



Bipartisan Policy Center

Strengthening Primary Care: Medicare Physician Payment and Related Reforms

June 2025

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ACKNOWLEDGMENTS

The Bipartisan Policy Center would like to thank The Commonwealth Fund for its generous support. We would also like to thank our Health Program advisors—Sheila Burke, Jim Capretta, Lee Fleisher, M.D., and Chris Jennings—for the continued support and guidance they provide to BPC’s Health Program.

HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC’s Health Program advances bipartisan policy solutions to build a more cost-effective, evidence-based health care system and improve population health. We work to strengthen and sustain Medicare and Medicaid, accelerate the shift toward value, address inefficiencies and misaligned incentives, and responsibly leverage technology and innovation.

DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC’s founders, board of directors, funders, or advisers.

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I. Executive Summary

America's chronic disease crisis continues to grow, driving poor health outcomes and unsustainable costs for patients and taxpayers alike. Older adults and individuals with disabilities—many of whom rely on Medicare—are disproportionately affected.^{1,2} Strengthening primary care by reforming Medicare Part B physician payment and related policies offers a powerful and bipartisan opportunity to reverse this trend.

Now is a critical time to act. The expiration of a key provision of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), along with the Trump administration's stated focus on reducing chronic disease, opens the door for federal policymakers to modernize Medicare's physician payment system.^{a,3,4,5} Doing so will improve patients' outcomes, better support clinicians, and ensure Medicare's sustainability over the long term.

Today's payment system discourages primary care clinicians from participating in alternative payment models (APMs) that encourage prevention, care coordination, and improved outcomes. It undervalues essential services, burdens providers with unnecessary red tape, and offers inadequate incentives for transformation—especially for smaller and rural practices.⁶ Without meaningful reform, Medicare will continue to reward volume over value and to underinvest in the care that matters most to beneficiaries.^b

To strengthen primary care and improve health outcomes in Medicare, policymakers should:

- **Extend and restructure the Advanced APM's** participation bonus to accelerate clinicians' participation in models that promote care coordination, prevention, and delivery system transformation.
- **Create an advisory body to the Centers for Medicare & Medicaid Services (CMS)** to improve data and processes to ensure the appropriate valuation of primary care services by developing a more transparent, empirically grounded rate-setting process.
- **Enable federal tracking and target-setting** to measure and report on primary care spending across federal health care programs.
- **Align the measurement reporting requirements on primary care quality** across payment models and payers to reduce administrative strain on clinicians.

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

^b Although this brief focuses on Medicare Part B physician payments, more comprehensive reforms to traditional Medicare and Medicare Advantage are needed to ensure the long-term sustainability of the program. To learn more, see BPC's December 2023 report, [Sustaining and Improving Medicare: The Path Forward](#).

Members of Congress have introduced several bipartisan proposals that reflect shared concern over these issues, as outlined in the Bipartisan Policy Center's March 2025 issue brief, [*The Need for Medicare Part B Physician Payment Reform*](#). Some of BPC's recommendations could require up-front federal investment to successfully shift clinicians, particularly underresourced practices, into sustainable APMs that reward them for delivering high-quality care at lower cost to Medicare. To raise beneficiaries' participation in these models, reforms might also need to reduce cost-sharing for Medicare beneficiaries. Lawmakers should offset these costs to avoid adding to the federal deficit.

For over a decade, BPC has advanced practical, evidence-based solutions to [*strengthen Medicare*](#), [*improve chronic disease management*](#), and [*support sustainable health care delivery*](#). This report builds on that legacy by offering concrete policy recommendations to reform Medicare Part B physician payment and related policies, encourage high-value care, and ensure that all beneficiaries can access high-quality, affordable primary care.

II. Background

A. THE VALUE OF PRIMARY CARE

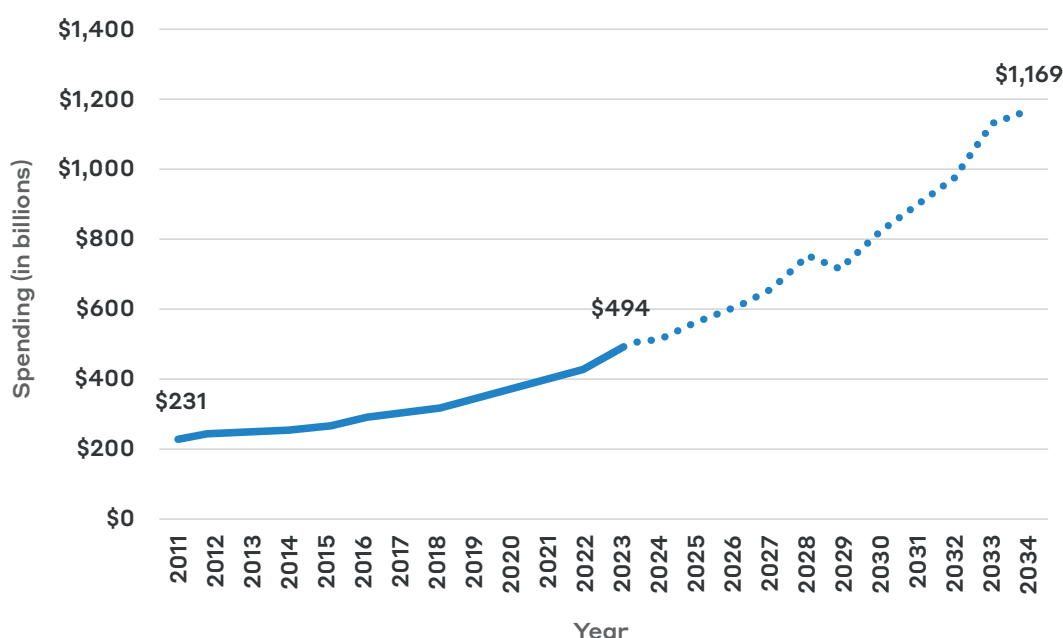
Primary care is the foundation of the U.S. health system. Yet the United States devotes only 5%-8% of health spending on it—far less than other high-income countries, which spend about 13%—despite evidence that greater investment in primary care leads to better outcomes and lower costs.^{7,8,9}

This continued underinvestment has created a system that is now less efficient and more fragmented than it needs to be.¹⁰ It has also left many clinicians without the financial incentives to deliver high-quality primary care services, which could prevent patients from needing more costly care in the future.

Chronic conditions such as heart disease, diabetes, and hypertension—among the leading U.S. causes of death—significantly drive up health care costs, particularly among Medicare beneficiaries.^{11,12} Primary care clinicians play a leading role in managing these chronic diseases, coordinating care for their patients, and delivering preventive services.

Medicare, which serves nearly 70 million older adults and individuals with disabilities or end-stage renal disease, helps shape the U.S. health care system and has historically set the standard for physician payment policies that influence both public and private insurance.¹³ As the Medicare population grows, Part B spending—which covers professional services rendered by clinicians and other services described below—has increased substantially since 2011 and is projected to grow from about \$500 billion in 2023 to \$1.17 trillion in 2034.^{14,15,16} **See Figure 1.**

Figure 1: Medicare Part B Historical and Projected Spending



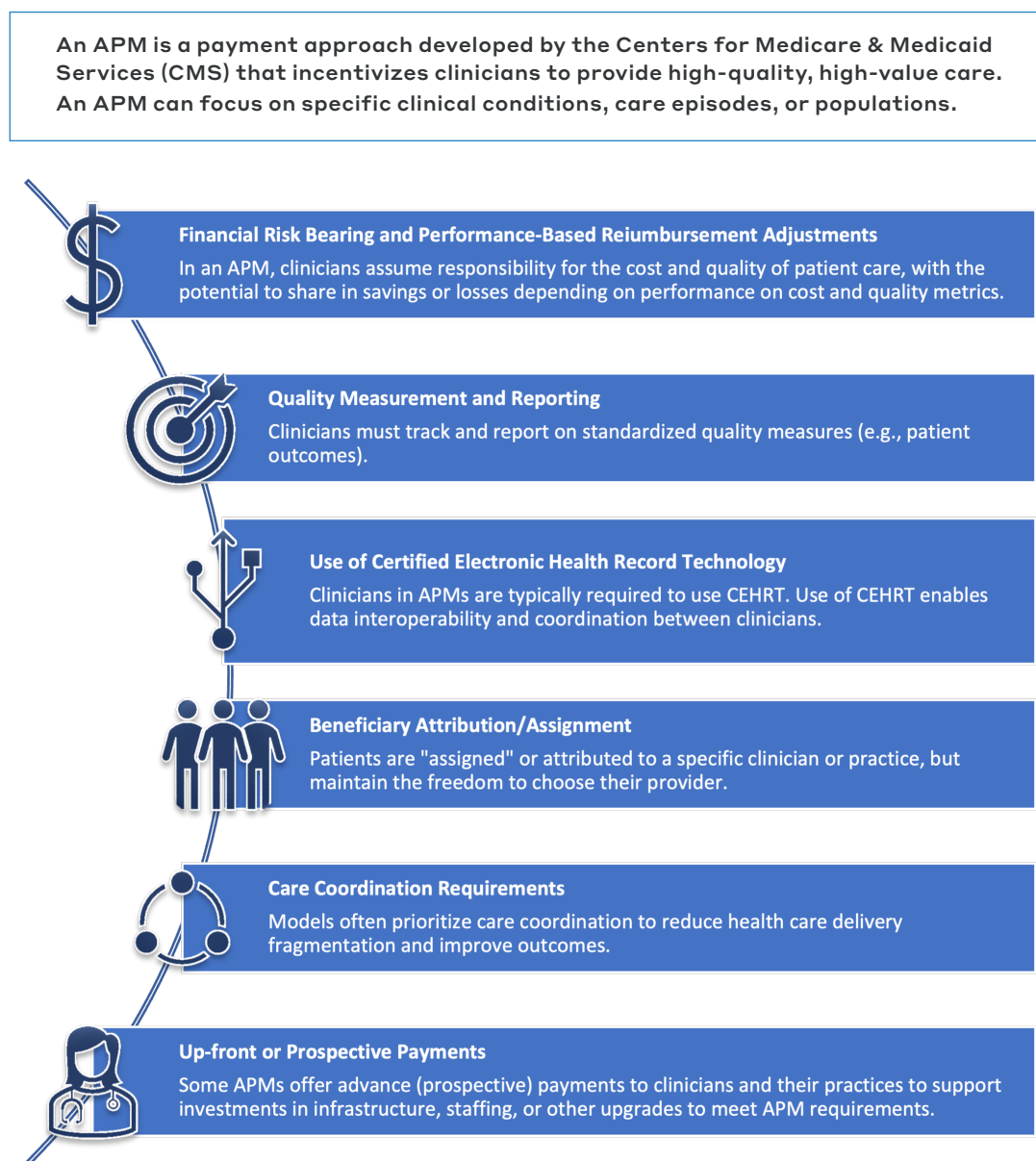
Sources: Congressional Budget Office, “March 2012 Medicare Baseline,” March 13, 2012. Available at: <https://www.cbo.gov/sites/default/files/recurringdata/51302-2012-03-medicare.pdf>; and Congressional Budget Office, “Baseline Projections: Medicare,” June 2024. Available at: <https://www.cbo.gov/system/files/2024-06/51302-2024-06-medicare.pdf>.

However, Medicare Part B’s payment policies have historically undervalued primary care services, compared with specialty services; failed to adequately reimburse for certain services essential to the delivery of high-quality primary care; and prioritized higher volumes of care over care that improves patient outcomes.¹⁷ That is, the Medicare physician fee schedule (MPFS), which underpins the nation’s fee-for-service (FFS) system, tends to reward specialty services—tests, scans, and procedures, for example—more than primary care services, such as managing a patient’s chronic condition. Unsurprisingly, Part B spending—which includes laboratory services, some home health services, physician-administered drugs, and other services—has increased over 80% since 2011.^{18,19,20,21}

In contrast, APMs seek to hold clinicians accountable for delivering high-quality care while giving them more flexibility to render high-value services that reduce the total cost of care. **See Figure 2.** These services are particularly valuable to high-quality primary care: consulting with other clinicians, coordinating care across providers, responding to communications from patients, educating patients on their health conditions, and addressing their chronic disease risk factors. However, misaligned financial incentives and design weaknesses in alternative payment models, described below in the Challenges section, limit primary care clinicians’ participation in these models.

Underinvestment in health care delivery modernization, administrative complexity, and workforce shortages contribute to the undervaluing of primary care and heighten barriers to participation in APMs. Primary care clinicians bear particularly heavy administrative burdens, given their role in coordinating patient care, as well as their high patient loads, both of which contribute to clinician burnout and can further exacerbate workforce challenges.²²

Figure 2: Common Elements of APMs



B. LEGISLATIVE HISTORY

For decades, federal policymakers have struggled to determine the best way to value and reimburse Medicare Part B-covered professional services while balancing access to care and fiscal responsibility.

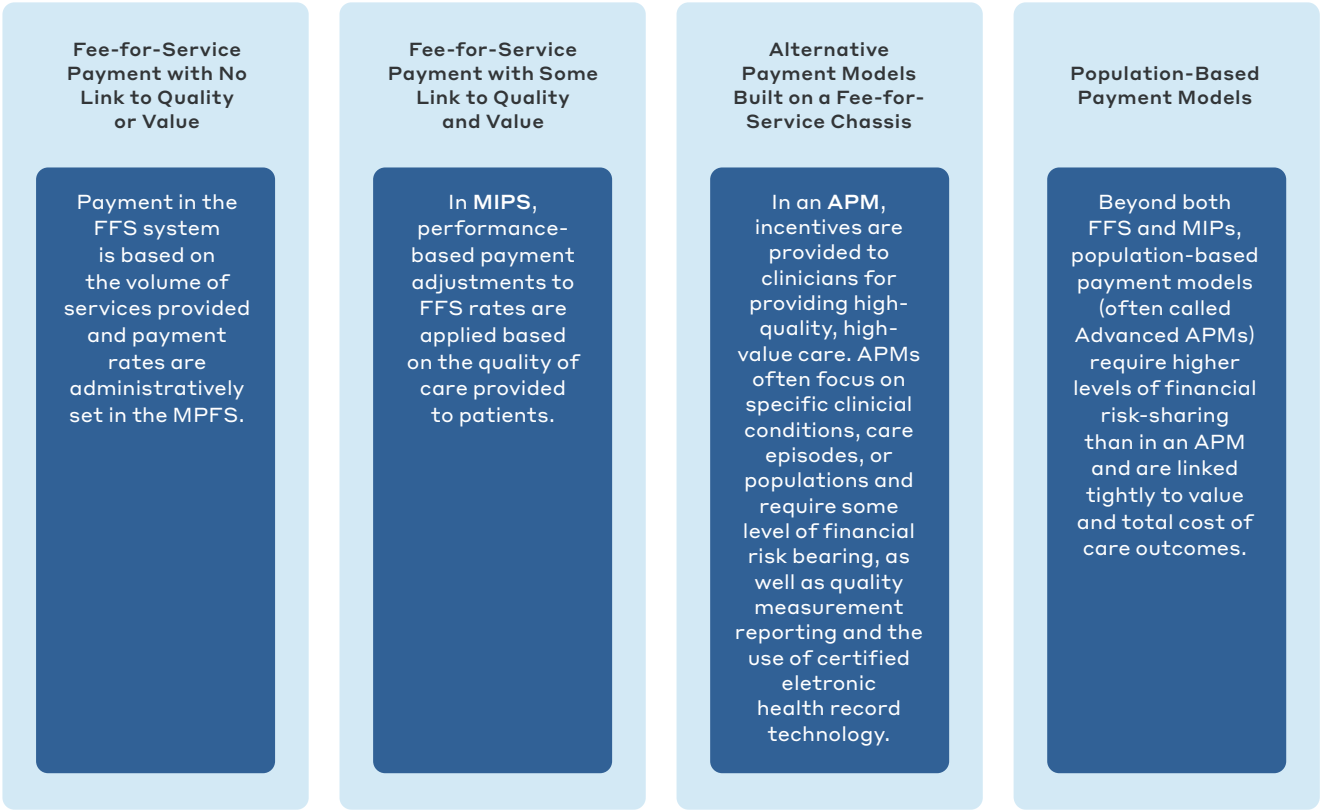
Before 2015, a statutory formula called the Sustainable Growth Rate (SGR) established annual clinician payment updates under the Medicare physician fee schedule. The SGR was flawed, however, because it restricted spending growth based on economic factors, such as per capita gross domestic product. This triggered recurring cuts to physicians' payments, prompting Congress to pass an annual "doc fix" to maintain adequate payment rates and ensure that beneficiaries had continued access to care.

To address these issues, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015 with bipartisan support. The legislation eliminated the SGR formula and introduced fixed annual updates to MPFS payment rates. The goal was to transform Medicare's physician payment system from a volume-based one that incentivized excessive service delivery to a value-based one that aligned the interests of clinicians, patients, and the Medicare program. It attempted to encourage clinicians to move from fee-for-service to value-based payment models (such as APMs) and aimed to curb unsustainable payment cuts and volume-driven care.²³

Unfortunately, while federal policymakers have made some progress in reforming Medicare Part B to encourage higher-value health care, MACRA has failed to fully meet its policy goals. Key MACRA provisions have also expired, and cuts to physicians' payments in Medicare Part B have forced lawmakers, since 2021, to annually pass a "doc fix" of the kind they did before MACRA.

MACRA consolidated multiple payment and performance programs into the Quality Payment Program (QPP), the foundation of alternative payment models. The QPP offers clinicians two options to receive Medicare payments: the Merit-based Incentive Payment System (MIPS), or Advanced Alternative Payment Models (Advanced APMs). Both pathways link physician reimbursement to the quality of care, but MIPS holds clinicians to a lower level of accountability than Advanced APMs, which require participating providers to take on a higher level of financial risk.²⁴ **See Figure 3.**

Figure 3: Medicare Part B Physician Payment Pathways and the Health Care Payment Learning and Action Network Framework



Note: In lieu of bearing significant financial risk, an Advanced APM can be a medical home model.

Adapted from: State Health & Value Strategies, "State Health Policy Highlights Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework," February 2018. Available at: https://www.shvs.org/wp-content/uploads/2018/02/SHVS_APM-Categorization_Highlights-Final.pdf.

III. Challenges

A. MISALIGNED INCENTIVES DISCOURAGE PRIMARY CARE CLINICIANS FROM PARTICIPATING IN APMS.

Primary care clinicians have more incentives to participate in fee-for-service than APMs. This is due to the recent expiration of the bonus payment for Advanced APM participation; infrastructure development and other APM startup challenges; barriers to hybrid payment models that support primary care delivery; and limited integration of primary and specialty care.

In establishing fixed, gradually declining annual payment updates to Medicare physician fee schedule rates and introducing the QPP, MACRA sought to *discourage* clinicians from remaining in payment structures with little accountability—i.e., fee-for-service—and to shift them to value-based APMs. These APMs are designed to offer clinicians payment adjustments based on quality performance, as well as bonus payments for participating in models with significant shared financial risk. For additional details, see BPC’s March 2025 issue brief, [The Need for Medicare Part B Physician Payment Reform](#).

MACRA also encouraged APM participation by offering a bonus payment of 5% of a qualifying clinician’s total Medicare payments for fee schedule services. Although lawmakers extended this bonus through 2026, it has shrunk over time due to a combination of legislative and policy shifts.²⁵ The Centers for Medicare & Medicaid Services (CMS) will pay out the last, reduced bonus of 1.88% in 2026 (for performance year 2024).²⁶ Unless Congress changes the law, clinicians participating in Advanced APMs from 2025 onward will no longer be able to earn a participation bonus payment—thus removing a key financial incentive for clinicians to enter APMs.

The winding down of this key financial incentive will be further magnified if Congress passes, and the president signs, the recent reconciliation package. A provision in the House-approved legislation would, beginning in 2026, replace the MPFS’ two conversion factors—which include 0.25% for clinicians who do not participate in an Advanced APM and 0.75% for Advanced APM participants—with a *single* conversion factor tied to a measure of inflation in practice costs.^{27,28} The proposed single conversion factor update for all clinicians in 2026 would be set at 75% of the Medicare Economic Index and at 10% for 2027 and beyond.²⁹ Although this change would address the need for Congress to annually “fix” payment rates, APM participation incentives will become more critical.

Despite growing clinician participation in APMs, the phaseout of these financial incentives—compounded by persistent uncertainty about their availability moving forward—will likely deter clinicians from joining or remaining in an APM, as will existing incentives to provide higher volumes of care.^{30,31,32}

APMs—particularly certain Accountable Care Organizations (ACOs)—have demonstrated their potential to improve primary care quality while controlling Medicare Part B spending.^{33,34} Physician-led ACOs in the Medicare Shared Savings Program (MSSP) have generated modest savings and improved care coordination; other ACO models, such as the Pioneer ACO Model and Next Generation ACO Model, have also demonstrated their ability to save money.^{35,36,37,38} Recognizing APMs' value, CMS launched the ACO Primary Care Flex Model in January 2025 to test whether increased primary care investment and prospective payments can improve patient outcomes by strengthening coordination between primary and specialty care.³⁹ Prospective payments are fixed, predetermined reimbursements.

Although some APMs offer the potential for more predictable and stable funding for clinicians—through prospective payments and shared savings arrangements that introduce shared financial risk—they often require clinicians to make significant investments up front, improve their infrastructure, and restructure their administrative processes.⁴⁰ These requirements are especially burdensome for many primary care practices, particularly those that are smaller or located in rural areas. As described below, excessive, complex, confusing, and duplicative reporting requirements can further discourage participation.

Hybrid payments—which combine FFS and capitated payments—can support primary care delivery and the shift to APMs, but the current payment system does not yet fully or effectively support such a payment model. As an initial step toward hybrid payments, CMS established a new set of Advanced Primary Care Management (APCM) service codes.⁴¹ These services offer clinicians prospective payments *and* better reward clinicians for their services by more adequately capturing the value of comprehensive, coordinated primary care. They will be valuable for clinicians who cannot fully shift into Advanced APMs. The codes are promising, but their impact will be limited if they do not truly reflect the value of services clinicians provide or if patients face significant out-of-pocket costs.

The integration of primary care and specialty care, particularly behavioral health, is another area where APMs have the potential to drive meaningful transformation. But existing models often fall short, despite evidence showing that untreated mental health and substance use disorders increase overall health care costs. This issue is outlined in greater detail in BPC's March 2021 report, [*Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*](#).

**B. INADEQUATE DATA AND PROCESSES
LIMIT CMS' ABILITY TO APPROPRIATELY
SET MPFS RATES, AND LIMITED DATA
PREVENTS POLICYMAKERS FROM
EVALUATING AND SETTING TARGETS FOR
THE PROPORTION OF FEDERAL HEALTH
CARE SPENDING DIRECTED TOWARD
PRIMARY CARE.**

Despite primary care's foundational role in the nation's health care system, primary care services lack adequate financial support. CMS' reliance on limited data sources to set MPFS rates, as well as the Health and Human Services Department's inadequate data on primary care spending in Medicare and other federal health care programs, contributes to undervaluing and underinvesting in primary care services.⁴² The MPFS' systemic undervaluation of primary care services also affects reimbursement within APMs.

Moreover, although greater clinician participation in APMs remains the long-term goal, short-term reforms to the FFS system are essential to support those clinicians who have not yet transitioned to Advanced APMs with significant risk bearing or who cannot participate due to a low volume of patients. This transition will take time, and FFS reforms will help to stabilize Medicare Part B's payment system in the short term.

Although CMS administers the MPFS and sets payment rates for clinicians, the American Medical Association's Relative Value Scale Update Committee (RUC) plays a significant and helpful role in informing how CMS values services in the MPFS. The RUC is an advisory committee whose membership is primarily made up of representatives from medical societies, and it recommends how CMS should value such services.⁴³ The RUC develops its recommendations based on survey data collected from specialty societies. The surveys ask clinicians to estimate the time, intensity, and complexity of specific services compared with other tasks. The RUC then evaluates those responses alongside other sources, such as historical payment data, and submits its findings to CMS for consideration.

Although it is not required to do so, CMS has adopted a large majority of the RUC's proposed payment values for services.⁴⁴ Some stakeholders and policy experts have said that CMS relies too heavily on the RUC's recommendations because it lacks the internal data and resources to evaluate and appropriately value services under the fee schedule.⁴⁵

Stakeholders have also raised concerns that because specialty medical societies are overrepresented on the RUC, it has undervalued primary care services.^{46,47} Lower reimbursement rates for primary care services—including within APMs—then contribute to less investment in primary care, poorer patient outcomes, and a weakened pipeline of future primary care clinicians.^{48,49,50}

Compounding the challenge is inadequate data collection on primary care spending in Medicare and other federal health care programs. No consistent federal reporting on a standard definition of primary care spending or the share of total health care spending on primary care services currently exists. This makes it hard to evaluate the impact of payment policies on primary care spending at both the national and state levels, or to reform policies to achieve policymakers' goals.

C. PRIMARY CARE CLINICIANS FACE EXCESSIVE ADMINISTRATIVE COMPLEXITY AND TIME-CONSUMING AND UNPRODUCTIVE REPORTING BURDENS WITHIN APMS; THESE BURDENS ARE AMPLIFIED IN UNDERRESOURCED PRACTICES, SUCH AS SMALL PRACTICES AND THOSE IN RURAL AREAS.

Primary care clinicians face excessive administrative complexity and burdens, including within APMs; the shortage of primary care physicians and other clinicians also creates strains for clinicians.^{51,52}

These administrative burdens often stem from misaligned and complex quality measurement reporting requirements and from uneven access to certified electronic health record technology (CEHRT).⁵³ Since its implementation, MACRA has increased quality measurement reporting requirements.⁵⁴ Through rewards and penalties, clinicians in APMs must report quality measure data through CEHRT systems.^{55,56,57} These requirements disproportionately affect smaller and rural primary care practices that lack the financial and operational resources to fully adopt and maintain these systems.^{58,59,60}

Moreover, primary care clinicians often participate in multiple payment models, including across public and private payers. Clinicians, as a result, often have to report duplicative data, or deal with inconsistent quality metrics. This complexity leads to confusion and to wasted effort, especially when similar measures differ slightly in definition or data entry format.⁶¹ Many quality measures also still fail to reflect the core functions of primary care, such as care coordination and patient engagement.^{62,63}

Key federal policies—including the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, MACRA, and the 21st Century Cures Act—have aimed to improve health IT and streamline data exchange.^{64,65,66,67} However, these laws have not fully addressed the challenges faced by low-volume clinicians, such as rural primary care clinicians, in adopting CEHRT or meeting Medicare’s quality measurement requirements.^{68,69,70,71} **See Figure 4.**

Figure 4: Federal Policy Efforts to Address Administrative Burden

Legislation	Key Components and Outcomes
HITECH Act of 2009	Provided funding for EHRs, with a focus on administrative savings
MACRA of 2015	Expanded CEHRT to include interoperability between providers
21st Century Cures Act of 2016	Required CMS and the Office of the National Coordinator for Health Technology (ONC) to further expand interoperability

Adapted from: David M. Cutler, “Reducing Administrative Costs in U.S. Health Care,” The Hamilton Project, The Brookings Institution, March 2020. Available at: https://www.hamiltonproject.org/wp-content/uploads/2023/01/Cutler_PP_LO.pdf.

Despite some progress, the adoption of CEHRT remains limited.^{72,73,74} An excessive workload involved with electronic health records (EHR) also contributes to clinician dissatisfaction. For example, primary care clinicians spend significantly more time per day on EHR tasks than their specialist counterparts. On average, primary care clinicians spend 115 minutes daily on EHR activities, compared with 85.7 minutes for nonsurgical medical specialists and 45.6 minutes for surgical specialists.^{75,76}

Furthermore, CMS’ recent requirement that all APM participants use CEHRT may further disadvantage rural providers, where EHR adoption remains disproportionately lower due to cost, staffing, and infrastructure constraints.^{77,78} Since 2021, the Government Accountability Office (GAO) and studies have reported that, despite progress, EHR adoption is significantly higher in urban areas (74%) than in rural areas (64%).^{79,80,81}

The Assistant Secretary for Technology Policy and the Office of the National Coordinator for Health Information Technology (ASTP/ONC), which leads the development of a national health information technology infrastructure, is seeking to standardize and improve data exchange between providers (i.e., interoperability).^{c,82} Ideally, CEHRT systems would hasten primary care clinicians’ shift to APMs by helping to streamline patient care and care coordination, including by supporting interoperability.⁸³ These goals remain

^c The Office of the National Coordinator for Health Information Technology (ONC) was created in 2004 and was renamed the ASTP/ONC in 2024.

unmet, however, and further federal action is needed. BPC’s forthcoming work on physician payment reform will further explore this challenge and potential policy solutions as this issue impacts all clinicians.⁸⁴

Finally, the growing primary care workforce shortage—projected by the Health Resources and Services Administration (HRSA) to exceed 87,000 clinicians by 2037—further compounds these administrative burdens, with the largest deficits in rural areas.^{d,85,86,87,88} Although Medicare supports graduate medical education (GME), the current allocation of residency slots does not align with workforce needs in primary care, particularly in underserved areas.^{89,90}

GME refers to the Medicare-supported, hospital-based training that medical school graduates—i.e., residents—receive nationwide within a medical specialty and that leads to eligibility for state licensure and board certification.^{91,92} HRSA has reported that the nation’s projected shortfall of primary care clinicians is driven in part by an aging workforce and uneven geographic distribution, which leaves rural and underserved areas with significantly fewer providers.⁹³ Given the current GME system’s concentration in urban hospital-based programs, it is poorly aligned with the nation’s growing need for primary care in rural areas. The challenge is not just a lack of GME slots but also difficulty in attracting and retaining trainees in these settings.⁹⁴

^d Primary care has several subspecialties, including family medicine, general internal medicine, pediatrics, and geriatric medicine.

IV. Federal Policy Solutions^e

A. ACCELERATE PRIMARY CARE CLINICIANS' PARTICIPATION IN PROMISING APMS

To address the nation's chronic disease epidemic, primary care clinicians must participate more in promising APMs. Alternative payment models hold clinicians financially accountable for delivering high-quality care while allowing them to deliver it in a way that is most cost effective and best meets their patients' needs.⁹⁵ APMs encourage all clinicians, but particularly primary care clinicians, to coordinate care with specialty providers, address their patients' mild-to-moderate behavioral health needs, and communicate more effectively with patients to improve their health outcomes.

Despite MACRA's progress in spurring APM growth, the financial incentives that the law provided have diminished over time.⁹⁶ As a result, Medicare Part B clinicians, including primary care clinicians, still have strong financial incentives to participate in fee-for-service.

The recommendations in this section are designed to address the misaligned financial incentives that encourage primary care clinicians to choose FFS over APMs. For clinicians currently in fee-for-service, this section offers recommendations on how to transition into APMs.

Some of these reforms might require federal investment up front if they are to shift primary care clinicians, particularly those in rural areas and/or smaller practices, into sustainable APMs that reward them for delivering high quality care at a lower cost to Medicare. Such investment might also allow clinicians to feel that they are true partners with CMS in achieving success in APMs. In addition, the reforms might require some reduced cost-sharing to encourage Medicare beneficiaries to participate in these models. Federal policymakers should offset any federal costs associated with these reforms rather than add these costs to the budget deficit.

^e Federal health care agencies are undergoing organizational restructuring that could result in changes to the names or responsibilities of the agencies and offices mentioned in this report. Notwithstanding any changes to the relevant agency or office, the goals of the reforms proposed here should advance through the most appropriate agency or office.

Recommendation 1: Congress should extend and restructure the Advanced APM participation bonus payment to address misaligned financial incentives between FFS and APM participation.

The bonus payment to incentivize clinicians to participate in APMs has fallen since 2019, from 5% to 1.88% of fee schedule payments, and it expired in performance year 2024 (payment year 2026).^{97,98,99} In 2025, clinicians can no longer earn a bonus for payment year 2027. To encourage continued participation in APMs, Congress should extend the 1.88% bonus payment at least long enough to allow CMS and clinicians to transition to a new bonus structure without a break in incentives. A new bonus structure should then be made available to clinicians for at least five years, or at least long enough to appropriately incentivize clinicians to transition into and remain in APMs.¹⁰⁰

Congress should also improve the current bonus structure by eliminating the APM patient and payment thresholds and restructuring the bonus as a flat (risk-adjusted) payment for each APM-attributed beneficiary (rather than for FFS and APM beneficiaries).^{f,101} MedPAC has also proposed this restructuring reform option.¹⁰² See figure 5.

Figure 5. Current and Potential Restructured Bonus Payment

2026 <i>Current 1.88% participation bonus expires</i>	2026 onward <i>Extended 1.88% participation bonus allows clinicians to transition</i>	2027 (or later) + five years <i>New flat, risk-adjusted bonus structure</i>
Current APM Participation Bonus	Transition Period: Short-Term Extension of Current APM Participation Bonus	New APM Participation Bonus
Structure		
Clinicians must see at least 35% of their Medicare patients through APM or receive at least 50% of their Part B payments through APM.	Clinicians must see at least 35% of their Medicare patients through APM or receive at least 50% of their Part B payments through APM.	Remove patient and payment thresholds.
Payment		
Receive 1.88% of total fee schedule payments through payment year 2026 (based on performance year 2024). The bonus expires thereafter.	Receive 1.88% of total fee schedule payments for one year or long enough to allow CMS and clinicians to transition to a new structure without interruption.	Institute a flat, risk-adjusted payment per APM-attributed beneficiary and maintain this new structure and payment for at least five additional years .

Note: Under current law, beginning in 2026, qualifying APM participants will receive a 0.75% increase in fee schedule rates, while non-APM participating clinicians will receive a 0.25% increase in fee schedule rates.

^f This recommendation should not affect the Quality Payment Program's MIPS low-volume threshold reporting exemption, as the intent is to retain reasonable exemptions to MIPS reporting requirements for certain clinicians, particularly small, often rural clinicians and practices who experience significant barriers to QPP participation.

Primary care clinicians tend to secure lower APM bonus payments than specialists due to their lower Medicare billing.^{103,104} This is because the bonus, which is currently based on all Medicare Part B payments (rather than on payments for APM-attributed beneficiaries), disproportionately benefits high-volume providers.

Eliminating the patient and payment thresholds and calculating the bonus as a flat (risk-adjusted) payment based on APM-attributed beneficiaries would remove the incentive for clinicians to deliver a higher volume of care.¹⁰⁵ It would also help ensure strong enough financial incentives to persuade primary care clinicians to choose APMs over both FFS and MIPS.

Restructuring the bonus in this way would preserve it for primary care clinicians, who offer continuous care and have more attributed beneficiaries overall, while specialists are most likely to lose access given the episodic nature of the care they often provide.

Extending the current bonus payment, eliminating thresholds, and restructuring the bonus as a flat payment would ensure that clinicians keep participating in APMs as policymakers address any complex model design issues, such as those related to benchmarking methodologies. Thereafter, Congress should consider making a new restructured bonus available to APM clinicians for five years and then consider the value of a further extension at that point.^g

Although APMs are a critical tool for aligning primary care delivery and payment, they may not be feasible for all provider types or practice settings. As such, BPC recommends thoughtful reforms to the FFS system (see Recommendations 3, 4, and 6).

Recommendation 2: CMS should elevate and apply lessons learned from promising primary care-focused APM demonstrations, including models that provide prospective payments to participating clinicians, to support transforming care delivery and reducing model complexity.

Many APMs involve financial risk, which can deter smaller primary care practices from moving into them.¹⁰⁶ Alternative payment models that offer adequate prospective payments reduce this risk, because they give primary care practices predictable funding that they can invest in improving care.

^g This recommendation is in alignment with a previous recommendation offered by BPC that CMS extend bonus payments for new Advanced APM participants. See BPC's May 2022 report, [The Impact of Covid-19 on the Rural Health Care Landscape](#), for more details.

As the Trump administration sets its strategic goals and develops APMs, the Center for Medicare and Medicaid Innovation (CMMI) should prioritize the elevation of the most promising primary care-focused APMs, particularly those models that offer prospective payments.¹⁰⁷ In alignment with the administration’s Make America Healthy Again initiative, CMMI has already indicated its intent to expand the use of models that offer prospective payments.¹⁰⁸

Within these models, CMMI should ensure that payments are predictable, flexible, and structured to encourage long-term participation and partnership between CMS and APM clinicians. **See Figure 6.** Where possible, CMS should apply lessons learned from promising primary care APM demonstrations.

Figure 6: The Value of Prospective Payments



For over a decade, CMMI has tested a series of primary care APM demonstrations that can inform permanent improvements in model design to support primary care clinicians’ participation and success in APMs. CMMI’s launch of the Comprehensive Primary Care (CPC) multipayer initiative in 2012 provided population-based care management fees and shared savings to support primary care delivery. This led to Comprehensive Primary Care Plus (CPC+), a hybrid payment and medical home model that operated from 2017-2021. This model showed that primary care clinicians valued prospective payments because they helped support care coordination, technology upgrades, and workforce expansion.^{109,110,111}

CMMI began testing the ACO Primary Care Flex Model in 2025.¹¹² This voluntary five-year model within the MSSP offers primary care clinicians both (1) a one-time advance shared savings payment to cover costs associated with forming an ACO and other administrative costs, and (2) monthly prospective payments for primary care services. The model seeks to increase the number of low-revenue (often clinicians and small hospitals serving rural areas) ACOs in the program.^{113,114}

Other recent primary care APM demonstrations have built on the principles of the CPC+ model, and these include the Primary Care First and Making Care Primary models.^{115,116} However, as part of an effort to better align CMMI demonstration models with statutory obligations and strategic goals, the current administration recently announced that these two models will be terminated by December 2025.¹¹⁷

Primary Care First (originally slated to operate from 2021-2026) is a multipayer model that is testing whether advanced primary care delivery can reduce the total cost of care by providing performance-based payments to clinicians along with greater flexibilities.^{118,119} A second multipayer model, Making Care Primary (originally slated to operate from 2024-2034), encourages primary care clinicians to gradually adopt fully prospective, population-based payments while building their infrastructure and improving integration with specialty care.¹²⁰

Given their potential to inform primary care delivery and payment improvements, ending these models prematurely curtails the opportunity to further study and optimize the potential of prospective payments. Ending these models early might also erode primary care clinicians' trust that demonstration models are a reliable option and potentially make them more reluctant to invest in care delivery transformation. In addition, early termination of the models decreases clinicians' exposure to prospective payment systems that provide primary care clinicians with the financial stability they need to transition away from FFS.¹²¹

CMS should continue to elevate, streamline, and reduce the complexity of primary care-focused APMs while implementing lessons learned from these models to ensure stable, permanent opportunities for clinicians to participate in APMs with promising features. If a model's design features, such as prospective payments, demonstrate the ability to improve health outcomes, quality, and costs of care, CMS should expand prospective payment mechanisms across APMs in a streamlined manner. It should also ensure that payments for primary care are substantial enough to drive care delivery transformation.^h CMS should design payment mechanisms to

^h In addition to prospective payment mechanisms, CMS offers advanced investment payments (AIPs) within several MSSP tracks to encourage clinicians in rural and underserved areas to join together to form ACOs. The AIPs can be used to build the necessary MSSP infrastructure.

support clinicians not only within these models but beyond their conclusion, as CMMI models sunset, new models emerge, and providers transition between initiatives.

Recommendation 3: Congress should exempt the new MPFS payment option, Advanced Primary Care Management services, from beneficiary cost-sharing requirements to increase their uptake, particularly among low- and middle-income beneficiaries.

CMS has introduced new APCM service codes within the fee schedule, a promising step toward an MPFS-based hybrid payment option. The 2025 MPFS introduced three new G-codes for APCM services, consolidating multiple care management and communication technology-based codes into a tiered system based on the number of a beneficiary’s chronic conditions and their status as a Qualified Medicare Beneficiary (low-income).^{122,123,124} See Figure 7. In creating the Advanced Primary Care Management service codes, CMS applied lessons learned from both the Comprehensive Primary Care Plus and Primary Care First models.¹²⁵

Figure 7: Advanced Primary Care Management Service Codes

Tier	Patient Criteria	Valuation per Month (approximate)^{126,127}
Level 1	No more than one chronic condition	\$15
Level 2	Two or more chronic conditions	\$50
Level 3	Meet Level 2 patient criteria and is a designated Qualified Medicare Beneficiary	\$110

Like other MPFS services, APCMs require a monthly 20% co-payment, or up to \$10 per month for beneficiaries with two or more chronic conditions.ⁱ This cost-sharing requirement, however, can be a barrier to access for Medicare beneficiaries.^{128,129}

APCMs will permit primary care clinicians to deliver primary care without the undesirable incentive to maximize the volume of services they provide. Most notably, APCMs will enable coordinated primary care for beneficiaries with chronic conditions.

Testing the use of a hybrid payment-like mechanism within the MPFS will offer primary care clinicians a smoother transition and give them the financial stability to participate more in APMs. Serving as a stepping stone toward fully hybrid payment

ⁱ Beneficiaries with one chronic condition will pay around \$3 per month, while beneficiaries with two or more chronic conditions who are also Qualified Medicare Beneficiaries (i.e., low-income) will have their \$22 monthly co-pay covered by Medicaid.

mechanisms, APCMs will prepare primary care clinicians to transition smoothly to models that require them to provide a greater range of services to patients *and* to take on more significant financial risk sharing, such as ACOs. As designed, APCMs could also direct more resources to primary care, enhancing both primary care delivery and the primary care workforce.¹³⁰

Recommendation 4: CMS should report on clinicians' use of, and other findings associated with, APCM services to inform the growth of primary care hybrid payment models.

To ensure that APCMs are used most effectively, CMS should collect and track comprehensive data on clinicians' use of the codes and provide other findings to inform the growth of primary care hybrid payment models. This effort could include tracking APCM utilization trends and code uptake, with particular attention given to geographic variations in code utilization to address disparities in adoption across different regions and practice settings.

Providers using APCM codes must report on both the quality and cost of care provided.¹³¹ As such, to gain clearer insights into the clinical and financial effects of APCM services, CMS should assess larger trends in these reported outcomes related to the quality and cost of care.^j Doing so will help to inform future efforts to increase the adoption of hybrid payments in new and existing APMs.

CMS should make all findings publicly available to promote transparency and inform stakeholders about outcomes. Using this data, as well as the feedback it generates, will allow CMS to continue to refine APCM codes and to potentially expand the use of hybrid payments for primary care. This will also allow CMS to align APCM code use in a way that ensures they remain a transitional step for primary care clinicians to enter more advanced APMs for delivery of primary care.

As discussed by the National Academies of Sciences, Engineering, and Medicine (NASEM) in its response to CMS' Calendar Year 2025 APCM Hybrid Payment Request for Information, refinements and expansion of APCM codes could include the bundling of additional primary care services. This effort could also include greater prospective payments to support resources or infrastructure, and reductions in the proportion of fee-for-service payments.¹³²

^j CMS could also evaluate clinician- and beneficiary-reported experiences with APCMs to determine their practical benefits and challenges. However, CMS does not currently mandate clinician or beneficiary experience reporting. CMS could consider incorporating this experience reporting in the future, including exploring how to best collect information on clinician and beneficiary experience without creating added reporting burdens.

Recommendation 5: Congress and CMS should directly incentivize primary and behavioral health care integration in new and existing APMs to ensure improved coordination of care.

Behavioral health conditions often co-occur with chronic physical illnesses.^{133,134} When left untreated, this co-occurrence increases medical costs.^{135,136,137} As with primary care generally, FFS does not adequately compensate primary care clinicians for delivering truly comprehensive care, much less alongside baseline behavioral health care, which can be time consuming and complex because such care requires added care coordination and collaboration with behavioral health care providers.

Strengthening primary care must include ensuring that Medicare Part B clinician payments adequately support primary care clinicians' ability to meet patients' mild to moderate behavioral health care needs alongside their physical needs. APMs that provide capitated payments for whole-person care, and which specifically account for integrated behavioral health care, are an ideal home for this type of integrated behavioral health care.^{k,138}

Integrated behavioral health care—in which primary care clinicians are incentivized and equipped to screen, manage, and coordinate treatment for patients with mild to moderate behavioral health conditions—improves patients' health outcomes and lowers costs.^{139,140,141,142} In support of delivering integrated care, CMMI is running an Innovation in Behavioral Health (IBH) Model focused on improving the quality of care and behavioral health outcomes for Medicaid and Medicare beneficiaries with moderate to severe mental health conditions and substance use disorders.¹⁴³

There is bipartisan support in Congress to increase this integration. The Connecting Our Medical Providers with Links to Expand Tailored and Effective Care Act, introduced by Sens. Catherine Cortez Masto (D-NV) and John Cornyn (R-TX) in 2023, proposes increased Medicare reimbursement rates for three years for primary care clinicians who integrate behavioral health care services in their practices.^{144,145}

Policymakers must continue to leverage existing APMs to further drive this behavioral health care integration, as outlined in greater detail in BPC's March 2021 report, [Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration](#). CMS, through CMMI, should test and scale successful APMs, such as the BHI model, that best prepare and allow primary care clinicians to offer integrated behavioral health care services to their patients. Congress should support this effort. In the meantime, policymakers

^k The CPC+ model is a good example of an APM that incentivized primary and behavioral health care integration: although concluded in 2021, the model directly incentivized providers to deliver integrated care through higher payments and operational incentives (such as technical assistance).

should also consider increasing the baseline service valuations for the Collaborative Care Model codes to encourage the uptake of its evidence-based approach to integrated care.^{146,147}

**B. ENSURE THAT DATA AND PROCESSES
(1) ENABLE CMS TO DETERMINE THE
APPROPRIATE VALUATION OF PRIMARY
CARE AND OTHER SERVICES UNDER
THE MPFS, AND (2) SUPPORT FEDERAL
POLICYMAKERS' ABILITY TO MEASURE
PRIMARY CARE SPENDING IN FEDERAL
HEALTH CARE PROGRAMS AND SET
PRIMARY CARE SPENDING TARGETS
TO BETTER PREVENT AND MANAGE
CHRONIC DISEASES.**

To ensure that primary care services are valued appropriately—both in how primary care services are priced and how effectively dollars are allocated—Congress and CMS must take deliberate steps. These will need to include building better data collection processes, deploying systems for evaluating and valuing Medicare fee schedule services, and implementing mechanisms to monitor primary care investments.

The recommendations in this section are designed to strengthen CMS' capacity to assess and value clinician services and to ensure transparency and accountability in primary care spending across federal health care programs.

Recommendation 6: Congress should establish a Department of Health and Human Services (HHS) advisory body within CMS, which acknowledges current payment imbalances and strengthens internal data collection processes that support the appropriate valuation of services, including primary care services, under the MPFS.

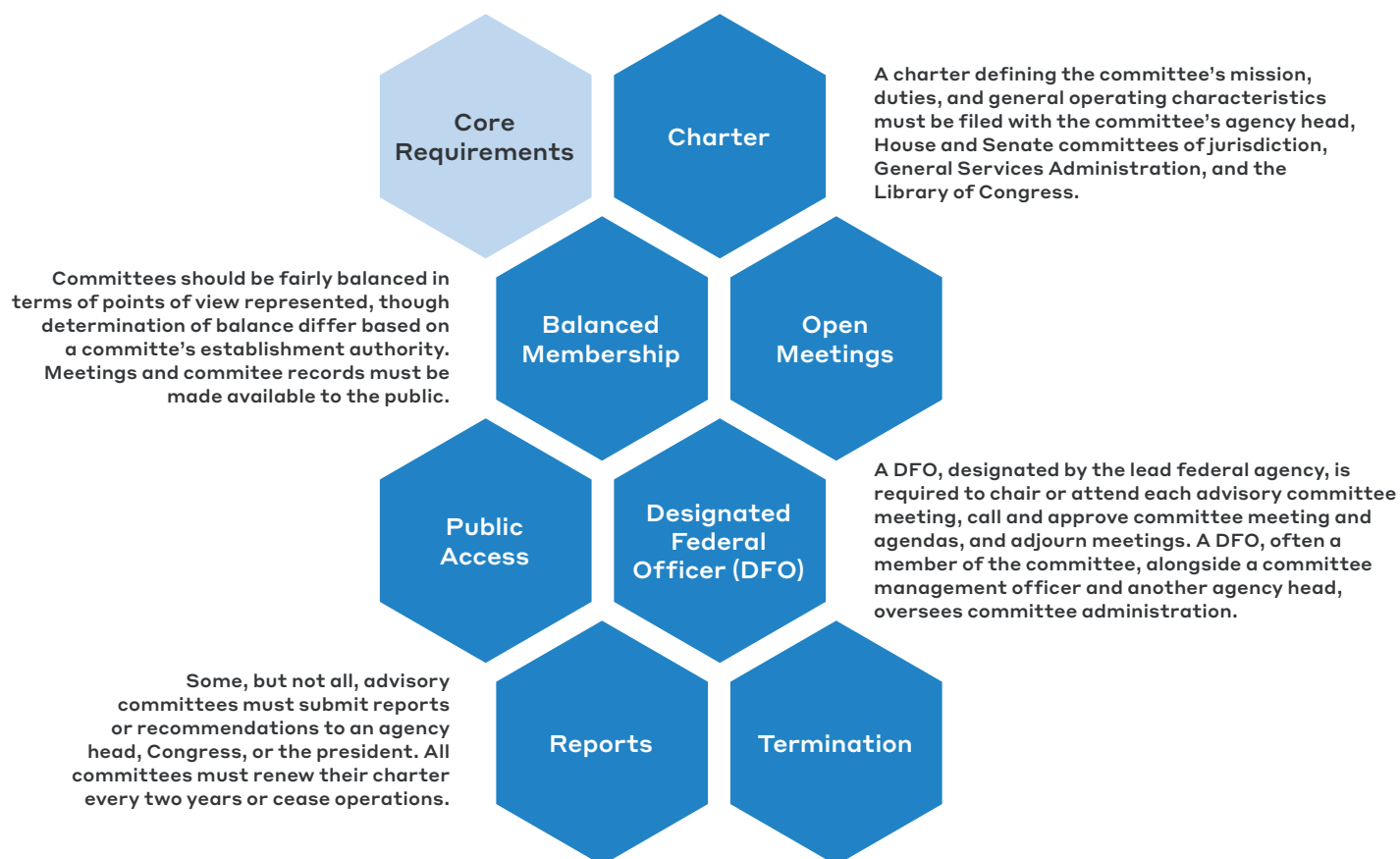
The MPFS dictates FFS payment rates for more than 8,000 physician-delivered services.¹ These payment rates then influence how CMS reimburses and incentivizes clinicians in APMs, as these models incorporate some fee-for-service elements. The undervaluation of primary care services within the MPFS makes it harder for APMs to deliver high-quality primary care and improve patients' health outcomes.^{148,149}

¹ In addition to clinicians, the MPFS also guides payments for nonclinician health care professionals, including nurses, physician assistants, therapists, optometrists, and others.

Historically, as mentioned above, CMS has accepted most of the recommendations from the Relative Value Scale Update Committee for valuing primary care services in the MPFS. Some stakeholders and experts believe this could be because CMS lacks the capacity and resources to conduct its own data collection and assessments for such valuation.^{150,151}

As such, Congress should establish an HHS advisory body within CMS to support the appropriate valuation of services in the MPFS. As it develops its own value assessments, this advisory body should be informed by the data and expertise of the RUC alongside other key stakeholders and policy experts. This advisory body should be subject to the Federal Advisory Committee Act (FACA), which would ensure that it operates in an open and transparent manner.^{152,153} FACA mandates that federal advisory body meetings be open to the public; that meetings be announced in the Federal Register; and that written materials prepared for meetings be made available to the public, among other requirements. **See Figure 8.**

Figure 8: Federal Advisory Committee Act Requirements Applicable to the Proposed CMS Advisory Body¹⁵⁴



Rate-Setting and Advisory Bodies

When CMS sets payment rates that diverge from RUC recommendations, the agency is not required to publicly explain why, although it often provides some written justification in rulemaking.^{155,156} In contrast to the Relative Value Scale Update Committee, a FACA-compliant advisory body would introduce procedural rigor and requirements, while still incorporating the valuable work and analysis done by the RUC.

Several stakeholders—both inside and outside the federal government—have acknowledged the shortcomings of current service valuation processes and recommended ways for CMS to strengthen them. Department of Health and Human Services Secretary Robert F. Kennedy Jr. has also expressed some interest in rethinking CMS' processes for Medicare Part B service valuation.¹⁵⁷

- In a 2015 report, [*Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy*](#), the GAO called for greater oversight and independent evaluation of MPFS service valuations; the report also highlighted potential data-related weaknesses with RUC's processes, such as the committee's use of limited survey data.^{158,159} The GAO suggested that CMS could better document its processes for establishing values for physician services and better incorporate data and expertise from other relevant stakeholder groups.
- A CMS-funded RAND Corporation study found that clinical service times were typically shorter than what is reflected in the MPFS, suggesting that CMS time estimates do not accurately assess physicians' work.¹⁶⁰
- MedPAC has expressed concerns with current RUC valuation processes and recommended that CMS use streamlined methods to more regularly collect current, accurate, and objective data on its own to establish service valuations.^{161,162}

Accordingly, BPC recommends that Congress establish a new HHS advisory body to CMS to make recommendations on primary care services and all other MPFS codes.

There is bipartisan interest in Congress in creating such an advisory committee, but these efforts have focused exclusively on primary care services. The Pay PCPs Act, discussed above, proposed the creation of such a committee to review and refine primary care service valuations.

Responding to a request for information from Sens. Sheldon Whitehouse (D-RI) and Bill Cassidy (R-LA), who is a physician, on the Pay PCPs Act, NASEM recommended that such a committee use empirically collected data (versus provider-reported surveys, as RUC uses) and provide transparency into its decision-making.¹⁶³

NASEM also recommended that lawmakers provide CMS with the resources and leadership it needs to establish its own data collection and service valuation processes to reduce its reliance on the RUC.¹⁶⁴ With that recommendation, NASEM seeks to return the RUC to its intended advisory status; BPC has interviewed several stakeholders who support this recommendation.¹⁶⁵ In alignment with NASEM's recommendations, Congress should consider providing HHS with the resources necessary to support adequate staffing and ensure that the CMS advisory body relies on a diverse range of data sources and provides transparency into its determinations.

Recommendation 7: Congress should require HHS to measure and report on primary care spending, including as a percentage of total health care spending, across all federal health care programs and move toward setting a minimum spending target.

Too little U.S. health care investment goes to primary care, hampering positive patient health outcomes.¹⁶⁶ This underinvestment in primary care extends to physicians' compensation, contributing to a growing workforce imbalance.^{167,168}

Among Organisation for Economic Co-operation and Development countries, the average share of total health care spending on primary care is about 13%.^{169,170,171} Research shows that the United States spends about half that amount.^{172,173,174}

The Assistant Secretary for Planning and Evaluation (ASPE) has made efforts to uncover primary care spending at the state level. According to an analysis the agency released in early 2024, average monthly per beneficiary spending on primary care in Medicare fee-for-service in 2019 ranged from \$32-\$69 across states, accounting for approximately 3%-6% of total Medicare spending.¹⁷⁵ The analysis also shows that the percentage of Medicare spending on primary care varied significantly by state, with the highest rates in Tennessee, South Carolina, Arizona, and North Carolina, and the lowest in Washington, DC, South Dakota, Maine, and California.¹⁷⁶ As such, any approach to measure and define primary care at the national level should account for the diverse characteristics of individual states, including the composition of their health care workforces, while also recognizing the unique challenges facing rural primary care providers.

By measuring and reporting on a standard definition of primary care spending—including as a percentage of total health care spending—policymakers can create a comprehensive, transparent framework through which to understand and improve primary care. Doing so will help policymakers and stakeholders make wise decisions about how to allocate limited resources. It will also help ensure that investments in primary care are adequate to reduce long-term costs by improving prevention and better managing chronic diseases.

Accordingly, BPC recommends that Congress require HHS to measure and report on primary care spending, including as a percentage of total health care spending, across all federal health care programs. This should include Medicare and Medicaid, as well as the Veterans Health Administration, TRICARE, Indian Health Services, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.¹⁷⁷ BPC also recommends that Congress move toward requiring HHS to set a minimum primary care spending target.

BPC has previously raised concerns about inadequate measurement of and investment in primary care. In a 2020 report, [*Advancing Comprehensive Primary Care in Medicaid*](#), we urged Congress to direct the HHS secretary to work with states and stakeholders to measure and report on primary care spending as a percentage of total health care spending.¹⁷⁸ This reform would create a clearer source of information on such spending, helping federal policymakers optimize primary care investments to achieve better patient outcomes.

C. REDUCE ADMINISTRATIVE COMPLEXITY AND THE STRAIN ON PRIMARY CARE CLINICIANS BY CONSOLIDATING PROGRAMS THAT SUPPORT THE USE OF CEHRT, BY SIMPLIFYING REPORTING REQUIREMENTS WITHIN APMS, AND BY MAXIMIZING THE IMPACT OF MEDICARE-SUPPORTED PRIMARY CARE RESIDENCY POSITIONS.

MedPAC's 2024 Report to Congress highlighted the importance of simplifying complex reporting requirements and reducing administrative burdens to foster greater primary care clinician participation in APMs.¹⁷⁹ The report said that by increasing administrative efficiency, CMS can encourage more clinicians, especially in primary care, to engage in APMs, which in turn will lead to better patient care and improved health care outcomes.

The recommendations in this section are focused on alleviating the administrative challenges that the strained primary care workforce faces when participating in APMs. By reducing these burdens, clinicians can dedicate more time to patient care.

Recommendation 8: Congress and HHS should improve administrative efficiency by simplifying and consolidating similar federal grant programs, while ensuring that consolidated programs support the adoption of CEHRT among small and rural primary care clinicians.

Certified electronic health record technology enables clinicians to document outcomes and adhere to clinical guidelines. This empowers clinicians to meet the criteria for APM participation and to be evaluated, incentivized, and rewarded for improving the quality of care and constraining costs.^{180,181}

Although the federal government has made some progress in enhancing administrative efficiency and reducing the administrative burden on Medicare Part B primary care clinicians overall, challenges remain. As the GAO reports, these challenges continue to disproportionately affect small, independent rural providers, who often lack the resources and support to keep pace with federal reforms.¹⁸² This is because even slight revenue changes can jeopardize their financial stability, as rural providers typically see fewer patients and generate lower revenue under payment models.^{183,184}

With limited financial reserves, these independent practices often struggle to afford essential resources like additional staff or health IT upgrades.¹⁸⁵

HHS should steer its limited resources toward those areas with the greatest impact by focusing on the unique needs of primary care clinicians in Medicare Part B—particularly smaller, rural, and independent providers—who face barriers to adopting CEHRT and participating in value-based payment reforms. Specifically, HHS should consolidate similar funding grant programs within its current authority that are available to primary care clinicians in small practices or rural areas who are not affiliated with a hospital or system.¹⁸⁶ HHS should report on and make recommendations to Congress on any programs that require legislation for consolidation to improve administrative efficiency, while ensuring that appropriated funds are not reduced.

Under HHS, agencies such as HRSA and the ASTP/ONC administer grants and provide technical assistance to support health IT adoption, including several ongoing programs that help rural providers adopt and optimize EHR technology.^{m,187} In fiscal year 2024, HRSA—through the Federal Office of Rural Health Policy—invested nearly \$365 million in expanding health care access and strengthening delivery systems across rural areas.¹⁸⁸ Although some of these grants expired at the end of FY2024, others remain active, with many allowing rural provider grantees to use funds for technical assistance, including efforts to advance the meaningful use of CEHRT.^{189,190}

^m As of the drafting of this brief, the Trump administration is reorganizing HHS. As part of this process, the roles and responsibilities of several agencies, including HRSA, are expected to be combined into a newly established Administration for a Healthy America within HHS.

Notable examples include HRSA's Rural Health Care Coordination Program (2023–2027), which helps rural health networks develop community-based solutions to improve care coordination and equitable access, including EHR adoption and regional health information exchange, as seen in the grant to the Adirondack Health Institute. Additionally, the Small Health Care Provider Quality Improvement Program (SHCPQIP) awarded \$11.3 million over three years to enhance rural primary care and patient outcomes.^{191,192} Although SHCPQIP is no longer accepting applications, the program's focus on small rural providers remains relevant as HHS considers streamlining HRSA initiatives.¹⁹³

HRSA currently funds at least six grant programs that provide data, evaluation, and technical assistance to rural providers; however, many grants primarily target rural hospitals and clinics, often overlooking independent, unaffiliated rural practices.^{194,195} Moreover, overlapping priorities across programs can lead to redundancy and inefficiencies. Further analysis is needed to assess the scope of HRSA-funded grants and to develop strategic recommendations for their consolidation.

Consolidating funding programs that are available to independent rural or small primary care practices is critical to avoiding duplication and inefficiencies while supporting CEHRT uptake.¹⁹⁶ Advancing EHR interoperability is also imperative for improving care coordination and reducing clinician burden, which BPC will address in its forthcoming work on physician payment reform.

Recommendation 9: CMS, with input from stakeholders and policy experts, should standardize and align primary care quality measures across payers and payment models to reduce administrative burdens on primary care clinicians in APMs.

To ensure high-quality patient care and address overly burdensome quality measurement reporting requirements—which can deter primary care clinicians from APM participation—CMS should standardize and align primary care quality measures across payers and payment models.¹⁹⁷ Federal policymakers have made progress toward this goal by advancing CMS' National Quality Strategy (NQS) and related initiatives, including Patients Over Paperwork and Meaningful Measures 2.0.^{n,198,199} However, the Trump administration should prioritize and accelerate efforts to standardize and align quality metrics and reporting requirements across payers and models to reduce the amount of time and resources that clinicians spend on excessive, redundant administrative tasks.^{200,201} There are already promising signs that

ⁿ CMS developed the Meaningful Measures 2.0 framework to reflect the quality measurement priorities of the Agency for its NQS as mandated by MACRA. The agency's NQS shapes the entire ecosystem of meaningful quality measures across all payers and providers.

CMMI is interested in reducing administrative burdens by standardizing quality measures in its models.²⁰²

Over the long term, federal policymakers should strive to achieve a unified quality measurement and reporting system for Medicare, Medicaid, and private payers. Under this approach, clinicians would report on standardized quality measures to a centralized database.^{203,204} This approach would address the challenge of clinicians often being required to report on too many different quality metrics, as well as on similar quality metrics that are defined in slightly different ways across payers and payment models.

Although limited data exist on the financial costs of quality measure reporting, one 2016 study estimated that the total amount of time that primary care clinicians spend on quality measure reporting translates to more than \$15.4 billion annually.²⁰⁵ This study also found that primary care clinicians spend an average of 3.9 hours per week on quality measures—more than cardiologists (1.7 hours), orthopedists (1.1), and multispecialty physicians (3.0)—including such tasks as tracking specifications, collecting data, entering records, billing, coding, and transmitting information.²⁰⁶ Establishing a standard set of quality reporting metrics for primary care would thus meaningfully reduce administrative tasks and expenses for primary care clinicians, marking an important initial step toward a unified quality measurement and reporting system.

This standardized approach to quality measure reporting would complement federal policymakers' recent efforts to standardize quality measures, such as through the CMS Universal Foundation for Quality Measures initiative as part of its National Quality Strategy.^{207,208} Congress required the HHS secretary to establish certain recommended core sets of health care quality measures in Medicaid, and it required states to report on the Child Core Set and behavioral health measures on the Adult Core Set beginning in 2024.²⁰⁹ Similar efforts to require streamlined and standardized quality measurement should continue to progress within Medicare, as intended by MACRA and the 21st Century Cures Act, specifically with the goal of aligning primary care quality measures across public and private payers.^{210,211}

CMS should lead this effort to develop a standard primary care quality measurement set, with significant input from a wide variety of stakeholders and policy experts.^{212,213} CMS should identify a standard set of primary care metrics that measure multiple components of whole-person care, in alignment with NASEM's guiding principles (2021).^{214,215,216} In doing so, CMS should leverage existing consortiums and collaboratives, including America's Health Insurance Plans and the National Committee for Quality Assurance (NCQA).

This effort could build on the Core Quality Measures Collaborative (CQMC) core measure set: ACOs, Patient Centered Medical Homes, and Primary Care.^{217,218,219} This recommendation also aligns with NCQA's recent report to the Trump

administration urging HHS to accelerate alignment with the CMS Universal Foundation to streamline quality measurement across HHS quality reporting and value-based payment models.²²⁰

Primary care clinicians' health information technology and EHR systems are key to efforts to reduce administrative burdens by streamlining quality measurement reporting. In APMs, particularly, these tools must effectively capture and share the necessary data to support care coordination and the aggregation of performance data for all clinicians within an APM entity (including clinicians across multiple tax identification numbers) for successful quality measurement reporting. Accordingly, as some experts have recommended, federal policymakers should develop the proposed primary care quality measurement set with an eye toward using information that clinicians are already entering into their electronic medical records. This would lower excessive administrative burdens by reducing the need for staff to re-record information into a separate quality assessment tool.²²¹

Beyond standardizing quality measures within APMs, some standardization of APM payment methodologies is also needed. This includes the standardization of benchmarking, risk-adjustment, and attribution methods, among others, across models and payers. BPC's forthcoming work on physician payment reform will further offer policy recommendations to address this need.

Recommendation 10: Congress and HHS should advance a comprehensive strategy to address the shortage of primary care clinicians, including by ensuring the adequate allocation and distribution of GME residency positions, particularly for primary care residencies.

Accelerating clinician participation in the most promising APMs, accurately valuing primary care services, and reducing the administrative complexities and burdens faced by primary care clinicians are each essential components of improving primary care delivery in the United States. Any such improvement, however, will be continually threatened if critical workforce challenges remain unaddressed.

Lawmakers must tackle workforce challenges by taking a multifaceted approach to address primary care clinician workforce issues, in particular, which are likely to be exacerbated by the needs of the nation's aging population. This effort includes making primary care a competitive career choice for future physicians and other clinicians, such as nurse practitioners and physician assistants, who are eligible to bill Part B-covered professional services.^{222,223}

Although this recommendation focuses on primary care, it is in support of a broader strategy to ensure a robust broader health care workforce. Accurately valuing the primary care services clinicians provide, as recommended above,

will hasten this progress, as well as to help reduce clinician burnout, improve job satisfaction, and ensure better care for patients.^{o,224}

Medicare is the nation's largest source of funding for residency positions, meaning that decisions on how to allocate funds are especially consequential.^{225,226,227} Generally, Congress determines how many residency slots Medicare can fund and whether these caps are increased; Congress also sometimes establishes criteria for the distribution of new slots to certain specialties or regions. CMS implements and awards any new slots based on criteria set by Congress. Given that lawmakers have capped GME payments, limiting the number of full-time resident equivalents and the per-resident amounts that Medicare will support, any increases in Medicare-supported residency positions will require new legislation.^{228,229,230,231}

Because many GME slots for primary care remain unfilled, simply funding more slots is unlikely to solve the underlying issues keeping potential clinicians from practicing primary care.^{232,233} Rather, Congress and HHS need a refined approach that ensures primary care GME slots are allocated in a way that is efficient and maximizes their impact.

HRSA's Council on Graduate Medical Education (COGME) reviews physician workforce trends, training issues, and financing policies and, in response, makes recommendations to the federal and private sectors.^{234,235,236} COGME also provides recommendations to the HHS secretary and Congress on the supply and distribution of physicians, as well as on the current and future shortages or surpluses of physicians in medical and surgical specialties and subspecialties.²³⁷ By leveraging COGME's expertise and findings on workforce shortages, Congress can ensure the most efficient use of resources by, for example, allocating any new GME residency slots to address the nation's most significant workforce shortages, particularly primary care. At the same time, HHS should ensure that any primary care slots are distributed in a way that will maximize their impact and address the shortage of primary care physicians.

Policymakers have historically supported bipartisan legislative solutions to address physician shortages in this way. The 2021 Consolidated Appropriations Act funded the first expansion of GME positions since 1996, with money for 1,000 new slots in 2022; at least 100 of these were directed to hospitals in areas with the most significant shortages.^{238,239}

If the bipartisan 2023 Resident Physician Shortage Reduction Act had been passed and signed into law, it likewise would have built on this momentum. The act specifically addressed the primary care workforce shortage and

^o Immigration reforms can play a critical role in strengthening the primary care workforce. BPC has published research exploring the intersection between immigration policy and health care workforce shortages. See BPC's April 2025 report, [Bridging the Gap: Meeting Workforce Needs Over the Next Decade](#), for more details.

proposed the allocation of 14,000 new Medicare-supported GME positions over seven years, with positions focused on primary care and specialties with critical workforce gaps.^{240,241}

Most recently, a bipartisan group of senators, including Bill Cassidy, M.D. (R-LA), Catherine Cortez Masto (D-NV), John Cornyn (R-TX), and Michael Bennet (D-CO), released a draft bill that would add 5,000 Medicare GME residency positions. The bill, introduced in December 2024, would allocate a portion of these for primary care and give preference to rural or underserved areas.²⁴²

Attention to the allocation and distribution of GME residency positions is an essential component of a comprehensive strategy to address the shortage of primary care clinicians. As recommended throughout this report, appropriate valuation of primary care services and reforms to help clinicians enter and succeed in APMs are critical to increase the number of primary care clinicians and to support their retention. The primary care workforce is essential to preventing and managing America's chronic conditions. Supporting primary care, in turn, will reduce avoidable, more expensive costs to the Medicare program by, among other things, preventing hospitalizations and the deterioration of patients' health.

V. Conclusion

To ensure that primary care clinicians thrive in APMs, provide high-quality care to beneficiaries, and constrain cost growth in the Medicare Part B program, Congress and the Trump administration should advance reforms to the current payment system. Existing flaws in this system—including misaligned financial incentives, outdated valuation methodologies, and excessive administrative burden—undermine the goals set out in MACRA and jeopardize the sustainability of the Medicare program. Primary care clinicians—especially those in rural and underserved areas—require stable, predictable support to fully partner with CMS and to participate meaningfully and successfully in APMs.

By extending and restructuring the APM bonus payment, expanding innovative payment mechanisms—such as prospective and hybrid payments—and improving the valuation and measurement of primary care services, federal policymakers can address flawed incentives that continue to drive up the total cost of patients' care over the long-term. Reducing excessive administrative burdens on primary care clinicians and addressing workforce shortages will likewise support these outcomes and improve efficiency. These reforms are particularly urgent as the nation's population grows older, sicker, and more reliant on primary care to manage chronic conditions and avoid costly, preventable illness.

Glossary of Acronyms

ACO	Accountable Care Organization	GME	graduate medical education
APCM	Advanced Primary Care Management	HHS	Department of Health and Human Services
APM	alternative payment model	HITECH Act	Health Information Technology for Economic and Clinical Health Act of 2009
ASPE	Assistant Secretary for Planning and Evaluation	HRSA	Health Resources and Services Administration
ASTP/ONC	Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Technology	IBH	Innovation in Behavioral Health Model
CEHRT	certified electronic health record technology	MACRA	Medicare Access and CHIP Reauthorization Act of 2015
CMMI	Center for Medicare and Medicaid Innovation	MIPS	Merit-based Incentive Payment System
CMS	Centers for Medicare & Medicaid Services	MPFS	Medicare physician fee schedule
COGME	Council on Graduate Medical Education	MSSP	Medicare Shared Savings Program
CPC	Comprehensive Primary Care	NASEM	National Academies of Sciences, Engineering, and Medicine
CPC+	Comprehensive Primary Care Plus	NCQA	National Committee on Quality Assurance
CQCM	Core Quality Measures Collaborative	NQS	National Quality Strategy
EHR	electronic health record	QPP	Quality Payment Program
FACA	Federal Advisory Committee Act	RUC	Relative Value Scale Update Committee
FFS	fee-for-service	RVU	relative value unit
FORHP	Federal Office of Rural Health Policy	SGR	Sustainable Growth Rate
FTE	Full-Time Equivalent	SHCPQIP	Small Health Care Provider Quality Improvement Program
GAO	Government Accountability Office		

Endnotes

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