AMERICA'S PHYSICIAN GROUPS

June 10, 2025

Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.cms.gov/medicare-regulatory-relief-rfi

Re: Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to the request for information on Unleashing Prosperity Through Deregulation of the Medicare Program. APG welcomes your agency's openness to stakeholder input and your ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's request for information (RFI), (III) a summary of APG's recommendations, (IV) our fuller comments and recommendations, and (V) our conclusion. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, person-centered health care.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

APG's motto, "Taking Responsibility for America's Health," underscores our physician groups' preference for being in risk-based, accountable, and responsible relationships with all payers, including

MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. Summary of CMS's Request for Information

On January 31, 2025, President Trump issued Executive Order (EO) 14192 "Unleashing Prosperity Through Deregulation," which encapsulates the Administration's goals of (1) significantly reducing private expenditures required to comply with federal regulations so as to (2) secure America's economic prosperity and national security and the highest possible quality of life for each citizen.[1] Through the RFI, the Centers for Medicare & Medicaid Services solicits public feedback on potential changes to Medicare regulations that would achieve these goals.

The RFI further seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, MA and Part D plans, and other stakeholders participating in the Medicare program. In line with ongoing efforts to reduce unnecessary administrative burdens and costs, and create a more efficient health care system, CMS requests information to better understand opportunities for deregulation, while also ensuring the continued delivery of high-quality care to beneficiaries.

Specifically, CMS invites responses on the following topics:

- **Streamline Regulatory Requirements:**
  - 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?
  - Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?
  - 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 providers?
- **Opportunities to Reduce Administrative Burden of Reporting and Documentation:**
  - What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?
  - Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?
  - Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones?
- **Identification of Duplicative Requirements:**

[1] https://www.whitehouse.gov/presidential-actions/2025/01/unleashing-prosperity-through-deregulation/

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

III. Summary of APG's Recommendations [will reconcile with final recs in body text]

A. Recommendations Related to Streamlining Regulatory Requirements

- **APG recommends that CMS default to consistency in waiver policies between and among programs to help reduce the confusion and undue regulatory burden providers face.**
- **APG recommends that the degree of specificity and multiplicity of documentation requirements in CMS waiver applications be reduced, particularly for provider participants that accept upside and downside financial risk and responsibility for quality of care.**
- **APG recommends that CMS consider relaxing some of the required criteria for advanced primary care management billing codes at least temporarily to allow for greater participation by smaller physician practices.**
- **APG recommends that CMS switch to a default opt-in approach to payer-to-payer data sharing when an MA enrollee changes plans, with an option for patients to opt-out.**
- **APG recommends that CMS require MA health plans to share historical claims and encounter data with new plans when individuals change their enrollment by any means available sooner than the January 1, 2027, required date to share these data through a Payer-to-Payer API.**
- **APG recommends that CMS allow providers to bill for annual wellness visits once per year rather than exactly every 365 days.**
- **APG recommends that CMS waive the one-per year limit for annual wellness visits for ACO participants that take responsibility for a patient's quality and total cost of care.**

B. Recommendations Related to Reducing Administrative Burden of Reporting and Documentation

- **APG recommends that CMS adhere to its commitment to a Universal Foundation set of parsimonious but meaningful outcomes measures; cease the introduction of new process measures; and focus instead on the development of a limited number of quality measures**

that assess health outcomes that are meaningful to patients in terms of morbidity and mortality.

- **APG recommends that CMS limit the number of new MSSP quality measures added and test new measures before making them required and scored measures for ACOs.**

- **APG strongly recommends that CMS make Medicare Clinical Quality Measures (CQMs) a permanent reporting alternative to all-payer eCQMs.**

- **APG recommends that CMS update the APM Performance Pathway (APP) provider taxonomy codes to differentiate specialists from primary care.**

- **APG strongly recommends that CMS remove the requirement that MSSP ACOs fulfill the MIPS Promoting Interoperability (PI) reporting requirements and revert to requiring MSSPs to attest to PI.**

- **APG strongly recommends that CMS provide clear guidance in sufficient time for 2026 participating group decisions and grant leniency to ACOs in 2025 and future years with provider groups that are found not to fulfill the CEHRT requirements, including avoiding all impacts on shared savings and losses.**

- **APG recommends that CMS establish a uniform, national set of standard prior authorization denial codes and require all payers to use only these codes in prior authorization processes.**

- **APG recommends that CMS reduce the frequency of MSSP provider roster change reporting from every 30 days to quarterly and provide ACOs with quarterly reports on attribution so that ACOs can ensure that their internal records match PECOS records.**

- **APG recommends that the annual requirement for Kidney Care Entities to collect signatures from all participating physicians on fee-reduction agreements be changed to: (1) a one-time submission beginning at the start of each contract period; and (2) requiring signatures only from each participating physician group's designated contact person.**

C. Recommendations Related to Identification of Duplicative Requirements

- **APG recommends that CMS provide detailed information about the proposed HCC encounter data-based calibration approach in a transparent manner in advance of the 2027 Advance Notice, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impact, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented.**

- **APG recommends that CMS alone should send beneficiary notifications and make participating groups aware of the contents of these letters.**

IV. APG's Detailed Comments and Recommendations

APG appreciates CMS's ongoing efforts to refine the Medicare program and ensure that regulations are not unduly burdensome. The agency clearly strives to be a responsible steward of the Medicare program while improving operations for beneficiaries, physicians, and other stakeholders. APG is especially grateful that CMS continues to solicit stakeholder input and incorporate this feedback into proposed policies.

APG welcomes CMS's focus on reducing policies that unnecessarily increase data collection burden. As an organization focused on value-based care, and whose members fully accept and welcome the need to measure and report on costs and quality, APG members are nonetheless aware that data collection efforts targeted at physicians are for various reasons not always justified by the reporting burden. Physicians have identified administrative burden as a top concern and asked CMS to address the issue for years. The role that the administrative burden plays in physician burnout prompts many providers to question why CMS continues to ask for input on the issue rather than taking action to address it. As one APG member, Colleen Inouye, MD, of the Hawaii Independent Physicians Association, observed, "Physicians want to take care of their patients, and they would like to enjoy it. Some of that joy has been taken away" by virtue of burdensome practices such as excessive data collection and reporting.

As CMS and Congress have adopted new ideas to improve Medicare, especially those that include data collection and reporting, the resulting policies often place additional burdens on physicians and other clinicians whose costs do not always appear to be equaled or eclipsed by the benefits achieved. As a result, physicians must hire outside consultants or expand their administrative teams to handle the additional work. As CMS develops new rules, the agency should consider the impact on providers for each new regulation, especially for smaller physician practices with relatively fewer resources. CMS should carefully consider whether each new policy will place additional burdens on providers and potentially affect patients' access to care.

Clinicians are burdened not just by policies implemented by CMS, but also by variations on policies implemented by other payers and programs. Synchronizing reporting requirements and other policies across payers should be the goal whenever possible – for example, by using the same quality measures, designing a single website that could populate every application and form that providers must complete, and implementing an all-payer claims clearinghouse.

A. Streamline Regulatory Requirements

1. Program Waivers

Under current policy, various Medicare programs employ policy waivers to encourage participation and promote better care coordination and patient outcomes. Often these waivers cover similar policies with detailed requirements but differ slightly in their application, creating undue confusion and administrative burden for participants and patients. For example, in both the Medicare Shared Savings Program (MSSP) and the Accountable Care Organization Realizing Equity, Access, and

Community Health (ACO REACH) model, the Skilled Nursing Facility (SNF) three-day rule waiver allows eligible beneficiaries to be admitted to a SNF for extended care without the standard requirement of a three-day inpatient hospital stay. CMS guidance documents for participating ACOs that wish to offer this waiver to their enrollees ranges from three pages for ACO REACH and 25 pages for MSSP.[2,3] In addition, as required by the in the 25-pages of MSSP guidance, each year ACOs must submit a SNF affiliate list; an executed SNF Affiliate Agreement; and documents including a communication plan, a care management plan, and beneficiary evaluation admission plan. Much of the content of these documents is redundant.

APG believes that creating consistent waiver details between and among programs and reducing the specificity and documentation requirements in many waiver applications offer significant opportunities to streamline regulatory requirements, especially for providers willing to accept responsibility for costs and quality and both upside and downside financial risk. These providers are already highly motivated to track many details of these arrangements closely and operate to maximize savings and quality. APG recognizes that the Innovation Center has a mandate to test new methods of providing care, but it is unclear that the minute differences between the application of the three-day waiver in the MSSP and ACO REACH models will yield meaningful results at the end of the model test. Thus, APG urges CMS to default to consistency in waiver policies between and among programs, and to reduce unnecessary complexity and specificity, to help reduce the confusion and undue regulatory burden that providers face.

In summary:

- **APG recommends that CMS default to consistency in waiver policies between and among programs to help reduce the confusion and undue regulatory burden providers face.**
- **APG recommends that the degree of specificity and multiplicity of documentation requirements in CMS waiver applications be reduced, particularly for provider participants that accept upside and downside financial risk and responsibility for quality of care.**

2. Advanced Primary Care Management Codes

In the 2025 Medicare Physician Fee Schedule Final Rule, CMS established a set of health care common procedure codes (HCPCs) to better describe advanced primary care management (APCM) services broadly; to provide more stability in payment and coding for practitioners in the context of continued evolution in advanced primary care; and to provide the agency with a mechanism for continued and intentional improvements to advanced primary care.[4] Specifically, CMS established payment rates for three new G-codes that describe a set of care management services and communication technology-based services (CTBS) furnished under a broader application of advanced primary care services (see Table 1).

[2] https://www.cms.gov/files/document/aco-reach-py25-part-pref-provider-mgmt-guide.pdf
[3] https://www.cms.gov/files/document/snf-3-day-rule-waiver-guidance.pdf
[4] https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

Table 1. APCM Bundled Codes and Valuation

Code	Short Descriptor	Crosswalk Codes	CMS Proposed Work RVU	CMS Proposed PE RVU	CMS Proposed MP RVU	CMS Proposed Full RVU	Approximate National Payment Rate
GPCM1	APCM for patients with up to one chronic condition	99490	0.17	0.14	0.01	0.31	$10
GPCM2	APCM for patients with multiple (two or more) chronic conditions	99490, 99439, 99487, 99489	0.77	0.72	0.05	1.54	$50
GPCM3	APCM for QMBs enrollees with multiple chronic conditions	Calculated as a relative increase from GPCM2	1.67	1.57	0.12	3.36	$110

* QMB (Qualified Medicare Beneficiary)

APG commends CMS for its leadership in fostering improvements in primary care and appreciates the introduction of the three new APCM billing codes. APG believes strongly that is imperative to strengthen primary health care in America and equip primary care physician practices with the tools and capabilities to move into more risk-based alternative payment models over time.

At the same time, because APG members are generally large primary and multispecialty care groups that are accomplished at operating in risk-based models (such as two-sided risk arrangements with MA plans and the more advanced alternative payment models like ACO REACH), it is unlikely that they would bill for the new APCM codes. However, because APG supports the APCM coding approach in principle, particularly for smaller physician practices, it is important to raise concerns about the degree of complexity and burden that use of such codes will impose on them – and that could thus serve as deterrents for practices to move in this direction.

CMS specifies for APCM services the practice-level characteristics and capabilities that are inherent in, and necessarily present when, a practitioner is providing covered services using an advanced primary care delivery model. As described in more detail below, included in the service descriptors for GPCM1, GPCM2, and GPCM3, CMS's practice-level capabilities that reflect care delivery using an advanced primary care model are focused on 24/7 access and continuity of care, patient population-level management, and performance measurement. CMS requires that providers must meet all the criteria enumerated in Table II below to bill APCM codes.

Table II: Criteria for Billing APCM Code

- Consent
    - Informing the patient of the availability of APCM services; of the fact that only one practitioner can furnish and be paid for these services during a calendar month; of the right to stop services at any time (effective at the end of the calendar month); and of the fact that cost sharing may apply (and/or may be covered by supplemental health coverage) [1]
    - Documenting in patient's medical record that consent was obtained
- Initiating Visit for New Patients (separately paid)
    - Initiation would occur during a qualifying visit for new patients
    - An initiating visit is not needed (1) if the beneficiary is not a new patient (has been seen by the practitioner or another practitioner in the same practice within the past three years), or (2) if the beneficiary received another care management service (APCM, CCM, or PCM) within the previous year with the practitioner or another practitioner in the same practice.
- 24/7 Access to Care and Care Continuity
    - Providing 24/7 access for urgent needs to care team/practitioner with real-time access to patient's medical information, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week
    - Affording continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
    - Delivering care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours, as appropriate
- Comprehensive Care Management
    - Overall comprehensive care management may include, as applicable, the following:
        - Systematic needs assessment (medical and psychosocial)
        - System-based approaches to ensure receipt of preventive services
        - Medication reconciliation, management and oversight of self-management
- Patient-Centered Comprehensive Care Plan
    - Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan. Such a plan will be available in timely fashion within and outside the billing practice, as appropriate, to individuals involved in the beneficiary's care. It can also be routinely accessed and updated by the patient's care team/practitioner, and a copy of the care plan can be shared with the patient and caregiver(s)
- Management of Care Transitions (for example, discharges, emergency department (ED) visit follow-up, and/or referrals, as applicable)
    - Coordination of care transitions between and among health care providers and settings, including transitions involving referrals to other clinicians, follow-up after an ED visit, or follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities, as applicable
    - Ensuring timely exchange of electronic health information with other practitioners and providers to support continuity of care.
    - Ensuring timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after ED visits and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated
- Practitioner, Home-, and Community-Based Care Coordination
    - Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and documenting in the patient's medical record of communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
- Enhanced Communication Opportunities
    - Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate
    - Ensuring access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits)
- Patient Population-Level Management
    - Analyzing patient population data to identify gaps in care and offer additional interventions, as appropriate
    - Risk-stratifying the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
    - Satisfaction of these requirements by a practitioner who is participating in an MSSP ACO; the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model; Making Care Primary, or Primary Care First
- Performance Measurement
    - Assessment of primary care quality, total cost of care, and meaningful use of CEHRT, which can be met in several ways:
        - For Merit-based Incentive Payment System (MIPS)-eligible clinicians, by registering for and reporting the Value in Primary Care MIPS Value Pathways (MVPs)[1]
        - For a practitioner who is part of a TIN participating in a MSSP ACOthrough the ACO's reporting of the APM Performance Pathway

Meeting the 10 detailed criteria listed in Table II above constitutes a substantial commitment, and physician groups would need to embrace significant practice transformation to meet them. In fact, if anything, given the level of practice transformation required to meet the criteria, meeting the requirements to bill for APCM could itself be a deterrent to physician groups that otherwise would wish to move in this direction. By the time physician groups have implemented this much practice transformation, they should already be close to considering joining or creating an ACO, thereby obviating the need to use such billing codes to assist in paying for practice transformation.

In summary:

- **APG recommends that CMS consider relaxing some of the required criteria for advanced primary care management billing codes at least temporarily to allow for greater participation by smaller physician practices.**

3. Payer-to-Payer Application Program Interface (API) to Exchange Patient Data

To manage the care of the patients whom they serve effectively, physicians need access to information on patients' longitudinal care, including historical claims and medical records. But all too often these data are not provided in a timely manner when Medicare beneficiaries enroll in new Medicare Advantage (MA) plans. APG is concerned about aspects of regulation that will make it even harder for APG member organizations to access this information on behalf of patients.

In the 2024 Interoperability and Prior Authorization Final Rule, CMS adopted new policies that require payers to use a Payer-to-Payer application programming interface (API) to exchange patient data with the patient's permission when a patient changes health plans.[5,6] These data are to include claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in the United States Core Data for Interoperability (USCDI) set, and information about certain prior authorizations (excluding those for drugs). Payers subject to the rule are only required to share patient data with a date of service within five years of the request for data. However, these new requirements will not be implemented until January 1, 2027, and will require a patient opt-in process that CMS is still finalizing.

APG is concerned about the delay in implementation and potential challenges presented by requiring patients to affirmatively opt-in to the exchange of their data when they change health plans. APG also notes that, when a patient changes health plans, the patient may also need to switch providers to be within a new plan's network. Therefore, it seems more reasonable to have a default opt-in option that would require the patient's former health plan to exchange the patient's data with the new health plan unless the patient opts out. Such a system would in the long run be best for patients, as it would assure the smooth transfer of patients' data to the new plan and therefore also assist patients' new providers (who in theory will also have access to patients' electronic health records).

[5] https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
[6] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

In summary:

- **APG recommends that CMS switch to a default opt-in approach to payer-to-payer data sharing when an MA enrollee changes plans, with an option for patients to opt-out.**

- **APG recommends that CMS require MA health plans to share historical claims and encounter data with new plans when individuals change their enrollment by any means available sooner than the January 1, 2027, required date to share these data through a Payer-to-Payer API.**

4. Annual Wellness Visits (AWVs)

APG is concerned about aspects of current regulation that work against the desirable goal of providing Annual Wellness Visits (AWVs) to patients. Current CMS regulations only permit AWVs (HCPCS Codes G0438 and G0439) to be billed once in a 12-month period. Medicare administrative contractors (MACs) have interpreted this policy as requiring providers to schedule future AWVs for more than 365 days after the prior year's AWV, regardless of the plan year in which the visit occurs. This interpretation has led APG members to experience claim denials and major scheduling hurdles, affecting the quality of care that APG members deliver to patients.

APG believes that providers and patients will be better served by being able to schedule their AWV any time during a given year provided that there is compliance with the statutory limit of one AWV per year. In addition, APG believes that there is no need to monitor the number AWVs for ACO participants that take responsibility for a patient's quality and total cost of care, both because these providers already have the incentive to operate in a cost-efficient manner and because wellness visits focused on prevention are a key ingredient in their success.

In summary:

- **APG recommends that CMS allow providers to bill for annual wellness visits once per year rather than exactly every 365 days.**

- **APG recommends that CMS waive the one-per year limit for annual wellness visits for ACO participants that take responsibility for a patient's quality and total cost of care.**

B. Reduce Administrative Burden of Reporting and Documentation

1. Universal Foundation

The 2026 Medicare Advantage Advance Notice indicates that CMS continues to move toward adopting Universal Foundation measures to align quality measures across all programs, including MA, traditional FFS Medicare, ACOs, and others.[7]

[7] https://www.cms.gov/files/document/2026-advance-notice.pdf

APG supports CMS's overall strategy of establishing a core set of quality measures in the Universal Foundation to align quality measures across Medicare programs. However, APG cautions CMS that, in addition to seeking alignment, the agency should continue efforts to focus on a core set of measures that reflect meaningful outcomes for patients and reduce undue administrative burdens on clinicians.

APG members continue to have concerns about the proliferation of clinical quality measures that inherently focus on care processes rather than outcomes. APG members also believe that CMS appears to be retreating from the previous goal of streamlining quality measurement. As it stands, the adoption of new measures, even those that offer an improvement relative to current options, increases reporting demands that are already significant. If CMS opts to continue to refine the Universal Foundation measure set, the agency must ensure there is not significant growth in the number of measures that MA plans, providers, and ACOs must report.

- **APG recommends that CMS adhere to its commitment to a Universal Foundation set of parsimonious but meaningful outcomes measures; cease the introduction of new process measures; and focus instead on the development of a limited number of quality measures that assess health outcomes that are meaningful to patients in terms of morbidity and mortality.**

2. MSSP Quality Measurement

For performance year 2025 and subsequent years, CMS requires MSSP ACOs to report the APM Performance Pathway (APP) Plus quality measure set. This measure set currently consists of six measures and will incrementally grow over performance years 2025 through 2028 to comprise eleven measures by incorporating five newly proposed measures from the Adult Universal Foundation measure set.

Beginning with the 2025 performance year, CMS added the Breast and Colorectal Cancer Screening measures. Also, for 2025, MSSP ACOs are required to report five electronic clinical quality measures (eCQMs)/Medicare CQMs in the APP Plus quality measure set and administer the Consumer Assessment of Health Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) survey. CMS calculates two claims-based measures.

APG members have concerns about the developments in clinical quality measurement that appear to be retreating from the previous goal of streamlining quality measures to reduce the reporting burden on clinicians. As it already stands, collection and reporting of data in connection with new measures, even those that offer an improvement relative to current options, places significant resource demands on ACOs.

As noted above, APG generally supports CMS's overall strategy of establishing a core set of quality measures in the Universal Foundation to align quality measures across Medicare programs. However, APG cautions CMS that, in addition to seeking alignment, it should continue efforts to reduce undue administrative burdens on clinicians.

As indicated above, as CMS refines the Universal Foundation measure set, the agency must ensure

there is not significant growth in the number of measures that ACOs must report. CMS began MSSP with more than 30 quality measures and over time reduced the measure set to reduce providers' reporting burden. APG encourages CMS to adhere to this winnowing approach. APG also urges CMS to test measures before making them required and scored measures for ACOs.

Finally, APG cautions CMS about implementing multiple major changes to the measure set in performance year 2025 as this is the year that the Web Interface is currently scheduled to sunset as a reporting option for ACOs, particularly as ACOs will now also be considering and preparing for the new reporting option, Medicare CQMs.

In summary:

- **APG recommends that CMS limit the number of new MSSP quality measures added and test new measures before making them required and scored measures for ACOs.**

The types of quality measures that MSSP ACOs are required to report have been shifting. As recently as 2023, MSSP ACOs were required to report through the APP and could choose to report using the CMS Web Interface or the eCQMs/MIPS CQMs. For performance year 2024 and subsequent performance years, CMS added the Medicare Clinical Quality Measures (CQMs) for MSSP ACOs as a new alternative collection type. CMS intended Medicare CQMs to serve as a transition collection mechanism to help ACOs build the infrastructure, skills, knowledge, and expertise necessary to report the all-payer/all-patient MIPS CQMs and eCQMs.

For performance year 2025 and subsequent years, CMS streamlined the APP measure collection types to eCQMS and Medicare CQMs. The decision to propose retiring MIPS CQMs was motivated by concerns raised by ACOs that this measure collection type is unattainable for many participants.

APG enthusiastically welcomed CMS's decision to allow MSSP ACOs to continue to report using Medicare CQMs in lieu of all-payer eCQMs, at least until 2029. APG also welcomed the agency's proposal to establish Medicare CQMs for ACOs participating in the MSSP as an alternative collection mechanism for MSSP ACOs. Medicare CQMs are far better matched to ACOs' reporting capabilities than are all-payer eCQMs. APG continues to urge CMS to make Medicare CQMs a permanent alternative to all-payer eCQMs.

For example, one multi-disciplinary ACO APG member noted that educating its providers on the new standard of reporting for MSSP ACOs has required developing workflow provisions to ensure that all specialists are documenting diagnoses and services fully and accurately so that measure data will map to reporting. If Medicare CQMs prove to be only a temporary fix to transitioning to eCQMs, they will create undue burden and unnecessary cost to move to a third quality measure collection method with providers. Limiting Medicare CQMs as only a temporary reporting option forces many MSSP ACOs to choose between continuing with preparation for eCQMs or pausing that work to devote attention to Medicare CQMs instead.

The current version of the APP uses provider taxonomy codes that do not differentiate specialists from primary care. This creates excessive administrative burden when the APP misattributes beneficiaries to specialists. APG request that CMS update the APP provider taxonomy codes to differentiate specialists from primary care.

In summary:

- **APG strongly recommends that CMS make Medicare Clinical Quality Measures (CQMs) a permanent reporting alternative to all-payer eCQMs.**

- **APG recommends that CMS update the APM Performance Pathway (APP) provider taxonomy codes to differentiate specialists from primary care.**

MSSP certified electronic health record technology (CEHRT) and provider interoperability (PI) requirements policies finalized in the 2024 Physician Fee Schedule Final Rule continue to prove onerous to APG members.[8] Since the 2024 performance year all MIPS-eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in an ACO, regardless of track, must report the MIPS PI performance category measures and requirements to MIPS, at the individual, group, virtual group, or APM level, and earn a MIPS performance category score. The policy further aligned MSSP with the MIPS program and was intended to promote greater CEHRT use among ACO clinicians.

APG is greatly concerned by CMS's ongoing push to align MSSP and MIPS. MACRA designed separate payment and performance measurement and reporting programs for MIPS and APMs with the clear intent of providing reporting relief for APM participants. It is unclear what goal aligning the requirements between MSSP and MIPS would serve. The MIPS program was designed to assess the quality of performance of individual physicians who opted to remain in the traditional fee-for-service Medicare program. By contrast, quality measurement for MSSP was designed for physicians and other ACO participants who opted collectively to take responsibility for the quality and total cost of care for the Medicare patients they serve.

Reporting multiple individual PI measures is unnecessary for MSSP participants, since ACOs must invest in transforming physician practices to be successful in meeting the program's existing quality measures and achieving shared savings. ACOs that remain in MSSP clearly promote interoperability. Requiring reporting of MIPS PI measures will significantly increase the reporting burden for MSSP participants at a time when CMS wants to encourage physician movement into and retention in accountable care arrangements.

In summary:

- **APG strongly recommends that CMS remove the requirement that MSSP ACOs fulfill the MIPS Promoting Interoperability (PI) reporting requirements and revert to requiring MSSPs to attest to PI.**

Beginning in performance year 2025, to qualify as an Advanced APM under the QPP, an ACO must require its participating "eligible clinicians" to use CEHRT. The 2024 final rule stated that AAPMs may find it appropriate to apply some limited exceptions, e.g., based on clinical criteria, but not blanket exceptions like percentages.[9]

However, ACOs lack clear guidance on how exceptions may be implemented and what exceptions

[8] https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

[9] https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

may be acceptable to CMS. In the absence of such clarification, some ACOs simply dropped practices that could not ramp up to full CEHRT use by January 1, 2025, to avoid risking Advanced APM / QP status for their entity and participants. In general, physician practices use a variety of EHRs, and not every CEHRT EHR is ready for MSSP reporting, which creates an added administrative burden ensuring for ACOs pursuing compliance. Although the deadline for including or dropping practices for 2025 has now passed, CMS should provide clear guidance in sufficient time for 2026 decisions and grant leniency to ACOs in 2025 and future with provider groups that are found not to fulfill the CEHRT requirements, including avoiding all impacts on shared savings and losses.

In summary:

- **APG strongly recommends that CMS provide clear guidance in sufficient time for 2026 participating group decisions and grant leniency to ACOs in 2025 and future years with provider groups that are found not to fulfill the CEHRT requirements, including avoiding all impacts on shared savings and losses.**

3. Prior Authorization and Utilization Management

Amid the ongoing provision of low-value care, utilization management techniques such as prior authorization are necessary and critical to assuring the value of health care for all stakeholders and the wellbeing and safety of patients. Yet policymakers have increasingly heard concerns that prior authorization may in too many instances be an overly restrictive impediment to patients' receipt of high-quality care. Hence, APG welcomes CMS's efforts to make electronic prior authorization more efficient by addressing process challenges.

APG members are especially grateful that CMS is invested in applying prior authorization policies to multiple payers and wholeheartedly endorses the agency's efforts to streamline prior authorization rules and processes across payers. Physicians often find it extremely problematic to comply with multiple payers' rules and processes.

As one APG member noted, multiple, often-conflicting requirements mean that "implementation [of prior authorization] is a nightmare." Physicians' efforts to stay on top of implementation for prior authorization and other tools required of medical practices requires time and resources that add to administrative costs. In fact, the multiple rules and application interfaces, along with the expertise needed to implement them, continue to drive physician consolidation as well as payer consolidation. The cost to implement prior authorization programs is the same for a solo physician practice as it is for 100-physician practice. Similarly, the cost is the same from a payer perspective for a 10,000-life plan as for a one-million-life plan.

Given ongoing pressure to keep costs low, such as through contract negotiations with payers and medical loss ratio rules, it is essential that physician groups keep administrative costs as low as possible. Standardizing prior authorization rules and processes across payers could help to keep administrative costs down. A key element of prior authorization that remains heterogeneous across payers is the denial codes reported back to physicians. There are various prior authorization denial codes; and payers can each use a unique set of authorization denial codes, which increases the burden on physicians who must understand and interpret what the various denial codes mean.

In summary:

- **APG recommends that CMS establish a uniform, national set of standard prior authorization denial codes and require all payers to use only these codes in prior authorization processes.**

4. Participating Provider Filings

Current policy requires MSSP ACOs to submit provider roster changes every thirty days, which is unduly burdensome. Furthermore, APG members note that submitted provider changes are not reflected in CMS's Medicare Provider Enrollment, Chain, and Ownership System (PECOS), leading to confusion among MSSP providers and participants. The lack of PECOS updates following provider roster submissions means that the 30-day requirement is another administrative burden for MSSPs that does not make sense.

APG urges CMS to reduce the frequency of MSSP provider roster change reporting to quarterly and provide ACOs with quarterly reports on attribution so that ACOs can ensure that their internal records match PECOS records.

In summary:

- **APG recommends that CMS reduce the frequency of MSSP provider roster change reporting from every 30 days to quarterly and provide ACOs with quarterly reports on attribution so that ACOs can ensure that their internal records match PECOS records.**

Current policy for the Innovation Center Kidney Care Choices model requires the Kidney Care Entities (KCEs) to sign a fee-reduction agreement with each participating physician every year. APG members note that the required wording of the agreement raises confusion for the participating physicians each year. APG requests that CMS modify this requirement so that the fee-reduction agreement be submitted once at the start of each contract renewal and that it be signed by each participating physician group's designated contact person.

In summary:

- **APG recommends that the annual requirement for Kidney Care Entities to collect signatures from all participating physicians on fee-reduction agreements be changed to: (1) a one-time submission beginning at the start of each contract period; and (2) requiring signatures only from each participating physician group's designated contact person.**

C. Identification of Duplicative Requirements

1. Risk Adjustment

In the 2026 Medicare Advantage Advance Notice, CMS noted that the agency has been working on calibrating the HCC risk adjustment model using MA encounter data (diagnosis, cost, and use data

submitted to CMS by MA plans) and may be able to start phasing in an MA encounter data-based model as early as 2027.[10] Use of an MA encounter data-based risk adjustment model is consistent with governing statute. Given that MA encounter data are likely to be a better predictor of relative costs in MA than FFS claims data from Traditional Medicare and using encounter data would obviate the need to make the adjustment for coding pattern differences, CMS believes that moving to a risk adjustment model based on encounter data will be an important improvement in achieving MA payment accuracy.

CMS notes that in response to prior Advance Notices, some commenters have cited wide variation in coding differences among MA plans and recommended that, to improve payment accuracy and address differential coding among MA plans, CMS develop a non-uniform adjustment approach to account for different coding behavior in MA and FFS. CMS has evaluated a variety of non-uniform approaches but has determined that more targeted approaches to adjust for coding pattern differences raise unique technical and methodological challenges.

The current HCC risk adjustment model is calibrated using fee for service diagnoses, utilization, and costs. It also makes a coding intensity adjustment (due to the differences between fee-for-service and MA populations) and requires MA plans to submit diagnoses. The coding intensity adjustment will be applied to risk scores until the implementation of risk adjustment that uses MA diagnostic cost and use data.

APG welcomes CMS's proposal to incorporate MA encounter data into calibrating the HCC risk adjustment model and agrees that this approach could be superior to the current one and could address many of the shortcomings of the current methodology. An MA encounter data-based model could rely on MA encounter data as a sole source for diagnoses and utilization and may not require a coding intensity adjustment. In addition, adoption of such a model could address the reality of inappropriate comparisons of diagnosis coding in MA versus TM.

However, as detailed below, APG has concerns that a potential thirty-day comment period between the introduction of a possible encounter data-based model in an Advance Notice would preclude thoughtful consideration by multiple stakeholders of the many implications of such a major change.

APG has repeatedly expressed its concern about inappropriate coding comparisons between TM and MA. As APG observed in its comment letter on the 2024 Advance Notice, it is illogical to compare diagnoses between the two programs given that the motivation to record diagnoses is completely different in from one to the other. That difference does not mean that the diagnoses that are recorded in MA are wrong and that the ones recorded in FFS are correct. In fact, given the lack of incentive to capture diagnoses in the FFS program, it is more likely that the opposite is true – that MA diagnoses provide a far more accurate reflection of the underlying health status of Medicare beneficiaries.

As noted, moving to a new calibration mechanism based on encounter data would address the concern about inappropriate coding comparisons between the two programs. However, the brief description that CMS has offered about the new calibration approach raises several questions as follows: (1) Will MA benchmarks that reflect fee-for-service spending and interact with risk adjustment

[10] https://www.cms.gov/files/document/2026-advance-notice.pdf

also be updated to incorporate encounter data; (2) will CMS extrapolate utilization for encounter data that are known to be less than complete, and (3) which data on costs will CMS use given that MA plans have multiple options for how these data are reported.

APG strongly encourages CMS to provide detailed information about the proposed approach in a transparent manner, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impacts, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented. Furthermore, APG asks that CMS begin sharing this information as soon as it is available rather than waiting for next year's Advance Notice so that stakeholders have time to review the planned changes and provide informed feedback in advance of implementation of another sweeping change in risk adjustment.

In summary:

- **APG recommends that CMS provide detailed information about the proposed HCC encounter data-based calibration approach in a transparent manner in advance of the 2027 Advance Notice, including, for example, through the issuance of white papers, mapping of diagnoses to condition categories, and simulation models of impact, so that stakeholders can provide meaningful feedback to refine the new model version before it is implemented.**

2. Beneficiary Notifications

Current CMS beneficiary notification policies often require that duplicative letters be sent to beneficiaries: one from the agency and one from participating organizations. Receiving similar but slightly different letters leads to patients receiving multiple pieces of documentation containing the same information, leading to confusion and sometimes suspicion and anxiety for patients. APG members appreciate the opportunity to communicate with patients, but given the downsides of duplicative missives, recommends that CMS alone should send beneficiary notifications and make participating groups aware that these letters have been sent and of the contents of these letters.

In summary:

- **APG recommends that CMS alone should send beneficiary notifications and make participating groups aware of the contents of these letters.**

V. Conclusion

APG appreciates CMS's efforts to ensure that Medicare regulations are designed to protect the health and safety of Medicare beneficiaries without unduly burdening participating physicians and beneficiaries. APG encourages CMS to consider the modifications to existing policies described in this letter as the agency seeks the ideal balance between these two goals.

Sincerely,

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