015," Yale Tobin Center for Economic Policy, April 13, 2023. Available at: https://tobin.yale.edu/sites/default/files/2023-06/20230413_MACRA%20Literature%20Review_0.pdf.

63 42 CFR § 414.1430. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-O/section-414.1430.

64 MedPAC, "A Data Book: Health care spending and the Medicare program," Chart 5-7, July 2024, 47. Available at: https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_Sec5_SEC.pdf.

65 Quality Payment Program, "Alternative Payment Models in the Quality Payment Program as of December 2022." Centers for Medicare & Medicaid Services. Available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2180/2022%20and%202023%20Comprehensive%20List%20of%20APMs.pdf.

66 Centers for Medicare & Medicaid Services, "Innovation Models." Available at: https://www.cms.gov/priorities/innovation/models.

67 Alexander O. Everhart, Peter F. Lyu, et al., "Medicare Part B Clinician Payment Programs And The Growing Costs Of Administrative Complexity," *Health Affairs*, September 11, 2024. Available at: https://www.healthaffairs.org/content/forefront/medicare-part-b-clinician-payment-programs-and-growing-costs-administrative-complexity.

68 Ibid.

69 Center for Medicare and Medicaid Innovation, "Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020," July 2021. Available at: https://www.cms.gov/priorities/innovation/data-and-reports/2022/wp-eval-synthesis-21models.

70 Congressional Budget Office, "Medicare Accountable Care Organizations: Past Performance and Future Directions," April 2024. Available at: https://www.cbo.gov/system/files/2024-04/59879-Medicare-ACOs.pdf.

71 J. Michael McWilliams, Laura A. Hatfield, et al., "Medicare Spending after 3 Years of the Medicare Shared Savings Program," *New England Journal of Medicine*, 379(12), September 2018. Available at: https://www.nejm.org/doi/full/10.1056/NEJMsa1803388.

72 Michael E. Chernew, Christopher Barbey, and J. Michael McWilliams, “Savings Reported by CMS Do Not Measure True ACO Savings,” *Health Affairs*, June 19, 2017. Available at: https://www.healthaffairs.org/content/forefront/savings-reported-cms-do-not-measure-true-aco-savings.

73 Asher Wang, Sara Debab, et al., “Medicare Accountable Care Organizations In 2022: Renewed Growth And Improved Savings Show Small Rebound From The COVID-19 Pandemic,” *Health Affairs*, October 19, 2023. Available at: https://www.healthaffairs.org/content/forefront/medicare-accountable-care-organizations-2022-renewed-growth-and-improved-savings-show.

74 MedPAC, “Chapter 2 Streamlining CMS’s portfolio of alternative payment models,” June 2021. Available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch2_medpac_report_to_congress_sec.pdf.

75 Ibid.

76 Center for Medicare and Medicaid Innovation, “ACO Investment Model (AIM) Final Evaluation of Three AIM Performance Years,” September 2020. Available at: https://www.cms.gov/priorities/innovation/data-and-reports/2020/aim-fg-finalannrpt. See also MedPAC, “Chapter 2 Streamlining CMS’s portfolio of alternative payment models,” June 2021. Available at: https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch2_medpac_report_to_congress_sec.pdf.

77 Section 1115A(c) of the Social Security Act. https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm.

78 Paul Spitalnic, “Certification of Pioneer Model Savings,” CMS Office of the Actuary, April 10, 2015. Available at: https://www.cms.gov/research-statistics-data-and-systems/research/actuarialstudies/downloads/pioneer-certification-2015-04-10.pdf. See also CMS, “CMMI Model Certifications.” Available at: https://www.cms.gov/data-research/research/actuarial-studies/cmmi-model-certifications.

79 AARP, “How Medicare ACOs Are Transforming Health Care,” January 30, 2024. Available at: https://www.aarp.org/health/medicare-insurance/info-2023/medicare-accountable-care-organizations-transform-health-care.html.

80 Families USA, “Implementing Accountable Care Organizations,” January 12, 2012. Available at: https://familiesusa.org/resources/implementing-accountable-care-organizations/.

81 Primary Care Collaborative, “Improve Care in Medicare by Growing Primary Care in ACOs,” February 28, 2024. Available at: https://thepcc.org/factsheet/improve-care-in-medicare-by-growing-primary-care-in-acos/.

82 Centers for Medicare & Medicaid Services, “ACO Primary Care Flex Model.” Available at: https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model.

83 Centers for Medicare & Medicaid Services, “ACO Primary Care Flex Model Frequently Asked Questions.” Available at: https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model/faqs.

84 Centers for Medicare & Medicaid Services, “Pathways for Specialty Care Coordination and Integration in Population-based Models,” June 17, 2022. Available at: https://www.cms.gov/blog/pathways-specialty-care-coordination-and-integration-population-based-models.

85 MedPAC, “A Data Book: Health care spending and the Medicare program,” July 2024, 47. Available at: https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_Sec5_SEC.pdf.

86 Centers for Medicare & Medicaid Services, “Quality Payment Program (QPP) 2022 Participation and Performance Results At-A-Glance,” April 2024. Available at: https://lnks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDAsInVyaSI6ImJwMjpjbGljayIsIn Vyb CI6Imh0dHBzOi8vcXBwLWNtLXByb2QtY29u dGVudC5zMy5hbWF6b25hd3MuY29tL3Vwb G9hZHMvMjgxNi9RUFAtMjAyMi1QYXJ0a WNpcGF0aW9uLWFuZC1QZXJmb 3JtYW5jZS1S ZX N1bHRzLUFOLUEtR 2x hbmNlLnBk ZiIsImJ1bGxldGluX2 lk IjoiMjAyNDA1MD guOTQ1MDM4 NDEifQ.PqtqN8Ox3t3qPb-RM8TUVOmvpU2HnQG iCfLusmQLpJA/s/31477 45029/br/24 2093212768-l.

87 Congressional Budget Office, “Medicare Accountable Care Organizations: Past Performance and Future Directions,” April 2024. Available at: https://www.cbo.gov/system/files/2024-04/59879-Medicare-ACOs.pdf.