HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

June 10, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

The Healthcare Business Management Association (HBMA) is pleased to respond to the Centers for Medicare and Medicaid Services (CMS) Request for Information (RFI) on Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information.

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.

Many of CMS' regulations are directed at healthcare providers. However, complying with these regulations is often handled by a medical practice's RCM company. Doing so allows clinicians to focus their time and effort on patient care – where it should be focused – instead of on paperwork and administrative functions. HBMA has many valuable relationships with the offices in CMS that oversee how clinicians and RCM companies interact with Medicare on a day-to-day basis. These relationships allow us to be a resource to CMS for understanding the on-the-ground impacts of CMS regulations.

We are proud of our reputation as a partner to CMS on these policies and programs. It is in this spirit that we submit these responses to the RFI's questions recommending how CMS can reduce regulatory burdens on the healthcare system.

- **Which Medicare administrative processes, or quality and data reporting requirements, place the most significant burdens on providers?**

Merit-based Incentive Payment System (MIPS)
Since its inception, MIPS has functioned as a pay for reporting program. Many practices spend more money complying with MIPS than they receive in bonuses from participating in the program. The goal for

many practices is to simply avoid getting a cut when the goal should be improving quality and efficiency of care.

The MIPS program, as currently implemented, is not meeting the goals Congress envisioned for the program. MIPS is not meaningfully measuring quality or cost performance. Rather, it is a program that measures the ability to follow processes and report data.

In addition to the reporting and maintenance burdens of this program, many specialties do not have enough quality measures to earn full credit for the MIPS Quality category. CMS is transitioning toward MIPS Value Pathways (MVPs) to simplify reporting; however MVPs rely on these same flawed quality measure sets. CMS has made some helpful improvements such as awarding more points for topped out measures and changing its methodology for benchmarking measures. However, this equates to patching a leak with tape instead of replacing the broken pipe.

In other ways, MIPS fails to recognize the realities of how our healthcare system is structured. In one notable example, MIPS penalizes practices because of an incorrect definition of how allied health professionals (AHPs) are scored under MIPS. Specifically for the Total Per Capita Cost (TPCC) measure. Radiology practices are penalized under this measure because AHPs who support imaging services are expected to report primary care measures even though they are not facilitating primary care services. CMS should consider aligning its approach for advanced practitioners with the American Medical Association (AMA) guidelines, treating them within the same specialty categories rather than as general providers. This approach would mirror the logic behind other CMS policies such as Split/Shared billing rules.

- **Are there specific administrative processes, or quality and data reporting requirements, that could be automated or simplified to reduce the administrative burden placed on facilities and providers?**

<u>No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process</u>
Since the NSA was passed into law by Congress and implemented by CMS through regulations, HBMA has been advocating for an operationally workable IDR process. The NSA statute lacks specificity for key details on how the IDR process should be operationalized. The lack of detail allows health plans to make it more difficult for healthcare providers to comply with the NSA's IDR requirements.

Examples of important details that are missing include:

- a standardized process that health plans must follow to notify a provider that a claim is subject to the NSA protections,
- a standardized process that health plans must use to share the Qualifying Payment Amount (QPA) with the provider,
- transparency for how health plans calculated the QPA amount,
- contact information within the health plan for who the provider should submit notification that an IDR dispute was initiated,
- a way to identify the specific health plan against which the dispute must be initiated, and
- enforcing payments from health plans to providers after an IDR determination is made.

The RCM industry specializes in operationalizing administrative processes on behalf of medical practices. The lack of basic information that providers need to comply with the NSA is incredibly frustrating for our industry and our provider clients. RCM companies and medical practices must utilize administratively burdensome, manual processes to get this essential information. There is great opportunity to standardize and automate these aspects of the NSA's IDR process to reduce burdens for providers and RCM companies.

In 2023, CMS proposed a rule that will address many of these issues. We are eager for CMS to finalize this rule so that we can achieve meaningful improvements to the NSA so that it functions as Congress intended.

Further, CMS is not doing enough to enforce the statutory and regulatory requirements for the IDR process.

While the NSA provides a framework for resolving payment disputes between providers and payers, in practice the system is severely hampered by the absence of a functional enforcement mechanism. At present, health plans are routinely failing to comply with IDR determinations by not remitting payment within the legally mandated timeframe. CMS is not adequately enforcing compliance with IDR outcomes, which renders these *binding* determinations effectively optional for noncompliant carriers.

HBMA members that handle IDR disputes for their provider clients have experienced many firsthand issues with this lack of enforcement. Some examples include:

- An IDR determination issued in October 2024 remains unpaid as of June 2025, despite repeated complaints submitted through CMS's designated portal.
- In another case, a payer explicitly refused in writing to honor a binding IDR decision. This communication was submitted to CMS as part of a formal complaint, yet there has been no resolution or follow-up.
- IDR entities regularly miss statutory deadlines, often taking months to issue determinations despite the NSA's clear 30-business-day deadline. Meanwhile, providers are subject to strict and inflexible deadlines at every stage of the process.
- One company has multiple 2023 IDR submissions still pending with no updates or outcomes.

The CMS complaint portal is intended to resolve these issues, but it is not functioning as intended. HBMA members have submitted numerous complaints—some with compelling supporting documentation, such as proof of payment of the administrative fee—that have gone entirely unanswered for months. In one instance, a provider paid over $1,000 to National Medical Reviews (an IDR entity), which later claimed non-receipt of payment. Despite providing CMS and the IDR entity with a receipt of payment, the determination wrongly defaulted in favor of the payer, and no refund or reversal has occurred. This represents a fundamental failure of process oversight.

Below are several recommendations for how CMS can strengthen its enforcement of the IDR process:

1. **Establish a Dedicated IDR Enforcement Office:**
   Create or designate a CMS-led NSA enforcement unit (within CCIIO or elsewhere in CMS) specifically tasked with monitoring post-determination compliance, investigating complaints, and levying penalties on noncompliant carriers. This office can also expedite CMS' audits of health

plan QPA calculations. HHS recently announced a reorganization that would create a new Assistant Secretary for Enforcement. A new NSA enforcement unit aligns with this reorganization.

2. **Mandate Payer Compliance Deadlines with Penalties:**
   Impose automatic penalties and interest on plans that fail to remit payment within the required 30-business-day timeframe following an IDR determination.
3. **Create an IDR Compliance Dashboard:**
   Publicly report metrics such as average determination times, payment compliance rates, and complaint resolution timelines to increase transparency and accountability among payers and IDR entities.
4. **Overhaul the Complaint Portal:**
   Redesign the CMS complaint portal to include estimated resolution timelines, and mandatory follow-up by CMS within a fixed period (e.g., 30 days). As well as a functionality that would allow you to track your open complaints or at least display their status.
5. **Enforce Deadlines on IDR Entities:**
   Hold IDR entities accountable to the same statutory deadlines required of providers. Delays of several months to a year should result in loss of accreditation or the ability to process disputes.
6. **Provider Fee Protection:**
   Require escrow or traceable electronic payment methods for all IDR administrative fees, with built-in audit trails and dispute protection to prevent untraceable fee denials.

<u>Good Faith Estimate and Advanced Explanation of Benefits</u>

CMS is currently developing a proposed rule to implement the NSA's Advanced Explanation of Benefits (AEOB) and the connected care portion of the Good Faith Estimate (GFE) provisions. We are deeply concerned that these requirements will add major administrative and financial burdens to practices. CMS is focused on developing data standards that parties will use to communicate the necessary information with each other to comply with these requirements. However, CMS has not shown an acknowledgement of the operational work processes that go into generating the data that will utilize the communication standards. Providers on the whole support the intent of these NSA initiatives for effective communication and price transparency, but not at the expense of timely patient care and provider burn-out. We urge CMS to avoid making the AEOB and GFE an added unfunded burden on clinician practices.

- **What changes can be made to simplify reporting and documentation requirements in Medicare without affecting program integrity?**

<u>PECOS 2.0</u>

We believe CMS can improve reporting and documentation requirements by implementing PECOS 2.0. HBMA is familiar with the improvements envisioned by PECOS 2.0, and we have provided advice and recommendations on this concept. We understand that developing new systems takes time. We encourage CMS to continue developing PECOS 2.0 so that we can benefit from these helpful improvements such as a centralized documentation database and the ability to centralize enrollments for Medicare and Medicaid.

In that context, we would also encourage CMS to review application developments and other processes that needlessly delay applications or generate communication and documentation requirements outside of PECOS. An easy example is the timeframe for the provider's e-signature before an application is developed. Providers usually delegate much of their application process to staff like their RCM company

because they are busy with patient care or training. When a staff member submits the application and issues the e-sign request to the provider, PECOS, or the CMS representative, should allow a reasonable amount of time for the provider to login and sign the application before developing it.

- **What opportunities are there to reduce the frequency or complexity of reporting for Medicare providers?**

Allow RCM Companies to Act on Behalf of Clinicians

Many of CMS' quality reporting and program integrity initiatives that require data submissions and supplemental documentation are directed at the clinician when it is often staff, such as an RCM company, facilitating these processes on behalf of the clinician.

CMS should make it easier for clinicians to designate their RCM company as their authorized agent to facilitate these functions on their behalf. CMS has made it easier for practices to authorize their RCM companies to receive communications and act on their behalf, but more can still be done.

- **Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or within other health care programs--Medicaid, private insurance, and state or local programs included?**

Overreliance on G-Codes

HBMA believes that recent Medicare Physician Fee Schedule (PFS) rules have too heavily relied on G-codes when CPT codes already exist for those services. Every new G code requires programming, training, coding modifications, etc., which are all unfunded mandates for medical practices and billing staff. In addition, the codes may be in direct violation of state laws.

The 2025 G codes added immense complexity that physicians could not understand or infer correct use. This type of confusion can lead to coding errors that may subject providers to recoupments or more severe enforcement actions. In some cases, it appears the G codes are for the sole purpose of gathering data vs. any meaningful care. An example is codes for diagnostic services that do not meet CMS medical necessity. CMS should not use a G code when a current CPT code and ICD-10 code would provide the same information needed for adjudication and data collection.

- **How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements--especially with regard to telemedicine, transparency, digital health and integrated care systems?**

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Replace LCDs with NCDs

Medicare Administrative Contractors (MACs) regularly utilize local coverage determinations (LCD) when we believe a national coverage determination (NCD) would be more appropriate. LCDs create confusion for billing staff who must track the coverage policies of different jurisdictions. We believe if one jurisdiction covers a service that all other jurisdictions should also cover it as Medicare is a national program. We believe CMS should replace LCDs with NCDs to reduce this burden.

Align Medicare with CPT

CMS can reduce regulatory burdens by aligning its coverage policies with that of CPT as much as possible. CPT code values and guidelines are informed by the RUC process which features direct input from physicians through surveys about the time and resources necessary to furnish each item or service. This makes CPT an accurate depiction of the cost and operational necessities for an item or service. Medicare is not obligated to follow CPT's guidelines though it often does.

An example of this is CMS' confusing and inconsistent policy on split or shared E/M services. CPT expanded its definition of split/shared services and CMS responded by updating its requirements, but not completely aligned with CPT's definition. CPT states that split/shared services may be billed under the practitioner who either spent more than 50% of the time treating the patient OR who made or approved the medical decision making (MDM). CMS has stated that they will require that split/shared services be billed under the practitioner who spent greater than 50% of the time with no consideration of MDM, but they have delayed implementing that requirement at least three times without walking it back. This type of pended but unchanged regulation creates confusion and stress in the provider community.

In addition, the Physician Fee Schedule verbiage on split/shared services is so vague that the MACs require the physician to document the entire MDM again, even if the NPP has already documented much of it. This represents a duplication of work for the sake of documentation and largely defeats the purpose of having the NPP team with the doctor in patient care. All of which adds additional work to the physician's day without enhancing patient care. It is notable to consider that the documentation requirements when working with residents only require an attestation. This means that CMS requires more documentation when working with an NPP who is fully trained and often has years of experience than when working with a resident who is still in training.

Inconsistent and unclear policies across payers add burdens to medical practices and RCM companies that must track, understand and implement these differing policies, which change at least yearly, if not more often. We believe Medicare and commercial payers should align their coverage policies with CPT as much as possible to reduce this burden on providers.

The Medicare program's size makes it a leader on coverage policy. Many commercial payers will follow Medicare's lead if it adopts CPT policies. This will further reduce burdens on the healthcare system.

❖ Other Recommendations

Medicare Advantage

Medicare Advantage (MA) plans are among the largest sources of burdens that practices face. As discussed above, having different polices for coverage of Medicare patients for every single MA plan in every single state creates significant burdens for tracking and implementing those requirements, until they change again. Then the practice and RCM company must try to understand what has changed and update programming, training, patient communication and various other processes. Prior authorization is an example of how MA plans have created administrative nightmares for practices. Many practices need to hire full time staff, who are typically non-physician providers (NPPs), solely to submit and manage prior authorizations. Studies have shown that many of these prior authorizations are approved and that most denied prior authorizations are overturned on appeal.

Traditional Medicare uses prior authorization very selectively and typically for hospital services. It does not make sense that MA plans are allowed to use it so far beyond how traditional Medicare utilizes it.

We also encourage CMS to better scrutinize MA upcoding. If any other contractor engaged in similar activities, they would not have their contract renewed and would potentially face legal action. However, CMS continues to enable MA plans to receive inappropriate payments that could otherwise be spent on PFS services, which have declined by over 20% compared to inflation since 2010. We support the recent announcement of expanded MA Risk Adjustment Data Validation (RADV) audits to that end. We wish to point out, however, that these expanded RADV audits have the potential to also increase burdens on medical practices as the source of the audited medical records. MA plans are also likely to proactively increase their own internal auditing, meaning additional requests for records and other claim reviews on providers.

❖ Conclusion

CMS policies are directed at healthcare providers when the provider often has very little to do with implementing those policies. Administrative staff and RCM companies are often delegated the responsibility to operationalize CMS policies on behalf of providers. As a national trade association for the RCM industry, HBMA is well positioned to serve as a resource to CMS on how its regulatory policies impact providers. We regularly serve as a resource to individual CMS offices and are happy to continue serving as a resource in any way that CMS feels would be helpful in achieving its deregulatory agenda.

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