

Making Medicare Sustainable

A Guide to Policy Options for Congress and the Administration

INTRODUCTION

In recent years, Medicare has faced increasing financial stress. The program, which provides health insurance to Americans ages 65 and older, as well as those living with certain disabilities, faces rising costs per enrollee and the “silver tsunami”¹ of a rapidly aging population.² According to projections from the nonpartisan Congressional Budget Office (CBO), “spending on Medicare accounts for over half of all spending on the major health care programs in 2025 and about two-thirds of such spending in 2055.”³ These dynamics have had the overall effect of increasing Medicare’s share of the federal budget, exerting pressure on American taxpayers, and driving up the cost of premiums paid by Medicare beneficiaries.

One of the more pressing financial issues for the Medicare program involves Part A, which covers services such as inpatient hospital stays, skilled nursing facility care, hospice care, and home health care.⁴ Part A services are financed through the Hospital Insurance (HI) Trust Fund. The Medicare Board of Trustees recently projected that the Trust Fund will become insolvent by 2033, at which point Medicare will only be able to pay 89 percent of scheduled Part A benefits.⁵ According to the most recent report from the Board of Trustees, “If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues— and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services could be rapidly reduced.”⁶

The growth of Medicare Advantage (MA) also has contributed to the Medicare program's financial challenges. In recent years, an increasing share of Medicare beneficiaries have opted to enroll in a private MA plan over traditional fee-for-service (FFS) Medicare. As of 2025, more than half of all Medicare beneficiaries—54 percent, or roughly 34 million people—are enrolled in MA, about double the percentage of beneficiaries enrolled in MA in 2012.⁷ The nonpartisan Medicare Payment Advisory Commission (MedPAC) has estimated that the Medicare program pays 20 percent more on average per MA beneficiary than it spends on similar beneficiaries in FFS Medicare—translating into an additional \$84 billion in payments from the government to MA plans in 2025.^{8,9} Given the substantial magnitude of MA expenditures, MA reforms could prove crucial to improving Medicare's overall financial solvency, particularly because roughly half of every dollar saved would go directly toward the HI Trust Fund.¹⁰

That said, policies targeted solely at Part A and MA would fall short of grappling with the broader fiscal challenges currently confronting the Medicare program, especially in light of dramatic growth in Medicare Part B spending and utilization. Part B covers services provided by physicians and other clinicians, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs), along with lab tests and certain other products and procedures.¹¹ For 2025, CBO projected that Part B benefits would cost \$562 billion, versus \$444 billion for Part A and \$137 billion for Part D, which covers outpatient prescription drugs.¹² By 2034, CBO's projections suggest Part B benefit spending could exceed \$1.1 trillion.¹³

While current projections indicate that clinician services, paid largely under Medicare's Physician Fee Schedule (PFS), will decline as a share of Part B spending over the next decade, numerous pressures seem likely to necessitate meaningful PFS reform in the years ahead. Because PFS payment updates are scheduled in advance and do not vary based on economic conditions, they have generally not kept pace with increases in costs incurred by physicians.¹⁴

Because of this, Congress has intervened repeatedly,¹⁵ most recently in the 2025 reconciliation legislation, to enact so-called 'doc fixes'—temporary, ad hoc, and expiring payment increases under the PFS. If this pattern persists, policymakers will continue to inflate Medicare spending on physician services without driving incentives for value-based care or creating predictability and stability for patients and health care providers. However, these dynamics provide policymakers with an opportunity to pursue clinician payment reforms that avert costly doc fixes and prioritize value over volume and also chart a sustainable course for clinician payments moving forward, thereby driving substantial long-term savings.

It is imperative that Congress and the Administration explore and enact bipartisan and durable policy changes to the Medicare program to reduce wasteful spending and avoid higher costs for beneficiaries and taxpayers. Meaningful reforms—such as those outlined in this policy guide—would put the program on a more sustainable fiscal path, extend the life of the HI Trust Fund, and create greater certainty for seniors and individuals with disabilities who rely on the program for high-quality health care.

How to Navigate This Guide

This document aims to serve as a streamlined resource for congressional staffers and administration officials interested in exploring and understanding meaningful policy options for reforming Medicare. Within each policy concept, we have outlined several key dials that policymakers and regulators could adjust to generate higher or lower amounts of savings for Medicare, or to increase the political feasibility of a given proposal. Concepts outlined in the guide include the following:

1. Site-Neutral Payment Reforms
2. Medicare Advantage Risk Adjustment Reforms
3. Competitive Bidding in Medicare Advantage
4. Reforms to the Medicare Advantage Quality Bonus Program (QBP)
5. Better Encouraging Value-Based Care Through MACRA Reform

We believe that all of these concepts have the potential for bipartisan support. Importantly, all of these concepts have been part of the “conversation” around reforming Medicare for at least the last several years—because of that, it is critical that policymakers interested in reforming the program understand each concept at a high level, at minimum. Our hope is that this document serves as an accessible entry point for these reform ideas and helps to launch conversations and collaborations between and among congressional offices and administration officials.

Concept #1: Site-Neutral Payment Reforms

Background

Within Medicare, many services are provided across a variety of settings, including physician offices, ASCs, and HOPDs. Medicare often reimburses for the same procedure at different rates depending on where it is performed – for example, the program’s payment for a given service is sometimes doubled if performed in an HOPD, relative to a stand-alone physician’s office. These cost differentials increase incentives for providers to bill in higher-acuity settings, as well as to consolidate¹⁶, which drives up costs overall, as well as for patients, given Medicare’s beneficiary cost-sharing requirements. Additionally, analyses have suggested that the quality of many of these services does not substantially vary between settings, indicating that the difference in reimbursement rates may not reflect substantive distinctions in the quality of the care provided or the acuity of the patients served.^{17,18}

Proposed Policy Concept

Equalize Medicare payment rates for a given service furnished across multiple sites of care, based on the lowest-cost setting.

Key Dials

The Scope of Services Addressed – Proposals could aim to capture a broad range of services for site-neutral payments or could take a more targeted approach, such as by starting with the services most frequently provided in physician offices or other lower-cost sites of care, or else by focusing on services with input costs (e.g., labor or materials) that do not vary substantially based on the setting of care.

The Target Reimbursement Rate – Policymakers will need to determine an appropriate payment amount to set as the site-neutral rate for any service addressed under this concept. Setting reimbursements based on Medicare’s physician office rates—generally the lowest of any setting—would maximize the budgetary savings achieved. For services with no physician office utilization (or minimal utilization in that setting), policymakers could reimburse based on the most common site of service—such as by paying the ASC rate for some elective, shoppable surgical procedures, in alignment with approaches currently leveraged by some private payers.¹⁹

Phasing in adjustments – Proposals could leverage a phased approach, such as by starting with a small subset of services to allow for providers to transition to payment shifts, or else policymakers could opt for a shorter timeframe for implementation.

Considerations for Political Viability

Many site-neutral policy proposals pair site-neutral payments with targeted reinvestment in certain hospitals (e.g., safety net or rural hospitals). The degree to which a given policy reinvests savings generated by site-neutral payments might limit the overall savings produced while increasing political feasibility. Policymakers might also opt to redirect savings into other provider priorities, such as PFS payment increases or telehealth expansions. For example, the Trump Administration’s FY 2020 budget proposal paired site-neutral payments for certain services with a primary care pay bump in the PFS.²⁰

Recent Policy Proposals

Site-neutral payment reform has drawn robust bipartisan interest and activity in recent years. For instance:

- Leavitt Partners team members proposed implementing a site-neutral fee schedule for certain non-complex outpatient services and reinvesting most of the savings into rural, safety net, and other community hospitals while still producing roughly \$13 billion in Medicare savings over ten years.²¹
- MedPAC has recommended aligning payments for certain outpatient services across HOPDs, ASCs, and physicians’ offices, with payment rates for a given service set based on its most common setting of care.²²
- Sens. Cassidy (R-LA) and Hassan (D-NH) outlined two options for site-neutral payment.²³

- The first would eliminate the grandfathering exception of the Bipartisan Budget Act (BBA) of 2015, which established site-neutral payments in some off-campus HOPDs, but *only for facilities that were built after the law was passed*. The first policy would extend site-neutral payments to all hospital-owned sites of care away from the hospital’s main campus.
- The second policy option largely aligns with MedPAC’s proposed approach, as described above.
- The Lower Costs, More Transparency Act (passed by the House of Representatives on a bipartisan basis in 2023), would establish site-neutral payments for drug administration services provided in off-campus HOPDs (with a phased-in implementation approach), in addition to requiring unique health identifiers and attestations for off-campus HOPD billing.

Fast Facts

<i>Would this involve regulatory or legislative actions?</i>	Likely both, although the Trump administration has recently taken action in a proposed Medicare payment rule to apply site-neutral payments to drug administration services in certain HOPD settings. ²⁴
<i>What are the estimated savings?</i>	Likely tens of billions, annually, or in the single-digit billions for more modest or targeted approaches. For example, CBO has estimated that paying site-neutral rates for most services to HOPDs would result in around \$157 billion of savings over ten years. ²⁵
<i>Likely sectors supporting?</i>	Payers (plans and employers), and certain patient groups (as most site-neutral proposals would lead to a reduction in premiums and beneficiary cost-sharing).
<i>Likely sectors against?</i>	Health systems, some clinicians, and medical device manufacturers. As noted above, some proposals attempt to mitigate concerns by reinvesting savings in certain provider types.

Concept #2: Medicare Advantage Risk Adjustment Reforms

Background

The Centers for Medicare & Medicaid Services (CMS) adjusts payments to MA plans based on enrollees' "expected relative risk for covered Medicare spending,"²⁶ calculated based on a number of factors, including diagnoses submitted by the plans (including through health risk assessments (HRAs) and chart reviews). As summarized by the nonpartisan Office of the Inspector General for the Department of Health and Human Services (OIG) in a 2024 report, appropriate risk adjustment "helps to ensure that plans receive sufficient payment to cover more costly care and enrollees have continued access to MA plans," but "taxpayers fund billions of dollars in overpayments to MA companies each year based on unsupported diagnoses for MA enrollees," and "[u]nsupported diagnoses inflate risk-adjusted payments and drive improper payments in the MA program."²⁷ Similarly, the Government Accountability Office (GAO) has called for increased oversight of risk adjustment in MA, in light of "concerns about the program's susceptibility to mismanagement and improper payments."²⁸

Analyses have shown that MA plan beneficiaries have higher risk scores than similar FFS beneficiaries because of plans' more intensive coding efforts ("coding intensity").²⁹ MedPAC estimates that in recent years, about half of overpayments to MA plans are due to MA plans coding intensity—accounting for about \$40 billion of the \$84 billion in overpayments to MA plans in 2025.³⁰ Importantly, not all MA plans code at the same intensity, as larger plans often have more resources to maximize coding efforts than do smaller plans—which raises concerns that existing coding policies put smaller plans at a competitive disadvantage.³¹

Proposed Policy Concept

Institute restrictions and/or reductions in MA plan risk-adjustment payments, aimed at offsetting coding intensity.

Key Dials

What diagnoses are allowed to be incorporated into MA risk adjustment – Diagnoses are collected in a variety of settings (e.g., through documentation by patients' health care providers, through HRAs conducted by MA plan staff, etc.), and the more diagnoses plans are allowed to submit for risk adjustment, the more likely it is that risk-adjustment payments will increase. One way to limit the amount of additional payments going to plans would be to limit the diagnoses that can be included in risk adjustment calculations.

For example, several proposals and recent actions from CMS have targeted the use of diagnoses collected by HRAs in risk adjustment—through limiting the diagnoses that may be collected through HRAs and requiring stricter oversight of HRA-collected data. The core rationale is that diagnoses collected only through HRAs—and *not confirmed by other medical records*—may be inaccurate and/or that beneficiaries did not actually receive care for such diagnoses.³²

How many previous years of diagnoses are used to predict a beneficiary's risk? Currently, a beneficiary's risk score for an upcoming plan year is based on the previous year's diagnoses. Analyses have indicated that basing risk scores on a greater time range of diagnoses (e.g., the previous two years) would increase the predictive power of risk adjustment and narrow the gap between FFS and MA payments. This is due to two years' diagnoses data capturing a broader picture of beneficiaries' health status and reducing fluctuations in diagnoses that might occur from year to year (e.g., if a chronic condition happened to not be coded for a patient in a given year).

The statutory minimum risk score reduction. Because MA beneficiaries have consistently higher risk scores than FFS beneficiaries, since 2010,³³ Congress has required CMS to reduce Medicare Advantage risk scores by a uniform, pre-determined factor – at least 5.91 percent since 2018. CMS has *never* reduced risk scores by an amount greater than the minimum required percentage, but CMS has the option to do so—or alternatively, Congress could increase the minimum required percentage. If Congress were to act on this front, policymakers could look to apply larger reductions to certain plans, such as based on previous risk-adjustment data or outlier status.

How aggressive are efforts to review and recoup improper payments? CMS conducts retrospective risk-adjustment data verification (RADV) audits to validate that the risk-adjustment diagnoses that MA plans submit for payment are supported by evidence in patient medical records. RADV audits are typically conducted on a small subset of plans, for a small sample of enrollees.³⁴ CMS has recently announced efforts to more aggressively conduct and recoup improper payments from MA plans, which they predict will finish their backlog of audits and result in more patient records from more plans being reviewed.³⁵ However, there are additional actions on RADV audits that CMS could pursue, including auditing providers directly and publishing the RADV audit findings to promote accountability.

Considerations for Political Viability

Although reforming risk-adjustment, which will ultimately curtail revenues for MA plans, may be difficult, pairing such policies with proposals that create tailwinds for MA plans could improve political viability. For example, policies that provide certain regulatory relief for plans (e.g., around compliance or oversight) could act as a “sweetener.” Congress could also look to reinvest a portion of the savings in other bipartisan Medicare priorities, such as extending telehealth flexibilities permanently or adjusting the annual payment updates for physicians scheduled under current law to avoid short-term “doc fixes” over time. That said, if there is broad popular support for reforms targeting certain MA practices, there may be less of a need to pair risk adjustment reforms with tailwind policies for plans.

Recent Policy Proposals

- Many MA risk adjustment reform proposals have suggested limiting the types of diagnoses that plans are able to submit for risk adjustment. For example, MedPAC, CBO, and HHS OIG all have recommended restricting or eliminating the use of HRAs in risk adjustment calculations.^{36,37,38}

- In tandem with limiting certain diagnoses, proposals have also suggested *expanding* the use of other diagnostic data in order to ensure risk adjustment accuracy. For example, those same MedPAC and CBO proposals also recommended incorporating two years of diagnostic data into risk adjustment rather than one, in order to ensure that a more representative picture of a given patient’s health status is used for risk adjustment calculations. Bellerose et. al have also suggested that combining risk-adjustment diagnoses with patient self-reported survey responses may improve the accuracy of MA risk adjustment.³⁹
- Legislative proposals in this area have largely followed a similar tack. The No UPCODE Act, introduced by Sens. Bill Cassidy (R-LA) and Jeff Merkley (D-OR) in March 2025, would require CMS to use two years of diagnostic data in risk adjustment while also prohibiting CMS from using diagnoses from chart reviews or HRAs for risk adjustment purposes.⁴⁰ The bill would also require CMS to evaluate and consider adjusting payments to MA plans based on coding pattern behaviors not otherwise accounted for—notably, with discretion for the agency to make these adjustments at a plan or contract level (i.e., rather than just an across-the-board adjustment for all plans), acknowledging that some plans use more aggressive coding practices than others.

Fast Facts

<i>Would this involve regulatory or legislative actions?</i>	Likely either regulatory or legislative actions, depending on the scope of the policy.
<i>What are the estimated savings?</i>	Likely up to more than ten billion dollars annually, depending on scope. According to one estimate, using two years of diagnostic data and excluding diagnoses from HRAs would generate about \$125 billion of savings over ten years. ⁴¹
<i>Likely sectors for?</i>	Providers, consumers, some smaller and mid-sized health plans. ⁴²
<i>Likely sectors against?</i>	Large health plans.

Concept #3: Competitive Bidding in Medicare Advantage

Background

MA plan payments are based on county-level benchmarks, which are based on historical FFS spend in that county.⁴³ Plans who want to serve beneficiaries in that county submit bids detailing how much they expect it will cost them to provide benefits to a standardized beneficiary. If the plan bid is below the benchmark, the government recoups a portion of the difference, and the plan receives the remaining amount as payment (called a “rebate”) to use to provide additional benefits or premium reductions to enrollees.

Because of this framework, even if a given plan determined that it could provide sufficient coverage to a county's beneficiaries for significantly less than the benchmark, it would not be allowed to pocket the bulk of that difference as revenue—the difference would either go back to the government or to beneficiaries. While this does provide some incentive for plans to bid below the benchmark, plans have weaker incentives to become more efficient than if they pocketed the full bid difference and instead compete to attract enrollees based largely on the generosity of their benefits. In addition, the current approach results in uneven rebates across counties, which results in some enrollees having more generous plans than others—while some variation in plan generosity is inevitable, it is unclear whether the current structure (of varying plan generosity based on geography) is efficient or effective.

Proposed Policy Concept

Transition the current MA bidding framework to a competitive bidding model.

Key Dials

How the benchmark is calculated based on the bids – For example, many proposals calculate county-level benchmarks based on an average of bids in the county. In theory, the benchmark could be calculated any number of ways based on the bids—e.g., the lowest bid—which would generate more or less savings to Medicare. In addition, the benchmark calculation could *weight* each bid based on enrollment—i.e., plans with more enrollees would count more toward computing the average.

The generosity of the standardized benefit package – In order to ensure that enrollees receive a similar value from MA plans regardless of their location, many of these proposals require plans to offer a standard benefit package whose actuarial value (AV) is locked at a certain percentage of the AV of Traditional Medicare. Ratcheting this percentage up or down would result in more or less generous plans to MA beneficiaries, but would result in smaller or greater total savings to Medicare.

Considerations for Political Viability

If this policy is too aggressive—i.e., if it resulted in significant savings due to much lower benchmarks—it could run the risk of plans withdrawing from certain counties. There are various tweaks to this policy that could minimize the chances of plans withdrawing—for example, certain counties could be exempt from competitive bidding, or the benchmark calculation could be adjusted to minimize loss in plan revenue. Of course, any adjustment that minimized plan losses would *also* reduce savings to Medicare.

Recent Policy Proposals

- Brookings proposed replacing the current bid system with a competitive bidding system based on standardized benefit packages.⁴⁴ Benchmarks would be set using the average of MA plan bids in each county, and Medicare would pay that rate to plans operating in the same area. Beneficiaries choosing plans whose bids are below the average bid would have their premiums reduced by the full amount of the difference (i.e., the government would **not** take a portion of the difference). In contrast, beneficiaries who choose plans with bids above the average bid would pay higher premiums.

- USC Schaeffer proposed a similar reform – replacing the current system with competitive bidding on standardized benefit packages.⁴⁵ They also proposed expanded market areas beyond counties to foster better competition, which is critically important for the vast majority of MA beneficiaries who live in highly concentrated MA markets.⁴⁶
- BPC likewise proposed a competitive bidding system with county benchmarks based on an average of the bids submitted.⁴⁷ BPC notes that the process would likely work similarly to a Medicare program that has been in place for decades: the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP), established by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.⁴⁸ Under this program, suppliers of equipment compete against other suppliers by submitting bids, and Medicare contracts go to the supplier that offers the best price, while meeting certain standards.

Fast Facts

<i>Would this involve regulatory or legislative actions?</i>	Likely legislative and regulatory, depending on scope.
<i>What are the estimated savings?</i>	Up to tens of billions, annually, depending on scope. Previous estimates of various proposals have estimated between \$30 billion to \$100 billion in savings over ten years.
<i>Likely sectors for?</i>	Beneficiaries, potentially, if the policies lead to lower premiums and clearer choices (as a result of a standardized benefit package).
<i>Likely sectors against?</i>	Plans, as this proposal would generally reduce their payments. Possibly providers and health systems, as plans may negotiate lower payment rates with providers under competitive bidding. Beneficiaries if competitive bidding is perceived to (or does) reduce either the amount of plans offered to beneficiaries or the generosity of plan benefits.

Concept #4: Reforms to the Medicare Advantage Quality Bonus Program (QBP)

Background

MA plans that receive 4 or more stars under MA’s quality measurement system, Star Ratings, financially benefit from the QBP through higher benchmark payments and higher rebates. The program is intended to incentivize quality improvement among MA plans, but there is little evidence that it provides meaningful quality information, has improved quality, or helps beneficiaries select a plan. Despite its failure to meet these goals, the QBP is a significant driver of spending in MA, as bonus payments to plans have increased from \$3 billion in 2015 to \$12 billion in 2025.⁴⁹

Proposed Policy Concept

Scale back or phase out the MA QBP.

Key Dials

The number of plans allowed to achieve a 4- or 5-star rating – Plans that receive 4 stars or higher are eligible for a quality bonus under QBP. Currently, 75 percent of MA enrollees are in plans rated 4 stars or higher, and thus eligible for a quality bonus.⁵⁰ Star Ratings could be modified such that only a certain number of MA plans could achieve 4 or 5 stars, and thus be eligible for a quality bonus.

Double bonus counties – Due to the Affordable Care Act, a certain amount of counties reward twice the quality bonus to eligible MA plans. The policy was intended to increase plan participation in certain markets that may otherwise have struggled to attract plans. The increased quality bonus to these counties could be removed or reduced.

Budget neutrality – Unlike other federal quality programs (such as the Merit-Based Incentive Payment System [MIPS]), the QBP is financed with additional program dollars, rather than being budget-neutral. In theory, bonuses to high-quality plans could be funded (in part or in full) by penalties to low-performing plans.

Considerations for Political Viability

As stated earlier, MA plans will generally oppose efforts to reduce their revenues. Consider pairing any QBP reforms with “sweetener” policies in other areas (e.g., policies that could reduce administrative overheads).

In addition, beneficiaries will be more likely to support policies that they understand as seeking to help them, such as through programmatic reforms aimed at improving the generosity of benefit packages, scaling back prior authorization and step therapy, or instituting other consumer protections.

Recent Policy Proposals

- Leavitt Partners proposed several changes to the QBP, including reducing and tiering the benchmark bonus, evaluating quality at the local market level, smoothing star ratings cut points, and eliminating double bonus counties.⁵¹
- BPC proposed removing the QBP and replacing it with a budget-neutral quality incentive that utilizes a smaller set of meaningful performance measures.⁵²
- In December 2018, CBO proposed and modeled deficit reduction options aimed at scaling back the QBP, although the figures have presumably become outdated.⁵³ MedPAC also proposed eliminating and replacing the QBP in June 2020.⁵⁴

Fast Facts

<i>Would this involve regulatory or legislative actions?</i>	Likely legislative and regulatory, depending on scope.
<i>What are the estimated savings?</i>	Up to tens of billions, annually, depending on scope. For example, converting the QBP to a fully cost-neutral program (i.e., funding the bonuses via penalties to low-performing plans) would save between \$115 and \$170 billion over ten years. ⁵⁵
<i>Likely sectors for?</i>	Beneficiaries—potentially—as lower Medicare spending will reduce Medicare Part A deductibles and Part B premiums.
<i>Likely sectors against?</i>	Plans, as this proposal would generally reduce their payments. Possibly providers and health systems, as plans may pass along any decrease to their revenues via reduced provider rates.

Concept #5: Encouraging Value-Based Care Through MACRA Reform

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan legislation that was signed into law in early 2015. MACRA introduced several changes to the Medicare program, including the creation of MIPS, which consolidated several FFS Medicare quality programs into a single program, and the creation of the Advanced Alternative Payment Models (A-APMs) incentive payment to encourage uptake of value-based payment models in Traditional Medicare.⁵⁶ The main goal of MACRA was to transform Traditional Medicare from a primarily fee-for-service-based payment system into one grounded in value-based care, with the hope that such a system would produce better outcomes at lower costs.⁵⁷

The MIPS quality program, or the “default” quality reporting option for Medicare clinicians established by MACRA, assesses clinicians across four areas: quality, improvement activities, promoting interoperability, and cost. Based on these scores, a clinician receives a positive or negative adjustment (up to 9 percent) to their Medicare Part B payments two years later (i.e., a clinician’s performance in 2025 will affect their 2027 payments).⁵⁸

The A-APM track, by contrast, is an option for physicians who decide to opt out of MIPS and undertake more advanced value-based payment practices. Under this program, beginning in 2019, physicians who participated in qualified A-APMs received a lump-sum payment bonus of 5 percent on their Medicare Part B payments.⁵⁹ The 5 percent A-APM bonus was phased down to 3.5 percent in 2025, 1.88 percent in 2026, and is phased out in subsequent years.

Starting in payment year 2026, instead of a lump-sum bonus to their payments, clinicians participating in A-APMs (qualifying participants [QPs]) receive a 0.75 percent annual update to their PFS conversion factor (CF), which affects how much reimbursement they receive for services covered by Medicare. Non-QP clinicians receive a much smaller annual CF increase of 0.25 percent, starting in 2026.

Although designed to encourage a move toward payment for quality, many MACRA provisions have been ineffective at best, and burdensome and costly at worst. For example, MIPS has been shown to have only a marginal impact on quality, despite imposing high costs and burdens on clinicians.⁶⁰ Moreover, while A-APMs have the potential to produce sizable budgetary savings⁶¹ and substantial quality improvements for the Medicare program, uptake remains far below initial MACRA expectations, and the statutory A-APM incentive payment bonus has transitioned to much more modest annual payment updates, limiting the upfront incentives for clinician to participate.⁶²

Because of the potential savings A-APMs offer, it is imperative that policymakers act to increase the number of clinicians that participate in these payment models. Given that A-APM participation is voluntary for clinicians, policymakers can incentivize clinician participation in A-APMs by making participation in these models more attractive (such as through targeted regulatory relief for A-APM participants, as well as financial incentives) and/or by making nonparticipation (i.e., MIPS) less attractive, such as by curtailing MIPS bonus payments.

Proposed Policy Concept

Eliminate or scale back MIPS and restructure and extend the A-APM incentive payment bonus.

Key Dials

A-APM bonus – Congress could look to restore the A-APM bonus in its pre-expiration form or could pursue restructuring, such as in line with some of the concepts floated by MedPAC in its June 2024 report.⁶³ Alternatively, Congress could adjust the difference in annual CF updates between clinicians participating in A-APMs and those who don't, which is currently 0.75 percent and 0.25 annually, respectively. Policymakers could also look to dial the QP thresholds—which currently require clinicians to receive 75 percent of their Part B payments or see 50 percent of their Medicare patients through an A-APM—in order to make it easier for clinicians to become a QP.⁶⁴

While such actions would likely increase spending in the short term, incentivizing A-APM participation will—over the long-term—drive more efficiencies in care delivery and realign current incentives that often drive higher costs. To that end, the Medicare Trustees note that “innovative payment and service delivery models,” including certain forms of A-APMs, “have the potential to reduce health care costs and cost growth rates and could, as a result, help lower health care spending.”⁶⁵ In its June 2024 Report to Congress, MedPAC warned, “Waning interest in A-APMs could result in missed opportunities to achieve better-quality care more efficiently.”⁶⁶

A-APM Modifications – Congress and the Administration could leverage other regulatory, sub regulatory, or statutory changes to incentivize participation in A-APMs, including to target specific specialties, practice sizes, and geographic regions with lower participation rates. Streamlining quality reporting requirements and enhancing waivers and flexibilities for participants, for instance, could facilitate broader participation and retention while reducing, rather than increasing, administrative complexity. For example, this could include waiving A-APM quality reporting requirements for small or rural providers, or permitting A-APM participants to provide patients with in-kind incentives for engagement, as was proposed in the Ambulatory Specialty Model in the proposed CY 2026 PFS rule.⁶⁷

MIPS – MIPS has received far-reaching criticism from experts and stakeholders. Policymakers and regulators could look to erase the program altogether, as proposed by MedPAC,⁶⁸ or else to simply modify its core contours and parameters, such as by constraining the potential for upside or downside payment adjustments for participating clinicians, by streamlining its quality measurement methodology, or by establishing more coherent pathways from MIPS to A-APMs.

Considerations for Political Viability

Specialists have long had limited opportunities to participate in A-APMs; any meaningful MACRA reform to encourage value-based care may want to consider ways to encourage specialist engagement.⁶⁹

Evidence has shown that certain A-APMs, including total cost of care models and Accountable Care Organizations (ACOs), are most effective at limiting cost increases and improving outcomes.⁷⁰ MACRA reforms should examine how best to push clinicians to these types of A-APMs.

In general, value-based care reforms will most likely accompany meaningful PFS relief—i.e., sufficient and regularly scheduled updates to PFS rates that keep pace with economic conditions, along with structural reforms intended to enable Medicare’s clinician payment system to adapt over time, ideally deterring incentives for future ad hoc ‘doc fixes.’ As Congress considers policies to increase physician payment on an ongoing basis, there is an opportunity to pair such PFS relief with reforms to MACRA policies that put FFS Medicare on the path toward greater incorporation of value-based care models.

Recent Policy Proposals

In its June 2024 Report to Congress, MedPAC explored various ways to extend and reform the A-APM bonus, including extending the bonus at 5 percent for several years and restructuring the bonus, such as by shifting away from the current threshold-based approach to basing bonus payments exclusively on services provided to beneficiaries within an A-APM. This alternative structure would incentivize clinicians to increase patients in an A-APM and eliminate the tie to FFS revenue.⁷¹

Accountable for Health proposed several changes to MACRA, including:

- Modify the MIPS bonus such that it cannot be larger than the A-APM bonus. Currently, the maximum MIPS bonus remains at 9 percent; even at its peak, the A-APM bonus was only at 5 percent.

- Shorten the time between performance and payment—currently, the bonus is paid to clinicians *two years* after A-APM performance.
- Ensure that A-APM bonuses are paid for accountable care work only. Once an A-APM entity crosses participation thresholds, the bonus applies to *all* of the clinician’s Part B revenue.⁷²

Matthew Fiedler (Brookings) proposed repealing MIPS and replacing it with small, targeted incentives for practices to undertake specific high-value activities, like using a certified Electronic Health Record (EHR) or reporting data into a clinical registry.⁷³ In parallel, he recommended strengthening incentives to participate in A-APMs.

Fast Facts

<i>Would this involve regulatory or legislative actions?</i>	Likely legislative and regulatory, depending on scope.
<i>What are the estimated savings?</i>	Difficult to estimate, as it would depend on the scope of incentives and how savings are calculated.
<i>Likely sectors for?</i>	Providers with substantial experience and successful track records as A-APM participants. Value-based care-focused organizations (such as ACO groups that partner with providers to facilitate A-APM participation). Beneficiaries, who generally would support reforms that could improve quality, care coordination, and patient outcomes.
<i>Likely sectors against?</i>	Small or rural practices, who may perceive that they do not have the resources to succeed in value-based payment. Specialist groups, who have historically had less participation in A-APMs and may be cautious about how their sector would be impacted by a shift away from fee-for-service.

ABOUT LEAVITT PARTNERS

Leavitt Partners, an HMA, company, is a leading consulting firm at the forefront of navigating change in health care. We provide a holistic view of economic, market, delivery system, public policy, and political influences impacting health care, helping clients successfully navigate from today's uncertainty to tomorrow's prosperity. The firm provides clients with federal insights and advocacy as well as member-based alliances, striving to make health more accessible, effective, and sustainable.

Leavitt Partners has been at the forefront of health policy development for more than three decades. The firm helps clients understand and navigate the legislative and regulatory environments to create opportunities, resolve problems, direct action, and build and maintain positive interactions with key federal policymakers. Leavitt Partners is comprised of professionals whose experience spans the executive and legislative branches of government. As former congressional staff and executive branch political appointees, its team members know the regulatory and legislative processes firsthand and are respected for integrity, expertise, and a record of success.

Our team in Washington, D.C., has deep federal policy expertise, having helped write significant health care legislation and regulation during their time in public service. We have been involved in developing most of the major health care legislation over that time, including Medicare Part D, the Affordable Care Act, the Drug Supply Chain Security Act, the Medicare Access and CHIP Reauthorization Act (MACRA), the Comprehensive Addiction and Recovery Act, the 21st Century Cures Act, the Mental Health Reform Act of 2016, the Bipartisan Budget Act of 2018, multiple FDA User Fee Acts, the SUPPORT Act in 2018, the Pandemic and All-Hazards Preparedness Act and its reauthorizations, multiple COVID-19 relief packages, and the health care provisions of the Consolidated Appropriations Acts of 2021, 2022, and 2023, including the major provisions related to mental health, substance use disorder, and pandemic preparedness.

ACKNOWLEDGEMENTS

Leavitt Partners thanks Arnold Ventures for supporting this guide.

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10.3 million assigned beneficiaries, are earning performance payments totaling \$4.1 billion, and Medicare saved \$2.4 billion relative to benchmarks. PY 2024 had the highest share of ACOs receiving performance payments and the highest amount of savings for ACOs and Medicare since the inception of the Shared Savings Program.” See <https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-and-quality-results.pdf>

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