HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

June 16, 2025

Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0042-NC
P.O. Box 8013
Baltimore, MD 21244-8013.

Dear Administrator Oz,

The Healthcare Business Management Association (HBMA) is pleased to submit this response to your request for information (RFI) on the Health Technology Ecosystem (CMS-0042-NC).

HBMA is a national non-profit professional trade association for the healthcare revenue cycle management industry. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

HBMA members have an essential role in the operational and financial aspects of the healthcare system. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care - where it should be directed - instead of on the many administrative burdens they currently face. The RCM process involves everything from the lifecycle of a claim to credentialing, compliance, coding and managing participation in value-based payment programs.

HBMA supports CMS' goals of achieving interoperability for electronic health records (EHRs), improving transparency for patients, and using digital tools to help improve patient care. Though challenges remain, technology has helped the RCM industry evolve from manual, paper-based processes to a highly automated and efficient system. We agree there is still great opportunity for how technology can improve the RCM process, patient care, and the patient's experience with the Medicare program.

We have served as a resource to CMS on these topics, including during an Office of Healthcare Experience and Interoperability (OHEI) industry roundtable on interoperability and related topics in October of 2024 and during an industry feedback session on OHEI's national provider directory initiative.

Below are answers to specific questions in the RFI. We welcome future opportunities to engage with CMS on the questions raised in this RFI and other policy concepts CMS is considering.

PC-1. What health management or care navigation apps would help you understand and manage your (or your loved ones) health needs, as well as the actions you should take?

a. What are the top things you would like to be able to do for your or your loved ones' health that can be enabled by digital health products?

Make Data Meaningful for Patients

Medical records are intended for clinicians. They are not designed for a lay person. We agree that patients should have portability and access to their medical records. However, translating medical records into a useful, consumer-friendly format is extremely difficult before considering other factors such as language barriers, and technology illiteracy. These issues are exacerbated by broader education and literacy disparities. The Medicare population's age makes it uniquely impacted by unfamiliarity with new technology products. Access to data does not equal improved care or quality care if patients cannot meaningfully understand it.

Technology has helped improve many aspects of how patients interact with the healthcare system. For example, online appointment scheduling has helped many patients schedule care more easily. However, just because this function exists does not mean it is without issues. For example, it does not matter how easily a patient can use technology to schedule an imaging appointment, surgery, or other medical procedure if they do not have a prior authorization from their health plan.

Interoperability

We encourage CMS to focus interoperability efforts on clinicians who play a care coordination role. These practitioners typically give patients care instructions and prescribe medications. It is important for all the other clinicians caring for this patient to be aware of these instructions and prescriptions. Clinicians typically rely on medical records rather than interpersonal conversations to stay informed on care provided by other clinicians. It is vitally important that clinicians can rely on medical records.

Price Transparency

Improving price transparency has been a consistent goal for CMS across recent Administration changes. However, achieving this goal is challenging. There are multiple "prices" for a healthcare item or service. The price that matters most to patients is their in-network allowable amount and what they are responsible to pay out of their own pocket. Patients also need to know if their health plan will cover an item or service and understand how their cost-sharing amount applies to this item or service.

For most patients, health insurance is an incomprehensible black box of constantly changing provider networks and benefits that seem to disagree with their provider on what care is appropriate. We support efforts to use technology to improve transparency. However, we urge CMS to focus on making the information simple and meaningful for patients. Otherwise, it will be nothing except an added burden on the healthcare system. To that end, we encourage CMS to develop software solutions or applications that can quickly identify whether a service is covered

by their insurance, including requirements or barriers to payment, such as pre-authorization, and final out-of-pocket cost.

We commend CMS for its leadership in advancing the goals of the No Surprises Act and for pushing health plans toward greater reimbursement transparency. However, from a provider's perspective, the current implementation of the machine-readable files (MRFs) falls far short of practical transparency.

Accessing usable data from these files is nearly impossible without the help of a paid third-party analytics vendor. Even with vendor support, the MRFs often contain incomplete, outdated, or inaccurate information. This is especially problematic when trying to verify or analyze a practice's contracted rates against this data. CMS should audit plan compliance and penalize those submitting incomplete or misleading data. CMS should also provide publicly accessible CMS-supported tools to help both providers and patients interpret MRF data without the need for costly intermediaries.

Moreover, the policy does not account for variations among different specialties. For example, payers are not uniformly presenting anesthesia-specific reimbursement methodologies—particularly when conversion factors are used. The unique nature of anesthesia billing, which depends on time units and conversion rates, is not well-represented or explained in most datasets. This makes comparisons and evaluations of fair market value difficult, even for the providers directly involved. CMS should therefore require standardization across all health plans in how anesthesia payments are displayed in MRFs, including full disclosure of conversion factors.

b. If you had a personal assistant to support your health needs, what are the top things you would ask them to help with? In your response, please consider tasks that could be supported or facilitated by software solutions in the future.

An ideal personal assistant to support a patient's health needs should function as a centralized, intelligent system — one that benefits both patients and providers by ensuring care is transparent, coordinated, and medically necessary.

Many of these functions could be facilitated by smart future software solutions that could notify patients about upcoming preventive care such as screenings, vaccines, or wellness visits. It can also provide an explanation to the patient for why these tests, screenings, etc. are needed and how it is covered by the patient's health plan. Equally important, it can centralize and explain lab and test results and help direct patients to appropriate follow up care. The assistant can help avoid duplicative testing by centralizing historical health data.

It can also help schedule the right appointments at the right time with in-network providers. Zocdoc's recent partnership with Blue Cross Blue Shield of California lets members schedule directly through the insurance portal — streamlining access. This partnership can be a model for CMS to follow.

Lastly, the portal can accept patient feedback on their experiences with providers and their insurance coverage. This feedback can integrate into quality reporting programs where appropriate. However, while we believe patient feedback is valuable, we caution CMS to only hold providers accountable for what they can control.

PR-3. How important is it for healthcare delivery and interoperability in urban and rural areas that all data in an EHR system be accessible for exchange, regardless of storage format (for example, scanned documents, faxed records, lab results, free text notes, structured data fields)? Please address all of the following:

a. Current challenges in accessing different data formats.
b. Impact on patient care quality.
c. Technical barriers to full data accessibility.
d. Cost or privacy implications of making all data formats interoperable.
e. Priority level compared to other interoperability needs.

Variability in data formats is one of the most common challenges our members experience when trying to integrate with different IT systems. Addressing this variability through stronger enforcement should be a main priority for CMS if it wishes to meaningfully improve interoperability. According to one HBMA member, "It seems like every new system we come across has different file formats, different available file types, and different data fields that are available."

CMS has helped promote standardization by emphasizing FHIR-based standards. However, CMS must improve its enforcement of these standards. We believe strong enforcement of even a targeted set of standards will result in broader improvements throughout the healthcare system. If an entity is required to use a standardized format for certain data fields, it will be incentivized to move all its data to that standard rather than operate multiple systems at once.

HBMA acknowledges CMS' concern that increased interoperability can pose new cybersecurity challenges. Better interoperability means more transfers of electronic protected health information (ePHI). However, we believe a more standardized interoperability environment will ultimately make it easier to implement cybersecurity policies.

It is critically important that all data in an EHR system be accessible for exchange. This is especially important for data sharing between hospitals and specialty groups.

Hospital-based specialties face unique interoperability challenges as they typically lack ownership or control of the EHR systems used in the facilities where they provide care. Hospital-based practices therefore have less control over how the EHR can access patient information, document clinical data efficiently, or report on quality.

CMS should encourage or require hospitals to provide read-write access to EHRs for credentialed specialty providers who are delivering care on-site. We also believe that CMS

should develop standards for data-sharing agreements between hospitals and independent specialty groups to ensure timely access to patient records for quality reporting, care coordination, and compliance. Another strategy is to support APIs that allow specialty groups to integrate limited EHR data into their own practice management systems without high-cost third-party interfaces.

Hospital-based specialties are often work in collaborative, team-based environments. The attribution of outcomes to individual providers is frequently inappropriate and leads to skewed performance results. CMS should adapt documentation and reporting requirements for hospital-based specialty workflows including options for facility or team-based reporting and develop composite measures that reward care coordination and patient safety.

Current interoperability standards do not adequately account for unique characteristics of certain specialties. For example, Anesthesia care differs significantly from primary care or episodic specialties. This specialty's workflow involves brief preoperative evaluations, intraoperative monitoring, and postoperative handoff—often all in the span of a few hours. Current EHR mandates and quality reporting structures fail to reflect this model. To help account for these differences, CMS should support specialty-specific digital templates that reduce time and improve accuracy. Specialty-specific templates would know to exempt certain irrelevant EHR components (e.g., medication reconciliation) when not applicable.

Office-based specialties also face challenges with accessing and extracting data into their practice management systems for coding, billing, and quality program reporting, especially when provided in-house or by an RCM company other than their EHR vendors. Many of the same solutions that would work for hospital-based specialties, such as read-write access and API support, would improve interoperability and transparency for providers and patients while decreasing burdens related to information blocking and manual processes.

One HBMA member describes a recent experience with a family member's hospitalization where the hospital's emergency department (ED) could not access the patient's medical record from other clinicians who managed her care even though those clinicians were part of the same health system as the ED. Then, after relocating that family member to a different state, her new set of healthcare providers could not easily access her electronic health records from her old providers even though all the providers involved use the same EHR vendor.

This example also shows how interoperability will reduce Medicare spending. While in the ED, the providers wanted to order several diagnostic tests but were informed by a family member that those tests had already been performed by a different clinician. If the ED had the patient's electronic medical record, they would have seen that those tests were already performed by other clinicians and had access to the results. Without the family member's intervention, the ED would have performed the test and billed Medicare for an unnecessary test that had already been performed.

PR-7. What strategies can CMS implement to support providers in making high-quality, timely, and comprehensive healthcare data available for interoperability in the digital product ecosystem? How can the burden of increasing data availability and sharing be mitigated for providers? Are there ways that workflows or metrics that providers are already motivated to optimize for that could be reused for, or combined with, efforts needed to support interoperability?

Patients and clinicians have wide variability of technology savvy and expertise. Regardless of what is built, if it is not or cannot be used successfully, nothing has been gained except cost. Interoperability does not currently exist as intended. The developers of EHR and other health information systems often restrict data sharing and interoperability in the interest of protecting their proprietary trade secrets and competitive edge in the marketplace.

New AI products have not led to meaningful improvements, sometimes for the same reason. While competition encourages innovation, lower prices, and increased options, it can also discourage interoperability. We observe many similar barriers to AI interoperability that we saw with EHRs. AI tools are proprietary products that are often tailored to a specific facility or client. They are not always interoperable with other AI products. We encourage CMS to consider financial and other incentives for facilitating data sharing that may help overcome the natural incentive to limit access or hoard data for competitive edge.

Many healthcare systems still utilize older "legacy" systems (sometimes multiple legacy systems). True modernization will require healthcare systems to integrate data from legacy systems into their EHRs, which is difficult to do and requires significant time and financial investments.

The benefits of technology are further limited by lack of reliable internet access, either because of limited availability in many geographic areas or lack of affordability in areas where internet is available.

Complying with cybersecurity requirements can make digital data sharing more challenging. Independent medical practices are subject to the same cybersecurity and HIPAA compliance requirements as large institutions, but without the same resources. The increasing digital infrastructure requirements create cost pressures that are not reimbursed or supported. CMS should provide a CMS-endorsed cybersecurity framework tailored to outpatient and hospital-based specialists. We also encourage CMS to include small and medium-sized providers, as well as large health systems, in any financial support for adopting recommended cybersecurity practices and interoperability activities.

CMS should focus its efforts on ensuring commercial payers are compliant with digital data sharing. Many payers force providers to use their proprietary portals for digital information transactions. These portals are difficult to use and differ across payers. Each portal requires specific programming and processes to get the needed data, which creates financial and operational burdens on providers, many of whom do not have either the financial or technical resources to automate those processes. Further, portals often provide outdated or incorrect

eligibility and reimbursement information. These inefficiencies result in denied claims, delayed patient care, and unnecessary administrative overhead.

In some cases, a portal might meet the letter of the law but not its spirit. The required information might be available but not in a useful format.

We believe payers should be held accountable for the performance and accuracy of their portals. We support using standardized APIs for real-time eligibility verification, prior authorization, claims status, and other data.

PR-8. What are ways CMS or partners can help with simplifying clinical quality data responsibilities of providers?

a. What would be the benefits and downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions? Can CMS reduce the burden on providers by performing quality metrics calculations leveraging Bulk FHIR data exports?

b. In what ways can the interoperability and quality reporting responsibilities of providers be consolidated so investments can be dually purposed?

c. Are there requirements CMS should consider for data registries to support digital quality measurement in a more efficient manner? Are there requirements CMS should consider for data registries that would support access to real-time quality data for healthcare providers to inform clinical care in addition to simplifying reporting processes?

RCM companies help their clients participate in quality programs such as MIPS. RCM companies therefore have a front row seat for all the changes CMS has made to its quality reporting programs and the challenges that exist today.

We believe CMS over relies on EHR vendors to achieve policy goals under consideration based on the RFI's questions. This is especially true for quality programs such as MIPS. CEHRT certification is a self-designation. As the EClinical Works case proved, a CEHRT vendor is not always compliant with the regulations. CMS cannot rely on EHR vendors to meet the goals of interoperability. For example, it is common knowledge that different health systems using the same EHR vendor often are not interoperable with each other.

Data quality within EHRs is another factor. A recent survey found 20% of patients say their medical record has "significant" errors. The experience of numerous patients and their representatives who have diligently tried to have their EHR corrected all agree it is almost impossible the errors are not corrected. Many EHR vendors utilize templates that result in massive visit notes with extraneous, irrelevant information. Most records are many pages long and include copy-paste, cloned and auto-template verbiage.

Using the information in the EHR to prepopulate records just exacerbates the problem. We encourage CMS to simplify and clarify the documentation requirements for clinical quality data,

both perceived and actual, to discourage the record bloat that currently exists as a result of trying to meet quality data and clinical support requirements.

EHR issues aside, the MIPS program is fundamentally flawed in ways that prevent providers from succeeding in the program. Most notably, many specialties do not have enough quality measures to earn full credit for that performance category, yet their composite performance score is still compared to specialties that have complete measure sets.

This anecdote from an HBMA member provides helpful context for why the current direction of quality programs such as MIPS are not working as CMS intends.

> *"As the Director of Billing Operations for an independent anesthesia group, I want to emphasize the disproportionate administrative burden that continues to accompany CMS quality reporting programs, particularly for specialties like anesthesiology."*
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> *"Our group was an early and enthusiastic adopter of CMS quality initiatives, participating in the original Physician Quality Reporting Initiative (PQRI) when it launched in 2007. In its initial phase, PQRI allowed for straightforward claims-based reporting using CPT Category II codes. It was a meaningful and manageable way to demonstrate our commitment to quality care for Medicare beneficiaries. We celebrated our performance scores and the incentive payments felt like true rewards for our efforts."*
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> *"Even during the PQRS era and early use of electronic registries, our participation remained strong, particularly while registry costs were low and reporting requirements aligned with standard clinical practice. However, over time, the cost of participation increased, while the available measures for anesthesiology became both limited in number and relevance. Many of the remaining measures simply documented routine standards of care and offered no opportunity to drive improvement or innovation in patient outcomes."*
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> *"At present, the administrative burden associated with reporting under MIPS is significant—particularly for specialties like ours where measure options are minimal and high-cost registry participation is necessary. The lack of return on investment, both financially and in terms of meaningful quality insight, has led our group to opt out of participation whenever exemption criteria are met."*

Many specialties cannot fully participate in MIPS because of lack of quality measures and their potential bonus payments do not fully compensate them for the costs associated with participating in the program.

To help address these issues, we recommend that CMS:

- Expand the development of specialty-specific measures that are both clinically relevant and meaningful.
- Provide low-cost or no-cost pathways for small and specialty groups to report data.
- Restore flexibility in reporting mechanisms, including claims-based options for specialties with low reporting volume.
- Re-evaluate the incentive structure to ensure it covers the real cost of participation.

PR-9. How might CMS encourage providers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins that need to be tracked for each provider relationship?

a. What would providers need help with to accelerate the transition to a single set of trusted digital identity credentials for the patient to keep track of, instead of one for each provider?

b. How might CMS balance patient privacy with convenience and access to digital health products and services that may lead to significant improvements in health?

Providers are generally supportive of this type of simplification but would need help with integrating any digital identity solution into existing system requirements. This would require the cooperation of the vendors of EHR and other digital health solutions. Providers of various sizes and experience would also require differing types of both financial and technological support for any required programming, implementation, training, and troubleshooting.

We support the intent behind providing digital identities but caution CMS about challenges achieving this policy. For example, patients do not always understand their Medicare Beneficiary Identification (MBI) number. Patients who are victims of cyber-attacks could be assigned a new MBI without realizing or understanding the change. Further, there are obvious cybersecurity risks associated with a digital health identity. Last year, one-third of Americans had their data compromised in the Change Healthcare cyberattack. Incidents such as this will make patients hesitant to participate in a digital identity program.

The December 2024 hack of a Department of Treasury third-party vendor and the Russian-backed June 2023 breach of several U.S. government agencies demonstrate the difficulty for even someone as well-funded and technologically advanced as the U.S. government to protect patient privacy within a single set of digital identity credentials. Hardening the protections for digital identity credentials would require investment to support the cybersecurity efforts of the digital identity vendors coupled with stringent compliance enforcement. It would also require equal investment in the education and support of the patient population, not only to overcome their natural hesitancy, but also because they represent an equal, if not greater, risk of compromise to their credentials, given that many successful cybersecurity attacks are the result of individual email or credential breaches.

PR-14. How can CMS encourage providers to submit information blocking complaints to ASTP/ONC's Information Blocking Portal? What would be the impact? Would it advance or negatively impact data exchange?

The most effective way to encourage providers to communicate issues with information blocking is demonstrated effectiveness in actions against the health IT companies found to be information blocking. If complaints never result in resolution of the issue, especially if filing and working through complaints are time-consuming and expensive, similar to existing issues with the NSA IDR process, then it represents a burden on providers without measurable value.

Conclusion

The questions in this RFI demonstrate that CMS recognizes many of the ongoing challenges that prevent our healthcare system from realizing technology's full potential. HBMA is happy to serve as a resource to CMS as it considers new policies for addressing these challenges.

Thank you for considering our recommendations. Please do not hesitate to contact HBMA Director of Government Affairs Matt Reiter (reiterm@capitolassociates.com) or HBMA Executive Director Brad Lund (brad@hbma.org) if you wish to discuss our recommendations further.

Sincerely,

Kirk Reinitz
President, HBMA