July 9, 2025

The Honorable Robert F. Kennedy Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via regulations.gov

RE: AHRQ-2025-0001, "Request for Information (RFI): Ensuring Lawful Regulation and Unleashing Innovation to Make American (sic) Healthy Again"

Dear Secretary Kennedy:

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, I write in response to the RFI published in the Federal Register on May 14, 2025, seeking "opportunities to produce cost savings, increase efficiency, and stoke health and economic innovation through deregulation." We greatly appreciate the opportunity to provide feedback.

Question 1: What HHS regulations and/or guidance meet one or more of the seven criteria identified in E.O. 14219? Should they be modified or repealed? What would be the impact of this change, especially the cost and savings?

In our response to the Department of Justice's Anticompetitive Regulations Task Force Request for Information, we identified several policies that meet criteria identified in E.O. 14219, including "regulations that impose significant costs upon private parties that are not outweighed by public benefits" and "regulations that impose undue burdens on small business and impede private enterprise and entrepreneurship." However, many of the regulations we identified are statutorily required by Congress. We therefore encourage HHS to partner with the DOJ and Congress to grant HHS (specifically the Centers for Medicare and Medicaid Services (CMS)) the authority to address the first three recommendations below.

1a) Eliminate barriers to participating in advanced alternative payment models. The AAFP continues to call for greater federal resources to appropriately support and sustain physician practice participation in alternative payment models (APMs). APMs are specific payment models or structures that are aligned with the concept of value-based payment. Well-designed APMs can provide practices with predictable, sustainable revenue streams needed

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to provide high-value, comprehensive care and support competition by enabling practices to remain independent.

We urge HHS to work with Congress to grant CMS the authority to eliminate requirements that create unnecessary barriers for independent physician practices transitioning to APMs. One incentive to encourage and sustain participation in APMs is the bonus payment to advanced APMs participants, which was originally enacted at five percent. However, these statutory bonuses have expired, effectively closing the door to new physicians seeking to participate in advanced APMs, which require significant upfront (and ongoing) investments in new staff, technology, and other practice improvements. **We urge HHS to work with Congress to eliminate the expiration date, which makes the decision to participate in APMs more complex and financially uncertain for practices.**

The Medicare Access and CHIP Reauthorization Act (MACRA) includes specific participation thresholds that a physician must meet to be considered a qualifying APM participant (QPs). As a reward for the financial risk assumed by those participating in an advanced APM (AAPM), QPs are eligible to receive financial incentives, including the AAPM bonus and a higher conversion factor update, and are exempt from many of the burdensome reporting requirements of the Merit-based Incentive Payment System (MIPS). The QP thresholds are explicitly defined in MACRA, which required CMS to dramatically increase them over the course of just a few years. Congress recognized the difficulties this created and temporarily froze the thresholds. However, that freeze has expired, and they have increased to levels that are unattainable for many independent practices. CMS lacks the authority to make adjustments that would encourage and allow smaller independent physician practices to participate. **Congress should eliminate these detailed requirements and defer authority to CMS, which would allow for more nuanced policy that supports independent practices and encourages greater market competition.**

1b) Eliminate site-based payment differentials. Medicare provides higher payments when services are provided at ambulatory and outpatient settings owned by a hospital compared to services provided in an ambulatory or outpatient office owned by a physician or other non-hospital entity. This payment differential is not aligned with the resources needed to deliver the service and encourages facilities to direct care to more expensive settings even if it may be safely and effectively delivered in a lower-cost setting. The payment differential also incentivizes hospitals to acquire physician practices, as they can receive higher payments for services. The site-based payment differential not only encourages physician consolidation, it also increases out-of-pocket costs for patients who are suddenly forced to pay higher cost-sharing amounts to see their physician after their physician's practice is acquired by a hospital.

While some reforms have been made, such as site-neutral payments for some off-campus hospital outpatient departments (HOPDs), Congress should build upon these efforts and

avoid pressure to reverse these changes. The AAFP supports site neutral payment policies that would establish payment parity across care settings, regardless of ownership, and has called for an expansion of site neutrality to all on-campus and off-campus hospital-based departments, as well as other facilities. Site-neutral payment would discourage anticompetitive forms of provider consolidation. **We ask HHS to partner with Congress to eliminate site-based payment differentials and improve market efficiency.**

1c) Simplify physician payment adjustments and eliminate budget-neutrality requirements. Each year, CMS sets payment rate updates for physicians in the Medicare Physician Fee Schedule (MPFS). The MPFS considers the estimated time and resources required to provide services; these estimate values are later multiplied by a conversion factor to establish specific payment rates for each service. Currently, Congress requires that CMS derive a conversion factor, and the conversion factor must ensure that updates made to the MPFS are budget neutral or do not result in increased Medicare Part B spending.
These budget neutral requirements make annual updates to the MPFS unpredictable and do not consider the impact of inflation on practice costs. The resulting financial uncertainty drives physician consolidation, as erratic payment changes leave independent practices unable to keep their doors open, reducing market competition. **We urge the HHS to work with Congress to eliminate anticompetitive budget neutrality requirements** and to include a required annual inflationary update to make payment updates more predictable and more likely to sustain independent physician practices.

1d) Keep existing HIPAA implementation specification flexibilities instead of finalizing a Biden Administration regulation that would significantly increase burden on physicians. In a recent proposed rule, HHS and the Office for Civil Rights (OCR) proposed to update HIPAA implementation specifications so as to remove the current categories of "addressable" and "required" and instead clarify that compliance with all implementation specifications included in the regulation would be required. The AAFP advocated strongly against this proposal, and we urged the Department not to move forward with this change. It is essential for physician practices to have the flexibility to assess HIPAA requirements and implement the solutions most reasonable and appropriate for their particular circumstance. Expanding physicians' administrative burdens by increasing requirements while eliminating practices' autonomy is not an effective way to improve the cybersecurity of electronic protected health information, further, the additional administrative burden will only drive further consolidation that results in less choice for patients. We strongly recommend this proposal not be finalized. Further, the Administration should rescind provisions of the final rule, *21st Century Cures Act: Establishment of Disincentives for Health Care Providers That Have Committed Information Blocking*, which bans a provider who has committed information blocking from the Medicare Shared Savings Program (MSSP) for one year. As noted in our response to the proposed rule, we remain concerned that the disincentives framework outlined in the rule disproportionately penalizes independent, small, rural, and other under-resourced practices, particularly because of the all-or-nothing approach taken to clinician disincentives,

regardless of whether information blocking was intentional or whether the actor has taken steps to address outstanding issues. We urge HHS to use its statutory authority to rescind the disincentives for clinicians and practices in MIPS and MSSP.

Question 2: What regulations should we reconsider as we look to achieve some of the policy objectives outline in E.O. 14212, "Establishing the President's Make America Healthy Again Commission," to focus on reversing chronic disease?

Sixty percent of Americans have at least one chronic disease,[i] and individuals living in areas with higher rates of chronic disease are more likely to have lower incomes and less likely to have insurance coverage.[ii] There is evidence demonstrating that eliminating cost sharing for high-value medical care improves clinical outcomes for individuals with chronic disease.[iii,iv] The AAFP believes that a defined set of visits and services to a primary care physician should be covered without cost sharing and supports providing a defined set of visits and primary care services to patients without cost-sharing.

Cost barriers such as cost-sharing discourage utilization of high-value care. This is true for patients with all forms of insurance but is acutely felt by those in high-deductible health plans (HDHP). For patients enrolled in a qualified HDHP, their eligibility for a health savings account (HSA) provides an important vehicle to facilitate patients' ability to access high value care. However, regulatory interpretations set forth by other agencies, including the Internal Revenue Service, create unnecessary cost barriers. We therefore encourage HHS to eliminate or revise the following two policies which discourage the uptake of high-value care:

2a) Eliminate cost-sharing requirements for high-value primary care services in Medicare including Advance Primary Care Management (APCM) and Chronic Care Management (CCM). In 2025, CMS implemented a new set of Advanced Primary Care Management (APCM) service codes. APCM codes aim to provide additional payment for the teams, technology, and community partnerships needed to deliver advanced primary care services. CMS also established Chronic Care Management (CCM) codes to more adequately support the additional coordinated, comprehensive care management to patients with chronic conditions. Both APCM and CCM codes help physician practices deliver high value primary care, but both programs require beneficiary cost-sharing, which makes patient enrollment more challenging and reduces utilization. We continue to encourage HHS to work with Congress to eliminate or waive cost-sharing requirements for these high-value primary care services. Cost sharing requirements are currently waived for Medicare preventive services, including the Annual Wellness Visit. Cost-sharing should also be waived for APCM and CCM services. Like the AWV, APCM and CCM services are meant to keep patients healthy and prevent the onset of chronic disease or reduce the harms for those with a chronic condition. These high-value services not only improve care for Medicare beneficiaries, but they also support the transition to more sustainable payment models that are necessary to slow the trend toward physician consolidation and preserve independent practice.

2b) Eliminate prohibitions against using HSA funds for high-value innovative care models. Direct Primary Care (DPC) is an innovative practice model in which patients pay a flat fee (monthly or annually) to receive a range of primary care services, most of which have no additional cost when provided directly by DPC physicians and their teams. The AAFP supports DPC as a way for family physicians to retain their professional autonomy and reduce the administrative burdens associated with insurance-based practices. Most DPC practices are physician-owned and led which the AAFP believes is essential to maintaining a competitive practice environment that ensures patient choice.

However, current interpretations of the Internal Revenue Code prohibit an individual from using health savings account (HSA) funds to pay for the monthly or annual fee to join a DPC practice. This barrier limits choice in selecting a PCP and prevents family physicians from adopting this innovative model. These HSA restrictions are a barrier for new DPC practices entering a market. The AAFP has supported legislation that would clarify the Internal Revenue Code and allow HSA funds to cover DPC fees. We ask HHS to work with the Internal Revenue Service, and Congress if needed, to update regulations and guidance that prohibit individuals from using HSA funds for DPC fees. Eliminating this barrier will encourage new DPC practices to enter the market, improving access to high-value care for individuals with chronic disease.

Question 3: Are there additional HHS regulations and/or guidance that should be considered under E.O. 14192?

HHS seeks to identify additional regulations that could be eliminated under E.O. 14192, such as regulations that require burdensome reporting or are confusing, overly complex, outdated, conflicting, or regulations that are obstructive to care, innovation, or efficiency. HHS poses the question of whether such regulations should be modified or repealed, considering the potential costs and benefits of doing so. We offer the following suggestions:

3a) Remove administratively burdensome and unnecessary documentation requirements in risk-adjustment methodologies. The CMS-Hierarchical Condition Categories (HCC) model requires physicians to re-code diagnoses every year to calculate a risk score even for lifelong conditions. For example, family physicians must annually code a patient's amputation, otherwise the patient's risk score does not accurately predict their healthcare costs. This step is time-consuming and wasteful; eliminating this annual requirement would save physicians time and allow them to focus more on patients. We encourage CMS to eliminate these unnecessary requirements by classifying certain chronic conditions as persistent and automatically renewing persistent conditions each year in the RAF score, instead of requiring repetitive and wasteful documentation. The CMS-HCC model methodology is updated in CMS' annual rule, "Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly,"

which was CMS-4208-F or RIN 0938-AV40. We encourage CMS to propose updates to this methodology in the CY 2027 rule that is expected to be published in late 2026.

3b) Abandon the use of MIPS and MIPS Value Pathway (MVP) measures that hold clinicians accountable for the use of health IT. Primary care physicians are still largely unable to access the data they need across the continuum of care without significant costs and burden, as detailed in the AAFP's policy and position paper, "Information Sharing in Value-based Payment Models for Primary Care." In addition to hampering care coordination, this lack of interoperability creates a significant burden in reporting many quality and performance measures.

Regulatory approaches to date have emphasized requiring clinicians to adopt or use health IT and have not evolved to measures of true meaningful use of these capabilities for the purpose of coordinating care across otherwise disparate organizations. For example, most of the MIPS measures available to assess the Promoting Interoperability category focus on whether a clinician uses existing health IT systems but do not adequately address the underlying issues that would improve data sharing and coordination. We continue to be concerned that the Promoting Interoperability category within MIPS does not motivate meaningful improvement, making it an ineffective mechanism and added administrative burden.

3c) Clarify regulatory guidance to prevent Medicare Administrative Contractors (MACs) from interpreting and applying unrealistic and overly prescriptive Annual Wellness Visit (AWV) Documentation Requirements that waste physician time and discourage AWV utilization. While not explicitly required by CMS, family physicians have reported that MAC auditors are applying documentation standards that go beyond what CMS intended when establishing AWV requirements. For example, one family physician reported failing a MAC audit because their documentation did not include a checkbox specific to the question about whether a patient does their own laundry independently or with assistance. We believe this is an overzealous interpretation of the components described in the Medicare Learning Network's instructions for Medicare Wellness visits. The publication states that physicians should collect information regarding, "…*activities of daily living (ADLs), including dressing, feeding, toileting, and grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, transportation, shopping, managing medications, and handling finances.*" This list of IADLs is meant to be illustrative, not a set of specific requirements. The text suggests that a patient's ability to do their own laundry independently is just *one* example of a daily activity that might help the physician assess the patient's overall status. We do not believe CMS intended to require physicians to click through over a dozen checkboxes to document just one element of a comprehensive, multifaceted review of a patient's status. **We urge CMS to clarify this guidance to ensure MACs are not enforcing overly prescriptive requirements to assess physician compliance with AWV documentation requirements.**

3d) Eliminate unnecessary constraints and requirements regarding how Accountable Care Organizations (ACOs) may use the savings and eliminate the requirement to submit a detailed spending plan. The AAFP was encouraged by the implementation of a prepaid shared savings option in the Medicare Shared Savings Program, as upfront cash flow is critical to enabling the transition to accountable care. However, reporting requirements and other restrictions create an administrative burden that makes this option difficult to adopt. These requirements are an unnecessary burden given that ACOs are already inherently motivated to invest in initiatives and practice infrastructure that will enhance beneficiary outcomes and improve performance. Moreover, ACOs should have the flexibility to allocate shared savings in a way that best supports their unique needs, whether that involves enhancing practice technology, increasing staffing, or investing in compensation. **CMS has the statutory authority to eliminate these requirements originally finalized in the CY 2025 Medicare Physician Fee Schedule rule.**

3e) Block enforcement of burdensome requirements imposed on primary care practices by implementation of the No Surprises Act. The AAFP recognizes the value of transparency in health care and has long supported federal policies promoting price transparency. These policies improve data collection and enable patients and their health care teams to compare prices across facilities and insurers, information that is key to ensuring an efficient and competitive market that supports patient choice. While the Academy appreciates and supports continued efforts to improve price transparency for patients, primary care services are most often low-cost and high-value, and are not the drivers of high, distorted health care prices. The AAFP has repeatedly shared concerns regarding the administrative burdens imposed on primary care practices by the good faith estimate (GFE) requirements and proposed advanced explanation of benefits (AEOB) requirements, resulting from the No Surprises Act (NSA). Congress did not intend for the NSA to impose burdensome regulatory requirements on primary care practices, which are already overwhelmed with administrative tasks. We urge the HHS to ensure transparency reporting requirements are designed to target the services and sectors that are driving price increases, and to prevent the adoption of burdensome requirements on primary care practices.

3f) Reduce unnecessary administrative burden in Medicare's Quality Payment Program (QPP.) The QPP was established under the Medicare Access and CHIP Reauthorization Act (MACRA) with the aim of easing the transition to value-based care by familiarizing physicians with performance and quality measurement. However, it has fallen short of this goal. There is widespread agreement that QPP has increased administrative complexity. A qualitative study found that participating in the Merit-based Incentive Payment System (MIPS) costs an average of $12,811 per physician annually, with over 200 hours spent on related tasks. Notably, this study only examined MIPS-related costs; other research shows that practices spend an average of 785 hours and over $40,000 per physician each year on quality reporting overall.

The AAFP appreciates efforts CMS has made to align quality measures across programs, such as the Universal Foundation. We support CMS' general approach to quality measurement as it exists in the current program and will continue to share comments on specific measures proposed for inclusion in the program. However, a lack of measure alignment and the proliferation of measures for primary care (but not specialty care) continue to create a heavy burden, as well as the variety of different measure reporting methodologies and mechanisms among different payers. Our position paper, Performance Measurement in Value-based Payment Models for Primary Care, outlines further details on burden-heavy aspects of measurement. Certain measures place an outsized administrative burden on practices due to the current lack of interoperability across disparate data systems. We highlight several of these measures below and encourage CMS to discontinue or delay their use in the QPP until barriers to their efficient use have been resolved:

- *Initiation and Engagement of Substance Use Disorder Treatment (Quality ID (QID) 305)* The AAFP appreciates the intent of this measure and shares CMS' desire to improve the quality of behavioral health care. We understand that measurement is one way to push toward health plan and system improvement. Although this measure is intended to be used only at the health plan level, health plans have historically applied health plan-level measures inappropriately to the individual clinicians and/or clinician groups in their networks. This is not appropriate for measures such as this that have only been tested and validated for use at the health plan level. The data sources cited for this measure include EHR data, which means that plans will likely require that providers submit data from their EHR systems, thus increasing burden, and potentially added cost. Additionally, this measure is very difficult, if not impossible, for clinicians to track in the current health care landscape with a lack of interoperability across care settings and providers. **Accordingly, we do not support this measure for use as a clinician-level measure in CMS' Universal Foundation.**

- *Adult Immunization Status (QID 493) and other vaccine measures including QID508)* The AAFP is a champion of safe and effective vaccines and agree that vaccination is a vital component of comprehensive primary care. However, the AAFP has repeatedly noted that immunization registry challenges create significant administrative burden for primary care physicians reporting the Adult Immunization Status composite measure, which can result in suboptimal performance on the measure at no fault of the physician. Many patients receive vaccines in settings other than their primary care clinic, including pharmacies, health departments, and workplaces. Despite the use of immunization information systems (IIS), vaccination data from other settings is not consistently or reliably reported back to the primary care physician. Recent reports confirm that interoperability and functionality challenges are common among IIS programs. A recent HHS Office of Inspector General report found that 44 of the 56 IIS programs (immunization registries) reported not receiving complete, accurate, and timely data from retail pharmacy providers during the COVID-19 pandemic. IIS are

not on the same technology platforms and in some cases, and do not communicate with IISs in other states or health systems. Ongoing challenges with immunization registries are common, limiting family physicians across the country from accessing patient immunization records on a regular basis. **The AAFP strongly urges CMS to partner with the Centers for Disease Control and Prevention (CDC), ASTP/ONC, and other federal partners to advance reliable, interoperable sharing of immunization data across the health care system.** As improvements are made to these systems, we encourage CMS to prioritize the use of other measures to measure the quality of care provided by individual clinicians under the MIPS program.

- *Preventive Care and Screening: Screening for Depression and Follow-Up Plan (QID134/CMS2)* This measure requires extra IT resources and IT build in the physician's EHR system to document follow-up in a discrete data field that can easily be reported. In order to capture this type of care, providers and practices often have to create extra "box clicking" workflows to "get credit" for the measure. Further, good clinical care, such as supportive counseling by the PCP or even a psychologist on the day of the medical office visit, does not always result in a discrete reportable data element. In this common scenario, the result would be poor performance on the measure even though this physician's patients are sufficiently supported for positive screens. It is also important to acknowledge that many patients receive care outside of their PCP's office. Fragmentation between medical and behavioral health systems makes it difficult to track and coordinate care.

- *Preventive Care and Wellness Composite Measure (QID 497)* We do not support the Preventive Care and Wellness composite measure and recommend against its inclusion in traditional MIPS or any Primary Care MIPS Value Pathway (MVP). Reporting the composite measure only counts as one quality measure when it represents the delivery of multiple high-value services. A physician who elects to report to this measure would need to collect and report a total of 10 measures to satisfy the quality requirements for the MVP, which is higher than traditional MIPS and serves as a disincentive to select it. The same challenges reporting composite vaccination measures due to ongoing issues with data interoperability (as described above) could also prevent primary care physicians from reliably receiving data on patients' screening mammograms, which could negatively impact performance on the composite measure. **We urge CMS not to use this measure or other composite measures in traditional MIPS or primary care MVPs.**

Finally, while we agree that obtaining qualitative and quantitative feedback from patients is important, it is also important to acknowledge that surveys of patients add administrative burden and often contribute to patient survey fatigue as well. It is difficult to obtain an adequate number of survey responses to gather enough data for it to be statistically significant. Surveys also can require a significant amount of IT build in the physician's EHR

system. We discourage mandatory requirements to report survey measures unless stakeholders have expressed support for such a measure.

3g) Eliminate burdensome requirements that MSSP ACOs report the APP Plus measure set and the MIPS promoting interoperability category. In the CY 2025 MPFS rule, CMS proposed a new Alternative Payment Model (APM) Performance Pathway (APP) Plus Quality Measure set that would align with Adult Universal Foundation measures. CMS later finalized requirements that MSSP ACOs report the APP Plus measure set starting in the 2025 performance year. **The AAFP strongly opposed this proposal, as well as the abrupt decision to sunset the MIPS CQM option. Since CMS announced the sunsetting of the CMS Web Interface option, ACOs have spent significant time, money, and resources to shift to reporting the eCQMs/MIPS CQMs. Forcing ACOs to divert shared savings into temporary technologies detracts resources from patient care.** MIPS CQMs and eCQMs expanded the population on which an ACO's quality is evaluated from a sample of Medicare beneficiaries to all payers. ACOs continue to face substantial challenges making this transition. These include aggregating data across all participating practices – often across multiple EHRs. CMS recently recognized the need to assist ACOs in their efforts to aggregate data and complete patient matching and released an open source dedupliFHIR tool. While this is a promising step forward, as with any new technology or tool, its first iteration is not comprehensive and will require refinement. No other entity that participates in CMS quality programs is required to complete this level of aggregation and reporting and while a tool such as dedupliFHIR will assist in these efforts, it does not address all the concerns, nor is it prudent to rely on its use without understanding whether it works as intended and produces consistent and accurate results.
The AAFP continues to strongly oppose requiring MSSP ACOs to report the MIPS promoting interoperability category. The additional reporting requirements do not contribute to better patient care or improved outcomes and will serve as a disincentive for participation in advanced APMs (AAPMs). CMS should repeal the Certified Electronic Health Record Technology (CEHRT) requirements for ACOs, as well as the increased CEHRT requirements for AAPMs taking effect in 2025. Instead, CMS should institute a "yes/no" attestation to demonstrate CEHRT adoption and compliance with information blocking requirements, and leverage the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC) data already set to be collected directly from certified health IT developers under the new Insights Condition and Maintenance of Certification finalized in the Health Data, Technology, and Interoperability (HTI-1) Final Rule. Under the new Insights Condition and Maintenance of Certification data finalized in the HTI-1 Final Rule, certified health IT developers will soon be required to report on use of their products across four areas related to interoperability, which will reflect real-world physician use of CEHRT in actual clinical settings, rendering this massive data reporting exercise largely obsolete.

3h) Waive or modify requirements related to Advanced Primary Care Management Services that are overly burdensome or confusing. CMS has acknowledged that there has been a limited uptake of existing care management service codes that provide enhanced payment for chronic care and/or transitions of care management. We understand from our members that limited uptake to be related more to the onerous tracking and documentation requirements associated with the use of these codes – not the absence of care management or transition of care management support for patients. Given the administrative complexity and demands associated with billing APCM—especially considering the modest payment amounts—uptake of these codes is also likely to be limited. **We urge CMS to modify the following elements of APCM services previously finalized in the CY 2025 Medicare Physician Fee Schedule rule**:

- **Practitioner, Home, and Community-based Care Coordination**: CMS modified some aspects of the "Home- and Community-based Care Coordination" service element compared to the standards established for CCM and APCM. CMS specified that the "ongoing communication and coordinating receipt of needed services" is not only with home- and community-based service providers but also with "practitioners," "community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable." While the AAFP is supportive of this requirement generally, we encourage CMS to make community-based social service providers optional until there are better systems in place to support coordination. There have been significant efforts to establish stronger collaboration between community-based social service providers and the health care system. We appreciate HHS' support of community care hubs. HHS funding has helped several states bolster the partnership between community-based organizations (CBOs) and physician practices.

  Despite progress, widespread collaboration and communication are far from the norm. The information exchange infrastructures between these historically siloed support systems are still in their infancy. Interviews with early adopters of technology used to coordinate community-based social services indicate that even when these platforms are provided at no cost to community organizations, their uptake is limited due to the community organizations' limited resources to train staff and update workflows. There are often privacy and security concerns related to information sharing. Additionally, technology platforms used by CBOs were not necessarily designed to securely transmit information to outside systems. **We therefore ask that with respect to meeting the requirements of the Home- and Community-based Care Coordination service element of the APCM, ongoing communication and coordinating receipt of services is optional (not required) with community-based social services providers.**

- Enhanced Communication Services: The AAFP recommends CMS remove "interprofessional telephone/internet/EHR referral service(s)" from this service element. Aside from interprofessional referral services, all other services in this element are focused, enhanced communication opportunities between patients and their care teams. Additionally, interprofessional referrals (CPT codes 99446-99449) are largely reported by specialties other than primary care.

- Clarify requirements and process for APCM service consent requirements. CMS has established consent is required for practices to bill APCM services for all patients, including both new and established patients. Additionally, an initiating visit is required for new patients but not established patients, which the AAFP fully supports. While it is clear consent can be obtained for new patients at the initiating visit, the AAFP seeks additional clarity from CMS on how practices can gain consent from established patients through multiple modalities including face-to-face encounters, telephone conversations, and written consent. We suggested CMS issue clarifying guidance, including an optional template or communication practices could use to obtain consent, but we have not seen any guidance released by CMS. We encourage CMS to be as specific and descriptive as possible. Implementation materials including optional templates for consent would reduce the administrative burden required to operationalize the APCM codes.

Question 4: What alternative approaches could be taken to achieve or accomplish the same goal with a lesser burden? For example, are there less burdensome approaches that are used by other entities such as State governments or private companies that could be adopted by HHS to achieve its goal with less burdensome requirements?

4a) Allow certain measures to apply across multiple MIPS categories to reduce duplicative reporting requirements. As described in our comments above (section 3g), measures in the Promoting Interoperability category emphasize adoption of health information technology and do not consider whether technology resources, once adopted, are being used to improve performance. However, there are measures in the Improvement Activities performance category that also assess whether a practice is using technology to improve coordination. For example, IA_CC_1 "Implementation of use of specialist reports back to referring clinician or group to close referral loop" is highly aligned with measures in the Promoting Interoperability category such as "Support Electronic Referral Loops by Receiving and Reconciling Health Information" and "Support Electronic Referral Loops by Sending Health Information." Similarly, there are improvement activities and quality measures that are related yet require separate reporting (e.g., IA_BMH_4 "Depression Screening" and Quality ID 134 "Screening for Depression and Follow-up Plan). There is an opportunity to use MIPS measures to encourage performance improvements while also reducing overall reporting burden—allowing practices to report measures that are applicable to more than

one category would encourage their adoption and reward practices for making the investments necessary to enhance practice infrastructure. We encourage CMS to move beyond a focus on mere implementation of technology and reward next-level implementations by allowing cross-category credit multiple MIPS categories.

4b) Use all available authorities to ensure health care information regarding patients, sources of care, and performance are readily available to primary care physicians at the right time. As discussed in our response to question three (see 3b, above), current measures to promote interoperability are limited to assessing whether a clinician is using health IT, and these measures do not assess when a clinician is meaningfully using technology to share and access health information. However, implementing new measures of data sharing and coordination is not appropriate until broader, cross-industry action has addressed systemic problems with health IT interoperability. The AAFP believes actions to improve information sharing are necessary and any hope for meaningful progress must involve purchasers, payers, policymakers, physicians and their staff, along with health IT entities, health information exchange organizations and technology vendors to be successful.

We therefore recommend that CMS use all available authorities to improve collaboration not only between PCPs and specialists, but to bring together cross-industry participants, including payers, to ensure health care information regarding patients, sources of care, and performance are readily available to primary care physicians at the right time. We urge CMS to work with ASTP/ONC and other agencies to support the creation and implementation of minimum health information-sharing requirements that more adequately address the needs of primary care. Practicing primary care physicians representing different settings should be integrated into the process, and health IT organizations should ensure solutions are both practical and affordable. **The AAFP stands ready to support these efforts in any way that is helpful to the administration and others.**

Until interoperability concerns are addressed, the AAFP asks CMS to eliminate requirements that all Qualified Participants (QPs) report under the MIPS Promoting Interoperability (PI) performance category in future rulemaking.

4c) Use all available authorities to eliminate the unnecessary use of prior authorization. A physician's attestation of a clinical diagnosis or order should be sufficient documentation of medical necessity for clinical services, medications, and/or durable medical equipment (DME). In rare circumstances when prior authorization (PA) or step therapy is clinically relevant, the American Academy of Family Physicians (AAFP) believes these processes should be evidence-based, transparent, and efficient to ensure timely access and ideal patient outcomes. Additionally, family physicians that contract with health plans to participate in a financial risk-sharing agreement or those with historically high approval rates should be exempt from PAs.

Question 5: Are there HHS regulations, guidance, or reporting requirements that are rooted in outdated technology? Can new technologies be leveraged to allow for rescinding or updating these policies?

5a) Study and consider incentivizing the use of technology to replace fax-based documentation, prior authorization, and orders. There's a critical need for innovative applications that are intuitive, easily incorporated into existing clinical workflows, supportive of cognitive processing and medical decision making, and transparent regarding any algorithms used and health information being accessed. Studies have shown that large language models (LLMs) can accurately process hospital quality measures, in some cases achieving 90% agreement with manual reporting, which could lead to more efficient and reliable approaches to health care reporting.[v] We urge HHS to study and consider incentivizing physicians in the Medicare program to utilize technologies that would reduce administrative burden and improve reporting processes.

Time-consuming prior authorization processes – which vary across payers and often require manual tasks – burden family physicians and their practice staff, divert valuable resources away from direct patient care, and lead to adverse health outcomes for patients. As such, family physicians are eagerly awaiting the availability of newly required application programming interfaces (APIs), and the AAFP appreciates CMS and ASTP/ONC's leadership and collaborative efforts that have made this possible. We urge HHS to eliminate fax-based prior authorization and orders from Medicare and instead mandate electronic submission, as has been done with the electronic prescribing for controlled substances (EPCS) system. This would improve patient safety, medication adherence, and workflow efficiencies while simultaneously deterring fraud and reducing burden. We also recommend HHS standardize and align payer regulations to eliminate as much variability in payer eligibility, coverage, and procurement requirements as possible. Setting a single, uniform standard would significantly reduce the work currently required of both physicians and the federal government.

5b) Improve the health care system's ability to securely share data in real time, including updating transparency requirements regarding attribution methodology. Locating and accessing the data required to enable success in a value-based care (VBC) setting is currently a large obstacle for primary care physicians, and we believe increased transparency is key to improving this issue. The AAFP believes clinically relevant and actionable patient information should be readily available in a "timely, accurate, secure, and efficient manner that does not place unnecessary administrative or financial burdens on primary care practices." We recognize the RFI is seeking to eliminate and streamline regulations, but this is an area where more regulation may be required to achieve HHS' stated goals. We encourage HHS to pursue every avenue for improving the health care system's ability to securely share health data in real time, including updating transparency requirements regarding attribution methodology. The AAFP calls on HHS and other stakeholders to make health care information regarding patients, sources of care, and VBP performance readily available to primary care physicians at

the right time, within optimized workflows, and in an actionable format. We support the creation and implementation of minimum health information-sharing requirements to more adequately address the baseline needs of primary care, which would also support health IT platforms' ability to efficiently implement those requirements.

Thank you for considering these recommendations. The AAFP appreciates the opportunity to comment and stands ready to work with HHS to revise or eliminate existing regulations that create unnecessary administrative burdens on family physicians and hamper their ability to deliver comprehensive, person-centered care. Should you have any questions, please contact Julie Riley, Regulatory and Policy Strategist, at jriley@aafp.org.

Sincerely,

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