Advancing High Performance Health

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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?

Three-Day Stay Requirement for Skilled Nursing Facility (SNF) Care (42 CFR § 409.30):

The longstanding Medicare policy that bases skilled nursing facility (SNF) coverage on a minimum three-day inpatient hospital stay is no longer aligned with contemporary clinical practice. Enacted in 1965, this requirement reflected care patterns of an earlier era, when inpatient stays were substantially longer and transitional care was less structured. Today, advances in medicine and care coordination render the rule both outdated and counterproductive. Allowing providers to base SNF referrals on clinical judgment and patient needs, rather than an arbitrary inpatient duration, would ease unnecessary hospital utilization, streamline transitions to post-acute care, and drive system-wide cost savings. Notably, between 2014 and 2019, CMS tested a waiver of this rule under select Centers for Medicare & Medicaid Services Innovation Center models for Accountable Care Organizations (ACOs), demonstrating reduced expenditures and improved outcomes when care teams could directly transition patients to SNFs without waiting for a three-day qualifying stay (https://www.cms.gov/priorities/innovation/data-and-reports/2023/snf-waiver-summary).

Requirement for face-to-face visits and excessive documentation for DMEPOS (42 CFR § 410.38(d)(1)-(2)):

CMS's current requirements mandating face-to-face encounters and extensive documentation prior to the delivery of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) under 42 CFR § 410.38(d)(1)-(2) impose an unnecessary and disproportionate burden on providers. These provisions not only exceed statutory requirements but disrupt timely patient access to medically necessary equipment – especially for vulnerable populations with mobility or transportation challenges.

The mandatory face-to-face visit and documentation protocols are overly prescriptive, duplicative of other existing clinical documentation and prior authorization processes and divert critical clinical resources toward administrative compliance rather than patient care. Providers must satisfy multiple layers of documentation that add no clinical value but significantly delay service delivery.

CMS should eliminate or substantially relax these requirements, especially for low-risk, commonly prescribed items, and consider broader use of electronic documentation and clinical discretion to confirm medical necessity. Doing so would preserve program integrity while reducing operational burdens, minimizing care delays, and ensuring beneficiaries receive essential equipment in a timely and efficient manner.

Policies on Preferred Provider Lists for Post-Acute Care in Value-Based Care Models:
Under the Next Generation ACO Model, CMS allowed participating organizations to provide beneficiaries with lists of preferred post-acute care providers, supporting better care coordination and accountability. AMGA urges CMS to extend this policy across all Medicare high-value care models, including ACOs and bundled payments. Restricting providers from identifying high-performing post-acute partners undermines the goals of value-based care and creates avoidable fragmentation during transitions of care. AMGA supports maintaining patient choice, but recognizes how allowing transparent, data-driven preferred provider lists can help patients make informed decisions and enable providers to guide care based on quality and outcomes. Expanding this flexibility system-wide would enhance care coordination, reduce readmissions, and align Medicare policy with modern clinical and operational best practices.

Prior Authorization Requirements under Medicare Advantage (42 CFR § 422.122, 422.568, 422.570, 422.572):
AMGA urges CMS to further streamline prior authorization requirements under Medicare Advantage. Prior authorization processes remain overly complex, opaque, and inconsistently applied across plans. These burdens divert provider time away from patient care and create avoidable barriers for beneficiaries, especially for those with chronic or complex conditions.

Recent rulemaking has taken steps in the right direction by imposing decision timeframes and requiring electronic prior authorization capabilities. However, more is needed. Requiring plans to adopt real-time and automated authorization for routinely approved services would simplify the process. Additionally, CMS should limit the use of prior authorization for providers with demonstrated high adherence to clinical guidelines and require greater transparency in criteria and denials. These changes would advance care coordination, improve timeliness of treatment, and reduce administrative burden across the Medicare Advantage landscape.

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

Electronic Clinical Quality Measure (eCQM) Reporting (for example, 42 CFR § 414.1405):
Requirements for electronic clinical quality measure (eCQM) reporting impose significant administrative burdens on providers. As codified in 42 CFR § 414.1405 and further implemented through the Merit-based Incentive Payment System (MIPS) and Hospital Inpatient Quality Reporting (IQR) Program, providers are required to extract, validate, and submit data using formats such as the Quality Reporting Document

Architecture (QRDA) for a prescribed set of measures.

The fragmented reporting process across multiple CMS programs, duplicative data submissions, inconsistent specifications across reporting platforms (e.g., IQR, Promoting Interoperability, MIPS), and the collection of data elements that do not meaningfully contribute to patient care or quality improvement burden medical groups and integrated systems of care across the nation. Many eCQMs also require documentation that is not part of natural clinical workflows, leading to excessive manual entry, workarounds, and misalignment between clinical practice and reporting expectations. These challenges are further exacerbated by technical delays and interface instability within CMS portals, which regularly experience lags, data submission errors, and system downtimes.

The lack of harmonization across CMS programs imposes costly and counterproductive documentation burdens on health systems. CMS should standardize eCQM requirements across programs, eliminate duplicative submission pathways, and revise measure specifications to align with routinely documented EHR fields, ensuring that quality reporting supports rather than disrupts patient care.

Annual Wellness Visit Documentation Requirements (42 CFR § 410.15):
The Medicare Annual Wellness Visit (AWV) requires documentation of a personalized prevention plan and a comprehensive health risk assessment, most of which already exists in the EHR. Requiring providers to re-document or extract data solely to satisfy rigid CMS formatting guidelines adds significant administrative burden and takes time away from meaningful patient interaction.

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?

Automate and Simplify Medicare Administrative and Reporting Requirements
Medicare administrative tasks like electronic clinical quality measure (eCQM) submission, Annual Wellness Visit documentation, and prior authorization appeals could be simplified through automation. CMS should adopt EHR-integrated templates for AWV compliance and expand capabilities for automated population of eCQMs. Prior authorization review should leverage predictive analytics and historical approval data to automate common services. Additionally, CMS could create a centralized, single interface reporting system to allow quality data submission across all programs.

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?

Extraneous CMS Quality Measures:
CMS's quality and value-based programs have grown increasingly complex, with

measure sets that have expanded well beyond what is practical or meaningful for providers and patients. Many existing measures are duplicative, process-oriented, or impose significant reporting burdens without offering proportionate value in terms of clinical outcomes or patient experience. CMS has acknowledged this issue and has taken important steps, most notably through the development of the Universal Foundation and recent rulemaking cycles, to streamline and align quality measurement across programs.

To build on this momentum, CMS should further prioritize patient-centered, outcome-based measures with simplified and standardized reporting requirements. The AMGA Value Measure Set offers a strong model. It reflects core measures that matter to patients and providers, emphasizes health outcomes over process, and reduces administrative complexity by limiting the number of required measures while maximizing their impact. CMS should consider similar approaches as it refines existing programs by focusing on meaningful, harmonized metrics that improve care delivery without overwhelming frontline clinicians with excessive reporting tasks.

Permanently Codify Existing Waiver Authority to Prescribe Controlled Substances Via Telemedicine (42 CFR § 1307.41):
The temporary authority to prescribe controlled substances via telemedicine, initially authorized under the COVID-19 public health emergency, has proven to be a critical tool for improving patient access to timely, safe, and effective care. These flexibilities currently are set to expire at the end of 2025, despite strong evidence that they enhance continuity of care and reduce avoidable barriers for patients with chronic conditions, behavioral health needs, and limited mobility or geographic access.

CMS and the Drug Enforcement Administration (DEA) should permanently codify these telehealth prescribing waivers to avoid a reversion to pre-pandemic rules that require unnecessary in-person visits prior to prescribing controlled medications. These outdated requirements are not supported by current clinical practice standards and pose significant access challenges, particularly for elderly, rural, or homebound Medicare beneficiaries.

MIPS and CMMI Model Low-Volume Thresholds (42 CFR § 414.1305):
AMGA has consistently advocated for the removal of low-volume threshold in MIPS and CMMI models, with MIPS requirements exempting providers billing less than $90,000 in Medicare Part B charges, treating fewer than 200 beneficiaries, or furnishing fewer than 200 services annually. While originally intended to ease administrative burden for small-volume providers, these thresholds now serve as barriers to equitable participation.

As AMGA members work to scale high-value, team-based care, applying MIPS requirements uniformly across providers is critical to fair benchmarking, accurate performance comparisons, and aligning financial incentives. AMGA urges CMS to phase out or significantly lower the low-volume threshold, especially as digital reporting tools and Universal Foundation measures make participation more accessible. Eliminating this exemption would reinforce the shift toward value-based care for all Medicare beneficiaries.

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

Consolidate and Align Reporting Timeframes Across CMS Quality Programs:
AMGA urges CMS to align quality measure reporting timeframes across its major programs, including the Medicare Shared Savings Program (MSSP), Hospital IQR, MIPS, and the Medicare Advantage Star Ratings system. As it stands, inconsistent reporting periods and deadlines force providers to submit overlapping data multiple times in different formats, creating unnecessary administrative burden. Standardizing submission timelines and performance periods would streamline data workflows, enhance measure comparability, and reduce the duplicative effort required for compliance.

In addition, CMS should allow providers with a track record of consistently high performance, particularly under MA Star Ratings, to report certain measures less frequently. Reducing the frequency of resubmission to a maximum of biannually for these providers would maintain program integrity while recognizing performance excellence and freeing up clinical and administrative resources to focus on improvement in other areas. These reforms would support a more efficient, equitable, and outcome-focused quality reporting system.

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.

Face-to-Face Encounter and Written Order/Prescription Requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (42 CFR § 410.38(d)) (OMB Control No. 0938-0679):
CMS's current requirements for face-to-face encounters and written orders prior to delivery of DMEPOS impose unnecessary administrative complexity that exceeds statutory intent. These duplicative requirements create confusion among providers, delay medically necessary equipment delivery to patients, and introduce avoidable barriers to care—particularly in post-acute and chronic care management settings.

CMS should eliminate or significantly scale back the "Required Face-to-Face Encounter and Written Order Prior to Delivery List," which imposes rigid documentation and timing constraints without corresponding benefit to program integrity or patient outcomes. Providers are already subject to multiple layers of compliance and clinical oversight. Removing these documentation burdens would allow clinicians to focus on care delivery while maintaining necessary safeguards through existing audit and oversight mechanisms.

Time Frame Requirements for Home Health Services (42 CFR §424.22 and §409.43):
The current regulatory framework governing home health services imposes rigid time frame requirements that hinder efficient patient care and place undue administrative burdens on providers. Specifically, the mandates for face-to-face encounters within narrow windows, 60-day recertification cycles, and unnecessarily detailed plan of care

documentation create procedural complexities that can delay service delivery and divert clinical resources from patient-centered activities.

Under 42 CFR § 424.22, a face-to-face encounter must occur within 90 days before or 30 days after the start of home health services. While intended to ensure medical necessity, this requirement often results in scheduling challenges, especially for patients with limited mobility or access to healthcare facilities. Additionally, the requirement for recertification every 60 days, as stipulated in the same section, demands frequent administrative attention without necessarily reflecting changes in the patient's condition or care needs.

42 CFR § 409.43 mandates that the plan of care be reviewed by a physician or allowed practitioner at least every 60 days. This frequent review cycle can be redundant for patients with stable conditions, leading to unnecessary paperwork and potential disruptions in care continuity.

To enhance the efficiency and effectiveness of home health services, CMS should extend recertification intervals and streamline plan of care reviews. Additionally, CMS should broaden the acceptable time frames for face-to-face encounters and consider alternative methods, such as telehealth, to accommodate patients' needs and circumstances.

Topic 3: Identification of Duplicative Requirements

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

2024 Final Rule: "21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking." (45 CFR § 171; RIN 0955–AA05; 21st Century Cures Act):
Finalized under the previous administration, the rule titled "*21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking"* imposes substantial penalties on Medicare-enrolled providers accused of information blocking. While promoting data sharing is a critical goal, the regulation is both overly punitive and poorly structured. The penalties are excessive, and the final rule disregarded industry feedback requesting a more balanced approach that includes provider education, technical assistance, and the opportunity to implement corrective action plans prior to enforcement.

Moreover, enforcement responsibilities are fragmented across CMS, the Office of the National Coordinator for Health Information Technology (ONC), and the Office for Civil Rights (OCR). Without clear coordination, the current framework risks duplicative audits, inconsistent compliance standards, and unnecessary burden on providers. CMS, ONC, and OCR should develop a unified, transparent enforcement strategy that streamlines oversight and supports provider compliance through clear guidance rather than disproportionate penalties.

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?

Geographic and Originating Site Restrictions for Telehealth (42 CFR § 410.78(b)):
Existing regulations for telehealth visits place onerous requirements on where beneficiaries can receive care, with most restrictions only temporarily waived through September 30, 2025. Originating site restrictions both limit the types of care that can be delivered through telemedicine and where care may be delivered. With only limited exceptions for certain providers and arbitrary location requirements that may include patients in one zip code but exclude those in a neighboring one, these regulations do not reflect the current reality of telehealth capabilities. For example, even though behavioral health can be safely and effectively delivered via telehealth, restrictions (that are currently waived through September 30, 2025) will require some in-person visits. Additionally, audio-only telehealth regulations place stringent limits on both the services that can be delivered and require the beneficiary of services to be in their home during the appointment. By restricting both the types of care and where this care can be delivered, patients and providers are unable to fully take advantage of care that can be delivered at lower costs and with fewer restrictions.

Medicare Advantage Survey Methodology (42 CFR § 422.162 and § 422.166)
The current Medicare Advantage (MA) survey tools—particularly those used in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for Star Ratings are increasingly misaligned with the diversity and complexity of the MA population. Low response rates among high-risk, non-English speaking, and dual-eligible enrollees limit the representativeness of the results, leading to potentially skewed assessments of plan performance. CMS should modernize these methodologies by incorporating alternative data collection modalities and ensuring accessibility in multiple languages and formats. Incorporating real-time feedback mechanisms would also improve the validity and utility of patient experience data used in Star Ratings.

Use of In-Home Assessment Data for Suspect Conditions (42 CFR § 424.22(c)(1)):
The requirement that home health agency (HHA) documentation must be corroborated by the certifying physician's or facility's records, and that the physician must sign and date the HHA documentation. places undue administrative burden on providers. Further, this requirement does not demonstrate improvement in program integrity or patient outcomes.

We recommend CMS streamline this process by allowing HHA documentation to stand as sufficient support for eligibility certification, provided it is clinically consistent and developed under existing care planning and assessment regulations.

Topic 4: Additional Recommendations

4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that

participate in the Medicare program.

Modernize the Stark Law and Anti-kickback Statute Regulations to Promote and Protect Value-Based Care Arrangements (42 CFR § 411.350 – § 411.389):
The current regulatory framework under the Stark Law and Anti-Kickback Statute remains overly rigid and discourages innovative care coordination and risk-sharing arrangements that promote value-based care. While recent safe harbor updates were a step forward, many provider organizations still face legal ambiguity and compliance burdens when structuring integrated care models. CMS and OIG should further refine these regulations to better support clinically integrated networks, shared savings programs, and non-fee-for-service models.

Provider Education in Dual Eligible Special Needs Plans (D-SNPs) (42 CFR § 422.107):
Dual Eligible Special Needs Plans (D-SNPs) are required to coordinate care for individuals eligible for both Medicare and Medicaid. However, existing provider education requirements are redundant, leading to unnecessary administrative burden.

Unify a Post-Acute Care Payment and Documentation Framework per the IMPACT Act of 2014
CMS should establish a unified post-acute care (PAC) payment framework that consolidates documentation and billing requirements across inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), long-term care hospitals (LTCHs), and home health agencies (HHAs). Currently, these settings operate under disparate statutory and regulatory rules with separate assessment tools (e.g., IRF-PAI, MDS, OASIS), inconsistent quality reporting systems, and payment methodologies that create complexity for multi-setting providers and care transitions.

This fragmentation imposes a significant administrative burden on providers who deliver care across multiple PAC settings or transition patients between them. It also undermines care continuity and makes it difficult to compare outcomes, manage resources, and reward value uniformly. CMS already has the statutory foundation for this reform under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and has taken steps toward standardizing assessment data elements.

We urge CMS to accelerate efforts to harmonize documentation, quality reporting, and payment methodologies under a single, site-neutral framework that aligns with patient need rather than care setting. Doing so would improve care coordination, reduce duplicative data collection, eliminate inefficiencies, and allow providers to focus on delivering the most appropriate care regardless of setting.

Support a National or Multi-State Licensing Framework for Clinicians:
AMGA recommends that CMS and Congress pursue legislation to create a national or multi-state licensing framework for healthcare professionals. The current state-by-state licensure model imposes significant administrative burdens on clinicians (particularly for multisite systems), telehealth providers, and clinicians participating in value-based care

arrangements across state lines. This fragmented licensing infrastructure limits provider flexibility, delays onboarding, and creates unnecessary regulatory duplication. This is especially problematic for organizations operating in multiple states.

A harmonized licensure framework would reduce credentialing delays, increase provider supply in shortage areas, and allow greater responsiveness during public health emergencies or disaster declarations. It would also enhance continuity of care for Medicare beneficiaries who relocate seasonally or reside in states different from their providers. CMS should support interstate licensure compacts or federal legislative action that facilitate provider mobility and expands access to care while preserving necessary quality and disciplinary standards.