# Arnold Ventures' Vision for Medicare Physician Payment

Medicare should compensate physicians for the delivery of high-value, patient-centered care, with a payment system that accurately reflects the resources required by physicians to furnish services. Current Medicare physician payment policy fails to do this. It is largely based on fee-for-service (FFS) — where providers are paid based on the number and type of services they deliver, rewarding volume over value. Furthermore, the current system does not accurately price physician services, resulting in underinvestment in primary care and overpayment for specialty care, compensating many procedural services at much higher rates regardless of whether they meaningfully improve patient health.

Arnold Ventures supports re-orienting the health care system toward delivering higher quality, lower-cost care. One lever to achieve that aim is to accelerate the adoption of payment models that give providers greater flexibility to deliver the care their patients need, while holding them accountable for the total cost of care. This should encourage coordination between clinicians, engage patients to manage chronic conditions, and incentivize the utilization of high-value services. Another lever is to improve payment accuracy and rebalance spending towards primary care.

It is also true that Medicare's current payment system fails to provide physicians with predictable payment levels, resulting in costly and temporary annual payment fixes. Correcting this is important, but any fix that fails to acknowledge Medicare's unsustainable projected spending growth and address the underlying structural issues with physician payments would be deeply inadequate.

It is time for policymakers to establish a lasting framework for fiscally responsible Medicare physician payment reform. The recommendations below are where they should start.

## POLICY RECOMMENDATIONS

**Strengthen incentives for participation in advanced alternative payment models (AAPMs).** After an initial decade of attempts at encouraging adoption of AAPMs, it is clear that policymakers should establish stronger incentives to encourage providers to assume accountability for cost and quality. This requires a two-pronged approach: making FFS less attractive and AAPMs more attractive.

First, reforms should better align financial incentives for AAPM participation with the goals of accountable care. This could involve restructuring the AAPM bonus payment to be based on a flat amount per beneficiary, removing the current percentage-of-revenue based incentive which can reward providers for increased utilization. Adopting a more meaningful payment differential between AAPMs and traditional FFS would also encourage more providers to move into AAPMs.

Second, policymakers should incentivize greater savings within AAPMs. For example, Medicare's Shared Savings Program (MSSP) uses historical benchmarks to determine shared savings, but the spending benchmarks get tighter as providers succeed at reducing spending — limiting future savings and discouraging continued participation. Instead, Congress could give CMS clear statutory authority to set administrative benchmarks (or similar overhaul) that could create a lasting pathway to savings for providers and Medicare.

Third, policymakers should establish a permanent hybrid primary care payment option within MSSP. This would pay primary care providers a fixed fee per beneficiary, incentivize delivery of comprehensive care, and correct the undervaluation of primary care while encouraging adoption of AAPMs.

Finally, strengthening AAPM incentives has become even more important as AI adoption becomes ubiquitous in health care provision. Incorporating AI into a system with incentives for value and efficiency makes it substantially more likely that AI could be used to help lower health care costs instead of accelerating spending growth under a FFS system.

**Reduce reliance on the AMA's Relative Value Scale Update Committee (RUC).** Policymakers should support efforts to modernize the process used to determine Medicare physician payment rates by reducing CMS' reliance on recommendations from the RUC and establishing an independent technical advisory committee to inform pricing decisions. Payment rates should be based on objective, empirical data sources rather than physician surveys alone. A more transparent, data-driven valuation process would improve payment accuracy, better reflect the resources required to furnish services, and help address longstanding biases in the physician fee schedule.

**Ensure sustainable and predictable physician payment updates.** Policymakers should replace the current cycle of temporary, last-minute physician payment patches with a stable and predictable update mechanism. Any permanent update policy should be designed to minimize unnecessary costs to the Medicare program. MedPAC recommends tying Medicare physician payment updates to a portion of growth in the Medicare Economic Index (MEI), specifically MEI minus one percentage point (MEI-1), to balance beneficiary access and cost to Medicare. Full indexing reduces physician incentives to become more efficient and adds unnecessary taxpayer expense.

**Maintain budget neutrality guardrails.** The physician fee schedule's budget neutrality threshold is intended to impose fiscal restraint and encourage revaluation of physician services as care evolves and physicians become more efficient. Thus, it is essential for protecting taxpayers and Medicare beneficiaries from even faster growth in spending and premiums.

There might be an argument that a one-time increase to the current threshold is warranted, as it has not been raised since the inception of the physician fee schedule in 1992. However, setting the budget neutrality threshold to grow on autopilot (as some in Congress want to do) especially while setting overall physician payment to grow on autopilot, would give physicians two opportunities for payment increases and abandon the discipline imposed by budget neutrality.

## CONCLUSION

Achieving a more sustainable Medicare physician payment system will require coordinated efforts across Congress, CMS, and CMMI. Congress should establish a statutory framework that includes predictable payment updates and stronger incentives for AAPM participation while maintaining fiscal guardrails. CMS should use its existing authorities to improve payment accuracy and reduce reliance on the RUC, and CMS and CMMI should continue advancing accountable care, including hybrid primary care payment, that moves providers away from FFS. These efforts can create a more durable payment system that rewards value, strengthens primary care, and provides greater stability for clinicians in a fiscally responsible manner.

Arnold Ventures is a philanthropy that supports research to understand the root causes of America's most persistent and pressing problems, as well as evidence-based solutions to address them. By focusing on systemic change and bipartisan policy reforms, AV works to improve the lives of American families, strengthen communities, and promote economic opportunity.