



Written Testimony of

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Payment Reforms”

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## **I. Introduction**

Chairman Griffith, Ranking Member DeGette, and members of the subcommittee. Thank you for the opportunity to testify at this hearing on Medicare payment reforms.

My name is Dr. Farzad Mostashari. I am the co-founder and CEO of Aledade. I am also the former National Coordinator for Health IT at the Department of Health and Human Services, and served as a distinguished expert at the Brookings Institute's Engelberg Center for HealthCare Reform. Prior to my work at the Office of the National Coordinator, I founded the NYC Primary Care Information Project.

Aledade is a physician-led public benefit corporation and national leader in value-based care. We help primary care organizations deliver better patient outcomes and thrive financially by keeping people healthy. Through our accountable care organizations, over 3,000 primary care partners in 46 states and the District of Columbia share in the rewards of improved care for over 3 million patients — supported by advanced insights, AI-driven technology, personal coaching, policy expertise and 200+ value-based contracts.

*We work with primary care organizations in every state represented by members of this Subcommittee. We value this Committee's continued leadership and commitment to advancing long-term policies that strengthen Medicare. My testimony today is based on the evidence and experience we have accumulated at Aledade from over a decade working with these organizations.*

### **1. Restore the original intent of the MACRA statute**

The purpose of the original MACRA framework was to provide both carrots and sticks to encourage practices to join Advanced Alternative Payment Models (AAPMs) instead of remaining in fee for service. To accomplish this, Congress created a bonus for practices that joined an AAPM and made the transition to value based care.

Unfortunately, the implementation of MACRA has played out very differently than Congress had hoped. Most practices do not see a stark difference between FFS and AAPMs. There are two reasons for this. First, the implementation of MIPS has not been consistent with Congressional intent. CMS has been reluctant to significantly penalize lower performing practices so MIPS has neither driven care improvements nor provided an incentive for practices to leave FFS. At the same time, CMS has diminished some of the advantages of participating in AAPMs. For example, even

though Congress explicitly exempted AAPMs from MIPS quality reporting, CMS now requires all MSSP ACOs to meet the MIPS Promoting Interoperability quality reporting requirements.

To restore the original vision of MACRA, Congress should fix the AAPM bonus and instruct CMS to accentuate the advantages of joining AAPMs, rather than making AAPMs more like MIPS.

- **Fix and Extend the Advanced APM (AAPM) Bonus:** It is very important that Congress maintain a policy favoring AAPMs to send a clear and strong signal to practices across the country that AAPMs are the better path for them and their patients. But if Congress truly wants to catalyze behavior change, the bonus has to be paid much more timely. We suggest Congress focus on rewarding practices for bringing *new* Medicare beneficiaries to their ACOs. Practices should be paid a one-time, "site-neutral" flat fee paid quarterly based on the number of Medicare FFS beneficiaries newly assigned to them. This would be a more targeted bonus that would save Medicare money while better incentivizing AAPM participation. It would directly incentivize existing ACOs to grow and new ACOs to form; it also would create a continuous incentive system that avoids arbitrary thresholds. We also support the differential fee schedule adjustment, which will increase the value of AAPM participation as it compounds over time. However, that extra revenue should be excluded from ACO benchmarks, just as Congress did with the AAPM bonus.
- **Reduce the quality reporting burden in MSSP:** ACOs are now required to report quality data on every patient seen by participating practices, instead of focusing on the Medicare patients the program is intended to benefit. In addition to increasing the expense and reducing the accuracy of reporting, this policy will discourage specialist participation. For example, it makes no sense to require dermatologists to have records of depression screening when all the patient wants is a wart removed. At the same time, for the most financially advantageous reporting method CMS restricts ACOs to EHR-only data sources, meaning practices that have invested in Health Information Exchanges and modern interoperable systems cannot use that richer, more accurate data in their quality reports. The result is that ACOs are spending more and money to send CMS less accurate information, mostly for non-Medicare patients. Congress should direct CMS to return quality measurement to a well-designed sample of Medicare beneficiaries and accept data from modern interoperable sources.
- **Create an "ACO Lite" standard in MIPS:** As part of MACRA reform, all primary care practices not in ACOs should be assigned to virtual groups and be held to the same cost standard as an ACO using MSSP-style benchmarks. (The concept of "virtual groups" was created in the original MACRA statute but has seen limited use.) This would introduce to MIPS a more accurate and meaningful measure of costs. And, once practices realize that success in controlling costs earns higher rewards in MSSP than in the Merit-based Incentive Payment System (MIPS), many more will voluntarily seek to join an ACO.

## 2. Congress was correct to encourage AAPMs in MACRA; MSSP is a success

When Congress passed MACRA in 2015, the hope was that AAPMs would be successful in providing better care at lower cost to Medicare beneficiaries. The good news is that it has come to fruition in MSSP. Today, ACOs are the largest and most established alternative payment models in Medicare. There are more than 580 ACOs coordinating care for over 13 million beneficiaries, meaning half of all traditional Medicare beneficiaries now receive care through an ACO.

These financial achievements are driven by lower cost growth among beneficiaries aligned to ACOs compared to those in unmanaged fee-for-service (FFS). Since 2018, the cost growth for beneficiaries in MSSP has been considerably less than the cost growth for non-aligned beneficiaries. By 2024, the difference between the two groups reached 18.5%<sup>1</sup>. This translates to \$63.7 billion in reduced cumulative Medicare spending over the last six years. Furthermore, value-based care translates directly to individual patient savings.

Crucially, these savings reflect real improvements for patients. In 2024, MSSP helped avoid over 400,000 hospitalizations<sup>2</sup>. ACOs also performed significantly better than comparable non ACO groups in controlling blood pressure—the single quality improvement strategy that saves the most lives—and in managing A1c levels<sup>3,4</sup>. They also consistently score higher in ensuring patients receive timely care and appointments. As Chris Klomp, the Deputy Administrator at CMS, recently stated, “...accountable relationships outperform on virtually every single quality metric that we track at the Center for Medicare.”<sup>5</sup>

These savings also extend beyond traditional Medicare. Because Medicare Advantage benchmarks are calculated relative to traditional Medicare spending in each county, every dollar saved by MSSP ACOs translates directly into lower MA benchmarks — and lower costs to taxpayers across the entire Medicare program. ACOs in traditional Medicare are not just improving care for their own patients; they are reducing costs for every Medicare beneficiary in their community, regardless of whether that beneficiary is in traditional Medicare or a Medicare Advantage plan.

### **3. Incentivizing MSSP ACOs to generate greater savings**

The aggregate gross savings in MSSP are approaching 5% of total cost of care<sup>6</sup> — remarkable for a voluntary, physician-led program. But measuring savings against CMS benchmarks may understate the true performance in MSSP because a series of MSSP policies (e.g., ratchets, rebasing, ACPT) operate to drive the benchmarks lower than the true spending level that would occur in the absence of ACOs. To

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<sup>1</sup> <https://www.naacos.com/naacos-recommends-improvements-to-the-medicare-shared-savings-program/>

<sup>2</sup> <https://aledade.com/policy-institute/mssp-fast-facts>

<sup>3</sup> <https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf>

<sup>4</sup> [https://www.ajpmonline.org/article/S0749-3797\(10\)00207-2/fulltext](https://www.ajpmonline.org/article/S0749-3797(10)00207-2/fulltext)

<sup>5</sup> <https://www.healthtechnerds.com/p/chris-klomp-joins-htn-to-discuss-the-2027-ma-final-notice>

<sup>6</sup> <https://accountableforhealth.org/accountability-delivered-in-medicare-shared-savings-program-results-from-2024/>

create a true transition to value based care, a few targeted policy adjustments would ensure that ACOs are rewarded for long-term performance rather than penalized for their own success.

- **Eliminate Ratchets:** When an ACO reduces spending in its community, it partially lowers its own future benchmark; we call this the “rural glitch” because it particularly hurts ACOs in rural communities. To mitigate this, CMS established the Accountable Care Prospective Trend (ACPT), which has heavily underestimated national Medicare cost growth and failed to live up to its promise. For example, CMS established the 2024 ACPT at 4.9%, but actual costs grew by 9.5% largely due to unforeseen spending on Part B skin substitutes.<sup>7</sup> ACOs had cost growth over 2 percentage points lower than the nation (7.1%), but instead of sharing savings, they were penalized. In 2025, CMS again set an ACPT that was below actual Medicare cost growth. We believe that CMS must zero out the ACPT for 2025 and 2026<sup>8</sup>.
- **Fix rebasing to allow a true, long-term transition:** Currently, when an ACO is rebased at the end of a five year contract, CMS policies allow that ACO to retain only 5% of their accrued savings. For example, an Aledade ACO in Louisiana saved Medicare \$23 million in 2024 by keeping costs 17.3% below their benchmark. This ACO had stellar patient outcomes, ranking number one in the nation in receiving timely care and possessing the highest CAHPS (patient experience) score of any ACO nationwide. This is precisely the type of ACO CMS should encourage to grow. Nine years of investment, community-level results, and the highest patient experience scores in the nation. Yet current rebasing policy slashed their revenue by 65% in 2025 — an unintended consequence that, if corrected, would signal to thousands of similar practices that long-term commitment is worth making. Congress should direct CMS to amend its rebasing policies on regional efficiency and/or prior shared savings to support a sustained transition to value based care and lift its 5% cap to 15%.
- **Measure performance locally:** CMS is making a fundamental mistake by increasingly relying on national data to measure the performance of ACOs in disparate communities across the country. Comparing Medicare costs in Los Angeles to Medicare costs in Little Rock doesn’t spur local doctors to innovate, it spurs the health systems in both places to consolidate. CMS must return to using full regional trend factors based on Hospital Referral Regions (HRRs).
- **Improve Cash Flow:** MSSP can help stabilize the finances of primary care practices that are enduring very precarious financial conditions.<sup>9</sup> However, the MSSP can take nearly two years for a practice to see shared savings revenue after making upfront investments. CMS created a Prepaid Shared Savings option, but the regulatory requirements were so overwhelming that only four out of roughly 400 eligible ACOs qualified in 2026. Congress should instruct CMS to eliminate these suffocating regulations and expand capitation options to allow ACOs to invest with greater confidence.

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<sup>7</sup> <https://oig.hhs.gov/reports/all/2025/medicare-part-b-payment-trends-for-skin-substitutes-raise-major-concerns-about-fraud-waste-and-abuse/>

<sup>8</sup> <https://www.modernizeacos.org/fixacptnow/>

<sup>9</sup> <https://docs.house.gov/meetings/IF/IF14/20260318/119075/HHRG-119-IF14-Wstate-MartinR-20260318.pdf>

- **Empower ACOs to Fight Fraud:** ACOs are uniquely positioned to monitor Medicare claims and identify suspicious billing patterns. ACOs provided the early warnings when catheter fraud<sup>10</sup> appeared in Medicare and when spending on skin substitutes<sup>11</sup> started to grow exponentially. CMS should enlist ACOs as full partners by allowing them to conduct pre-payment claim reviews and submit suspect cases to Medicare Administrative Contractors. Furthermore, ACOs must be held harmless and have fraudulent costs removed from their performance year calculations to create stronger financial alignment.

Thank you for holding this hearing. The foundation is already built. More than 580 ACOs, 13 million beneficiaries, \$63 billion in savings — this program has proven it works and delivers long-term enduring results for Americans. With targeted refinements that restore the original vision for MACRA to drive participation in AAPMs and to build a long-term economic case for alternative models, we can bring the other half of traditional Medicare into accountable care and realize Medicare's full potential for patients and the trust funds. We welcome the Committee's partnership in getting there.

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<sup>10</sup> <https://www.nytimes.com/2024/02/09/health/medicare-billing-scam-catheters.html>

<sup>11</sup> <https://www.nytimes.com/2025/04/10/health/skin-substitutes-medicare-costs.html>