January 26, 2026

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 the National Association of ACOs (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 the Deregulation of the Medicare Program Request for Information (RFI). NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) and value-based care (VBC) entities in Medicare, Medicaid, and commercial insurance working on behalf of physicians, health systems, and other providers across the nation to improve quality of care for patients and reduce health care costs. NAACOS represents more than 10 million beneficiary lives through Medicare's population health-focused payment and delivery models, such as the Medicare Shared Savings Program (MSSP), the ACO Realizing Equity, Access, and Community Health (REACH) Model, and specialty care models, along with other alternative payment models (APMs). Beyond Medicare, our members participate in accountable care arrangements across payers, including Medicaid and Medicare Advantage (MA) programs.

The Centers for Medicare and Medicaid Services (CMS) seeks input on approaches to streamline regulations and reduce administrative burden on providers and other stakeholders participating in the Medicare program. NAACOS supports CMS' focus on deregulation and creating a more efficient health care system. Reducing administrative burden enables providers to participate in accountable care more efficiently, allowing more focus on implementing innovations in care delivery that keep patients healthy, better manage chronic conditions, and eliminate unnecessary care. VBC providers routinely participate in risk arrangements across multiple payers. Expanding VBC arrangements in MA strengthens the shift toward payments based on outcomes and quality rather than volume. NAACOS has previously submitted broad comments on deregulation to a RFI coordinated by the Office of Management and Budget. Our comments below focus on MA.

CMS should use its position and authority to drive alignment and standardization across payers by providing access to comprehensive MA data sets. Many providers do not have sufficient information about their MA-enrolled patients. For those that manage risk in MA, this is particularly challenging, as predictability and transparency are key to transforming care delivery and implementing meaningful and actionable interventions. To make data sets more accessible and usable to providers, we ask that CMS require plans to report accurate and timely MA network data, particularly on network adequacy and in- and out-of-network providers, in standardized file formats that are easily accessible, updated, and digestible for providers.

CMS should create a seamless pathway for providers to remain in risk-bearing arrangements while exploring short-term solutions and long-term improvements. To do this, **CMS should collect data to understand the structure of provider incentives and implications for downstream provider payments in MA risk arrangements.** Sustainability of successful models and predictability in financial benchmarks are essential to sustaining and retaining providers in VBC models.

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

Quality Measures and Reporting
CMS should align quality measures and methodologies between ACOs and MA plans, where appropriate. This will alleviate the administrative burden on providers in VBC arrangements across payers. Specifically, CMS should collaborate with payers and providers in VBC arrangements to determine the best ways to structure measurement and data gathering so that the quality data collected could be used across multiple efforts and is shared in a timely fashion to inform real-time interventions.

As an interim step, CMS should seek greater transparency into the quality measures MA plans require reporting from providers to help identify future measure development needs and accelerate alignment across programs. Quality reporting directly influences provider payment. MA plans seeking to improve their Star Ratings frequently tie provider incentives to Star-related quality measures. However, the proliferation of disparate quality measure sets across payers, contracts, and models creates significant challenges, as each arrangement uses different metric specifications and timelines. While we appreciate the work of the Core Quality Measures Collaborative (CQMC) in developing core measure sets, adoption has been slower than anticipated.

VBC providers already rely on real-time care navigation tools and predictive analytics to close care gaps, identify early indicators of illness, and intervene before conditions worsen or unnecessary acute events occur, but the continued proliferation of quality measures makes this increasingly difficult. Electronic health records (EHRs) and digital platforms can automate the capture of HEDIS, CAHPS, and Star Ratings data across patient panels and payers, however these tools require robust, standardized data inputs to function effectively. More streamlined and consistent measurement requirements, data exchanges, and reporting would meaningfully support this work.

*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?*

Standardized Data Elements and Formats
CMS should work with MA plans to create accessible, real-time, and standardized data sets for providers in value-based arrangements. A major challenge for providers bearing financial risk in MA

contracts is the effort required to ingest multiple data formats from various health plan portals. Effective population management depends on access to timely, comprehensive data that enables providers to understand patient needs and analyze trends in utilization, cost, and quality. Standardized reporting requirements and file formats would significantly reduce administrative burden and enable providers to more effectively manage quality performance across multiple arrangements. Many provider groups and VBC entities also lack the staffing and analytic capacity to ingest disparate data sources. In contrast, traditional Medicare APMs offer standardized data feeds that even resource-limited providers can readily use.

These data sets should include full claims information, summaries of patient care, hospitalization histories, utilization data, and clinical and demographic information at both the individual and population levels, as well as prescription drug data. Standardizing data elements and formats – and aligning them across payers – would significantly improve provider experience, reduce administrative burden, and support broader adoption of VBC contracts in MA.

Reducing Platform Fragmentation

We also urge CMS to regularly coordinate with health IT vendors and health information exchanges (HIEs), ensuring systems consistently meet regulatory requirements and interoperability goals. A Providers face significant burden when required to interact with multiple portals and systems that use inconsistent formats and tools. CMS can reduce fragmentation by limiting the number of platforms practices must use and instead promote:

- Automated data feeds
- Standardized documentation
- Consistent definitions across reporting requirements

Creating an Interoperable Data Ecosystem

CMS should create an interoperable data ecosystem, where digital measurement enables seamless quality reporting that reduces burden and provides real-time performance data that can be used to improve patient care. CMS can encourage MA plans to streamline quality and data reporting so that providers can focus on quality care and not nuanced compliance requirements of each individual program, contract, or type of payer. MA risk arrangements should align with the same tech-driven, digital quality reporting standards across ACOs and other APMs.

CMS can reduce burden of accountable care quality reporting by focusing on the progression to digital quality measures rather than interim steps, including leveraging HL7 Fast Healthcare Interoperability Resources (FHIR) standard across lines of business and plans. Adopting industry exchange standards – such as FHIR with open APIs – will support automated data exchange, standardized encounter data submission, and more efficient reporting processes. These standards are foundational to building a scalable, interoperable data ecosystem that supports accountable care.

VBC entities 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.

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?*

Medicare Advantage Encounter Data

CMS has an opportunity to provide additional insights into MA through collection of aggregate data related to MA plan practices. MA encounter data reported to CMS is one of the most important data sets for insights into MA programs. However, MA encounter data is limited compared to the data available from traditional Medicare. This prohibits meaningful comparisons between traditional Medicare and MA and further disadvantages providers in payment and risk arrangement negotiations. Particularly for those providers who have committed to managing risk through advanced primary care and population health management, more robust data can support design and implementation of innovative approaches for payment models.

Over time, MA encounter data can be bolstered using the data elements outlined below:

- **National Provider Identifier (NPI)-level Data:** Encounter data needs collected and shared at the NPI level. Having populated provider identification data (e.g., NPIs for provider-level services, Tax ID Numbers, CMS Certification Numbers (CCNs) for facility-level providers) enables more accurate analyses of which providers rendered what services, utilization patterns, provider coverage, network optimization, etc. These data elements would also allow stakeholders and VBC entities to produce more accurate calculations on performance for distribution purposes.
- **In/Out-of-Network Data:** CMS should require plans to report accurate and timely MA network data, indicating whether care was rendered in or out-of-network. This insight helps to elucidate any potential challenges with network adequacy and provide more transparency about out-of-network costs.
- **CMS Physician Supplier & Beneficiary Summary Public Use File (PUF):** CMS could leverage any existing private sector data by including MA data in the PUF with separate distinctions for data provided by traditional Medicare or MA .
- **Hierarchical Condition Category (HCC) Risk Score Data:** CMS should make available beneficiary HCC risk scores for all Medicare beneficiaries in a format that can be linked to the MA encounter data. Specifically, each beneficiary's prospective risk score should be included in the Master Beneficiary Summary File (MBSF) that is part of the Research Identifiable Files (RIF) that are available for use by those with valid data use agreements with CMS. This would give users better information about the types of beneficiaries selecting MA plans and specific plan offerings. It would also provide important context for comparing populations' utilization rates across plans. It is important to make these HCC risk scores available not just for current and future years, but also historical years to support accurate analyses of MA utilization trends and track data on patients who have changed plans. Having this prior history would allow for better continuity of care and prevent delays in care coordination and interventions.
- **Cost Data:** Cost data is essential for analyzing the relative performance of MA plans compared with traditional Medicare. As a first step, CMS should add standardized prices based on traditional Medicare fee schedules. Eventually, it would be beneficial to include actual rates paid by MA plans. The addition of standardized prices would go a long way to help providers and other stakeholders accurately analyze MA plan spending, as well as leveraging MA data for predictive modeling. CMS could leverage the plan price transparency requirements to support more comprehensive and standardized information about costs in MA across agencies.
- **Part D Drug Data:** CMS should integrate pharmacy data including billing claims, pharmacy benefit details, and dispensing information. VBC providers often lack visibility into plan-level decisions – such as bids, copays, benefit designs, and manufacturer rebates – that directly shape

patient affordability and adherence. Greater transparency in these areas would give providers the insights they need to better support medication adherence and reduce avoidable patient burden and costs. CMS should also include rebate details that the current data sets do not include because this data helps providers understand beneficiary costs when rebates are applied.

- **End-of-Life Care:** CMS should require reporting of hospice data elements as some MA plans choose to carve-in hospice benefits. Data elements should include the type, volume, timing, and cost. Hospice services are an essential aspect of delivering care to Medicare beneficiaries. Including this data will help evaluate value of hospice services and whether they are meeting the needs of patients at the end of life.

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

CMS should work toward making access, format, and timeliness of MA data sets comparable to those available in traditional Medicare. Standardizing data files, including data elements and file formats, would meaningfully improve the frequency and reduce the complexity of reporting for Medicare providers by ensuring that providers receive timely, consistent data sets rather than navigating multiple, inconsistent MA data processes.

Because plans face inconsistent reporting requirements, data submissions vary widely. Although completeness has improved over time, it still does not support the growing need for real-time analytics. Key categories – such as skilled nursing facility and home health encounters – remain incomplete, leaving out critical components of patient care and undermining the reliability of data analysis. CMS should prioritize improving the accuracy of encounter data and release MA encounter files simultaneously with traditional Medicare claims. The current two-year lag prevents timely analytics, limits predictive modeling, and delays insights needed to inform program performance.

Aligning MA data with traditional Medicare, standardizing formats, and reducing lag times would streamline regulatory requirements without compromising program integrity. Providers also need real-time data feeds—including demographic and social risk factor information—to inform care decisions, identify high-risk patients, and enable timely clinical interventions. Strengthening the MA data infrastructure is essential for supporting high-quality, accountable care.

*2C. Are there documentation or reporting requirements within the Medicare program that are **overly complex or redundant**? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.*

Prior Authorization

CMS should make data methodologies, calculations, and algorithms available and fully transparent to reduce the need for repeated clarifications. Today's highly variable and opaque utilization-management practices across payers create significant administrative burden, forcing providers to navigate inconsistent rules, documentation standards, and approval processes. Transparency and standardization in the reporting processes will contribute to better care coordination, improved scheduling, clearer provider expectations, and visibility of network access patterns.

CMS should require MA plans to report all services (at the procedure code level) that require prior authorization along with indicating rates of denial. This would highlight any patterns regarding claims

denial for certain services or enrollees and inform the effectiveness and efficiency of prior authorization as a tool for utilization management. Specifically, CMS should collect the following data points:

- Total number of denials, successful overturn of denials to approvals, and any payment information,
- Total number of denials that stayed denied and received no payments for rendered services, and
- Timing of decision process from denials and approvals, appeals and overturn, and decisions leading to payment.

This data should be made publicly available to promote accountability regarding access to care.

Topic 3: Identification of Duplicative Requirements

*3A. Which specific Medicare requirements or processes do you consider **duplicative, either within the program itself, or with other healthcare programs** (including Medicaid, private insurance, and state or local requirements)?*

Supplemental Benefits

CMS should require MA plans to share supplemental benefit data and utilization in real time and in standardized formats to give providers clear, actionable insight into how these benefits are administered, including which services or items require prior authorization and how frequently they are approved or denied. Although MA plans may offer a wide range of supplemental benefits, there is currently no visibility into how often these benefits are used or whether they deliver value to beneficiaries. Given the central role supplemental benefits play in MA bids, understanding their actual impact is essential for both program oversight and beneficiary protection.

Currently, MA plans communicate these benefits inconsistently, forcing providers to independently verify eligibility, coverage rules, and check prior-authorization requirements. This creates duplicative administrative processes between payers and providers and diverts resources away from patient care. This is particularly important in VBC arrangements when providers are at risk for cost and outcomes, visibility into supplemental benefit information is needed to manage costs and add value to the patient's overall care journey.

Greater transparency around the use of supplemental benefits is also essential to prevent duplicative care-management and navigation efforts between payers and providers that could cause beneficiary confusion and work directly against efforts to keep patients engaged in their care. Making this information available – ideally stratified by beneficiary characteristics – would provide clarity on benefit availability, reduce unnecessary administrative burden, and support more effective communication and care coordination for patients.

For example, if only certain beneficiaries are eligible for telehealth or other supplemental services, providers must manually check eligibility for each patient at scheduling and again at the point of care. This delays access, increases administrative burden, adds cost, and complicates care management. Standardized, automated benefit information would allow providers to connect patients to available services more efficiently and support whole-person care.

*3B. How can **cross-agency collaboration** be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?*

Cross-Agency Collaboration

CMS should work toward harmonizing industry standards across agencies, payers, and states. Conflicting data-exchange requirements and inconsistent reporting expectations create significant challenges for providers operating VBC arrangements, particularly as more organizations take on financial risk in MA. Today, providers operating in VBC arrangements must navigate conflicting data-exchange rules, overlapping documentation requests, and inconsistent reporting formats across MA plans, state Medicaid agencies, and federal programs. These inconsistencies create unnecessary administrative burden—especially as more organizations assume financial risk in MA.

Enhanced cross-agency collaboration could include establishing uniform data-submission standards, shared audit protocols, and aligned timelines for reporting across programs. Creating a single set of expectations for data elements, file formats, and validation processes would prevent providers from having to re-submit the same information in different formats to different entities. Greater transparency – both in how risk is calculated and how VBC arrangements are structured – is essential for building trust, improving predictability, and enabling providers to sustain successful results in VBC.

*3C. How can Medicare better align its requirements with **best practices and industry standards** without imposing additional regulatory requirements, particularly in areas such as **telemedicine, transparency, digital health, and integrated care systems**?*

Transparency in Risk Scoring

NAACOS encourages CMS to work closely with MA plans to increase transparency in risk scoring. While risk scores should be incorporated into encounter data, it is equally important that providers in VBC arrangements receive timely information on risk scores and known chronic conditions for their attributed patients. VBC models rely heavily on Risk Adjustment Factor (RAF) scores to establish budgets and determine whether savings can be achieved. This system places substantial administrative burden on providers, as RAF accuracy is critical for organizations that have taken on higher levels of risk. Improving visibility into how risk scores are calculated and ensuring providers have access to this information will strengthen confidence in the system, enhance predictability, and support more equitable and accurate financial benchmarks.

Transparency in Value-Based Care Arrangements

As more providers assume risk in MA, there is a greater need for transparency in understanding VBC payment arrangements. **CMS should expand data collection and reporting on how provider payment arrangements are structured,** since a clearer understanding of contract design is essential for scaling downside risk models and enabling more sophisticated predictive analytics. Greater visibility into these models would give providers the confidence to transition into VBC and contribution to continued growth of provider-led transformation in MA.

CMS can support greater transparency by collecting and publicly reporting standardized information on VBC arrangements, including:

- The types of VBC contracts each MA plan offers and implements.
- The percentage of patients, payments, and providers participating in VBC arrangements.
- Sub-capitated or other alternative payment structures, potentially integrating this information into encounter data over time.

While voluntary reporting to the Health Care Payment Learning and Action Network (LAN) has provided some insight, CMS is uniquely positioned to standardize and expand these data. Public reporting would offer valuable feedback on how MA plans engage in VBC, the degree of provider participation, and the overall readiness of the market to take on greater levels of risk.

In the future, **CMS should consider adopting these metrics into Star Ratings, to help promote greater adoption of VBC arrangements**.

Standardizing data feeds, increasing transparency around payment arrangements, and ensuring access to comprehensive MA data sets will reduce burden and promote program and payment clarity. As providers take on more risk, transparent, timely, and consistent data becomes essential to operating effectively in MA risk arrangements.