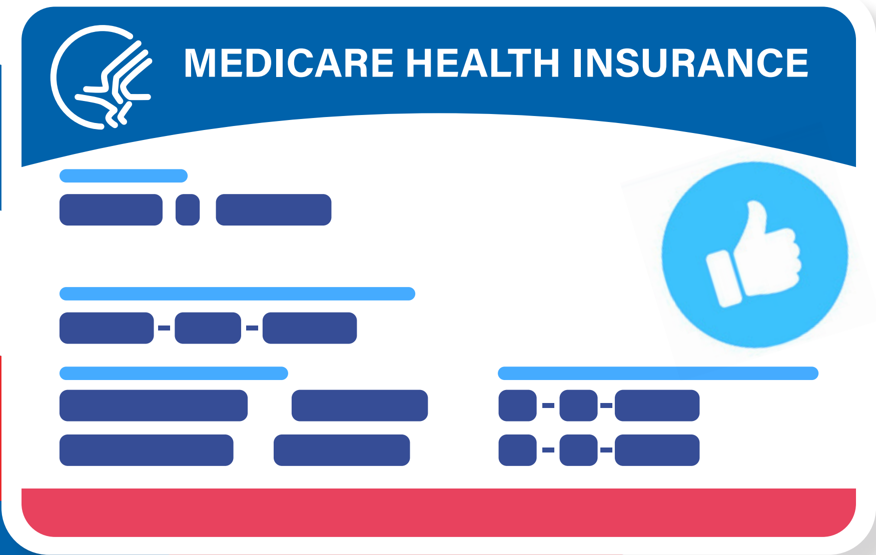
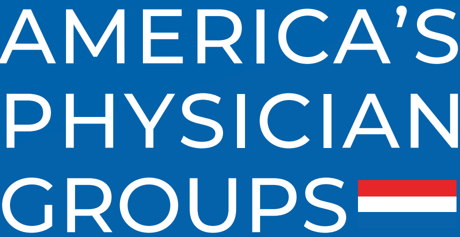
MEDICARE DONE RIGHT

PRESCRIPTIONS FOR SUCCESS

RESHAPING AN ESSENTIAL PROGRAM FOR THE 21ST CENTURY





A REPORT BY AMERICA'S PHYSICIANS GROUPS | MARCH 2025

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Major challenges face the U.S. Medicare program, which is projected to grow from 69 million to 82 million beneficiaries by 2033 amid a growing burden of chronic disease, pressure on health care access, and financial strains. Consider:

- As of 2025, 69 million Americans will be qualified for Medicare, a number that will rise to a projected 82 million in 2033.[1]
- The high and growing prevalence of chronic disease and disability among older Americans portend considerable demands on the U.S. health care system, at a time of widespread provider shortages and growing challenges in accessing care.
- Health care costs continue to rise faster than the growth in the nation's economy, with affordability challenges especially acute for the half of Medicare beneficiaries with annual incomes below $36,000 and savings of less $103,800.[2]
- Much of U.S. health care spending, including in Medicare, goes toward low-value or "no value" health care, even as pressures grow for financing treatments that may truly benefit patients.

Two Program Arms: The Medicare program, which is projected to spend nearly $1.15 trillion in 2025,[3] offers two options for beneficiaries: traditional fee-for-service Medicare, which allows wider provider access but entails higher out-of-pocket costs for beneficiaries, and Medicare Advantage (MA), which offers lower costs and additional benefits but in which plans have defined provider networks. The differences between the two arms of the program create unique challenges and opportunities for beneficiaries, provider groups, and the nation, as detailed in the body of this report.

As one example, MA enrollment is growing faster than enrollment in traditional Medicare as more beneficiaries appear drawn to both the broader benefit structure and limited out-of-pocket cost exposure in MA. Building on the successes of MA in delivering superior health outcomes to beneficiaries represents an important opportunity for the nation.[4]

At the same time, the reality of a growing MA program poses a challenge in calculating how much MA plans should be paid to provide Medicare benefits. The reason is that the current formula for doing so depends on costs in traditional Medicare, which is likely to be a shrinking and increasingly less relevant share of the program.

Core Issues: This report from America's Physician Groups (APG) analyzes the core issues behind many of these challenges and opportunities and makes recommendations for addressing them. APG is particularly well suited to advance these proposals. This national organization represents roughly 360 physician groups that have led the nation's move to taking greater accountability for the quality and costs of health care. The expertise that APG groups have developed in both parts of Medicare — first, in Accountable Care Organizations and other alternative payment models in the traditional program, and second, in caring for Medicare Advantage patients in at-risk arrangements — makes APG particularly well qualified to advance ideas for reforming the overall program to improve health outcomes and deliver greater value for the dollars expended on health care.

The costs of *not undertaking reforms* to drive greater accountability and improve both arms of the program cannot be understated. A growing imbalance within the program will worsen beneficiaries' health and access to care will suffer, the nation will spend even more on health care that is at best of indeterminate value, and at worst is wasteful and even harmful. What's more, APG believes, competition between two strong arms of the Medicare program could drive superior financial and operational performance, as innovations in one portion could set new standards for the other.

This report lays out two sets of recommendations for near-term steps to deliver on the promise of Medicare and adapt it to the evolving realities of this century. These recommendations for the two parts of the program are summarized below.

> ***"There is a need to drive greater accountability in both parts of the Medicare program Medicare cannot be understated.***

Recommendations for Traditional Medicare

Increasing Accountability

1. To maintain the momentum toward accountable care and help lay the groundwork for needed reforms, the Trump administration should recommit itself to having every Medicare beneficiary in accountable relationships with care providers. Only through greater accountability of the health care sector will Americans' health outcomes improve and rates of growth in spending remain sustainable.
2. To enhance accountability in traditional Medicare, the Trump administration and Congress should work together to maintain and improve existing Medicare alternative payment models — both those fully in law, such as the Medicare Shared Savings Program, as well as the model experimentation under way under the auspices of CMS's Innovation Center. The greatest emphasis should be on large population-based alternative payment models that appear likely to be the most transformational.
3. Congress and the new administration should examine policies that would provide a stronger incentive to participate in accountable care in traditional Medicare — including the possibility of imposing "non-accountability penalties" on health systems and large physician practices that decline to participate in at least one two-sided risk MSSP ACO or other designated accountable care model.

FACT #1

Health care costs continue to rise faster than the growth in the nation's economy, posing acute affordability challenges for many Medicare beneficiaries.

Equalizing Benefits With Medicare Advantage In Accountable Care Organizations

1. To create a more equal benefits structure between traditional Medicare and Medicare advantage, Congress and the new administration should develop a conceptual pathway, and enact legislation, that would phase in comprehensive dental, vision, and hearing benefits in traditional Medicare within alternative payment models. Such benefits would be made available to enrollees who agreed voluntarily to be attributed — that is, assigned to a provider group to manage these patients' health — to two-sided risk MSSP ACOs, direct contracting models, or other designated accountable care models on the basis of their affiliation with a primary care clinician.
2. In tandem with improving traditional Medicare benefits, Congress and the new administration should take steps to move away from, if not terminate, the current method of attributing Medicare beneficiaries to ACOs based on medical claims and and strengthen the process of, and incentives for, voluntary beneficiary alignment within two-sided risk accountable care models.

Increasing the Sustainability of Accountable Care Models

1. To make MSSP and other accountable care models more sustainable over the long run, Congress and the new administration should revisit current methodologies for setting spending benchmarks that effectively punish model participants that achieve savings, and/or regions of the country that achieve lower Medicare spending. CMS should continue to model and test alternative methodologies and share results with stakeholders.
2. Because the "direct contracting"[5] approach in Medicare continues to hold promise in advancing accountable care, the CMS Innovation Center should create a new ACO model that builds on the lessons learned from the ACO Realizing Equity, Access, and Community Health (REACH) model.

Adopting Site-Neutral Payments

The Centers for Medicare & Medicaid Services should enact a suite of site-neutral payment reforms as identified by MedPAC.[6] The commission has identified 66 ambulatory procedures (listed by their ambulatory payment classifications, or APCs) for which payment could be aligned across hospital-based and non-hospital-based settings while still ensuring safety and appropriateness of care and supporting the ability of hospitals and health systems to deliver emergency care and retain standby capacity. MedPAC's proposal is budget-neutral, so it would also increase payment rates for 108 primarily hospital-based services. As a result, according to MedPAC, "aggregate Medicare spending in the short term would be unchanged," but providers would have better incentives to "make site-of-care decisions based on financial rather than clinical factors, which could eventually result in lower aggregate spending."

Restructuring Cost and Quality Incentives in Traditional Medicare

To accelerate the movement toward greater accountability in health care, Congress and the new administration should begin the process of reauthorizing the 2015 MACRA legislation with the aim of adopting changes no later than fiscal 2026-2027. In the context of MACRA reform legislation, Congress and the new administration should draft provisions for the following:

1. Abolishing the Merit-Based Incentive Payment System (MIPS) program and establishing a new voluntary quality payment program along the lines proposed by MedPAC.
2. Creating a revised Advanced Alternative Payment Model bonus program that is not based on a percentage of fees but rather links bonuses to the number of attributed Medicare beneficiaries in the AAPM model in which a clinician participates.
3. Incorporating a regular annual inflation factor update into the MPFS — at minimum, at the rate of the Medicare Economic Index minus one percentage point.
4. Incorporating hybrid payment arrangements into the MPFS for benefit of primary care clinicians.

Recommendations for Medicare Advantage

Advancing At-Risk Payment Arrangements With Providers

Recognizing the superior performance of at-risk relationships between Medicare Advantage plans and providers as documented in the literature,[7] policy makers should actively encourage and incentivize more of these relationships within the MA program.

Improving Risk Adjustment

Because risk adjustment is essential in risk-based models, policymakers should develop and test new approaches that will better tie assessments of Medicare Advantage enrollees' health conditions with funding that reflects realistic costs of their care. Requisite steps in the near term should be taken as follows:

1. Evaluation of the full effects of implementation of the current risk adjustment model.
2. Maintenance of robust federal audits of coding practices and data and continued enforcement actions in instances of fraud and abuse
3. Preservation of the use of tools such as Health Risk Assessments and chart reviews under new guardrails.
4. Investment of federal time and resources in better understanding the actual resource use necessary to care appropriately for Medicare beneficiaries with various health conditions.

Improving Prior Authorization

Because prior authorization is an essential tool in utilization management, and an important safeguard for patients and society, policymakers should take several steps to improve it. Key steps are as follows:

1. Speeding the move to electronic prior authorization enhanced by proven technologies.
2. Standardizing prior authorization criteria across MA plans and making them transparent.
3. Requiring MA health plans and their partnered providers to increase the quality and timeliness of their communications with patients regarding prior authorization requests and denials.

> *“Policymakers should encourage more at-risk payment relationships between MA payers and providers.*

4. Incentivizing or, if such efforts fail, requiring MA pans to devise and adopt “gold card” programs for their contracted providers.

Improving the Quality Bonus Program

Star Ratings are designed to help Medicare Advantage enrollees choose their health plans, and as such, they underpin the Medicare Advantage Quality Bonus Program that financially rewards top-scoring MA plans. But it is not at all clear the ratings capture higher quality in terms of improved health outcomes for MA enrollees — even as changes in the methodology of computing the ratings have recently shaved revenues to many MA plans. As a result, APG recommends the following:

1. CMS should test new aspects of the Quality Bonus Program before it implements them, to afford time for plans and providers alike to understand the implications, and
2. CMS should continue its process of seeking input ahead of time from stakeholders via requests for information before adopting new measures.
3. The agency should also redouble its focus on a relatively parsimonious list of “measures that matter” along the lines of the Universal Foundation, and prioritize measurement of outcomes that matter to MA enrollees and demonstrably improve their health.
4. CMS should refine the current methodology of calculating Star Ratings to ensure that all MA plans are included in comparisons and that scores are predictable and transparent each year.

Evaluating Supplemental Benefits

Most Medicare Advantage plans provide supplemental benefits — both the traditional ones covering dental, vision, and hearing care, as well as other benefits linked to addressing enrollees’ health-related social needs, such as food or transportation. Yet not enough is known about the use of these benefits nor the degree to which they improve health.

APG recommends that policymakers proceed to seek greater evaluation of, and transparency around, the costs and value of these benefits. Such an expanded knowledge base should be a prerequisite for continuing them within MA, as well as for extending them into the alternative payment models in the traditional Medicare program as this report has also recommended.

Conclusion

This report has described multiple issues in both the traditional Medicare program and in Medicare Advantage, drawing on the expertise that APG groups have developed in both parts of Medicare: first, in Accountable Care Organizations and other alternative payment models in the traditional program, and second, in caring for Medicare Advantage patients in at-risk arrangements. If many of the recommendations in this report are enacted, both arms of the program will be improved, and the nation, the health care system, and patients alike will all benefit.

The alternative to not moving forward on many of these recommendations is that the current adverse trends in Medicare will only be exacerbated further, to the detriment of national wellbeing. The growing imbalance in enrollment between traditional Medicare and Medicare Advantage will become greater. Accountability for quality and costs among health care providers will not grow and will arguably decline. Medicare beneficiaries’ health outcomes will not improve as they should.

Adverse consequences: Without this accountability, the nation will spend more than ever on health care that, at best, is of indeterminate value, and at worst, is wasteful and even harmful to Medicare beneficiaries and others. The resulting opportunity costs will mean that fewer resources than ever will be devoted to other activities that society values, such as education, which have also been shown to be integral to long-term health.

APG looks forward to working with policymakers of all political persuasions and at all levels to advance these recommendations further. America’s Physician Groups believe that the American people deserve no less.

INTRODUCTION

A perfect storm is brewing in U.S. health care, with the nation's Medicare program at the center of the tempest. Consider:

- As of 2025, 69 million Americans will be qualified for Medicare, a number that will rise to a projected 82 million in 2033.[8]
- The high and growing prevalence of chronic disease and disability among older Americans portend considerable demands on the U.S. health care system, at a time of widespread provider shortages and growing challenges in accessing care.
- Health care costs continue to rise faster than the growth in the nation's economy, with affordability challenges especially acute for the half of Medicare beneficiaries with annual incomes below $36,000 and savings of less $103,800.[9]
- Much of U.S. health care spending, including in Medicare,[10] goes toward low-value or "no value" health care, even as pressures grow for financing treatments that may truly benefit patients.

The structure of Medicare faces financial challenges, with spending from the Part A trust fund now projected to exceed revenues in 2030 and the fund itself — which generally pays for hospital and other institutional care for Medicare beneficiaries — expected to be depleted in 2036. More broadly, the entire Medicare program is growing rapidly as a share of domestic output, with uncertain benefits in terms of enrollees' health.[11]

Crucial differences: Beneath these broad challenges are multiple issues specific to other aspects of Medicare itself. Medicare today is not one program, but two — and as of today, the two parts have evolved into fundamentally very different programs. This report from America's Physician Groups examines the fundamental differences between the programs; the policy issues raised by these differences; and the opportunities for improving both arms of the programs that can lead to greater quality of care and better value for the dollars expended for both Medicare beneficiaries and the nation.

"

Medicare is at the center of the perfect storm brewing in U.S. health care.

One part of Medicare is the original, traditional fee-for-service Medicare program, which in general covers hospital (Part A) and physician (Part B) services plus a separate (Part D) insurance program for outpatient prescription drugs. Another main part is Medicare Advantage (MA), also known as Part C, under which private health plans receive payment from the government to provide Medicare benefits to enrollees. The plans then typically offer enrollees an expanded package of benefits not available in traditional Medicare — including dental, vision, and hearing coverage, often at low or no additional premiums — as well as lower cost-sharing for beneficiaries compared to traditional Medicare.

The existence of these two distinct and fundamentally different parts of Medicare creates multiple challenges and opportunities for patients, providers, taxpayers, and the government broadly. For example, Medicare beneficiaries themselves face tradeoffs in choosing to enroll in traditional Medicare versus MA, as follows:

- Enrolling in traditional Medicare gives beneficiaries wide latitude to see any "participating" provider that accepts Medicare payment, which as a practical matter means virtually all U.S. hospitals and most physicians. By contrast, MA plans typically contract with specific hospitals and doctors to create either exclusive or preferred provider networks and will generally not pay for care provided outside these networks.
- Because traditional Medicare is built on an older model of insurance coverage dating back to the 1960s, it requires beneficiaries to pay significant deductibles and coinsurance — for example, in 2025, a $1,676 deductible for a hospital stay, and coinsurance of $419 for days 61-90 of hospitalization.[12] There is also no annual cap on beneficiaries' out-of-pocket spending, which can expose very sick beneficiaries to excessive costs.
- To the degree that traditional Medicare coverage "works" for people, it is because 90 percent of beneficiaries have some form of additional coverage, such as Medigap (42%), at an out-of-pocket cost of $50 to $300 per month; employer or union-sponsored retiree health benefits (31%); or Medicaid (16%). However, 11 percent (three million Medicare beneficiaries) have no additional coverage.[13]

- MA enrollees on average incur as much as 24 percent less in out-of-pocket costs than those in traditional Medicare, with many MA plans offering low or no co-pays for seeing in-network providers.[14] All MA plans are required to cap total annual out-of-pocket costs for in-network services at $9,350 in 2025, and many plans offer even lower caps to enrollees. MA enrollees thus have little need for, and cannot buy, Medigap coverage plans.
- At the same time, as noted above, MA plans typically offer additional benefits not available in traditional Medicare, such as comprehensive dental, vision, and hearing coverage as well as many “supplemental” benefits such as assistance for transportation and food. Meanwhile, to control costs and assure appropriate use, MA plans also actively manage enrollees’ care, such as by requiring their providers to receive prior authorization approvals to deliver certain types of care.[15]

FACT #2

Medicare Advantage enrollees on average incur as much as 24 percent less in out-of-pocket costs than do enrollees in traditional Medicare.

For the nation, the two parts of Medicare also pose opportunities and challenges, as follows:

- MA enrollment is growing faster than enrollment in traditional Medicare as more beneficiaries appear drawn to both the benefit structure and limited out-of-pocket cost exposure. As of 2025, 52 percent of all Medicare beneficiaries will be enrolled in MA plans, a share that is expected to rise to 57 percent in 2033. This reality will present growing difficulties in calculating how much MA plans should be paid to provide Medicare benefits, as the current formula for doing so depends on costs in traditional Medicare, which will be a shrinking and increasingly less relevant share of the program.
- Through a combination of deliberate program design features and market responses, MA costs more on a per-beneficiary basis than does traditional Medicare — although many experts consider this relationship an apples-to-oranges type of comparison. The exact amount of the cost difference is subject to debate; some estimates peg it at about 10 percent per beneficiary and others at 22 percent.[16] A 2021 Milliman study noted that 9 percent and 2.5 percent of the higher amounts paid to MA plans compensates them for administrative costs and profits, two forms of expenses not borne by the government in financing fee-for-service Medicare.[17]
- The differential in costs between the two arms of the program stems from multiple sources, including adjustments to the benchmarks against which plans must bid; efforts by MA plans to gain higher risk-adjustment payments through assiduous coding of diagnoses; and payment of quality bonuses to plans through the Star Ratings program. Although MA plans may capture some of this surplus as profit, the higher payment levels to plans also enable them to provide more generous benefits than does traditional Medicare.[18]

A key question for the nation is what to do about this difference in costs between the two parts of Medicare: Increase benefits and raise costs in the traditional Medicare program, to bring them more in line with Medicare Advantage; cut costs and lower benefits in Medicare Advantage, which would expose enrollees to significantly higher cost burdens and fewer benefits; or accept the fact that the two parts of the programs are fundamentally different, and potentially let the disparity in benefits and costs between them continue to exist and probably grow. Choosing any of these courses of action will require serious national debate, and changing direction will demand far-reaching policy actions.

In the meantime, there are also multiple other issues that require examination and action, including the roles of risk adjustment and prior authorization in Medicare Advantage; the role of quality bonuses or Star Ratings; and how best to harness the capabilities of MA plans and providers working together to achieve optimal outcomes for patients.

America's Physician Groups' Perspective

America's Physician Groups is a national organization representing approximately 360 medical groups caring for approximately 1 in 4 Americans. Our primary and multi-specialty groups are committed to being held responsible for providing high quality, coordinated, and patient-centered care that is accountable for its costs and value to patients and society.

Nearly all APG member groups, except for our pediatric-focused members, care for Medicare patients in both the traditional and MA parts of the program. In traditional Medicare, APG member groups have been heavily engaged in Medicare's Accountable Care Organization models such as the Medicare Shared Savings Program, with many of them among the top performers in terms of achieving quality outcomes for beneficiaries and shared savings for themselves and the nation's taxpayers (citation here). At the same time, many APG members contract with MA plans to provide care to MA enrollees, providing that care to roughly 1 in every 3 MA enrollees nationwide.

Differences within Medicare Advantage: MA plans are not monolithic and take multiple different forms, the three largest of which are so-called Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plans, and Special Needs Plans (SNPs). In general, MA plans themselves do not provide much if any actual health care, but most contract with hospitals, physician groups such as APG members, and other provider organizations to deliver most of the care.

The various types of MA plans have different contractual arrangements with provider groups, particularly with respect to payment. For example, PPO-type plans engage broader networks of providers and typically pay them on a fee-for-service basis, at rates roughly at or below typical Medicare rates. HMO-type plans have narrower networks of providers and typically pay them so-called capitation rates — in effect, a lump annual sum for each MA patient. In these arrangements, providers are subject to "two-sided risk," meaning that they are financially responsible for both the costs and quality of care that they provide to patients and must pay the plan if they fail to meet agreed-upon goals. These arrangements are sometimes referred to as "delegated" payment arrangements from MA plans, and in effect, are a form of sub-capitation through which both financial risk and accountability for meeting quality goals are fully shared between an MA plan and a given medical group.

Growing evidence: APG groups have compiled substantial evidence that outcomes for MA enrollees are superior under these risk-based models, compared to MA enrollees in non-risk-based arrangements or to traditional Medicare enrollees. For example, in a study of the experience of more than 1 million patients cared for by APG member groups from 2016 to 2019, superior outcomes were obtained for MA patients in at-risk arrangements in 18 of 20 measures when compared to MA patients in fee-for-service MA arrangements (see Exhibit).[19] In particular, lower hospitalization rates for these MA patients with chronic conditions such as diabetes, high blood pressure, and heart failure signaled that patients were being well cared for by their primary care doctors and other clinicians, and avoiding the frequently debilitating hospital stays that may otherwise result.

Additional research focused on care provided by APG member groups has shown that when groups adopt the advanced primary care models made possible through MA, the benefits can "spill over" onto patients in traditional Medicare who are also cared for by these groups.[20] This research showed that substantial reductions in hospitalization and emergency department visits, as well as increases in medication adherence, were among the important improvements in the quality and costs of care. An as-yet unpublished, high-level estimate by APG is that potential savings to traditional Medicare could be as much as $22.4 billion annually.[21]

> *"Evidence shows superior outcomes for MA patients in at-risk pay arrangements.*

Why APG?

The expertise that APG groups have developed in both parts of Medicare — first, in Accountable Care Organizations in the traditional program, and second, in caring for MA patients in at-risk arrangements — makes APG particularly well qualified to advance ideas for reforming the overall program. The nation, the health care system, and patients alike will all benefit from having two strong arms of the Medicare program that offer coverage alternatives for beneficiaries and payment alternatives for providers. What's more, competition between the two arms can drive superior financial and operational performance as innovations in one portion can set new standards for the other.

In following sections of this report, APG lays out its analysis of key issues in both arms of the program and its recommendations for change. APG hopes that the report will serve as a useful guide for policymakers and others seeking to achieve lasting improvements in a program vital to the health and wellbeing of tens of millions of older adults, disabled individuals, and their families, friends, and communities who also care for them.

TRADITIONAL MEDICARE

SUMMARY: *The traditional Medicare program serves as a critical option for many eligible Americans. Although the program has notable benefits, it also presents significant challenges, particularly related to its benefits structure and financial framework. Research commissioned by APG highlights how traditional Medicare beneficiaries navigate their choices and are often heavily reliant on supplementary forms of coverage such as Medigap.*

This section also explores other notable issues, including the impact of fee-for-service payment in Medicare; the structure of the Medicare Physician Fee Schedule; the role of alternative payment models; and the need for broad reforms in Medicare physician payment.

The traditional Medicare program remains an important enrollment option for many eligible Americans, who include those age 65 and older as well younger people with disabilities, patients with end-stage renal disease, and those with ALS.[22] Although the program has many positive attributes, it also has drawbacks, and its structure poses increasing challenges for beneficiaries and the nation.

This section of this report will focus primarily on two sets of challenges: (1) The benefits structure of the traditional Medicare program and the resulting issues for enrollees, and (2) the multiple problems that stem from the program's underlying financial structure; and (3) issues arising from payment in the program, or the way that providers are compensated for services provided to beneficiaries.

Benefits Structure Challenges

Traditional Medicare coverage — first created through legislation in 1965 and modified multiple times through legislation over the intervening years — can be described as an indemnity insurance model onto which other parts, such as prescription drug coverage operated through private health plans, have also been attached. It is funded through a combination of federal payroll and income taxes and premiums paid by enrollees.

As noted, the benefits structure in traditional Medicare is in many respects not at all generous, requiring a deductible payment of $1,676 in 2025 for inpatient care during a benefit period; coinsurance of $419 in 2025 for days 61-90 of hospitalization; coinsurance for skilled nursing facility and hospice care; Part B premiums of $185 per month in 2025 ($2,200 for the year), plus a $257 deductible; 20 percent coinsurance for physician visits and other outpatient care, including drugs administered in a physician's office; no out-of-pocket maximum on all out-of-pocket care costs; and no automatic coverage for prescription drugs, and dental, vision, and hearing care, all of which must be purchased separately. What's more, the average enrollment-weighted monthly premium for a Medicare Part D stand-alone plan in 2025 is projected at $45, with a new limit of $2,000 on beneficiary out-of-pocket costs as of 2025 limit[23]; dental, vision, and hearing plans can vary widely in cost based on benefits and location, but the average cost for a dental, vision, and hearing plan is between $30-$45 per month.[24]

Cost exposure: The result is that enrollees are exposed to potentially large out-of-pocket costs of more than $7,000 annually, and thus the need to have or to purchase supplemental coverage. In 2019, for example, people with traditional Medicare spent an average of $6,663 on out-of-pocket spending for medical premiums and services; that sum represented about 38 percent of the average annual Social Security retirement benefit ($17,460).[25]

Unless enrollees have access to Medicaid or retiree health coverage from previous employers, their main source of protection against some or most of these out-of-pocket costs will be the array of Medicare supplemental plans known as Medigap.[26]

To understand how Medicare beneficiaries make enrollment choices in the face of these realities, APG commissioned a study by the Berkeley Research Group that examined the coverage options available to Medicare enrollees in five illustrative markets: Tampa, Florida; Dallas, Texas; Reno, Nevada; Brooklyn,

"Traditional Medicare enrollees face potentially large out-of-pocket costs Medigap coverage supplemental coverage.

New York; and New Orleans, Louisiana. The study also developed three different "personas" of individuals of different ages and with different health issues, to illustrate how these issues may affect enrollees' choices (see graphs below).

Fig. #1

PERSONA	AGE & SEX	HEALTH STATUS & CONDITIONS	MEDICATIONS	EXPECTATIONS FOR COMING YEAR
#1: "Healthy"	Female, 75	Non-smoker; 1-2 Chronic	2 generics	Remain healthy
#2: "Episodic"	Male, 70	Non-smoker; 3-5 Chronic	4 generics	Short hospitalization
#3: "Chronic"	Female, 65	Non-smoker; 6+ Chronic	4 generics, 1 brand; 1 physician-administered brand	Multiple episodes of hospitalization

Fundamentally, each of these personas must weigh their optimal coverage options as between (1) traditional Medicare coverage, most likely supplemented by Medigap and purchase of a standalone Part D prescription drug benefit (PDP) plan, and (2) a Medicare Advantage (MA) plan, which either may include Part D benefits or also require purchase of a standalone PDP plan. Although their traditional Medicare Parts A and B benefits would be consistent nationwide, their PDP and MA plan choices will depend to some degree on their county of residence and the private plan options available to them in different locations. Beneficiaries' choices will also be affected by their income status, and as noted, the degree to which they are eligible for Medicaid, Supplemental Security Income, and special forms of assistance to low-income beneficiaries such as the Medicare Savings Programs[27] or Extra Help.[28]

FACT #3

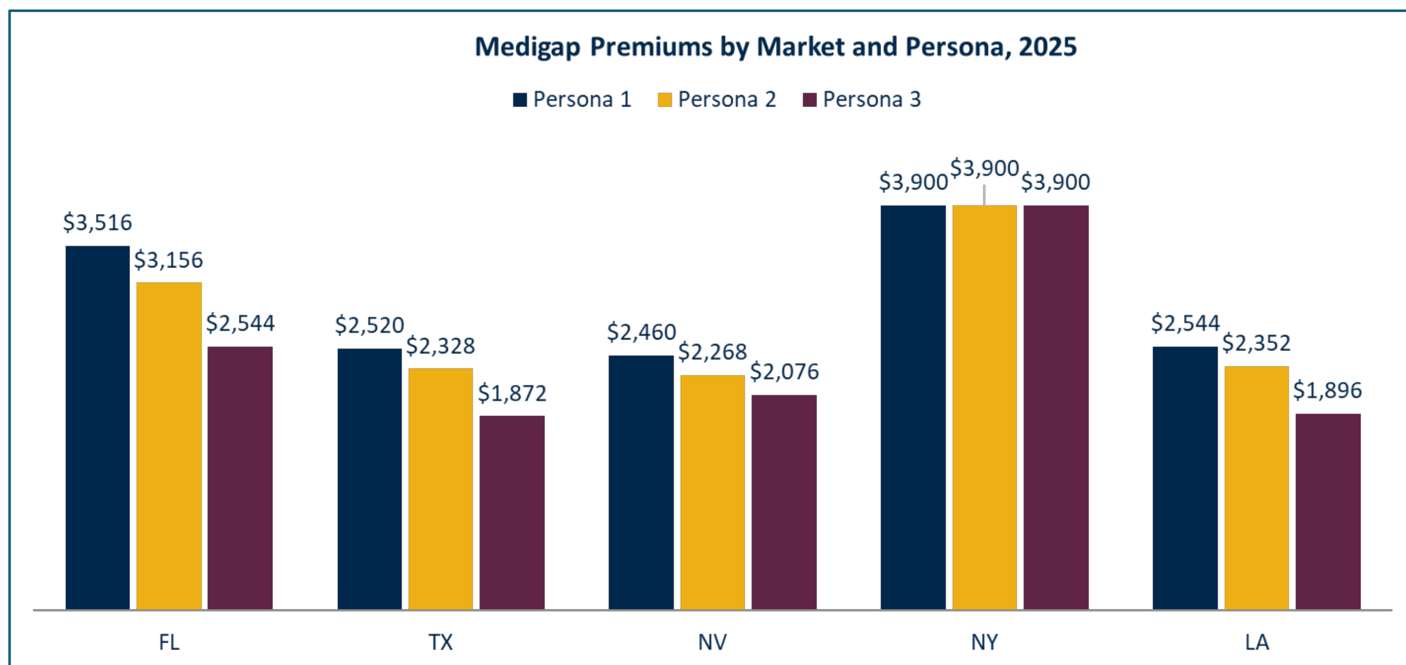
Traditional Medicare enrollees can face daunting choices in their coverage – chief among them the range of costs for Medigap plans, which are based on their underlying health status and the plan that they select.

Array of choices: The resulting BRG analysis shows that the spread of choices available to beneficiaries is daunting. Chief among them is the range of costs for Medigap, depending on their underlying health status and the plan option that they select. (In most states, beneficiaries applying for Medigap plans may be subject to underwriting unless they are applying during a special enrollment period (SEP), such as the 7 months surrounding their initial Medicare eligibility date. Outside of SEP enrollment, Medigap carriers may charge a higher premium or refrain from offering coverage based on the results of the underwriting process.)

The Medigap plan selected for the purposes of this analysis is the Medigap G plan, which is the most popular and most generous plan available and covers all the Part A deductible and all Part A coinsurance and hospital costs; Part A hospice care coinsurance and copayments; all Part B coinsurance and copayments (although not the Part B deductible); and any Part B "excess charges," which are additional fees that providers not accepting Medicare "assignment" can charge — of up to 15 percent more than Medicare will pay — for services covered by Medicare Part B.)[29]

According to BRG, depending on the market and the individual, annual Medigap premiums for a Medigap G plan can vary by more than two-fold, from $1,872 in 2025 to $3,900. (For purposes of comparison, household median income for those age 65 and older was estimated at $54,710 in 2023.[30] Enrollees who selected Medigap would thus face these premium rates, in addition to premiums for Part B and Part D plans. (It is also bears noting that some Medigap plans require payment of deductibles and may offer high-deductible plan options as well.)

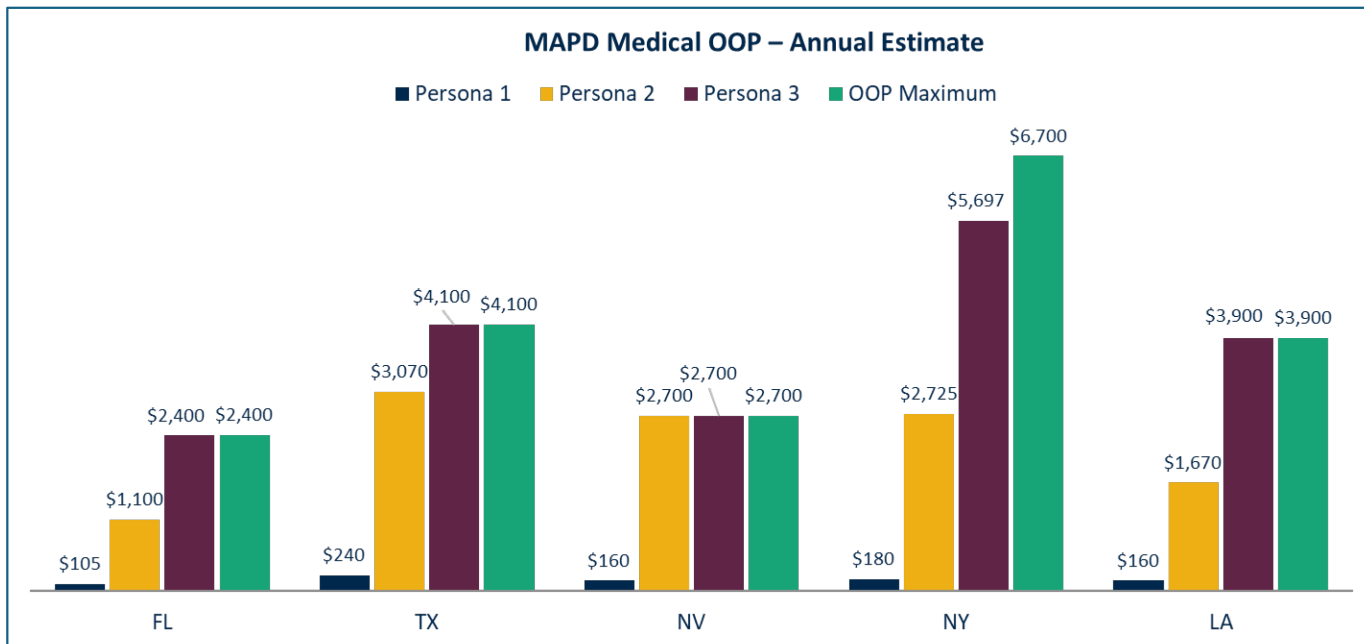
Fig. #2



Given these Medigap costs, and the prospect of buying additional private insurance for hearing, dental, and vision, it is little wonder that more Medicare beneficiaries elect to enroll in Medicare Advantage plans. The BRG analysis also examined the MA options available to the various "personas" in the five different markets selected and showed a range of estimates, both as to their MA plan options and the potential out-of-pocket costs that they could face even after enrolling in these plans. (As noted, MA plans have a mandatory cap on out-of-pocket costs of $9,350 in 2025, with some plans having lower OOP caps). The analysis assumes that the various personas selected the most popular MA plan available in each market.

Range of costs: Figure #3 below illustrates the wide range of out-of-pocket costs the various personas could face, from a low of $105 for the healthiest enrollee (persona #1) in Tampa, Florida, to a high of $5,697 for the sickest enrollee (persona #3) in Brooklyn, New York. In no case did any of these personas face the total out-of-packet maximums for all MA plans of $9,350 in 2025, and in fact, the most popular plans in each area set the allowable out-of-pocket maximums well below that level (for example, at $2,400 in Tampa and at $6,700 in Brooklyn). In addition, it bears noting that all these MA plans charge no premium for enrollees beyond the monthly Part B premium of $185 monthly in 2025, and include both Part D coverage and dental, vision, and hearing benefits at no additional premium.

Fig. #3

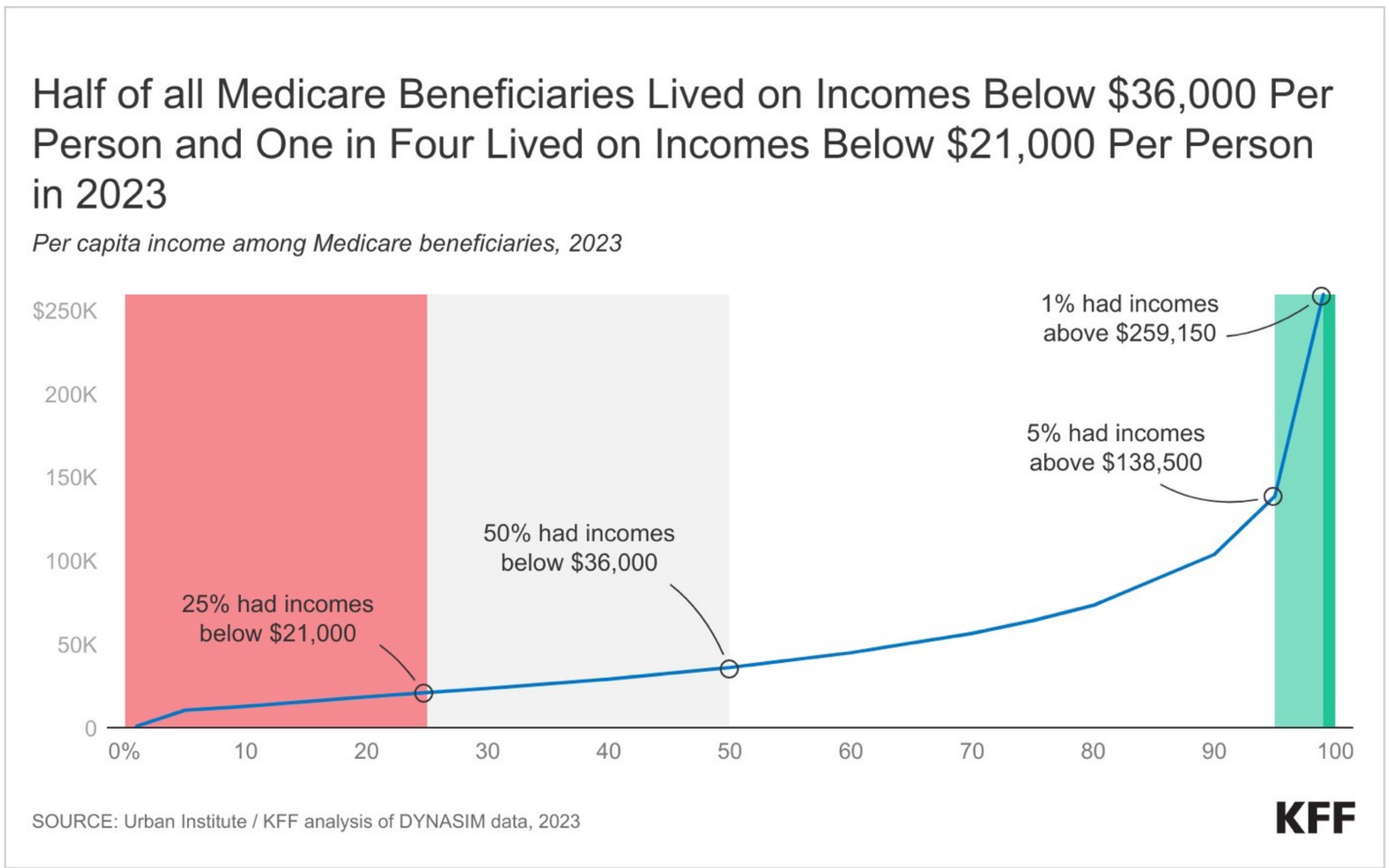


Given the disparities in potential costs to beneficiaries, it is perhaps no surprise that so many opt for MA plans that will insulate them from greater costs without necessitating the purchase of additional Medigap coverage. Many MA enrollees are willing to accept the tradeoff of choosing plans with specified provider networks versus the open-ended arrangements in traditional Medicare, under which they can be treated by any provider accepting Medicare assignment. In practice, this reality means that while MA provider networks are more limited, traditional Medicare beneficiaries have covered access to the vast majority of U.S. hospitals (more than 7,000) and to more than 98 percent of all non-pediatric U.S. physicians (although perhaps disturbingly, nearly 2 in 5 psychiatrists, more than 1 in 5 family medicine physicians, and nearly 1 in 8 internal medicine physicians have now opted out of Medicare).[31]

A central issue is whether the differences in benefits between traditional Medicare and Medicare Advantage are so great that they distort enrollment between the two programs. There is growing evidence that this is so.

Income differences: Relatively little information is available about the income distribution of enrollees in traditional Medicare, but it is known that, as of 2023, 5 percent had incomes above $138,500 and 1 percent had incomes above $259,150. Individuals with incomes at these levels are probably more likely to be able to afford purchase of Medigap plans and thus to remain in traditional Medicare. By contrast, 50 percent of Medicare beneficiaries have incomes of $36,000 or below, and many are perhaps more likely to prefer the more predictable costs and diverse benefits of MA plans. Further research to document these potential realities would be instructive.

Fig. #4



Source: https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/#:~:text=Income%20among%20Medicare%20Beneficiaries,incomes%20below%20%2421%2C000%20per%20person

Congressional Democrats have in the past proposed that benefits in traditional Medicare be expanded to include some Medicare coverage of dental, vision, and hearing care — specifically, for (1) routine dental cleanings and exams, basic and major dental services, emergency dental care, and dentures; (2) routine eye exams, eyeglasses, and contact lenses; and (3) routine hearing exams, hearing aids, and exams for hearing aids.[32] In 2020, the Congressional Budget Office estimated that adding these benefits would increase federal spending by $358 billion between 2020 and 2029.[33] Although adding these benefits would more clearly equalize the choices available to Medicare enrollees, the proposed changes to date have been dismissed as too costly and have not moved forward in Congress. (A small exception has been that a modest amount of dental coverage was added to traditional Medicare in 2023–4 through CMS rulemaking.[34]

Traditional Medicare's Financial Structure and Challenges

A separate set of issues arises from the financial underpinnings of the traditional Medicare program. Key components of this structure are how the program is financed through taxes and beneficiary contributions; the composition of the U.S. population; and the projected growth in health expenditures, among others.

As an example of issues in tax-based financing of Medicare — in other words, of money coming into the program — Part A of Medicare is financed almost entirely through payroll tax contributions, whereas other components of the program (Parts B and D) are financed through general revenues and beneficiary premiums. Because payroll taxes are borne by workers and their employers, the share of people of working age in the population will help to determine the revenues that can be raised. The fact that the U.S. population is projected to become older, on average, over the 2025–2055 period, and that the growth in the number of people aged 65 or older will outpace the growth of younger age groups is therefore critical.[35]

Looming shift: Absent other variables — such as rates of fertility, immigration, and labor force participation, among others — the ratio of older adults to working-age adults, also known as the old-age dependency ratio, has been rising and will continue to rise. In 2020, for example, there were about 3.5 working-age adults for every person 65 and older; by 2060, that ratio will fall to just two-and-a-half working-age adults for every retirement-age person. This likely shift will constitute a major change with large consequences for the payroll tax component of financing for Medicare and Social Security.[36]

As an example of issues arising from Medicare spending — in other words, money flowing out of the program — current projections from CMS actuaries are for annual Medicare expenditure growth to shift from 8.4 percent in 2023 and 6.1 percent in 2024 to 7.1 percent in 2025-6 and 7.6 percent in 2027-32.[37] These projected growth rates are all multiples of projected real U.S. economic growth for all those years.[38] As a result, Medicare spending is projected to rise from 3.2 percent of U.S. gross domestic product in 2024 to 4 percent of GDP in 2035 (citation). Absent major changes in policy, this increase will occur against the backdrop of steep U.S. federal budget deficits and rising levels of federal debt.[39]

Funding issues: Within this broader context, individual aspects of the Medicare program face specific challenges. Medicare Part A spending is financed through the Hospital Insurance Trust Fund, to which the Medicare component of payroll taxes is dedicated. Part A spending is currently projected to exceed incoming revenues in 2030, which means that the trust fund will have to draw on its reserves — essentially IOUs from the government — to pay benefits. Those reserves are projected to be depleted in 2036, again absent any policy changes to decrease spending or shore up revenues, such as through a payroll tax increase.[40]

To state the issues succinctly, a rapidly growing share of older, sicker Americans — many of them likely to obtain health care in the costliest health care system in the world — portends major fiscal challenges for the nation. What is equally worrisome is that, without substantial policy changes, there could be extraordinary difficulties in ensuring that Medicare beneficiaries receive needed care — not only through failure to address the fiscal challenges, but also due to the structure of much of Medicare payment, as the next section of this report details.

Challenges Arising From Provider Payment in Traditional Medicare

Medicare, the largest purchaser of health care services in the United States, pays providers through multiple payment systems, some of which are classified as "prospective" — that is, they are based on predetermined payment regardless of the intensity of services provided.[41] The methodologies behind payment systems to different types of providers vary, however. Physicians and other clinicians are paid through a fee schedule that is set annually by CMS, operating under the authority of Congress. This fee

> *"A growing share of older, sicker adults portends challenges.*

schedule is perhaps the clearest example of so-called fee-for-service payment: Because providers receive set fees for specific services, their overall payments are driven by the volume and intensity of services provided.[42]

All payment methods, including fee-for service, have strengths and weaknesses, but the U.S. version of fee-for-service payment is criticized for two principal reasons: It "creates an incentive for physicians to prescribe more services, including more low-value services," and it distorts the relative prices of different types of services because of the way in which the various fees are set. Thorough critiques of this system of setting fees through the Medicare Physician Fee Schedule have been covered by others and reforms have been proposed.[43]

Payment bias: An especially compelling critique focuses on the inherent bias created in the fee schedule that rewards procedures at the expense of more cognitive aspects of medicine. The Medicare Physician Fee Schedule is also poorly suited for paying adequately for primary care, which "requires ongoing care coordination and relies upon routine activities that are under- or non-reimbursed in the Fee Schedule."[44]

Although APG agrees with many of these critiques, many specific suggestions for major reforms in the MPFS are beyond the scope of this report. This section will focus instead on two aspects of Medicare physician payment that warrant attention: (1) ongoing efforts to spread alternative payment models, some of which are still based on fee-for-service payment; and (2) efforts to redress cuts in the Medicare Physician Fee Schedule, reform the 2015 MACRA law, and address longer-term concerns that declining physician payment may adversely affect beneficiaries' access to care.

Alternative Payment Models in Medicare

There is a substantial literature on the movement in recent years to institute and test alternatives to fee-for-service payment in Medicare to improve the quality of health care and curb cost growth.[45] The preponderance of these alternative payment models (APMs), such as the Medicare Shared Savings Program, have still been based on fee-for-service payment, but with provisions that incentivize participants to achieve quality improvements and cost savings.

Overall evaluations have found that these accountable care organization (ACO) models have produced small net savings in Medicare.[46] Factors that have been identified as limiting these savings include "relatively weak incentives for ACOs to reduce spending, a lack of the resources necessary for providers to participate in ACO models," and the fact that the models are voluntary — thus, providers can "selectively enter and exit the program on the basis of the financial benefits or losses they anticipate from participating."[47] Other disincentives to participate have also been described at length by experts such as Harvard Medical School economist J. Michael McWilliams.[48]

Key exceptions: There are two important exceptions to the general assessment of low savings from APMs, however. The first is that ACOs led by ACOs led by independent physician groups, as well as those with a larger proportion of primary care providers (PCPs), are associated with greater savings than other ACOs, such as those led by hospitals. A simple explanation is that such organizations have been more successful in lowering avoidable use of costly hospitalization for beneficiaries. A second exception cited to the general assessment that APMs have produced little savings for Medicare is that most evaluations have not captured so-called spillover effects, which occur when changes in health care practice spurred by APMs "spill over" to more generalized patient care. Some spillover effects can be clearly quantified,[49] whereas others are backed by qualitative evidence that nonetheless suggests that APMs can lead to broader system transformation beyond those organizations that were direct participants in each model.[50]

America's Physician Groups' Perspective

As organizations committed to being held accountable for quality and costs of health care, multiple APG members have participated for years in MSSP, and in Innovation Center models such as the ACO Realizing Equity, Access, and Community Health (ACO REACH) and Kidney Care Choices models, among others. More than 20 APG members have participated in MSSP, and a comparable number have participated in ACO REACH. Some of these ACOs have been among the top performers in terms of savings and improved quality metrics achieved.[51]

FACT #4

Policy constraints have limited the participation of many providers and patients in traditional Medicare's alternative payment models – and therefore, the Medicare savings.

As an example, several APG members have participated in High Needs Population ACOs, a variant of the ACO REACH model that serves older adults whose significant chronic or other serious illnesses and signs of frailty. These patients are typically at high risk of hospitalization, including near the end of life. However, participating High Needs members helped to achieve a more than 5 percentage point improvement in the model's quality score for average days at home in 2023.[52] This result suggests that participating organizations had become even more successful than previously in keeping these ailing beneficiaries as healthy as possible and avoiding costly hospital stays. Other APG members participating in two-sided risk MSSP arrangements have also achieved savings that they have reinvested into substantial practice improvements, such as hiring nurse care coordinators to help manage chronically ill patients' care.

Case for APMs: Notwithstanding the correct observation that overall savings for Medicare have been relatively low, APG disagrees with the conclusions of some analysts that Medicare's alternative payment models have been a failure. As noted, policy constraints over the models — including that participation in them is voluntary for both providers and beneficiaries — have limited the degree of system transformation that might otherwise have been achieved. Multiple financial aspects of these models have also made participation difficult for many providers, and these can and should be addressed, and the overall stability of models improved. In addition, incentives for providers to participate in these models should be maintained and, for newer entrants, increased. There are also important opportunities to create hybrid payment models that blend fee-for-service and population-based payments. APG provides its perspective on these needed changes with respect to alternative payment models in the Traditional Medicare Recommendations section of this report.

The bottom line: APG member groups know that additional opportunities exist for saving more money in traditional Medicare. Based on research involving APG member groups on the "spillover" effects of actively managing the care of Medicare Advantage patients in two-sided risk arrangements with MA plans, the savings from similar management of traditional Medicare patients could save Medicare $22.4 billion a year (unpublished estimates by APG).[53]

Addressing Medicare Physicians' Fees

Although many APG members embrace population-based payment — that is, when providers are paid a set amount to manage the health of a group of patients — it is understood that there is a role for fee-for-service payment in the health care system. It is also the case that multiple alternative payment models based on fee-for-service are likely to remain in place for some time. Therefore, it is critical to

address some key aspects of the MPFS, as well as other aspects of Medicare physician payment that merit reform.

One central issue is the ongoing declines in Medicare physician fees, which have dropped an average of 33 percent between 2001 and 2024.[54] Payment constraints within the MPFS stem from multiple sources, including a requirement for budget neutrality within the fee schedule and de facto limits imposed by the 2015 MACRA law on raising fees until 2026.[55] In recent years, Congress has acted to moderate some scheduled fee cuts that were adopted in annual rule changes put forward by CMS. A new round of scheduled fee cuts went into effect on January 1, 2025, and as of the publication of this report, Congress has not acted to moderate or reverse them.

An additional constraint on physician fees has been the lack of an inflation update in the MPFS, in contrast to other forms of Medicare provider payment such as to inpatient hospitals.[56] This failure to build in a mechanism to compensate for rising practice costs is a special problem at a time when labor costs are rising, and providers must also make substantial investments in information technology and other infrastructure. The Medicare Payment Advisory Commission has recommended a one-time, one year increase in the MPFS at the level of the Medicare Economic Index for 2026 minus 1 percentage point.[57] If enacted by Congress, such a step would be helpful, but it will also be necessary to look at more permanent ways to address rising practice costs in the context of the MPFS.

Grim forecasts: For two years running, in 2023 and 2024, the annual reports published by the Medicare Trustees — the Secretaries of the Departments of Health and Human Services, the Treasury, and Labor, and the Commissioner of Social Security — have warned that declining real Medicare payment to physicians could ultimately lead to a serious lack of access to care by Medicare beneficiaries.[58,59] This perspective further strengthens the case for a wholesale reexamination of the MPFS, most likely to occur in the context of a major reform of the MACRA law.

MACRA Reform

For several years, members of Congress have discussed a reauthorization and update of the 2015 MACRA law that would revisit aspects of the fee schedule and other of the law's features. APG believes that a reexamination and recalibration of the law will be important, both to discard sections of the law that have not proven effective, and to extend and buttress other sections to stimulate the ongoing move into alternative payment models in Medicare.

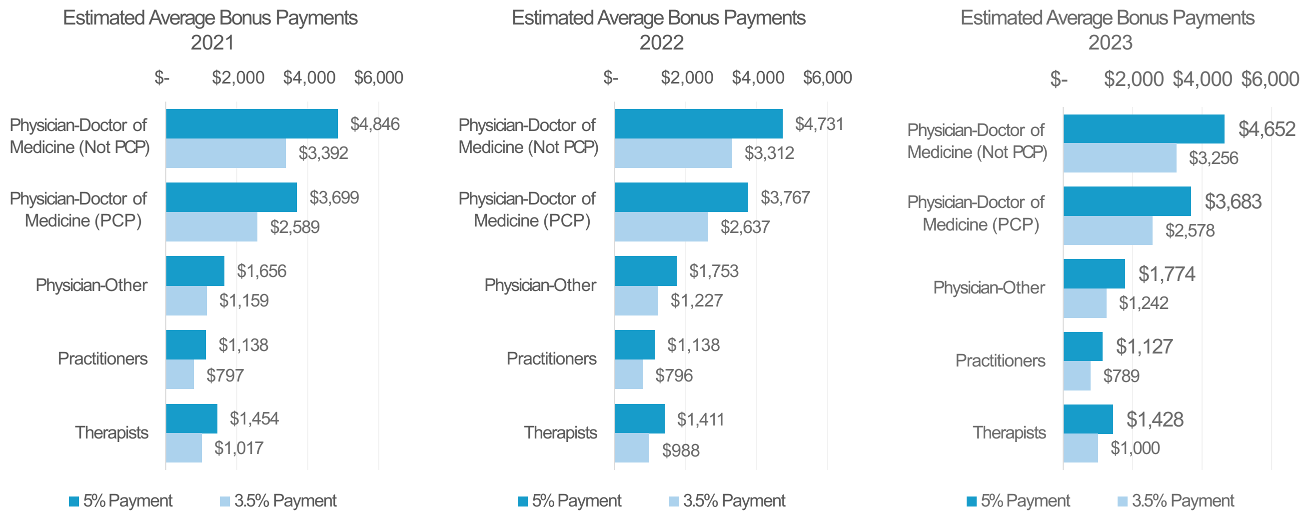
The MACRA law instituted a Quality Payment Program in Medicare based on a Merit-Based Incentive Payment System, known as MIPS.[60] MIPS was based on a hopeful but deeply flawed premise that motivating individual physicians to improve their quality of care by measuring their performance in a few chosen metrics will lead to broad quality improvement systemwide. The Medicare Payment Advisory Commission has recommended since 2018 that this system be jettisoned and replaced with a new voluntary value program in fee-for-service Medicare in which clinicians could elect to be measured as part of a voluntary group and qualify for a value payment based on their group's performance on a set of population-based measures.[61]

Bonuses: Another provision of MACRA created Advanced Alternative Payment Model bonuses for clinicians participating in a specified list of APMs, and meeting specified thresholds in terms of the share of Medicare payments received or patients seen through these APMs. The bonuses were designed to incentivize clinician participation in these payment models; however, the bonuses have not been sufficient to overcome other limitations of participation in ACOs.[62] What's more, the already limited value of these APMs — initially set at 5 percent on top of regular Medicare fee-for-service payment — has fallen considerably. For the 2024 performance year, Congress set the bonus at 1.88 percent, and as of the publication of this report, there is no bonus in place for the 2025 performance year. Ironically, clinicians can now receive substantially

> “
> ***Declining real Medicare payment to physicians could ultimately lead to a serious lack of access to care.***

Fig. #5

Advanced Alternative Payment Model Bonus by Provider Classification, 2021–2023



Source: Muhlestein, Copyright © 2023

higher bonuses for participating in MIPS than for participating in AAPMs — no surprise given that the current year AAPM bonuses are now zero.

Not only is a paltry or nonexistent bonus of little help in motivating clinicians to participate in AAPMs, but it is also true that the underlying AAPM bonus formula has been deeply flawed. As a percentage on top of standard Medicare fees, it inherently directs the greater bonuses to better-paid specialists versus lower-paid clinicians, including those in primary care, as seen in the exhibit below. Even within specialties, the bonus amounts received are highly variable, according to as-yet unpublished research that APG commissioned from David Muhlestein, founder and CEO of Simple Healthcare. APG therefore presents recommendations for reauthorizing MACRA and addressing Medicare physician fees in the section below.

PART IV

RECOMMENDATIONS FOR TRADITIONAL MEDICARE

With APG's member groups and their patients participating in both arms of the Medicare program, APG strongly believes that the nation benefits from having both parts of the program offer viable pathways for beneficiaries to be in accountable relationships with their health care providers. However, as noted above, the fact that Medicare Advantage is growing rapidly in enrollment also means a dwindling traditional Medicare program.[63]

The analysis above illustrates that the relatively poorer benefits structure of traditional Medicare is routinely augmented by millions of enrollees with the costly additional protections of supplementary coverage — especially Medigap. It is likely that this suboptimal benefits structure will be shunned increasingly by many patients accustomed to richer benefits packages.

At the same time, an unmanaged, unaccountable fee-for-service Medicare program is not in anyone's best interests. It is critical to add benefits to strengthen traditional Medicare, but only in the context of accountable care models that are even stronger themselves.

Below, APG sets forth its recommendations for both strengthening and inducing greater accountability into traditional Medicare.

Increasing Accountability

1. To maintain the momentum toward accountable care and help lay the groundwork for needed reforms, the Trump administration should commit itself to having every Medicare beneficiary in an accountable relationship with care providers by 2035. This new commitment should transcend both arms of the Medicare program — traditional Medicare as well as Medicare Advantage (as discussed further in the MA section below).
2. To enhance accountability in traditional Medicare, the Trump administration should maintain and improve existing Medicare alternative payment models — both those fully in law, such as the Medicare Shared Savings Program, as well as the model experimentation under way under the auspices of CMS's Innovation Center. Simply because these models, as currently designed, have not achieved greater savings for Medicare is not a sufficient reason to abandon them; rather, this reality constitutes an opportunity to improve them further. Under no circumstances should provisions for accountable care models that are currently in law be scrapped, nor should the CMS Innovation Center be eliminated or defunded.
3. Congress and the Trump administration should examine policies that would provide a stronger incentive to participate in accountable care in traditional Medicare — including the possibility of imposing "non-accountability penalties" on health systems and large physician practices that decline to participate in at least one two-sided risk MSSP ACO or other designated accountable care model.

Equalizing Benefits With Medicare Advantage in Accountable Care Organizations

1. To create a more equal benefits structure between traditional Medicare and Medicare Advantage, congress and the Trump administration should develop a conceptual pathway, and enact legislation, that would phase in comprehensive dental, vision, and hearing benefits to traditional Medicare for enrollees who agreed voluntarily to be attributed to two-sided risk MSSP ACOs or other designated accountable care models. (This proposal would be tied to changes in beneficiary attribution as described further below.) Similar to Part D, these additional benefits could be available as a package available through private health plans that would compete to offer a specified set of benefits. Medicare enrollees would pay a premium, with the balance of the cost of benefits paid by taxpayers — but linked to projections of savings derived from the performance of more highly accountable ACO arrangements and voluntary attribution by beneficiaries.
2. Congress and the new administration should revise aspects of law and regulation to move away from, if not terminate, claims-based beneficiary alignment and strengthen the process of, and incentives for, voluntary beneficiary alignment within two-sided risk accountable care models.[64] The ability to purchase dental, vision, and hearing benefits at relatively modest premiums would be one incentive, but expanding Beneficiary Incentive Program offerings[65] should also be considered.

> ***The administration should commit to having all Medicare beneficiaries in accountable care models.***

Increasing the Sustainability of Accountable Care Models

1. To make MSSP and other accountable care models more sustainable over the long run, Congress and the new administration should revisit current methodologies for setting spending benchmarks that effectively punish model participants that achieve savings, and/or regions of the country that achieve lower Medicare spending.[66] CMS should continue to model and test alternative methodologies, such as administrative benchmarks, in demonstrations prior to adoption. Benchmarks methodologies should be developed based on stakeholder input, and these methodologies and amounts must be shared transparently and in a timely manner so that participants and potential participants can make decisions based on predictable targets.
2. Because the "direct contracting" approach in Medicare continues to hold promise in advancing accountable care, the CMS Innovation Center should create a new ACO model that builds on the lesson learned from ACO REACH. If necessary, the Innovation Center should first extend the ACO REACH program, which will currently expire with the end of the 2026 performance year, through at least the 2027 performance year while the Innovation Center develops a replacement model that would take effect with the 2028 performance year.

FACT #5

MedPAC has identified potential site-neutral and budget-neutral payment reforms that would align payment for 66 ambulatory procedures across hospital-based and non-hospital settings and increase rates for 108 others.

Adopting Site-Neutral Payments

CMS should enact a suite of site-neutral payment reforms for selected services as identified by the Medicare Payment Advisory Committee (MedPAC).[67,68] The commission has identified 66 ambulatory procedures (listed by their ambulatory payment classifications, or APCs) for which payment could be aligned across hospital-based and non-hospital-based settings while still ensuring safety and appropriateness of care and supporting the ability of hospitals and health systems to deliver emergency care and retain standby capacity. MedPAC's proposal is budget-neutral, so it would also increase payment rates for 108 primarily hospital-based services. As a result, according to MedPAC, "aggregate Medicare spending in the short term would be unchanged," but providers would have better incentives to "make site-of-care decisions based on financial rather than clinical factors, which could eventually result in lower aggregate spending."

Restructuring Cost and Quality Incentives in Traditional Medicare

To further accelerate the move to accountability in health care, Congress and the Trump administration should begin the process of MACRA authorization to be enacted no later than fiscal 2026-2027. The process should begin in earnest in calendar 2025 with a broad request for information from stakeholders similar to what has been conducted in the past with respect to the 21st Century CURES Act of 2016 and the subsequent proposed CURES 2.0 Act.[69]

In the context of MACRA reform legislation, Congress and the new administration should draft provisions for the following:

1. Abolishing the MIPS program and establishing a new voluntary quality payment program along the lines proposed by MedPAC.

2. Creating a new Advanced Alternative Payment Model bonus program that ties bonuses to the number of attributed Medicare beneficiaries in the AAPM model in which a clinician participates. In essence, the bonus would become a flat dollar amount per assigned beneficiary, independent of a participant's Part B revenue and not variable with provider revenue. Such an approach would make the bonus "analogous to a benchmark increase for APM participants."[70]
3. Incorporating a regular annual inflation factor update into the MPFS at the rate of the Medicare Economic Index minus one percentage point, as MedPAC has recommended for 2026 only. An inflation factor update will be essential to maintaining physician payment at a level that will sustain physicians in practice and forestall an access crisis for Medicare beneficiaries. It will be sustainable within the context of the broader reforms described above that will accelerate the move to accountable care.
4. Incorporating hybrid payment arrangements into the MPFS for benefit of primary care doctors, as proposed by Sen. Sheldon Whitehouse (D-RI) and other lawmakers.[71] Hybrid payments would afford primary care providers upfront payments for under-reimbursed activities such as care coordination, while maintaining some traditional fee-for-service payments for certain other services. They would constitute a good transition pathway for smaller primary care practices in particular that are not yet ready to take on the risk inherent in alternative payment models but could develop more of these skills and capabilities over time.
5. Diversify the input into CMS about relative value units and other factors that feed into the Medicare Physician Fee Schedule. One option could be a new advisory committee within CMS that would advise on ways to correct distortions that lead to inappropriate levels of reimbursement for various activities. As proposed, again by Sen. Whitehouse, the new agency's input to CMS would supplement the work of the AMA/Specialty Society RVS Update Committee (RUC).

MEDICARE ADVANTAGE

SUMMARY: *In a popularity contest between the traditional Medicare program and Medicare Advantage (MA), the latter appears to be pulling ahead in its appeal to beneficiaries. This section of the report examines the reasons behind the enrollment growth in MA; the fundamental cost issues arising from this growth; and multiple other issues in the MA program, including risk adjustment, prior authorization, Star Ratings, and the fundamental relationships between MA plans and health care providers that can influence beneficiaries' health outcomes.*

MA's Growth

As previously noted, as of 2025, 35.7 million people — 52 percent of all Medicare beneficiaries — will be enrolled in MA plans, a share that is expected to rise to 57 percent in 2033. However, these percentages of enrollment pertain to all Medicare enrollees, a number that includes individuals enrolled in Part A only and who have not elected to pay premiums to enroll in Part B. By contrast, beneficiaries who wish to enroll in MA must be enrolled in both Parts A and B. When this alternative group is examined — Medicare beneficiaries enrolled in both Parts A and B, and therefore "eligible" to enroll in MA — a total of 55 percent will be enrolled in MA in 2025.

There are many reasons for the growing popularity of MA, largely having to do with the expanded benefits and lower cost-sharing available to beneficiaries through MA plans. In this regard, MA has been an essential avenue for updating Medicare's benefit structure to bring it more in line with benefits commonly offered to the non-Medicare population through commercial health plans and employer-provided coverage. As previously noted, adding benefits such as hearing, vision, and dental coverage to Medicare, for example, would require an act of Congress, a goal that has been proposed in the past but not yet achieved (although as noted, a modest amount of dental coverage was added to traditional Medicare via CMS rulemaking). By contrast, if MA plans offer the benefits prescribed in Medicare Parts A and B, they can add other benefits to tailor their offerings to appeal to potential enrollees.

Lower costs: One key reason MA plans have been able to add benefits beyond is that, on average, they provide Part A and B benefits for less money than these benefits cost the U.S. government to provide through traditional Medicare, judging by the fact that almost 100 percent of MA plans bid below Medicare fee-for-service spending benchmarks for Parts A and B in 2024.[72] One well-regarded study found that, adjusting for enrollee mix, health care spending per enrollee in MA is 9 to 30 percent lower than in traditional Medicare,[73] almost entirely because of lower health care utilization by MA enrollees. This lower spending due to lower health care utilization is partly due to the active management of care by MA plans and their contracted providers, and partly due to some "selection" into MA plans by relatively healthier employees. However, given that MA enrollment has shown particular appeal to specific racial and ethnic groups and is now "the dominant form of Medicare coverage for Black, Hispanic, and Asian or Pacific Islander beneficiaries" and, increasingly, for the dually eligible population,[74] it is unclear how large a selection effect exists.

Higher payments: The flip side of this coin — that health care spending is lower for each MA enrollee than each traditional Medicare enrollee — is that MA plans are paid more per beneficiary to provide care than the U.S. government currently spends on care for each traditional Medicare enrollee. Much of the reason for this disparity stems from explicit government decisions to subsidize MA plans and encourage their expansion.[75]

For example, the so-called "benchmarks" against which MA plans bid to provide Parts A and B coverage have been explicitly set higher than county-level fee-for-service spending in traditional Medicare in select counties, largely to encourage expansion of plans into lower-spending rural areas of the country. To encourage MA plans to deliver higher quality care and enable enrollees to comparison shop among plans, the Star Ratings program awards quality bonuses to plans that achieve high ratings; these bonuses amounted to $11.8 billion in 2024.[76]

> "
> ***MA has been essential to updating Medicare's benefits structure.***

Risk Adjustment in Medicare Advantage

Additional increases in government payments made to MA plans come from the risk-adjustment system established for MA by the U.S. government. This system is designed to ensure that plans and providers have incentives to care for sicker individuals rather than just healthier, less costly patients. Under risk adjustment, the per-enrollee payments made by the government to MA plans are adjusted upward or downward based on each enrollee's diagnoses and demographic characteristics. In principle, then, plans are paid more to care for an MA enrollee who suffers from multiple chronic illnesses than for one who does not. As such, risk adjustment is a critical mechanism that "evens the playing field," as the Centers for Medicare & Medicaid Services describes it, and removes any incentive that plans would otherwise have to avoid enrolling or caring for sicker patients.[77]

Diagnosis-based system: How much plans receive in risk adjustment payments depends in part on the diagnoses — and specifically, the diagnostic codes that map to so-called Hierarchical Condition Categories — that are captured by providers and plans about the MA enrollees for whom they care. Typically, when MA enrollees join plans, they select a primary care provider who conducts an initial visit, examines them thoroughly, and records any diagnoses that they enrollees have. Providers, and sometimes plans, may also send clinical teams to visit patients —often in their homes— to conduct so-called health risk assessments that can help surface other health problems and diagnoses that may not have been discussed or disclosed in a regular office visit. Detailed records of the health care provided to MA enrollees — including clinical diagnoses, care, and treatments, and known collectively as "encounter data" — are then sent to CMS to determine appropriate risk adjustment payments.

No comparable system of thoroughly documenting beneficiaries' diagnoses exists in traditional Medicare — other than for total cost of care models in the traditional Medicare program, so a fully accurate comparison of diagnoses between enrollees in the two parts of the program isn't possible. The claims data used to generate payment to providers in traditional Medicare "do not accurately capture many diagnoses and risk factors and reflect care patterns not necessarily representative of care in accountable health care organizations," notes a recent report from the Duke-Margolis Institute of Health Policy.[78]

Nonetheless, the fact that MA plans have clear financial and operational reasons to thoroughly document diagnostic codes constitutes the incentive "to vigorously code diagnoses," as various policy analysts have noted[79,80]; There is a built-in mechanism to adjust annually for increases in "coding intensity," in that CMS is required by law to impose a coding intensity adjustment of a minimum of 5.9 percent, which effectively reduces risk scores by at least that amount annually.[81] CMS retains the authority to raise the coding intensity adjustment further, as some analysts have argued is advisable.

The fundamental structure of the existing risk adjustment model in Medicare Advantage has been in place for nearly two decades and has undergone multiple revisions over the years to add or subtract HCC codes and alter the numerical weights assigned to them for the purposes of computing risk scores. In addition, CMS in 2023 adopted the latest major revisions to the risk adjustment model that dropped nearly 2,300 of some 74,000 diagnostic codes for various reasons, including its finding that many of the dropped codes did not accurately predict costs.

New model: This new, current risk adjustment model, known as Version 28 (V28), is being phased in during 2024-2026 and has resulted in lower risk scores for MA enrollees and, as a result, lower risk adjustment payments to plans for many enrollees. To date, most MA plans appear to have adjusted to the changes by modestly increasing beneficiaries' cost sharing or withdrawing from markets in which operations were deemed less attractive. Even as this version of the MA risk adjustment model is in its second year of a three-year phase in, however, CMS has indicated that is preparing the next version of the model. As indicated in its Advance Notice of 2026 MA rate changes published in January 2025,[82] it intends to use MA encounter data — the diagnoses, cost, and use data submitted by CMS to MA plans — to calibrate the next version of the model, and phase it in as early as 2027.

> "
>
> ***Unlike MA, no broad system for recording diagnoses exists in traditional Medicare.***

Amid the recent risk adjustment changes and discussions about further refinements to the model, a fierce policy debate continues to rage about how much MA plans are still "overpaid" relative to traditional Medicare, and how much of this "overpayment" results from excessive diagnostic coding for the purposes of risk adjustment. To reduce the "overpayment," meanwhile, some policy analysts have recommended specifically disallowing diagnostic coding for the purposes of risk adjustment that derives from approaches used by MA plans and providers, such as the health risk assessments or so-called chart reviews. (cite MedPAC recommendations here).

Beyond the annual coding intensity adjustment and the shift to V28, other measures have been contemplated to broadly attack the issues of upcoding or excessive coding. Organizations such as the Medicare Payment Advisory Commission and the Office of the Inspector General of the Department of Health and Human Services have pointed to tactics such as health risk assessments and chart reviews as a source of overpayment, allegedly because diagnoses coded for risk adjustment purposes are not always matched by clear documentation of any treatment that was provided.[83]

Evolution needed: More fundamentally, multiple parties have recommended evolving the current system of risk adjustment, and in general, refining the HCC-based coding system originally set up for the purposes of risk adjustment more than two decades ago. There are ample opportunities to improve the system and create less contentious "sources of truth" about MA enrollees' conditions and health risks, and the realistic costs of caring for people and keeping them as healthy as possible.

FACT #6

Payment rates under the Medicare Physician Fee Schedule have fallen by a third in inflation-adjusted terms since 2001 – a key reason that many APG groups prefer different payment arrangements under Medicare Advantage.

America's Physician Groups' Perspective

As noted above, many APG member organizations are engaged in close partnerships with MA plans in which they are paid on a capitated basis by plans to care for MA enrollees. Because the amounts that they are paid by MA plans are derivatives of what MA plans receive from the government, they thus have a major stake in risk adjustment.

APG vigorously opposes inappropriate upcoding or overcoding of diagnoses purely for the purposes of boosting payment to MA plans and has advocated for increased resources for the federal government to prosecute fraudulent and abusive activity as well as to maintain a thorough set of Risk Adjustment Data Validation audits.

At the same time, APG is also concerned about conflating the issues of inappropriate coding with coding that is necessary for capturing a 360-degree view of the patient's present, and likely future, health status, particularly if adequate prevention and secondary prevention strategies are not carried out to prevent exacerbations of existing disease. APG is also concerned that the discussion of "overpayment" to MA plans neglects the realities of what is required to provide optimal care to the Medicare population — in particular, advanced primary care — and in ways that simply are not economically viable in the traditional Medicare program.

Physicians and other clinicians participating in Medicare are typically paid under the Medicare Physician Fee Schedule (MPFS), which compensates them on a fee-for-service basis for aspects of care that they provide. For various reasons, and as noted above, after adjusting for practice cost inflation, payment levels in the MPFS have fallen by a third since 2001. More broadly, the structure of the MPFS skews heavily in favor of procedures; rewards more cognitively oriented areas such as primary care less generously than procedure-oriented care such as surgery; and omits payment altogether for many services and service providers, such as

counseling by social workers, that are increasingly seen as integral to the provision of advanced primary care.

By contrast, APG member organizations operating in close partnerships with MA plans have different contractual relationships that essentially de-link payment from the MPFS and substitute for that capitated, per-beneficiary payments. The benefits of risk adjustment, in the form of higher payments for sicker enrollees, thus flow through to them directly from plans as part of these per-beneficiary payments. These relatively higher payments then afford APG member organizations the wherewithal to assemble broad primary care teams, including employment of personnel who can't recoup payment directly from Medicare, such as pharmacists and social workers; develop the capacity to better coordinate care for enrollees, such as by employing designated care coordinators to ensure that patients secure needed tests or appointments with specialists; and develop the infrastructure to ensure that patients' needs are met, such as creation of registries to track patients with specific chronic conditions and contact them proactively to bring them in for office visits.[84]

Benefits for patients: In this context, APG groups working in these partnerships with plans believe that they are best able to serve patients, and in ways that are not financially possible in the traditional fee-for-service Medicare program. They also believe that they achieve superior outcomes for patients, as demonstrated by the study referenced earlier (repeat citation here) and the lower hospitalization rates and other positive outcomes that result. From this perspective, if MA plans and consequently providers are being "overpaid" relative to traditional Medicare, the result is at least in part the provision of superior care to patients. Stated differently, what is often labeled "overpayment" is in fact more appropriate payment, and risk adjustment is part of making that appropriate payment possible.

APG groups also note that tactics such as health risk assessments and chart reviews that have come under fire for helping to generate inflated risk scores and overpayments are in fact used differently — and commonly — by medical groups themselves when they are in close partnership with MA plans. APG member organizations in at-risk relationships with MA plans will frequently send their own clinical teams to patients' homes to conduct health risk assessments, and find these instrumental to uncovering some diagnoses, such as for behavioral health conditions, that are not always evident in a relatively brief office visit. They also point to many instances when it is important to capture diagnoses for conditions even if specific treatment is not immediately provided — for example, coding a cancer patient undergoing chemotherapy for neutropenia, in part to signal the need to be on guard against a patient developing other infections. Similarly, because of the complexities of coding, these medical groups also rely on internal chart reviews to ensure that their own providers have accurately captured MA enrollees' diagnoses and therefore paved the way for patients to achieve appropriate risk scores.

Improvements needed: Nonetheless, APG groups agree that features of risk adjustment in MA can and should be improved, while preserving the fundamental principle that payment should be adjusted appropriately relative to patients' conditions and relative costs of care. Aspects of risk adjustment, such as health risk assessments and chart reviews, can and should be preserved while at the same time bringing risk scores more clearly in line with actual and expected costs. Recommendations for how to achieve this goal follow in the "Recommendations" section below.

Prior Authorization

Prior authorization is a process through which health care providers obtain approval from a health insurance plan before a designated medical service or prescription drug to a patient. It is a standard feature of all commercial health insurance in the United States, including MA, especially for high cost services such as inpatient hospital and skilled nursing facility stays. But this key utilization management tool is used much less in traditional Medicare, where the so-called Medicare Administrator Contractors (MACs) — the nonprofit organizations that administer traditional Medicare claims — are charged with reviewing only a relatively narrow list of services for pre-authorization purposes.[85]

> *"Health risk assessments and chart reviews can be important tools members in at-risk relationships with MA health.*

The growing number of prior authorization requests in MA in recent years[86] has been a special pain point not only for beneficiaries, who may experience delays in receiving necessary care, but also for many of the nation's health care providers, many of whom view PA as a major source of administrative burden.[87] Numerous CMS regulations and proposed Congressional legislation have sought improvements in various aspects of PA, especially in the timeliness and efficiency of the process. APG has been supportive of many of these changes, in addition to bringing its unique perspective to bear on the utility of this essential tool.[88,89]

As noted above, multiple APG member organizations are engaged in close partnerships with MA plans through at-risk or "delegated" relationships. As these medical groups seek to manage risks and achieve quality metrics, they take on responsibility for prior authorization as well on behalf of both the MA enrollees whom they serve and their own providers giving the care. In APG member organizations' view, it is essential to preserve PA as a utilization management tool, drastically improve its efficiency, and reduce administrative burden on providers. Further recommendations for improving PA are in the MA Recommendations section of this report.

Quality Bonuses and Star Ratings

Medicare Advantage Star Ratings were introduced in 2007 to help measure the quality performance of MA plans and to help potential enrollees choose a plan. Based on a five-star system, with five being the top, the ratings have undergone substantial evolution over the years, as various quality components were added to the measures while others have been retired. With the enactment of the Affordable Care Act, the ratings gained substantial value for MA plans, with CMS now using the ratings to adjust the benchmarks against which plans bid, as well as the share of the "rebate" (the difference between the benchmark and the plan bid) that plans can retain. The resulting bonus payments to plans totaled $12.9 billion in 2023[90] before falling substantially in 2024 due to changes made by CMS.

There are multiple issues with the quality bonuses and Star Ratings that are beyond the scope of this paper and its recommendations, beginning with the reality that it is not at all clear that the ratings capture higher quality in terms of improved health outcomes for MA enrollees. For example, CMS has made several recent major changes in its methodology for calculating the Star Ratings that have produced "an unprecedented decline in Quality Bonus Payments" and thus revenue cuts estimated to reach $5 billion in 2030.[91] These revenue decreases for MA plans will ultimately affect both beneficiaries — most likely through plans' benefits structure — and the provider groups contracted to care for MA enrollees, most likely through contractual arrangements for payment. The revision in Star Ratings could thus be deleterious to quality, but if this were to happen, it is doubtful that the existing set of ratings could even begin to capture this result.

For the purposes of this paper, APG thus focuses primarily on a more limited issue: the underlying quality metrics that make up the Star Ratings, which ultimately bear largely on the performance of medical and other provider groups contracted with MA plans.

At present, these metrics[92] fall into five domains: "Staying Healthy "(screenings, tests, vaccines); managing chronic conditions (e.g., blood sugar control for patients with diabetes); member experience with health plan; member complaints and changes in the health plan's performance; and health plan customer service, such as making timely decisions on appeals.[93] Three new measures were added for 2026: Kidney Health Evaluation for Patients with Diabetes, Improving or Maintaining Physical Health, and Improving or Maintaining Mental Health.

Problematic measures: Although many of these aspects of MA plans probably do warrant measurement, their inclusion in the Star Ratings means that the ratings are mainly focused on health plan operations. To the degree that the measures focus on enrollees' health, they are mainly process measures (e.g., were screenings performed, and tests administered), rather than being a more discrete set of outcomes measures that demonstrate improved health — and especially the health outcomes that matter most to patients. Since it is ultimately clinicians' responsibility not just to carry

> *Not all Star Ratings capture higher quality in terms of improved health outcomes.*

out most of the interventions that underlie the measures, but also to “deliver” improved health, this paper offers recommendations for how CMS can better test and consult with stakeholders as it contemplates adding new measures to Star Ratings and retiring older ones.

In addition to recommending new Star Ratings measures, APG also offers recommendations for changes in the methodology that CMS uses to calculate its current ratings. These are contained in the next section of this paper.

Supplemental Benefits

The additional benefits available to MA enrollees are clearly a draw for many beneficiaries who sign up for MA plans, with the value of these benefits currently estimated at $64 billion annually (roughly 17 percent of total government payments to plans).[94] The most longstanding benefits offered have been for dental, vision, and hearing coverage, but in recent years, CMS has added such benefits as in-home support services by home health aides and caregiver supports, while Congress authorized so-called Special Supplemental Benefits for the Chronically Ill (SSBCI) such as food and produce benefits, transportation for non-medical appointments, and financial support for living expenses, such as rent or utilities. These SSBCI benefits must be targeted to enrollees with specific health conditions, ranging from autoimmune disorders, to dementia, HIV AIDS, and other chronic conditions.[95]

Benefits value: In general, APG’s member organizations, particularly those participating in at-risk contracts with MA plans, have appreciated the ability to offer some of these benefits. Several of them, such as provision of food, are directly related to patients’ health. Yet despite the apparent value of these benefits to many enrollees, it is in fact the case that less is known than would be desirable about which enrollees use these benefits, nor which of these benefits is most useful in achieving improved beneficiary health.

CMS in its various statements, requests for information, and rulemaking, has indicated that it seeks far more information on supplemental benefits — for example, by requiring MA plans to provide the agency with evidence of the efficacy of services that the plans offer as special supplemental benefits for the chronically ill (SSBCI).[96] Congressional lawmakers have also introduced bills that would require MA plans to submit data to CMS on enrollees’ use of these benefits, as well as costs and payments for their use.[97] APG has concurred with the thrust of much of CMS’s rulemaking and related proposals to require more transparency and evaluation of the role of supplemental benefits.

Two-Sided Risk And Delegation From MA Plans to Providers

As discussed, a growing body of evidence indicates that APG member organizations engaged in at-risk relationships with MA plans deliver superior outcomes for the MA enrollees who are cared for under these relationships.[98] Yet the fastest growth to date in the MA marketplace is occurring among Preferred Provider Organization-type MA plans that pay providers on a fee-for-service basis, and at rates that are sometimes below those paid in traditional Medicare.

These non-risk-based payment relationships are far easier for MA plans to administer, but far less satisfactory for the many APG member organizations that would prefer deeper partnerships and the more aligned incentives with MA plans that have also been shown to deliver superior results for patients. As noted earlier, the capitated/delegated payment relationships in which many APG groups participate with MA plans reenforce the benefits of MA. These benefits include the dedicated resources available to them through risk adjusted payments that make possible advanced primary care strategies that can help avoid costly hospitalization, as well as utilization management tools such as prior authorization that help to weed out low-value care.

Need for incentives: Thus, in the view of APG member groups, incentivizing more capitated/delegated relationships between MA plans and providers should be seen as a core strategy for moderating excessive growth in Medicare spending while also improving outcomes for beneficiaries.

CMS has historically taken a hands-off approach to contractual issues between MA plans and providers, pointing to a so-called noninterference clause in federal law governing Medicare Advantage. Specifically, Section 1854(a)(6)(B)(iii) of the Social Security Act (the Act), commonly known as the "non-interference clause," "prohibits CMS from requiring an organization to contract with a particular health care provider or to use a particular price structure for payment under such a contract.[99] As CMS has previously noted, this strcture means that "the MA program today effectively functions as an [alternative payment model]-like arrangement" between CMS and MA plans, and that "the value-based incentives for insurers under MA may not always reach the provider(s) of care."[100]

APG has long argued that CMS could operate within that strcture and still incentivize, although not require, more two-sided risk arrangements between MA plans and providers in the interests of having aligned payment models that reinforce accountability for quality and costs. An obvious way to encourage more two-sided risk arrangements between MA plans and providers would be to create an add-on to Star Ratings that rewarded plans that forged such arrangements with provider organizations. Alternatively, Congress could also change the law to give CMS more latitude in this direction. Additional recommendations in this vein appear in the Medicare Advantage Recommendations section of this report below.

FACT #7

Supplemental benefits in Medicare Advantage — which cover services such as for dental, vision, hearing, as well as special services for the chronically ill — are currently valued at $64 billion annually, or 17 percent of total government payments to MA plans.

PART VI

RECOMMENDATIONS FOR MEDICARE ADVANTAGE

Given the analysis above about key issues in Medicare Advantage, APG proposes the following recommendations for making substantial improvements in the program.

Advancing At-Risk Payment Arrangements With Providers

Recognizing the superior performance of at-risk relationships between MA plans and providers, CMS should actively encourage more of these relationships to form within the MA program. It should also reflect these arrangements as central to the strategy of having most Medicare beneficiaries in accountable relationships with providers. In 2019, for example, the Health Care Payment Learning and Action Network —the group of public and private health care leaders working to accelerate the growth of alternative payment models — set a goal of having 100 percent of both traditional Medicare and Medicare Advantage enrollees receiving their health care under two-sided risk alternative payment models by 2025.[101] Six years later, the nation remains well short of that goal — but staying on course to achieve it within a decade is more important than ever.

FACT #8

The nation remains well short of the goal set in 2019 of having all Medicare beneficiaries — including those in MA in two-sided risk alternative payment models by 2025.

As noted, APG has periodically commented to CMS on the desirability of incorporating some measure of this type of accountability into the Star Ratings program. CMS should seek to have its legal counsel determine whether doing so would run afoul of the non-interference clause. If counsel determines that it does not, CMS could proceed to develop such a Star Rating, which would increase the financial incentives for MA plans to move in this direction. Alternatively, should examine alternative means for incentivizing these relationships and spreading the two-sided risk, or "delegated" model.

Improving Risk Adjustment

Again, as noted in the above analysis, risk adjustment is at once fundamental to Medicare Advantage; an avenue for sending more funds into the program to deliver optimal care to enrollees; and a possible source of "overpayments" when the tactic is subject to abuse. In APG's view, it is imperative to move to a new system of risk adjustment in which less contentious "sources of truth" about MA enrollees' conditions and health risks are matched by funding that reflects the realistic costs of caring for these enrollees.

To achieve this new system, while taking steps in the interim to make the current system more viable and fully credible, APG recommends the following:

1. **Evaluate the effects of full implementation of V28.**

   CMS adopted the major revisions to the previous risk adjustment model, known as V24, in 2023, and scheduled a three-year phase in of the new model, V28, which will be fully in effect as of 2026. MA plans have responded to the first two years of the phase-in, 2024 and 2025, as well as to changes in Star Ratings, by scaling back some benefits for enrollees and exiting unprofitable markets. It is unclear what additional steps they will take for the fully-phased-in year 2026.

   Because changes in payment to MA plans flows through to their contracted provider groups, APG member organizations have not been immune from the resulting payment pressures. At a time of rapid practice cost inflation, particularly for labor, any worsening of these payment pressures may imperil the ability of APG member organizations to retain robust primary care capabilities for their most chronically ill MA enrollees.

APG recommends that CMS undertake of full implementation of V28 before making further large changes in the risk adjustment model. This evaluation should include a determination of whether clinical outcomes have worsened for diagnoses in which codes were eliminated and therefore revenue removed. A full evaluation report should be published and shared with stakeholders even as discussions and possible demonstrations proceed to test new risk adjustment models.

2. **Maintain robust Risk Adjustment Data Validation (RADV) audits and continue enforcement actions in instances of fraud and abuse.**

   There have been enough documented instances of actual fraud and abuse in MA risk adjustment[102] to warrant increased vigilance in this important area of payment integrity. Although the Risk Adjustment Data Validation audits carried out by CMS have been an important tool for identifying instances of inappropriate coding, the capacity to carry out these audits is underfunded and therefore, underutilized, recouping only a fraction of potentially recoverable amounts. Congress should appropriate double or triple the amount currently dedicated to the audits — limited to just $43 million in 2023 — while the OIG, the Department of Justice and other federal agencies should continue and even ramp up their efforts to find and prosecute coding-related fraud.

3. **Preserve HRAs and chart reviews under new guardrails, with clinician-certified documentation of both any resulting diagnoses and required care plans in enrollees' electronic health records.**

   As noted in the above analysis, to correct inappropriate coding intensity in Medicare Advantage, MedPAC and others have proposed excluding diagnoses from risk adjustment that are documented only on health risk assessments (HRAs).[103] Chart reviews have also been criticized as well as a means of generating inappropriate coding, particularly when these reviews have been carried out not by clinicians directly involved in the care of patients, but rather by outside entities retained by MA plans.[104]

   APG disagrees with proposals to disallow all coding for the purposes of risk adjustment that emerges from HRAs and chart reviews, and recommends that the ability to use these tools continue, but under a new set of guardrails, as follows:

   a. In general, clinicians directly involved in the care of MA enrollees should conduct both HRAs and chart reviews. To the degree that HRAs and chart reviews are undertaken by any outside entities — either those retained by MA health plans or by provider groups themselves — a clinician directly involved in the care of a given enrollee should be required to certify approval in the enrollee's electronic health record of any change or addition to diagnostic coding that results from the HRA or chart review.

   b. Diagnoses captured through these mechanisms must be matched in patients' electronic health records with care plans that spell out clearly what will happen because of diagnosis capture.

   c. The diagnoses, clinician certifications, and care plans crafted to match them should be auditable as part of an expanded set of RADV audits.

4. **Transition to a new system that aligns risk adjustment with direct performance reporting from electronic health records or other achievable methodology, and better determinations of the actual costs inherent in caring for MA enrollees with various health conditions.**

   In moving to a new risk adjustment model, CMS should develop alternatives transparently with stakeholders and test them prior to adoption.

5. Building on the recommendation above, policymakers should **refine the current risk adjustment model, developing various proposals to succeed the current system and testing them transparently before adoption.**

"

It is essential to transition to a new risk adjustment system in Medicare Advantage.

As noted above, even as the current Version 28 of the MA risk adjustment model is in its second year of a three-year phase in, CMS has indicated that is preparing the next version of the model. Specifically, it intends to use MA encounter data — the diagnoses, cost, and use data submitted by MA plans to CMS — to calibrate the next version of the model, and phase it in as early as 2027.

APG concurs with the recommendations of other organizations that the goal should be having "aligned, accurate electronic data for modernized risk adjustment and performance measurement" across Medicare Advantage and alternative payment models, such as Medicare Shared Savings Program (MSSP) ACOs.[105] Various alternatives to current practices have been proposed, such as inferring diagnoses through analysis of Medicare claims and assigning risk scores to enrollees[106] or drawing data directly from electronic health record systems to calibrate risk adjustment models.[107] Policymakers should explore these and other proposals for modifying risk adjustment, testing the most promising ones in demonstrations and reporting the results transparently, as APG has previously recommended.[108]

FACT #9

There are no well-established ways of estimating the spending associated with valid clinical diagnoses in payment models that are not based on fee-for-service — but these will be critical to devising better risk-adjustment systems in the future

Pilot tests needed: In addition, in recognition of an important reality — that "No well-established data standards exist for estimating the spending associated with valid clinical diagnoses for beneficiaries in non-FFS care delivery systems"[109] — CMS should also invest time and resources in better understanding the actual resource use necessary to care appropriately for Medicare beneficiaries with various health conditions. APG submits that these appropriate resources will approximate what is currently spent in two-sided risk models to care for MA beneficiaries, but this proposition should be tested further. Toward this end, APG concurs with Duke-Margolis that CMS should "design and launch a pilot program through one or more independent contractors to use electronic health data from a range of accountable care providers in MA and [MSSP] to develop more representative measures of beneficiary resource use."[110]

Because it could take multiple years to accomplish these objectives, an appropriate interim strategy would be to continue HCC diagnostic coding as a basis for risk adjustment, subject (1) to the guardrails described above for health risk assessments and chart reviews, and (2) to a requirement that any diagnosis captured for the sake of risk adjustment must be accompanied by a "care plan" documented in the electronic health record and subject to expanded RADV audits. Although it may seem that such a requirement would increase the administrative burden on provider groups, APG believes that it would be an appropriate interim step to assuage concerns that diagnostic coding does not always match up with treatment. Documented care plans can and should include specific discussions and rationales for circumstances in which a diagnosis does not necessarily lead to immediate action — such as when a diagnosis instead calls for "active surveillance" of a condition and plans for ongoing monitoring, rather than an intervention.

Improving Prior Authorization

As discussed above, prior authorization is an essential tool in utilization management, and an important safeguard for patients and society alike. Used wisely, this tool can help secure the "right care for the right patient at the right time," while also preventing the provision of low-value or no-value care that will be of minimal benefit, or even harm patients, while also driving up costs unnecessarily. But the tool must be used wisely; excessive burdens on providers and

patients must be reduced; and rationales for care denials must be communicated transparently and quickly to both providers and patients by clinically competent professionals.

Several important steps are needed, as follows:

a. To improve the efficiency of the prior authorization process, the Improving Seniors' Access to Care Act should be adopted into law, with the following provisions: For plan years beginning on or after January 1, 2027, MA plans that impose any PA requirements would have to establish an electronic PA program that provides for the secure electronic transmission of both PA requests from health care providers and suppliers to the MA plan, as well as the corresponding response from the plan to the provider or supplier.

b. Although CMS has adopted regulations to shorten the standard response time to prior authorization requests as of 2026 and is standardizing the electronic exchange of PA information as of 2027[111] more should be done to induce greater efficiencies in prior authorization processes. The U.S. government is sending mixed messages to MA plans and provider groups engaged in prior authorization by simultaneously demanding greater efficiencies in the PA process, but with some lawmakers decrying the use of artificial intelligence to enable those greater efficiencies. It is well established that, used correctly, AI systems can uniquely recognize patterns in data and exceed human capacities to process gigabytes of data efficiently. Both the Congress and the agencies need to coalesce around a plan to spur the use of AI in prior authorization with appropriate audits and other guardrails.

c. There should be greater transparency and standardization of prior authorization criteria across MA plans and delegated providers to minimize excessive burden on providers and unwarranted delays and denials for patients. Congress should enact the provisions contained in the "Improving Seniors' Timely Access to Care Act" that would require substantial reporting about prior authorization from MA plans to CMS.[112] With this reporting in hand, CMS should conduct an audit across MA plans and delegated providers of the prior authorization required for the costliest services and medicines. A useful proposal in this regard is proposed legislation introduced by Sen. Sheldon Whitehouse (D-RI), which could be the basis of further discussions to shape a final proposal.[113]

d. Because patients are frequently flummoxed by prior authorization denials, both MA health plans and providers alike should take steps to increase the quality and timeliness of their communications with patients regarding the disposition of prior authorization requests and denials. These efforts would follow through on requirements of the Improving Seniors' Timely Access to Care Act, which would require "adoption of transparent programs developed in consultation with enrollees and contracted providers and suppliers."[114]

e. Medicare Advantage plans should be first, incentivized, and if such efforts are insufficient, required, to devise and adopt "gold card" programs for their contracted providers. Such programs simplify the approval process for designated medical services for providers who are in-network with insurance plans, and who have consistently maintained a high prior authorization approval rate over a period. [115] Approximately eight states now require gold card programs[116]; at least two MA organizations, including United Healthcare,[117] have adopted them. and legislation has been introduced in Congress to require adoption at the federal level.[118] CMS could incentivize the adoption of gold card programs via Star Ratings or require them via regulation. The agency should also encourage via incentives standardization of the parameters of gold card programs across MA plans — for example, agreement on the number and type of services covered under gold carding, as well as a pathway to increasing the number of services governed over time.

Improving The Quality Bonus Program/Star Ratings

As discussed above, although Star Ratings underpin the Medicare Advantage Quality Bonus Program, it is not at all clear that the ratings capture higher quality in terms of improved health outcomes for MA enrollees. Even so, the quality bonuses based on Star Ratings flow to MA plans, and any changes in these bonuses and ratings ultimately affect both beneficiaries and providers. As a result of changes in Star Ratings, MA enrollees may see changes in the benefits that they are offered by MA plans, while providers — including APG member organizations — can experience changes in

> ***"MA plans should be incentivized to adopt more 'gold card' programs.***

the payments they receive to provide care. Multiple recent changes in the Quality Bonus Program and Star Ratings have recently shaved revenues to many MA plans and are likely to do so in coming years.

APG recommends that CMS test new aspects of the Quality Bonus Program before it implements them, to afford time for plans and providers alike to understand the implications and adapt — including to the likely payment changes that frequently follow. Particularly with respect to the underlying quality measures, CMS should continue its process of seeking input ahead of time from stakeholders via requests for information before adopting new measures. It should also redouble its focus on a relatively parsimonious list of "measures that matter" along the lines of the Universal Foundation and prioritize measurement of outcomes that matter to MA enrollees and demonstrably improve their health.

There is also a need to refine the underlying methodology of calculating Star Ratings, as is clear from ongoing legal disputes between MA plans and CMS. CMS should ensure that all MA plans are included in comparisons and that scores are predictable and transparent each year.

FACT #10

A far greater understanding is needed about the impact of many MA supplemental benefits on patients' health and outcomes.

Evaluating Supplemental Benefits

In general, APG's member organizations, particularly those participating in at-risk contracts with MA plans, have appreciated the ability to offer some of these benefits. Several of these benefits, such as provision of food, are directly related to patients' health. Yet despite the apparent value of these benefits to many enrollees, it is in fact the case that less is known than would be desirable about which enrollees use these benefits, nor which of these benefits is most useful in achieving improved beneficiary health.

APG concurs with perspectives voiced by CMS and members of Congress that far greater understanding is needed on the role of supplemental benefits in improving beneficiaries' health. APG recommends greater evaluation of and transparency around the costs and value of these benefits, which should be a prerequisite not just for continuing them within MA, but also for extending any benefits into the traditional Medicare program through ACOs, as this report discussed above.

Conclusion

This report has described multiple issues in both the traditional Medicare program and in Medicare Advantage, drawing on the expertise that APG groups have developed in both parts of Medicare first, in Accountable Care Organizations and other alternative payment models in the traditional program, and second, in caring for Medicare Advantage patients in at-risk arrangements. If many of the recommendations in this report are enacted, both arms of the program will be improved, and the nation. the health care system, and patients alike will all benefit.

The alternative to not moving forward on many of these recommendations is that the current adverse trends in Medicare will only be exacerbated further, to the detriment of national wellbeing. The growing imbalance in enrollment between traditional Medicare and Medicare Advantage will become greater. Accountability for quality and costs among health care providers will not grow and will arguably decline. Medicare beneficiaries' health outcomes will not improve as they should.

Without this accountability, the nation will spend more than ever on health care that, at best, is of indeterminate value, and at worst, is wasteful and even harmful to Medicare beneficiaries and others. The resulting opportunity costs will mean that fewer resources than ever will be devoted to other activities that society values, such as education, which have also been shown to be integral to long-term health.

APG looks forward to working with policymakers of all political persuasions and at all levels to advance these recommendations further. America's Physician Groups believe that the American people deserve no less.

Endnotes

[1] Seshamani M, Brooks-LaSure C, Weiss R. *A Stronger Medicare Program—Now And Into The Future*. Available from: https://www.healthaffairs.org/content/forefront/stronger-medicare-program-now-and-into-future [Accessed 28th January 2025].

[2] Cottrill A, Cubanski J, Neuman T, Smith K. *Income and assets of Medicare beneficiaries in 2023*. Available from: https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/ [Accessed 28th January 2025]

[3] Office of the Actuary, Centers for Medicare and Medicaid Services, "National Health Expenditure Projections, 2023-32, at cms.gov

[4] See, for example, this published research article based on results delivered by APG member groups: Vabson B, Cohen K, Ameli O, et al. Potential spillover effects on traditional Medicare when physicians bear Medicare Advantage risk. *Am J Manag Care*. Published online February 26, 2025. doi:10.37765/ajmc.2025.89686.

[5] Mercado J, "Understanding the Direct Contracting (DC) Payment Model." Monograph by CareJourney By Arcadia, June 12, 2020, at https://carejourney.co

[6] "Aligning fee-for-service payment rates across ambulatory settings." Report to the Congress, Medicare Payment Advisory Commission, June 2023, at https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

[7] See, for example, Cohen KR et al, Medicare Risk Arrangement and Use and Outcomes Among Physician Groups. *JAMA Netw Open. 2025; 8(1):e2456074. 10.1001/jamanetworkopen.2024.56074*

[8] Seshamani M, Brooks-LaSure C, Weiss R. *A Stronger Medicare Program—Now And Into The Future*. Available from: https://www.healthaffairs.org/content/forefront/stronger-medicare-program-now-and-into-future [Accessed 28th January 2025].

[9] Cottrill A, Cubanski J, Neuman T, Smith K. *Income and assets of Medicare beneficiaries in 2023*. Available from: https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-in-2023/ [Accessed 28th January 2025]

[10] Chant E, Crawford M, Yang C-W W, Sources of Low-Value Care Received by Medicare Beneficiaries and Associated Spending Within US Health Systems. JAMA NetwOpen. 2023;6(9):e2333505.doi:10.1001/jamanetworkopen.2023.33505

[11] Congressional Budget Office. *The Budget and Economic Outlook: 2025 to 2035.* Available from: https://www.cbo.gov/system/files/2025-01/60870-Outlook-2025.pdf [Accessed 28th January 2025].

[12] CMS Fact Sheet, 2025 Medicare Parts A & B Premiums and Deductibles, Nov 08, 2024, at https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles

[13] Ochieng N, Cubanski J, Neuman T. *A Snapshot of Sources of Coverage Among Medicare Beneficiaries.* Available from: https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries [Accessed 28th January 2025]

[14] Ippolito B, Trish E, Vabson B. Expected out-of-pocket costs: Comparing Medicare Advantage with fee-for-service Medicare. *Health Affairs*. 2024 Nov 1;43(11):1502–7.

[15] Fuglesten Biniek J, Sroczynski N, Neuman T. *Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022*. Available from: [https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/] [Accessed 28th January 2025]

[16] MedPAC. *The Medicare Advantage Program: Status Report*. Available from: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf [Accessed 28th January 2025]

[17] Gervenak C, Mike D. *Value to the Federal Government of Medicare Advantage.* Available from: https://www.milliman.com/en/insight/Value-to-the-federal-government-of-medicare-advantage [Accessed 28th January 2025]

[18] Ippolito (n24)

[19] Cohen KR, Vabson B, Podulka J, et al. Medicare Risk Arrangement and Use and Outcomes Among Physician Groups. *JAMA Netw Open.* 2025;8(1):e2456074. doi:10.1001/jamanetworkopen.2024.56074

[20] Vabson B, Cohen K, Ameli O, et al. Potential spillover effects on traditional Medicare when physicians bear Medicare Advantage risk. *Am J Manag Care*. Published online February 26, 2025. doi:10.37765/ajmc.2025.89686.

[21] APG estimates by Kenneth R. Cohen, MD, and others, unpublished.

[22] Centers for Medicare & Medicaid Services. *Original Medicare (Part A and B) Eligibility and Enrollment.* Available from: https://www.cms.gov/ medicare/enrollment-renewal/original-part-a-b [Accessed 28th January 2025]

[23] Cubanski J, Damico A. *Medicare Part D in 2025: A First Look at Prescription Drug Plan Availability, Premiums, and Cost Sharing.* Available from: https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2025-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing [Accessed 28th January 2025]

[24] See, for example, quote by Medicare FAQ, a private entity, at https://www.medicarefaq.com/faqs/dental-and-vision-insurance-for-seniors/

[25] Noel-Miller C. Beneficiaries in Traditional Medicare: Out-of-Pocket Spending for Health Care. AARP Public Policy Institute Spotlight, March 2023. https://www.aarp.org/content/dam/aarp/ppi/2023/3/beneficiaries-in-traditional-medicare-out-of-pocket-spending-for-health-care.doi.10.26419-2fppi.00184.001.pdf (accessed March 2025)

[26] Centers for Medicare & Medicaid Services. *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*. Available from: https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf [Accessed 28th January 2025]

[27] Centers for Medicare & Medicaid Services. *Medicare Savings Programs.* Available from: https://www.medicare.gov/basics/costs/help/medicare-savings-programs [Accessed 28th January 2025]

[28] Centers for Medicare & Medicaid Services. *Fact Sheet: Medicare Extra Help Program.* Available from: https://www.medicare.gov/sites/default/files/2024-07/12203-medicare-extra-help-program.pdf [Accessed 28th January 2025]

[29] Whelan C. *What Are Medicare Part B Excess Charges?* Available from: https://www.healthline.com/health/medicare/medicare-part-b-excess- charges [Accessed 28th January 2025]

[30] Guzman G, Kollar M. *Income in the United States: 2023.* Available from: https://www.census.gov/library/publications/2024/demo/p60-282.html [Accessed 28th January 2025]

[31] Cottrill A, Ochieng N, Neuman T. *How Many Physicians Have Opted Out of the Medicare Program?* Available from: https://www.kff.org/medicare/ issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program [Accessed 28th January 2025]

[32] Doggett L. *H.R. 33 – Medicare Dental, Vision, and Hearing Benefit Act of 2023.* Available from: https://www.congress.gov/bill/118th-congress/house-bill/33 [Accessed 28th January 2025]

[33] Katch H, Van de Water P. *Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits.* Available from: https://www.cbpp.org/ research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits [Accessed 28th January 2025]

[34] Freed M, Neuman T, Cubanski J. *Coverage of Dental Services in Traditional Medicare.* Available from: https://www.kff.org/medicare/issue-brief/coverage-of-dental-services-in-traditional-medicare/ [Accessed 28th January 2025].

[35] Congressional Budget Office. *The Demographic Outlook: 2025 to 2055.* Available from: https://www.cbo.gov/publication/60875 [Accessed 28th January 2025]

[36] Rogers L, Wilder K. *Working-Age Population Not Keeping Pace With Growth in Older Americans.* Available from: https://www.census.gov/library/stories/2020/06/working-age-population-not-keeping-pace-with-growth-in-older-americans.html [Accessed 28th January 2025]

[37] Centers for Medicare & Medicaid Services. *National Health Expenditure Data Projected.* Available from https://www.cms.gov/data-research/ statistics-trends-and-reports/national-health-expenditure-data/projected [Accessed 28th January 2025]

[38] Congressional Budget Office. *An Update to the Budget and Economic Outlook: 2024 to 2034*. Available from: https://www.cbo.gov/publication/60419#_idTextAnchor049 [Accessed 28th January 2025]

[39] Congressional Budget Office. *The Budget and Economic Outlook: 2025 to 2035.* Available from: https://www.cbo.gov/system/files/2025-01/60870-Outlook-2025.pdf [Accessed 28th January 2025]

[40] Centers for Medicare & Medicaid Services. *The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Available from: https://www.cms.gov/oact/tr/2024 [Accessed 28th January 2025]

[41] Centers for Medicare and Medicaid Services. *Medicare Payment Systems.* Available from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html [Accessed 28th January 2025]

[42] Ginsburg P, Fee-For-Service Will Remain A Feature Of Major Payment Reforms, Requiring More Changes In Medicare Physician Payment. Health Affairs 31, No. 9 (2012): 1977-1983, doi: 10.1377/hlthaff.2012.0350

[43] Dowd BE, Laugesen MJ. Fee-for-service payment is not the (main) problem. Health Serv Res. 2020 Aug;55(4):491-495. doi: 10.1111/1475-6773.13316. PMID: 32700387; PMCID: PMC7375993

[44] Berenson RA, Emanuel EJ. The Medicare Physician Fee Schedule and Unethical Behavior. *JAMA.* 2023;330(2):115–116. doi:10.1001/jama.2023.6154

[45] Berenson R, Hayes K. The road to value can't be paved with a broken Medicare physician fee schedule. Health Affairs. 2024 Jul 1;43(7):950–8. doi:10.1377/hlthaff.2024.00299

[46] Liao J, Navathe A, Werner R. The impact of Medicare's alternative payment models on the value of care. *Annual Review of Public Health*. 2020 Apr 2;41(1):551–65. doi:10.1146/annurev-publhealth-040119-094327

[47] Congressional Budget Office. *Medicare Accountable Care Organizations: Past Performance and Future Directions.* Available from: https://www. cbo.gov/system/files/2024-04/59879-Medicare-ACOs.pdf [Accessed 28th January 2025]

[48] McWilliams J. *Testimony of J. Michael McWilliams, MD, PhD Warren Alpert Foundation Professor of Health Care Policy, Professor of Medicine Harvard Medical School Before the U.S. House Committee on Energy & Commerce Subcommittee on Oversight & Investigations Hearing on "MACRA Checkup: Assessing Implementation and Challenges That Remain for Patients and Doctors"* Available from: https://docs.house.gov/meetings/IF/IF02/20230622/116159/HMTG-118-IF02-Wstate-McWilliamsJ-20230622.pdf [Accessed January 28th 2025]

[49] Einav L, Finkelstein A, Ji Y, Mahoney N. Randomized trial shows healthcare payment reform has equal-sized spillover effects on patients not targeted by reform. *Proceedings of the National Academy of Sciences.* 2020 Jul 27;117(32):18939–47. doi:10.1073/pnas.2004759117

[50] Fowler E, Rawal P, Calloway R. The Spillover Effect of the CMS Innovation Center. NEJM Catalyst, January 21, 2025. DOI: 10.1056/CAT.24.0427

[51] America's Physician Groups. *America's Physician Groups Members Were Among Organizations Producing Big Savings And High Quality Scores in ACO REACH Model in 2023.* Available from: https://www.apg.org/news/americas-physician-groups-members-were-among-organizations-producing-big-savings-and-high-quality-scores-in-aco-reach-model-in-2023/ [Accessed 28th January 2025]

[52] Fowler E, Brooks-Lasure C, Rawal P. *Innovation at CMS: Advancing a Person-Centered Health System.* Available from: https://www.healthaffairs.org/ content/forefront/innovation-cms-advancing-person-centered-health-system [Accessed 28th January 2025]

[53] Estimates by Kenneth R. Cohen, MD, and colleagues; as yet unpublished.

[54] Estimate by the American Medical Association at https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf

[55] Norris C, Chreten M, MACRA: Overview for Providers. Milliman, 2016, at https://www.milliman.com/en/insight/MACRA-Key%20considerations%20for%20health%20plans

[56] Chernew M et al, Strengths And Weaknesses Of Introducing An Inflation Factor Into The Medicare Physician Fee Schedule, *Health Affairs* 43, NO. 12 (2024): 1689–1697

[57] Cottrill A, Cubanski J, Neuman T. *What to Know About How Medicare Pays Physicians.* Available from: https://www.kff.org/medicare/issue-brief/ what-to-know-about-how-medicare-pays-physicians/ [Accessed 28th January 2025]

[58] Centers for Medicare & Medicaid Services. *The 2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds.* Available from: https://www.cms.gov/oact/tr/2024 [Accessed January 28th 2025]

[59] Centers for Medicare & Medicaid Services. *The 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds.* Available from: https://www.cms.gov/oact/tr/2023 [Accessed January 28th 2025]

[60] Centers for Medicare & Medicaid Services. *Learn About MIPS.* Available from: https://qpp.cms.gov/mips/mvps/learn-about-mips [Accessed January 28th 2025]

[61] MedPAC. *Moving Beyond the Merit-Based Incentive Payment System.* Available from: https://www.medpac.gov/wp-content/uploads/import_data/ scrape_files/docs/default-source/reports/mar18_medpac_ch15_sec.pdf [Accessed January 28th 2025]

[62] McWilliams n 48

[63] McWilliams JM. The future of Medicare and the role of traditional Medicare as competitor. *New England Journal of Medicine*. 2024 Aug 22;391(8):763–9. doi:10.1056/nejmsb2313939

[64] Mills C, Jacobson N, Champagne N. *Why Voluntary Alignment may not Meet Your ACO's Expectations*. Available from: www.milliman.com/en/insight/Why-voluntary-alignment-may-not-meet-ACO-expectations [Accessed January 28th 2025]

[65] Centers for Medicare & Medicaid Services. *Medicare Shared Savings Program Beneficiary Incentive Program Guidance May 2021.* Available from: https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/bip-guidance.pdf [Accessed January 28th 2025]

[66] Chen AJ, McWilliams JM. How benchmark changes affect participation in accountable care organizations. *American Journal of Health Economics*. 2025 Jan 1;11(1):38–62. doi:10.1086/726748

[67] "Aligning fee-for-service payment rates across ambulatory settings." Report to the Congress, Medicare Payment Advisory Commission, June 2023, at https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch8_MedPAC_Report_To_Congress_SEC.pdf

[68] Cooper Z, Jurinka E, Stern D. *Review of Expert and Academic Literature Assessing the Status and Impact of Site-Neutral Payment Policies in the Medicare Program.* Available from: https://tobin.yale.edu/sites/default/files/2023-10/Site-Neutral%20Payment%20Literature%20Review%2010302023.pdf [Accessed January 28th 2025]

[69] DeGette D, Bucshon L. *A Roadmap for 21st Century Cures: Next Steps for the Cures 2.0 Act and the 21st Century Cures Initiative*. Available from: https://degette.house.gov/sites/evo-subsites/degette.house.gov/files/evo-media-document/Cures%202.1%20White%20Paper%20FINAL.pdf [Accessed January 28th 2025]

[70] McWilliams, n 47.

[71] Whitehouse S, *Discussion Draft: Primary Care Legislation.* Available from: https://www.whitehouse.senate.gov/wp-content/uploads/2024/03/ Primary-Care-Discussion-Draft-Fact-Sheet.pdf [Accessed 28th January 2025]

[72] Medicare Payment Advisory Commission, March 2024 Report to Congress, Chapter 12, The Medicare Advantage Program: Status Report, p. 10. At https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf

[73] Curto V, Einav L, Finkelstein A, Levin J, Bhattacharya J. Health care spending and utilization in public and private Medicare. *American Economic Journal: Applied Economics*. 2019 Apr;11(2):302–32. doi:10.1257/app.20170295

[74] Ochieng N, Fuglesten Biniek J, Cubanski J, Neuman T. *Disparities in Health Measures by Race and Ethnicity Among Beneficiaries in Medicare Advantage: A Review of the Literature.* Available from: https://www.kff.org/report-section/disparities-in-health-measures-by-race-and-ethnicity-among-beneficiaries-in-medicare-advantage-report/ [Accessed January 28th 2025]

[75] McWilliams JM. *Don't Look Up? Medicare Advantage's Trajectory and the Future of Medicare.* Available from: https://www.healthaffairs.org/ content/forefront/don-t-look-up-medicare-advantage-s-trajectory-and-future-medicare [Accessed January 28th 2025]

[76] Fuglesten Biniek J, Freed M, Damico A, Neuman T. *Medicare Advantage Quality Bonus Payments Will Total At Least $11.8 billion in 2024*. Available from: https://www.kff.org/medicare/issue-brief/medicare-advantage-quality-bonus-payments-will-total-at-least-11-8-billion-in-2024/#:~:text=Medicare%20Advantage%20Quality%20Bonus%20Payments%20Will%20Total%20at%20Least%20%2411.8%20Billion%20in%202024,Jeannie%20Fuglesten%20Biniek&text=The%20quality%20bonus%20program%2C%20established,a%20five-star%20rating%20system [Accessed January 28th 2025]

[77] Centers for Medicare & Medicaid Services. *Risk Adjustment.* Available from: https://www.cms.gov/priorities/innovation/key-concepts/risk-adjustment [Accessed January 28th 2025]

[78] McClellan M, Debab S, McStay F, Japinga M, Saunders R. *Modernizing Medicare Risk Adjustment and Performance Measurement: Moving Beyond Fee-for-Service for Payment Accuracy, Care Improvement, and Burden Reduction*. Available from: https://healthpolicy.duke.edu/sites/default/files/2024-03/Modernizing%20Medicare%20Risk%20Adjustment%20and%20Performance%20Measurement.pdf [Accessed January 28th 2025]

[79] Skopec L, Garrett B, Gangopadhyaya. *Reimagining the Medicare Advantage Risk Adjustment Program.* Available from: https://www.urban.org/sites/default/files/2023-05/Reimagining%20the%20Medicare%20Advantage%20Risk%20Adjustment%20Program_0.pdf [Accessed January 28th 2025]

[80] Geruso M, Layton T. Upcoding: Evidence from Medicare on Squishy Risk Adjustment. *Journal of Political Economy*. 2020 Mar;12(3):984-1026. doi: 10.1086/704756. Epub 2020 Jan 29. PMID: 32719571; PMCID: PMC7384673.

[81] Better Medicare Alliance. *Coding Practices and Adjustments in Medicare Advantage.* Available from: https://bettermedicarealliance.org/wp- content/uploads/2022/06/BMA-Fact-Sheet-Coding-Practices-and-Adjustments-in-Medicare-Advantage-1.pdf [Accessed January 28th 2025]

[82] Centers for Medicare & Medicaid Services, Advance Notice of Methodological Changes for Calendar Year (CY) 2026 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, at https://www.cms.gov/files/document/2026-advance-notice.pdf (Accessed March 2025)

[83] Department of Health and Human Services: Office of Inspector General. *Medicare Advantage: Questionable Use of Health Risk Assessments Continues to Drive Up Payments to Plans by Billions.* Available from: https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf [Accessed January 28th 2025]

[84] Cohen (n 19, Vabson (n 21)

[85] Fuglesten Biniek J, Sroczynski N, Freed M, Neuman T. *Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023.* Available from: https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/ [Accessed January 29th 2025]

[86] Centers for Medicare & Medicaid Services. *Prior Authorization and Pre-Claim Review Initiatives.* Available from: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives [Accessed January 29th 2025]

[87] Neprash H, Mulcahy JF, Golberstein E. The extent and growth of prior authorization in Medicare advantage. *The American Journal of Managed Care*. 2024 Mar 7;30(3):85–92. doi:10.37765/ajmc.2024.89519

[88] Anderson KE, Darden M, Jain A. Improving Prior Authorization in Medicare Advantage. *JAMA*. 2022 Oct 3;328(15):1497–1498. doi:10.1001/ jama.2022.17732

[89] Whitehouse S. *Whitehouse Introduces Legislation to Reform Prior Authorization Practices and Get Care to Patients Faster*. Available from: https://www.whitehouse.senate.gov/news/release/whitehouse-introduces-legislation-to-reform-prior-authorization-practices-and-get-care-to-patients-faster/ [Accessed January 29th 2025]

[90] Shartzer A, Pugazhendhi A, Garret B. *Quality Bonus Payments in Medicare Advantage.* Available from https://www.urban.org/research/publication/quality-bonus-payments-medicare-advantage [Accessed March 2025]

[91] Rogers H, Smith MH. *Star Ratings in Retrograde: Decoding the 2025 Decline*. Available from: https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2024-Articles/11-6-24-Stars-in-Retrograde-Decoding-the-2025-decline.pdf [Accessed January 29th 2025]

[92] Centers for Medicare & Medicaid Services. *2026 Star Ratings Measures and Weights.* Available from: https://www.cms.gov/files/document/2026-star-ratings-measures.pdf [Accessed January 29th 2025]

[93] Centers for Medicare & Medicaid Services. *Medicare 2025 Part C & Part D Star Ratings Technical Notes.* Available from: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf [Accessed January 29th 2025]

[94] Roberts ET, Burke R, Haddad K. *Medicare Advantage Supplemental Benefits: Origins, Evolution, and Issues for Policy Making.* Available from: https://www.healthaffairs.org/content/forefront/medicare-advantage-supplemental-benefits-origins-evolution-and-issues-policy-making [Accessed January 29th 2025]

[95] Coleman K. *Implementing Supplemental Benefits for Chronically Ill Enrollees*. Available from https://www.cms.gov/medicare/health-plans/healthplansgeninfo/downloads/supplemental_benefits_chronically_ill_hpms_042419.pdf [Accessed January 29th 2025]

[96] Centers for Medicare & Medicaid Services. *Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024-Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE).* Available from: https://www.federalregister.gov/documents/2024/04/23/2024-07105/medicare-program-changes-to-the-medicare-advantage-and- the-medicare-prescription-drug-benefit [Accessed January 29th 2025]

[97] See, for example, proposed legislation introduced by Sen. Mark Warner (D-VA) in the 118th Congress, S.3573, the Medicare Advantage Supplemental Benefits Transparency Act, at https://www.congress.gov/bill/118th-congress/senate-bill/3573/text

[98] Cohen (n 19), Vabson (n21)

[99] Centers for Medicare & Medicaid Services, Report to Congress, Alternative Payment Models & Medicare Advantage, at https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/Report-to-Congress-APMs-and-Medicare-Advantage.pdf

[100] Ibid.

[101] Health Care Payment Learning & Action Network. *While Progress Continues, the LAN launches new goals to increase reach and impact of value-based payment reform.* Available from: https://hcp-lan.org/workproducts/2019-APM-Progress-Press-Release.pdf [Accessed January 29th 2025]

[102] Office of Public Affairs: U.S. Department of Justice. *Medicare Advantage Provider Independent Health to Pay up $98M to Settle False Claims Act Suit.* Available from https://www.justice.gov/opa/pr/medicare-advantage-provider-independent-health-pay-98m-settle-false-claims-act-suit [Accessed January 29th 2025]

[103] MedPAC. *The Medicare Advantage Program: Status Report.* Available from: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch12_MedPAC_Report_To_Congress_SEC-1.pdf [Accessed January 29th 2025]

[104] Jacobs PD. In-home health risk assessments and chart reviews contribute to coding intensity in Medicare advantage. *Health Affairs*. 2024 Jul;43(7):942–9. doi:10.1377/hlthaff.2023.01530

[105] Duke Margolis Institute for Health Policy. *Modernizing Medicare Risk Adjustment and Performance Measurement: Moving Beyond Fee-for-Service for Payment Accuracy, Care Improvement, and Burden Reduction.* Available from: https://healthpolicy.duke.edu/sites/default/files/2024-03/Modernizing_Medicare_Risk_Adjustment_and_Performance_Measurement.pdf [Accessed January 29th 2025]

[106] Sutton A, Drapos G. Inferred risk: Reforming Medicare risk scores to create a fairer system. *Health Affairs Forefront*. 2024 Apr 24; doi:10.1377/forefront.20240423.744938

[107] Duke Margolis (n 103)

[108] Dentzer S. *APG Comment Letter on 2025 Medicare Advantage Advanced Notice.* Available from: https://www.apg.org/news/apg-comment-letter- on-2025-medicare-advantage-advance-notice/ [Accessed January 29th 2025]

[109] Duke Margolis (n 103)

[110] Ibid

[111] Pestaina K, Lo J, Wallace R, Long M. *Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain.* Available from: https://www.kff.org/private-insurance/issue-brief/final-prior-authorization-rules-look-to-streamline-the-process-but-issues-remain/#:~:text=Shortened%20Timeframes,,for%20current%20and%20new%20timeframes [Accessed January 29th 2025]

[112] Marshall R. *The Improving Seniors' Timely Access to Care Act: Section-by-Section Summary*. Available from https://www.marshall.senate.gov/wp-content/uploads/Seniors-Act-Section-by-Section-Summary.pdf [Accessed January 29th 2025]

[113] Whitehouse S, Prior Authorization Relief Act, (S. 5612), introduced in the 118th Congress, at https://www.congress.gov/bill/118th-congress/senate-bill/5612

[114] Marshall R (n 107)

[115] Pharmaceutical Care Management Association, What Is Gold Carding? October 2023, at https://www.pcmanet.org/wp-content/uploads/2023/10/Gold-Carding-Explainer_FINAL.pdf#:~:text="Gold%20Carding"%20is%20a%20program%20used%20by%20some,services%20provided%20by%20clinicians%20who%20are%20deemed%20"high-performing. [Accessed March 2025]

[116] Frieden J, State 'Gold Card' Laws Sound Good — But Are They Working? MedPage Today, Dec. 10, 2024, at https://www.medpagetoday.com/practicemanagement/practicemanagement/113331

[117] United Healthcare National Gold Card Program at https://www.uhcprovider.com/en/prior-auth-advance-notification/gold-card.html

[118] See, for example, Burgess M, GOLD CARD Act of 2023, HR 4968, introduced into the 118th Congress, at https://www.congress.gov/bill/118th-congress/house-bill/4968