August 21, 2026

The Honorable Greg Murphy
Co-Chair, Republican Doctors Caucus
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce
Co-Chair, Republican Doctors Caucus
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier
Chair, Democratic Doctors Caucus
1110 Longworth House Office Building
Washington, DC 20515

Re: Patients First Act

Dear Doctors Murphy, Joyce, and Schrier:

On behalf of the National Association of Accountable Care Organizations (NAACOS), thank you for your leadership in developing the Patients First Act and for your continued commitment to strengthening Medicare's physician payment system and advancing accountable care. NAACOS is a member-led and member-governed nonprofit organization representing nearly 500 accountable care organizations (ACOs) and value-based care entities serving nearly 10 million beneficiary lives across Medicare, Medicaid, and commercial insurance. Our members are committed to improving quality, enhancing patient outcomes, and reducing costs through accountable care.

ACCOUNTABLE CARE IMPROVES QUALITY AND REDUCES COSTS

The Medicare Access and CHIP Reauthorization Act (MACRA) was enacted to accelerate Medicare's transition from volume-based reimbursement to value-based reimbursement by encouraging physicians to take on downside financial risk in Advanced Alternative Payment Models (AAPMs). These models emphasize prevention, care coordination, and better patient outcomes rather than the volume of services delivered. This enables providers to proactively manage chronic conditions, reduce unnecessary utilization, and focus on whole-person care.

MACRA's incentive payments have been instrumental in advancing this shift, particularly through growth in ACOs. Since the law's enactment, the number of clinicians participating in AAPMs increased by over 400 percent. As a result, more than half of traditional Medicare beneficiaries receive care through an accountable care arrangement. These payment arrangements are growing beyond Medicare and

across the health care system, with nearly 45 percent of all health care payments tied to models with downside risk.

AAPM incentive payments are used by practices 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 have delivered meaningful results for patients and taxpayers alike. ACOs have generated more than **$37.4 billion** in gross savings while improving care quality for seniors in Medicare. Over the last 10 years, average savings per ACO beneficiary have grown from $77 to more than $700 as practices have expanded investments in population health. These benefits are especially evident for Medicare beneficiaries with complex health needs. For example, a senior with multiple chronic conditions receiving coordinated care through an ACO could generate nearly $40,000 in savings for Medicare while reducing their own out-of-pocket costs by nearly $2,000.[1]

As Congress considers long-term physician payment reforms, policymakers should prioritize reforms that support payment models that improve outcomes, strengthen care delivery, and generate savings for Medicare.

SUPPORTING ACCOUNTABLE CARE THROUGH PHYSICIAN PAYMENT REFORM

MACRA was passed to create a more sustainable physician payment system that encourages and rewards clinicians for taking on greater accountability. While MACRA represented an important step forward, Medicare's physician payment system still fails to adequately account for rising practice costs and inflationary pressures. Additionally, MACRA's incentives were structured in a way that does not consistently encourage all clinicians to move into AAPMs.

Patients First Act

The Patients First Act is an encouraging first step that includes several important reforms that will help protect patient access to high-quality care and strengthen Medicare's transition to accountable care, including:

- **Providing Inflationary Payment Updates and Addressing Budget Neutrality.** NAACOS remains concerned that recurring physician payment cuts threaten beneficiary access to care and undermine investments in accountable care. The Patients First Act moves Medicare physician payment rates towards inflation-based payment updates and increases the budget neutrality threshold. These reforms will provide greater payment stability and support long-term investments in care transformation.
- **Continuing Incentives for Risk-Bearing APMs.** The Patients First Act appropriately recognizes that physicians and other clinicians participating in AAPMs take on additional financial accountability and invest in population health infrastructure that improves patient outcomes.

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

We believe Medicare incentives should remain strongest for clinicians in AAPMs and appreciate the bill's continued higher payment updates for clinicians participating in risk-bearing models.

- **Freezing Qualifying Participant Thresholds.** We support the bill's proposal to freeze Qualifying Participant (QP) thresholds for three years and provide the Centers for Medicare and Medicaid Services (CMS) with authority to establish future thresholds. MACRA's statutory thresholds have increasingly become a barrier to participation and do not reflect how ACOs and other AAPMs operate in practice, particularly for organizations seeking to integrate specialists and other providers across the continuum of care into accountable care arrangements.
- **Establishing Innovation Center Transparency and Stakeholder Engagement.** We support the Patients First Act's requirement for notice-and-comment rulemaking for mandatory Innovation Center models and significant model changes. Greater transparency and stakeholder engagement will be particularly important for organizations who make multi-year commitments to support the federal government in testing new payment approaches while preserving the Innovation Center's ability to test and scale successful payment reforms.

Aligning Payment Incentives

While the Patients First Act establishes a strong foundation for long-term physician payment reform, additional short-term support is needed to sustain participation in AAPMs. The expiration of Medicare's AAPM incentive payment after 2026 will weaken the financial incentive for clinicians to take on downside risk. Under the proposed payment system outlined in the Patients First Act, there is a stronger short-term financial incentive to remain in the Merit-based Incentive Payment System (MIPS), or the new Patient Outcome Improvement National Tabulation System (POINTS), because the maximum payment adjustments will be higher than the annual growth of the AAPM conversion factor until the early 2030s.

Without stronger financial incentives to join and remain in AAPMs, some clinicians may determine that staying outside these models is more financially advantageous, undermining Congress' goal of accelerating the transition to accountable care. To support continued participation in AAPMs during the transition to the new physician payment framework, **NAACOS urges Congress to retain and strengthen AAPM incentives by restoring an AAPM incentive with modifications to address long-standing challenges.** These policies would help ensure that participation in AAPMs remains a more attractive financial option and reinforces Medicare's long-term commitment to accountable care.

Primary Care Hybrid Payments

NAACOS appreciates that the Patients First Act seeks to increase investment in comprehensive primary care while reducing reliance on fee-for-service reimbursement. At the same time, we are concerned that the proposed definition of an "excluded practice" could unintentionally prevent many physician-led independent practices from participating simply because they rely on ACOs, clinically integrated networks, independent practice associations, or other organizations for administrative assistance, analytics, care management services, or contracting support. As drafted, the bill would likely exclude most primary care practices as approximately 77 percent of primary care clinicians participate in an ACO.[2]

[2] https://www.medpac.gov/wp-content/uploads/2026/07/July2026_MedPAC_DataBook_Sec5_SEC.pdf

We recommend clarifying that affiliation with an ACO does not constitute "de facto control" provided physicians retain ownership, governance authority, and independent clinical decision-making. This clarification is particularly important because many small and independent practices rely on partnerships with ACOs to successfully participate in both Medicare APMs and accountable care payment arrangements across payers. If organizations that negotiate or administer contracts on behalf of physician-owned practices are deemed to exercise prohibited control, the legislation could inadvertently undermine years of federal efforts to promote APM adoption across Medicare, Medicaid, Medicare Advantage (MA), and commercial payment models.

These concerns are especially acute in rural and underserved communities, where physician practices often operate on thin margins and face significant workforce and financial challenges. In many cases, partnerships with ACOs, health systems, or other value-based care organizations are essential to maintaining practice viability and preserving access to local primary care. Excluding practices solely because they receive support through these arrangements could reduce primary care capacity and further limit access to care for Medicare beneficiaries in already underserved areas.

Aligning Quality Reporting Requirements

As Congress proposes transitioning from MIPS to the POINTS framework, policymakers should ensure administrative burden is reduced rather than simply shifted from one program to another. Many clinicians participating in accountable care models continue to face overlapping quality reporting requirements despite already being evaluated through robust quality and accountability frameworks within the model. This duplicative reporting creates unnecessary administrative burden without improving quality measurement, accountability, or patient outcomes. Congress should clarify that clinicians in accountable care arrangements are exempt from all MIPS or POINTS reporting requirements if they are meeting quality-reporting obligations through their APM.

Similarly, ACOs should be permitted to satisfy applicable reporting requirements through data submitted by the ACO on behalf of participating clinicians rather than requiring duplicative reporting at the individual clinician level. Aligning reporting requirements would better reflect the team-based nature of accountable care and reduce unnecessary compliance costs. These targeted statutory updates would reinforce the original intent of MACRA by recognizing APMs as Medicare's primary vehicle for measuring and rewarding value.

MODERNIZE ACCOUNTABLE CARE

Investing in Medicare's transition to accountable care remains one of the most effective strategies for improving care coordination, enhancing quality, and generating long-term savings for the Medicare program. Policymakers should continue to strengthen incentives for providers to participate in accountable care models that hold clinicians responsible for both the cost and quality of care.

Congress and CMS have taken important steps in recent years to improve the sustainability and effectiveness of these payment models. Looking ahead, policymakers should build on this momentum by modernizing the program and models to:

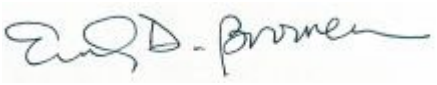
- **Ensure long-term sustainability** by addressing the benchmark ratchet effects that disadvantage high-performing ACOs that lower costs, as well as developing targeted benchmarks for certain populations, such as the high-needs benchmark included in CMMI ACO models. This also includes establishing predictable safeguards to protect clinicians from fraud, waste, and abuse outside their control. Additionally, removing incentive payments from MA benchmarks or requiring that incentives incorporated into MA benchmarks be used to support the expansion of risk-based payment arrangements.
- **Reduce administrative burden** by supporting a smooth transition to electronic clinical quality measures (eCQMs), piloting the use of digital quality measures (dQMs), and improving beneficiary education and support for ACO participation and provider choice.
- **Promote innovation in accountable care** by allowing ACOs to reduce or eliminate beneficiary cost-sharing, advancing primary care capitation opportunities, expanding beneficiary assignment to include patients receiving primary care from ACO-participating advanced practice clinicians, strengthening specialist engagement, and supporting technology-enabled care.

Together, these policies would strengthen the long-term viability of Medicare ACOs, expand participation, and accelerate the transition to higher-value care.

CONCLUSION

Thank you for the opportunity to share feedback on the Patients First Act. 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 apittman@naacos.com.

Sincerely,



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