

January 16, 2026

The Honorable Greg Murphy
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier
1110 Longworth House Office Building
Washington, DC 20515

Re: Congressional Doctors Caucuses MACRA Modernization Request for Information

Dear Representatives Murphy, Joyce, Schrier and Members of the Doctors Caucuses:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit a response to the House Doctors Caucuses request for information on modernizing the Medicare Access and CHIP Reauthorization Act (MACRA). NAACOS is a member-led, member-governed nonprofit of nearly 500 ACOs and value-based care entities in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems, and other providers across the nation. These value-based care providers seek to improve the quality of care while reducing costs. NAACOS represents more than 10 million beneficiary lives through Medicare's population health-focused payment and delivery models.

UPDATING MEDICARE PHYSICIAN PAYMENT TO PROMOTE ACCOUNTABLE CARE

MACRA was enacted to shift Medicare physician payment away from volume-driven care toward approaches that reward quality, efficiency, and accountability. Alternative payment models (APMs) advance this goal by aligning incentives around prevention, care coordination, and outcomes rather than volume. By encouraging providers to proactively manage chronic conditions, reduce unnecessary utilization, and focus on whole-person care, APMs have demonstrated their ability to improve quality while lowering costs—benefiting patients, providers, and the broader health system.

Over the past two decades, the growth of APMs has enabled providers to collaborate more effectively and invest in critical infrastructure to improve patient care. Accountable care organizations (ACOs), the largest and most established APMs in Medicare, exemplify this success. Since their inception, ACOs have generated more than \$34 billion in Medicare savings while outperforming traditional models on key quality measures, including preventive care, reduced hospitalizations, and fewer avoidable readmissions.¹

¹ <https://www.naacos.com/wp-content/uploads/2025/09/VBC-in-the-US.pdf>

MACRA Reforms to Drive Accountability

To fully realize the benefits of accountable care, Congress should:

- **Retain financial incentives that encourage clinicians to adopt and remain in APMs.** Additionally, physician payment approaches should reflect inflationary pressures. **As part of a 2026 health extenders package, Congress should support a short-term extension of APM incentives and lower qualifying thresholds to ensure accountable care clinicians have reduced burdens to reward their efforts to transform care.**
- **Work with the Center for Medicare and Medicaid Services (CMS) to ensure models support sustainability and innovation.**
- **Support the CMS Innovation Center with more predictable and inclusive pathways for developing, evaluating, and permanently adopting successful models.**

INCENTIVIZING APMS THROUGH PHYSICIAN PAYMENT REFORM

MACRA included financial incentives and higher physician payment updates through a conversion factor to encourage participation in downside risk APMs. APM incentive payments have proven successful in supporting the transition to new payment models. Led by the success of ACOs, downside-risk APM participation increased by more than 433% since the passage of MACRA. As of 2025, 75 percent of ACOs are in downside risk arrangements with Medicare and encompass more than 500,000 clinicians. As a result, more than 50 percent of beneficiaries with traditional Medicare are cared for through an ACO.

While the incentives have proven successful, APM adoption has advanced more slowly than Congress initially envisioned due to the time and effort required to change clinical care. With the expiration of MACRA's APM incentive payments at the end of 2024, the current policy framework increasingly favors volume-based care and MIPS. Medicare's higher APM differential conversion factor (0.75 percent for APMs vs. 0.25 percent for MIPS) will not create a stronger financial incentive for clinicians until 2030. This prolonged incentive gap threatens clinician participation and undermines the long-term transition to accountable care.

Any new approach to physician payment should provide long-term, predictable financial incentives that encourage sustained investment and participation in APMs. Incentives should remain highest for clinicians participating in APMs to reflect the additional responsibilities and care transformation required under these models. Importantly, these incentives should apply to all clinicians in APMs, not solely those bearing downside risk, to support broad participation and continued progress toward APM adoption.

Redesigning Long-Term APM Financial Incentives

To encourage new and continued participation in APMs, Congress should redesign financial incentives to encourage clinicians to join and meaningfully participate in APMs. MACRA restricts incentives to clinicians in APM entities who have a certain percentage of revenue or patients through the APM. The current qualifying APM participant (QP) thresholds are arbitrary and do not reflect realistic opportunities for APMs to increase the amount of revenue or patients in the APM. A better approach

would provide incentives based on number of beneficiaries served or revenue through the APM.

Per-Beneficiary Approach

One of the primary approaches that stakeholders have been considering is providing incentive payments based on the number of patients attributed to an APM. Under this approach, APMs would receive a fixed payment based on the number of patients aligned to a given APM. The incentive should go directly to the APM entity, allowing the APM entities to distribute incentives to all participating clinicians equitably based on a clinician's contributions and performance within the model. This approach eliminates the administrative complexity associated with varying attribution models, allows CMS to speed up the rate of payments to clinicians (eliminating the current two-year lag with monthly or quarterly payments), and gives ACOs and other APM entities more financial resources to recruit specialists into total cost of care models.

Revenue Approach

Another option would be to design an incentive that would be paid based on a percentage of a clinician's revenue through the APM, rather than all Part B services. The Medicare Payment Advisory Commission (MedPAC) outlined this approach in their June 2024 Report to Congress.² This would reward clinicians who have more significant participation across APMs and incentivize clinicians to participate in multiple APMs. A criticism of MACRA's original APM incentive payment structure is that it encouraged clinicians to increase all Part B revenue to receive higher incentive payments. This concern is mitigated when limiting the incentive payment to revenue through the APM as APMs require reductions in costs.

Additional Considerations for Incentives

- Provide enhanced incentives for small, independent practices and those serving rural or underserved beneficiaries.
- Develop safeguards to ensure that financial incentives and payment updates do not negatively impact a clinician's ability to meet the benchmarks in their payment model.
- Remove APM incentive payments from Medicare Advantage (MA) benchmarks or require that incentive payment dollars included in MA benchmarks are used to provide similar incentives for clinicians that are participating in risk-based payment arrangements with plans.

APM Participants Should Not be Subject to Burdensome FFS Requirements

New approaches should ensure that all clinicians in APMs are not subject to burdensome fee-for-service quality reporting requirements. MIPS, which is an overly complex system, and administrative burdens remain a significant barrier to APM participation. Clinicians who participate in APMs should be excluded entirely from MIPS to avoid duplicative reporting and conflicting incentives. MACRA created pathways for reducing provider burden by excluding all clinicians in risk-based APMs from MIPS. Similarly, other clinicians in APMs (i.e., those who do not meet qualifying thresholds or do not bear risk) were exempt from all MIPS categories except quality.

While this has been a strong non-financial incentive for providers to join APMs, we are concerned that

² https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf

CMS has removed some of this burden reduction. Specifically, CMS has aligned APM reporting requirements with MIPS by requiring clinicians in APMs to report Promoting Interoperability (PI) and requiring ACOs to report electronic clinical quality measures (eCQMs) ahead of industry readiness. Fundamentally, we believe aligning APM measurement with MIPS is a flawed approach and runs counter to the original goals of MACRA. More broadly, MIPS should be explicitly structured to encourage a transition into APMs rather than functioning as a parallel, permanent payment system. Aligning measures across programs will also further reduce burden and improve program consistency.

Extending Incentives and Lowering APM Qualifying Thresholds

As part of the 2026 health care extenders bill, Congress should support a short-term extension of Medicare’s advanced APM incentives and lower the QP status thresholds to 2024 levels. The goal of MACRA was to encourage a transition from MIPS to APMs. From 2022 to 2023, there was a 20 percent increase in the percentage of clinicians participating in risk-based APMs and a 41 percent increase in those achieving QP status.³ With more than 500,000 clinicians participating in down-side risk models, extending these incentives will provide financial resources to maintain and continue growing participation in APMs as Congress works on longer term reforms.

Lowering APM QP thresholds

Recognizing the challenges faced by ACOs, Congress froze the QP thresholds for performance years 2021-2024 to help maintain growth and participation. While the original intent of the QP thresholds was to encourage deeper participation in risk-bearing models over time, many clinicians have struggled to meet increasing thresholds due to flawed structure of the program. ACOs – especially those with multispecialty practices – often struggle to meet higher QP thresholds because traditional Medicare patients often receive care both inside and outside of an ACO’s coordinated care structure.

CMS made two regulatory modifications to the QP methodology in the 2026 Medicare Physician Fee Schedule to help address concerns regarding specialist participation in APMs and eligibility for QP status. Despite those changes, CMS acknowledges that the statutory increase in qualifying thresholds that took place beginning with Performance Year 2025 could result in upwards of 150,000 clinicians failing to qualify for APM status.⁴ The increase in QP thresholds will have unintended consequences, including:

- Pushing clinicians involuntarily back into MIPS, which significantly increases regulatory burden,
- Removing specialists from APMs models to meet increased thresholds,
- Reducing the number of physicians receiving higher conversion factor updates, and
- Weakening the overall momentum and progress toward risk-bearing model adoption.

Physician Payment Updates

The original intent of MACRA was to develop a more sustainable payment system that invests in care redesign by encouraging and rewarding clinicians that participate in APMs. While MACRA was a step in the right direction, it’s clear that Medicare’s current physician payment system does not adequately

³ <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf>

⁴ <https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other>

adjust payments to account for rising costs. NAACOS remains concerned that annual cuts to physician payment jeopardizes beneficiary access to care and prevents clinicians from investing and transitioning to accountable care models. Stabilizing and ensuring payment adequacy through inflationary updates is necessary to support the infrastructure and staffing necessary for this transition.

ENHANCING SUSTAINABILITY & INNOVATION FOR ACOS

The success of ACOs is driven by innovation and collaboration. ACOs integrate claims and clinical data to improve population health, identify inefficiencies, waste, and fraud, and deliver more personalized care. Reforms such as cost-sharing waivers and reduced regulatory burdens further strengthen the patient-provider relationship and enable seamless coordination across primary care, specialty care, hospitals, post-acute facilities, and home-based setting. This improves outcomes and experiences, particularly for patients with complex chronic conditions.

To ensure the long-term success of ACOs, Congress should work with CMS to ensure that the models:

- **Use sustainable benchmarks** to enable meaningful investments in care while delivering a clear return on investment for providers participating in ACOs. This requires the use of accurate trend factors. Congress should work with CMS to eliminate the Accountable Care Prospective Trend (ACPT) in the Medicare Shared Savings Program (MSSP) and remove the Retrospective Trend Adjustment (RTA) corridors in the ACO REACH program. Opportunities for shared savings should be strengthened by addressing the ACO “ratchet,” ensuring that success is not penalized over time. ACOs are also on the front lines of identifying and addressing fraud, waste, and abuse, and they should be held harmless for fraudulent and wasteful spending that is outside of their control.
- **Enhance capabilities to innovate care** to allow ACOs to design innovative payment approaches that do not rely on fee-for-service and provide beneficiaries with enhanced care approaches. This includes alleviating persistent cash flow challenges through expanded capitation options and more effective advanced payment opportunities to enable ACOs to invest with greater confidence. Improving alignment through both voluntary and geographic methodologies will further strengthen participation and accountability, ensuring organizations are better positioned to manage population health at scale. Over time, additional tools should be incorporated to deepen these capabilities, including enhanced support for network management and pre-payment claims review, helping ACOs manage risk more proactively while improving efficiency and care delivery.
- **Reduce unnecessary regulatory burden to allow ACOs to focus on improving care and outcomes.** Quality measurement should be streamlined to emphasize measures that are meaningful, actionable, and aligned across programs, while minimizing administrative complexity. Digital quality measurement is one area that holds significant promise for advancing population health by enabling seamless, real-time performance tracking. However, the current pathway is complex, costly, and burdensome.⁵ **NAACOS encourages Congress to support the Health Care Efficiency Through Flexibility Act (H.R. 5347) that requires CMS to pilot new digital**

⁵ <https://www.healthaffairs.org/content/forefront/building-future-tech-enabled-health-care-let-accountable-care-lead-way>

reporting methods while maintaining existing reporting options during the transition. By easing these regulatory requirements, providers can redirect resources to care delivery innovation rather than compliance. Other regulations should be improved to reduce burdens for participants, including simplifying beneficiary notification requirements, removing the arbitrary high/low revenue distinction, streamlining the waiver process, and ensuring greater consistency of waivers across programs.

- **Create greater alignment between APMs and the MA program** to ensure that both models provide attractive, sustainable options for innovating care delivery and to ensure that APMs do not face a competitive disadvantage. Providers are increasingly engaging in risk-based arrangements across payers. Because there is a variation in program rules this often means that providers must manage to the model rather than the patient. Congress should establish parity between programs to reduce clinician burdens, improve patient access to care, and drive the adoption of value-based arrangements in MA.

ADAPTING THE CMS INNOVATION CENTER TO SUPPORT SCALEABLE INNOVATION

Over the past decade, the CMS Innovation Center has tested multiple models that have improved patient care while reducing Medicare costs. However, successful models have not been permanently expanded due to restrictive criteria. **Congress should work with the CMS Innovation Center to establish a more predictable and inclusive pathway for developing, evaluating, and permanently adopting successful models.**

Evaluation strategies should recognize that achieving results comparable to MSSP is sufficient for model expansion instead of requiring models to outperform MSSP in order to meet statutory criteria. In addition, the CMS Innovation Center should develop more robust methods for comparing APM performance to MA and make greater use of evidence generated by specific innovations and waivers.


The criteria for model expansion should also be broadened beyond short-term cost savings to include quality improvement, patient access, enhanced benefits, and reduced clinician burden. Addressing gaps in APM opportunities is equally important. The CMS Innovation Center should prioritize the development of models tailored to safety-net providers, rural communities, and small or independent practices. Finally, stronger stakeholder engagement during model development would improve participation and trust. Leveraging the Physician-Focused Payment Model Technical Advisory Committee and providing stakeholders with more detailed program data would enhance transparency and model design.

CONCLUSION

Thank you for the opportunity to share feedback with the Congressional Doctors Caucuses. With targeted policy improvements and sustained Congressional support, these models can continue to enhance quality, strengthen care coordination, and ensure Medicare's long-term sustainability. We appreciate your continued leadership and look forward to working together to advance policies that keep Americans healthier and make our health care system more effective and efficient. If you have any

questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

A handwritten signature in black ink that reads "Emily D. Brower". The signature is fluid and cursive, with the first name being the most prominent.

Emily D. Brower
President and CEO
NAACOS

Cc:

Representative Brian Babin
Representative Buddy Carter
Representative Andy Harris
Representative Scott DesJarlais
Representative Neal Dunn
Representative Diana Harshbarger
Representative Ronny Jackson
Representative Mike Kennedy
Representative Richard McCormick

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