U.S. Chamber of Commerce Response to CMS RFI: Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192)

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?

Reducing Administrative Burden by Rescinding Unwarranted Health Equity Reporting Requirements

CMS has finalized a requirement for Medicare Advantage plans to publicly report prior authorization data stratified by social risk factors under 42 CFR §§ 422.137(d)(6)–(7). While promoting health equity is an important goal, this provision imposes significant IT and administrative burdens on plans without clear operational guidance, standardized data collection methods, or evidence that it will yield actionable insights or improve patient outcomes.

Recommendation: CMS should rescind the prior authorization stratification requirements under 42 CFR §§ 422.137(d)(6)–(7) and instead pursue more targeted, outcomes-focused health equity strategies. These efforts should be developed in consultation with health plans and other stakeholders to reduce unnecessary reporting burdens, and promote meaningful progress toward equitable care delivery.

Eliminating Redundant Mid-Year Supplemental Benefit Notices

CMS now requires Medicare Advantage plans to send physical mid-year notices to enrollees regarding unused supplemental benefits, as outlined in 42 CFR §§ 422.111(l) and 422.2267(e)(42). While intended to improve beneficiary awareness, this mandate introduces significant operational costs and risks confusing enrollees with potentially irrelevant or duplicative information.

Recommendation: CMS should rescind the mid-year supplemental benefit notice requirement and explore more effective, lower-cost alternatives such as digital, on-demand notifications. These approaches can improve enrollee engagement and awareness while reducing administrative burden and preserving plan resources for patient care.

Restore Predictability in Medicare Advantage Star Ratings

Since CMS discontinued pre-determined cut points for the Medicare Advantage Star Ratings program in 2016, plans have faced growing uncertainty in how quality performance is assessed. The resulting lack of transparency complicates strategic planning, hinders long-term investment in quality improvement, and reduces the ability of plans to consistently deliver high-value care.

Recommendation: CMS should amend 42 CFR § 422.166 to require the advance publication of measure-level cut points before the start of each measurement year. Restoring this predictability would strengthen the integrity of the Star Ratings program, provide clarity for plans and providers, and support sustained investments in care quality and beneficiary experience.

Reinstating the Star Ratings Reward Factor

CMS's removal of the Star Ratings reward factor, coinciding with the introduction of the Health Equity Index, weakens incentives for consistent high performance. Many Medicare Advantage plans depend on quality bonus payments to enhance benefits and innovate care delivery for beneficiaries.

Recommendation: CMS should amend 42 CFR § 422.166(f)(1) to reinstate the reward factor. Maintaining this incentive will promote innovation, quality, and equity by enabling high-performing plans to reinvest in services and care models.

Preserving Star Ratings Stability

Proposals to eliminate performance guardrails and reduce protections for the improvement measure threaten the consistency and fairness of the Star Ratings system. These changes could penalize plans that maintain high quality and introduce volatility that undermines performance-based planning.

Recommendation: CMS should not finalize proposed changes to 42 CFR §§ 422.166(a)(2)(i), (g)(1) and 423.186(a)(2)(i), (g)(1). Maintaining existing safeguards will ensure stability and encourage sustained improvement across plans.

Modernizing Model Document and Translation Requirements

Current rules requiring full printed document translations and extensive mailings, such as the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC), do not reflect how beneficiaries consume health information in the digital age.

Recommendation: CMS should provide flexibility for plans to use real-time translation tools and accessible digital formats. Additionally, CMS should convene a stakeholder workgroup to streamline and modernize model documents to reduce waste, enhance comprehension, and lower administrative burden.

Simplifying SSBCI Evidence Requirements

CMS currently requires each Medicare Advantage plan to develop and maintain a separate evidence bibliography supporting the Special Supplemental Benefits for the Chronically Ill. This requirement is duplicative, creates unnecessary administrative burden, and diverts plan resources away from patient care and innovation. The process of compiling individual bibliographies for each plan is inefficient and may lead to inconsistent evidence standards across the program.

Recommendation: CMS should establish and maintain a centralized, publicly accessible list of validated SSBCI services and supporting evidence. MA plans should be allowed to reference this CMS maintained repository in lieu of producing their own individual bibliographies, as outlined in 42 CFR § 422.102(f)(3)–(4). This approach would reduce administrative complexity, promote consistency in evidence standards, and enable plans to focus more resources on delivering effective supplemental benefits to chronically ill beneficiaries.

Reconsidering Pending Burdensome MA & Part D Proposals

The proposed 2026 Medicare Advantage and Part D rule includes several new policies, including expanded prior authorization requirements, enhanced oversight of artificial intelligence (AI) applications, and revisions to the Star Ratings program, that collectively impose substantial operational and compliance burdens on plans and providers. Many of these proposals lack comprehensive analysis of their practical impact on plan administration, and beneficiary access to care. Without sufficient stakeholder input and detailed impact assessments, these rules risk creating unintended barriers to care delivery and innovation.

Recommendation: CMS should pause finalization of these proposals and conduct a thorough regulatory analysis to better understand the operational and financial consequences for plans, providers, and beneficiaries. Following this review, CMS should reissue the proposals for a new notice-and-comment period, providing stakeholders an opportunity to offer feedback and suggest refinements. This measured approach will help ensure that final regulations are both effective and feasible, supporting improved outcomes while minimizing unnecessary burden on the Medicare program.

Advancing Whole-Person Care in Medicare by Reforming 42 CFR Part 2

Medicare beneficiaries, particularly those with complex or chronic conditions, often require coordinated physical and behavioral health care. However, current regulations under 42 CFR Part 2, which mandate the segregation of substance use disorder (SUD) records from other medical information, create substantial barriers to delivering integrated care within Medicare programs, including Medicare Advantage and Accountable Care Organizations (ACOs). These outdated rules restrict providers' access to essential patient information, despite existing privacy protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Recommendation: As part of efforts to modernize and streamline Medicare regulations, CMS should work with HHS to eliminate duplicative and burdensome 42 CFR Part 2 requirements. Aligning SUD data protections with HIPAA would allow care teams in Medicare programs to more effectively share information, reduce administrative burden, and deliver comprehensive, whole-person care, particularly for vulnerable populations managing both physical and behavioral health needs. This reform is critical to improving quality outcomes and advancing value based care across the Medicare system.

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

Streamlining Oversight of Accrediting Organizations

As part of its oversight of Medicare Conditions of Participation, CMS conducts "look back" validation surveys of accrediting organizations (AOs), re-surveying a sample of hospitals to compare CMS findings with those of recent accreditation surveys. While intended to assess AO performance, this duplicative process imposes unnecessary administrative burden and operational disruption on hospitals and health systems without delivering proportional oversight benefits.

Recommendation: CMS should eliminate duplicative "look back" validation surveys under 42 CFR § 488.9 and permanently adopt concurrent validation surveys. This approach would allow CMS to directly observe AO performance in real time, enhancing transparency and accountability while minimizing burden on providers. Shifting to concurrent validation would streamline oversight, reduce redundant compliance efforts, and support hospitals in focusing more resources on patient care.

Modernizing Complaint Survey Procedures

During the COVID-19 pandemic, CMS permitted accrediting organizations (AOs) and state survey agencies to conduct complaint surveys for low-risk quality issues virtually. This approach allowed for effective oversight while conserving resources and minimizing disruption. However, CMS has since reverted to requiring most complaint surveys to be conducted in person, regardless of risk level, which has resulted in increased operational burden and unnecessary costs for hospitals, as each AO visit incurs associated expenses.

Recommendation: CMS should resume allowing virtual complaint surveys for low-risk quality issues. Restoring this flexibility would enable more efficient allocation of survey resources, reduce administrative costs for hospitals and health systems, and preserve the capacity for in-person oversight for higher-risk concerns.

Enhance Data Transparency During Star Ratings Preview

Currently, CMS provides only limited data and summary information during the Star Ratings preview periods, restricting plans' ability to fully understand their performance metrics and underlying calculations. This lack of comprehensive data transparency hampers plans' capacity to conduct thorough, accurate validations and identify areas for improvement in advance of final ratings publication. As a result, plans often must perform duplicative data collection efforts, consuming valuable time and resources that could otherwise be directed toward quality improvement initiatives.

Recommendation: CMS should amend 42 CFR §§ 422.166(h)(2) and 423.186(h)(2) to require the agency to provide complete data sets, including detailed methodological information, during the initial Star Ratings preview window. By releasing comprehensive and transparent data early,

CMS would enable plans to perform more effective reviews, enhance strategic planning, and accelerate efforts to improve quality. This greater transparency will strengthen trust in the Star Ratings program and promote more consistent, data-driven quality enhancements across Medicare Advantage and Part D plans.

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 providers?

Aligning Quality Measures Across Medicare Fee-for-Service and Other Payers

The growing number of quality performance measures across payers creates unnecessary burdens for providers and leads to confusion among stakeholders. The Core Quality Measures Collaborative (CQMC) provides an effective model for harmonizing these measures to promote consistency and reduce duplication.

Recommendation: CMS should continue to partner with the CQMC and other stakeholders to encourage the adoption of streamlined quality measures that are consistent across Medicare Fee-for-Service and other payers. This alignment will reduce administrative burden, improve data comparability, and enhance quality improvement efforts.

Ensuring a Feasible Transition to Digital Quality Measurement (dQMs)

The premature implementation of electronic Clinical Quality Measures (eCQMs) and Electronic Clinical Data Systems (ECDS) without sufficient infrastructure has led to increased costs, reporting complexity, and misaligned incentives for providers. This rushed transition undermines the effectiveness and reliability of quality measurement.

Recommendation: CMS should support hybrid reporting models during the transition to digital quality measurement to reduce burden and improve data accuracy. Exclusive reliance on ECDS should be avoided until digital quality measures and national infrastructure are fully developed. CMS should collaborate with the National Committee for Quality Assurance (NCQA) to ensure ECDS data, benchmarks, and performance results are publicly available and reliable. Additionally, CMS should work closely with the Office of the National Coordinator for Health Information Technology (ONC) to standardize the United States Core Data for Interoperability (USCDI) Plus Quality elements and ensure their inclusion in APIs required by the Interoperability and Prior Authorization rule.

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

Consolidate Medicare Advantage Prior Authorization Reporting Requirements

CMS currently requires Medicare Advantage plans to report similar prior authorization data through both the annual Part C reporting process and the public website disclosure mandate (42

CFR § 422.122(c)). This duplication creates inefficiencies, conflicted data formats, and increases administrative burden for plans.

Recommendation: CMS should harmonize these reporting requirements by consolidating data submissions into a single, standardized process. This would reduce redundancy, minimize administrative costs, and improve data consistency and transparency.

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

Reducing Reporting Frequency and Complexity for Medicare Providers

The Chamber supports efforts by CMS to reduce regulatory burden on providers while advancing value-based care accountability. A key strategy is promoting alignment across payers (Medicare, Medicaid, and commercial) to streamline Alternative Payment Models (APMs) such as the Medicare Shared Savings Program (MSSP) and Innovation Center demonstrations. This alignment enhances provider incentives and reduces duplicative administrative requirements, allowing providers to focus on delivering improved care outcomes.

We encourage CMS to prioritize early engagement with health plans and leverage their extensive experience in value-based contract design and execution. Incorporating private sector innovation reduces duplicative federal spending and facilitates broader scaling of successful models.

Recognizing operational challenges faced by Medicare Advantage organizations, including bid cycle planning and business strategy considerations, the Chamber commends CMS's commitment to minimizing mid-model changes to ensure program stability and encourage provider participation.

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.

Streamlining Supplemental Benefit Reporting Requirements

CMS's recent expansion of supplemental benefit reporting (CMS-10261, OMB No. 0938-1054) has introduced substantial operational burdens on MA plans, with limited value due to inconsistent benefit standardization. This duplication is exacerbated by separate supplemental benefit data submissions through encounter data and medical loss ratio reporting requirements.

Recommendation:
The Chamber recommends CMS reevaluate and streamline supplemental benefit reporting to reduce redundancy and administrative costs. Historical precedent shows CMS can successfully eliminate duplicative reporting sections without compromising program integrity.

Addressing Duplication and Enhancing Cross-Agency Coordination

Inconsistent state regulations that duplicate or conflict with federal rules governing MA and Part D programs significantly increase administrative burdens and costs. The Chamber calls on CMS to collaborate with AHIP and the National Association of Insurance Commissioners (NAIC) to ensure clear and consistent application of federal preemption.

Audit processes also impose heavy demands on plan sponsors due to uncoordinated timing and overlapping requests from multiple federal entities. The Chamber recommends improved audit coordination, advance notification, standardized data requests, and scheduling that prevents resource strains on plans.

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)?

Clarifying Federal Preemption in Medicare Advantage and Part D

Some states have sought to regulate Medicare Advantage and Part D plans in areas such as marketing practices and drug benefits, despite clear federal preemption that limits state authority to basic licensure and solvency oversight. Inconsistent application and understanding of federal preemption create duplicative or conflicting state requirements, increasing administrative burdens for plans and driving up federal program costs. This regulatory uncertainty undermines efficient program administration and can disrupt beneficiary access.

Recommendation: CMS should collaborate with the American Health Insurance Plans (AHIP) and engage with the National Association of Insurance Commissioners (NAIC) to provide clear guidance to states on the scope and application of federal preemption for MA and Part D programs. Strengthening coordination among federal and state regulators will reduce duplicative oversight, promote regulatory consistency, and support efficient program operations that benefit both beneficiaries and plans.

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

Improving Coordination of Medicare Advantage and Part D Plans

Medicare Advantage and Part D plans face audits from multiple entities within the Department of Health and Human Services (HHS) and beyond each year. These include the Center for Medicare, the Center for Program Integrity, the Office of the Actuary, the Office of the Inspector General, and the Government Accountability Office. Audits cover a broad range of areas such as program compliance, financial performance, bid submissions, risk adjustment data validation, network adequacy, and marketing practices. Preparing for these audits demands significant resources from plan sponsors, especially when audits are unannounced or protocols and timelines are unclear. Overlapping responsibilities among staff and insufficient lead time for IT coordination further strain plan operations.

Recommendation: CMS and other relevant government agencies should better coordinate audit schedules to avoid simultaneous or consecutive audits that overwhelm plans. Data requests should be standardized and consolidated to prevent repetitive information from being submitted. Additionally, CMS should provide advance notification ideally at the start of the calendar year informing plans of upcoming audits to allow adequate preparation time. This coordinated approach will reduce administrative burdens, improve operational efficiency, and support effective oversight without compromising program integrity.

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?

Improving Provider Directory Accuracy and Modernizing Network Adequacy Standards

Accurate provider directories are critical for credentialing, payment, quality measurement, and consumer transparency. However, current federal databases and health plan directories often contain conflicting or outdated information, exacerbated by varied and inconsistent regulatory requirements.

Recommendation: CMS should foster a public-private partnership involving federal agencies, providers, payers, and technology vendors to harmonize provider directory data collection, improve accuracy, and reduce provider and plan burden. The Chamber supports the development of a National Directory of Health Care Providers & Services as part of this effort.

Additionally, MA network adequacy standards must evolve to recognize telehealth and innovative care delivery models that offer alternatives to traditional geographic and time-based criteria. Expanding exception criteria to include provider shortages, contracting challenges, and unique community factors will better reflect current care realities and improve beneficiary access.

Modernizing Medicare Advantage Network Adequacy Standards to Reflect Telehealth and Innovative Care Models

Medicare Advantage network adequacy standards are based on time-and-distance requirements outlined in CMS's Health Service Delivery (HSD) tables, which are determined by county and provider specialty. While these rules allow limited credit for telehealth, they fail to account for the full range of innovative care delivery and payment models that offer effective alternatives to traditional in-person services. In addition, CMS's current network adequacy exception criteria are narrow and do not reflect challenges outside plan control, such as provider shortages and contracting barriers.

Recommendation: CMS should revise MA regulations at 42 CFR § 422.116 to allow greater flexibility in meeting network adequacy requirements through innovative delivery and payment models, including expanded use of telehealth and virtual care. The agency should also broaden the exception criteria to include provider shortages (e.g., behavioral health), non-cooperative provider contracting practices, geographic limitations, and other unique community

characteristics. These reforms would modernize the network adequacy framework to reflect evolving care delivery methods and improve access for beneficiaries.

Modernizing Medicare Telehealth Policy to Expand Access and Reduce Costs

Current Medicare rules restrict the use of telehealth by requiring patients to be located in designated geographic areas (typically rural) and at specific originating sites, such as clinics or hospitals, in order to receive virtual care. These outdated requirements codified at Section 1834(m)(4)(C)(i)–(ii)(X) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(3)–(4), undermine the promise of telehealth by limiting patient access, adding unnecessary costs for providers, and slowing adoption of digital health innovations.

Recommendation: CMS should eliminate Medicare's geographic and originating site restrictions for telehealth. Specifically, Congress and CMS should amend relevant statutory and regulatory provisions to allow beneficiaries to receive telehealth services in their homes, regardless of geographic location. This change would modernize Medicare to reflect current capabilities and patient preferences, and expand access to care, especially for patients with mobility, transportation, or caregiving challenges, and promote a more efficient, flexible, and patient-centered delivery system.

Removing Unnecessary In-Person Visit Requirements for Behavioral Health Telehealth

Medicare regulations currently require an in-person visit within six months prior to initiating behavioral health services via telehealth, as outlined in Section 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(3)(xiv). This requirement imposes an unnecessary barrier to care, particularly for patients with mental health needs who may face transportation, stigma, or mobility challenges. It also creates a disparity between the delivery of physical and behavioral health services, undermining the goal of integrated, whole-person care.

Recommendation: CMS should eliminate the in-person visit requirement for behavioral health telehealth services in Medicare. Removing this outdated restriction would promote equitable access to mental health care, reduce administrative burden on providers, and enable patients to initiate and maintain care in a timely and effective manner. Aligning Medicare policy with clinical best practices would support greater utilization of behavioral telehealth and enhance care continuity across diverse populations.