Bipartisan Policy Center

The Need for Medicare Part B Physician Payment Reform

Key Barriers to Clinicians' Participation in Promising Alternative Payment Models

Issue Brief #2 of 3

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

Our first issue brief, *The Need for Medicare Part B Physician Payment Reform*, underscored the importance of accelerating clinicians' participation in the most promising alternative payment models (APMs), which growing evidence shows are more effective than the prevailing payment system in promoting efficient, quality-driven care.[1] The brief also detailed how clinicians are paid under Medicare Part B and outlined the relevant federal legislative history and current landscape for legislative and regulatory reform.[a] This second issue brief focuses on the main barriers that limit clinicians' participation in promising APMs. These include:

- **Misaligned financial incentives for APM participation**, including the expiration of the Advanced APM participation bonus payment and flaws in valuation processes under the Medicare Physician Fee Schedule (MPFS).

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

- **A fragmented and complex landscape of APMs**, including structural limitations within Medicare's permanent APM program, known as the Medicare Shared Savings Program (MSSP).
- **Excessive administrative burdens** related to quality measurement reporting and electronic health record (EHR) interoperability within APMs.

Although Congress and the Trump administration have made some progress in addressing these barriers, the fee-for-service (FFS) system is still popular with many clinicians, as reflected by their steady FFS participation alongside some growth in APM adoption.[2,3] Given that APMs reward clinicians for delivering high-quality care rather than a high volume of services, federal policymakers should advance reforms to accelerate clinicians' participation in these promising models. In alignment with the priorities of Congress and the administration, these reforms should ensure that Medicare better supports prevention and management of patients' chronic health conditions, improves administrative efficiency for clinicians, and constrains the growth in health care costs.

Federal policymakers could also consider advancing these reforms alongside making improvements to the MPFS that address the ongoing need for Congress to annually update payment rates. This could help establish a more sustainable, permanent solution that would balance appropriate clinician reimbursement with Medicare's long-term fiscal stability.

Drawing on assessments of APMs to date, this issue brief offers key themes and lessons learned from the most successful models and details how misaligned financial incentives, model design flaws, and excessive administrative burdens continue to limit clinicians' participation in alternative payment models.

BPC's forthcoming third and final issue brief in this series, as well as an accompanying report, will offer specific, actionable bipartisan federal legislative and regulatory policy recommendations to enhance clinicians' participation in the most promising APMs.

MISALIGNED FINANCIAL INCENTIVES ENCOURAGE FEE-FOR-SERVICE OVER APM PARTICIPATION

Addressing misaligned financial incentives within Medicare's physician payment system requires a multipronged approach that includes ensuring clinicians are rewarded adequately for the high-quality care that APMs are designed to enable. It also includes ensuring that these models provide the financial predictability and supports necessary to sustain clinicians' participation in APMs and engagement with beneficiaries.

Expiring Incentives Reduce Long-Term Participation in Advanced APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established fixed and gradually declining annual payments to MPFS rates and introduced the Quality Payment Program (QPP). Both changes sought to *discourage* clinicians from remaining in the fee-for-service system and to gradually shift them into value-driven models of health care payment and delivery such as APMs.[b] MACRA did this by providing financial incentives for clinicians to participate in the QPP's Merit-based Incentive Payment System, as well as *additional* financial incentives for clinicians to participate in Advanced APMs, which require clinicians to bear greater financial risk.

These financial incentives included (1) an Advanced APM participation bonus payment, which has expired, and (2) beginning in calendar year 2026, an updated and higher MPFS conversion factor for Advanced APM participants relative to clinicians who do not participate in these advanced payment models. Performance year 2024 was the last year that clinicians could earn the Advanced APM participation bonus payment, which they will receive in payment year 2026.[c] As a standalone change, the expiration of this incentive undermines efforts to attract and retain clinicians' participation in APMs.

A modest countervailing factor is the one year, 2.5% conversion factor update in calendar year 2026 for clinicians enacted as part of H.R. 1, the One Big Beautiful Bill Act.[4] As a result, and in accordance with existing MACRA provisions and updates enacted via H.R. 1, clinicians who do not participate in Advanced APMs can expect a 3.62% increase from the current conversion factor, while those participating in these models can expect a 3.83% increase. However, although this update creates some incentive for clinicians to participate in APMs, it still falls short of the stronger, more intentional incentives envisioned by MACRA. It is unlikely, on its own, to drive a substantial shift in clinicians' participation in alternative payment models. As such, the need for APM participation incentives is even more critical.

Financial incentives for Advanced APM participation are important to clinicians, because these incentives help them counterbalance the initial costs and potential revenue losses associated with transitioning away from FFS, including their initial investments in transforming care delivery.[5] Research also suggests that financial incentives, while not the sole contributing factor to increasing APM participation, are an important way to raise this participation.[6]

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[b] Although MACRA was signed into law in 2015, its changes only took effect in 2017. Clinician payment adjustments took effect two years later in payment year 2019.

[c] Qualifying Advanced APM participants receive their bonus payment two years after the performance year. The Centers for Medicare & Medicaid Services measures performance and payment years according to the calendar year (January 1-December 31).

In addition to the diminishing financial incentives for APM participation, current patient and payment thresholds for receiving the Advanced APM participation bonus hinder clinicians' participation. The current bonus structure can also disincentivize clinicians' participation in alternative payment models.

To qualify for the Advanced APM participation bonus, clinicians must have seen at least 35% of their Medicare patients through the APM or have received at least 50% of their Part B payments through an APM in 2024.[d,7]

INCENTIVIZING HOSPITALS' AND HEALTH SYSTEMS' PARTICIPATION IN APMS

Within Medicare, hospitals are primarily reimbursed through the Inpatient Prospective Payment System (IPPS) for inpatient stays and the Outpatient Prospective Payment System (OPPS) for outpatient services. These prospective payments remain fundamentally volume-based, as payments are tied to the number of services that hospitals provide. And even though some percentage of hospital-based clinicians participate in APMs that hold them accountable for cost and quality, hospitals' base payments continue to flow through IPPS and OPPS, as well as through the Medicare Physician Fee Schedule for hospital-based clinicians. So, although APM participants might share in savings or absorb losses based on their performance in an APM, these arrangements are still layered atop underlying fee-for-service structures.

This dual structure creates considerable misalignment: APMs encourage care alignment, but hospitals are still primarily rewarded based on volume. As a result, many hospitals and health systems default to the more predictable revenue stream available in fee-for-service, although some evidence indicates that more physicians in hospitals, and particularly those in well-resourced hospitals, are starting to participate in greater numbers in APMs.

These institutions account for a substantial share of total Medicare spending, at 37%. Aligning their financial incentives appropriately is important to realize the potential meaningful return on investment and savings possible through value-based care.

Despite intending to reward and incentivize participation, these sharp eligibility thresholds can discourage clinicians' participation in APMs. Because bonuses are awarded based on a clinician's total Part B payments or number of attributed patients—and not on care delivered through an APM—clinicians who fall short of thresholds receive no incentive at all. This can disincentivize APM participation and discourage clinicians from gradually transitioning away from fee-for-service-based care delivery.[8,9] For details on incentivizing hospitals' and health systems' participation in APMs, see **Incentivizing Hospital's and Health System's Participation in APMs** text box above.[10,11,12,13]

[d] Any changes to the structure of the Advanced APM participation bonus payment should not impact the QPP'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 that experience significant barriers to QPP participation.

A more fundamentally misaligned incentive lies in the current bonus payment structure, which evaluates a clinician's percentage of *total* fee schedule payments across all patients, rather than limiting the calculation *only to payments for APM-attributed beneficiaries*. Tying the bonus amount to total fee schedule payments in this way favors larger, higher-volume practices rather than rewarding the delivery of high-value care through an APM.

The Medicare Physician Fee Schedule's Misvaluation of Certain High-Value Services Limits and Negatively Affects APM Participation

Improving Medicare's existing FFS system *in tandem* with reforms to shift more clinicians into APMs, such as through direct financial incentives for participation, would ensure that high-value health care is appropriately reimbursed within alternative payment models. This is especially important to counteract the entrenched, predictable incentives for service delivery volume that drive hospitals and large health systems to prioritize FFS participation over APMs.[14,15,16,17]

Even if policymakers advance structural and financial incentive reforms to improve APMs, their effectiveness will be limited by foundational shortcomings of the Medicare Physician Fee Schedule, which many APMs are built upon. This is because the MPFS continues to undervalue or does not recognize core functions of value-based, coordinated care delivery, and this affects clinicians' success within APMs.

Contributing to this challenge is the reliance of the Centers for Medicare & Medicaid Services (CMS) on limited data sources. The lack of robust empirical data hinders CMS' ability to set fee schedule rates, particularly for primary care services, that adequately reflect the value of services. So, even when clinicians shift into an APM, their base reimbursement rate remains tied to an existing fee-for-service system that continues to undervalue coordinated, and often preventive, health care. This misalignment undermines policymakers' efforts to better prevent and manage costly chronic conditions—such as diabetes and heart disease—that require sustained, team-based interventions.

CMS determines physician payment rates under the MPFS by calculating base payment amounts for each service—distinguished by one of over 7,000 codes—using relative value units (RVUs). These RVUs represent the resources needed to provide each service and include separate RVUs for physicians' work, practice expenses, and malpractice insurance costs (also known as professional liability insurance). These RVUs are then adjusted using geographic practice cost indices that reflect cost variations across the country, multiplied by a conversion factor, and then modified by policy-based adjustments. See **Appendix A** for an overview of Medicare's physician rate calculation process and **Appendix B** for an example of a fee schedule payment calculation.

Stakeholders, including clinicians, continue to raise concerns that the codes that most support patient-centered care (such as primary care and care coordination services) are often undervalued. The Government Accountability Office has made several recommendations to improve the process for establishing service values, but meaningful reforms based on these recommendations have not materialized.[18] Developing an evidence-based, transparent process for ensuring the appropriate valuation of MPFS services is critical to the success of alternative payment models.

A FRAGMENTED, COMPLEX PAYMENT LANDSCAPE AND APM DESIGN FLAWS LIMIT SUCCESS

As the nation's health care system continues its shift toward greater use of value-based models of care, the proliferation of APMs—many with varying requirements, structures, and timelines—has led to a fragmented and confusing payment landscape for clinicians and health systems. This complexity is particularly acute for smaller practices and safety-net providers that often lack the resources to adapt to shifting models and administrative demands. The result is a landscape of models that deters sustained APM participation and limits the scalability of successful innovations.

Stakeholders and policy experts interviewed by BPC say that available APMs are too numerous, change too frequently, offer inconsistent performance feedback, and lack predictability. This leads to "model churn," undermining clinicians' confidence in the stability of available models and their ability to plan for long-term APM participation.[19] Fragmentation also causes misalignment between clinician workflows, patient populations, and provider risk capacity necessary for successful participation in APMs.

Lessons from the Center for Medicare and Medicaid Innovation's Recent APM Demonstrations

Evidence increasingly suggests that APMs—and particularly accountable care organizations (ACOs)—are better than fee-for-service in enabling efficiency in health care delivery without negatively affecting health care quality.[20] The Center for Medicare and Medicaid Innovation (CMMI) plays a central role in developing and testing these APMs; it has launched dozens of payment and care delivery models over the years, although only a handful are ACOs.

Evaluations of CMMI models highlight common themes among the most successful APMs: timely, actionable data, predictable benchmarks, and aligned incentives. In an evaluation of models from 2012-2022, the Assistant Secretary for Planning and Evaluation found that several CMMI models, as well as the MSSP ACO, generated annual gross savings *and* had spillover effects for non-model-attributed beneficiaries.[21] However, the sheer volume of models, their variation in design, and early terminations have each contributed to an APM landscape that

clinicians find fragmented and difficult to navigate. Examples of models worth highlighting and reflecting on include:

- The ACO REACH model, which began as the Pioneer ACO model (2012-2016), tested population-based payments similar to the MSSP.[22] It evolved into Next Generation ACO (2016-2021), incorporating higher financial risk structures.[23] In 2021, it briefly became the Global and Professional Direct Contracting Model before it was quickly rebranded as ACO Realizing Equity, Access, and Community Health (ACO REACH).[e,24] Recent evaluations show incremental improvements in quality and reductions in gross spending, although CMS is planning to institute several changes to improve the model's sustainability in 2026.[25,26]
- Making Care Primary, which, like its predecessors the Comprehensive Primary Care model (2012-2016) and Comprehensive Primary Care Plus (2017-2021), aimed to advanced multipayer primary care models.[27,28] Launched in 2024, Making Care Primary introduced expanded levels for clinicians' gradual adoption of prospective, population-based payments.[29] CMS has announced it will end the model almost a decade early, in 2025, cutting short further testing and potentially eroding clinician trust in the reliability of model availability.[f,30]
- The Primary Care First Model, which, like Making Care Primary, built on the successes of the Comprehensive Primary Care Plus model, is also ending early.[31] The model, initially slated to end in 2026, will now conclude at the end of 2025.[32]
- The ACO Primary Care Flex model launched in 2025 and is set to run through 2029. Limited to MSSP participants, it aims to strengthen participation in team-based, primary care-based ACOs.[33]

Although CMS and CMMI continue to make meaningful, thoughtful efforts to refine and update APMs, future efforts must balance innovation and meaningful improvements with stability. Frequent changes or early model terminations can discourage clinicians' participation and erode trust that the significant upfront investments, workflow redesigns, and compliance efforts required for participation will ultimately be worthwhile.

Design Flaws in the Medicare Shared Savings Program Undermine Clinician Engagement

The MSSP—Medicare's permanent, largest, and most established APM—offers clinicians an ACO participation pathway under the Advanced APM Track. **See Figure 2.**[34] The Congressional Budget Office's April 2024 report, *Medicare Accountable Care Organizations: Past Performance and Future Directions*, identified factors supporting greater federal savings from ACOs, including independent

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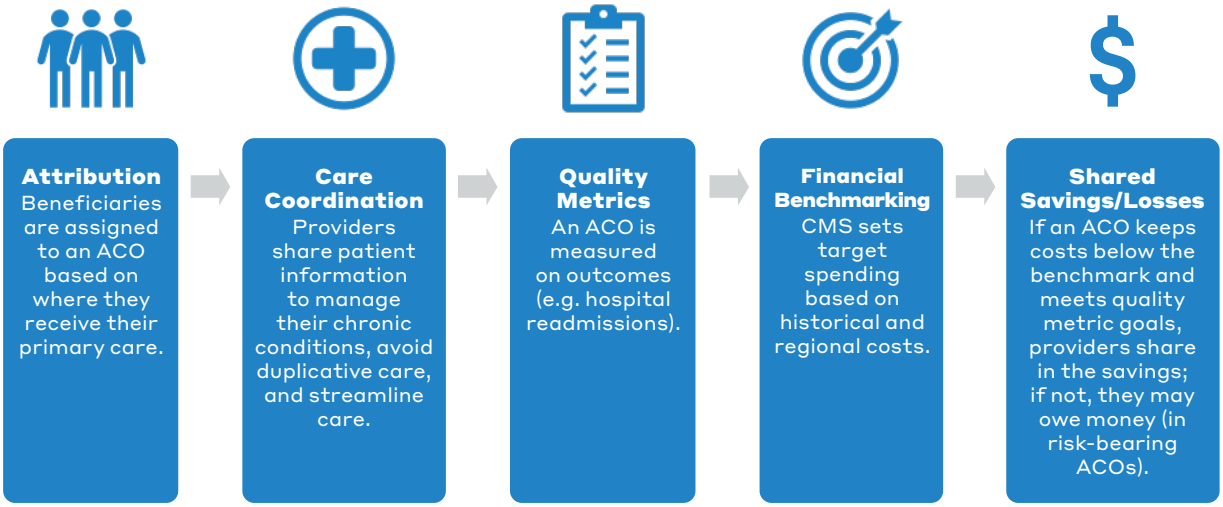
[e] The Global and Professional Direct Contracting Model was relaunched due to stakeholders' criticisms and concerns about transparency, equity, and governance safeguards.

[f] As part of an effort to better align CMMI demonstration models with statutory obligations and strategic goals, the current administration has announced that the Making Care Primary and Primary Care First models will be terminated in 2025.

physician-led ACOs, primary care ACOs, and ACOs with baseline spending higher than the regional average.[35] It also found that in some cases, the shared savings rates were not high enough to incentivize large health systems and hospitals to generate savings that outweighed their loss in potential FFS revenue.[36] Another study found that ACOs reduced spending per patient (including increased spending reductions over time) and saved Medicare $4.1 billion to $8.1 billion between 2012 and 2019.[37]

Figure 2. Accountable Care Organizations



Note: ACOs are groups of clinicians and other providers who deliver coordinated, high-quality care and take on financial risk in return for the ability to share in the savings they achieve for the Medicare program. "Attribution" refers to how Medicare beneficiaries are assigned to a specific provider or practice that is responsible for the total cost and quality of their care. Beneficiaries are generally attributed to an ACO through claims or voluntary alignment. CMS' ACO models are part of traditional Medicare, and beneficiaries attributed to an ACO can choose among traditional Medicare providers and supplies. They are not required to receive services from the ACO.

Although the MSSP remains one of the most stable APM pathways, several design flaws limit growth in clinicians' participation. Chief among these is the "ratchet effect"—a dynamic that occurs when benchmark-setting methodologies inadvertently financially penalize ACOs for achieving savings by making it harder to earn savings in future performance years.[38] An ACO's financial benchmark—or the spending target it must beat to earn shared savings—is periodically recalculated based on its own historical performance. For ACOs—and particularly those that are already high-performing—this ratchet effect makes it increasingly difficult to generate additional savings and creates a disincentive for long-term participation and growth in the MSSP.

Inadequate risk adjustment methodologies also distort benchmarks and financial accountability by failing to accurately capture the true cost of care for high-cost beneficiaries with complex needs.[39] As a result, the calculations may inadvertently incentivize selective participation—where providers opt in only when they believe they can outperform benchmarks based on favorable patient populations—rather than encouraging broad-based or equitable participation.[40]

Additionally, limited options for clinicians to gradually transition into higher levels of financial risk-sharing under the MSSP can deter participation from smaller, rural, or underresourced practices. Expanding model pathways with more flexible options could ease this transition and enable more clinicians to take on risk-based arrangements.

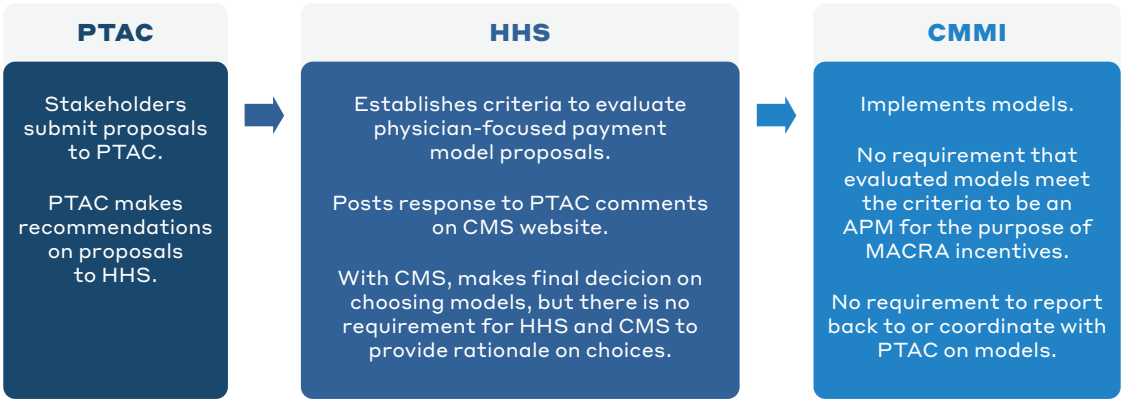
Opportunity to Streamline APMs Using the Physician-Focused Payment Model Technical Advisory Committee and through MSSP Reforms

Addressing structural limitations in the MSSP and fragmentation across APMs requires reforms focused on streamlining existing models rather than perpetually launching new ones. BPC's interviews with policy experts and stakeholders found some support for transitioning toward fewer, more permanent models that potentially require mandatory participation, particularly when informed by lessons from the most successful APMs.

Given these challenges, lawmakers have an opportunity to enable the Physician-Focused Payment Technical Advisory Committee (PTAC) to collaboratively pursue, alongside CMMI, alternative payment models that balance stability alongside meaningful innovation. The PTAC is uniquely positioned to help identify the most promising scalable models while guiding the refinement of both current and potential CMMI models; long-standing programs, such as the MSSP; and other MPFS-based, value-driven payment reforms.

MACRA established the PTAC to make recommendations to the U.S. Department of Health and Human Services (HHS) on stakeholder-submitted physician-focused payment models and provide recommendations to test and evaluate recommended models.[41,42,43] And while the PTAC is uniquely positioned to influence the evolution of physician-focused APMs, several challenges limit its impact. One key barrier is the misalignment between PTAC-reviewed proposals and CMMI's model considerations. Despite rigorous evaluations and recommendations, many innovative physician-focused payment models reviewed by the committee have not been meaningfully assessed for integration into CMS payment structures, as CMS is not obligated to act on the PTAC's advice.[44] **See Figure 3**. This lack of formal coordination diminishes stakeholder-driven innovation and discourages engagement from clinicians and organizations seeking to develop APMs.

Figure 3: Current PTAC Proposal, Evaluation, and Implementation Process



Adapted from: McDermott+ Consulting, "Overview of the PTAC Proposal Process," March 28, 2017. Available at: https://www.mcdermottplus.com/wp-content/uploads/2018/06/PTAC_Overview_Process_PPT.pdf.

Greater coordination between CMMI and the PTAC could create clearer pathways for integrating PTAC-recommended models—or components of models—into existing CMS payment structures and CMMI models in a way that allows for innovation while prioritizing the streamlining and stability of models.[45]

EXCESSIVE ADMINISTRATIVE BURDENS AND INEFFICIENCIES SLOW APM GROWTH

Administrative burdens also continue to hinder greater participation in the most promising APMs. For clinicians, the most notable burdens are challenges with quality measurement reporting requirements and the use of electronic health record (EHR) systems, including a lack of EHR interoperability.

Although studies suggest that the growth in administrative burdens has slowed in recent years, it continues to be a major barrier to clinicians' participation in APMs, as these models often create additional layers of complexity for clinicians by introducing time-consuming quality reporting and EHR interoperability requirements and protocols.[46,47] A lack of interoperability in electronic health record systems also prevents the real-time feedback and care coordination that is foundational to the success of APMs.[48] Many clinicians, particularly those in small or underresourced practices, may lack the infrastructure—such as data systems, care management tools, or trained staff—needed to succeed in APMs. This resource gap can further deter clinicians' participation in alternative payment models, especially if they believe the time required to see positive results exceeds a demonstration model's implementation period.[49]

Redundant Quality Measurement Reporting Requirements Increase Burdens

Quality measures are a fundamental tool for assessing the effectiveness of health care services. Two key factors shape the value of quality measures involving high-quality care delivered through APMs: (1) to avoid duplicative and excessive requirements, strong alignment with the clinical data that clinicians are already capturing in the EHRs, and (2) how these quality measures hold clinicians accountable for patients' health outcomes.[50] The alignment of quality measures across various health care programs, particularly within APMs, is critical to reducing administrative complexity for clinicians and improving patients' outcomes.[51]

To improve quality measurement within APMs, one key challenge is the persistent misalignment of quality measures across CMS' payment models and payers. Several stakeholders BPC interviewed, including clinicians and policy experts, noted that while private payers historically sought to align with CMS' quality measures, they do so less today. Stakeholders attributed this change to a reporting environment that prioritizes required reporting on an excessive number of quality measures over meaningful quality improvement.

Despite CMS' efforts to standardize metrics through such initiatives as the Core Quality Measures Collaborative and the Universal Foundation, the lack of consistent application across payment models and payers hinders widespread adoption.[g,52,53] The fragmented measurement landscape increases clinicians' administrative burdens and undermines the utility of these tools for driving high-value care.[54] Absent the alignment of quality measurement reporting requirements across different payment models and payers, providers must often report on duplicative or inconsistent quality measures, even for the same disease or condition, which drain the time and resources they could otherwise be spending on patient care. These reporting requirements are often more burdensome than purposeful, making participation in APMs unattractive to clinicians.[55]

Electronic Health Record Fragmentation and Poor Interoperability Inhibit Data-Driven APM Implementation

Federal agencies, such as CMS and the Assistant Secretary for Technology Policy/the Office of the National Coordinator for Health Information Technology (ASTP/ONC), play a critical role in setting and enforcing clear standards for EHR data exchange. Together, these agencies work to align payment incentives with interoperability goals and ensure that all health care providers, regardless of size or location, have the guidance and technical assistance to implement interoperable EHR systems.[56,57] By facilitating patient and clinician communication and decision-making, EHR systems improve the quality of patient care delivery and support clinicians' successful participation in APMs.[58,59]

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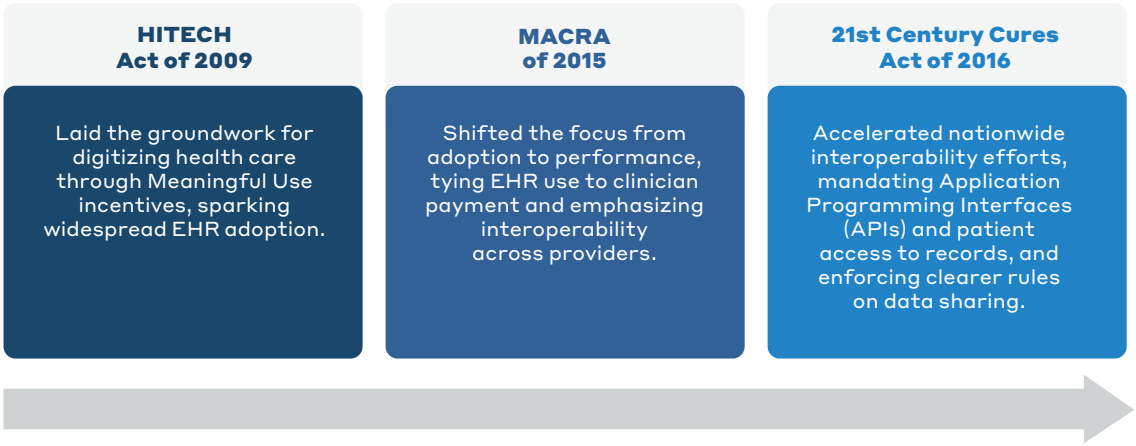
9 The Core Quality Measures Collaborative is a public-private partnership that facilitates cross-payer measure alignment through the development of core sets of measures that assess the quality of the nation's health care.

MACRA, the Health Information Technology for Economic Clinical Health (HITECH) Act, and the 21st Century Cures Act each introduced reforms to streamline billing, payment, and data collection and exchange systems in Medicare Part B.[60,61,62] **See Figure 4**.

Figure 4: Development of EHR Adoption and Meaningful Use Standards in Federal Policy



Electronic health record systems of varying complexity and cost are available to clinicians and payers. Clinicians often select an EHR vendor depending on which system aligns most with their financial situation, patient populations, and internal technology infrastructure (e.g., the reliability of their internet connection). Clinicians can then contract with an EHR vendor to perform their data collection requirements. However, many EHR vendor platforms operate in silos, perpetuating the lack of interoperability. This limited interoperability undermines coordinated care and creates inefficiencies—duplicative tests, care gaps, and increased costs—that are especially detrimental to the success of APMs, which depend on timely, aggregated data.[63,64]

Despite legislative efforts to promote health IT modernization and advancements in EHR technology, data sharing remains fragmented.[65,66,67] This is especially true for rural clinicians and providers in small practices who face financial constraints and limited access to technical support.[68] Even within ACOs, interoperability remains a major challenge when clinicians and health systems use different EHR systems.[69] For example, a hospital might use Epic while affiliated clinicians rely on eClinicalWorks or NextGen, creating data silos that block the seamless exchange of information.[70]

Since 2021, CMS, the ASTP/ONC, and other federal agencies have been advancing the national TEFCA framework, a national data-sharing framework first directed by the 21st Century Cures Act, to promote secure, interoperable health information exchange. [71] Officially launched in 2023, TEFCA establishes standardized policy, technical, and operational requirements to improve coordination across health care systems.[72] The framework continues to evolve, with the most recent, Version 2.0, released in May 2024.[73] Policymakers must now consider how best to ensure that participating in the framework is affordable and accessible to all providers and that they can purchase a fully interoperable, secure, and efficient system.[74]

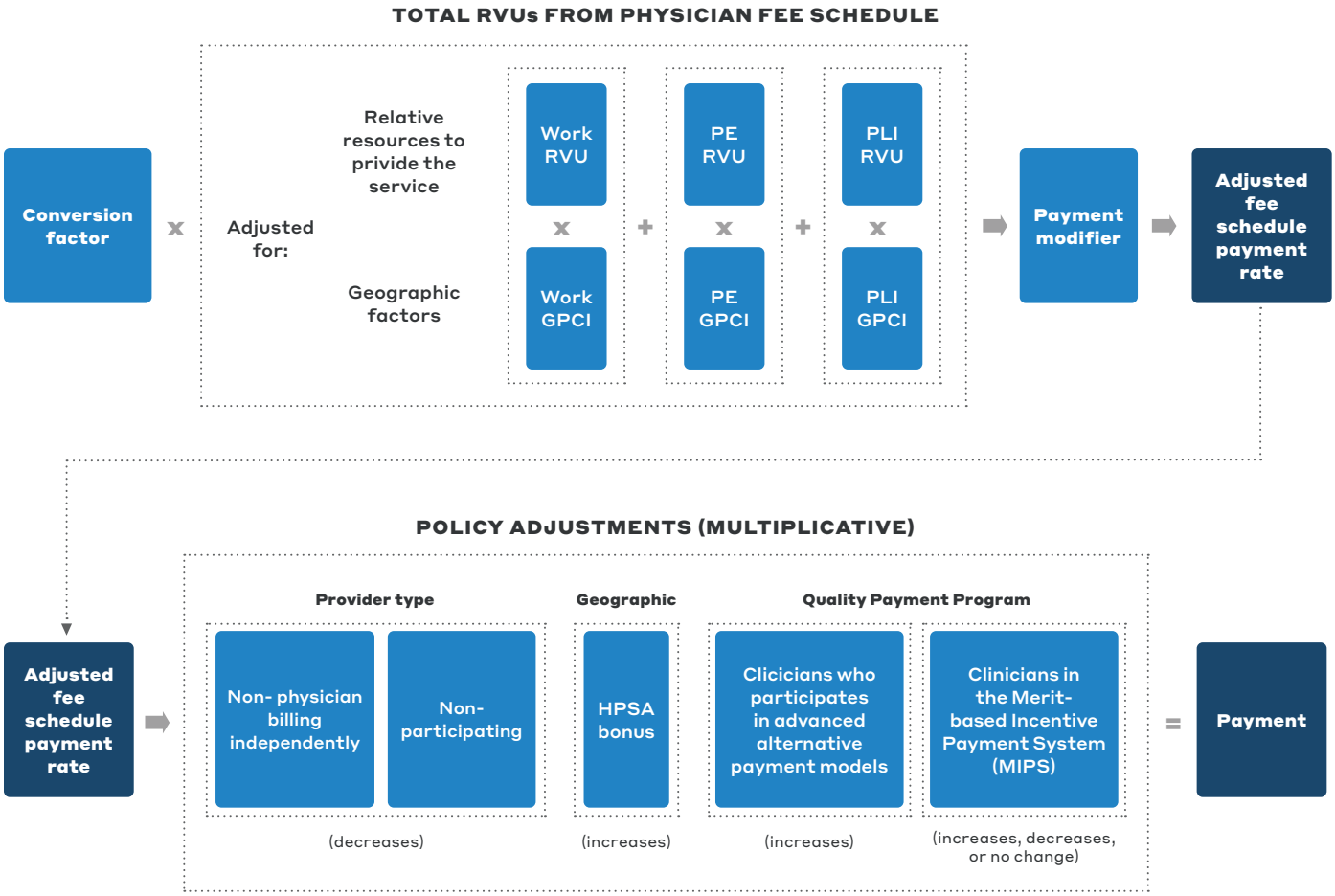
Policy Direction and Next Steps

Now is a critical time for members of Congress and regulators, in line with the priorities of the Trump administration, to act to increase clinicians' participation in the most promising alternative payment models. Alongside such reforms, federal policymakers could consider finding a permanent, sustainable solution that would keep Congress from having to annually set payment rate updates under the MPFS.

HHS Secretary Robert F. Kennedy Jr. has already signaled his interest in expanding the use of value-based care—including APMs—to address the nation's chronic disease and health care spending challenges.[75] He has similarly expressed a desire to rethink how MPFS service valuations and billing codes are determined.[76,77] Centers for Medicare & Medicaid Services Administrator Mehmet Oz has demonstrated similar engagement in these issues. This includes rethinking how the nation's health care system can better support chronic disease management and prevention, hold providers accountable for health outcomes, and reduce administrative burdens.[78] And, as demonstrated by CMMI's new strategy, the current CMMI director appears interested in scaling high-performing APMs and, specifically, ACOs, by promoting prevention and better aligning financial incentives for value-driven health care.[79]

Increasing clinicians' participation in the most promising APMs requires policymakers to address the barriers outlined in this issue brief. BPC's forthcoming reports, as well as our third and final issue brief in this series, will offer specific bipartisan federal policy reform recommendations to enhance clinicians' participation in the most promising alternative payment models.

Appendix A: Medicare Physician Payment Rate Calculation Process



Note: "Work" in this graphic is a relative value unit (RVU) measuring time spent (before, during, and after a service or procedure); technical skill and physical effort required; mental effort and clinical judgment; and psychological stress required of a clinician for a specific service or procedure (e.g., on high-risk patients); geographic price cost index (GPCI); practice expense (PE); and professional liability insurance (PLI).

Source: Medicare Payment Advisory Commission, "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.

Appendix B: Example of a Medicare Physician Fee Schedule Payment Calculation (before Policy Adjustments)

Procedure and Procedure Code: Bronchoscopy, CPT 31622

Procedure Location: Minnesota, outpatient

Conversion Factor (March – December 2024): $33.29

Note: The conversion factor for January 1-March 8, 2024, was $32.74; the 2024 Consolidated Appropriations Act increased the conversion factor to $33.29 from March 9-December 31, 2024.

Base RVUs 2024[80]

Work RVU: 2.53

PE RVU: 4.46

PLI RVU: 0.31

Minnesota Geographic Price Indices (GPCIs) 2024[81]

Work GPCI: 1.00

PE GPCI: 1.013

PLI GPCI: 0.300

Component	Base RVU	X	GPCI	=	Adjusted RVU
Work	2.53		1.000		2.53
					+
PE	4.46		1.013		4.51798
					+
PLI	0.31		0.300		0.093
					=
Total Adjusted RVU					*7.14098*

Total Adjusted RVU	x	Conversion Factor	=	Total Payment
7.14098		$33.29		**$237.73**

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Health Program

BPC's Health Program advances bipartisan policy solutions to build a more cost-effective, evidence-based health care system to 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

Endnotes

1 Michael E. Chernew and J. Michael McWilliams, "The Case For ACOs: Why Payment Reform Remains Necessary," *HealthAffairs*, January 24, 2022. Available at: https://www.healthaffairs.org/content/forefront/case-acos-why-payment-reform-remains-necessary.

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