May 20, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
House Committee on Energy and Commerce
2333 Rayburn House Office Building
Washington, DC 20515

Re: Examining The Medicare Physician Fee Schedule, MACRA, And Opportunities for Payment Reforms

Dear Chairman Griffith and Ranking Member DeGette:

The National Association of ACOs (NAACOS) applauds the subcommittee for holding this important hearing on Medicare payment reform. NAACOS is a member-led, member-governed nonprofit of nearly 500 accountable care organizations (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. NAACOS represents more than 10 million beneficiary lives through Medicare's population health-focused payment and delivery models. Our members seek to improve the quality of care while reducing costs.

We value your continued leadership and commitment to advancing long-term policies that strengthen Medicare. As the subcommittee continues its work to improve health care access and affordability, we encourage you to pursue opportunities to evaluate and advance proposals that further Medicare's transition to accountable care.

1. Strengthen financial incentives that drive participation in alternative payment models (APMs).
2. Update physician payment to account for inflationary pressures.
3. Ensure payment models support long-term sustainability and innovation.

ACCOUNTABLE CARE IMPROVES OUTCOMES AND DRIVES SAVINGS

The Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in 2015 to transition physician payment away from volume-driven reimbursement toward models that reward quality, efficiency, and accountability. APMs focus on prevention, care coordination, and improved patient outcomes rather than the volume of services delivered. By encouraging providers to proactively manage chronic conditions, reduce unnecessary utilization, and focus on whole-person care, APMs have demonstrated an ability to improve quality while lowering costs. This benefits patients, providers, and the broader health care system.

MACRA's Incentives Are Driving Growth in Accountable Care

One of the primary goals of MACRA was to encourage clinicians to take on greater accountability for their patients' health by joining advanced APMs that take on downside financial risk. MACRA's incentive payments have played a critical role in supporting Medicare's transition by accelerating participation in ACOs. Driven largely by the growth of ACO participation, Medicare has seen more than a 400 percent increase in the number of clinicians taking on downside risk in accountable care models. **As of 2025, more than half of traditional Medicare beneficiaries receive care through an accountable care relationship.**[1]

There are now more than 580 ACOs coordinating care for over 14.3 million Medicare beneficiaries.[2] ACOs provide a voluntary alternative to the fragmented fee-for-service system by emphasizing prevention, care coordination, and improved patient outcomes. With primary care serving as the foundation, ACOs use a team-based approach to ensure patients receive high-quality care in the right setting, at the right time. The model encourages collaboration across the continuum of care while allowing providers to remain independent.

As of 2025, more than 75 percent of ACOs and over 500,000 clinicians are participating in downside risk arrangements. Recent participation trends demonstrate continued progress toward this goal. From 2022 to 2023, the percentage of clinicians taking on downside risk in APMs increased by 20 percent, while the number achieving APM qualifying participant (QP) status grew by 41 percent.

Accountable Care Saves Money Across the Health System

Since 2012, ACOs have generated more than $34 billion in savings and returned $13.5 billion in net savings to the Medicare Trust Fund. In 2024 alone, ACOs in Medicare's Shared Savings Program generated $6.5 billion in savings and returned $2.4 billion in net savings to the Medicare Trust Fund. Beyond reducing costs, ACOs are providing higher quality care to America's seniors.[3] The broader health care system has also continued to move steadily toward accountable care payment arrangements.

In 2024, across all lines of business, 44.9 percent of health care payments flowed through advanced APM contracts that included downside financial risk, demonstrating the continued growth of these payment arrangements.[4] The Congressional Budget Office (CBO) also reported that actual Medicare and Medicaid spending between 2010 and 2020 was approximately 9 percent lower than originally projected, citing improved care management and more efficient use of technology among the contributing factors.[5]

[1] https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives
[2] https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights
[3] https://www.modernizeacos.org/acos-work/
[4] https://www.ahip.org/resources/2025-apm-measurement
[5] https://www.cbo.gov/system/files/2023-03/58997-Whitehouse.pdf

ACOs Reinvest Incentives to Improve Patient Care

ACOs use Medicare's advanced APM incentive payments to reinvest in patient care, fund wellness initiatives, provide transportation and meal assistance, hire care coordinators and patient navigators, and retain clinical staff. These investments support services that are often not reimbursed directly through Medicare but are essential to improving patient outcomes and reducing avoidable utilization.

These investments also result in cost savings for seniors on Medicare. NAACOS conducted a case study of Medicare claims data to compare how a patient in an ACO can have better outcomes and lower costs. For an 86-year-old patient with multiple chronic conditions, it's project that care coordinated through an ACO could result in saving Medicare nearly $40,000 and lower the patient's out of pocket costs by nearly $2,000.[6]

SUPPORTING CLINICIANS THROUGH PAYMENT REFORM

It's clear that MACRA's incentive payments have been a good investment as it has driven significant growth in ACOs and accountable care across all payers. **We thank the committee for its leadership in advancing accountable care by including a one-year 3.1 percent extension of MACRA's advanced APM incentive payment and modifications to QP thresholds in the Consolidated Appropriations Act of 2026.** This extension sends an important signal to physicians, hospitals, and ACOs that Congress remains committed to supporting the transition to payment models that encourage accountability.

Extending MACRA's Incentives Payments

Eligibility to earn incentive payments will expire at the end of 2026. While clinicians in advanced APMs began receiving a higher payment update in 2026, this incentive is weaker than remaining in fee-for-service until 2030. **We encourage lawmakers to support an extension of Medicare's advanced APM incentive payments for performance years 2027 and 2028.** With more than 500,000 clinicians now taking on downside risk, another extension will help sustain and expand participation as Congress considers longer-term reforms.

Lawmakers should also freeze the QP thresholds to quality for advanced APM incentives (both the higher payment update and any extension of incentive payments) at 50 percent for performance years 2027 and 2028 and adjust the maximum threshold to 65 percent. The original intent of MACRA's QP thresholds was to encourage deeper participation in downside risk models over time. While advanced APM incentives have helped drive growth, the current statutory threshold structure no longer reflects market realities or how ACOs operate in practice.

In particular, the attribution methodology used in ACOs is driven largely by primary care services. As a result, adding specialists to an ACO — despite strengthening care coordination and improving patient outcomes — can make it more difficult for organizations to meet higher QP thresholds. This creates a structural disincentive for multispecialty participation and undermines efforts to build more integrated, patient-centered care models.

[6] https://www.modernizeacos.org/wp-content/uploads/2026/03/Final-Infographicv2.pdf

CMS data further demonstrates that MACRA's statutory thresholds are functioning less as a meaningful incentive and more as a barrier to sustained participation as most ACOs cluster around a 60-65 percent average payment threshold score. [7] Maintaining a maximum threshold within this range would better align policy with real-world performance while still promoting meaningful participation in advanced APMs.

Long-Term Medicare Payment Reforms to Increase Accountability

The original intent of MACRA was to create a more sustainable physician payment system that encourages and rewards clinicians for taking on more accountability. While MACRA represented an important step forward, Medicare's current physician payment system still fails to adequately account for rising practice costs and inflationary pressures. Additionally, the incentives to join APMs are structured so that not all clinicians are encouraged to join advanced APMs. We recommend that Congress consider the following as part of long-term reforms.

Inflationary Payment Updates

We remain concerned that recurring physician payment cuts threaten seniors' access to care and undermine clinicians' ability to invest in and transition to accountable care models. Stabilizing physician payment and providing predictable inflationary updates are essential to supporting the staffing, infrastructure, and care coordination capabilities necessary for long-term success in APMs. Any long-term reforms to physician payment should address inflationary pressures and provide predictable financial incentives that encourage sustained participation and investment in APMs. Medicare payments and incentives should remain strongest for clinicians participating in APMs that take on downside risk. Payments should reflect the additional accountability, operational responsibilities, and care transformation required under these models.

Advanced APM Incentives

To encourage both new and sustained participation in APMs that take on downside risk, Congress should redesign financial incentives to better reflect meaningful participation in these payment models. Under MACRA, eligibility for incentive payments is tied to clinicians meeting QP thresholds based on a specified percentage of payments or patients flowing through the APM entity. However, as noted above, the current QP thresholds are increasingly disconnected from operational realities and do not reflect realistic opportunities for many APM entities to substantially increase attributed revenue or patient volume under existing program structures.

A more effective approach would be to base incentives on meaningful participation metrics such as the number of beneficiaries served or the proportion of revenue managed through the APM entity, rather than relying solely on rigid threshold calculations. As Congress considers reforms to MACRA's incentive structure, additional policy considerations should include:

- Providing enhanced incentives for small, independent physician practices and clinicians serving rural or underserved communities.
- Eliminating the current two-year lag between performance and payment years.
- Establishing safeguards to ensure that incentive payments and physician payment updates

[7] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf

do not adversely affect a clinician's ability to meet their model's financial benchmarks.

- Removing incentive payments from Medicare Advantage (MA) benchmarks or requiring that incentives incorporated into MA benchmarks are used to support expansion of risk-based payment arrangements within MA.

ENHANCING SUSTAINABILITY AND INNOVATION

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:

- *Establish More Sustainable Benchmarks.* ACOs need predictable financial targets and reliable benchmarking structures. Congress should work with CMS to develop effective guardrails to ensure that trend adjustments accurately reflect Medicare spending. Policymakers should also address the ACO "ratchet" effect, where successful organizations face progressively more difficult benchmarks over time. This penalizes ACOs that successfully lower spending.
- *Embrace Innovation for ACOs.* ACOs need more flexibility to move beyond the limitations of Medicare's fragmented fee-for-service reimbursement system. Expanding access to prospective payments, capitation arrangements, and other advanced payment mechanisms will help alleviate persistent cash flow constraints. This will give ACOs the financial stability needed to invest confidently in care management infrastructure, technology, workforce, and enhanced beneficiary services.
- *Leverage ACOs to Fight Fraud.* ACOs are on the front lines of identifying and mitigating fraud, waste, and abuse and should not be held financially accountable for fraudulent or inappropriate spending that falls outside their operational control. Expanding access to enhanced network management tools and pre-payment claims review capabilities will allow ACOs to identify inappropriate utilization, fraud, waste, and abuse earlier in the care delivery process while helping ACOs manage financial risk more proactively.
- *Remove Burdensome Quality Reporting Requirements.* Quality measurement should be streamlined to emphasize measures that are meaningful, actionable, and aligned across programs, while minimizing administrative complexity. Clinicians in APMs should not be required to adopt burdensome MIPS requirements. Congress can also support a more streamlined transition to digital quality measurement by passing the Health Care Efficiency Through Flexibility Act (H.R. 5347), which tests new digital reporting methods while maintaining existing reporting options during the transition to digital quality. This will allow clinicians to redirect resources to care delivery innovation rather than compliance.

CONCULSION

Thank you for holding this hearing on improving Medicare's physician payment system. 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. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,

Emily D. Brower
President and CEO
NAACOS