June 10, 2025

The Centers for Medicare and Medicaid Services (CMS) released a request for information (RFI) seeking public input on opportunities to streamline regulations and reduce administrative burdens in the Medicare program. The following responses were submitted by NAACOS through the RFI portal.

RE: Unleashing Prosperity Through Deregulation of the Medicare Program RFI
Submitted electronically to: https://www.cms.gov/medicare-regulatory-relief-rfi

Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to this request for information (RFI) on deregulation of the Medicare program. NAACOS is a member-led and member-owned nonprofit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve quality of care for patients and reduce health care costs. Collectively, our members are accountable for the care of over 9.5 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and Direct Contracting/ACO REACH.

Participation in accountable care enables clinicians, health systems, and other providers to implement innovations in care delivery that keep patients healthy, better manage chronic conditions, and eliminate unnecessary care. By design, ACOs and other alternative payment models (APMs) offer financial and nonfinancial incentives for participation. The strongest nonfinancial incentives have been freedom from regulatory burdens of fee-for-service; however, in recent years the Centers for Medicare and Medicaid Services (CMS) began to reinstate some of the regulatory burden on ACOs and other APMs. We strongly support your focus on deregulation and recommend that you reduce regulatory burden in MSSP by:

- Restoring prior benchmark approaches
- Employing a quality reporting approach that leverages data in a streamlined manner
- Eliminating redundant beneficiary communications
- Improving the use of data to support whole-person care
- Standardizing waivers and simplifying implementation requirements to drive innovation

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Restoring Prior Benchmark Approaches
Regulations cited: 42 CFR 425.652(b)

CMS established the Accountable Care Prospective Trend (ACPT) to address benchmark ratchets, where ACOs are penalized for their prior success and ongoing growth of the program. While well-intentioned, this policy lacks guardrails to account for times when projected trends vary significantly from actual spending. As with Medicare Advantage, CMS should establish policies to correct inaccurate trend predictions. Specifically, CMS should ensure that application of the ACPT is not worse than the prior approach using a blend of national and regional trends to update benchmarks.

While CMS explores policies to place guardrails on the ACPT, it should use its existing authority to reweight the ACPT to 0 percent for the 2024 and 2025 performance years. The 2024 ACPT estimated Medicare cost growth to be 4.9 percent, however, actual growth was nearly double (8 percent). This means that the ACPT will artificially and unfairly reduce ACO benchmarks by 1.03 percent, which, for the average ACO, could reduce revenue from shared savings by 25 percent. Significantly underfunding ACOs will force ACOs to reconsider their approaches for managing patients, reducing the burden of chronic illness, and providing patients with services that promote wellness but are not typically covered by Medicare.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers?

Beneficiary Communications and Engagement
Regulations cited: 42 CFR 425.312, 42 CFR 425.20, 42 CFR 422.2260, 42 CFR 425.402(e)

Accountable care is built on the foundation of strong patient-provider relationships. Current regulations in the MSSP hamper ACO providers' ability to effectively communicate with beneficiaries about accountable care. Rigid beneficiary notification requirements add cost and burden to ACO participants and have caused confusion and frustration for Medicare beneficiaries, in direct contrast with the intention of the requirements. Revising duplicative, complex, and burdensome requirements will help foster patient-provider relationships while improving beneficiaries' understanding of accountable care. To eliminate unnecessary burden and improve patient engagement and education, NAACOS recommends:

- Eliminating the follow-up communication requirement for beneficiary notifications, removing language at 42 CFR 425.312(a)(2)(v), and modifying language at 42 CFR 425.312(a)(2) to vastly simplify overall beneficiary notification requirements to alleviate beneficiary confusion. ACOs know their patients best and should have flexibility in how they communicate with patients.
- Creating parity between marketing rules for ACOs and Medicare Advantage (MA) by modifying the definition of "Marketing materials and activities" for ACOs at 42 CFR 425.20 to align with the intent and content standards for MA plans under the definition of "Marketing" at 42 CFR 422.2260, which would enable ACOs to create more educational resources for beneficiaries.
- Streamline the approach for voluntary alignment to make it a more useful tool for increasing beneficiary engagement and fostering patient choice. This includes aligning the MSSP approach with signed voluntary alignment in REACH by removing the language at 42 CFR 425.402(e) that restricts voluntary alignment to an electronic designation. While the authorizing statutory language does reference "electronic designation," we believe CMS can go beyond the current Medicare.gov-based approach to empower beneficiaries to choose a primary clinician.

Additionally, we recommend allowing ACO providers to discuss voluntary alignment with patients who are homebound or reside in a long-term care facility, which is currently prohibited by the ACO REACH Participation Agreement.

Topic 2: Opportunities to Reduce Burden of Reporting and Documentation

2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

Quality Reporting Burden
Regulations cited: 42 CFR 425.512, 42 CFR 425.508, 42 CFR 425.510, 42 CFR 425.506(f), 42 CFR 425.507, 42 CFR 414.1415(a), 42 CFR 414.1305

Reduce burden of ACO quality reporting by focusing on the progression to digital quality rather than interim steps
CMS' current quality reporting requirements for MSSP ACOs add significant administrative burden without additional value and force ACOs to make investments in infrastructure that will be wasted as ACOs would otherwise be transitioning to the HL7 Fast Healthcare Interoperability Resources (FHIR) standard. The mandatory transition to ACO clinical quality measure (CQM) reporting is burdensome and does not move ACOs closer to true digital quality measurement (dQM) that accurately represents quality of care and provides actionable insights for quality improvement. To alleviate these burdens:

- Modify language under 42 CFR 425.512(a)(2) and 42 CFR 425.512(a)(5) to retain access to all existing ACO reporting options, including Web Interface reporting, during the transition to dQM, which will require appropriate industry-readiness.
- Modify language under 42 CFR 425.508(c) and 42 CFR 425.510(b) to ensure ACOs are not required to report on any new measures during the transition to dQM to allow time for electronic health record (EHR) vendors to ensure technical capabilities and workflows are in place.

ACOs have a desire to see more digital measurement approaches incorporated into quality reporting. An efficient, technology-enabled future where data can be shared bi-directionally to better inform patient care is the future state many in the health care industry want to achieve. Digital measurement should allow for seamless quality reporting that reduces burden and provides real-time performance data that can be used to improve patient care. ACOs are working towards efficient, technology-enabled quality reporting. By correcting the additional regulatory burdens that have been placed on ACOs to implement CQM reporting options, CMS can more quickly and efficiently make the transition to dQM.

Remove flawed and burdensome MIPS requirements from APM participants
Significant burden associated with MSSP quality reporting has been created by CMS' efforts to align it with the incredibly flawed and complex Merit-based Incentive Payment System (MIPS). This is counter to the congressional intent of the Medicare Access and CHIP Reauthorization Act (MACRA), which sought to exempt physicians and other clinicians who meaningfully participate in APMs from burdensome MIPS requirements. Additionally, regulation text has not been consistently updated under the MSSP regulations at 42 CFR 425 and MIPS regulations at 42 CFR Part 414 Subpart O, further exacerbating confusion and burden for participants. The following burdensome requirements that were implemented to align with MIPS should be corrected:

- *All-patient all-payer reporting.* Modify text under 42 CFR 425.508, 42 CFR 425.510, and 42 CFR 425.512 such that ACO quality performance is assessed for ACO assigned beneficiaries, which is

the population for whom ACOs agree to take on accountability for managing the cost and quality of care for. This requirement inadvertently penalizes ACOs with specialist participants by requiring reporting and assessment of all-payer and all-patient data rather than focusing on ACO-assigned patients. As a result, specialists in the ACO are held accountable for primary care measures that are not clinically appropriate. For example, dermatologists in the ACO would be required to assess and do follow-up on depression screenings, which would not be clinically appropriate. Ultimately this would lead to artificially lowering the ACO's quality score and assessing ACOs based on the case-mix of their population and the proportion of specialists in the ACO.

- *Certified Electronic Health Record Technology (CEHRT) attestation.* Remove 42 CFR 425.507 from MSSP regulations. Modify text under 42 CFR 425.506(f), 42 CFR 414.1415(a), and the definition of "Certified Electronic Health Record Technology (CEHRT)" under 42 CFR 414.1305 to revert to the previous approach using a simplified attestation. Recently, CMS required ACOs and their participants to report MIPS Promoting Interoperability (PI). This significantly increases burden without any added value and jeopardizes participation in MSSP, particularly for small practices. CMS has also failed to publish appropriate guidance on how to comply with the new requirements in a timely fashion, further increasing burdens.

Any future efforts to align requirements across Medicare programs should instead align individual clinician requirements with those for APMs to encourage clinicians to participate in models that include accountability for quality and cost of care.

2B. Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

Waivers and Innovation
Regulations cited: 425.612

Waivers offer APM participants unique opportunities to innovate care delivery and create a strong nonfinancial incentive to participate. Waivers available to MSSP ACOs have been limited to-date, hampering potential innovations in the permanent program. Further, arduous documentation and implementation requirements to utilize waivers have hindered their use. To unlock innovation in Medicare's value models, CMS should:

- Implement all Innovation Center waivers in MSSP and allow a process for APM participants to recommend and test new waivers.
- Simplify required reporting for waiver implementation and use.
- Allow ACOs to select subpopulations for which to implement waivers.
- Expand access to primary care capitation in MSSP by simplifying the payment approach from what is in the ACO Primary Care Flex Model and allowing all MSSP ACOs the option to elect primary care capitation and shift the underlying payment mechanism away from fee-for-service.
- More closely align APM waivers with MA flexibilities; for example, by waiving the scheduling restriction on Annual Wellness Visits (AWVs) and instead allowing AWVs to be scheduled once per calendar year.

Data and Reporting
Regulations cited: 42 CFR 425.708(c), 42 CFR 425.702(c)(1)(ii), 42 CFR 425.118

Complexities in reporting requirements and data sharing regulations for ACOs create additional burden for providers who are working to create efficiencies in Medicare. Managing populations requires access to data to understand patient health needs and analyze trends in utilization, cost, and quality. More efficient requirements around data exchange and reporting requirements for ACOs would reduce burden and improve integration of care, which can be achieved by:

- Removing 42 CFR 425.708(c), which restricts secure sharing of substance use disorder (SUD) claims data, despite Congress' efforts to align 42 CFR Part 2 with Health Insurance Portability and Accountability Act (HIPAA) through Section 3221 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). CMS currently excludes these data from the Claim and Claim Line Feed (CCLF) files ACOs receive, which creates barriers to providing coordinated, integrated behavioral health care.
- Modifying text under 42 CFR 425.702(c)(1)(ii) to expand Medicare data available to ACO participants, regardless of attribution methodology, on assignable fee-for-service beneficiaries to facilitate population health activities and accurate benchmarking and provider evaluation.
- Eliminating the ACO public reporting requirement under 42 CFR 425.308 as it is duplicative and instead require ACOs to link to publicly available data from CMS.
- Removing the monthly ACO provider/supplier reporting requirement under 42 CRF 425.118(c), which does not change CMS provider records under Provider Enrollment, Chain and Ownership System (PECOS), is duplicative with the requirement at 42 CFR 425.118(d), and offers no benefit while creating unnecessary burden.