Medicare Regulatory Relief: Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192)- Request for Information

Final Aggregated Comment Report

About this document:

- This report contains comments that have been aggregated from individual comments coded to "Detailed Response" codes **from across the taxonomy,** grouped together based on a unique, specific idea or sentiment.
- Aggregated comments are listed by individual comment volume from highest to lowest, then alphabetically by Aggregated Comment Title.
- Each aggregated comment includes a display of the number of submissions contributing, the number of comments contributing, and a breakdown of submitters by type:
    - If an organization has been identified, the submission is identified by the organization's name.
    - If no organization has been identified, but an individual has, the submission is identified by the individual's name.

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
February 26, 2026

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Aggregated Comments by Volume

Aggregated Comment Title: ***Consolidate Quality Reporting and Eliminate Overlapping Requirements***

Summary: Duplicative quality reporting requirements within and across various programs and payers causes unnecessary administrative burden for providers, while providing little benefit to improving quality. A single patient encounter might trigger reporting to multiple programs. CMS could streamline much of the reporting with automated extraction from EHR or claims data. Establishing Universal Measures across all payers and programs, and harmonizing reporting timelines would streamline and align quality reporting metrics to reduce redundancy and improve the provider experience. Establishing a Unified Federal Quality Reporting Framework with standardized data formats and benchmarks already used would align with best practices and industry standards. Current Medicare overlap includes programs such as IQR, HVBP, Medicare Advantage Star Ratings, MIPS, HEDIS, PQRS, ACOs like MSSP, HRRP, and QIP. Collaboration among CMS, ONC, CDC, and state Medicaid agencies can simplify reporting processes and reduce administrative waste across multiple compliance and quality programs. Furthermore, CMS should eliminate duplicative ER and Urgent Care reporting by removing quarterly reporting requirements and relying solely on required ICD-10 codes, reducing administrative burden and allowing providers to focus on patient care.

Total Comments Contributing: 162

Total Submissions Contributing: 78

Organization(s): AMGA; Academy of Nutrition and Dietetics; Accountable for Health; Alabama Hospital Association; Alignment Health Plan; Alliance of Specialty Medicine; America's Essential Hospitals; American Academy of Allergy, Asthma & Immunology; American Academy of Neurology; American College of Gastroenterology (ACG); American College of Physicians; American College of Surgeons; American Osteopathic Association; American Podiatric Medical Association; American Psychiatric Association; American Urological Association, Inc.; Association of American Medical Colleges; BAYADA Home Health Care; Berkshire Medical Center; Bipartisan Policy Center; Booz Allen Hamilton; CGI Federal Inc.; Cityblock Health; Danaher Diagnostics; Direct Supply, Inc.; Fresenius Medical Care; Health Alliance Plan of Michigan; Highlands Oncology Group, P.A.; Infectious Diseases Society of America; International Consortium for Health Outcome Measurement (ICHOM); Intersocietal Accreditation Commission (IAC); Kansas Hospital Association; Keystone ACO; Kingdom Insurance Group; Lantana Consulting Group; LeadingAge Illinois/Iowa; Lumeris Healthcare; Microsoft; NCH Naples Comprehensive Health; National Association of ACOs (NAACOS); National Board for Certified Counselors (NBCC); National Infusion Center Association; Ohio Hospital Association; PACE Southeast Michigan; Patient Experience Policy Forum - The Beryl Institute; Physicians Advocacy Institute; PointClickCare; Premier Inc; Price Services Group, L.L.C.; Project PAUSE (Psychoactive

Appropriate Use for Safety and Effectiveness)/Alliance for Aging Research; Providence Health and Servicess; Sanford Health - Good Samaritan Society; Sutter Health; The American College of Cardiology; The Physicians Foundation; UltraSight Inc.; Virginia Hospital & Healthcare Association; WEDI; WelbeHealth; Wellbox

Aggregated Comment Title: ***Normalize Telemedicine and Simplify Requirements***

Summary: Telehealth practitioners are facing uncertainty due to expiring waivers, which could lead to a return to pre-PHE regulations. Ensuring Medicare and Medicaid beneficiaries have access to telehealth services where clinically appropriate can improve care efficiency and reach, especially in underserved areas. Aligning regulations with best practices, removing unnecessary restrictions, and expanding provider types eligible for telehealth can enhance healthcare flexibility and improve patient access. Making telehealth waivers permanent, standardizing policies, and simplifying billing processes are recommended to sustain gains in telehealth access and innovation. Addressing barriers and providing clarity on reimbursement can encourage investment in scalable telehealth solutions.

Total Comments Contributing: 115

Total Submissions Contributing: 68

Organization(s): AMGA; ATA Action; Aegis Therapies; Aeroflow Health; Alliance for Connected Care; American Academy of Hospice and Palliative Medicine; American Academy of Physical Medicine & Rehabilitation; American Association for Homecare; American Association of Critical-Care Nurses; American Association of Orthopaedic Surgeons; American Commitment; American Health Care Association (AHCA); American Nurses Association; Ascension; Association of American Medical Colleges; Bright Day Psychology PLLC; California Hospital Association; Children's Hospital Association; Community Care Cooperative; Connected Health Initiative; Endocrine Society; Eventus WholeHealth; Florida Hospital Association; Health Services of the Pacific; Henry Ford Health; Highlands Oncology Group, P.A.; Illinois Health and Hospital Association; Illinois HomeCare & Hospice Council; Johns Hopkins Health System; Keystone ACO; LeadingAge Illinois/Iowa; Maplewood of Cheshire County; Mayo Clinic; National Association of Community Health Centers (NACHC); National Council for Mental Wellbeing; Ohio Hospital Association; Omada Health, Inc.; Patient Experience Policy Forum - The Beryl Institute; Physicians Advocacy Institute; Place of Peace Counseling Center; PointClickCare; Post-Acute and Long-Term Care Medical Association (PALTmed); Premier Inc; Reveleer; Sanford Health; Sanford Health - Good Samaritan Society; Select Medical Holdings Corporation; Sutter Health; The American College of Cardiology; The Helmsley Trust; The Ohio State University Wexner Medical Center; UHS, Inc.; University of Wisconsin Hospital and Clinics (UW Health); WEDI; WellSpan Health; Wheelchair Clinic Inc

Aggregated Comment Title: ***Align Data Collection and Reporting Across Programs and Settings***

Summary: The current compliance and reporting requirements are burdensome and create existential threats that deter participation in Medicare, especially for small and rural providers. CMS could leverage data collected through existing quality and safety monitoring systems operated by other agencies to eliminate redundant reporting across federal programs and various clinical settings. Undertake a top-down review of all reporting mandates, eliminating those with no demonstrable impact on care or compliance. The current volume of required mandates demands enormous volumes of data. Simplify and align data collection across various programs to streamline the reporting process and minimize burden and redundancies, including aligning and consolidating quality measures, adopting common data standards, standardizing state-reported data on the direct care workforce, and allowing a single submission to satisfy multiple Medicare programs such as Hospital Readmissions Reduction and Value-Based Purchasing. Providers could then be asked to verify information as opposed to submitting the information from scratch. For example, implement a single, standardized reporting form to gather quality, demographic, and clinical data from various programs, or utilize the same MDS form for both state and Medicare reporting. Additionally, CMS could create a centralized repository for the data that could be used to satisfy all mandated reporting requirements across Medicare, MA, Medicaid, PBMs, private insurers, states, and other entities as well as a national provider database of provider information. A uniform repository could facilitate real-time data exchange. CMS could also implement the X12 Trading Partner Profile (838) transaction to standardize data collection and exchange. In addition, incentives to use TEFCA and WHINs to retrieve clinical data or quality reporting will allow more complete data from all settings to be included in the calculation of the clinical quality measures.

Total Comments Contributing: 102

Total Submissions Contributing: 50

Aggregated Comment Title: ***Nonspecific or General Feedback for this RFI***

Summary: Healthcare organizations face significant challenges due to administrative burden, duplicative actions, and outdated and opaque systems which hinder systemic improvement efforts and care delivery. Voluminous regulations and constantly changing expectations from CMS diverts attention and resources from enhancing care and efficiency and often prioritizes complexity and gatekeeping over person-centered care. It is crucial that CMS listen to suggestions from a variety of stakeholders and take appropriate actions to alleviate this burden and prioritize the essential work of improving healthcare and maintaining currency with emerging treatments, while maintaining the qualities that are appreciated by beneficiaries.

Total Comments Contributing: 88

Total Submissions Contributing: 53

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; Alliance for Person-Centered Care; American College of Osteopathic Family Physicians (ACOFP); American College of Surgeons; American Health Care Association (AHCA); American Osteopathic Association; Ascension; BJC Health System; CPAC Foundation Center for Regulatory Freedom; California Hospital Association; Curana Health; Devoted Health; Dr. Lorna Breen Heroes' Foundation, on behalf of the ALL IN: WellBeing First for Healthcare coalition; Eastern Michigan University; Health Alliance Plan of Michigan; Henry Ford Health; Infectious Diseases Society of America; Johns Hopkins Health Plans; Kingdom Insurance Group; LeadingAge; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Massachusetts Coalition for the Prevention of Medical Errors; Medical Group Management Association; National Association of ACOs; National Association of Community Health Centers (NACHC); National Association of Local Long Term Care Ombudsman (NALLTCO); National Board for Certified Counselors (NBCC); Oak Lane Nursing & Rehab; Ohio Hospital Association; Orthotic & Prosthetic Lab, Inc.; Patient Experience Policy Forum - The Beryl Institute; Price Services Group, L.L.C.; Reliable Medical Supply; Shekina Glory Legacy Hospice and Palliative Services; Society of Hospital Medicine; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead; The American College of Cardiology; Virginia Hospital & Healthcare Association; WEDI

Aggregated Comment Title: ***Eliminate Mandatory NHSN Acute Respiratory Illness Reporting Requirements***

Summary: Mandatory National Health Safety Network (NHSN) Acute Respiratory Illness Reporting requirements should be eliminated, or at least be required less frequently, due to the administrative burden they place on facilities, with reports indicating spending 2-8 hours per week on reporting. Commenters have multiple concerns about these requirements, including that they duplicate state reporting and that the NHSN reporting definitions and ICD-10 coding standards are misaligned, leading to inconsistencies and inefficiencies in data reporting. The suggestion is to transition to voluntary reporting to reduce the burden on facilities without compromising public health oversight, while maintaining the ability to share acute respiratory illness data with state and local public health entities for outbreak or flu season monitoring and response.

Total Comments Contributing: 88

Total Submissions Contributing: 55

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); AVIA-Leavitt Partners Nexus Collaborative; Alabama Hospital Association; Alliance of Safety-Net Hospitals (ASH); American Association of Post-Acute Care Nursing (AAPACN); American Health Care Association (AHCA); Ascension; Association of American Medical Colleges; California Hospital Association; Catholic Health Association; Children's Hospital Association; Christian Living Communities / Cappella Living Solutions; Encompass Health; Federation of American Hospitals; Greater New York Hospital Association; Guardian Angels Senior Services;

Healthcare Association of New York State; Illinois Health and Hospital Association; Kansas Hospital Association; LeadingAge New York; LeadingAge PA; MaineHealth; Maplewood of Cheshire County; Mayo Clinic; National Rural Health Association; Ohio Hospital Association; Oklahoma Hospital Association; Optalis Healthcare; PointClickCare; Post-Acute and Long-Term Care Medical Association (PALTmed); Sanford Health - Good Samaritan Society; Select Medical Holdings Corporation; Tampa General Hospital - Tampa, FL; The Ohio State University Wexner Medical Center; UHS, Inc.; Virginia Hospital & Healthcare Association; Vivie; WEDI; WellSpan Health

Aggregated Comment Title: ***MIPS is Overly Complex***

Summary: Navigating MIPS complexity is challenging with changing weights, measures, timelines, and rules, along with lack of transparency and rational attribution in cost category scoring. Single-provider reporting rules are misaligned with team-based care and additional reporting methods like MVP and Virtual group add confusion. Incompatibility of submission platforms creates additional challenges. The manual submission of MIPS performance and quality data using QRDA files in the Quality Payment Program (QPP) is also inefficient, duplicative, and prone to errors. Many measures are difficult to collect, overly detailed, redundant and/or irrelevant to healthcare services and/or patient outcomes, especially for non-patient-facing specialties or subspecialty care. Further, there is some evidence that MIPS inadvertently penalizes providers who work with complex or underserved populations. Additionally, EHRs with certified reporting capabilities often require manual validation of numerators and denominators and the cost of compliance is staggering, favoring larger systems with more compliance resources. MIPS pulls clinicians away from the bedside into a burdensome administrative effort that does little for quality improvement.

Total Comments Contributing: 85

Total Submissions Contributing: 32

Aggregated Comment Title: ***Prior Authorization Creates Burden***

Summary: Healthcare providers face a significant administrative burden with prior authorization requests, particularly from Medicare Advantage plans. Burdens involve explanations, submissions, verifications, and multiple communications with insurance companies, each with its own criteria and processes, impacting patient care and workflow efficiency. Prior authorization processes are burdensome due to unclear internal criteria and inconsistent application of rules by Medicare Advantage plans and their delegated entities. These burdens lead to care delays and denials, as well as provider burnout and attrition. Standardization of CMS requirements and guidelines would help. Other suggestions are to exempt services below a certain dollar threshold from prior authorization requirements, explore longer approval periods for stable conditions, and accept broader ranges of codes to allow for intra-procedure changes if

needed without new approvals. Furthermore, prior authorization presents significant financial and clinical challenges due to outdated, non-electronic systems causing delays and inefficiencies. The burdensome nature of PA leads to major care delays and denials, hindering patient access to necessary treatments. Calls for reform have largely been ignored, resulting in a lack of transparency and consistency across plans, further complicating the process for providers and patients. Moreover, Medicare Advantage organizations can request prior authorization for specific therapy services, which causes delays in treatment interventions for patients in skilled nursing facilities. This delay impacts patients' return to function and increase overall care costs as they wait for approval. The prior authorization process is a hindrance for patients and healthcare providers, especially in the field of innovative medical technologies. The increasing complexity and inconsistency of prior authorization requirements result in delays in care, administrative burdens, and inefficiencies.

Total Comments Contributing: 82

Total Submissions Contributing: 67

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); AMGA; Agadia Systems; Alabama Hospital Association; Alliance for Physical Therapy Quality and Innovation; America's Essential Hospitals; American Academy of Family Physicians; American Academy of Hospice and Palliative Medicine; American Academy of Neurology; American College of Osteopathic Family Physicians (ACOFP); American College of Physicians; American College of Rheumatology; American College of Surgeons; American Health Care Association (AHCA); American Medical Association; American Medical Informatics Association; American Occupational Therapy Association; American Osteopathic Association; American Psychiatric Association; American Society of Pediatric Nephrology; American Urological Association, Inc.; Association for Clinical Oncology; BAYADA Home Health Care; Booz Allen Hamilton; CPAC Foundation Center for Regulatory Freedom; California Hospital Association; Coalition of State Rheumatology Organizations; College of American Pathologists; Consumer Action for a Strong Econmy; HL7 Da Vinci Project; Johnson & Johnson; Kentucky Hospital Association; Large Urology Group Practice Association (LUGPA); LeadingAge; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Medical Device Manufacturers Association (MDMA); Memorial Sloan Kettering Cancer Center; Microsoft; National Organization of Rheumatology Management; O&P Insight; Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; Premier Health; Regulatory Relief Coalition; RetireSafe; Society for Gynecologic Oncology; Sutter Health; The American College of Cardiology; The American Psychological Association Services, Inc.; The Coalition for 21st Century Medicine; The Helmsley Trust; UHS, Inc.; University Family Medicine at Pali Momi Medical Center; University Radiology Group, LLC; WEDI

Aggregated Comment Title: ***Eliminate the 3-Day Hospital Rule for SNF Transfer***

Summary: Eliminate the 3-day hospital stay rule for accessing Part A SNF benefits. The rule causes issues with billing, hinders patients from receiving necessary rehabilitation care, and slows care transitions. Despite changes in healthcare utilization patterns, such as increased outpatient treatment and shorter inpatient stays, this policy remains in place, contradicting the trend towards lower-cost care options. Elimination of the three-day rule will reduce preventable readmissions, allow for more time-efficient transfers of residents to SNFs to receive care in an appropriate setting, and free up hospital beds for patients in greater need of acute care. Additionally, CMS instituted 3-day rule waivers during COVID-19 and in new CMS models which suggests that the rule does not always need to apply. The rule is outdated and should be revised to align with modern medical standards.

Total Comments Contributing: 77

Total Submissions Contributing: 60

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); AMGA; AdventHealth; Advocating for Seniors; Aegis Therapies; Alliance of Safety-Net Hospitals (ASH); American Association of Post-Acute Care Nursing (AAPACN); American College of Surgeons; American Occupational Therapy Association; American Physical Therapy Association; Catholic Health Association; Christian Living Communities / Cappella Living Solutions; Cleveland Clinic; DSHS/HCLA/RCS; Essentia Health; Eventus WholeHealth; Greater New York Hospital Association; Healthcare Association of New York State; Home Care and Hospice Association of New Jersey; Illinois Health and Hospital Association; Keystone ACO; LeadingAge New York; LeadingAge PA; Louisiana Rural Health Association; Maplewood of Cheshire County; Martha T. Berry Medical Care Facility, Macomb County Michigan; Mayo Clinic; Mercy; National Association of Local Long Term Care Ombudsman (NALLTCO); National Association of Rehabilitation Providers and Agencies (NARA); OCHIN; Ohio Hospital Association; PointClickCare; Post-Acute and Long-Term Care Medical Association (PALTmed); Premier Health; Premier Inc; R1 RCM; Sanford Health - Good Samaritan Society; Society of General Internal Medicine; Society of Hospital Medicine; Sutter Health; The Ohio State University Wexner Medical Center; University of Wisconsin Hospital and Clinics (UW Health); Vivie; WellSpan Health

Aggregated Comment Title: ***Streamline Appeals Processes***

Summary: The appeals processes for denied claims are time-consuming, causing delays of weeks or months that impact patients and providers. The current appeals processes do not meet basic standards of procedural due process and providers deal with shifting requirements and duplicative documentation. Simplify, consolidate, and standardize the appeals processes with strict time limits and automatic approvals if deadlines are not met. A standard Medicare Advantage plan appeals process for providers would reduce burden. Additionally, modify policies to allow real-time billing corrections for minor issues instead of formal appeals. Also allow medical records to be uploaded at the time of claim filing and to be submitted once to

serve all appeals levels. CMS should also establish uniform interpretation guidelines to prevent the regional variations in claim processing that lead to appeals. Also create standardized appeal templates specific to mental health services. Regarding appeals-related reporting, CMS may improve processes by implementing presumptive approval frameworks for historically compliant providers, tailoring appeal frequency to actual provider performance using a tiered model, allowing self-attestation in low risk cases subject to post-hoc audit, and eliminating appeals for high-approval-rate therapies and drugs that have a proved record of safety and efficacy.

Total Comments Contributing: 73

Total Submissions Contributing: 13

Aggregated Comment Title: ***Simplify and Streamline MIPS***

Summary: CMS should simplify and streamline the Merit-based Incentive Payment System (MIPS) to reduce administrative burdens and ensure the program provides meaningful data for patients and clinicians, especially rural providers. Suggestions include: providing regular performance feedback, reweighting the cost category to zero, more flexibility in measure testing and adoption and engagement with registries to develop more appropriate measure testing requirements, exploring new scoring methodologies, allowing cross-category credit under MIPS, maximizing the use of EHR and other emerging technologies, and incentivizing adoption of new measures. To ensure more accurate assessment of providers, include Heard and Understood and Help Wanted for Pain in MIPS as well as MVPs.

Total Comments Contributing: 65

Total Submissions Contributing: 30

Aggregated Comment Title: ***Expand Services Eligible for Telehealth***

Summary: CMS should expand the list of services and provider types eligible for telehealth to align Medicare with industry standards, improve patient access, especially in rural and underserved areas, and support long-term investments in telehealth services. CMS could remove the case-by-case approval of new telehealth services and instead, include all Medicare-covered services as eligible telehealth services. If considering services individually, the following should be eligible: Therapy services, including physical therapy, occupational therapy, and speech language pathology; teleradiology; home, domiciliary, and nursing facility visits; hospice services; lactation services; FQHCs and Rural Health Clinics (RHCs); Routine Home Care (RHC); PACE Organizations (POs); intensive cardiac rehab (ICR); subsequent care inpatient services; critical care consultations; synchronous and asynchronous care. CMS could use a claims-based mechanism, such as a modifier, to identify and track telehealth claims. Additionally, CMS could

allow teaching physicians to have a virtual presence for purposes of billing for telehealth services. Language should also be added to include the minimum credentials of on-site providers.

Total Comments Contributing: 65

Total Submissions Contributing: 30

Organization(s): ATA Action; Aeroflow Health; Alliance for Connected Care; American Academy of Hospice and Palliative Medicine; American Academy of Physical Medicine & Rehabilitation; American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR); American Occupational Therapy Association; American Physical Therapy Association; Association of American Medical Colleges; Caprock Home Health; Cleveland Clinic; Henry Ford Health; Home Care Alliance of Massachusetts; Illinois Health and Hospital Association; Intersocietal Accreditation Commission; Kansas Hospital Association; Mayo Clinic; Michigan Health & Hospital Association; National Association of Rehabilitation Providers and Agencies (NARA); National Association of Rural Health Clinics; National Board for Certified Counselors (NBCC); National PACE Association; Net Health; OCHIN; Select Medical Holdings Corporation; University of Wisconsin Hospital and Clinics (UW Health); Vivie; WelbeHealth

Aggregated Comment Title: ***Reduce Redundant Audits and Documentation Requests in Compliance Monitoring***

Summary: There are redundant assessments, surveys, and certification requirements across Medicare, Medicaid, state agencies, and accrediting organizations, and these audits create a huge amount of waste and resource use. Integration and communication between these entities would reduce provider burden for reporting the same information multiple times in different formats. Cross-agency sharing of survey findings, standardized templates and rubrics, and reduction in multiple survey visits covering similar standards would eliminate much of this waste. CMS should create interoperable compliance monitoring, such as a single-source reporting tool or audit hub/portal for CMS, ONC, OCR, FDA, state agencies, and other relevant entities. Additionally, CMS should withdraw the proposed CMS-10913 audit protocol which is duplicative for Medicare Advantage. Furthermore, CMS should use initial enrollment documentation as the primary compliance record and require additional documentation only for changes or issues, reducing redundant reporting while ensuring accountability.

Total Comments Contributing: 62

Total Submissions Contributing: 32

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; Alliance of Wound Care Stakeholders ("Alliance"); American Health Care Association (AHCA); Blue Cross Blue Shield of Massachusetts; CPAC Foundation Center for Regulatory Freedom; Centro De Amigos; Coalition of State Rheumatology Organizations; DSHS/HCLA/RCS; Intersocietal Accreditation Commission

(IAC); Lantana Consulting Group; LeadingAge; LeadingAge Illinois/Iowa; LeadingAge PA; Michigan Home Health Association; Microsoft; NCQA; Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; Price Services Group, L.L.C.; Prime Therapeutics LLC; SCAN Health Plan; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead; The U.S. Chamber of Commerce; UltraSight Inc.; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Revisit COVID-19 and Influenza Vaccination Reporting Requirements***

Summary: The COVID-19 and influenza vaccination reporting requirements for patients and staff have led to significant administrative burden and resource demands for healthcare facilities. Stakeholders are calling for a reevaluation of these requirements, citing minimal value in improving care, potential risks, concerns about data quality and excessive data-gathering processes. Suggestions include incorporating vaccination data into existing reports or leveraging data already captured, repealing outdated reporting requirements, making vaccination voluntary, and streamlining reporting mechanisms to reduce fragmentation and ease the burden on facility teams. Calls to eliminate irrelevant metrics and reconsider reporting frequencies highlight the need for a more efficient and effective approach to vaccination reporting. The COVID-19 Achievement for Staff Improvement Activity (IA) should be removed from the MIPS Value Pathway (MVP) framework.

Total Comments Contributing: 61

Total Submissions Contributing: 45

Organization(s): Adara Home Health; Advocating for Seniors; Alabama Hospital Association; American Health Care Association (AHCA); American Hospital Association; Ascension; California Hospital Association; Christian Living Communities / Cappella Living Solutions; Florida Hospital Association; Greater New York Hospital Association; Gulf Coast Outpatient Surgery Center, Laurel Surgery & Endoscopy Center; Illinois Health and Hospital Association; Kentucky Hospital Association; Kona Community Hospital; Large Urology Group Practice Association (LUGPA); LeadingAge; LeadingAge PA; Maplewood of Cheshire County; Oak Lane Nursing & Rehab; Ohio Health Care Association; Ohio Hospital Association; Oklahoma Hospital Association; Pennsylvania Health Care Association; Premier Health; Premier Inc; Sanford Health - Good Samaritan Society; Select Medical Holdings Corporation; The Meth-Wick Community; Vivie; WellSpan Health

Aggregated Comment Title: ***Automate Prior Authorization Processes Where Possible***

Summary: Streamlining prior authorization through standardized electronic interfaces, simplifying complex coding rules, considering provider history, and enhancing automated denial management could significantly decrease administrative effort and costs. CMS should also incorporate AI tools and require real-time determinations for high-volume, low-risk services in Medicare Advantage plans, aiming to reduce the burden on hospitals during discharge planning

and post-acute transitions. Integrating real-time electronic authorization platforms into EHRs using standardized FHIR APIs could eliminate manual submissions, reduce denials, and expedite care delivery. Additionally developing dynamic status tracking through automated case management systems can provide real-time appeals status updates via provider portals, SMS, or email notifications, eliminating the need for follow-up calls and inquiries. CMS should implement an electronic prior authorization process for Part B drugs and transition away from fax-based prior authorization to more advanced technological solutions as well. CMS should also group PA requirements in a manner that matches the USCDI to enable automation and prevent duplication. Furthermore, CMS should consider automating repeat authorizations for therapies like chronic biologic treatments by allowing multi-month PA approvals or conditional renewals, based on consistent approval histories. To add to this, automating the prior authorization process for preventive services, such as HIV screening, based on USPSTF recommendations and beneficiary eligibility criteria could streamline approvals and reduce manual review and documentation requirements for providers.

Total Comments Contributing: 61

Total Submissions Contributing: 31

Organization(s): AMGA; American College of Osteopathic Family Physicians (ACOFP); American College of Physicians; American Medical Informatics Association; American Psychiatric Association; American Urological Association, Inc.; BAYADA Home Health Care; Bipartisan Policy Center; Booz Allen Hamilton; CGI Federal Inc.; CPAC Foundation Center for Regulatory Freedom; Christian Living Communities / Cappella Living Solutions; Coalition of State Rheumatology Organizations; HL7 Da Vinci Project; Johnson & Johnson; National Board for Certified Counselors (NBCC); Oncology Nursing Society; Patient Experience Policy Forum - The Beryl Institute; RadNet; The Ohio State University Wexner Medical Center; The University of Texas MD Anderson Cancer Center; University of Wisconsin Hospital and Clinics (UW Health); Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Automate Technology to Support Reporting Requirements***

Summary: Integrating EHRs and telehealth data with CMS reporting systems would automate most data submission. CMS should allow and incentivize standards-based interoperability (e.g., FHIR frameworks, DRLS, PGx) and secure real-time data feeds from various systems so providers can meet multiple reporting requirements more efficiently, emphasizing care quality over navigating reporting and manual abstraction requirements. For example, integrate validation or human-supported AI tools into EHRs to streamline measure calculations and submission processes, and use existing EHR audit trails and metadata. This would shift the focus back to clinical practice by reducing redundancies, errors, and the emphasis on earning points through documentation complexity. CMS can define necessary data elements and leverage existing technology ecosystems to further simplify reporting and documentation processes and improve

patient care prioritization. CMS can also encourage compliance management software that provides real-time updates for regulatory changes.

Total Comments Contributing: 60

Total Submissions Contributing: 35

Organization(s): AHIP; Alliance for Person-Centered Care; American Academy of Family Physicians; American Psychiatric Association; BAYADA Home Health Care; Bipartisan Policy Center; Booz Allen Hamilton; Christian Living Communities / Cappella Living Solutions; Eventus WholeHealth; Hartford Healthcare; Lantana Consulting Group; Meals on Wheels of Northwest Indiana; National Association of ACOs (NAACOS); National Board for Certified Counselors (NBCC); Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; Providence Health and Servicess; Reveleer; SCAN Health Plan; Sanford Health - Good Samaritan Society; Seaford Endoscopy Center; Sentia Health; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead; The American College of Cardiology; Vivie; WEDI

Aggregated Comment Title: ***Standardize Processes for Medicare Administrative Contractors (MACs)***

Summary: Medicare Administrative Contractors (MACs) and Administrative Law Judges (ALJs) often interpret guidance from CMS differently, which can lead to gaps in patient access, increase complexities, and disrupt appropriate coding in accordance with HIPAA transaction requirements. To address these issues, CMS should require MACs to abide by transparent and standard processes when making changes or updates to local coverage determinations (LCDs). For example, require them to provide a public notice period before changes to policy or billing and coding articles take effect, including changes to covered procedure and diagnosis codes. CMS should also address the lack of clarity and transparency in the LCD process, including uncertainty about where an LCD stands in the queue, the timeline for development, and the prioritization of requests by MACs. There should be a centralized MAC to administer the entire provider experience and MACs should provide a publicly available dashboard of LCD requests to improve transparency and understanding of the process, along with publicly posting locally-determined rates and a summary of the MAC's rationale on their website. Additionally, CMS should consolidate and standardize documentation requirements across all MACs, creating a core set of criteria that considers regional adjustments. These changes will provide clarity, reduce administrative burden, and allow for adequate response, education, and preparation.

Total Comments Contributing: 59

Total Submissions Contributing: 27

- ***Organization(s):*** Alliance of Dedicated Cancer Centers (ADCC); Amedisys, Inc.; American Academy of Physical Medicine & Rehabilitation; American Clinical Laboratory Association (ACLA); American Hospital Association; American Medical Rehabilitation

Providers Association; American Podiatric Medical Association; Booz Allen Hamilton; CGI Federal Inc.; Castle Biosciences Inc; Danaher Diagnostics; Diversified Service Options, Inc., dba GuideWell Source (Including First Coast Service Options and Novitas Solutions, Inc.); Illinois Health and Hospital Association; Large Urology Group Practice Association (LUGPA); National Association of Community Health Centers (NACHC); National Association of Rehabilitation Providers and Agencies (NARA); National Board for Certified Counselors (NBCC); National Council for Mental Wellbeing; National Partnership for Healthcare and Hospice Innovation; Net Health; O&P Insight; Sanford Health; Sutter Health; Texas Association for Home Care and Hospice

Individual(s): drsusanurmetz@gmail.com Urmetz

Aggregated Comment Title: ***Telehealth Geographic and Originating Site Restrictions***

Summary: Telehealth modernization involves removing outdated geographic and originating site restrictions within the Medicare program to allow patients to receive telehealth services in their homes and enable beneficiaries in non-rural areas to have equal access to virtual care as those in rural areas. These restrictions hinder efficient care delivery, limit adoption, and add costs for providers. The removal of these barriers would enhance access to care for Medicare beneficiaries, save time and money for healthcare providers, and align with current technological capabilities and patient preferences.

Total Comments Contributing: 58

Total Submissions Contributing: 38

Organization(s): AMGA; Alabama Hospital Association; Alliance of Dedicated Cancer Centers (ADCC); American Academy of Hospice and Palliative Medicine; American Society of Hematology; Association for Clinical Oncology; Association of American Medical Colleges; BJC Health System; California Hospital Association; Catholic Health Association; Cleveland Clinic; Eventus WholeHealth; Federation of American Hospitals; Greater New York Hospital Association; Healthcare Association of New York State; Illinois Health and Hospital Association; Infectious Diseases Society of America; Johns Hopkins Health System; Kansas Hospital Association; Kentucky Hospital Association; MaineHealth; Mayo Clinic; Memorial Sloan Kettering Cancer Center; Michigan Health & Hospital Association; Premier Inc; Sanford Health - Good Samaritan Society; Tampa General Hospital - Tampa, FL; The American College of Cardiology; The U.S. Chamber of Commerce; UHS, Inc.; Virginia Hospital & Healthcare Association; WellSpan Health

Aggregated Comment Title: ***Modernize the PBJ System***

Summary: Modernize the Payroll-Based Journal (PBJ) system. Modernization efforts can include: counting all shift hours in staffing data submissions including telework hours by RNs, hospice staff care, and all administrator and administrator in training hours, which will help assess

compliance with minimum staffing standards and enhance quality monitoring; removing meal break deductions; allowing facilities a reasonable opportunity to submit corrected or missing data and clarify the rating impact; enhancing the transparency of and process for audits by giving providers the opportunity the chance to submit a reconsideration request, receive prompt audit results, and engage in an exit conference before the audit concludes; improving how PBJ data is incorporated into the Five-Star Rating System, especially staffing star ratings during temporary shortages; providing additional training and information; stopping forced rating downgrades to 1 star as a PBJ audit penalty; allowing invoices from contractors acknowledging the presence of contract staff to validate hours for contract staff; and accepting modern data formats such as Excel. Additionally, CMS should more closely align PBJ staffing data with electronic health records (EHR), timekeeping platforms, and the Minimum Data Set (MDS) and facilitate the integration of certified digital systems for real-time, automated, and auditable submissions.

Total Comments Contributing: 57

Total Submissions Contributing: 18

Organization(s): American Health Care Association (AHCA); Christian Living Communities / Cappella Living Solutions; LeadingAge; LeadingAge Illinois/Iowa; LeadingAge PA; Oak Lane Nursing & Rehab; Ohio Health Care Association; Pennsylvania Health Care Association; PointClickCare; The Meth-Wick Community; Vivie

Aggregated Comment Title: ***Simplify Quality Reporting Processes***

Summary: Current quality reporting processes are complex and burdensome, often resulting in an over-collection of data. They may be simplified by: consistent use of claims-based and patient-reported data across all payers; adjusting reporting timelines that maximize operational effectiveness; tailoring mandates based on provider specifications, including high performance and low patient volumes; reducing low-value data collection; implementing a universal reporting portal to centralize submissions; simplifying complex measure definitions; shifting toward less frequent reporting for metrics with consistently low incidence, but introducing quarterly reporting (instead of annual) with rolling feedback where providers are required to submit data retrospectively in order to reduce errors; providing grace periods or corrective windows for errors; eliminating low-value or clinically misaligned measures; enhancing provider support and training; developing streamlined claims pathways; eliminating duplicative surveys; reducing requirements where appropriate; reducing redundant documentation; reducing frequent, small-scale changes; establishing universal interoperability standards to health technology vendors; using billed information to the payer for QA purposes instead of relying on other administrative data sources; and taking appropriate action based on results. CMS should also allow self-assessments.

Total Comments Contributing: 56

Total Submissions Contributing: 30

Organization(s): American Psychiatric Association; CPAC Foundation Center for Regulatory Freedom; Coalition of State Rheumatology Organizations; Curana Health; Danaher Diagnostics; Eich Plastic Surgery, PC; Federation of American Hospitals; Health Level Seven International (HL7); Henry Ford Health; HomeTown Health LLC; Infectious Diseases Society of America; Lantana Consulting Group; Massachusetts Coalition for the Prevention of Medical Errors; National Board for Certified Counselors (NBCC); Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; Price Services Group, L.L.C.; Reveleer; Riverside Eye Center; Sanford Health - Good Samaritan Society; Sutter Health; The American College of Cardiology; The Ohio State University Wexner Medical Center; VillageMD; Vivie; WEDI

Aggregated Comment Title: ***Simplify PACE Processes***

Summary: Simplify processes associated with the Program of All-Inclusive Care for the Elderly (PACE). Recommendations include: streamlining the application process by eliminating certain requirements for organizations that want to expand their service areas and allowing multiple expansion applications per cycle; clarify the requirements so that only one contract per organization is allowed, per state; simplifying the Standard Determination Process (SDR) by establishing clear criteria for differentiating which SDR request must be reviewed by the IDT review or staff; increasing the frequency of accepting new provider applications; allowing providers to determine nursing home level of care eligibility; defining semi-annual care plans as being due no later than the last day of the sixth month after the most recent care plan was re-evaluated; and streamlining requirements to expand PACE. Removing anti-competitive federal regulations and revising service area overlap restrictions could also enhance patient choice and access to PACE services.

Total Comments Contributing: 56

Total Submissions Contributing: 7

- ***Organization(s):*** Bipartisan Policy Center; InnovAge; National PACE Association; PACE Southeast Michigan; SCAN Health Plan; WelbeHealth

Aggregated Comment Title: ***Streamlining Audit Processes***

Summary: Audits and medical reviews by various entities like TPE, RAC, MACs, and UPICs are onerous. Retroactive documentation requests, uncoordinated, overlapping audits, constricted timelines, and inexperienced reviewers lead to significant compliance burdens for facilities. Audits should be streamlined and restructured to reduce unnecessary audits and the resources that are used to contest them and require CMS auditors to access prior documentation digitally before re-requesting records. Using standardized digital logs and metadata tagging can provide compliance without requiring extensive narrative documentation. Initial claim evaluation and

redeterminations should use the same standards. CMS should also extend the timeline or adjusting requirements for self-audits under Medicare's overpayment rule. Alternative Dispute Resolution processes are also burdensome. To prevent duplication, audits in Medicare, Medicaid, and commercial insurance should be coordinated to avoid multiple overlapping reviews triggered by a single event like service denial or utilization flag and CMS should prohibit multiple audits on the same claim. More broadly, CMS could coordinate an HHS-wide audit schedule wherein multiple groups ask for data at once so that plans can focus on accurately and efficiently reporting data to HHS rather than spending time and effort providing duplicate information in new formats.

Total Comments Contributing: 54

Total Submissions Contributing: 36

Organization(s): American Association of Post-Acute Care Nursing (AAPACN); American College of Physicians; American College of Surgeons; CPAC Foundation Center for Regulatory Freedom; Cleveland Clinic; Coalition of State Rheumatology Organizations; CrownQuest Inc; Health Services of the Pacific; Highlands Oncology Group, P.A.; Hospital Association of Rhode Island; Johns Hopkins Health Plans; Microsoft; National Board for Certified Counselors (NBCC); Oak Lane Nursing & Rehab; Ohio Hospital Association; Point32Health; PointClickCare; Price Services Group, L.L.C.; SCAN Health Plan; Shekina Glory Legacy Hospice and Palliative Services; Texas Association for Home Care and Hospice; The American Psychological Association Services, Inc.; The Ohio State University Wexner Medical Center; The U.S. Chamber of Commerce; University Radiology Group, LLC; Virginia Hospital & Healthcare Association; Vivie; WelbeHealth; Wellbox

Aggregated Comment Title: ***Standardize Prior Authorization Processes Across Payers***

Summary: Variation in prior authorization policies and procedures among federal and commercial insurers creates confusion and unnecessary delays. To streamline the process and improve access to timely care CMS should implement a standardized electronic prior authorization process, as well as standardizing submission formats and clinical documentation requirements. Harmonizing prior authorization requirements and enforcing consistent documentation standards would alleviate the complexities faced by providers dealing with multiple systems and improve the overall efficiency of the healthcare system. Standardizing prior authorization processes would improve consistency and transparency.

Total Comments Contributing: 54

Total Submissions Contributing: 39

Aggregated Comment Title: ***Merge or Streamline Beneficiary Notice Forms***

Summary: Beneficiaries receive various complex and confusing notices. These letters are too technical, repetitive and not user-friendly for elderly patients and their caregivers. Streamlining and simplifying the language and layout of required beneficiary notices could ease burden. For example, CMS could merge the Notice of Medicare Non-Coverage Form CMS 10123-NOMNC with Detailed Explanation of Non-coverage Form CMS-10124-DENC and/or ABN into one to streamline the process. This would reduce redundancy when individuals request an immediate appeal. Other candidates to streamline include the Medicare Outpatient Observation Notice (MOON), Important Message from Medicare (IMM) form, the Medicare Change of Status Notice, and MSSP requirements. CMS should also consider combining forms that can be used across Medicare and Medicare Advantage. CMS could also eliminate the requirement for MAOs to provide the DENC or modify the requirement to only be necessary if an enrollee requests it. CMS could also remove the requirement of notification to beneficiaries assigned to a Medicare ACO since it already informs beneficiaries about ACOs through the "Medicare and You Handbook." CMS should update its guidance to allow compliance with WCAG requirements, which will encourage providers to digitize the forms. CMS should allow the use of Doing Business As names without penalty, provided the identity is traceable.

Total Comments Contributing: 49

Total Submissions Contributing: 34

Organization(s): AdventHealth; Aledade; Alliance of Dedicated Cancer Centers (ADCC); America's Physician Groups (APG); American Association of Post-Acute Care Nursing (AAPACN); American Hospital Association; Ascension; BJC Health System; Booz Allen Hamilton; Cleveland Clinic; Curana Health; Epic Systems; Faith Regional Health Services; Florida Hospital Association; Health Alliance Plan of Michigan; Healthpilot; Humana; Illinois Health and Hospital Association; Lumeris Healthcare; National Association of ACOs (NAACOS); Ohio Hospital Association; PSW and MultiCare Connected Care; Premier Health; Premier Inc; R1 RCM; Sanford Health - Good Samaritan Society; Society of Hospital Medicine; UHS, Inc.; VillageMD

Aggregated Comment Title: ***Modify or Repeal Disincentives Under the 21st Century Cures Act***

Summary: CMS should modify or repeal the finalized disincentives outlined in the final 21st Century Cures Act. This rule causes concerns due to excessive, confusing, and imbalanced penalties that could jeopardize the financial stability of hospitals, particularly small and rural facilities. The rule's disincentive structure, including reductions in Medicare payments, reimbursement adjustments, lower performance scores, and potential program ineligibility, is deemed overly punitive and could hinder effective healthcare information sharing. The 21st Century Cures Act already assigns the HHS Office of Inspector General (OIG) and the ASTP/ONC clear power to investigate, and the Office for Civil Rights (OCR) to sanction, information blocking. CMS' new payment cuts punish the same conduct a second time, often through multiple programs (MIPS, Promoting Interoperability, MSSP, IPPS, CAH). The lack of clarity in the determination processes by the Office of Inspector General and the arbitrary enforcement

concerns further highlight the need to repeal the rule in order to alleviate provider burden and promote a more effective healthcare information-sharing environment.

Total Comments Contributing: 44

Total Submissions Contributing: 29

Organization(s): AMGA; Alliance of Safety-Net Hospitals (ASH); American College of Radiology; American Medical Association; Ascension; Association for Clinical Oncology; Association of American Medical Colleges; Availity; California Hospital Association; Cleveland Clinic; Federation of American Hospitals; Florida Hospital Association; Illinois Health and Hospital Association; Kentucky Hospital Association; Louisiana Rural Health Association; MaineHealth; Medical Group Management Association; Ohio Hospital Association; Partnership to Empower Physician-Led Care; Select Medical Holdings Corporation; Sutter Health; Virginia Hospital & Healthcare Association; WEDI; WellSpan Health

Aggregated Comment Title: ***Rethink Implementation of Mandatory CMMI Models Including TEAM and IOTA***

Summary: CMMI models including the Transformation Episode Accountability Model (TEAM) and Increasing Organ Transplant Access (IOTA) mandatory payment models potentially force hospitals to assume more risk than they can manage and impacts post-acute care providers in mandatory participation areas. The model design may lead hospitals to prioritize cost-cutting over quality patient care and preferences. CMS should make models like TEAM and IOTA voluntary, as the current structure maintains significant financial risk for participating hospitals without adequate piloting or stakeholder engagement. This model could destabilize hospitals with limited experience in alternative payment models, risking community access to care. CMS should also ensure adequate risk adjustment and revise pricing methodology.

Total Comments Contributing: 44

Total Submissions Contributing: 22

Organization(s): Alabama Hospital Association; Alliance of Safety-Net Hospitals (ASH); American Medical Rehabilitation Providers Association; Ascension; Association of American Medical Colleges; California Hospital Association; Cleveland Clinic; Federation of American Hospitals; Greater New York Hospital Association; Illinois Health and Hospital Association; Kentucky Hospital Association; Mayo Clinic; Ohio Hospital Association; Sutter Health; The Renal Healthcare Association; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Rescind or Revise Requirements for Mid-Year Notification of Unused Supplemental Benefits***

Summary: The CY 2025 MA-PD Final Rule requires MA plans to notify beneficiaries of unused supplemental benefits mid-year, but these individualized reports may cause beneficiary

confusion, especially when the individual does not have a need for the unused services. CMS should rescind or revise 42 CFR 422.111(l) and 422.2267(e)(42). Instead, allow MA plans to remind beneficiaries of all supplemental benefits, rather than member-specific reports. CMS should also allow plans to incorporate the notification into existing communications, such as annual benefit change notices, to streamline communication and to reduce administrative burden. Other recommendations include targeting the notice to specific eligible members such as SSBCI, aligning notification timing with pre-enrollment marketing materials, excluding certain MA plans, and providing concise benefit descriptions with links to more detailed information.

Total Comments Contributing: 42

Total Submissions Contributing: 19

Organization(s): AHIP; Alignment Health Plan; Association for Community Affiliated Plans (ACAP); Blue Cross Blue Shield Association; Blue Cross Blue Shield of Massachusetts; Center for Medicare Advocacy; Humana; Johns Hopkins Health Plans; Medica; Point32Health; SCAN Health Plan; Sanford Health - Sanford Health Plan and Security Health Plan; South Country Health Alliance; Special Needs Plan Alliance; The National MLTSS Health Plan Association; The U.S. Chamber of Commerce; Triton Health Systems; UnitedHealthcare

Aggregated Comment Title: ***Eliminate In-Person Requirements for Telehealth***

Summary: In order to align with best practices and industry standards, Medicare should eliminate the requirement to meet in-person with all telehealth clients within a designated timeframe. Make telehealth services, specifically phone calls without an in-person requirement, a permanent option to provide consistency and certainty for future healthcare access. These in-person visits are not necessary for effective telehealth services. Remove the in-person visit requirements for behavioral health telehealth at Sec. 1834(m)(7) of the Social Security Act (42 U.S.C. 1395m) and 42 CFR 410.78(b)(3)(xiv). CMS should also remove the in-person requirement under 42 CFR 483.30(b)-(c), F712 in the long-term care surveyor guidance, Appendix PP of the State Operations Manual.

Total Comments Contributing: 41

Total Submissions Contributing: 37

Aggregated Comment Title: ***Simplify or Eliminate the SEP-1 Severe Sepsis and Septic Shock Management Bundle***

Summary: The Severe Sepsis and Septic Shock: Management Bundle (SEP-1) is burdensome for providers. SEP-1 is criticized for its constantly-changing criteria, complexity, and potential to drive antibiotic overuse which could lead to antibiotic resistance. Recent research challenges the notion that SEP-1 improves survival rates and other outcomes, highlighting the need for a

reevaluation of this quality measure. Additionally, SEP-1 and Patient Safety Indicators (PSI) quality measures are duplicative. For instance, the repetition of a lactate does not offer clinical benefits and causes unnecessary lab utilization. Further, measure specifications undergo frequent updates to align with changes in national guidelines and to address technical issues, which can make it difficult for hospitals/clinicians to implement in terms of educating staff and updating their EHRs. Stringent documentation requirements such as the sepsis focused exam should be reconsidered. Removing SEP-1 requirements could alleviate abstraction burdens and allow hospitals to prioritize sepsis care over documentation standards. CMS could simplify the measure by focusing only on septic shock defined by hypotension or using a measure of sepsis outcomes. Alternatively, CMS could replace SEP-1 with a risk-adjusted sepsis-mortality measure.

Total Comments Contributing: 41

Total Submissions Contributing: 32

Organization(s): Alabama Hospital Association; American Hospital Association; Ascension; California Hospital Association; Catholic Health Association; Cleveland Clinic; Florida Hospital Association; Hartford Healthcare; Infectious Diseases Society of America; Kansas Hospital Association; Mainline Health; Mayo Clinic; Ohio Hospital Association; Piedmont Healthcare; Providence Health and Servicess; Sanford Health; Society of Hospital Medicine; Sutter Health; Tampa General Hospital - Tampa, FL; The Ohio State University Wexner Medical Center; Virginia Hospital & Healthcare Association; Vizient, Inc.

Aggregated Comment Title: ***Eliminate Burdensome Chart-Abstracted and Structural Measures***

Summary: Structural Measures (e.g., Patient Safety Structural Measure, Age-Friendly Hospital measure, transfer of health information measures, and drug regimen review measures) are unendorsed process measures that increase reporting burdens, especially in small rural hospitals. CMS should prioritize outcome-based measures and eliminate those lacking demonstrated value for patients and providers. CMS should consider removing these measures as they have little evidence tying their use to better care or outcomes. Implementing patient safety structural measures presents significant challenges, including resource allocation, operational disruptions, and financial investments. Establishing Patient and Family Advisory Councils, mandating team communication training, integrating human factors engineering principles, implementing safety huddles, and requiring patient safety curricula all require extensive efforts and sustained engagement. Specific requirements such as "zero preventable harm" goals, board reporting percentages, and tool mandates can create administrative burdens, diverting attention from critical safety priorities. Agencies could consider reporting some measures less frequently to reduce administrative load without compromising data quality.

Total Comments Contributing: 40

Total Submissions Contributing: 20

Organization(s): Advocating for Seniors; American Hospital Association; American Society of Anesthesiologists; Ascension; Association of American Medical Colleges; California Hospital Association; Dale Medical Center; Healthcare Association of New York State; Illinois Health and Hospital Association; Microsoft; Northwestern Medicine; Ohio Hospital Association; Pennsylvania Health Care Association; Premier Inc; The Ohio State University Wexner Medical Center; Vizient, Inc.; Wooster Community Hospital

Aggregated Comment Title: ***Address Challenges with HQRP, HIS, and HOPE Requirements for Hospice***

Summary: Quality reporting for hospice is challenging, including HQRP and the Hospice Item Set (HIS). The transition from the HIS to the HOPE tool is complex and poses financial risks for hospice providers. Furthermore, the HOPE tool requests information already provided on the Notice of Termination/Revocation (NOTR). Additional concerns include technical challenges, timing, penalties, and training needs. Recommendations include delaying implementation, providing additional training, and streamlining reporting requirements to ensure a successful transition.

Total Comments Contributing: 39

Total Submissions Contributing: 12

Organization(s): American Academy of Hospice and Palliative Medicine; Essentia Health; Home Care Alliance of Massachusetts; LeadingAge; National Alliance for Care at Home; Ohio Health Care Association; Oregon Hospice & Palliative Care Association and Washington State Hospice & Palliative Care Organization; Sanford Health - Good Samaritan Society; Shekina Glory Legacy Hospice and Palliative Services; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Eliminate the CED Policy***

Summary: Eliminate or reform the Coverage with Evidence (CED) policy to improve patient access to drugs and devices, especially where it impedes access to otherwise approved treatments. The CED duplicates the role of the FDA. Revert to covering FDA-approved drugs based on their labeled use. The CED imposes burdens on patients without clear public health outcomes, lacks standards, and fails the Administrative Procedure Act's requirements. The program's requirement for patients to enroll in trials delays coverage and disproportionately affects underserved populations and the elderly, creating structural barriers to care. The CED program is inefficient, discriminatory, and hinders access to CMS-approved treatments, and CMS should pause, reassess, and reform the program by reaffirming FDA approval as the sole basis for Medicare coverage, therefore restoring statutory clarity and inter-agency coherence. Establish uniform, public criteria for any evidence development requirements that remain. CED contradicts Medicare's mandate to provide 'reasonable and necessary' care, stifles access to treatments and creates unnecessary bureaucratic obstacles.

Total Comments Contributing: 39

Total Submissions Contributing: 11

Organization(s): American Commitment; CPAC Foundation Center for Regulatory Freedom; Consumer Action for a Strong Econmy; National Taxpayers Union; Pfizer, Inc.; RetireSafe; Survivors for Solutions; Taxpayers Protection Alliance

Aggregated Comment Title: ***Reconsider THA/TKA PRO-PM***

Summary: Data collection for THA/TKA Patient-Reported Outcome Performance Measure (PRO-PM) is burdensome for hospitals due to the extensive resources needed to track patients for post-operative questionnaires. Hospitals find the data collection process challenging, duplicative with other efforts, and time-consuming, especially with the requirement for a 50% response rate one year after surgery. Additionally, relying on subjective patient-reported outcomes for such measures could lead to significant impacts on hospital finances. Given the complexity of patient needs and administrative burden in collecting these measure CMS should reconsider if these measures should be mandatory. If these measures continue to be mandatory, CMS should consider alternative methods for data collection to alleviate the strain on hospitals, for instance using a sampling as opposed to all patients. For example, shifting this measure to outpatient settings or orthopedic groups could better reflect patient outcomes and reduce penalties on hospitals without orthopedic departments.

Total Comments Contributing: 39

Total Submissions Contributing: 22

Organization(s): Cleveland Clinic; Dale Medical Center; Federation of American Hospitals; Florida Hospital Association; Franciscan Missionaries of Our Lady Health System (FMOL Health); Greater New York Hospital Association; Healthcare Association of New York State; Henry Ford Health; Illinois Health and Hospital Association; Kona Community Hospital; Mayo Clinic; NCH Naples Comprehensive Health; Northwestern Medicine; Ohio Hospital Association; Piedmont Healthcare; Premier Health

Aggregated Comment Title: ***Remove Supervision Requirements for CRNAs***

Summary: The current physician supervision requirement for Certified Registered Nurse Anesthetists (CRNAs) in hospitals, ambulatory surgical centers (ASCs), and rural areas under Medicare regulations imposes significant administrative burdens, increasing costs and diverting resources from patient care. Studies show that CRNAs provide safe anesthesia care independently, and removing the supervision requirement aligns with state licensure laws, reduces administrative burdens, and enhances provider flexibility without compromising patient safety. Recommendations include amending 42 CFR § 482.52(a) and 42 CFR § 416.42(b)(2) to eliminate the physician supervision requirement for CRNAs, streamlining compliance and reducing administrative oversight costs.

Total Comments Contributing: 38

Total Submissions Contributing: 24

Organization(s): American Association of Nurse Anesthesiology; Columbus Regional Healthcare System; Evolutionary Healthcare; Excel Anesthesia, LLC; Froedtert and Medical College of Wisconsin; Midwest Pain Partners; Nodaway Anesthesia Professionals; Northeastern Vermont Regional Hospital; Premier Inc; Providence Alaska Kodiak; Safe Anesthesia Staffing LLC; The American Association of Nurse Anesthesiology; USA grace anesthesia services

Aggregated Comment Title: ***Prohibit Step Therapy***

Summary: The 2018 CMS policy allowing Medicare Advantage plans to implement step therapy and prior authorization for Part B drugs caused delays in accessing necessary therapies, increased administrative burdens on practices, and disparities in treatment between Medicare Advantage and original Medicare beneficiaries. Step therapy forces patients to try multiple medications, even if less effective, causing exhaustion, wasted time, eroded hope, and despair. CMS needs to revoke or revise regulations permitting Medicare Advantage plans to enforce step therapy for Part B drugs to ensure equitable access to therapies and reduce administrative burdens on providers and patients.

Total Comments Contributing: 38

Total Submissions Contributing: 18

- ***Organization(s):*** American Academy of Allergy, Asthma & Immunology; American Academy of Hospice and Palliative Medicine; American Academy of Neurology; American College of Rheumatology; American Medical Association; American Society of Hematology; American Urological Association, Inc.; BIO; Coalition of State Rheumatology Organizations; Highlands Oncology Group, P.A.; Humana; Johnson & Johnson; National Infusion Center Association; National Organization of Rheumatology Management; Oncology Nursing Society; Pfizer, Inc.; PhRMA; Survivors for Solutions

Aggregated Comment Title: ***Reduce Administrative Burden Associated with NHSN Reporting***

Summary: Commenters describe the NHSN reporting process as burdensome, time-consuming, error-prone, and lacking in meaningful outcomes. They express frustration with the complexity of some modules (Antimicrobial Use and Resistance, for example), the logistics of obtaining access via SAMS, the manual tracking requirements, the outdated nature of the system itself, and the lack of value in the data collected, especially post-pandemic. Suggestions include eliminating reporting or improving interoperability to streamline it using existing and more user-friendly systems (e.g., MDS), and processes to reduce administrative burden and improve compliance (e.g., implementing a real-time proof of submission notification.) Commenters also

recommend that CMS first vet NHSN data request changes for validity and then approve them once every two years.

Total Comments Contributing: 37

Total Submissions Contributing: 18

Organization(s): American Health Care Association (AHCA); American Medical Rehabilitation Providers Association; Berkshire Medical Center; Encompass Health; Federation of American Hospitals; Fresenius Medical Care; Guardian Angels Senior Services; Kansas Hospital Association; Martha T. Berry Medical Care Facility, Macomb County Michigan; Oak Lane Nursing & Rehab; Ohio Hospital Association; Premier Health; Sanford Health; Sanford Health - Good Samaritan Society; The Meth-Wick Community

Aggregated Comment Title: ***Rescind Telehealth Home Address Rule to Overcome Privacy Concerns***

Summary: CMS should remove the requirement for practitioners providing telehealth services from home to report their home addresses on Medicare enrollment and claim forms. This policy, waived during the COVID-19 public health emergency, poses privacy risks and administrative burdens without clinical or billing utility. Rescinding this requirement would protect providers' privacy and safety, ensuring continued access to telehealth services for Medicare beneficiaries.

Total Comments Contributing: 37

Total Submissions Contributing: 32

Aggregated Comment Title: ***Streamline Credentialing Processes to Reduce Duplication***

Summary: CMS should streamline credentialing and move toward a national system. The current process is too complex and making simple changes is burdensome for providers. CMS could collaborate with state Medicaid programs to centralize credentialing services for managed care organizations (MCOs) and fee-for-service (FFS) programs, similar to what some states and MCOs do with CAQH. CMS should reevaluate the enforcement of credentialing regulations to prevent unnecessary barriers and ensure retroactive payments for physicians, as well as improve quality and information for consumers. Even if a provider was previously credentialed by a payer, they must be credentialed at their new facility, which is redundant. CMS could also consider using NPI number and CAQH or PECOS portals to minimize credentialing burden. Streamlining credentialing processes and frequencies would reduce duplication and lower costs while improving access to care.

Total Comments Contributing: 37

Total Submissions Contributing: 27

Organization(s): Alliance for Physical Therapy Quality and Innovation; American Dental Association; American Physical Therapy Association; Association of American Physicians and Surgeons; Availity; Bright Day Psychology PLLC; Cityblock Health; Endocrine Society; Excel Anesthesia, LLC; Kentucky Hospital Association; National Association of Rehabilitation Providers and Agencies (NARA); National Nurse Practitioner Entrepreneur Network; Ohio Hospital Association; The American Psychological Association Services, Inc.; The Helmsley Trust; University Radiology Group; VillageMD; WEDI; Wheelchair Clinic Inc

Aggregated Comment Title: ***Standardize and Streamline Care Plan Documentation***

Summary: Interdisciplinary Plan of Care (IPOC) documentation is a significant time and resource burden that detracts from direct patient care, and the requirement for consistent oversight and updating of the IPOC adds to the challenge, especially when patient conditions change rapidly. Creating a standardized, person-centered documentation template that works across interdisciplinary teams, and for both Medicare and Medicaid, would reduce redundancy and wasted time from duplicative forms and processes. Implementing a shared digital care plan platform for both clinical and non-clinical providers with standardized IPOC templates that allow electronic signatures within the EHR would simplify the process. Other suggestions include automatically tracking visit compliance through EHR integration and affording flexibility in the frequency of required updates, especially in patients with stable conditions. Such changes could ease administrative burden and improve care coordination. CMS should also ease Individualized Overall Plan of Care (IOPOC) requirements when patients have unplanned discharges or interrupted stays before the fourth day. CMS should also allow a single consent to be obtained as many patients have longitudinal treatment programs related to the same care plan.

Total Comments Contributing: 37

Total Submissions Contributing: 18

Organization(s): Alliance for Connected Care; Amedisys, Inc.; American Academy of Physical Medicine & Rehabilitation; AnewHealth; Centro De Amigos; Highlands Oncology Group, P.A.; Hospital Association of Rhode Island; Microsoft; Netsmart; Select Medical Holdings Corporation; Tampa General Hospital - Tampa, FL; Vivie; WellSpan Health

Aggregated Comment Title: ***Utilize Risk-Based Auditing and Survey Schemes***

Summary: To streamline Medicare reporting and documentation, CMS can implement a risk-based audit and survey model that reduces demands on providers so they can focus on patient care. Tailoring audits and surveys based on compliance history or risk profile of either the facility or the pertinent issue can maintain program rigor while allowing CMS to redirect resources towards higher-risk outliers. Risk-based surveys have been proven to identify deficiencies effectively in a shorter amount of time and with fewer personnel. Other suggestions include

conducting routine surveys or audits virtually and limiting MIPS Improvement Activities attestation audits to outliers. The hours and time spent reviewing and denying low-dollar claims is inefficient.

Total Comments Contributing: 36

Total Submissions Contributing: 20

Organization(s): ATA Action; American Health Care Association (AHCA); CPAC Foundation Center for Regulatory Freedom; California Hospital Association; Illinois Health and Hospital Association; Infectious Diseases Society of America; LeadingAge; National Alliance for Care at Home; Ohio Health Care Association; Point32Health; Texas Association for Home Care and Hospice; The U.S. Chamber of Commerce; UHS, Inc.

Aggregated Comment Title: ***Streamline MDS Documentation***

Summary: The Minimum Data Set (MDS) and care plan documentation can become burdensome due to excessive length, detail, and frequency, leading to a paperwork-focused process that does not honor person-centered care and the right to choose. For example, weight monitoring may not be appropriate for some residents, but penalties may still apply, or questions A1005 on Ethnicity, 1010 on Race and 1110 on language are asked on every assessment, but do not change. Frequent updates and redundant questions are burdensome, and much of the data is already recorded electronically and could feed directly into MDS fields. Minor, non-clinically significant changes and cumbersome questions pull staff away from residents for mundane documentation. Additionally, the MDS overlaps with other Medicare-required assessments for similar services. CMS should evaluate which data points are actively used for care improvement or reimbursement accuracy and streamline or remove those that are not. In the context of drug dosing, CMS could expand the list of acceptable reasons for not attempting gradual dose reduction to include "documented use of the drug and dose as clinically appropriate" and require attestation by both a physician and pharmacist in such cases. Furthermore, simplifying the Minimum Data Set (MDS) for Resident Assessment would reduce the regulatory burden on skilled nursing facilities. Currently, the 32-page MDS form is accompanied by 920 pages of rules for completion, which CMS deems necessary for each nursing home resident every 92 days.

Total Comments Contributing: 36

Total Submissions Contributing: 15

Organization(s): American Health Care Association (AHCA); CCL Hospitality Group; Compass Community Living; Edison Christian Health Center; Essentia Health; LeadingAge; LeadingAge PA; Maplewood of Cheshire County; Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness)/Alliance for Aging Research; Vivie

Aggregated Comment Title: ***IRF RCD Claims Review is Redundant and Overly Complex***

Summary: The Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD) delays necessary patient care, adds administrative burden, and threatens access to critical services for Medicare beneficiaries. The current pre-claim review process is unnecessary, as most requests are affirmed, and the additional paperwork duplicates existing documentation requirements. The IRF RCD's 100% claims review process undermines care delivery and substitutes third-party contractors' judgment for treating physicians, leading to unjustified denials that are often overturned on appeal. Therefore, the IRF RCD should be repealed.

Total Comments Contributing: 36

Total Submissions Contributing: 21

Organization(s): Alabama Hospital Association; Alliance of Safety-Net Hospitals (ASH); American Academy of Physical Medicine & Rehabilitation; American Hospital Association (AHA); American Medical Rehabilitation Providers Association; American Occupational Therapy Association; California Hospital Association; Compassion Home Health; Encompass Health; Federation of American Hospitals; Georgia Hospital Association; Hands of Wellness; Illinois Health and Hospital Association; Ohio Hospital Association; Select Medical Holdings Corporation; The Ohio State University Wexner Medical Center; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Support Integrated Medical and Behavioral Health Care***

Summary: Current Medicare policies create a divide between medical and behavioral health care, hindering the delivery of whole-person care and impeding Americans' health. Behavioral health quality measures lack practical data sources and interoperability, while administrative burdens related to integrated care clinician credentialing pose challenges. Medicare's separate billing codes for medical and psychiatric care lead to administrative complexity and disincentivize integration. To address these issues, Medicare could offer reimbursement for interdisciplinary teams providing integrated care, revise policies to ensure mental health parity, and expand access to behavioral health clinicians in hospital settings. Strengthening transitional care rules, establishing national quality measures for behavioral health, and building a quality measurement infrastructure with shared accountability are crucial steps towards improving integrated care delivery and patient outcomes.

Total Comments Contributing: 36

Total Submissions Contributing: 5

Organization(s): American Psychiatric Association; NHMH - No Health w/o Mental Health; National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Streamline OASIS Assessments***

Summary: Streamline the OASIS assessment and related forms to reduce the burden of data collection and restore the focus on patients, as the requirement stretches a thin nursing staff

even further. For example, CMS could shorten the form and require it only at admission and discharge; reconsider medication sections M2001-M2030, N0415; and eliminate listing COVID-19 vaccination status. Restore flexibility regarding eligible staff that were enacted during the PHE. Eliminate the requirement for a new OASIS due to changes in Medicare payer source (e.g., going from Medicare Advantage to Traditional Medicare). Furthermore, the expansion of OASIS has led to longer assessment times, often requiring clinicians to spend hours on documentation rather than direct patient care as many items are redundant or outdated.

Total Comments Contributing: 35

Total Submissions Contributing: 20

Organization(s): Aegis Therapies; AnewHealth; Caprock Home Health; Compassion Home Health; Lantana Consulting Group; National Alliance for Care at Home; Ohio Health Care Association; Sanford Health - Good Samaritan Society; Society of Hospital Medicine; Sutter Health; Texas Association for Home Care and Hospice; Vivie

Aggregated Comment Title: ***Streamline Claims Adjudication Processes***

Summary: The CMS claims adjudication processes are burdensome and predate the proliferation of electronic data systems. Further, providers often have to submit two claims for the same service, and some MA plans have additional documentation or billing requirements on top of Medicare's requirements. Additionally, the process for managing rejected claims in the Fiscal Intermediary Shared System (FISS) is outdated, lacks integration with other systems, and has limited reporting capabilities. CMS should streamline the claims submission process for MA and traditional Medicare by implementing a unified claims submission system and enhancing integration between EHRs and Medicare's claim system. CMS should also allow providers to submit claims beyond strict timely filing deadlines when insurance coverage or coordination of benefits information was unavailable at the time of service. To address claim denials, CMS could partner with clearinghouses to communicate rejections using 277 claim status responses. A unified system would enable healthcare providers to submit a single claim that would automatically and electronically route to both the Medicare Advantage plan and Medicare. Streamlining claims submission processes could reduce duplicative work, errors and claim denials, while improving payment timeliness.

Total Comments Contributing: 35

Total Submissions Contributing: 16

Organization(s): Agadia Systems; Booz Allen Hamilton; California Hospital Association; Cleveland Clinic; Florida Hospital Association; Healthcare Financial Management Association; Henry Ford Health; LeadingAge; LeadingAge PA; Ohio Hospital Association; Quest Diagnostics; Sanford Health; Sanford Health - Good Samaritan Society; Shekina Glory Legacy Hospice and Palliative Services; Society of Hospital Medicine

Aggregated Comment Title: ***Align Regulatory Requirements Across Entities to Reduce Redundancy and Alleviate Burden***

Summary: CMS should minimize conflicting requirements across regulatory bodies and align definitions and expectations across entities. Opportunities include creating shared compliance templates for use across programs, collaborating with state health departments, minimizing duplicative audits by recognizing when other regulatory bodies have already done the job (such as FDA, state boards, and payer audits verifying licensure and compliance), and streamlining the rules and regulations for all healthcare entities to create one universal set of rules. Additionally, CMS can leverage existing standards and work with high-performers to promote innovation and voluntary adoption without adding burden.

Total Comments Contributing: 35

Total Submissions Contributing: 20

Organization(s): Highlands Oncology Group, P.A.; Johns Hopkins Health Plans; Kingdom Insurance Group; Oak Lane Nursing & Rehab; Patient Experience Policy Forum - The Beryl Institute; Price Services Group, L.L.C.; Providence Health and Servicess; Sanford Health - Good Samaritan Society; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead; The American Association of Nurse Anesthesiology; The Ohio State University Wexner Medical Center; Virginia Hospital & Healthcare Association; WelbeHealth

Aggregated Comment Title: ***Automate Quality Data Abstraction and Reporting***

Summary: Current software for chart-abstracted measures is inefficient, leading to reliability issues and quality concerns. Automating quality data extraction from EHRs using AI, cloud infrastructure, or FHIR-based tools can simplify Medicare processes by pre-populating measure fields, flagging care gaps, and assigning patients to cost measures. This would save time on manual abstraction, reduce reporting burden, and improve data interoperability between systems, providers, and patients. Adding real-time dashboards could offer opportunities to track compliance efficiently. Shifting from manual chart-abstracted measures to automation could eliminate this burden and reduce costs. Automating quality reporting can also integrate appeals analytics to automatically generate quality reports from data already in the system.

Total Comments Contributing: 34

Total Submissions Contributing: 20

Organization(s): American College of Osteopathic Family Physicians (ACOFP); American Osteopathic Association; American Psychiatric Association; Booz Allen Hamilton; CPAC Foundation Center for Regulatory Freedom; Cleveland Clinic; Endocrine Society; Infectious Diseases Society of America; Lantana Consulting Group; Massachusetts Health Data Consortium; National Board for Certified Counselors (NBCC); Ohio Hospital Association; Piedmont

Healthcare; Premier Health; Price Services Group, L.L.C.; Reveleer; The American College of Cardiology; The Ohio State University Wexner Medical Center; Vizient, Inc.

Aggregated Comment Title: ***Telehealth and Home Care***

Summary: Make the telehealth waiver permanent for completing face-to-face visits (including for certification and recertification) in home health and hospice care, as it has proven beneficial, especially in rural areas with limited physician coverage. This change would alleviate burdens on patients, caregivers, and clinicians, while modernizing care delivery and expanding access to essential Medicare services. Furthermore, the Time Frame Requirements for Home Health Service are rigid and burdensome to providers, limiting efficient patient care. Suggestions include broadening acceptable time frames for face-to-face encounters, eliminating prescribing restrictions, and exploring alternative methods like telehealth to better accommodate patients' needs and circumstances.

Total Comments Contributing: 34

Total Submissions Contributing: 30

Aggregated Comment Title: ***Address Prior Authorization Issues Related to Laboratory Medicine***

Summary: The use of prior authorization in MA plans poses challenges for clinical laboratories, as plans set the date of service to be the date of specimen collection rather than the date the test is performed. This discrepancy often leads to denied claims because the prior authorization request is made after the date of service has passed, creating a regulatory burden for clinical laboratories. CMS should reform the current date of service rule at 42 CFR 414.510. Additionally, many MA plans do not permit labs to file prior authorization. CMS should clarify and enforce that plans cannot restrict prior authorization to ordering providers or primary care providers; they must allow enrollees, an enrollee's representative, and any eligible provider, including laboratory professionals, to request prior authorization. CMS could also consider eliminating prior authorization by MA plans for services explicitly covered under an NCD or LCD, especially if indicated for advanced cancer patients. Additionally, laboratories face challenges when prior authorization is missing for tests, as many Medicare Advantage plans do not permit labs to initiate the authorization process, leading to administrative burdens. When ordering clinicians are required to obtain prior authorization for laboratory tests, it often results in delays that can render specimens unusable or force testing without authorization—leading to denied claims. Therefore, laboratories and ordering providers must have the option to submit prior authorization requests to payors to prevent reimbursement denials for tests already ordered.

Total Comments Contributing: 34

Total Submissions Contributing: 8

- ***Organization(s):*** AdvaMed; American Clinical Laboratory Association (ACLA); Association for Molecular Pathology; Castle Biosciences Inc; Guardant Health; Mayo Clinic; Quest Diagnostics; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Duplicative Credentialing and Provider Enrollment Processes Across Payers***

Summary: The credentialing and provider enrollment processes in healthcare are redundant and fragmented across Medicare, Medicare Advantage, Medicaid, and commercial insurers, leading to inefficiencies, errors, and delays. For example, the enrollment management systems, including the Provider, Enrollment, Chain, and Ownership System (PECOS), the National Directory Hub (NDH), and the National Plan and Provider Enumeration System (NPPES), require the same information to be completed in different formats. Moreover, each plan typically has specific verification procedures and distinct review timelines. These overly complex processes delay and disincentivize provider participation in Medicare. Removing requirements for payers and plans to have separate credentialing processes and implementing aligned standards and shared credentialing systems, or even a single federally governed credentialing repository, could streamline this process, reduce administrative waste, and enhance the provider experience across payers. Additionally, allow payers to recognize hospital credentialing and remove redundant credentialing processes under 42 CFR 482.22 and 482.23 that duplicate accrediting body requirements. Finally, automated credential management systems can monitor completion, renewal cycles, scopes, and continuing education across entities. CMS could endorse these systems to minimize duplication and uphold competency standards.

Total Comments Contributing: 34

Total Submissions Contributing: 24

Organization(s): Aegis Therapies; American Dental Association; Availity; Booz Allen Hamilton; CGI Federal Inc.; Cleveland Clinic; Gastroenterology Associates of the Piedmont; Georgia Hospital Association; Kansas Hospital Association; LeadingAge; Memorial Sloan Kettering Cancer Center; Microsoft; National Board for Certified Counselors (NBCC); Patient Experience Policy Forum - The Beryl Institute; Price Services Group, L.L.C.; Reveleer; The American Psychological Association Services, Inc.; The Ohio State University Wexner Medical Center; University of Vermont Medical Center; WEDI; Wheelchair Clinic Inc

Aggregated Comment Title: ***Documentation Requirements for Home Care Eligibility***

Summary: The complex documentation requirements for home care (including home health and hospice) are duplicative, burdensome, and lead to high denial rates and payment delays. Recommendations include revising policies to accept relevant clinical data and streamlining documentation standards to prevent claim denials for minor inconsistencies.

Total Comments Contributing: 34

Total Submissions Contributing: 13

Organization(s): All Star Hospice Inc; Home Care Alliance of Massachusetts; Humana; Illinois HomeCare & Hospice Council; National Alliance for Care at Home; Ohio Health Care Association; Patient Experience Policy Forum - The Beryl Institute; Sanford Health - Good Samaritan Society; Society of General Internal Medicine; Sutter Health; Texas Association for Home Care and Hospice; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Face to Face Encounters in Home Care***

Summary: Face-to-face encounter requirements for home health providers create significant administrative challenges and CMS should clarify face-to-face documentation standards. Eliminate or simplify the requirement for certain face to face encounters in home care, such as at 42 CFR 424.22(a)(1)(v). Current Medicare regulations mandate hospice face-to-face (F2F) visits within 30 days before the third benefit period recertification and subsequent periods. New admissions in their third or later benefit period have a two-day window post-admission for the F2F encounter to be considered timely. However, logistical constraints, provider availability, and issues with CMS systems often lead to delayed access to care, especially in rural areas, during weekends and holidays. Coordinating timely visits becomes challenging under these circumstances, and CMS should re-examine issues related to 'exceptional circumstances'. Furthermore, the certifying practitioner's medical record must now independently support the patient's homebound status and need for skilled care, leading to duplication and increased risk of technical denials. These rigid requirements hinder care coordination, delay access to necessary services, exceed statutory authority, impose unnecessary burdens on providers and patients due to unclear CMS expectations. CMS should allow attestation on the plan of care to satisfy the F2F requirement, permitting the certifying practitioner to document that the F2F encounter was conducted by a physician or an authorized NPP, and generally streamline face-to-face encounter documentation. CMS should also extend the timeline for accepting delayed hospice face-to-face from two days to seven days or 90 days after care starts to allow additional time to schedule and organize the necessary details for the face-to-face.

Total Comments Contributing: 30

Total Submissions Contributing: 18

Organization(s): Adara Home Health; American Academy of Hospice and Palliative Medicine; American Physical Therapy Association; BAYADA Home Health Care; Eventus WholeHealth; Home Care Alliance of Massachusetts; Home Care and Hospice Association of New Jersey; Humana; Illinois HomeCare & Hospice Council; LeadingAge; MaineHealth; Sanford Health - Good Samaritan Society; Sutter Health; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Eliminate Variation Between CMS Contractors***

Summary: Various CMS contractors, including MACs, RACs, QIOs, UPICs, SMRCs, and ACO REACH entities, have overlapping or conflicting guidance and may not follow CMS guidelines for timely processing, and this variation is particularly challenging for providers with facilities in multiple regions of the US. Alternatives include consolidating and/or reducing the number of MACs and SMRCs altogether; no longer allowing MACs to have different guidelines; establishing NCDs; and requiring MACs to publish the policies and procedures that are no more restrictive than Medicare clinical/medical, operational, billing, ABN, and payment policies. Aligning standards for performance evaluation and strengthening oversight across contractors can streamline compliance workflows and reduce redundancy and reversals. Unified clinical documentation standards across all audit contractors, centralizing coverage determinations, and creating one assigned contractor for supporting management of the LCDs and answering questions would greatly reduce administrative burden. Contractors should also provide clear and proactive guidance on what specific elements auditors are looking for to demonstrate medical necessity. Additionally, CMS should standardize and enforce timely workflows through shared playbooks and a centralized issue-tracking system while implementing consistent guidelines.

Total Comments Contributing: 30

Total Submissions Contributing: 20

Aggregated Comment Title: ***Update or Remove Outdated NCDs***

Summary: CMS should focus on updating or eliminating outdated National Coverage Determinations (NCDs) that do not align with current clinical evidence and streamline this process to be more efficient. For example, CMS should streamline the process for reconsidering or updating existing NCDs that broaden coverage for new technologies and ensure the coverage aligns with the expanded intended use of the services. The current process lacks efficiency and prevents timely review of innovative services for Medicare beneficiaries. CMS should require MACs to respond to proposed LCDs or reconsideration requests within 6-12 months using objective and transparent criteria. Additionally, accepting public comments on policy development and proposing NCD policy changes annually based on stakeholder feedback would allow for quicker implementation of well-supported changes aligned with scientific evidence. CMS should allow technical updates to LCDs and NCDs, such as the removal of outdated language, to be made through an expedited process as opposed to the full reconsideration process which could help with the backlog. Large-scale reconsideration requests or those aiming to narrow existing coverage should not qualify for a streamlined pathway. These changes will reduce backlogs and improve beneficiary access to new and innovative services.

Total Comments Contributing: 30

Total Submissions Contributing: 18

Organization(s): Abbott; AdvaMed; Alliance of Wound Care Stakeholders ("Alliance"); American Academy of Dermatology Association; American Clinical Laboratory Association (ACLA); American Health Care Association (AHCA); American Podiatric Medical Association; American Society of Anesthesiologists; Castle Biosciences Inc; Danaher Diagnostics; Guardant Health; Houston Methodist; Ohio Hospital Association; R1 RCM; RadNet; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Streamline LTC Survey Processes and Frequency***

Summary: Streamline nursing home survey processes, including complaint investigations, align survey criteria across states, and implement reforms to enhance quality improvement principles, such as realistic action plan timelines and system-based evaluations. The current survey inspection process results in tremendous burden for SNFs and does little to directly focus on SNFs that require the most oversight. Resuming virtual complaint surveys for low-risk issues could lead to more efficient resource allocation and reduced administrative costs for hospitals. CMS could align recertification survey frequency with CMS Five-Star Quality Ratings to reduce administrative burden and enhance efficiency in long-term care facilities. A tiered approach could enhance efficiency by conducting surveys every 3 years for 5-star communities, every 2 years for 4-star communities, and maintaining an annual cycle for 3-star and below facilities.

Total Comments Contributing: 30

Total Submissions Contributing: 14

Organization(s): American Health Care Association (AHCA); Eventus WholeHealth; Greater New York Hospital Association; LeadingAge Illinois/Iowa; LeadingAge New York; LeadingAge PA; MaineHealth; Mayo Clinic; Ohio Health Care Association; Sanford Health - Good Samaritan Society; The U.S. Chamber of Commerce; Vivie

Aggregated Comment Title: ***Timeframe Requirements for Home Care***

Summary: Timeframes for eligibility and re/certification visits for home care (including home health and hospice) are conflicting, unwieldy, and burdensome. Refine the timeframes to be more consistent, streamline access to care, and reduce burden.

Total Comments Contributing: 29

Total Submissions Contributing: 14

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); Aegis Therapies; Amedisys, Inc.; American Academy of Hospice and Palliative Medicine; Health Services of the Pacific; Home Care Alliance of Massachusetts; National Alliance for Care at Home; National Partnership for Healthcare and Hospice Innovation; Netsmart; Ohio Hospital Association; Texas Association for Home Care and Hospice; Vivie

Aggregated Comment Title: ***Increase Information Sharing to Reduce Redundancy***

Summary: Current processes require duplicate collection and submission of the same information. Federal, state, and healthcare entities need to better communicate and share information when patients consent to data sharing and utilize existing data whenever possible. Basic patient demographics and surgical and medical history forms should be one and done. One suggestion to streamline data collection is to implement a secure identification system like those used in banking or social security to tie all information to an individual so it does not need to be duplicated by each provider. Another is to implement a data policy of "report once and reuse" so providers can rely on the same data across reporting programs. By enhancing data-sharing initiatives and adopting secure, interoperable standards like APIs and FHIR, regulatory frameworks can be more efficient, reduce provider burden, and improve coordination between providers, payers, and digital health platforms.

Total Comments Contributing: 29

Total Submissions Contributing: 26

Organization(s): BAYADA Home Health Care; Booz Allen Hamilton; Caprock Home Health; Hands of Wellness; Henry Ford Health; Highlands Oncology Group, P.A.; Humana; Infectious Diseases Society of America; Lantana Consulting Group; National Association of ACOs (NAACOS); National Board for Certified Counselors (NBCC); Patient Experience Policy Forum - The Beryl Institute; Piedmont Healthcare; Point32Health; Reveleer; Virginia Hospital & Healthcare Association; WEDI; WelbeHealth

Aggregated Comment Title: ***Reduce Burden Related to Hospital Price Transparency Requirements***

Summary: The Hospital Price Transparency Rule (45 CFR Part 180) pose challenges in data aggregation and utility and are redundant while adding unnecessary administrative burden. Compliance efforts divert resources from patient care, prompting calls for alignment with existing standards to streamline reporting requirements and reduce frequency. This information is already mandated by the Transparency in Coverage Final Rule for all healthcare providers, which offers more informative and useful insights than machine-readable files. CMS should incentivize provider use of price transparency tools, streamline the requirements to reduce burden, and make the data publicly available in an easily accessible format. Price transparency should also only apply to providers for uninsured or cash-pay patients, as insurance providers are in the best position to provide cost information to insured patients. Also, consider exemption of rural hospitals from these requirements.

Total Comments Contributing: 29

Total Submissions Contributing: 19

Organization(s): American Commitment; Ascension; Children's Hospital Association; Georgia Hospital Association; Henry Ford Health; HomeTown Health LLC; Illinois Health and Hospital Association; Louisiana Rural Health Association; Memorial Sloan Kettering Cancer Center; Ohio Hospital Association; Premier Health; Premier Inc; R1 RCM; Sanford Health - Good Samaritan Society; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Create a National Medicare Provider Directory and Remove Current Provider Directory Requirements***

Summary: CMS should remove burdensome provider directory requirements and instead work toward establishing a national directory. CMS should require plans to use the national directory rather than their own directories to eliminate duplication and data collection burden. The current requirements such as including cultural and linguistic capabilities (422.111(b)(3)) and verifying provider data on an ongoing basis are burdensome. A national directory would reduce provider and plan burden and benefit dual-eligibles. Create a National Bookable Medicare Provider Directory and AI-powered phone scheduling hotline. By integrating this system into Medicare Compare, seniors can easily find and book appointments, improving access to healthcare. This solution aims to streamline the process, providing a seamless search and booking platform for beneficiaries to make informed healthcare decisions efficiently. A national provider directory to centralize provider information would ensure accuracy and allow providers to update their details in one place instead of multiple locations.

Total Comments Contributing: 28

Total Submissions Contributing: 22

Organization(s): AHIP; Alliance of Dedicated Cancer Centers (ADCC); Ascension; Association for Community Affiliated Plans (ACAP); Blue Cross Blue Shield Association; Blue Cross Blue Shield of Massachusetts; Booz Allen Hamilton; Cleveland Clinic; Florida Hospital Association; Highmark Inc.; Illinois Health and Hospital Association; Johns Hopkins Health Plans; Kansas Health Information Network, Inc. dba KONZA; Kentucky Hospital Association; LeadingAge; LeadingAge PA; Michigan Health & Hospital Association; Sanford Health - Sanford Health Plan and Security Health Plan; The U.S. Chamber of Commerce; UnitedHealthcare; Zocdoc

Aggregated Comment Title: ***Ease Regulation of QCDR and QR Audits***

Summary: CMS requires Qualified Clinical Data Registries (QCDRs) and qualified registries (QR) to conduct annual data validation audits, as per 42 C.F.R. § 414.1400(b)(3)(v). If they find deficiencies or errors, registries are subject to targeted audits to identify root causes and correct them. However, these requirements may be duplicative of CMS audits on clinicians and overlook the rigorous internal quality controls and external audits conducted by QCDRs and QRs. Such requirements may also contravene regulations intended to promote their use. Further, CMS should modify policies around measure testing, harmonization, data validation, and topped out measures to reduce burden on registries.

Total Comments Contributing: 28

Total Submissions Contributing: 7

Organization(s): American Academy of Dermatology Association; American College of Rheumatology; American Society of Anesthesiologists; College of American Pathologists; Lantana Consulting Group; Physician Clinical Registry Coalition

Aggregated Comment Title: ***Improve the 855A Reporting Process***

Summary: The current Medicare 855A certification and revalidation process is overly burdensome on providers, taking a long time to approve and requiring detailed vendor information that is difficult to obtain. Medicare revalidation is confusing, with little instruction or assistance for providers, and facilities and MACs are interpreting the process differently. CMS should revise this process, as it takes valuable time away from providing care. Improvements could include removing Attachment 1 or reverting to the previous version of 855A and revising CMS-855A enrollment and revalidation to auto-populate ownership/control fields from state licensure and Medicaid enrollment systems, removing redundant attestations. CMS should also accept fully electronic signatures and PECOS attestations in place of the paper CMS-855A packet and standardize provider enrollment data element across all plans.

Total Comments Contributing: 27

Total Submissions Contributing: 13

Organization(s): Booz Allen Hamilton; Direct Supply, Inc.; LeadingAge; LeadingAge New York; Maplewood of Cheshire County; National Association of Rehabilitation Providers and Agencies (NARA); Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Reform 5-Star Quality Rating System for SNFs***

Summary: Current monitoring through the 5-Star Quality Rating System for Skilled Nursing Facilities skews reality via "working" the system or flawed reporting definitions. This flawed system leads to manipulation, financial penalties, exclusion from excellence programs, lower ratings, restrictions on admissions, and limits on CNA training, hindering high-quality care provision in LTC facilities. The 5-Star Quality Rating System for Skilled Nursing Facilities needs reforming to improve data accuracy and reliability. Reforms could include, streamlining the rating system, basing the overall star rating primarily on quality measures rather than surveys, remove measures that have a 100% threshold, prioritizing data over opinions to better reflect SNFs' quality performance, giving facilities the ability to correct data discrepancies before forcing downgrades, and shifting to 20% at each star rating distribution for surveys. Utilizing data from the minimum data set (MDS) assessment, which is consistent across all facilities and using only the last two survey cycles instead of three could provide a more accurate depiction of a SNF's current performance. Additionally, consider eliminating the forced distribution of ratings which arbitrarily rates twice as many facilities as one-star vs. five-star, no matter how they

actually performed. CMS could also eliminate the red hand icon, which is excessively alarming and not always indicative of actual abuse. Especially in cases of self-reports, removing the red hand icon will encourage continued transparency and early intervention.

Total Comments Contributing: 27

Total Submissions Contributing: 7

Organization(s): Aledade; American Health Care Association (AHCA); Greater New York Hospital Association; LeadingAge PA; Ohio Health Care Association; Pennsylvania Health Care Association

Aggregated Comment Title: ***Update Regulations to Clarify the Scope of Physician Assistants (PAs)***

Summary: CMS should make revisions and rescissions to various sections of the Code of Federal Regulations related to the authorization and responsibilities of Physician Assistants (PAs) in different healthcare settings. These changes would reduce administrative burden, increase efficiency, and clarify the roles and qualifications of PAs in providing care. These changes include authorizing PAs to establish treatment plans, perform face-to-face visits, order specific tests and procedures, order medications, and sign documentation in emergency situations. The revisions would eliminate duplicative requirements, unnecessary qualifications, and outdated guidance documents that currently impose additional burdens on physicians and hinder the optimal utilization of PAs in healthcare delivery.

Total Comments Contributing: 27

Total Submissions Contributing: 3

- ***Organization(s):*** American Academy of Physician Associates; Home Care and Hospice Association of New Jersey; National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Streamline Assessments for Inpatient Rehabilitation Facilities***

Summary: Inpatient rehabilitation facilities must complete multiple admission documents under strict timelines, which imposes an administrative burden and diverts attention from patient care. There should be consolidation into a single admission assessment. Moreover, there is redundant information collected which should be removed. Specifically, the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) is extensive, complex, and burdensome. Suggestions for streamlining include: remove the Brief Interview for Mental Status (BIMS); change timeframe of completion of the IRF-PAI; simplify the Functional Abilities and Goals section (Section GG); change the guidance for reporting of interrupted stays or leaves of absence; and remove duplicative or unnecessary sections including race (A1005), ethnicity (A1010), and payer information (A1400). Additionally, the IRF-PAI is not valid or reliable for use

with children and adolescents. CMS should remove the requirement for IRF-PAI data collection for pediatric patients, work with providers to identify alternative assessments suitable for this population and exclude pediatric IRF-PAIs from public reporting. Resources invested in the Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD) should instead be used to improve education and transparency around medical necessity documentation and engage IRF stakeholders in developing sustainable oversight mechanisms.

Total Comments Contributing: 26

Total Submissions Contributing: 7

Organization(s): American Medical Rehabilitation Providers Association; American Occupational Therapy Association; Encompass Health; Mary Free Bed Rehabilitation; National Association for Behavioral Healthcare; Select Medical Holdings Corporation

Aggregated Comment Title: ***Streamline ESRD Core Survey and Quality Programs***

Summary: To improve consistency and oversight in the ESRD Core Survey process, it is recommended to address surveyor variability by reintroducing centralized, clear guidance to surveyors and ensuring their qualifications, training, and adherence to protocols. Standardizing survey interpretation and execution would reduce administrative burden, maintain program integrity, and enhance patient safety. Inconsistent training and guidance among surveyors lead to discrepancies in standards interpretation and enforcement, creating unpredictable and burdensome experiences for providers. Streamline ESRD quality programs by reducing measures and ensuring alignment to eliminate contradictory and duplicative reporting. The current system has too many programs, too many measures, and lacks consistency, causing confusion and frustration for providers and patients. CMS should streamline the ERSD quality programs by focusing on measures in areas that are actionable by the dialysis facility and not penalize them for factors beyond their control (e.g., bloodstream infection rates). For example, CMS should eliminate the measures related to COVID vaccine administration, COVID infections, and hypercalcemia, and streamline peritonitis reporting. Additionally, CMS should consider excluding pediatric dialysis facilities from the ESRD QIP as the system is facing challenges in providing meaningful quality information for children with End-Stage Kidney Disease (ESKD).

Total Comments Contributing: 25

Total Submissions Contributing: 5

- ***Organization(s):*** American Society of Pediatric Nephrology; Berkshire Medical Center; Kidney Care Council; Kidney Care Partners; The Renal Healthcare Association

Aggregated Comment Title: ***Enhance Specialty-Specific Quality Measures***

Summary: Develop and maintain specialty-specific quality measures to enhance participation and reduce unnecessary reporting for programs (e.g., MIPS). For example, consider meaningful and defined specialty measure sets for anesthesia and radiology practices as well as for hospice and palliative medicine, and apply the policy 'Scoring for Topped Out Measures in Specialty Measure Sets with Limited Measure Choice' universally to all topped-out measures. Additionally, CMS should create categorical MIPS exemptions for highly specialized, single-service practices, such as office-based infusion centers, or use its low-volume threshold authority to exempt narrowly focused practices from MIPS participation. These providers should not be penalized for failing to report on measures that are not clinically relevant to their scope of care.

Total Comments Contributing: 25

Total Submissions Contributing: 13

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; American Academy of Hospice and Palliative Medicine; American College of Radiology; American Osteopathic Association; American Podiatric Medical Association; Association for Clinical Oncology; National Association of Rehabilitation Providers and Agencies (NARA); National Infusion Center Association; Net Health; The American College of Cardiology; University Radiology Group; University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Improve the Provider Enrollment Form and Process***

Summary: Provider enrollment and verification processes are costly, burdensome, and duplicative. The enrollment process involves excessive manual data entry and duplicate submissions for information such as ownership details and electronic funds transfer information for each enrollment. Additionally, the 855-B Medicare Provider Enrollment form is overly complex, redundant, and time-consuming, causing delays in provider credentialing. The lack of urgency and/or responsiveness from MACs can lead to patient access issues as Medicare must approve providers before they see Medicare patients. The $730 fee is prohibitive for some providers. Implementing a fully digitized enrollment platform would allow for greater automation and reduce administrative and operational costs. Further, centralizing relevant enrollment data at the entity level would allow for standardized, pre-filled updates across all enrollments associated with a provider.

Total Comments Contributing: 25

Total Submissions Contributing: 13

Organization(s): American College of Physicians; Booz Allen Hamilton; CGI Federal Inc.; Gastroenterology Associates of the Piedmont; Medical Group Management Association; National Association of Community Health Centers (NACHC); National Board for Certified Counselors (NBCC); National Council for Mental Wellbeing; Ohio Hospital Association; RadNet; Reveleer

Aggregated Comment Title: ***Eliminate Physician Signature on Rehabilitation Therapy Plans of Care***

Summary: CMS should rescind the requirement at (42 CFR § 410.61) for a physician signature on therapy plans every 90 days as it is burdensome and unnecessary. An additional signature on the care plan is duplicative because the physician has already signed the order for the services. Medicare requires a physician order to initiate therapy services, but Sections 1835(a)(2)(C) and 1835(a)(2)(D) of the Act require that payment for Medicare therapy services based on physician certification, which occurs as a signature on the plan of care. Why can the physician order not serve as evidence that the patient is under the physician's care? Sending the plan to the patient's provider should satisfy the certification requirement, rather than a signature.

Total Comments Contributing: 25

Total Submissions Contributing: 15

Aggregated Comment Title: ***Streamline Prior Authorization Approvals***

Summary: The prior authorization process needs to be streamlined to reduce unnecessary manual approvals for treatments with proven efficacy and safety. Adopting an evidence-based presumptive approval model for providers and therapies with high approval rates or established clinical success will streamline the process by focusing on evidence-based guidelines to ensure appropriate care delivery. Additionally, eliminating prior authorization requirements for procedures or treatments approved over 90% of the time or mandating real-time PA decisions within 24 hours for all non-emergent requests would reduce administrative waste and simplify documentation for healthcare providers. CMS should also lead implementation with flat file requests for authorizations, as authorization decisions are taking 14 days to return causing potential delays in patient care. Further, CMS should replace or amend 42 CFR 422.568 and 42 CFR 422.572 with language that requires more timely decision-making in PA processes. PA approvals should remain valid for the entire course of treatment.

Total Comments Contributing: 25

Total Submissions Contributing: 16

Organization(s): America's Essential Hospitals; American College of Rheumatology; American Medical Association; American Psychiatric Association; American Urological Association, Inc.; Ascension; BAYADA Home Health Care; CPAC Foundation Center for Regulatory Freedom; Highlands Oncology Group, P.A.; Infectious Diseases Society of America; Johns Hopkins Health System; Riverside Eye Center; Sanford Health; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Improve Coordination between MAOs and RNHCIs***

Summary: The processing of prior authorization requests and claims for Religious Nonmedical Health Care Institutions (RNHCI) under Medicare Advantage (MA) is fraught with inefficiencies and administrative burdens. MA organizations (MAOs) are often unfamiliar with the RNHCI benefit and fail to apply the correct coverage criteria, leading to frequent denials, resubmissions, and prolonged delays. Current MAO systems are not configured to accept RNHCI-specific coding, causing claims to be initially denied and necessitating manual workarounds. The lack of clear protocols and centralized resources for verifying Medicare-certified RNHCI providers exacerbates confusion and delays. Prior authorization processes remain paper-based, requiring multiple exchanges and phone calls, which significantly burdens providers, patients, and MAOs alike. These systemic issues contribute to attrition of Medicare-participating RNHCIs and hinder timely access to care. To address these challenges, a systemic overhaul is needed to automate and streamline prior authorization and claims processing, ensure MAO staff are trained on RNHCI benefits, and develop interoperable systems that align with Medicare coverage criteria, especially as MAOs increasingly adopt AI technologies.

Total Comments Contributing: 25

Total Submissions Contributing: 2

- ***Organization(s):*** Christian Science Provider Network; Committee on Publication, U.S. Federal Office - The First Church of Christ, Scientist

Aggregated Comment Title: ***Improve Consistency of Medicare Advantage Prior Authorization Rules***

Summary: Navigating the prior authorization and concurrent review processes for Medicare Advantage (MA) plans can be challenging for providers due to the variability in portals, processes, and documentation requirements across different organizations and plans. Improving the consistency of MA Prior Authorization rules through standardizing requirements will reduce the likelihood of documentation errors and delays and improve timely access to care. Suggestions to operationalize this include requiring delegated entities to follow the same standards and be subject to CMS oversight, limiting the use of internal plan criteria to ensure that Medicare coverage rules are the primary basis for medical necessity determinations, appointing CMS to govern the appeals process, eliminating prior authorization for services explicitly covered under a National Coverage Determination (NCD) or Local Coverage Determination (LCD), and requiring MA plans to follow the same prior authorization protocols as traditional Medicare.

Total Comments Contributing: 24

Total Submissions Contributing: 16

Organization(s): American College of Osteopathic Family Physicians (ACOFP); American Health Care Association (AHCA); Association of American Medical Colleges; Georgia Hospital Association; Guardant Health; Healthcare Business Management Association; Kansas Hospital Association; LeadingAge; National Association of ACOs (NAACOS); RadNet; Society of Hospital Medicine; The Commonwealth Fund; Vivie

Aggregated Comment Title: ***MVPs Do Not Resolve MIPS Flaws***

Summary: CMS plans to replace the traditional Merit-based Incentive Payment System (MIPS) with MIPS Value Pathways (MVPs) by 2029, but CMS should maintain MVPs as a voluntary option. MVPs introduce complexity, particularly for multispecialty groups, and MVPs do not address the existing issues within traditional MIPS, such as problematic scoring rules. Because MVPs are based on the MIPS measure set, it lacks clinical relevance for many specialties such as hospice and palliative medicine. To improve, CMS should focus on patient conditions and episodes of care rather than specialty-specific frameworks, prioritizing population-based MVPs. Clinically meaningful measures within population-focused MVPs can promote team alignment, reduce administrative burden, reduce duplicative reporting, and enhance quality of care.

Total Comments Contributing: 24

Total Submissions Contributing: 9

Aggregated Comment Title: ***Eliminate the CAH 96-Hour Physician Certification Rule***

Summary: Eliminate the 96-Hour Rule for Critical Access Hospitals (CAHs) requiring physicians to certify each patient's length of stay. The 96-hour physician certification rule places a significant burden on critical access hospitals (CAHs), making it more difficult for people in rural areas to access health care. This rule diverts limited resources away from bedside care and creates pressure to transfer patients to other facilities, which may already be at capacity. Additionally, this rule is duplicative with the existing CoP requirement that the average LOS must be 96 hours or less at the institutional level for CAHs and creates an unrealistic administrative burden for physicians. Elimination could allow longer patient stays without financial penalties.

Total Comments Contributing: 24

Total Submissions Contributing: 13

Organization(s): American Hospital Association; California Hospital Association; Catholic Health Association; DSHS/HCLA/RCS; Federation of American Hospitals; Healthcare Association of New York State; Illinois Health and Hospital Association; Louisiana Rural Health Association; OCHIN; Society of Hospital Medicine; University of Vermont Medical Center

Aggregated Comment Title: ***Simplify Transfer/Discharge Notice Requirements***

Summary: The transfer/discharge notice requirements at 42 CFR 483.15(c)(3) create administrative burden for nursing homes, particularly during emergent resident hospital transfers. While these notices may be necessary for planned discharges, they are excessive and are low priority for urgent hospital visits. Eliminate transfer/discharge notices for emergent resident hospital transfers and eliminate the requirement to send a copy of the notice to the ombudsman to reduce administrative burden and confusion for families. CMS could also consider only requiring a notice for residents residing in the facility for greater than 30 days. Only require the safe discharge plan to be documented once while waiting on the QIO decision. Additionally, streamline the content of the notice and consider limiting the notice to only nursing facility-initiated transfers/discharge by clarifying the distinction between voluntary and involuntary notices and exempting planned discharges initiated by residents from formal notice requirements. The 30-day notice should only be given to residents who are not on a skilled stay (Medicare Advantage or Medicare Part A). These residents are given a Notice of Medicare Non-Coverage (NOMNC).

Total Comments Contributing: 23

Total Submissions Contributing: 12

Organization(s): American Health Care Association (AHCA); Christian Living Communities / Cappella Living Solutions; Healthcare Association of New York State; Hospital Association of Rhode Island; LeadingAge; LeadingAge New York; LeadingAge PA; Maplewood of Cheshire County; Ohio Health Care Association

Aggregated Comment Title: ***Improve Nutrition and Access to Healthy Food Through Deregulation***

Summary: CMS should simplify federal regulations and remove barriers to Medicare Advantage plans covering healthy food as a 'primarily health related' supplemental benefit and deregulate In-Lieu-of-Services (ILOS). Eliminating complex rules and exempting nutrition components from the Special Supplemental Benefits for the Chronically Ill (SSBCI) 10-year bibliography requirement would allow for greater flexibility in providing nutrition support through health plans, ultimately improving health outcomes and reducing costs. Additionally, utilize existing CMS healthy food measures supported by physicians nationwide, rather than creating new measures, to enhance the quality and cost-efficiency of care for chronically ill patients.

Total Comments Contributing: 23

Total Submissions Contributing: 5

- ***Organization(s):*** Academy of Nutrition and Dietetics; Food Is Medicine Coalition; National Produce Prescription Collaborative (NPPC); The Food is Medicine Institute at the Friedman School of Nutrition Science and Policy at Tufts University; The Physicians Foundation

Aggregated Comment Title: ***Simplify Patient Satisfaction Survey Processes***

Summary: Patient satisfaction surveys (e.g., CAHPS, HCAHPS) are most fiscally and staff burdensome and require a complete overhaul to reduce costs and improve response rates. CMS has demonstrated innovative adaptations in the past and should continue to leverage these. For example, simplify and/or reduce the number of questions, reduce the time between encounter and survey distribution, employ multiple language versions, retire paper surveys, and utilize text or email to solicit brief feedback. This will be more effective than the current expensive third-party system that produces low returns. CMS may also deregulate CAHPS entirely and rely on PROMs to avoid penalizing providers for their perceptions of patients.

Total Comments Contributing: 23

Total Submissions Contributing: 19

Organization(s): AMGA; Cleveland Clinic; Gulf Coast Outpatient Surgery Center, Laurel Surgery & Endoscopy Center; Illinois Health and Hospital Association; International Consortium for Health Outcome Measurement (ICHOM); Keystone ACO; NCH Naples Comprehensive Health; Netsmart; Patient Experience Policy Forum - The Beryl Institute; Society of Hospital Medicine; Texas Association for Home Care and Hospice; The Renal Healthcare Association; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Consider Removing Mandatory eCQM Reporting Requirements***

Summary: CMS should consider removing mandatory reporting requirements for Electronic Clinical Quality Measures (eCQMs). eCQMs require extensive technical effort but do not yield actionable insight. Many providers, especially those in resource-limited settings, face challenges with the sophisticated EHR systems required to collect the information necessary for reporting. Suggestion to lessen the burden of eCQMs include standardizing eCQM requirements across programs, reducing measure to a targeted set of core measures, eliminating duplicative submission pathways, ensuring clear specifications, lead time, and technical support, limiting new measures, and revising measure specifications to align with routinely documented EHR fields. ECQMs originally designed to streamline data collection have now become burdensome due to ever-changing specifications and inconsistent EHR vendor readiness.

Total Comments Contributing: 23

Total Submissions Contributing: 20

Organization(s): AMGA; Ascension; Booz Allen Hamilton; California Hospital Association; Curana Health; Federation of American Hospitals; Illinois Health and Hospital Association; Microsoft; Ohio Hospital Association; Oklahoma Hospital Association; PSW and MultiCare Connected Care;

Piedmont Healthcare; Premier Health; The American College of Cardiology; The Ohio State University Wexner Medical Center; ViiV Healthcare; VillageMD

Aggregated Comment Title: ***Update Fire Safety Codes***

Summary: CMS should implement the most current edition of the National Fire Protection Association (NFPA) 101 Life Safety Code and NFPA 99 Healthcare Facilities Code for compliance with the built environment and adopt consensus codes as they are published to provide consistent application of federal, state, and local codes. Setting codes to auto-update would also prevent conflict between state and federal standards in the future. Specifically, 42 CFR Parts 403, 416, 418, 460, 482, 483, and 485 Fire Safety Requirements should be updated to newer code editions. CMS should also exempt hospitals in remote areas from rules applied to building upgrades that do not impact patient safety.

Total Comments Contributing: 23

Total Submissions Contributing: 8

Organization(s): American Health Care Association (AHCA); Cleveland Clinic; Jensen Hughes; Mayo Clinic

Aggregated Comment Title: ***Enhance and Expedite the NCD Process***

Summary: CMS should improve the turnaround of the NCD development process, which is excessive. CMS should align the national coverage determination (NCD) and coverage with evidence development (CED) processes and/or US Preventive Services Task Force (USPSTF) recommendations to reduce administrative burdens, improve clarity, and expedite approvals. Modifications could include setting deadlines for formal NCD requests and transmitting implementation instructions to Medicare Administrative Contractors (MACs) after NCD completion; establishing a timeline and pathway to review long-standing NCDs with CED to remove unnecessary study requirements; and creating an expedited process for minor NCD updates. Congress should provide CMS with sufficient appropriations to allow the Coverage and Analysis Group (CAG) to create more effective and timelier NCDs for new items and services. Additionally, categorizing NCDs with CED as “ready for review” or “awaiting evidence,” along with detailing the required evidence, could further streamline the process. Furth

Total Comments Contributing: 23

Total Submissions Contributing: 6

Organization(s): Abbott; Danaher Diagnostics; Guardant Health; National Taxpayers Union; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Reform CMS Approach to Preventive Services***

Summary: CMS should shift its role in preventive services to a facilitator rather than a gatekeeper, recognizing the value of evidence-based prevention. Implementing burden reduction metrics and public reporting, not requiring providers to document medical necessity for preventive services, aligning with industry standards like the 30-day implementation timeline for U.S. Preventive Services Task Force (USPSTF) recommendations, utilizing Modifier 33 to identify USPSTF services, accepting USPSTF's evidence review process for NCDs can improve program sustainability and ensure timely access to preventive care, and implementing a single annual attestation where providers simply confirm they follow USPSTF guidelines for preventive services.

Total Comments Contributing: 23

Total Submissions Contributing: 3

Organization(s): Danaher Diagnostics; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Eliminate Long-Stay Antipsychotic Medication Quality Measure***

Summary: CMS should eliminate the Long-Stay Antipsychotic Medication quality measure in CMS's Nursing Home Care Compare system. The quality measure is duplicative, as it overlaps with existing state-level medication reviews, quality assurance programs, and Medicare oversight mechanisms such as the Plan Program Integrity Medicare Drug Integrity Contractors (PPI MEDICs). The Long-Stay Antipsychotic measure is burdensome to providers, prioritizes compliance over patient-centered care, and can result in misrepresentations of quality of care. Additionally, the measure is not aligned with the Nursing Home Quality Initiative (NHQI) or current clinical standards such as those of the APA.

Total Comments Contributing: 23

Total Submissions Contributing: 3

- ***Organization(s):*** American Medical Association; LeadingAge PA; Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness)/Alliance for Aging Research

Aggregated Comment Title: ***Reconsider Enhanced Barrier Precautions***

Summary: Enhanced Barrier Precautions (EBP) are operationally and financially burdensome for SNFs, disrupt the homelike environment, and create dignity issues for residents requiring special PPE and signage, leading to psychological burdens for patients who feel stigmatized. EBPs are also inconsistent with other widely accepted infection control standards applicable to similar settings, e.g., hospitals. Staff must use PPE for simple tasks, which can be redundant with proper handwashing, and staff must pause to wear PPE before assisting residents in hazardous situations, which creates a safety risk. Residents should be permitted to opt out of EBP, as not

allowing residents to opt out appears to contradict the right to be informed and choose treatment options as outlined in 42 CFR 483.10(c)(5). Existing infection control practices in nursing homes are sufficient. If EBPs are retained, facilities should receive additional funding support, and the precautions should be more targeted.

Total Comments Contributing: 22

Total Submissions Contributing: 11

Organization(s): American Health Care Association (AHCA); Greater New York Hospital Association; LeadingAge New York; LeadingAge PA; On With Life; Optalis Healthcare; Sanford Health - Good Samaritan Society; The Meth-Wick Community; Vivie

Aggregated Comment Title: ***Eliminate or Simplify the 14-Day Rule for Laboratory Billing***

Summary: The 14-day rule (42 CFR 414.510) creates burdensome administrative processes for hospitals and laboratories, delaying patient care and hindering timely access to critical diagnostic tests, particularly in cancer care. Removing this rule would allow labs to bill directly, streamline workflows, and improve patient outcomes by reducing redundant documentation and conflicting results. Instead, change the date of service for molecular pathology tests performed during an inpatient hospital stay to the date of test performance instead of specimen collection. Aligning Medicare policies with current precision medicine practices would facilitate rapid access to molecular testing, enhance care coordination, and eliminate unnecessary billing complexities, ultimately benefiting Medicare beneficiaries with cancer and improving the efficiency of healthcare delivery.

Total Comments Contributing: 21

Total Submissions Contributing: 10

- ***Organization(s):*** AdvaMed; American Society for Clinical Pathology; American Society of Hematology; Association for Clinical Oncology; Association for Molecular Pathology; Castle Biosciences Inc; Danaher Diagnostics; Guardant Health; Johnson & Johnson; Sharsheret

Aggregated Comment Title: ***Telehealth Direct Supervision Regulations***

Summary: Many commenters advocate for the Centers for Medicare & Medicaid Services (CMS) to permanently allow direct supervision through telehealth, enabling supervising providers to be "immediately available" virtually. This would expand access to healthcare services and benefit patient care. Stakeholder collaboration is recommended to identify appropriate services for virtual supervision, with a focus on patient safety. Examples include cardiac, intensive cardiac, and pulmonary rehabilitation services, and diagnostic imaging. This change reduces operational

constraints, expands service capacity, and ensures patient care continuity. Commenters also urge CMS to align supervision rules and make general supervision via telehealth permanent for Community Health Centers (CHCs).

Total Comments Contributing: 21

Total Submissions Contributing: 13

Aggregated Comment Title: ***Standardize Coverage Policies Across Payers***

Summary: The lack of a uniform coverage policy among Medicare, Medicare Advantage, Medicaid, private insurance, and other health plans complicates processes, creates confusion for providers, increases administrative costs, and delays care for beneficiaries. CMS should enforce the regulation that requires MA plans comply with NCDs, LCDs, and general coverage and benefit conditions included in traditional Medicare. Eliminating varying coverage policies and adopting national policies for all services for Medicare beneficiaries would alleviate burdens from varying MAC policies. Additionally, cross-agency collaboration must be significantly strengthened to reduce redundant oversight and ensure that Medicare coverage policies are scientifically consistent and up to date. Specifically, agencies such as CMS, HRSA, CDC, and FDA must establish formal mechanisms for data sharing, data security, policy alignment, and real-time communication to ensure coverage decisions reflect current clinical guidelines and scientific consensus. Further, CMS must mandate that organizations meet the requirements for making these policies meaningfully publicly accessible and should remove requirements surrounding internal coverage criteria.

Total Comments Contributing: 21

Total Submissions Contributing: 16

Organization(s): Agadia Systems; Houston Methodist; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); MCG Health, part of the Hearst Health network; National Board for Certified Counselors (NBCC); Quest Diagnostics; RadNet; Sanford Health - Sanford Health Plan and Security Health Plan; Society of Hospital Medicine; The American College of Cardiology; The Coalition for 21st Century Medicine; The University of Texas MD Anderson Cancer Center; University Radiology Group, LLC

Aggregated Comment Title: ***Innovation Instead of Additional Regulation***

Summary: To meaningfully reduce burden without compromising integrity, CMS should embrace innovation in care delivery without adding regulation, especially in areas like telemedicine and digital care coordination. A health information services safe harbor in the Anti-Kickback Statute would provide clear guidelines to modernize this regulation and remove the ambiguity that exists for American healthcare innovators. Streamline internal regulatory

processes to ensure that burdens on innovation and access are minimized, not compounded. CMS should direct funding to innovative digital health solutions to promote their adoption through pilot programs and partnerships and expand telemedicine in less resourced health centers and non-traditional settings like schools and community centers. Promote new care models or interoperability standards like HL7 FHIR through incentives, not mandates, and convene Technical Expert Panels to discuss best practices and industry standards in telemedicine, digital health, and integrated care systems, allowing impacted entities time to respond to any new requirements or regulations.

Total Comments Contributing: 21

Total Submissions Contributing: 15

Organization(s): American College of Physicians; CPAC Foundation Center for Regulatory Freedom; Henry Ford Health; Infectious Diseases Society of America; Lantana Consulting Group; Massachusetts Health Data Consortium; Ohio Hospital Association; PointClickCare; Reveleer; Sanford Health - Good Samaritan Society; The University of Texas MD Anderson Cancer Center; Zocdoc

Aggregated Comment Title: ***Remove Unnecessary Supervision Requirements***

Summary: Reduce administrative burden by eliminating unnecessary supervision mandates for licensed and credentialed individuals, who are already qualified to perform tasks independently, without oversight from physicians or nurse practitioners (NPs). Additionally, supervision requirements for residents and Advanced Practice Providers (APPs) such as NPs and PAs should be reviewed. Federal and state level supervision requirements are complex and do not always align (e.g., supervision may be a condition of payment, condition of participation or a state or industry entity scope of practice issue). Also, waiving these requirements could address provider shortages by giving APPs more flexibility to practice in rural and underserved communities. For example, revise §424.22 and §484.4 to align with the CARES Act, and align federal regulations at 42 CFR 491.8 with state scope of practice laws for NPs and PAs in Rural Health Clinics. CMS should ensure that APPs can practice at the top of their license, which will increase access and reduce burden.

Total Comments Contributing: 20

Total Submissions Contributing: 14

Organization(s): Advanced Medical Software Solutions Inc; Alliance of Dedicated Cancer Centers (ADCC); American Association of Nurse Practitioners; American Nurses Association; Catholic Health Association; Henry Ford Health; Illinois Health and Hospital Association; LeadingAge; Louisiana Rural Health Association; National Council of State Boards of Nursing; Omada Health, Inc.; Texas Association for Home Care and Hospice; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Update COVID-19 Isolation Protocols***

Summary: The COVID-19 isolation and testing protocols for long-term care facilities (LTCFs) are outdated, expensive, and time-consuming, and they do not align with CDC and general public standards. The requirement for staff to remain out of work for at least seven days contributes to staffing shortages and results in lost wages. Additionally, serial testing and isolating asymptomatic residents for ten days or more poses challenges to their well-being. These protocols, applicable only to staff and residents, do not prevent the spread of infection from visitors who are not required to follow these guidelines. CMS should update COVID-19 isolation and testing protocols in nursing homes and other LTCFs to be current and more patient-centered, such as 24-hours fever free.

Total Comments Contributing: 20

Total Submissions Contributing: 9

Organization(s): American Health Care Association (AHCA); Grafton County Nursing Home; LeadingAge; LeadingAge Illinois/Iowa; LeadingAge PA; Oak Lane Nursing & Rehab; Sanford Health - Good Samaritan Society; The Meth-Wick Community

Aggregated Comment Title: ***Explore New Licensure Framework to Support Telemedicine Across States***

Summary: CMS should explore establishing a national or multi-state licensing system for healthcare professionals to streamline telehealth services across states. The current state-by-state licensure model creates administrative burdens for clinicians and limits provider flexibility, especially for organizations operating in multiple states. A harmonized licensure framework would reduce credentialing delays, increase provider supply in shortage areas, improve responsiveness during public health emergencies, and enhance continuity of care for Medicare beneficiaries. Consider providing technical assistance and financial incentives to help states adopt model language or frameworks that support telehealth licensure portability for Medicare providers. CMS should also not duplicate requirements already implemented through state licensure.

Total Comments Contributing: 20

Total Submissions Contributing: 13

Organization(s): AMGA; AdventHealth; American Association of Critical-Care Nurses; Bipartisan Policy Center; Cleveland Clinic; Hospital Association of Rhode Island; Infectious Diseases Society of America; Johns Hopkins Health System; Mayo Clinic; Microsoft; Sanford Health - Good Samaritan Society; WellSpan Health

Aggregated Comment Title: ***Operationalize CMS-0057-F***

Summary: Implementing the Interoperability and Prior Authorization Final Rule (CMS-0057-F) would standardize electronic prior authorization processes in Medicare Advantage, Health Insurance Marketplaces, and Medicaid, reducing delays and administrative burdens for providers. By leveraging HL7 Fast Healthcare Interoperability Resources (FHIR)® standards, CMS aims to streamline insurance-related administrative transactions and ensure patients have access to their health information. This initiative encourages industry innovation, automation, and efficiency, paving the way for improved data exchange and collaboration between stakeholders.

Total Comments Contributing: 19

Total Submissions Contributing: 18

Organization(s): Alliance of Dedicated Cancer Centers (ADCC); California Hospital Association; Children's Hospital Association; Essentia Health; Florida Hospital Association; HL7 Da Vinci Project; Kansas Hospital Association; Kentucky Hospital Association; Memorial Sloan Kettering Cancer Center; Ohio Hospital Association; Premier Health; Sanford Health - Good Samaritan Society; The American College of Cardiology; University of Vermont Medical Center; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Streamline Audit Protocol for Oversight of Health Plans***

Summary: To minimize inefficiencies and reduce burden, CMS should streamline regulatory audits and consider adopting one audit protocol for oversight of health plans such as CMS Program audit, MLR audits, Data Validation audits, and NCQA accreditation. Align with best practices by ensuring consistency across state and federal regulations for data sharing for health care operations, care coordination, and payment and prohibit states from imposing requirements that are more restrictive than HIPAA. CMS should consider waiving annual audits and requiring once every three years for plans that achieve 100% in their data validation audit, along with alternative submission methods such as FTP upload capability.

Total Comments Contributing: 19

Total Submissions Contributing: 11

Organization(s): Essentia Health; Humana; Johns Hopkins Health Plans; Lumeris Healthcare; Point32Health; SCAN Health Plan; Sanford Health - Sanford Health Plan and Security Health Plan; South Country Health Alliance; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Reduce Redundant and Excessive ACO Reporting Requirements***

Summary: Reduce redundant and excessive reporting to ACOs, including rolling back requirements for ACOs to report measures through reporting mechanisms other than the web interface, removing the monthly ACO provider reporting requirement, and providing time to ramp up reporting new eCQMs. Eliminate the ACO public reporting requirement under 42 CFR

425.308 instead require ACOs to link to publicly available data from CMS. This will improve patient care by freeing up resources for direct patient support. The need for additional staff to handle excessive reporting requirements, such as Continuous Improvement/Sustained Exceptional Performance (CI/SEP) is costly.

Total Comments Contributing: 19

Total Submissions Contributing: 12

Organization(s): Aledade; Ascension; Association of American Medical Colleges; Lumeris Healthcare; National Association of ACOs; PSW and MultiCare Connected Care; Premier Inc; Rettig Family Health Care; Sutter Health

Aggregated Comment Title: ***Simplify and Clarify Guidance for Clinical Documentation***

Summary: CMS can streamline Medicare reporting by simplifying and clarifying guidance for clinical documentation and reducing the number of new elements added for reporting. This could reduce burden, unnecessary variation, and defensive charting, enabling nurses and providers to focus on patient care while upholding program integrity. Areas of opportunity include documentation of complex conditions like sepsis and malnutrition; time-based reporting; swing bed, observation, and outpatient rehab; hospice; transitions of care; and newly added questions regarding AFHM and SDOH reporting. Furthermore, CMS may clarify that brokers and agents should document interactions based on the level of risk, focusing on enrollment and plan selection discussions rather than routine or service-related communications. In addition to this, simplifying compliance by using a single, comprehensive record to meet multiple documentation requirements can reduce administrative burden and maintain a clear audit trail.

Total Comments Contributing: 19

Total Submissions Contributing: 14

Organization(s): American Academy of Dermatology Association; American Psychiatric Association; Eventus WholeHealth; Hartford Healthcare; Lantana Consulting Group; Price Services Group, L.L.C.; The Ohio State University Wexner Medical Center; WKHS

Aggregated Comment Title: ***Correct Flaws Related to the MIPS Value Pathways (MVPs) Framework***

Summary: The MIPS Value Pathways (MVPs) framework is flawed and poses challenges for many specialties as well as for large multispecialty groups. There is a lack of applicable measures for many specialties, lack of benchmarks for existing QCDR measures, lack of relevant cost measures, and siloed performance categories. CMS has also declined to adopt clinically meaningful QCDR measures recommended by medical societies and made measure development for QCDRs overly onerous, constantly changing testing requirements with little

direction on what they really are. In multispecialty groups, MVPs are an administrative nightmare. Also, MVP reporting will necessitate costly IT support. In general, the incentives rarely justify the costs of compliance.

Total Comments Contributing: 19

Total Submissions Contributing: 9

Organization(s): American Academy of Hospice and Palliative Medicine; American College of Rheumatology; Physician Clinical Registry Coalition; Post-Acute and Long-Term Care Medical Association (PALTmed); The American Psychological Association Services, Inc.; University of Colorado Medicine

Aggregated Comment Title: ***Expand the Use of Electronic Clinical Quality Measures (eCQMs)***

Summary: Utilizing EHR-based reporting with certified electronic clinical quality measures (eCQMs) automates the collection of quality data elements and reduces the need for manual abstraction. Using eCQMs to aggregate data from various sources would enhance data accuracy while reducing administrative burden. However, the utility and usability of eCQMs need to be improved to ensure they can be automatically extracted from EHR data without manual entry. Coordinate with stakeholders to advance the development of aligned eCQMs. Expanding eCQM use aligns Medicare with best practices and improves quality measurement accuracy and timeliness. In addition to this, MSSP requires submission of all electronic clinical quality measures (eCQMs) available within EHRs

Total Comments Contributing: 19

Total Submissions Contributing: 13

Organization(s): American College of Physicians; Booz Allen Hamilton; Cleveland Clinic; Kona Community Hospital; Lantana Consulting Group; Massachusetts Health Data Consortium; NCH Naples Comprehensive Health; Piedmont Healthcare; Providence Health and Servicess; The American College of Cardiology; The Helmsley Trust; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Provider Types and Home Care Eligibility***

Summary: CMS should align regulations with the CARES Act, allowing Advanced Practice Providers (such as APRNs and PAs) to certify and order home care services (including home health and hospice) without mandatory physician collaboration. Further, relax restrictions on when therapists can conduct eligibility assessments and restore flexibilities that were in place during the PHE. Together, these measures will reduce barriers to care and improve access.

Total Comments Contributing: 19

Total Submissions Contributing: 11

Organization(s): Aegis Therapies; Humana; Illinois HomeCare & Hospice Council; LeadingAge; National Alliance for Care at Home; Sanford Health - Good Samaritan Society; Sutter Health; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Rethink Star Ratings***

Summary: CMS should revise star ratings, as they are burdensome for providers and plans and often do not provide meaningful information for beneficiaries. For example, reduce the frequency of resubmission for MA star ratings to a maximum of biannually for high performing providers or remove star ratings measures that rely on member responses from the Health Outcomes Survey. Further, communicate set points well in advance to facilitate provider understanding and compliance. Other recommended changes include: requiring new measures to remain on the display page for three years; retiring outdated measures that have been updated to align with clinical guidelines; retiring medication adherence measures; establishing defined and expanded annual plan preview periods; considering the number of changes proposed each year and ways to minimize extensive changes in a specific year or over a short period of years; and adding or transitioning measures to the new Electronic Clinical Data Systems (ECDS) infrastructure. In addition, CMS's Star Ratings calculations removed outliers, impacting smaller Medicare plans disproportionately. This change resulted in many plans being excluded from qualifying for the Excellent Health Outcomes for all rewards due to having fewer members with Social Risk Factors, which does not reflect health plan quality.

Total Comments Contributing: 19

Total Submissions Contributing: 9

Organization(s): AMGA; American Medical Association; Blue Cross Blue Shield Association; Johns Hopkins Health Plans; Lumeris Healthcare; UCare; UnitedHealthcare; WEDI

Aggregated Comment Title: ***Streamline NTAP Eligibility Requirements***

Summary: CMS should streamline New Technology Add-On Payment (NTAP) eligibility requirements. CMS should adopt more frequent reviews, such as quarterly, biannual or review on a rolling basis, and grant three full years of NTAP for all qualifying technologies. Streamlining NTAP eligibility for FDA-designated RMATs and BTs would align NTAP policy with CMS' existing approach to FDA-designed Breakthrough Devices, QIDPs, and products approved under LPAD, reflecting the rigorous evidentiary standards required for such designations and reducing unnecessary administrative burden for both applicants and CMS. CMS should not require QIDPs to have an active FDA market authorization at the time of NTAP submission, especially applicants under the Alternative Pathway for Certain Transformative New Devices, in order to prevent lags in patient access to devices. Beyond devices, CMS could also consider applying this same process to drugs and therapies. In addition to this, modernize the NTAP Program by aligning the process for medical devices with Breakthrough Therapy Designation to drugs and therapies applying for an NTP.

Total Comments Contributing: 19

Total Submissions Contributing: 10

- ***Organization(s):*** Abbott; AdvaMed; Alliance for Regenerative Medicine; BIO; Danaher Diagnostics; Johnson & Johnson; Medical Device Manufacturers Association (MDMA); Osteal Therapeutics; Pfizer, Inc.; PhRMA

Aggregated Comment Title: ***Add Cardiac Catheter Ablation and Related Procedures to ASC Covered Procedures List***

Summary: CMS should add cardiac catheter ablation and related procedure codes including cardioversion (CV) and transesophageal echocardiography (TEE) to the Ambulatory Surgical Center Covered Procedures List (ASC CPL). These procedures were found safe and feasible when performed in ASCs during the CMS Hospital Without Walls program, and some commercial payers already approve them.

Total Comments Contributing: 19

Total Submissions Contributing: 1

Aggregated Comment Title: ***Home Health Aide Supervision***

Summary: CMS should simplify the rules for home health aide supervision. Only Registered Nurses (RNs) and therapists can supervise home health aides, even though a Licensed Practical Nurse (LPN) or assistant could perform the task effectively. Regulation 484.80(h)(1)(iv) needs more clarity to reduce confusion. Additionally, CMS could revert to the original proposed language for home health aide (HHA) supervision under 42 CFR §484.80(h)(2)(i), as the current regulation's requirement for individual observation every six months is redundant and ineffective in improving care quality. Allow registered nurses to conduct supervisory visits without the need for one-on-one observation with every patient and opt for a risk-based model. The revised regulation was finalized without public input and places a disproportionate burden on HHAs. Furthermore, allow other healthcare professionals, such as physical or speech therapists, to provide in-service training for home health aides under the direction of a registered nurse.

Total Comments Contributing: 18

Total Submissions Contributing: 14

Aggregated Comment Title: ***Reform Prior Authorization Appeals Processes***

Summary: Prior authorization appeals lack transparency, potentially violate due process, cause delays in treatment that can harm patients, and lack empirical evidence to support their effectiveness. These appeals are burdensome to providers and delay patient care. Appeals frequently result in approval, raising the question of why such initial denials are permitted. Recommendations include reducing the frequency of appeals, creating streamlined appeals pathways, establishing a standard appeal process, limiting their application to high-risk therapies, limiting retroactive denials, and ensuring procedural safeguards are in place to improve the process. Additionally, CMS should provide evidence that the current appeal system effectively mitigates risks.

Total Comments Contributing: 18

Total Submissions Contributing: 5

- ***Organization(s):*** AdventHealth; American Association for Homecare; CPAC Foundation Center for Regulatory Freedom; California Hospital Association; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Employ Flexibilities in SNF QRP Reporting***

Summary: CMS should modify SNF QRP reporting to reduce the number of required data elements and waive penalties on certain MDS questions for patients with unplanned discharges. Conversely, CMS should update MDS to reflect QRP changes by removing the data elements from the MDS assessment associated with the SNF QRP process measures. Additionally, codify the agency's stated policy in the FY 2015 LTCH PPS Final Rule that allows for QRP noncompliance to be excused under extenuating circumstances or valid excuses. Recommendations include repealing and replacing regulations t 42 C.F.R. 412.560(d) and 42 C.F.R. 412.634(d) to ensure fair review standards for LTC and IRF QRP appeals and limiting CMS's use of exceptions. CMS should strive for more appropriate measures in the IRF QRP, every measure should have CBE endorsement and CMS should exclude non-Medicare patients from IRF QRP compliance and payment determinations.

Total Comments Contributing: 18

Total Submissions Contributing: 6

Organization(s): American Association of Post-Acute Care Nursing (AAPACN); American Health Care Association (AHCA); American Medical Rehabilitation Providers Association; PointClickCare; Select Medical Holdings Corporation

Aggregated Comment Title: ***Integrate SUD Data into the Health Record***

Summary: Waive the requirement for providers to separate medical records related to substance use disorder (SUD) to enable integrated care, as the current practice hinders coordinated healthcare due to the inability to integrate behavioral and physical health data. Enable alignment of requirements for 42 CFR Part 2 and HIPAA when used for care coordination by removing special privacy protections.

Total Comments Contributing: 17

Total Submissions Contributing: 17

Organization(s): BJC Health System; Catholic Health Association; Cityblock Health; Illinois Health and Hospital Association; Kansas Hospital Association; Kentucky Hospital Association; National Association of ACOs; PSW and MultiCare Connected Care; Society of Hospital Medicine; The Ohio State University Wexner Medical Center; The U.S. Chamber of Commerce; UHS, Inc.; WellSpan Health

Aggregated Comment Title: ***Reform the Inpatient Psychiatric Facility Quality Reporting Program***

Summary: The Inpatient Psychiatric Facility Quality Reporting (IPFQR) program faces challenges such as lack of meaningful measures, consensus-based entity endorsement, measure stability, and consumer clarity. The program's focus on compliance rather than data integrity and utility results in significant spending without achieving material benefits. Recommendations include selecting measures important to patients, obtaining consensus-based entity endorsement, ensuring patient representation, and focusing on measures within facilities' control. Transforming the IPFQR program to align with its purpose of improving behavioral health care quality and patient information is crucial for achieving meaningful outcomes and program integrity. CMS should remove quality measured from the IPFQR that are not directly relevant to inpatient psychiatric care, such as whether the facility offers smoking cessation services. Additionally, requiring 300 PIX surveys, or 100% of patients if less than 300 discharges, is unreasonable given that patients may decline to participate.

Total Comments Contributing: 17

Total Submissions Contributing: 8

Organization(s): Cleveland Clinic; Dale Medical Center; Georgia Hospital Association; Illinois Health and Hospital Association; MHO; National Association for Behavioral Healthcare; Sutter Health

Aggregated Comment Title: ***Medicare Cost Reports Are Complex***

Summary: The annual Medicare Cost Report is complex and requires detailed financial and statistical data compilation, often necessitating the use of external consultants. The process involves detailed documentation of costs, visit counts, allocation methods, and regulatory

compliance, requiring significant time, expertise, and meticulous attention. Moreover, errors can lead to reimbursement delays, audits, and financial penalties, ultimately impacting cash flow and service delivery. This is true for cost reports across facility types. Streamlining, consolidating the requirements, allowing EHR/claims data prefill, simplifying time studies requirements, or reducing the frequency of reporting could alleviate administrative burden.

Total Comments Contributing: 17

Total Submissions Contributing: 10

Organization(s): Adara Home Health; Citizens Memorial Hospital; Hands of Wellness; Henry Ford Health; National Association of Community Health Centers (NACHC); Ohio Hospital Association; The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Modernize Stark Law and Anti-Kickback Statutes to Promote Value-Based Arrangements***

Summary: Modernize the Stark Law and Anti-Kickback Statutes to promote value-based arrangements and address disparities between providers and payers. Hospitals want to provide food and transportation support but are limited because of these restrictions. The Anti-Kickback Statute was written in 1972, decades before today's prevailing digital technology. When applied too broadly, it hampers innovation and, in doing so, can obstruct or delay care. Most physician practices have transitioned to an employment model with health systems, and by attaching penalties to many health system-physician collaborations that could improve care, the current Stark and anti-kickback regulations impede the creation of value. CMS could make exceptions in cases of established patients, extend waivers for Stark, or identify ways to further refine these laws in value-based care.

Total Comments Contributing: 17

Total Submissions Contributing: 12

- ***Organization(s):*** AVIA-Leavitt Partners Nexus Collaborative; Illinois Health and Hospital Association; Kentucky Hospital Association; Kidney Care Council; Lumeris Healthcare; Ohio Hospital Association; Physicians Advocacy Institute; Premier Health; Sutter Health; The American College of Cardiology; The Ohio State University Wexner Medical Center; Zocdoc

Aggregated Comment Title: ***Consolidate Documentation Requirements Into One Process and Platform***

Summary: Streamline reporting by consolidating provider information and documentation requirements into a single submission process or platform. A single data submission platform

could reduce compliance risks and enhance care quality by maintaining consistent expectations and eliminating redundant reporting to various entities and in different formats. Unified reporting portals and/or shared care management platforms can enhance data usability and efficiency across systems.

Total Comments Contributing: 17

Total Submissions Contributing: 15

Aggregated Comment Title: ***Rescind or Revise Obstetrical Care CoPs***

Summary: Remove or revise the new Obstetric Service Conditions of Participation (CoP) as they add burden without demonstrable improvements in health outcomes. The Conditions of Participation (CoPs) mandate hospitals and critical access hospitals (CAHs) to meet specific requirements for offering obstetric (OB) services. However, smaller hospitals and those in rural areas may not meet these standards due to financial constraints, potentially leading to closures of labor and delivery units.

Total Comments Contributing: 17

Total Submissions Contributing: 13

Aggregated Comment Title: ***Eliminate Duplicative Look Back Validation Surveys***

Summary: CMS should eliminate duplicative look back validation surveys of accrediting organizations at 42 CFR 488.9 and permanently adopt concurrent validation surveys.

Total Comments Contributing: 17

Total Submissions Contributing: 12

Organization(s): Association of American Medical Colleges; California Hospital Association; Cleveland Clinic; Georgia Hospital Association; Kansas Hospital Association; Kentucky Hospital Association; MaineHealth; Mayo Clinic; Select Medical Holdings Corporation; Tampa General Hospital - Tampa, FL; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Streamline Access to Diabetes Self-Management Training and Medical Nutrition Therapy***

Summary: CMS should improve access to Diabetes Self-Management Training (DSMT) and medical nutrition therapy (MNT). Suggestions include: allow the services to be delivered on the same day by changing the waiting period from 1 day to 0 days; increase the availability and flexibility of the limited number of DSMT hours including eliminating the 12-month clock on

initial hours; streamline and reduce paperwork burden by simplifying the information required in the referral order; allow NPs or PAs to refer beneficiaries for MNT; remove mandates that most of the initial DSMT benefit be group-based, limiting patient access to individualized care; address coverage gap for those with a GFR < 15 who are clinically eligible but not yet dialyzing; aligning benefit timelines and simplifying accreditation regulations.

Total Comments Contributing: 17

Total Submissions Contributing: 4

- ***Organization(s):*** Academy of Nutrition and Dietetics; Association of Diabetes Care and Education Specialists; Diabetes Advocacy Alliance; Diabetes Technology Access Coalition (DTAC)

Aggregated Comment Title: ***Streamline Reporting for Supplemental Benefits***

Summary: Plans were required to report on supplemental benefits for the first time in 2024, which posed challenges due to the data not typically maintained at the plan level. This reporting also duplicated information already submitted for supplemental benefits, leading to operational and cost burdens. CMS should streamline or eliminate the reporting requirements for supplemental benefits in future years to alleviate the burden on Medicare Advantage plans. Requiring MA plans to report patient encounters for supplemental benefits in the same manner as encounters for medical benefits is unnecessary. CMS should assess the quality, completeness, and utility of the current data before determining if additional reporting is necessary. The expansion of supplemental benefit reporting has placed significant operational burdens on MA plans with limited value. The benefits lack standardization and create duplication issues with separate data submissions through encounter data and medical loss ratio reporting. CMS should also adjust the due date for supplemental benefit reporting data to later in the calendar to align with the submission timeline for the Bid Pricing Tool. Furthermore, streamline supplemental encounter data reporting, which aren't typically able to be reported in the same way as medical services.

Total Comments Contributing: 16

Total Submissions Contributing: 12

Organization(s): AHIP; Blue Cross Blue Shield of Massachusetts; Humana; Johns Hopkins Health Plans; Lumeris Healthcare; National Association of ACOs (NAACOS); The U.S. Chamber of Commerce; Triton Health Systems; UnitedHealthcare

Aggregated Comment Title: ***Remove Restrictions on Transitional Pass-Through Payment***

Summary: CMS should eliminate barriers to Transitional Pass-Through (TPT) payments for innovative medical technologies, including in the outpatient setting, in 42 CFR Part 419 Subpart G; 419.66(b)(3). This regulation restricts medical devices, such as clinical laboratory tests, from qualifying for TPT status. Suggestions include removing restrictions on in vitro diagnostics, aligning TPT policies for Medicare Advantage beneficiaries with Traditional Medicare, and addressing issues related to TPT expiration, payment guidance in Ambulatory Surgery Centers, and device offset amounts. These changes aim to promote timely access to cutting-edge treatments and promote patient access to innovation in healthcare.

Total Comments Contributing: 16

Total Submissions Contributing: 3

Aggregated Comment Title: ***Modify Prior Authorization Rule 0057***

Summary: The Interoperability and Prior Authorization Final rule (CMS-0057) does not cover drugs, leading to ongoing administrative challenges for clinicians and patients. Modify and simplify the CMS Prior Authorization Rule 0057. For example, include provider adoption requirements and clear but flexible timelines for small and rural providers; allow small health plans to request to opt out; and streamline requirements that are burdensome to implement. While mandating provider adoption of electronic prior authorization standards (with technical and/or financial support) and aligning payer, provider, and vendor obligations could reduce administrative costs and improve care coordination for Medicare beneficiaries, recognize there are many providers who are resource constrained. CMS should delay implementation of the rule until these standards are aligned.

Total Comments Contributing: 16

Total Submissions Contributing: 11

Organization(s): Agadia Systems; American Health Care Association (AHCA); American Medical Association; Association for Clinical Oncology; Microsoft; Minnesota Association of County Health Plans; Sanford Health - Sanford Health Plan and Security Health Plan; UCare; WEDI

Aggregated Comment Title: ***Age-Friendly Health Systems Questions***

Summary: CMS should retain and standardize Age-Friendly Health Systems (AFHS) questions and validated tools and streamline current processes, including updates pertinent to the collection of certain demographic data that are used in stratification. Respondents indicate this measure is both useful and cost-effective and recognizes that older adults have elevated risks for certain complications. There are no other geriatric-specific measures in the IQR. However, there are suggestions to improve data capture and reduce redundancy: clearly define

"caregiver"; assimilate these questions with the Patient Safety Structural Measure (PSSM); and eliminate duplication with related measures, such as Advance Care Plan (00037-01-C-MIPS).

Total Comments Contributing: 16

Total Submissions Contributing: 6

Organization(s): American College of Surgeons; Institute for Healthcare Improvement; Massachusetts Coalition for the Prevention of Medical Errors; Northwestern Medicine; WKHS

Aggregated Comment Title: ***Streamline Annual Wellness Visits***

Summary: Providers encounter redundancy and complexity in documenting Medicare Annual Wellness Visits (AWVs), including for health risk assessments and screenings. Allow these visits to be billed along with other visits on the same day to make it easier for beneficiaries. For rural health clinics specifically, allow these billable visits to be performed by RNs. Additionally, adopting EHR-integrated templates may also help with compliance. Alternatively, replacing the AWV and all surrounding reporting and quality metrics with the Preventive Medicine codes would allow for greater patient care and less administrative burden. Also allow providers access to updated patient attribution lists via the plan's portal in order to verify the eligibility of the entire attribution list, which would help improve their efforts in identifying and reaching out to patients to schedule their AWV, a crucial component of overall care. Furthermore, allowing 'episode-based' oncology documentation, which is an initial comprehensive oncology history and plan at diagnosis to be referenced in subsequent visits, reducing the need for repetitive documentation of the same narrative.

Total Comments Contributing: 16

Total Submissions Contributing: 10

Organization(s): AMGA; Gritman Medical Center Kendrick Family Care; Highlands Oncology Group, P.A.; National Association of Community Health Centers (NACHC); National Association of Rural Health Clinics; Ohio Hospital Association; Rettig Family Health Care; Sanford Health

Aggregated Comment Title: ***Hospice and Home Health Audit and Medical Review Processes are Burdensome***

Summary: The audit and medical review processes for hospice and home health are burdensome and pose significant challenges for providers, including the risk of recoupment for non-compliant claims, high compliance costs, penalties for minor documentation issues, and repayment demands. They are often targeted for multiple audits at the same time, from multiple audit contractors, and often for the same issue. These processes often focus on documentation related to patient eligibility for hospice services and target hospice providers for post-payment reviews, particularly for services rendered at higher levels of care like General Inpatient and Continuous Home Care. Provider education could help reduce errors. CMS should

adopt a transparent, data-driven algorithm to guide the selection of providers for audit and review.

Total Comments Contributing: 16

Total Submissions Contributing: 6

Organization(s): American Academy of Hospice and Palliative Medicine; Home Care and Hospice Association of New Jersey; National Alliance for Care at Home; Netsmart; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Minimum Staffing Rule Strains Nursing Facilities***

Summary: CMS has implemented minimum staffing standards for nursing facilities under 42 C.F.R. 483.35(b)(1), which many facilities find challenging to meet. This means significant increases in staff and expenses would be required, which may not be feasible. With nursing facilities closing and a shortage of nurses in the industry, this regulation may worsen staffing issues without additional federal funding. This could lead to more closures and reduced access to care.

Total Comments Contributing: 15

Total Submissions Contributing: 12

Organization(s): Catholic Health Association; Greater New York Hospital Association; Guardian Angels Senior Services; Healthcare Association of New York State; LeadingAge; LeadingAge New York; LeadingAge PA; Ohio Hospital Association; Premier Inc; Select Medical Holdings Corporation; WellSpan Health

Aggregated Comment Title: ***Reconsider Mandatory Subgroup Reporting Requirement***

Summary: CMS should reconsider mandating MVP subgroup reporting in 2026 due to the significant administrative burden it places on multi-specialty group practices. The current structure of MIPS MVPs may increase clinician burden, as requiring subgroups for participation could force practices to reorganize infrastructure, adding complexity and cost. Defining mandatory subgroups for multispecialty practices is premature and logistically challenging, especially during the transition from MIPS to MVPs, increasing administrative burdens for practices switching to MVP reporting. Before requiring mandatory subgroup reporting, CMS should gather appropriate data to evaluate the formation and reporting/performance patterns of subgroups, and each practice should have the discretion to determine which clinicians/specialists comprise a subgroup. At the least, CMS should exempt small practices from subgroup reporting.

Total Comments Contributing: 15

Total Submissions Contributing: 8

- ***Organization(s):*** Alliance of Specialty Medicine; American Academy of Hospice and Palliative Medicine; American College of Rheumatology; Association for Clinical Oncology; College of American Pathologists; Medical Group Management Association; Physician Clinical Registry Coalition; The American College of Cardiology

Aggregated Comment Title: ***Standardize Format for Payment, Coding, and Coverage Across Payers***

Summary: Standardizing payment, coding, and coverage formats across payors can streamline processes, reduce administrative costs, and minimize delays in service for beneficiaries. The array of operations is especially challenging for providers who deal with multiple Medicare Advantage plans, each with their own processes. Having separate coding systems, which include G-Codes, for instance, is inefficient and many may be unnecessary. CMS should also pay attention to rules suggesting or requiring prior use of a CPT code that pays only a fraction of the cost of providing a service. Coordinating benefits for dually eligible individuals is particularly challenging, leading to additional paperwork and delays due to varying coverage criteria. Simplifying these processes would ultimately benefit beneficiaries by improving efficiency and access to care.

Total Comments Contributing: 15

Total Submissions Contributing: 9

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); Cleveland Clinic; Emergency Department Practice Management Association (EDPMA); MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Sanford Health - Good Samaritan Society; The American College of Cardiology; The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Rural and Critical Access Hospitals Struggle with SDOH Reporting Requirements***

Summary: The reporting requirements for measures related to health equity and social determinants of health (SDOH) pose a significant burden on rural hospitals, particularly Critical Access Hospitals (CAHs), as they struggle to address these unique challenges. Unlike urban hospitals with more resources, hospitals in rural areas face difficulties in meeting the requirements due to the lack of established support systems for addressing SDOH. Additionally, SDOH screening creates a burden for healthcare providers due to insufficient training, time constraints, impact on provider-patient relationships, limited actionability of collected data, potential patient distrust, and increased administrative tasks. These challenges can lead to frustration and divert resources away from direct patient care, highlighting the complexities and limitations of addressing SDOH in healthcare settings.

Total Comments Contributing: 15

Total Submissions Contributing: 4

Organization(s): Wooster Community Hospital

Aggregated Comment Title: ***Simplify Dietary Regulations***

Summary: To ease burden on facilities, CMS should modify and simplify regulations pertinent to food service operations so that surveyors can focus on critical risks to resident health and safety. Some targets for simplification include [§483.60(i)(1)–(2), §483.60(a)(1), §483.60(a)(1), §483.30(e)(2)]: align food storage regulations and reporting with national standards; use of hair restraints; definitions of "qualified dietitian" and director of food/nutrition services; scope of practice for Registered or Certified Dietitian Nutritionists; and flexibility in meal timing. Reporting meal intake for every resident at every meal is also burdensome.

Total Comments Contributing: 15

Total Submissions Contributing: 8

Organization(s): American Health Care Association (AHCA); American Senior Communities; CCL Hospitality Group; Compass Community Living; DSHS/HCLA/RCS; LeadingAge Illinois/Iowa; Pennsylvania Health Care Association

Aggregated Comment Title: ***Repeal Health Equity Analysis of Utilization Management Data***

Summary: CMS should repeal the health equity analysis requirement for utilization management data under sections 422.137(d)(6) and (7) for Medicare Advantage Utilization Management Committees. These requirements impose significant IT and administrative costs with limited value to beneficiaries or CMS. Aligning requirements with CMS-0057-F and addressing misleading data in the health equity analysis, along with guidance and templates, could help streamline reporting and ensure accurate evaluations. Additionally, concerns are raised about conflicts of interest if the Utilization Management committee is involved in medical necessity approvals.

Total Comments Contributing: 15

Total Submissions Contributing: 8

Aggregated Comment Title: ***Medicare Provider Enrollment Forms are Confusing and Overly Complex***

Summary: Medicare enrollment forms such as CMS 855A, 855B, 855I, 855S, 855O, and the Opt-Out form are notoriously complex, frequently updated, and require redundant information already available in PECOS, making the process time-consuming and confusing. The 65-page

CMS-855A form, for instance, demands personal addresses of owners and managing employees, even though this data is already stored in PECOS. Despite the availability of digital verification, wet signatures are still required, adding to the administrative burden. Providers must also navigate separate documentation processes for enrollment and claims appeals, while digital submission through PECOS is hindered by login difficulties and a confusing interface. Additional requirements—such as enrollment fees, Medicaid site approval, and address consistency with HRSA forms—further delay provider payments and access to care. To reduce these barriers, CMS should consolidate and standardize forms, enable structured data reuse, reinstate a 90-day enrollment window, and allow multi-entity facilities to submit a single comprehensive enrollment list.

Total Comments Contributing: 15

Total Submissions Contributing: 10

Organization(s): CGI Federal Inc.; Citizens Memorial Hospital; Healthcare Business Management Association; National Association of Community Health Centers (NACHC); National Association of Rehabilitation Providers and Agencies (NARA); National Board for Certified Counselors (NBCC); The American Psychological Association Services, Inc.; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Revise the Annual Review of Marketing Materials***

Summary: To enhance consistency in reviewing marketing materials (423.2261 and 422.2260 - 422.2267), CMS could implement an automated review system to identify content risks based on customized compliance rules developed with MAOs and TPMOs. This tool would streamline the review process, flagging potential compliance risks and providing uniform feedback to stakeholders. Additionally, CMS could modify its filing process to differentiate new content from existing material in ads and parts of ads. The content that is not new could go through the file and use process and the new content could go through the file and approve process. Another suggestion is to reduce the review timeframe for MAO marketing materials from 45 days to 2-3 weeks and to use a 5-day file.

Total Comments Contributing: 15

Total Submissions Contributing: 9

- ***Organization(s):*** Healthpilot; Humana; Kingdom Insurance Group; Lumeris Healthcare; Price Services Group, L.L.C.; Quote Velocity; Special Needs Plan Alliance; Triton Health Systems; UnitedHealthcare

Aggregated Comment Title: ***Avoid Layering New Rules Over Existing Requirements***

Summary: Every time a new priority (e.g., equity, SDOH, AI) emerges, CMS adds new documentation requirements or data elements. CMS should map new priorities to existing certified capabilities (e.g., use USCDI v3 to support SDOH goals rather than layering new interfaces) and use shared test beds and open-source tooling to accelerate alignment with new standards in a resource-efficient way. Additionally, rather than expanding mandates, CMS could provide technical guidance and APIs that make it easier for hospitals and health systems to comply using their existing platforms and adopt existing FHIR-based standards, and CMS could enhance its use of data that is already available for public reporting rather than mandating new data collection from providers. Instead of Medicare-specific reporting, pull from existing ONC-certified data flows like API logs. By building on existing data standards such as HIPAA, HL7 FHIR implementation guides like PDex, Plan-Net, and CARIN Blue Button, CMS can reduce burden and costs.

Total Comments Contributing: 15

Total Submissions Contributing: 8

Organization(s): America's Physician Groups (APG); American Academy of Physical Medicine & Rehabilitation; American Urological Association, Inc.; National Board for Certified Counselors (NBCC); Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Empower PTs/OTs to Address the Needs of Beneficiaries with Disabilities***

Summary: Empower disability competent clinicians like physical or occupational therapists to assess and address the needs of individuals with disabilities without requiring constant medical justification for services. Allow occupational therapists to conduct initial and comprehensive assessments when both nursing and therapy are ordered and allow payment for HBAI services under the MPFS when delivered by OT practitioners as part of an OT plan of care developed to address physician health conditions where psychosocial and mental health factors are identified as a barrier to recovery. Also unbundle payment of measuring and fitting of lymphedema compression garments when the service is provided by an OT or PT, so that they may be reimbursed separately.

Total Comments Contributing: 14

Total Submissions Contributing: 11

Organization(s): Adara Home Health; American Occupational Therapy Association; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); National Association of Rehabilitation Providers and Agencies (NARA); Net Health; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Rethink eCQM for Excessive Radiation Dose***

Summary: The implementation of the eCQM "Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults" (CMS eCQM ID: CMS1074v2) will introduce unnecessary complexity and burden without improving patient safety. This measure was not developed for radiology and currently lacks the capability to access or utilize elements from Digital Imaging and Communications in Medicine (DICOM) objects. Accreditation through programs with the American College of Radiology and the Intersocietal Accreditation Commission is already effective in ensuring proper radiation dose and image quality in diagnostic CT scans. CMS should either remove this measure or standardize it and the calculation of CT Global Noise using existing validated metrics and scanner calculations, which would simplify and automate the process, and reduce administrative burden on healthcare providers. The metric as currently detailed is neither reliable nor sufficiently detailed. Additionally, the algorithm is proprietary, so providers must implement a specific company's software to comply.

Total Comments Contributing: 14

Total Submissions Contributing: 4

Organization(s): AdvaMed; Mayo Clinic; The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Simplify the Medicare Cost Report***

Summary: Simplify Medicare cost reports and related audits to allow health centers to focus on delivering high quality while ensuring compliance and enhancing efficiency. For example, use a shortened version of Medicare Cost Reports for hospitals without cost reimbursed areas. The shortened report should focus on essential information like wage data, settlement worksheets, single worksheets for cost-to-charge ratios, and be applicable to the population in question. CMS should also align quality and cost reporting requirements across Medicare programs, commercial payers, and with other payer initiatives. Additionally, CMS can pull wage-index days, bad-debt claims and uncompensated-care charges directly from claims files provide pre-populated Medicare cost reports for providers to attest or correct. Furthermore, CMS should require small providers with fewer than 100 beds or under $10 million in Medicare revenue to submit an abbreviated cost report, reducing compliance costs while ensuring accurate Medicare payment data.

Total Comments Contributing: 14

Total Submissions Contributing: 9

- ***Organization(s):*** American Society of Pediatric Nephrology; Booz Allen Hamilton; Citizens Memorial Hospital; Henry Ford Health; Kansas Hospital Association; National Association of Community Health Centers (NACHC); The American College of Cardiology; UHS, Inc.; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Reduce Documentation Burden for Diabetic Shoes***

Summary: Simplify the documentation and audit processes for securing diabetic shoes. For example: do not require chart notes; allow APPs to fulfill documentation requirements; reduce requirements for coordination between primary care and podiatric providers; and reduce the volume of audits.

Total Comments Contributing: 14

Total Submissions Contributing: 9

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance"); American Association of Nurse Practitioners; American Podiatric Medical Association; CrownQuest Inc; Eastern Michigan University; Eventus WholeHealth; Healthstrides/Crownquest/Neurogenx; Michigan Home Health Association; Society of General Internal Medicine

Aggregated Comment Title: ***Uniform Clinical Criteria for Medical Necessity***

Summary: To reduce administrative burden, standardizing clinical criteria and simplifying documentation for medical necessity decisions is crucial. Plans aim to adopt national criteria like InterQual®, NCDs, or LCDs to ensure consistency across locations. Presently, varying criteria based on member location create complexity for providers. Implementing a single set of criteria would streamline the process, benefiting both providers and plans by ensuring consistent application of medical necessity standards.

Total Comments Contributing: 14

Total Submissions Contributing: 12

Organization(s): American College of Surgeons; Castle Biosciences Inc; Georgia Hospital Association; National Board for Certified Counselors (NBCC); RadNet; South Country Health Alliance; Texas Association for Home Care and Hospice; The American Psychological Association Services, Inc.; The Coalition for 21st Century Medicine; University Radiology Group, LLC

Aggregated Comment Title: ***Streamline Care Plan Documentation Requirements at 42 CFR 483.23(b)(4)***

Summary: To improve care quality and efficiency, streamline care plan documentation requirements at 42 CFR 483.23(b)(4) to align with team-based and interdisciplinary care models. As patient care increasingly involves interdisciplinary teams, outdated regulations mandating separate nursing-specific care plans lead to redundant paperwork and hinder holistic care delivery. Alignment will reduce redundancy and improve care coordination.

Total Comments Contributing: 14

Total Submissions Contributing: 10

Organization(s): California Hospital Association; Catholic Health Association; Cleveland Clinic; Federation of American Hospitals; Kansas Hospital Association; Kentucky Hospital Association; Virginia Hospital & Healthcare Association; Westminster Medical Clinic

Aggregated Comment Title: ***Streamline Medicare Advantage Prior Authorization Requirements***

Summary: Prior authorization for Medicare Advantage (MA) plans is causing delays in patient care access. Current regulations grant MA plans broad discretion in implementing prior authorization processes and lack specificity on approval timelines, transparency, or alignment with clinical guidelines, creating administrative barriers that disproportionately burden patients and providers. CMS should establish timeframes for electronic prior authorization requests, increase transparency regarding MA prior authorization, establish electronic prior authorization for MA, and waive PA requirements for routine diagnostic procedures and post-acute care. These changes aim to streamline the process and enhance access to care for MA beneficiaries.

Total Comments Contributing: 14

Total Submissions Contributing: 11

Organization(s): Alabama Hospital Association; American Association for Homecare; American Health Care Association (AHCA); Booz Allen Hamilton; Illinois Health and Hospital Association; Physicians Advocacy Institute; Select Medical Holdings Corporation; UHS, Inc.; UltraSight Inc.

Aggregated Comment Title: ***Reconsider Acceptance-to-Service Policy Requirements for Home Health Agencies***

Summary: CMS should rescind or revise the Acceptance-to-Service Policy Requirements (42 CFR §484.105) as they place a heavy burden on nonprofit, hospital-based home health agencies (HHAs) serving high-Medicaid and high-acuity populations. The policy's focus on documenting staffing levels and operational variables for each patient referral is overly punitive and complex, failing to address broader systemic capacity issues like recruitment and retention challenges faced by HHAs. Agencies also already assess their ability to accept services continuously with every referral they take. Additionally, CMS has not published guidance regarding compliance, leaving many HHAs potentially out of compliance at no fault of their own.

Total Comments Contributing: 14

Total Submissions Contributing: 8

Organization(s): Adara Home Health; Home Care Alliance of Massachusetts; Illinois HomeCare & Hospice Council; LeadingAge; National Alliance for Care at Home; Ohio Health Care Association; Sutter Health

Aggregated Comment Title: ***Electronic Member Correspondence for Medicare Advantage***

Summary: Allowing electronic communications as the primary method for member correspondence with an opt-out framework under 42 CFR 422.2267(d) benefits Medicare Advantage plans by reducing costs and improving member engagement, while creating an auditable, time-stamped record. Opt-out systems ensure that members have control over their communication preferences, while also reaching them more promptly and accurately. Shifting to electronic delivery as the default method can help plans save on administrative expenses and reinvest in member services, especially as traditional mail delivery becomes less reliable. However, enrollees should be able to opt into one preference for all communications from the plan as requirements for electronic delivery of plan materials can be operationally burdensome and require excessive work on the part of the enrollee.

Total Comments Contributing: 14

Total Submissions Contributing: 6

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts; DentaQuest; Point32Health; SCAN Health Plan; Sanford Health - Sanford Health Plan and Security Health Plan; UCare

Aggregated Comment Title: ***Radiology Coding and Billing Guidance***

Summary: CMS should update guidance on coding and billing practices for radiology services related to the place of service and date of service for professional component (PC) claims. To avoid increased processing costs for payors and providers, as well as potential claim denials, providers should align the date of service for imaging studies with the date the technical component (TC) was performed and allow providers the option to bill the PC using the location where the service TC was performed. These changes would streamline Medicare policy, reduce administrative burdens, reduce confusion, and minimize costs associated with managing multiple dates of service.

Total Comments Contributing: 14

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***Require Transparency from MA Plans on UM***

Summary: Require transparency on utilization management (UM) activities from Medicare Advantage (MA) plans through regular public reporting on metrics such as rates of prior authorization denials and appeals to improve oversight, compliance, and clarity around their

processes and policies. Data should be more specific, such as by item and service along with top reasons for denial. Specifically, replace or amend 42 CFR 422.111 to mandate transparency and accountability in payer prior authorization (PA) practices and denial data. CMS could also increase the weighting of patient experience metrics in Star Ratings to better reflect the impact of prior authorizations.

Total Comments Contributing: 13

Total Submissions Contributing: 13

Organization(s): AdventHealth; American Academy of Dermatology Association; American College of Rheumatology; American Medical Association; American Urological Association, Inc.; Association of American Medical Colleges; Center for Medicare Advocacy; Federation of American Hospitals; Martha T. Berry Medical Care Facility, Macomb County Michigan; Quest Diagnostics; UCare; UHS, Inc.

Aggregated Comment Title: ***Streamline Beneficiary and Payer Communication***

Summary: Streamline the communication process between payers and beneficiaries. To prevent duplication and misidentification of requests, CMS should allow Medicare Advantage plans to require beneficiaries to specify the type of request they are making—whether it is a coverage determination request, a grievance, or an appeal. Plans currently offer beneficiaries guidance resources that define these request types and can provide additional tools to help them make their requests effectively. Additionally, default the delivery of required beneficiary communications, such as the Explanation of Benefits (EOB), to electronic format when beneficiaries provide an email address, and update the requirements in 42 CFR § 423.2267(d) and 42 CFR § 422.2267(d) to reflect these changes.

Total Comments Contributing: 13

Total Submissions Contributing: 5

Organization(s): DentaQuest; Sanford Health - Sanford Health Plan and Security Health Plan; UCare; UnitedHealthcare

Aggregated Comment Title: ***Remove Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) MIPS Measures***

Summary: CMS should remove the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) clinician measures from the MIPS Cost performance category. There are concerns about inappropriate comparisons, lack of precise adjustment, and potential negative impacts on care goals for seriously ill populations. These measures also place significant reporting burdens on clinicians, fail to align cost accountability with patient outcomes, and provide limited actionable feedback for both clinicians and patients.

Total Comments Contributing: 13

Total Submissions Contributing: 5

- ***Organization(s):*** American Academy of Hospice and Palliative Medicine; American Academy of Physical Medicine & Rehabilitation; American Podiatric Medical Association; Association for Clinical Oncology; The American College of Cardiology

Aggregated Comment Title: ***Reform MIPS***

Summary: Since its implementation in 2017, the Merit-based Incentive Payment System (MIPS) has not shown significant improvements in health outcomes or reductions in avoidable healthcare spending. It is a flawed program that increases bureaucracy and burden. The program requires significant reform, as it drives providers to weigh the cost of incurring or avoiding penalties rather than focusing on improving patient care and incentivizes physicians to manipulate the system by utilizing EMR note templates that automatically fulfill quality measures, rather than focusing on delivering genuinely high-quality care. Further, there is growing concern about the budget-neutral design.

Total Comments Contributing: 13

Total Submissions Contributing: 11

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; American Academy of Allergy, Asthma & Immunology; Association of American Medical Colleges; Eich Plastic Surgery, PC; Healthcare Business Management Association; Large Urology Group Practice Association (LUGPA); Net Health; Physician Clinical Registry Coalition; RadNet; The Society of Thoracic Surgeons

Aggregated Comment Title: ***Hospice Cap Burdens Agencies***

Summary: Hospice Cap puts significant burden on hospice agencies as it focuses on length of stay and numbers, often requires external auditors or consultants, and penalizes hospices when exceeding the cap. Calculations are complex, and small hospices find it particularly challenging. Appropriate patient care takes resources and can increase the length of stay, but if hospice ends then the patient may decline significantly and end up hospitalized, increasing costs. CMS could alleviate burden by increasing clarity, offering technical assistance with Cap reporting to hospices that are resource-constrained, and alerting hospices automatically if they are approaching the cap so they can adjust and prevent penalties.

Total Comments Contributing: 13

Total Submissions Contributing: 4

Organization(s): Aaryn Hospice LLC; All Star Hospice Inc; Serenity care solutions

Aggregated Comment Title: ***Update the Regulations for PAMA***

Summary: Sec. 216 of the Protecting Access to Medicare Act faces numerous challenges. Congress has delayed reporting requirements and payment cuts annually since 2019. CMS should maintain current rates in 2026 and update the data collection period to January 1 - June 30, 2025. PAMA reform would ensure stability for beneficiaries, Medicare, and clinical laboratories. The reform should involve utilizing statistically valid sampling of private payer rates, limiting decreases in Medicare payment rates, excluding Medicaid managed care rates, and extending data collection and reporting intervals.

Total Comments Contributing: 13

Total Submissions Contributing: 4

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Association for Molecular Pathology; Danaher Diagnostics; Quest Diagnostics

Aggregated Comment Title: ***Address Flaws in the Clinical Laboratory Fee Schedule***

Summary: The Clinical Laboratory Fee Schedule (CLFS) rates, set by the Protecting Access to Medicare Act (PAMA), have faced challenges with significant rate reductions exceeding projections, impacting investment in diagnostics and patient access to testing services. For example, annual cuts of up to 10% to the CLFS during its first three years of implementation have already far exceeded the Congressional Budget Office's (CBO) estimated reduction of $2.5 billion over ten years. CMS should maintain current rates in 2026 and refrain from further reductions to prevent harm to innovation and patient care. The current methodology, based on limited data from independent laboratories, lacks representation from the full market, necessitating revisions to create a more stable and accurate payment system aligned with commercial rates. CMS should take immediate action to address the flaws in the CLFS payment system.

Total Comments Contributing: 13

Total Submissions Contributing: 3

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Mayo Clinic; Quest Diagnostics

Aggregated Comment Title: ***Rescind the OASIS Form Requirement***

Summary: The OASIS form is onerous, time-consuming, and provides limited value in clinical-decision making while duplicating information already in the medical record. The form should not determine payment, which should be based on factors like diagnosis codes, length of stay, and reduced hospital admissions by an agency. The requirement to collect OASIS data on commercial patients drives up the cost of care, but then providers receive significantly lower reimbursement for these patients. CMS should rescind the OASIS requirement, as it imposes uncompensated administrative strain. CMS should make the new certification optional for HHAs in cases where a new Start of Care OASIS is required for administrative reasons. Reporting obligations should remain limited to Medicare and Medicaid beneficiaries, for whom the OASIS instrument is designed and directly applicable. Additionally, it seems unnecessary that HHAs must complete an OASIS for patients receiving outpatient therapy services under Medicare Part B when patients receiving therapy at home from other providers under Part B are not subjected to the same data collection process.

Total Comments Contributing: 12

Total Submissions Contributing: 10

Organization(s): Caprock Home Health; Compassion Home Health; Home Care Alliance of Massachusetts; Lantana Consulting Group; National Alliance for Care at Home; Ohio Health Care Association; Sanford Health - Good Samaritan Society; Sutter Health

Aggregated Comment Title: ***Measure What Matters***

Summary: The burden of participating in data collection could be alleviated by focusing on measuring meaningful outcomes data and limiting use of process measures that have minimal impact on outcomes. Quality reporting is important but may not fully promote shared accountability in health systems. Population performance measures should encompass a broad range of conditions to improve care effectiveness and serve the needs of patients and taxpayers.

Total Comments Contributing: 12

Total Submissions Contributing: 9

Organization(s): American Psychiatric Association; Keystone ACO; National Board for Certified Counselors (NBCC); Price Services Group, L.L.C.; Society of General Internal Medicine; Solventum

Aggregated Comment Title: ***Eliminate Prior Authorizations***

Summary: Prior authorization should be eliminated as being beyond the professional scope of insurance companies. They are the single greatest administrative burden facing providers. CMS should minimize the major barriers to coverage and payment related to prior authorization by eliminating all prior authorization requirements for items and services furnished under the

Medicare FFS program. Payers should be given flexibility to create incentive programs for prior authorization reduction or elimination.

Total Comments Contributing: 12

Total Submissions Contributing: 9

Organization(s): Alliance of Dedicated Cancer Centers (ADCC); American College of Surgeons; Association of American Medical Colleges; CPAC Foundation Center for Regulatory Freedom; Consumer Action for a Strong Econmy; The Helmsley Trust; WEDI

Aggregated Comment Title: ***Duplicative Prior Authorization Requirements Across Entities***

Summary: Prior authorization requirements are duplicated across various entities including Medicare, MA, Medicaid, private insurers, and PBMs. Examples of duplicative oversight where prior authorization still occurs include: the REMS Prescriber Tool; Review Choice Demonstration (RCD) for Inpatient Rehab. Although well-intended, duplicating these requirements drains resources and negatively impacts providers in underserved or rural areas and does nothing to improve safety or care. Each payer often uses distinct portals, forms, or documentation standards, forcing providers to repeatedly enter identical information.

Total Comments Contributing: 12

Total Submissions Contributing: 7

Organization(s): American Urological Association, Inc.; National Board for Certified Counselors (NBCC); Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead; UltraSight Inc.

Aggregated Comment Title: ***Adjust Topped Out Measures Policies and Scoring***

Summary: Some measures have no benchmark or are topped out, so clinicians have little incentive to report, which may produce unreliable results. Current scoring policies reduce points for consistent high-quality care, discouraging excellence. To address concerns surrounding topped out measures CMS should consider; extending the policy (from the 2025 Physician Fee Schedule Final Rule) of defining a "topped out measure benchmark" as an alternative to a scoring cap for all topped out measures; reviewing whether topped-out measures still provide meaningful value to Medicare; revising the methodology for addressing topped out measures to prevent penalizing clinicians for sustained high performance; reducing the number of topped out measures; and adopting a self-attestation approach for these measures to report that the requirements have been met. Additionally, CMS could apply the Scoring for Topped Out Measures policy universally to all topped-out measures or conduct a detailed review of each specialty's measure availability and scoring policies to ensure fair evaluation.

Total Comments Contributing: 12

Total Submissions Contributing: 9

Organization(s): American Academy of Hospice and Palliative Medicine; American College of Rheumatology; American Podiatric Medical Association; Emergency Department Practice Management Association (EDPMA); Fresenius Medical Care; Physician Clinical Registry Coalition; RadNet; Society of Hospital Medicine

Aggregated Comment Title: ***Modify DME Limits and Simplify Documentation***

Summary: Durable medical equipment (DME) documentation and prior authorization requirements can be burdensome and time-consuming. CMS can improve access to necessary devices and equipment by simplifying DME documentation requirements and modifying certain limits on DME, such as front-wheeled walkers and wheelchairs that are approved only once every five years, requiring multi-component devices to align with a specific DME category, and limiting access to complex rehab technology. Using electronic documentation to confirm medical necessity could also streamline processes and ensure timely equipment delivery. Alternatively, consider a capitated contractor, similar to how the VA operates their DME services.

Total Comments Contributing: 12

Total Submissions Contributing: 10

Organization(s): AMGA; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Orthotic & Prosthetic Lab, Inc.; Patient Experience Policy Forum - The Beryl Institute; Sutter Health; Vibrant Gastro, Inc.; Wheelchair Clinic Inc

Aggregated Comment Title: ***Modify Translation Policies***

Summary: CMS should modify policies pertinent to translation and interpretive services to reduce burden on providers. For example, the cost of providing interpreters and translated signage is unreimbursed and expensive, especially for small and rural providers, and may require providers to cover languages not used by their populations. CMS should remove the requirement that hospitals provide translation services for patients in 15 different languages and instead allow hospitals to ensure adequate translation for the populations they serve. Consider additional flexibility such as using artificial intelligence tools and verbal translation.

Total Comments Contributing: 12

Total Submissions Contributing: 12

Organization(s): Alliance for Connected Care; Ascension; Florida Hospital Association; Illinois Health and Hospital Association; Seaford Endoscopy Center; Sentia Health; Sutter Health; The National MLTSS Health Plan Association; University of Vermont Medical Center

Aggregated Comment Title: ***Eliminate the Two-Midnight Rule***

Summary: The two-midnight inpatient rule at 42 CFR 412.3(d)(1) establishes an arbitrary guideline for inpatient care that is not based on clinical criteria and is significantly burdensome. The rule should be eliminated.

Total Comments Contributing: 12

Total Submissions Contributing: 9

Organization(s): American College of Surgeons; American Hospital Association; Booz Allen Hamilton; Hospital Association of Rhode Island; Illinois Health and Hospital Association; MaineHealth; Society of General Internal Medicine

Aggregated Comment Title: ***Adjust Personnel Requirements for Independent Diagnostic Testing Facilities***

Summary: The qualification requirements for nonphysician personnel in Independent Diagnostic Testing Facilities (IDTFs) are burdensome due to vague and imprecise criteria in the regulations, leaving IDTFs vulnerable to false claims actions. This ambiguity imposes a costly burden on businesses providing diagnostic services separate from hospitals and physician groups, especially when recruiting nonphysician technologists. CMS should repeal or revise ambiguous qualification requirements for nonphysician personnel in Independent Diagnostic Testing Facilities (IDTFs) and instead rely on the IDTF's responsibility to comply with Federal and State licensure and regulatory requirements. CMS should define clear certification requirements for nonphysician personnel in IDTFs, ensuring they demonstrate basic qualifications and training through licensure or certification by appropriate State health or education departments or national credentialing bodies. Additionally, CMS should clarify that technicians completing related educational programs overseen by State education departments meet Medicare qualification requirements for nonphysician personnel in IDTFs. Clarity and consistency in personnel qualification requirements across different healthcare settings, like Comprehensive Outpatient Rehabilitation Facilities and Portable X-ray Suppliers, would ensure transparency and compliance.

Total Comments Contributing: 12

Total Submissions Contributing: 1

Aggregated Comment Title: ***Required Visits for Diabetic Supplies***

Summary: National Coverage Determinations like CAG-041N require Type 1 diabetic patients to visit an endocrinologist every 3 months for insulin pump supply refills, or every 6 months for continuous glucose monitoring prescriptions. This leads to unnecessary expenses for the healthcare system and poses risks to patient health. The process involves burdensome paperwork for endocrinologists and can result in patients rationing supplies. A semi-annual or annual visit would be adequate. CMS should rewrite CAG-041N and each MAC's Local Coverage Determinations.

Total Comments Contributing: 12

Total Submissions Contributing: 2

Organization(s): University of Colorado

Aggregated Comment Title: ***Decrease the Number of Quality Measures***

Summary: To improve quality measurement in healthcare, it is recommended that CMS collaborates with stakeholders to adopt streamlined and consistent quality measures across different payers. This alignment will reduce administrative burden, enhance data comparability, and improve quality improvement efforts. It is suggested to stabilize measure sets, avoid frequent changes, and streamline reporting requirements. By focusing on high-impact quality and safety measures tied to patient outcomes while eliminating low-value or duplicative measures, healthcare providers can better allocate resources and improve patient care. Additionally, collapsing overlapping quality programs and retiring low-value measures can further streamline reporting processes and free up clinical hours for patient care.

Total Comments Contributing: 12

Total Submissions Contributing: 11

- ***Organization(s):*** AMGA; Booz Allen Hamilton; Cleveland Clinic; Infectious Diseases Society of America; Massachusetts Health Data Consortium; National Board for Certified Counselors (NBCC); OCHIN; Ohio Hospital Association; The Ohio State University Wexner Medical Center; The U.S. Chamber of Commerce; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Overhaul Self-Administered Drug List Determination and Manufacturer Appeal Processes***

Summary: CMS should overhaul the process for adding drugs to the self-administered drug list (SAD). Recommendations include: establish a transparent analytical framework for Medicare administrative contractors (MACs) to make decisions on whether a product is "not usually" self-administered; overhaul the notice and response process for manufacturers and other stakeholders to respond and appeal decisions; clarify current criteria in guidance that would exempt a subcutaneously administered product from being excluded from Part B coverage and require MACs review an FDA-approved label as a starting point to determine if the FDA has determined a product may be self-administered based on label language. Additionally, CMS should consider the implications of SAD list determinations on CMS's ASP calculation.

Total Comments Contributing: 12

Total Submissions Contributing: 2

- ***Organization(s):*** BIO; National Organization of Rheumatology Management

Aggregated Comment Title: ***Align Data Reporting Cadences Across and Within Programs***

Summary: Require consistent and clear data reporting cadences within and across all programs and standardize definitions. It is burdensome when different measures have different reporting and submitting timeframes, even within the same program. Examples include IQR and IPFUR (Psych), MIPS and ACOs, Health Equity measure, THA/TKA, and eCQM OP40. Harmonizing reporting periods could streamline workflows, reduce data duplication, and expedite performance assessments for providers.

Total Comments Contributing: 11

Total Submissions Contributing: 10

Organization(s): Booz Allen Hamilton; CGI Federal Inc.; Franciscan Missionaries of Our Lady Health System (FMOL Health); NCH Naples Comprehensive Health; Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; Piedmont Healthcare; Price Services Group, L.L.C.

Aggregated Comment Title: ***Simplify Excessive Quality Reporting Requirements***

Summary: CMS should simplify excessive reporting requirements, including preventive services and MIPS reporting requirements that do not enhance quality. Hiring staff to report data to various agencies is problematic and overwhelming for providers. The most significant administrative burdens for ID physicians stem from the duplexity and volume of quality reporting requirements across multiple quality programs.

Total Comments Contributing: 11

Total Submissions Contributing: 9

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; American Urological Association, Inc.; CPAC Foundation Center for Regulatory Freedom; Infectious Diseases Society of America; Rettig Family Health Care; Shekina Glory Legacy Hospice and Palliative Services

Aggregated Comment Title: ***Eliminate or Streamline PASRR***

Summary: CMS should streamline or entirely eliminate the Preadmission Screening and Resident Review (PASRR) because it delays admissions, especially the physician review and signature components. The PASRR process for nursing homes is burdensome and often managed by an external company at a cost. Additionally, the benefit to patients is questionable and shortages in community housing force some long-term care facilities to seek ongoing PASRR

extensions. Suggestions include replacing physician concurrence with attestation and reducing the number of PASRR elements. Also require the PASRR to be completed within 48 hours.

Total Comments Contributing: 11

Total Submissions Contributing: 8

Organization(s): Cleveland Clinic; LeadingAge New York; LeadingAge PA; Maplewood of Cheshire County; Ohio Hospital Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***MSP Reporting is Complex***

Summary: Medicare Secondary Payer (MSP) reporting under Section 111 adds complexity to the Medicare regulatory landscape, affecting insurers and reporting entities with intricate requirements. Its complexity and inconsistency with other payer coordination efforts frustrate patients and providers. Simplifying or shortening the process would reduce patient confusion and provider workload. For example, a streamlined online workflow for MSP Coordination of Benefits could simplify the process by offering clear visibility of the primary payer and facilitating easy reconciliation of claims. Streamlining the MSP questionnaire by simplifying its content and reducing the frequency of distribution to the initial visit and annually thereafter. This change aims to alleviate patient and provider confusion, minimize administrative burden, and lower associated financial costs.

Total Comments Contributing: 11

Total Submissions Contributing: 11

Organization(s): AdventHealth; Alliance of Dedicated Cancer Centers (ADCC); Ascension; Lumeris Healthcare; Memorial Sloan Kettering Cancer Center; Ohio Hospital Association; Premier Inc; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Standardize Patient Experience Surveys***

Summary: CMS should retain standardized, rigorous patient experience surveys, like the HCAHPS framework, to improve transparency and benchmarking, but reduce provider and patient/respondent burden by streamlining this type of quality reporting. Strengthen the processes by which these data are reviewed and updated, to ensure health care organizations are responding to patient needs.

Total Comments Contributing: 11

Total Submissions Contributing: 4

Organization(s): Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Streamline the Two-Midnight Rule and Standardize Criteria***

Summary: CMS needs to provide Medicare Advantage plans standardized criteria for the Two-Midnight Rule. MA plans must adhere to the Two-Midnight Rule for inpatient admissions, but many use their own criteria, causing inconsistencies and burdens for healthcare providers. CMS should review MA plans who continue to disregard the rule.

Total Comments Contributing: 11

Total Submissions Contributing: 10

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; Alabama Hospital Association; Booz Allen Hamilton; Henry Ford Health; Hospital Association of Rhode Island; Ohio Hospital Association; Premier Health; Sutter Health; UHS, Inc.

Aggregated Comment Title: ***Reduce Documentation Burden by Focusing on Patient-Centered Outcome Measures***

Summary: Shifting from process-based metrics to patient-centered outcome metrics can simplify outcome measurement by focusing on results that matter to patients, reducing administrative burden, and improving accuracy. By replacing incentive-driven documentation with outcome-based metrics, providers can prioritize patient care over compliance, ensuring that measures truly reflect patient-centered outcomes and drive meaningful improvement. This approach aims to streamline documentation, enhance care quality, and promote shared decision-making in healthcare settings. Furthermore, reducing documentation requirements for meetings and recordings, especially with existing clients will eliminate repetitive forms.

Total Comments Contributing: 11

Total Submissions Contributing: 7

Organization(s): Association of American Medical Colleges; David R Sneen Enterprises; Infectious Diseases Society of America; International Consortium for Health Outcome Measurement (ICHOM); NCH Naples Comprehensive Health

Aggregated Comment Title: ***Improve the M3P***

Summary: The Medicare Prescription Payment Plan (M3P) is duplicative and labor-intensive. CMS should closely monitor beneficiary engagement and collaborate with industry partners to enhance the program within the statutory framework. By reducing administrative burdens and enhancing member experience, CMS could increase the program's effectiveness and provide better returns for Part D plans. CMS could eliminate certain communication requirements that impose high administrative costs on sponsors with little benefit to members, such as mailing a M3P election request form to all new members. Additionally, CMS could revert to its CT 2025 standard for grace period for non-payment.

Total Comments Contributing: 11

Total Submissions Contributing: 6

Organization(s): Humana; Johns Hopkins Health Plans; Medica; Sanford Health - Sanford Health Plan and Security Health Plan; South Country Health Alliance

Aggregated Comment Title: ***DME Order Requirements Create Burden***

Summary: DME (Durable Medical Equipment) order requirements, especially for items like NIH and oxygen, are excessive and burdensome, especially when the prescribing orders are incomplete. CMS should streamline the ordering process for durable medical equipment (DME) by eliminating unnecessary steps and eliminating burdensome paperwork requirements. Some of this burden could be eliminated through checkbox template formats or comprehensive electronic data exchange. The current process for ordering Durable Medical Equipment (DME) involves redundant and inefficient administrative burdens, particularly with face-to-face encounter requirements and the associated documentation requirements. Requiring annual face-to-face visits and redundant clinical documentation for chronic conditions creates unnecessary obstacles for patients with ongoing needs.

Total Comments Contributing: 11

Total Submissions Contributing: 6

Aggregated Comment Title: ***Eliminate "Must-Bill" Policy for Dual Eligible Beneficiaries***

Summary: Eliminate the "must-bill" policy for dual eligible beneficiaries, which requires providers to bill both Medicare and Medicaid even though no Medicaid payment may be expected. Eliminating the Medicaid billing requirement in these circumstances would decrease the administrative burden and streamline the billing process. Instead, allow reimbursement of dual eligible bad debts when the provider confirms the beneficiary's Medicaid eligibility.

Total Comments Contributing: 11

Total Submissions Contributing: 7

Aggregated Comment Title: ***Formalize the AHCaH Program***

Summary: Make the Acute Hospital Care at Home (AHCaH) program permanent. Expand the eligibility to include pediatric patients. Consider waiving some of the service requirements and the inpatient status requirement for the program, allowing dedicated cancer hospitals and specialty hospitals to implement this innovative healthcare delivery model. By waiving certain Medicare Conditions of Participation, such as the need for 24/7 nursing care, patients can

receive acute care at home, providing cost benefits, quality improvement, and patient-centered medical care.

Total Comments Contributing: 11

Total Submissions Contributing: 10

Aggregated Comment Title: ***Form-Specific Feedback for CMS-2552-10 OMB Control Number: 0938-0050***

Summary: Form CMS-2552-10 (OMB Control Number 0938-0050), the Medicare Cost Report, is overly complex and often incurs burdensome, low-value audits. The form includes over 1,200 data fields and requires a unique file upload, separate from the claims that CMS already receives. Additionally, many of the lines in the form repeat information that is already present in CMS's claims warehouse, such as wage index days and charges for uncompensated care. It should be revisited to utilize currently available data and auto-populate fields when available.

Total Comments Contributing: 11

Total Submissions Contributing: 5

Aggregated Comment Title: ***Eliminate Quality Reporting***

Summary: Eliminate quality reporting entirely, including MIPS and ACOs. All quality reporting is unnecessary and has not improved patient care or cost containment. CMS's quality and data reporting mandates lack justification and may not contribute to improved care, cost reduction, or fraud prevention. These mandates could infringe upon constitutional protections and limit patient access by causing provider attrition. Additionally, many of these requirements are disconnected from actual patient outcomes, serving more as regulatory box-checking rather than meaningful measures for healthcare improvement.

Total Comments Contributing: 11

Total Submissions Contributing: 4

Organization(s): CPAC Foundation Center for Regulatory Freedom; Keystone ACO; Place of Peace Counseling Center

Aggregated Comment Title: ***Expand Gold Card Prior Authorization Exemptions***

Summary: Implementing 'Gold-Carding' programs for prior-authorization would streamline access to testing and treatment by providing exemptions or automatic approvals for items and

services ordered by compliant and high-performing providers. By exempting these providers, patients can receive timely and efficient care without unnecessary administrative hurdles.

Total Comments Contributing: 11

Total Submissions Contributing: 10

Aggregated Comment Title: ***Improve Patient Safety and Lower Costs for Drugs with Targeted Actions***

Summary: To enhance patient safety and safeguard the Medicare program, CMS should take several steps to better regulate PBMs and pharmacy practices including: banning "Preferred Pricing" for affiliated pharmacies of PBMs; reimbursing LTC pharmacies at no more than maximum fair price for a drug and adopting a $30 supply fee for LTC pharmacies affected by reimbursement changes; prohibiting maximum allowable cost pricing for generic drugs in Part D; preventing limitations on legal rights for unaffiliated LTC pharmacies; prohibiting faxed "Opt-Out" contract amendments; ensuring provider network notification by October 1; and mandating appropriate dispensing fees for LTC pharmacies. Additionally, CMS should extend other reforms such as prior authorization simplification, to Part B physician-administered medications, and CMS should enforce rules to prevent gaming of patents and other policies that stifle pharmaceutical competition.

Total Comments Contributing: 11

Total Submissions Contributing: 5

Aggregated Comment Title: ***Revisions to NCCI Policy Manual to Align with Current Standards***

Summary: Advocates are calling for the elimination or revision of various elements of the National Correct Coding Initiative (NCCI) Policy Manual, including specific coding policies such as those outlined in Section F.8, general coding policies, Anesthesia Services, Molecular Pathology, Microbiology, Total-Contact Casts and Compression Therapy, and Medically Unlikely Edits (MUE). These changes would streamline coding policies and align them with national standards.

Total Comments Contributing: 11

Total Submissions Contributing: 6

Aggregated Comment Title: ***Eliminate MIPS***

Summary: The Merit-based Incentive Payment System (MIPS) creates administrative burdens without enhancing the quality of care. Simplify Medicare reporting and documentation requirements by eliminating MIPS.

Total Comments Contributing: 11

Total Submissions Contributing: 9

Organization(s): American Academy of Family Physicians; American College of Rheumatology; Lighthouse Counseling Center, PC; Salem Surgical Associates; Society of Hospital Medicine

Aggregated Comment Title: ***Update Civil Monetary Penalties Reinvestment Program Policies***

Summary: The Civil Monetary Penalties Reinvestment Program (CMPRP) aims to enhance access to funds for nursing homes to recruit and retain nursing staff and improve the quality of care. However, the funding application process is multi-layered and inefficient, and since September 2023, CMPRP funds have been restricted from supporting workforce initiatives, despite significant unused balances in state accounts. CMS should allow State Agencies more flexibility and authority to determine the allocation of Civil Monetary Penalty (CMP) reinvestment funds based on funding levels and needed improvements to enhance resident quality of life. States are well-positioned to understand the priorities of their providers and should have the flexibility to support initiatives. Recommendations include updating CMPRP policies to remove caps, considering innovation and workforce requests, and tailoring funding to the unique needs of each facility. These changes could address post-pandemic workforce challenges and promote quality care in nursing homes.

Total Comments Contributing: 11

Total Submissions Contributing: 3

- ***Organization(s):*** American Health Care Association (AHCA); DSHS/HCLA/RCS; LeadingAge PA

Aggregated Comment Title: ***Allow Nursing Homes to Utilize "Deemed Status"***

Summary: CMS should allow nursing homes to utilize deemed status via statute change, allowing them to demonstrate compliance with CMS standards through accreditation. Accrediting bodies are equipped to determine whether a nursing home has demonstrated compliance because they apply rigorous standards. This will offer a pathway to greater efficiency, free-up CMS resources to focus on other priorities, foster a culture of innovation and strides for care quality in nursing homes, and lower administrative costs. Moreover, deemed status has proven successful in other facility types like hospitals, and extending this model to nursing homes will promote parity.

Total Comments Contributing: 11

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); LeadingAge PA

Aggregated Comment Title: ***Redundant Medicare Cost Reports***

Summary: The CMS-2552-10, CMS-2540-10, and CMS-1728-94 (OMB Control No. 0938-0050) are redundant Medicare cost reports. Each form contains numerous line items that must be manually reconciled across multiple worksheets, using outdated formatting and providing limited digital guidance. However, other CMS systems, such as the Hospital Quality Reporting (HQR) System and Provider and Statistical Reimbursement (PS&R) System, along with claims data, contain most of the information needed for these cost reports. Therefore, CMS already has access to much of the necessary data. CMS should modernize the Medicare cost reports.

Total Comments Contributing: 11

Total Submissions Contributing: 3

- ***Organization(s):*** Booz Allen Hamilton; CGI Federal Inc.; Home Care Alliance of Massachusetts

Aggregated Comment Title: ***Documentation Requirements are a Burden***

Summary: Documentation requirements, such as annual height requirements, are a burden and stem from overly prescriptive and granular regulations. They can be reduced where redundant and streamlined where a clinical need is well established.

Total Comments Contributing: 11

Total Submissions Contributing: 8

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; BAYADA Home Health Care; Booz Allen Hamilton; Coalition of State Rheumatology Organizations; Ohio Hospital Association; Shekina Glory Legacy Hospice and Palliative Services

Aggregated Comment Title: ***Streamline Election Statement Addendum Requirement***

Summary: CMS requires hospices to furnish an election statement addendum upon request, detailing non-covered items, services, and drugs to patients and families. This requirement burdens providers, who find the documentation duplicative, and confuses patients because of non-standardized language. Additionally, the risk of compliance violations if not executed

correctly adds additional workload. CMS should eliminate the election addendum form. Alternatively, CMS could provide clearer guidance to help providers and patients understand this addendum, automate it via EHRs, and use automated systems or EHR-integrated tools to facilitate signature collection. Providing and obtaining patient signatures, making information accessible, and the strict timelines for compliance also contribute to the challenges faced in this process.

Total Comments Contributing: 11

Total Submissions Contributing: 3

Organization(s): Oregon Hospice & Palliative Care Association and Washington State Hospice & Palliative Care Organization

Aggregated Comment Title: ***Rethink Facility Assessment Requirement***

Summary: CMS should eliminate or reduce the frequency of the § 483.71 Facility Assessment Requirement via rulemaking. It is duplicative, burdensome, and does not necessarily lead to better care for residents. The assessment may be integrated with existing care plans, MDS, and emergency risk assessments, or could use standardized templates auto-filled from existing systems.

Total Comments Contributing: 11

Total Submissions Contributing: 3

- ***Organization(s):*** American Health Care Association (AHCA); Christian Living Communities / Cappella Living Solutions; PointClickCare

Aggregated Comment Title: ***Revise Complex Rehab Technology Determinations***

Summary: CMS should revise and standardize approval processes for certain Complex Rehab Technology (CRT) products and repair services based on the beneficiary's diagnosis and presumed life-long need for such devices. The current approach is overly burdensome. Empower clinicians to select products based on their evaluation and expertise to ensure the best fit for the patient's needs. CRT and Non-Invasive Ventilators (NIVs) should be subject to prior authorization, with consistent and objective coverage criteria. A disability-competent team should perform coverage determination reviews and other policy development for CRT, informed by input from consumers.

Total Comments Contributing: 11

Total Submissions Contributing: 3

- ***Organization(s):*** American Association for Homecare; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Reliable Medical Supply

Aggregated Comment Title: ***Removing State Licensure Barriers***

Summary: Rethink the policy that requires providers to be licensed in the state where they are physically located, and remove skills examination as part of nurse aide/assistant licensure, as it is duplicative to the educational and hiring processes. Removing state licensure barriers can improve access to care, especially specialty care, for patients in underserved and rural areas while maintaining patient safety.

Total Comments Contributing: 10

Total Submissions Contributing: 6

- ***Organization(s):*** Endocrine Society; Illinois Health and Hospital Association; National Board for Certified Counselors (NBCC); National Society of Genetic Counselors (NSGC); Sanford Health - Good Samaritan Society; Washington State Board of Nursing

Aggregated Comment Title: ***Ease Notification Requirements for Changes in Provider Networks***

Summary: Eliminate the requirement for Medicare Advantage organizations at 42 CFR 422.111(e)(1) to make one telephonic notice attempt to beneficiaries regarding changes to a provider network, citing low success rates in reaching them and substantial administrative costs. Also, shorten the provider termination notice lookback period from 3 to 1 year for beneficiaries who have seen the provider.

Total Comments Contributing: 10

Total Submissions Contributing: 6

Organization(s): Kaiser Permanente; Point32Health; SCAN Health Plan; UnitedHealthcare

Aggregated Comment Title: ***The ADR Process is Burdensome***

Summary: Responding to Additional Documentation Requests (ADRs) is a time-consuming process that diverts staff resources away from patient care and administrative tasks, leading to inefficiencies and potential access to care issues. The turnaround time of 30-45 days for submitting documentation is often insufficient due to the complexity of patient records and the need to coordinate across multiple providers. The lack of standardized formats for ADRs results in submission errors and unnecessary denials. CMS should: standardize ADR request protocols

across all CMS contractors; implement a centralized electronic ADR portal accessible to all providers; and place limits on the frequency and volume of ADRs.

Total Comments Contributing: 10

Total Submissions Contributing: 3

- ***Organization(s):*** ADVION (formerly National Association for the Support of Long-Term Care [NASL]); National Association of Rehabilitation Providers and Agencies (NARA); Society for Gynecologic Oncology

Aggregated Comment Title: ***Enhance Guidance on Information Blocking***

Summary: Provide guidance on the implementation of interoperability and information blocking rules and align with other similar regulations. Offer technical assistance and education to help smaller practices understand the rules. Rescind provisions that may unfairly penalize providers participating in MSSP who have committed information blocking. A unified HHS "Interoperability Assistance Hub" could provide physicians with authoritative guidance, technical help, and standardized interpretation of information-blocking rules.

Total Comments Contributing: 10

Total Submissions Contributing: 4

Organization(s): American Medical Association; Partnership to Empower Physician-Led Care; UHS, Inc.

Aggregated Comment Title: ***End ASC-20 COVID-19 Vaccination Coverage Among Health Care Personnel Reporting***

Summary: The Ambulatory Surgery Centers (ASC) face staffing and financial challenges with the burdensome quality reporting requirement of ASC-20 COVID-19 Vaccination Coverage Among Health Care Personnel, and CMS should remove this measure. The reporting of COVID vaccination status for healthcare workers is unnecessary and time-consuming for ASCs. The monthly reporting and documentation processes are labor-intensive and do not directly impact patient care or safety.

Total Comments Contributing: 10

Total Submissions Contributing: 8

Aggregated Comment Title: ***Reporting SDOH Measures is a Burden for Ambulatory Surgical Centers***

Summary: The addition of screening ambulatory surgery patients for social determinants of health (SDOH) in ASC-22, ASC-23, and ASC-24 has raised concerns about the burden it places on staff resources and the lack of comfort patients feel discussing these topics during brief encounters. While currently voluntary, these measures are set to be required in 2026, leading to financial and time strains on ASCs and potential challenges for CMS and taxpayers. These measures do not directly impact the quality of care provided at ASCs and should be removed, as addressing social drivers is more relevant in hospital settings.

Total Comments Contributing: 10

Total Submissions Contributing: 6

Organization(s): AdventHealth Surgery Center of Rome; Gulf Coast Outpatient Surgery Center, Laurel Surgery & Endoscopy Center; Seaford Endoscopy Center

Aggregated Comment Title: ***Revise or Eliminate Good Faith Estimate Requirements in No Surprises Act***

Summary: Under the No Surprises Act, the Good Faith Estimate requirements (45 CFR 149.610) are overly complex and administratively burdensome. These requirements are also confusing for patients and providers and misaligned with insurance dynamics. They impose unrealistic timelines and have an excessively broad scope, which makes it challenging to generate detailed and accurate estimates for patients. This administrative complexity diverts resources from clinical care, as facilities must dedicate considerable time and effort to meet compliance demands. Insurance companies, who have accurate information on deductible and copay requirements, are in the best position to manage these. They should be eliminated, or rural providers should be exempted. if kept, eliminate the requirement to include co-provider or co-facility costs.

Total Comments Contributing: 10

Total Submissions Contributing: 7

Organization(s): Cleveland Clinic; Kansas Hospital Association; Louisiana Rural Health Association; Ohio Hospital Association; Seaford Endoscopy Center; WEDI

Aggregated Comment Title: ***Simplify APM Regulations***

Summary: Simplify and minimize regulatory requirements within the APM framework to reduce burden and enable participation from smaller providers, such as health centers. CMS should work with ACOs and providers to identify opportunities to streamline reporting demands under A-APMs. APM reporting can benefit from standardized benchmarking that establishes uniform benchmarking methodologies across all APM programs. Specifically, CMS should make the full Medicare data set available to all APM participants to facilitate accurate benchmarking and provider evaluation.

Total Comments Contributing: 10

Total Submissions Contributing: 7

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; American Academy of Allergy, Asthma & Immunology; National Association of Community Health Centers (NACHC); National Board for Certified Counselors (NBCC); Oklahoma Hospital Association; The American College of Cardiology

Aggregated Comment Title: ***Amend and Streamline CMMI Models***

Summary: Amend and streamline CMMI models. For example, the Kidney Care First (KCF) program within the Kidney Care Choices (KCC) model is a distraction for providers, and ACO REACH could be eliminated by including the preferred provider discounts in the MSSP program. Include more flexibilities in future models, such as: reconsider mandatory participation, inclusion of MA beneficiaries, and adaptations for smaller providers; remove mandatory participation requirements for the Transformation Episode Accountability Model (TEAM) and ensure participation does not result in destabilization of their finances; and change the annual requirement for Kidney Care Entities to collect signatures from all participating physicians on fee-reduction agreements to a one-time submission at the start of each contract period with signatures only from each participating physician group's designated contact person. In addition to this, upfront infrastructure funding and advanced shared savings payments can help facilitate participation and success for independent practices.

Total Comments Contributing: 10

Total Submissions Contributing: 9

Organization(s): America's Physician Groups (APG); American Society of Anesthesiologists; California Hospital Association; International Consortium for Health Outcome Measurement (ICHOM); Nonprofit Kidney Care Alliance; Physicians Advocacy Institute; The Renal Healthcare Association

Aggregated Comment Title: ***Repeal Policies Restricting Physician-Owned Hospital Expansion***

Summary: Repeal policies hindering physician-owned hospital expansion. Repealing these policies allows physician-owned hospitals to expand to underserved areas which would increase patient satisfaction and promote cost-effective care. Policy changes to consider include restoring statutory compliance by ensuring CMS follows Section 6001 of the ACA without additional hurdles for providers; restoring alignment with prior CMS policy by rescinding discretionary factors in § 411.363; and repealing policies that were finalized in the FY 2024 IPPS final rule.

Total Comments Contributing: 10

Total Submissions Contributing: 3

- ***Organization(s):*** American Medical Association; Doctors Hospital at Renaissance, Ltd. (DHR Health); Physicians Advocacy Institute

Aggregated Comment Title: ***Reform or Rescind Medicare Appropriate Use Criteria Mandate***

Summary: The Protecting Access to Medicare Act (PAMA) established the Medicare Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging, aiming to ensure the appropriate use of imaging orders. However, the program's complexity, including real-time claims processing, poses challenges for imaging providers, including an increased risk of claims denials. CMS has also been unable to fully operationalize real-time claims-based reporting to collect meaningful and accurate information on AUC consultation and patterns. CMS should completely rescind the AUC requirement, as it adds unnecessary administrative burden without significant clinical benefits, given that most physicians already utilize clinical decision support to enhance patient care quality and safety. At the least, CMS should exempt small and rural practices participating in clinical trials from the AUC program. In lieu of the requirement to report AUC consultation information on each claim for advanced diagnostic imaging services prospectively, CMS could instead allow ordering providers to self-attest to this consultation which will be collected by qualified clinical decision support mechanisms and provided to CMS for retrospective review, so audits are performed only as needed. Alternatively, rather than imposing additional administrative requirements, CMS should support and promote the continued use and development of trusted, specialty-driven clinical tools that are integrated into real-world practice. Clinicians are utilizing evidence-based risk calculators developed by professional specialty societies to guide care decisions.

Total Comments Contributing: 10

Total Submissions Contributing: 5

- ***Organization(s):*** American College of Radiology; American College of Surgeons; American Medical Association; RadNet; The Society of Thoracic Surgeons

Aggregated Comment Title: ***Revisions to LTCH PPS Rules to Improve Access to Care***

Summary: Repeal and replace LTCH PPS rules that limit access and underpay Medicare beneficiaries. Changes in FY 2022, like calculating the charge inflation factor, need to be rescinded and replaced with previous rules. Recognizing CAHs and REHs as "subsection (d) hospitals" would increase access to post-acute care services for rural beneficiaries. Adjustments to the LTCH PPS, such as increasing payment rates in underserved areas, are recommended. Additionally, new LTCHs should be exempt from site neutral payments for the first two years.

Total Comments Contributing: 10

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Variation Across Payers Leads to Duplicative Efforts***

Summary: The variation in payer policies, particularly regarding peer-to-peer reviews, coverage decisions, and quality and cost reporting requirements, create confusion and lead to duplicated efforts. This fragmentation unnecessarily complicates the documentation and reporting process for providers. Additionally, the disparities between plans, such as the prohibition of segmentation in Medicare Part D plans compared to the allowance in Part C plans, hinder innovation and lead to redundant filings. CMS should ensure that payer requirements are consistently available via the API and eliminate variations across payers that force providers to navigate different rules and different levels of readiness. Furthermore, reducing carrier-specific variations can significantly decrease administrative workload while maintaining program integrity.

Total Comments Contributing: 10

Total Submissions Contributing: 7

Organization(s): American Urological Association, Inc.; Healthpilot; Ohio Hospital Association; Price Services Group, L.L.C.; Prime Therapeutics LLC; The American College of Cardiology

Aggregated Comment Title: ***Simplify Special Supplemental Benefits for the Chronically Ill Requirements***

Summary: CMS should simplify SSBCI administration by removing the bibliography requirement for chronic conditions on the CMS list. Recommendations include updating requirements for relevant, contemporary bibliographical information; exempting certain interventions; and allowing plans to offer established SSBCIs without additional documentation. The requirement for a bibliography of evidence also duplicates other evidence-collection efforts already in place across the program. To address this issue, CMS could leverage existing quality review assessments for SSBCI through the Star Ratings program and National Committee for Quality Assurance (NCQA). This approach would allow Dual-Eligible Special Needs Plans (D-SNPs) to have the flexibility to test solutions without having to adhere to the strict administrative requirement of maintaining a bibliography.

Total Comments Contributing: 10

Total Submissions Contributing: 9

- ***Organization(s):*** AHIP; Blue Cross Blue Shield Association; Curana Health; Humana; National Produce Prescription Collaborative (NPPC); Special Needs Plan Alliance; The National MLTSS Health Plan Association; The U.S. Chamber of Commerce; Triton Health Systems

Aggregated Comment Title: ***Use Recognized Industry Standards as the Default Documentation Frameworks***

Summary: CMS should stop reinventing the wheel when industry standards already exist, as in the case of HL7 FHIR, NCPDP, QI-Core, and US Core Implementation standards for documentation frameworks. These standards define required data for quality reporting and health assessments, enhancing interoperability, and enabling providers to report quality measures once and reuse data for various purposes.

Total Comments Contributing: 10

Total Submissions Contributing: 10

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); American College of Physicians; AnewHealth; BAYADA Home Health Care; Health Level Seven International (HL7); Lantana Consulting Group; NCQA; National Association of ACOs (NAACOS); PSW and MultiCare Connected Care; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Streamline the Molecular Test Process***

Summary: The molecular test 14-day rule (42 CFR 410.508) results in duplicative billing entries, redundant test requisitions, and added compliance reviews by hospital finance teams due to the need for hospitals to act as intermediaries in lab test billing despite labs operating independently. CMS should: consider pilot waivers or demonstrations to modernize molecular test billing in oncology; issue updated billing guidance for clarity; and create a carve-out for molecular tests, allowing the performing lab to bill Medicare directly.

Total Comments Contributing: 10

Total Submissions Contributing: 2

- ***Organization(s):*** American Society for Clinical Pathology; Sharsheret

Aggregated Comment Title: ***Retract and Revise 2025 Updates to the Appendix PP Guidance***

Summary: CMS is advised to retract the Appendix PP guidance changes from April 28, 2025, revert to the August 8, 2024 version, and make additional necessary modifications. The updated guidance exceeds regulatory limits, increasing administrative burden, diverting attention from care to documentation, and setting challenging standards for medical prescribers and nursing homes. CMS should eliminate clinical judgment from surveyor expectations and focus solely on compliance with regulations. Recommended changes include remove citations for paperwork violations; abuse protection; physician visits; and psychotropic medication regulations in nursing homes.

Total Comments Contributing: 10

Total Submissions Contributing: 6

Aggregated Comment Title: ***Rethink the Revalidation Process***

Summary: Rethink and revise or discontinue the Medicare Revalidation process for providers. The deadline has shifted multiple times, and the process is not workable. Providers are not paid if they miss a deadline with no notification. Revisions could include CMS implementing a risk-stratified revalidation model that considers historical compliance, billing activity, adverse actions, and additional screenings; lengthening the timeframe for provider revalidation; and ensuring MAC policies and practices support consistent evaluation of enrollment applications across both the electronic PECOS and paper applications. This approach would allow low-risk providers to be automatically revalidated through provider attestation, simplifying and streamlining the revalidation process. Additionally, it would help produce cost savings while rewarding and incentivizing providers who demonstrate good faith. SNF providers undergoing off-cycle revalidations with Medicare Administrative Contractors encounter challenges such as limited support, inconsistent responses, and requests for hard-to-obtain details about ownership, organizational structure, and third-party employees. The revalidation processes for psychologists are lengthy, complex, and duplicative, creating significant administrative barriers that result in delayed access to care and decreased provider participation.

Total Comments Contributing: 10

Total Submissions Contributing: 8

Organization(s): American Health Care Association (AHCA); CGI Federal Inc.; Health Alliance Plan of Michigan; National Council for Mental Wellbeing; Texas Association for Home Care and Hospice; The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Provider Support for Payroll Based Journal Processes***

Summary: CMS should provide support to providers regarding Payroll-Based Journal. Support could include updating the PBJ Policy Manual FAQs with additional questions and answers,

webinars, allowing the PBJ call line to offer rapid escalation for unresolved issues, and providing additional time for data submission if problems persist close to the deadline.

Total Comments Contributing: 10

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); Maplewood of Cheshire County

Aggregated Comment Title: ***Provide Standardized Templates and Forms***

Summary: To streamline Medicare reporting and documentation, utilizing standardized templates and forms can reduce variability and enhance efficiency by simplifying the process and minimizing the burden of documentation. Standardization not only makes it easier but would allow a number of these forms to be pre-populated with necessary demographic data. Standardizing disclosures, acknowledgments, enrollment documentation, and post-enrollment records reduces confusion, decreases errors, and enhances consistency.

Total Comments Contributing: 10

Total Submissions Contributing: 7

- ***Organization(s):*** Booz Allen Hamilton; Microsoft; National Association of ACOs (NAACOS); National Nurse Practitioner Entrepreneur Network; Ohio Hospital Association; Price Services Group, L.L.C.; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Standards for Electronic Signatures for Lab Orders***

Summary: The absence of an electronic signature on X12 and HL7 test orders leads to added administrative tasks for laboratories and ordering providers, who must now provide the patient's medical record to Medicare or other payors to prove the ordering provider's intent to order the test for the patient. CMS should collaborate with ASTP/ONC to set standards for electronic signatures on laboratory test orders, clarifying that an electronic signature on an EHR order signifies a signed laboratory order and the physician's intent to request the A meeting with key stakeholders should be held to address the critical issue of clarifying standards for electronic signatures as evidence of a physician's intent to order a laboratory test. CMS should work with the ASTP/ONC to set standards for electronic signatures for laboratory tests and to make clear that an electronic signature on an order sent through a certified EHR is considered a signed laboratory order, demonstrating the physician's intention to request the test. These changes will modernize diagnostic testing policies and reduce administrative burdens.

Total Comments Contributing: 10

Total Submissions Contributing: 4

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Essentia Health; Mayo Clinic; Quest Diagnostics

Aggregated Comment Title: ***Increase Oversight of MA Administrative Processes***

Summary: Physicians face excessive administrative burdens with Medicare Advantage plans, often resulting in delays or denials of payment and care. Streamline and enforce MA processes so they are similar to original Medicare for better efficiency. CMS must engage in additional regulation, oversight, and enforcement of Part C administrative, coverage, and utilization policies. To the extent that reports must be submitted annually in respect of MA patients, there should be constructive feedback.

Total Comments Contributing: 10

Total Submissions Contributing: 9

Organization(s): Alliance of Dedicated Cancer Centers (ADCC); American Academy of Allergy, Asthma & Immunology; American Physical Therapy Association; Gastroenterology Associates of the Piedmont; LeadingAge; RetireSafe

Aggregated Comment Title: ***Remove Sections C and D from NCD 90.2***

Summary: National Coverage Determination 90.2 for Next Generation Sequencing (NGS) does not align with the standard of care and current scientific advancements for cancer patients, as it restricts coverage to a narrow patient population, leading to an unusual policy of non-coverage for NGS tests outside of this group. Remove Sections C and D from NCD 90.2 to allow MACs to assess and provide coverage for innovative diagnostics that do not fit the original use-cases outlined in the determination. This change would provide MACs with the flexibility to determine coverage policies as needed, potentially streamlining the process for coverage of innovative NGS tests and reducing administrative burdens.

Total Comments Contributing: 9

Total Submissions Contributing: 3

- ***Organization(s):*** AdvaMed; American Clinical Laboratory Association (ACLA); Guardant Health

Aggregated Comment Title: ***Conflicting Guidance in the NCCI***

Summary: The National Correct Coding Initiative (NCCI) Medicare Policy Manual presents conflicting guidance in several areas. In the NCCI Manual, Chapter 1: GENERAL CORRECT CODING POLICIES- This language causes confusion for coders and should be deleted. In the General Coding Policies Chapter 1, page I-22, CMS should modify the quoted language "CMS may adopt NCCI edits that are not consistent with CPT Assistant" to "CMS shall not adopt NCCI edits that are not consistent with CPT instructions and guidance, including CPT Assistant". In Chapter X, Section A CMS should delete the following sentence from the manual: "If a laboratory procedure produces multiple reportable test results, only a single HCPCS/CPT code shall be reported for the procedure. If there is no HCPCS/CPT code that describes the procedure, the laboratory shall report a miscellaneous or unlisted procedure code with a single unit of service." This section creates confusion and payment denials. Additionally, a current restriction prohibits reporting certain codes together, hindering necessary procedures, such as reporting genomic sequencing codes for different neoplasms, leading to compliance issues and payment denials. To address this, CMS should modify the manual to allow simultaneous reporting with a modifier for distinct procedural services.

Total Comments Contributing: 9

Total Submissions Contributing: 5

- ***Organization(s):*** AdvaMed; American Podiatric Medical Association; Association for Molecular Pathology; Mayo Clinic; Quest Diagnostics

Aggregated Comment Title: ***Provider Directories Increase Burden***

Summary: Provider directories are subject to constant change and out of date materials are frustrating for beneficiaries. Accurately updating multiple formats of the provider directory within 30 days is also challenging. Meeting Medicare's goals around provider directories increases documentation burden.

Total Comments Contributing: 9

Total Submissions Contributing: 7

Organization(s): Booz Allen Hamilton; DentaQuest; Humana; Johns Hopkins Health Plans; SCAN Health Plan; The National MLTSS Health Plan Association

Aggregated Comment Title: ***End Reimbursement Disparities for Different Sites of Service***

Summary: Medicare's current payment structure incentivizes care delivery in higher-cost facilities and zip codes over more cost-effective options. This disparity in reimbursement rates for the same services leads to increased costs and limits patient choice. Implementing site-

neutral payment policies could help reduce healthcare expenses, promote quality care delivery, and enable flexibilities such as teleradiology (remote interpretation).

Total Comments Contributing: 9

Total Submissions Contributing: 8

Aggregated Comment Title: ***Reduce Burdens Related to SDOH Data Collection***

Summary: Collecting data for Health Equity/SDOH metrics is challenging. Collecting SDOH data requires additional training and tools, which are not easy to integrate into existing EHR systems. Therefore, providers may have to complete a duplicative process to collect and report information between multiple platforms. Additionally, questions are often repetitive and induce survey fatigue. Consolidation and less frequent collection would improve the utility of this data. Structured EHR tools could streamline reporting of SDOH Z-codes for CMS's health equity initiatives.

Total Comments Contributing: 9

Total Submissions Contributing: 8

Aggregated Comment Title: ***Prior Authorization Delays Patient Care and Imposes Financial Burdens***

Summary: Prior authorization imposes administrative and financial burdens and delays care. Many gastroenterology patients face insurance barriers that are linked to poor outcomes. Gastroenterologists report that prior authorization worsens patient care, with surveys showing increased hospitalization and serious adverse events due to delays. Obtaining prior authorization for medical care often leads to delays in patient treatment initiation and places a substantial financial burden on healthcare providers due to the time and resources required, especially when appeals are involved. To protect timely patient care, CMS needs to eliminate or strictly limit prior authorization. In addition, CMS mandates that Medicare Advantage Organizations (MAOs) must notify providers of prior authorization decisions within 72 hours for expedited decisions and 7 days for standard decisions. However, these requirements still pose challenges for providers needing to offer expediated care, potentially impacting patients' access to necessary medical services. CMS introduced a prior authorization requirement for hospital outpatient services under the OPPS, a first for Medicare fee-for-service. While intended as a utilization management tool, prior authorization can lead to delays in necessary care, increased administrative burden for providers, and higher costs for both providers and patients.

Total Comments Contributing: 9

Total Submissions Contributing: 7

Organization(s): American College of Gastroenterology (ACG); Association of American Medical Colleges; Memorial Sloan Kettering Cancer Center; National Association of ACOs (NAACOS); Riverside Eye Center; Select Medical Holdings Corporation

Aggregated Comment Title: ***Clarify and Enable Easy Access to LCDs and Related Updates***

Summary: Clarify and centralize guidance and local coverage determinations (LCDs) through a user-friendly web-based CMS tool for public and provider access. Monitor Comprehensive Error Rate Testing (CERT) to identify policies with the highest rates and revise LCSs and/or policy articles accordingly. Regular updates, including new, deleted, and revised coverage rules, are essential for clear understanding and transparency, especially when guidance seem insufficient or misaligned. Quarterly documentation of and rationales for changes are crucial for stakeholders to stay informed.

Total Comments Contributing: 9

Total Submissions Contributing: 9

Organization(s): American Association for Homecare; American Clinical Laboratory Association (ACLA); Minnesota Association of County Health Plans; Panacea Healthcare Solutions; South Country Health Alliance; Taxpayers Protection Alliance

Aggregated Comment Title: ***Enhance the Medicare Diabetes Prevention Program***

Summary: CMS should update the Medicare Diabetes Prevention Program (MDPP) to align with the CDC National Diabetes Prevention Program (DPP). These alignments include permitting virtual suppliers to offer essential diabetes prevention services to Medicare beneficiaries; permitting make-up virtual sessions; removing the per lifetime cap on benefits; and allowing repeat participation by beneficiaries. Currently many organizations do not participate in the MDPP because it is more stringent than the CDC's DPP. Enhancing MDPP could effectively help prevent Type 2 diabetes.

Total Comments Contributing: 9

Total Submissions Contributing: 5

Aggregated Comment Title: ***Include Audio-Only in Telehealth***

Summary: Removing restrictions on telehealth modalities, such as allowing audio-only services, would greatly enhance access to comprehensive care, especially for individuals without reliable internet or video capabilities. It would enable a broader range of services to be delivered through telehealth, ensuring that patients in underserved areas or with limited technological

resources can still access essential healthcare. By expanding telehealth options while maintaining safety and quality standards, this change would increase the overall reach and flexibility of telehealth services, providing crucial support for various care needs.

Total Comments Contributing: 9

Total Submissions Contributing: 8

Organization(s): ATA Action; American College of Physicians; Ascension; Cleveland Clinic; Hands of Wellness; National Association of Community Health Centers (NACHC); Place of Peace Counseling Center

Aggregated Comment Title: ***Streamline Complaint Surveys***

Summary: Streamline complaint surveys. For example, conduct low-risk surveys virtually, ease requirements for self-reported incidents (SRIs), investigate non-validated complaints, and revise the timeliness requirements for conducting complaint surveys.

Total Comments Contributing: 9

Total Submissions Contributing: 7

Organization(s): California Hospital Association; Kentucky Hospital Association; Ohio Health Care Association; Virginia Hospital & Healthcare Association; WellSpan Health

Aggregated Comment Title: ***Streamline Abuse and Neglect Reporting and Stop Disincentives***

Summary: CMS should simplify the abuse and neglect mandatory reporting timeframe from 2 hours to 24 hours or more for all incidents in Long-Term Care and Skilled Nursing Facilities to allow staff to prioritize resident safety over paperwork in the immediate aftermath of an incident. When the facility initiates a report, they should not be penalized, as it discourages transparency with regulators and unfairly punishes organizations acting in good faith. Additionally, removing reporting requirements for clearly unsubstantiated abuse/neglect allegations after internal review within 24 hours would alleviate burdens on facilities.

Total Comments Contributing: 9

Total Submissions Contributing: 4

Aggregated Comment Title: ***Streamline the HPMS***

Summary: The Health Plan Management System (HPMS) application process is complex and contains administrative obstacles and redundancies, especially for smaller or newer plans. Issues include limited contract-level functionality, unclear differentiation between H-contract and Plan

Benefit Package (PBP) changes, and the intricacy of new plan versus service area expansion applications.

Total Comments Contributing: 9

Total Submissions Contributing: 5

Organization(s): Humana; PACE Southeast Michigan; Quote Velocity; WelbeHealth

Aggregated Comment Title: ***Simplify Complex IQR Reporting***

Summary: The documentation and reporting requirements for Inpatient Quality Reporting (IQR), OMB Control Number 0938-1148, are overly complex. Multiple revisions and additions add to the burden. Key concerns that have been raised by providers include measure overlap and repetition, reporting burdens, the inconsistencies of all-cause measures, the limited scope of the programs, and the limitations of risk adjustment tied to the measures. Consolidate provisions of the programs into a single payment pay-for-outcomes adjustment based on the combined performance impact of eight measures of potentially avoidable outcomes and collapse duplicative hospital quality programs into a single outcome-focused set. Also allow hospitals with excess rates of potentially avoidable outcomes to apply for grants to be used to adopt programs that will help improve their patient outcomes, provide hospitals reports on both inpatient and outpatient potentially avoidable outcomes performance, and compare the rates of potentially avoidable outcomes of individual hospitals on a risk-adjusted basis to national potentially avoidable outcome target rates such that hospitals with excess rates of potentially avoidable outcomes would have a payment penalty while hospitals with lower rates of potentially avoidable outcomes would have a payment bonus.

Total Comments Contributing: 9

Total Submissions Contributing: 5

- ***Organization(s):*** Mayo Clinic; Ohio Hospital Association; Piedmont Healthcare; Solventum; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Enhancing Cross-Agency Collaboration Through Shared Digital Technology***

Summary: Cross-agency collaboration can be enhanced through shared digital infrastructure. For example, State Immunization Registries are not standardized and cannot be accessed across states. Creating a federal registry could streamline vaccination efforts by reducing the burden on facilities to collect data. Furthermore, to enhance efficiency and reduce administrative workload for providers, CMS aims to establish interoperability between its national database and various public and private databases, such as private health insurer directories, group health plan

directories, Medicare, Medicaid, state licensing databases, health agencies, and other relevant data sources.

Total Comments Contributing: 9

Total Submissions Contributing: 6

Aggregated Comment Title: ***Implementation of Digital Quality Measures (dQMs)***

Summary: CMS can reduce regulatory burden on providers and payers by transitioning to digital quality measures (dQMs) and a harmonized digital quality measure reporting system through a single entity. This would allow for cost-effective changes in data collection. Piloting dQMs promptly would facilitate real-world learning and drive rapid-cycle changes in the healthcare ecosystem. Additionally, CMS should retain access to all existing ACO reporting options during the transition to dQMs and not require reporting on any new measures.

Total Comments Contributing: 9

Total Submissions Contributing: 9

Organization(s): American Medical Association; Curana Health; Danaher Diagnostics; Kansas Health Information Network, Inc. dba KONZA; NCQA; National Association of ACOs; PSW and MultiCare Connected Care; Reveleer

Aggregated Comment Title: ***Ease Regulations for Psychotropic Medications***

Summary: Ease regulations on psychotropic medications for nursing home residents, including by eliminating the 14-day provider visit for PRN psychotropics use and modifying documentation of informed consent. These rules can lead to unnecessary transfers, wasting of medication, delays in providing necessary care, and patient anguish, affecting costs and residents' well-being, dignity, and quality of life. The current policies reflect an inflexible, one-size-fits-all oversight model.

Total Comments Contributing: 9

Total Submissions Contributing: 7

Organization(s): Greater New York Hospital Association; Post-Acute and Long-Term Care Medical Association (PALTmed); Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness)/Alliance for Aging Research; The Meth-Wick Community

Aggregated Comment Title: ***Ease Requirements for SNPs***

Summary: Ease burdensome requirements for SNPs. For example, obtaining a second HRA annually from members may be challenging; requiring provider verification of chronic

conditions, in lieu of other diagnostic reports, results in unnecessary disenrollments; and translation requirements. Adjust CAI expectations for SNPs whose members may have periods of ineligibility for Medicaid. The SNP Model of Care (MOC) requirements are contradictory to the requirements under Part C, and CMS should require that plans adhere to the SNP MOC requirements.

Total Comments Contributing: 9

Total Submissions Contributing: 6

- ***Organization(s):*** Alignment Health Plan; Cityblock Health; Humana; Johns Hopkins Health Plans; Sanford Health - Sanford Health Plan and Security Health Plan; Special Needs Plan Alliance

Aggregated Comment Title: ***Evaluate and Streamline the OASIS All-Payer Data Collection Form (CMS-10545)***

Summary: The OASIS All-Payer Data Collection Form, CMS-10545, mandates collecting OASIS on all patients regardless of payer source, effective July 1, 2025. Providers are concerned about compliance ambiguity, potential 2% payment reduction for non-compliance, and facing increased administrative costs. Furthermore, the form has grown into a lengthy document with 200 data elements, taking nearly an hour to complete during the Start of Care assessment. This reporting requirement diverts time from patient care and observation, as well as provider education and training. OASIS data collection should remain limited to Medicare and Medicaid patients. A thorough evaluation of the current OASIS assessment is needed, identifying and removing items which are not used to calculate quality measures, items that could be pulled automatically from other sources of information maintained by CMS, and items that are redundant to other items in the same assessment. This has the potential to reduce the burden of providers and clinicians significantly.

Total Comments Contributing: 9

Total Submissions Contributing: 4

- ***Organization(s):*** Adara Home Health; Illinois HomeCare & Hospice Council; LeadingAge; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Reconsider the Medicare Drug Price Negotiation Program***

Summary: CMS should reform Medicare Part D by eliminating mandatory participation in the Medicare Drug Price Negotiation (MDPN) Program through PBM/plan contracts to protect beneficiary access and independent pharmacies. Additionally, some commenters believe the

MDPN Program is a coercive price control regime that imposes excise taxes on manufacturers who refuse to negotiate. The MDPN could negatively impact R&D investments and access to future cures if pricing mandates hinder manufacturers' ability to innovate.

Total Comments Contributing: 9

Total Submissions Contributing: 4

Aggregated Comment Title: ***Revisit Hospice Certifying Physician Part B Enrollment Requirement***

Summary: Hospice certifying physicians must enroll in Part B, even when exclusively providing services under Part A hospice claims, which has led to billing confusion, MAC processing errors, and deactivation of compliant physicians for non-billing. This duplicative enrollment process does not significantly enhance oversight or integrity, and instead it threatens access to effective and timely hospice service. CMS should exempt hospice physicians billing solely under Part A from this unnecessary requirement to alleviate credentialing burdens.

Total Comments Contributing: 9

Total Submissions Contributing: 5

- ***Organization(s):*** Home Care Alliance of Massachusetts; Ohio Health Care Association; Sanford Health - Good Samaritan Society; Sutter Health; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Amend IOAS to Streamline Access to Medications***

Summary: Modify Stark regulations, retract relevant portions of the September 2021 CMS FAQ, and amend the existing In-Office Ancillary Services (IOAS) exception set forth in 42 CFR § 411.355(b) to allow physicians to mail drugs to patients or have caregivers pick them up. This would lower drug prices by reducing reliance on PBM mail order pharmacies and improve the pharmaceutical value chain. CMS could also create a “rural exemption” to Stark Law’s Site-of-Service requirements and the In-Office Ancillary Services Exception, as current restrictions have forced many specialists to discontinue satellite office operations in rural communities, where access to specialty care is already limited.

Total Comments Contributing: 9

Total Submissions Contributing: 5

- ***Organization(s):*** AbbVie Inc.; American Medical Association; Association for Clinical Oncology; Community Oncology Alliance; Large Urology Group Practice Association (LUGPA)

Aggregated Comment Title: ***Streamline EHR Attestations***

Summary: Simplify EHR attestations from manual to automated verification within certified EHR systems, streamlining the process and ensuring consistency. The complexity of attestation alignment places a disproportionate strain on organizations that don't have large IT or regulatory teams. CMS could configure a centralized, cloud-based dashboard to extract this information directly from EHRs or utilize automated digital logs transmitted via standard APIs.

Total Comments Contributing: 9

Total Submissions Contributing: 3

Organization(s): American Academy of Neurology; BAYADA Home Health Care; Ohio Hospital Association

Aggregated Comment Title: ***Conduct Thorough Review of All Medicare Documentation Requirements***

Summary: Medicare's documentation requirements are outdated and do not align with the current healthcare landscape. CMS should conduct a thorough review of current forms, documentation requirements, and templates - including across MACs and MA plans - rather than addressing issues on a case-by-case basis. Review the requirements in collaboration with providers to streamline, simplify, and potentially eliminate unnecessary paperwork burdens that are remnants of a past era, in order to better reflect today's healthcare practices. Specifically, CMS should: reinforce the "Patients Over Paperwork" initiative with measurable targets, timelines, and accountability mechanisms; reduce the punitive consequences of minor administrative errors especially where medical necessity is well-documented; and simplify and standardize documentation for therapy referrals.

Total Comments Contributing: 9

Total Submissions Contributing: 4

Organization(s): AVIA-Leavitt Partners Nexus Collaborative; Eventus WholeHealth

Aggregated Comment Title: ***Streamline PROMs***

Summary: Patient Reported Outcome Measures (PROMs) should be streamlined for efficiency. They are not well-integrated into EHRs and are often collected for a variety of different programs, so they represent an administrative burden. CMS should support digital PROM tools,

enable modular PROM, use a universal PROM library across programs, and generally harmonize the outcome measures.

Total Comments Contributing: 9

Total Submissions Contributing: 1

- ***Organization(s):*** International Consortium for Health Outcome Measurement (ICHOM)

Aggregated Comment Title: ***Increase MA Reimbursement Rates***

Summary: Reimbursement rates for Medicare Advantage (MA) plans are notably below standard. Require MA plans to reimburse at the same level as Medicare, as MA plans currently pay substantially less, impacting small offices and critical access hospitals significantly and resulting in lower quality and time spent with patients.

Total Comments Contributing: 9

Total Submissions Contributing: 7

Aggregated Comment Title: ***Streamline Documentation Requirements for Patient Visits***

Summary: Streamline and simplify required clinical documentation for patient visits, especially those that are routine or low-risk for fraud or abuse. The current process is cumbersome and inefficient, especially for clinicians who may spend equivalent amounts of time with patients and on documentation. Facilitate the opportunity for meaningful input from family/caregivers. To alleviate burden, consider the need for mandatory elements such as patient history in evaluation and management (E/M) visits even when not clinically relevant.

Total Comments Contributing: 9

Total Submissions Contributing: 8

Organization(s): American College of Physicians; Highlands Oncology Group, P.A.; Premier Health

Aggregated Comment Title: ***Streamline DMEPOS Accreditation Requirements***

Summary: Streamline the accreditation requirements for Durable Medical Equipment, Prosthetic Devices, Prosthetics, Orthotics, and Supplies (DMEPOS). The current enrollment and location compliance requirements burden clinics and increase audit risk for legitimate clinics due to data inconsistencies. State-licensed DMEPOS providers should not be required to participate in facility accreditation since their certification becomes voluntary once they obtain

state licensure. Additionally, they should not be required to maintain accreditation, as their licensure covers all necessary standards. Instead, CMS should reintroduce two distinct tracks of requirements: one for those licensed as healthcare providers by the state to dispense DMEPOS, and another for individuals or companies that employ certified professionals, which would necessitate facility accreditation. Furthermore, mandate that licensed DMEPOS providers maintain their own National Provider Identifier (NPI) number, similar to other healthcare providers.

Total Comments Contributing: 8

Total Submissions Contributing: 3

Organization(s): O&P Insight; Orthotic & Prosthetic Lab, Inc.

Aggregated Comment Title: ***Modify PACE Enrollment Guidelines***

Summary: Modify PACE enrollment guidelines so that participants can enroll at any time. 42 CFR 460.158 limits participant enrollment to the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement. This change will help prevent delays in services for those participants that may have previously missed cut off dates.

Total Comments Contributing: 8

Total Submissions Contributing: 4

- ***Organization(s):*** Catholic Health Association; InnovAge; WelbeHealth

Aggregated Comment Title: ***Revise Medication Therapy Management Program***

Summary: CMS should update the Medication Therapy Management (MTM) program under Medicare Part D to allow greater flexibility in beneficiary targeting through the incorporation of digital tools and pharmacist-led outreach. CMS could revert to previous targeting criteria to identify members who would benefit most from the program, and focus on outcomes rather than administrative measures, as the current rules impose significant costs and burdens on sponsors.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Aggregated Comment Title: ***Streamline MSSP Reporting***

Summary: Streamline and simplify reporting for MSSP ACOs. Burdensome requirements include reporting for any significant, anomalous, or highly suspect billing activity under 42 CFR § 425.672 and required roster changes every 30 days. CMS should reduce the frequency of roster change reporting to quarterly and provide ACOs with quarterly reports on attribution. Also, remove the cost category or improve transparency to help organizations better track their performance throughout the year.

Total Comments Contributing: 8

Total Submissions Contributing: 4

Aggregated Comment Title: ***Improving Digital Health Education and Technology Access***

Summary: Continuous education for healthcare providers on telemedicine protocols and technologies is crucial for ensuring quality care delivery. By investing in digital health literacy, both providers and patients can effectively utilize tools like applications, patient portals, telehealth platforms, and hospital websites to improve healthcare access and information sharing. CMS should also focus on eliminating burdens related to broadband infrastructure and affordable smart-enabled devices, including providing funding for IT infrastructure upgrades in rural areas. Partnering with broadband expansion programs to ensure rural and underserved areas have access to stable internet could help close the digital divide. Additionally, CMS should clarify and refine the requirement for Medicare Advantage plans to offer digital health education to members with low digital health literacy which is currently too vague.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Aggregated Comment Title: ***Reconsider Transitional Coverage for Emerging Technologies (TCET) to Align with Prior Policy***

Summary: The Transitional Coverage for Emerging Technologies (TCET) program was introduced in August 2024 to address similar access and coverage challenges to the Medicare Coverage of Innovative Technology (MCIT), but the restrictive nature and resource-intensive implementation of the TCET program are too challenging. CMS should reconsider the structure of TCET and explore more efficient pathways, like those in the original MCIT rule, to facilitate timely coverage of breakthrough technologies for Medicare beneficiaries.

Total Comments Contributing: 8

Total Submissions Contributing: 5

- ***Organization(s):*** ATA Action; AdvaMed; Medical Device Manufacturers Association (MDMA); Philips; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Remove Restrictions on ACO Prepaid Shared Savings***

Summary: In the CY 2025 Physician Fee Schedule, CMS introduced a "prepaid shared savings" option for eligible MSSP ACOs to provide upfront cash flow for accountable care delivery. CMS should remove restrictions on how shared savings can be spent and the requirement for ACOs to submit a spending plan. ACOs should have autonomy in using shared savings to address unique provider needs, such as investing in healthcare infrastructure, staffing, or provider reimbursement, without unnecessary burdens. In addition to this, CMS is urged to streamline access to prepaid shared savings for ACOs in the Medicare Shared Savings Program by eliminating restrictions on use and reporting requirements on these funds. Imposing restrictions on these funds diminishes their potential benefits, especially since the amounts are deducted upfront based on CMS estimates. CMS should also expand the billing activity policy to allow ACOs to report suspected fraud.

Total Comments Contributing: 8

Total Submissions Contributing: 6

- ***Organization(s):*** Accountable for Health; Aledade; American Academy of Family Physicians; Association of American Medical Colleges; Oklahoma Hospital Association; Partnership to Empower Physician-Led Care

Aggregated Comment Title: ***Simplify Special Needs Plan (SNP) Training Requirements***

Summary: Simplify Special Needs Plan (SNP) training requirements. Providers should not have to complete duplicative model of care (MOC) training for each plan. A single standardized training or attestation would suffice and approvals that receive a passing score should be for three years and updated only where there is significant training.

Total Comments Contributing: 8

Total Submissions Contributing: 7

- ***Organization(s):*** AMGA; Devoted Health; Ohio Hospital Association; Premier Health; Sanford Health - Sanford Health Plan and Security Health Plan; Special Needs Plan Alliance; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Required Use of the KX Modifier is Redundant***

Summary: The required use of KX modifiers for rehabilitation therapy services is redundant and burdensome, as Medicare already mandates that all services must be reasonable and medically necessary, with supporting documentation, and has a mechanism for medical review when appropriate. It is difficult for clinicians to ascertain what benefits beneficiaries have used. Moreover, tracking the threshold can be difficult because a provider's gross charges do not match the allowable charges set by Medicare. This issue becomes even more complicated when a patient receives care from different organizations, as these entities do not have access to each other's billing records. CMS should amend its requirements to require the KX modifier to be applied to claims only when the beneficiary has exceeded the KX modifier threshold of incurred expenses with that provider.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); Aegis Therapies; American Physical Therapy Association; Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Maintain MVPs and Traditional MIPS Reporting as Optional***

Summary: Retain and enhance optional reporting for MIPS Value Pathways (MVPs) and the traditional MIPS program and work with stakeholders to develop a solution that is responsive to concerns. Mandatory reporting of MVPs will require physicians to alter their established high-value care strategies, potentially reversing progress in outcomes and efficiencies. The optional approach allows small single specialty clinics to benefit from the clinical relevance of MVP tracks without unfairly penalizing larger multispecialty groups.

Total Comments Contributing: 8

Total Submissions Contributing: 8

Organization(s): Alliance of Specialty Medicine; American College of Rheumatology; Association of American Medical Colleges; Physician Clinical Registry Coalition; Society of Hospital Medicine; The American Psychological Association Services, Inc.; University of Colorado Medicine

Aggregated Comment Title: ***Allow Bad Debt Write Offs***

Summary: Eliminate burdensome requirements for billing of bad debts for dual-eligible beneficiaries. Allow Medicare bad debts to be written off as contractual allowances, which is consistent with standard accounting practices and was permitted under prior policies. Eliminate the policy that to receive Medicare bad debt reimbursement for dual eligible beneficiaries,

providers must bill the state Medicaid program and receive/submit the remittance advice listing any Medicaid payment. Remove all unnecessary and redundant steps in claims processing.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Organization(s): American Hospital Association; Florida Hospital Association; HomeTown Health LLC; Illinois Health and Hospital Association; University of Vermont Medical Center

Aggregated Comment Title: ***Beneficiary Notification for MSSP are Burdensome***

Summary: Providers find the Medicare Shared Savings Program's regulations on beneficiary notification, specifically at 42 CFR 425.312, overly burdensome and confusing for patients. The burdens could be simplified by eliminating the 180-day follow-up requirement, removing language at 42 CFR 425.312(a)(2)(v), modifying language at 42 CFR 425.312(a)(2), and reverting to CMS sending the notices on behalf of the ACOs.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Organization(s): AdventHealth; Keystone ACO; National Association of ACOs; WellSpan Health

Aggregated Comment Title: ***Eliminate Medicare Inpatient Only List***

Summary: The Medicare Inpatient Only (IPO) List, regulated under 42 C.F.R. 419.23, is unnecessary and costly, limiting patient care options and impacting the Medicare trust fund. The regulations governing the IPO list lack statutory authority and hinder medical practice without sufficient benefits. CMS should follow through with plans to eliminate the IPO list, as previously proposed, to address these concerns and improve healthcare delivery. The IPO list restricts the ability of group practitioners to effectively manage care provided in unaffiliated hospital settings. Maintaining and updating the inpatient list for computer systems is complex and burdensome for providers. Additionally, some Medicare Advantage programs do not align with the IPO, requiring proof of medical necessity for stays.

Total Comments Contributing: 8

Total Submissions Contributing: 4

Organization(s): Cleveland Clinic; Large Urology Group Practice Association (LUGPA)

Aggregated Comment Title: ***Automate Functions Through APIs and Pre-Populated Forms***

Summary: Automating functions through APIs and pre-populated forms support the 21st Century Cures Act interoperability framework and Executive Order 14192's push for deregulation to boost prosperity. This shift streamlines processes by replacing paperwork with

digital exchanges, enhances data validation for program integrity, and allows healthcare professionals to prioritize patient care over manual data entry tasks.

Total Comments Contributing: 8

Total Submissions Contributing: 6

- ***Organization(s):*** Booz Allen Hamilton; Healthpilot; National Board for Certified Counselors (NBCC); Patient Experience Policy Forum - The Beryl Institute; Select Medical Holdings Corporation; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Simplify Medicare Laboratory Date of Service Policy***

Summary: Simplify the Medicare laboratory date of service policy by amending 42 CFR 414.510 to remove unnecessary complexities, particularly for specific tests. Clarify the date of service for certain tests and emphasize that the date should not be used to deny coverage or restrict access to services. CMS should notify relevant parties of these changes and encourage parallel updates in Medicaid. By streamlining the rule, billing processes can be made more efficient, reducing manual errors and ensuring consistent access to diagnostic services. CMS should amend 42 C.F.R. 414.510 to read: The date of service for either a clinical laboratory test or the technical component of physician pathology service determines which provider should bill for the service and is as follows to clarify the purpose of the definition and clearly state that the lab date of service is not intended to be used to deny appropriate coverage or restrict beneficiary access to appropriate services.

Total Comments Contributing: 8

Total Submissions Contributing: 5

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); American Society for Clinical Pathology; Quest Diagnostics; Sharsheret; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Eliminate Medicare Advantage***

Summary: CMS should eliminate Medicare Advantage completely. The plans overpromise and underdeliver, leading to patient suffering. The excessive medication prior authorizations and denied diagnostic services are concerning and entail significant provider workload. This system, dubbed "Medicare dis-advantage," is impacting rural healthcare and undermining patients' access to necessary care, raising questions about insurance companies' authority over medical decisions. Everyone should be on Medicare so coverage remains consistent, and beneficiaries can stay with their providers and medications.

Total Comments Contributing: 8

Total Submissions Contributing: 7

Organization(s): Eastern Virginia Medical School; Rettig Family Health Care

Aggregated Comment Title: ***Preparing for Audits is Burdensome***

Summary: The frequency of audits for healthcare organizations is on the rise. Preparing for audits is burdensome, especially for organizations that have to do so using manual processes. Preparation often involves working with hospitals and other partners to collect documents and materials that show compliance, which can take significant time and effort. Moreover, the look back period for audits of 4 years is burdensome. CMS should explore options to minimize duplication in the audit process to improve simplicity, including by reducing the frequency of audits for plans that have consistently performed well.

Total Comments Contributing: 8

Total Submissions Contributing: 8

Organization(s): Endocrine Society; Hospital Association of Rhode Island; Kaiser Permanente; Minnesota Association of County Health Plans; National PACE Association; National Partnership for Healthcare and Hospice Innovation; Price Services Group, L.L.C.

Aggregated Comment Title: ***Multiple Procedure Payment Reduction is Unfair***

Summary: The Multiple Procedure Payment Reduction (MPPR) under Medicare reduces payment for therapy services when providers bill multiple "always therapy" codes on the same day, affecting OT, PT, and SLP disciplines. This policy, applied across disciplines, not providers, leads to unfair payment cuts and financial hardship for therapy providers, discouraging coordinated care for patients. CMS's application of the MPPR policy should be revised to apply only within individual therapy disciplines.

Total Comments Contributing: 8

Total Submissions Contributing: 4

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); American Occupational Therapy Association; American Physical Therapy Association

Aggregated Comment Title: ***Supervision Requirements***

Summary: Medicare's supervision requirements are complex, inconsistent, often outdated, and do not utilize modern technology to improve patient safety and provider flexibility. Align supervision guidelines across Medicare.

Total Comments Contributing: 8

Total Submissions Contributing: 4

- ***Organization(s):*** AVIA-Leavitt Partners Nexus Collaborative; American Occupational Therapy Association; American Psychiatric Association; BAYADA Home Health Care

Aggregated Comment Title: ***Revise Guidance on Organization Determinations for Supplemental Benefits***

Summary: CMS should revise its guidance regarding organization determinations for supplemental benefits with annual dollar limits, to better align with the operational realities of these benefits and reduce member abrasion. Current guidance treating any question of benefit coverage as an organization determination can be problematic for supplemental benefits with annual dollar limits, because prior authorization may not guarantee payment if other claims exhaust the member's benefit limit, leading to denials and member dissatisfaction. CMS should allow plans to issue benefit confirmations for supplemental services and clarify that approval does not guarantee payment when tied to a capped dollar limit.

Total Comments Contributing: 8

Total Submissions Contributing: 3

- ***Organization(s):*** DentaQuest; Special Needs Plan Alliance; UCare

Aggregated Comment Title: ***The ESRD Network Model is Ineffective***

Summary: The ESRD Network model imposes high costs without proven quality improvements, lacks local facility relevance, and imposes burdensome administrative tasks on small, independent facilities, leading to staff fatigue and burnout. Projects and requirements are inconsistent and/or misaligned.

Total Comments Contributing: 8

Total Submissions Contributing: 2

- ***Organization(s):*** Kidney Care Council; The Renal Healthcare Association

Aggregated Comment Title: ***Recording and Storage of Member Communications***

Summary: Recording and storage of member communications is burdensome. CMS could eliminate this from oversight and all together, or else automate the process. Furthermore, reducing agents' multi-year record retention from 10 to 3-5 years could align with industry

standards, easing storage, compliance, and cost challenges for small agencies while maintaining audit integrity.

Total Comments Contributing: 8

Total Submissions Contributing: 3

Organization(s): Kingdom Insurance Group; Price Services Group, L.L.C.

Aggregated Comment Title: ***Coordination Lacking Between State and Federal Entities for Oversight of Agents and Brokers***

Summary: Medicare Communication & Marketing Guidelines (MCMG) for Medicare Advantage and CMS oversight of agents, brokers, and TPMOs are unnecessary and duplicative, as insurance carriers and state departments of insurance already have oversight responsibilities. The lack of coordination between state and federal regulatory entities has led to state regulatory agencies deferring oversight responsibilities to CMS, resulting in substantial fraud, waste, and abuse in the Medicare Advantage program. This lack of coordination also leads to billions in additional funding and reimbursement through duplicative billing and funding from providers and carriers for the same patients and services to multiple payors.

Total Comments Contributing: 8

Total Submissions Contributing: 4

- ***Organization(s):*** Kingdom Insurance Group; Price Services Group, L.L.C.

Aggregated Comment Title: ***Streamline Eligibility Verification Processes***

Summary: To streamline eligibility verification for dual-eligible beneficiaries, allow providers to submit a single application for both Medicare and Medicaid eligibility or utilize a shared eligibility system that can cross-check Medicaid and Medicare eligibility in real-time, reducing redundancy in eligibility determinations. Also remove the eligible hospital and MIPS eligible clinician requirement of only allowing one year in the pre-production and validation option to reduce the complexity of reporting for providers. The 60-day verification window creates timeliness issues and disenrollment risks.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Organization(s): Booz Allen Hamilton; Devoted Health; National Board for Certified Counselors (NBCC); The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Support Value-Based Care***

Summary: CMS can streamline alignment with best practices and industry standards by supporting value-based care (VBC) models that are holistic, flexible, and interoperable with ACOs, MA plans, and Medicaid initiatives, rather than creating siloed compliance structures. Suggestions include enabling VBC providers to access PHI on all attributed members and establishing a definition of value-based care providers that aligns with the definition in the Anti-Kickback statute. CMS and payers should also share transparent, continuous, and accurate attribution numbers and a simple methodology to enter value-based care arrangements, including how patients are transferred into and out of a provider's attributed population.

Total Comments Contributing: 8

Total Submissions Contributing: 5

Organization(s): Cityblock Health; National Association of ACOs (NAACOS); National Association of Community Health Centers (NACHC); The Helmsley Trust

Aggregated Comment Title: ***Late Enrollment Penalties for Part D***

Summary: Collecting late enrollment penalties for Part D is resource-intensive and a source of strain with beneficiaries. To streamline the collection process, the federal government should automate the collection of Part D late enrollment penalties for Medicare Advantage enrollees alongside the monthly Medicare Part B premium payments. Given the administrative and beneficiary burdens of the LEP, CMS should narrow the application of it by removing the limitations on the timeframe requirements for a beneficiary's attestation of creditable coverage or allowing a beneficiary's current plan to accept an attestation for creditable coverage from their prior plan.

Total Comments Contributing: 8

Total Submissions Contributing: 4

- ***Organization(s):*** Kaiser Permanente; Lumeris Healthcare; Point32Health; UnitedHealthcare

Aggregated Comment Title: ***Rethink Discharge Planning 42 CFR 482.43***

Summary: Regulation 42 CFR 482.43 places hospitals under pressure to manage patient discharges, even in the absence or scarcity of adequate community resources, leading to longer stays and overcrowded emergency departments, despite external limitations. Simplify and expedite discharge process by relaxing requirements such as mandating hospitals provide patients with a list of post-acute care providers, allowing "pending placement" or "family to assist" as valid discharge plans, and creating a process for temporary discharge status when payment is unresolved.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Organization(s): Christian Living Communities / Cappella Living Solutions; Cleveland Clinic; MaineHealth; Mayo Clinic; Sutter Health

Aggregated Comment Title: ***Engage and Support Continuous Improvement and Feedback Loops***

Summary: Agencies should routinely evaluate the effectiveness of their collaboration, using both quantitative and qualitative data, and make iterative improvements to processes to ensure that partnerships remain responsive and efficient over time. Support healthcare organizations in their continuous improvement efforts by offering learning collaboratives and ongoing expectations for improvement without rushing to financial penalties, as long as there is genuine leadership engagement and organizational efforts. Provide more timely feedback from quality reporting to support organizational improvement, as real-time quality improvement is not possible with annual feedback models.

Total Comments Contributing: 8

Total Submissions Contributing: 7

Organization(s): American Osteopathic Association; Lantana Consulting Group; Massachusetts Coalition for the Prevention of Medical Errors; PointClickCare; Quality and Performance Measures Committee of the Society for Vascualr Surgery; WEDI

Aggregated Comment Title: ***Standardize Surveyor Processes***

Summary: Streamline and standardize the processes that guide surveyor behavior to reduce burden on facilities, variation between individual surveyors, and inconsistent application of regulations. Institute policies for surveyors to inspect providers with superior track records less often.

Total Comments Contributing: 8

Total Submissions Contributing: 6

Organization(s): LeadingAge New York; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Create a Centralized Coverage Portal***

Summary: Create a centralized portal for beneficiary coverage, cost-sharing, and eligibility information across plans. The excessive administrative and financial challenges faced by post-acute care providers due to MA plans needs to be addressed. The implementation of a centralized benefits portal or API to provide real-time access to patient cost-sharing information would enhance reimbursement processes and alleviate administrative burdens. CMS mandating

real-time cost-sharing transparency would lower costs and bolster the financial sustainability of post-acute care providers.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Organization(s): Booz Allen Hamilton; Globe Life Insurance Company; Kingdom Insurance Group; LeadingAge; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Simplify Part B vs Part D Drug Determination to Streamline Related CMS Guidelines***

Summary: If CMS simplified Part B vs Part D Drug Determination, then the following CMS guidelines could also be streamlined: 40.2 - Part D Coverage Determinations, 40.4 - Prior Authorization and Other Utilization Management Requirements, 40.1 - Part C - Organization Determinations, 10.6 - Outreach for Additional Information to Support Coverage Decisions, Part C and D Enrollee Grievances, and the appeals guidance chapter.

Total Comments Contributing: 7

Total Submissions Contributing: 4

Aggregated Comment Title: ***Repeal Standing Translations Requirement for Health Plans***

Summary: CMS should repeal the CY2024 Final MA PD Rules requirement for standing translations of materials and the mandate to publish translated materials online. Alternative methods like real-time verbal translations or technology aids for visually impaired individuals could offer similar benefits more efficiently and cost-effectively. Plans would still be obligated to provide translations or accessibility upon request and activate interpreters when needed.

Total Comments Contributing: 7

Total Submissions Contributing: 4

- ***Organization(s):*** AHIP; Point32Health; Sanford Health - Sanford Health Plan and Security Health Plan; UnitedHealthcare

Aggregated Comment Title: ***Allow Reimbursement for Qualified Medical Trainees***

Summary: Enable medical trainees, such as medical school graduates or supervised students in clinical rotations to perform and bill for services under Medicare. The current policy creates unnecessary barriers to clinical training, places an undue burden on supervising providers who

are required to essentially duplicate all documentation provided by students, and limits the capacity of providers to accept and mentor students.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Aggregated Comment Title: ***Challenges with Advanced Diagnostic Laboratory Tests***

Summary: The Advanced Diagnostic Laboratory Tests (ADLTs) criteria, as defined by Section 216(a) of the Protecting Access to Medicare Act (PAMA) of 2014, includes a requirement that the test "provides new diagnostic information," which is subjective and burdensome for both CMS and manufacturers and causes delays in both processing and in caring for patients. ADLTs are crucial for patient care and outcomes, but only 18 tests have been granted ADLT status since PAMA's implementation in 2016. One commenter suggests CMS staff may not have sufficient expertise to make determinations. To streamline the process, CMS should remove the subjective requirement from the ADLT definition to align with the statutory PAMA language and ensure competent staff.

Total Comments Contributing: 7

Total Submissions Contributing: 3

- ***Organization(s):*** AdvaMed; Guardant Health; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Complaint Tracking Modules***

Summary: Revise Complaint Tracking Modules (CTMs). Consolidate duplicate Complaints Tracking Module entries from a single beneficiary or provider to improve the accuracy of performance measures on Complaints About the Health Plan (C25) and Complaints About the Drug Plan (D020). The current methodology can be distorted by excessive complaints from individual sources, impacting smaller contracts disproportionately. Allow plans to contest CTM cases and implement a validation step before forwarding complaints to plans. By validating complaints prior to plan notification, only substantiated issues would be escalated, minimizing unnecessary work and enabling plans to focus on resolving legitimate beneficiary concerns. Establishing criteria for disputable CTMs versus final decisions would clarify distinctions and prevent confusion, ultimately improving efficiency and potentially impacting Medicare plan Star Ratings positively.

Total Comments Contributing: 7

Total Submissions Contributing: 5

Organization(s): Highlands Oncology Group, P.A.; Humana; Johns Hopkins Health Plans; SCAN Health Plan

Aggregated Comment Title: ***Medicare Secondary Payer Documentation is Duplicative***

Summary: Providers are required to collect and report extensive information for Medicare Secondary Payer (MSP) documentation to ascertain if Medicare or another insurer is the primary payer. This can result in redundant efforts, particularly when patients have multiple insurance coverages. The MSP questionnaire and Medicare Change of Status Notification (MCSN) also create confusion for patients.

Total Comments Contributing: 7

Total Submissions Contributing: 5

Organization(s): Lumeris Healthcare; Ohio Hospital Association; The Ohio State University Wexner Medical Center; University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Align Traditional Medicare and Medicare Advantage***

Summary: CMS should work to align traditional Medicare and Medicare Advantage. Aligning and streamlining requirements would significantly reduce administrative burden, free up clinical and administrative staff time, and allow providers to focus more on patient care rather than paperwork.

Total Comments Contributing: 7

Total Submissions Contributing: 6

- ***Organization(s):*** American College of Physicians; Federation of American Hospitals; LeadingAge PA; Ohio Hospital Association; Premier Health; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***End Redundant MU Attestations***

Summary: Annual attestations are costly without benefit. Replace attestations with automated submission of metadata from EHRs. Specifically, eliminate redundant Promoting Interoperability attestations after providers meet Meaningful Use requirements.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Aggregated Comment Title: ***Simplify Self-Administered Medication Policies***

Summary: Simplify self-administered (SAD) medication policies and billing requirements to preserve safety, prevent waste, and reduce administrative burden. Require MACs to abide by policy guidelines. Reforming CMS's SAD Exclusion List policy is crucial to prevent MACs from denying Part B coverage based on flawed determinations, ensuring access to necessary physician-administered drugs. Establish exclusion criteria that allow coverage and payment of the Part B formulation of medications where physical or cognitive limitations are present and documented. The reform should prioritize program integrity and restore access for patients requiring in-person monitoring and treatment.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Organization(s): American Academy of Allergy, Asthma & Immunology; BIO; Coalition of State Rheumatology Organizations; Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Rethink RUL Policies***

Summary: CMS's Reasonable Useful Lifetime (RUL) policies for DME such as orthoses lack flexibility, especially for upper extremity devices, causing inconsistencies and administrative challenges. Denials based on "same or similar" devices received within five years hinder access to necessary care, despite new diagnoses or functional needs, placing a burden on providers and restricting patient access. This rigid application delays necessary care increases the risk of complications and fails to address the changing clinical needs of patients at various stages of recovery.

Total Comments Contributing: 7

Total Submissions Contributing: 2

- ***Organization(s):*** American Occupational Therapy Association; American Podiatric Medical Association

Aggregated Comment Title: ***Reduce Duplication by Relying on Accrediting Organization Surveys***

Summary: To reduce duplication for providers who elect accreditation from CMS-approved accrediting organizations, CMS could further enhance its reliance on AO surveys, limiting the need for routine federal oversight surveys by SAs, while retaining essential validation surveys.

Total Comments Contributing: 7

Total Submissions Contributing: 7

Aggregated Comment Title: ***Streamline Emergency Plan Requirements Across Provider Types***

Summary: Long-term care (LTC) and hospitals should have the same requirements as the other provider types regarding emergency plan review and updates, including two-year reviews instead of annual. In Appendix Z Emergency Preparedness Testing (42 CFR 483.73(d)(2)), the requirement for two annual emergency preparedness exercises when one full-scale, community-based test is sufficient, creates unnecessary burden.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Organization(s): California Hospital Association; LeadingAge PA; MaineHealth; Vivie

Aggregated Comment Title: ***Prior Authorization for Medicare Advantage is Duplicative***

Summary: The prior authorization process in Medicare Advantage plans is currently fragmented and duplicative, leading to delays in care and administrative inefficiencies. CMS currently requires Medicare Advantage plans to report similar prior authorization data through both the annual Part C reporting process and the public website disclosure mandate (42 CFR 422.122(c)). This duplication creates inefficiencies, conflicted data formats, and increases administrative burden for plans. CMS should evaluate and align prior authorization reporting requirements to eliminate duplication and reduce administrative burdens and costs.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Organization(s): Bipartisan Policy Center; Humana; LeadingAge PA; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Automate Provider Directory Data Validation***

Summary: Automating provider directory data validation for Medicare Advantage plans would significantly reduce burdens on provider systems without compromising data integrity or program oversight.

Total Comments Contributing: 7

Total Submissions Contributing: 3

Organization(s): Booz Allen Hamilton; Health Alliance Plan of Michigan

Aggregated Comment Title: ***Revise HCO Rate-setting Methodology***

Summary: CMS should repeal its ratesetting rule that includes dialysis cases in the dataset used for calculating the LTCH high-cost outlier (HCO) FLA, as these cases have significantly higher costs that skew projections. Annual increases should be capped and not budget neutral over the cap. The current policy is burdensome for LTCHs, which have had to bring dialysis services in-house at a much higher cost due to the pandemic-related changes in service provision. Without changes to the ratesetting methodology, the FLA could continue to increase, limiting access to LTCHs for the sickest beneficiaries and causing financial strain on LTCHs. CMS should also study the systemic factors that are driving such large annual increases to the FLA to determine if other changes to its methodology are needed.

Total Comments Contributing: 7

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Duplicative Nursing Service Requirements***

Summary: Medicare nursing documentation requirements often overlap with both state and Medicaid mandates, leading to duplicated paperwork across programs without improving the quality of care. Additionally, the nursing-specific care plan requirements, as outlined in 42 CFR 483.23(b)(4), are already incorporated into interdisciplinary care plans that include a nursing care component. As a result, this requirement causes providers to maintain separate documentation for identical care planning activities.

Total Comments Contributing: 7

Total Submissions Contributing: 6

Organization(s): Georgia Hospital Association; MaineHealth; Mayo Clinic; Ohio Hospital Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***Streamline PECOS Processes***

Summary: The Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is an administrative burden to practices due to its lack of user-friendliness, reporting requirement, and the need for providers to recredential after being placed on inactive status. Long delays in obtaining credentials for PECOS and retroactive collections only corresponding to the date of CMS approval rather than application exacerbate the burden. Given the multitude of insurance carriers and systems to track provider demographic information, there should be centralized documentation database and the ability to centralize Medicare enrollments. Additionally, consider implementing a user fee for Medicare Advantage Organizations (MAOs) to support the maintenance and enhancement of PECOS and to incentivize provider participation.

Total Comments Contributing: 7

Total Submissions Contributing: 7

Organization(s): American Society of Anesthesiologists; American Society of Anesthesiologists (Part 1 of 2); Bright Day Psychology PLLC; Healthcare Business Management Association; SCAN Health Plan; WEDI

Aggregated Comment Title: ***Remove Burdensome Requirements for CAHs***

Summary: Remove burdensome requirements for critical access hospitals (CAHs), such as the mandatory six-month operation under the prospective payment system before converting to CAH status and the requirement that CAH based ambulance services only receive cost-based reimbursement if they are the sole ambulance provider within 35 miles, as well as reporting requirements that mirror the intensive MDS reporting standards applied to SNFs, in order to streamline administrative processes.

Total Comments Contributing: 7

Total Submissions Contributing: 5

Organization(s): American Hospital Association; Kansas Hospital Association; MaineHealth; OCHIN

Aggregated Comment Title: ***Biosimilar Substitution Rules***

Summary: Rules governing substitutions of biosimilar products on Part D formularies are inconsistent and represent potential challenges for patients in terms of disrupting stability of therapy. Part D plans often prioritize expensive reference biological products over cost-effective biosimilars, inflating Medicare costs. CMS should streamline and standardize requirements across the Part D program to maximize Part D plans' flexibility to promote use of biosimilar products and maximize member access, including when a selected drug faces biosimilar competition. Placing biosimilars in the same or a preferred tier than the reference biological product could lead to significant cost savings. CMS should also consider options to safeguard patient preferences, such as allowing patients to remain on a drug for the remainder of the plan year, instead of 30-day notice.

Total Comments Contributing: 7

Total Submissions Contributing: 3

- ***Organization(s):*** BIO; Biosimilars Forum; Humana

Aggregated Comment Title: ***Leverage EHR Automation to Streamline Documentation***

Summary: EHRs have the potential to streamline documentation processes by automatically generating structured notes, streamline complaints, reconcile errors, pull quality data, and lessen documentation review burden. This automation aligns with evidence-based guidelines, satisfying documentation requirements for program integrity and eliminating manual documentation burdens.

Total Comments Contributing: 7

Total Submissions Contributing: 4

Organization(s): Price Services Group, L.L.C.; Reveleer

Aggregated Comment Title: ***Eliminate Redundant Beneficiary Communications***

Summary: CMS can reduce administrative burden by eliminating forms requiring providers to share information that payers typically communicate to patients directly. Furthermore, assess the need for forms to be distributed to patients at every encounter, suggesting that generic information like rights and contact details could be provided annually in the Medicare Handbook or on the provider's website instead. In addition, hospitals are required to provide various notices to Medicare patients, including HIPAA Privacy Forms. Patients have been receiving these notices repeatedly from every healthcare provider they visit for years. Consolidating multiple Medicare beneficiary notices into a single, simplified document with plain language to improve understanding, reduce confusion, and ensure beneficiaries receive comprehensive coverage and financial information would be beneficial. In addition to this, providers can streamline the process by posting HIPAA privacy information on their websites.

Total Comments Contributing: 7

Total Submissions Contributing: 4

Organization(s): Booz Allen Hamilton; PSW and MultiCare Connected Care; UHS, Inc.

Aggregated Comment Title: ***Establish Regulatory Flexibilities for Rural Providers***

Summary: Rural clinics and solo practitioners encounter challenges in meeting standardized administrative protocols, limiting their access to federally funded healthcare programs. Uniform mandates without considering providers' capabilities or locations raises concerns about equal protection. Automate and streamline administrative procedures, offering exemptions or adjusted requirements for smaller and rural providers, and tailor administrative rules to ensure fairness, proportionality, and necessity in compliance. Specific regulatory flexibilities for providers in rural and underserved areas, such as accommodations for workforce constraints, technology access, distance challenges, and financial strains, would improve access to care.

Total Comments Contributing: 7

Total Submissions Contributing: 4

Aggregated Comment Title: ***Rethink Advance Healthcare Directives***

Summary: 42 CFR 489.102 mandates an advance healthcare directive opportunity upon admission, with providers using a binary full code or no code response in clinical records. The regulation lacks guidance on complex scenarios, resulting in many patients being treated as full code by default. If there is no documented advance healthcare directive, there should be a requirement to create one to be used to inform care wherever the patient is treated. Further, CMS should establish a national digital registry for retention of directives.

Total Comments Contributing: 7

Total Submissions Contributing: 2

Aggregated Comment Title: ***Rethink CLIA***

Summary: CMS should reassess the CLIA waiver standard's legislative history and implementation to help identify ways to improve healthcare accessibility to diagnostic tests. The CLIA 88 Annual Competency evaluation requirements are excessive and often ineffective for assuring the competency of laboratory professionals, and 42 CFR part 493.1251 and related regulations that list the same requirements for competency assessment are burdensome. CMS should include the phrase "by the user" in 42 U.S.C. §263a(d)(3). Additionally, the criteria for waivers should prioritize the user's performance in testing and the likelihood of operator error during the test. Furthermore, the study design should emphasize demonstrating accuracy, ensuring that the test performs equally well in the hands of both waived users and laboratory professionals. For clinical laboratory methods that have not changed significantly from the previous year, CMS should require only two of the following annual competency requirements: 1. direct observation of routine patient test performance and specimen handling, 2. monitoring and recording of test result reporting, 3. reviewing quality control records and proficiency testing results, 4. observing instrument maintenance and function checks, 5. testing previously analyzed specimens or proficiency testing samples, and 6. evaluating problem-solving skills. Additionally, the direct observation requirement may be ineffective because people are unlikely to reveal inadequacies when they know that they are being watched.

Total Comments Contributing: 7

Total Submissions Contributing: 2

- ***Organization(s):*** Abbott; St Charles Health System

Aggregated Comment Title: ***Transparency in Deregulation***

Summary: Stakeholders seek transparency on how outdated regulations will be reviewed and revised. CMS needs to clarify the definition of "regulation" to include subregulatory guidance and policy documents, as subregulatory guidance is crucial for Medicare Advantage operations. Additionally, aligning federal and state requirements is essential for data consistency. Rolling back federal standards may lead to fragmented data and hinder national-level performance evaluation. Preserving core federal standards is vital for program integrity. As the administration considers deregulatory actions, any changes should preserve the efficiency and integrity of the Medicare program and work only to improve the experience for both providers and beneficiaries.

Total Comments Contributing: 7

Total Submissions Contributing: 2

- ***Organization(s):*** Better Medicare Alliance; Bipartisan Policy Center

Aggregated Comment Title: ***Approve Telehealth Permanently for All Clinicians***

Summary: Telehealth/telemedicine is a valuable tool in healthcare delivery, enhancing the ability to provide care in home settings and offering follow-up care efficiently. It benefits patients with disabilities, mobility issues, or in rural areas by eliminating transportation barriers. Telehealth is cost-effective and should be permanently approved for all clinicians to assist with comprehensive medical care and delivery. Permanently add services covered by Medicare that can be delivered via telehealth to the Medicare Telehealth Services List.

Total Comments Contributing: 7

Total Submissions Contributing: 7

Organization(s): Alliance of Wound Care Stakeholders ("Alliance"); BAYADA Home Health Care; Cleveland Clinic

Aggregated Comment Title: ***Streamline Clinical Laboratory Regulations***

Summary: CMS should consider regulatory revisions to streamline laboratory operations. The review of physical slides or specimens should be conducted at a laboratory with its own CLIA certificate, unless exceptions apply. An exception for remote testing sites should be added to allow for the review of images by board-certified pathologists or other professionals using secure remote access protocols, without requiring a separate CLIA certificate if the designated primary site holds a certificate. Entities analyzing de-identified information to support clinical laboratory examinations should not be regulated under CLIA. To enable remote review of cytology slides, the standard should be revised to allow slide review by a certified laboratory

that received digital images from the transmitting laboratory. Minor revisions to 42 CFR 493.1274(a) are needed to facilitate this change.

Total Comments Contributing: 7

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Modernize and Streamline TPMO Requirements***

Summary: TPMOs face significant barriers complying with CMS marketing rules, which require listing all relevant plan sponsors in ads despite strict character limits. This limits TPMOs' ability to use paid digital advertising, creating unfair conditions where compliant organizations are disadvantaged while non-compliant ads persist. Long, complex TPMO disclaimers given at the start of interactions disrupt conversation flow and reduce beneficiary understanding. To improve clarity, fairness, and operational efficiency, CMS should modernize its framework by creating safe harbors for approved templates and adopting an activity-based approach that applies requirements proportionately to an entity's role, influence on beneficiary decisions, and proximity to enrollment. In addition to this, streamlining into a single standardized disclosure per interaction could reduce costs while maintaining transparency.

Total Comments Contributing: 7

Total Submissions Contributing: 2

Organization(s): Healthpilot

Aggregated Comment Title: ***Considerations for Policies Aimed at Reducing Opioid Misuse***

Summary: It is important to ensure that policies aimed at reducing opioid misuse do not restrict access for patients with serious illnesses. Quality measures for opioid use disorder should include exclusions for patients with complex chronic conditions or those at the end of life to protect their access to treatment. These measures should be based on clinical evidence to address public health concerns. Additionally, policies should hold payers accountable for covering opioid treatments in line with clinical guidelines.

Total Comments Contributing: 7

Total Submissions Contributing: 2

- ***Organization(s):*** Agadia Systems; American Academy of Hospice and Palliative Medicine

Aggregated Comment Title: ***Proving Medical Necessity for Prior Authorization is a Burden***

Summary: Cumbersome prior authorization processes are burdensome due to redundant requirements for medical necessity documentation. This is true for both providers of services (e.g., inpatient admissions, particularly for short stays) and for patients (e.g., in the case of a diagnosed permanent disability). A letter of medical necessity should be all that is needed, as additional requirements such as visit notes do not add value.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** AVIA-Leavitt Partners Nexus Collaborative; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Ohio Hospital Association; Reliable Medical Supply; The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Simplify ACA Section 1557 Regulations***

Summary: CMS should simplify ACA Section 1557 regulations for smaller and rural providers and rescind the revised non-discrimination notification rule entirely. HHS should also conduct a review of the administrative processes associated with the program to ensure the most efficient use of resources to deal with non-discrimination.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** AdventHealth; Kansas Hospital Association; Lumeris Healthcare; Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Standardize Electronic Prior Authorization Submissions***

Summary: It is recommended that CMS replace or amend 42 CFR 422.138, 42 CFR 422.122, and 42 CFR 423.120 with the option for providers to submit a prior authorization electronically. This would simplify reporting requirements and operationalize standard electronic prior authorization as finalized in the Interoperability and Prior Authorization Final Rule (89 FR 8758, RIN 0938-AU87). The creation of an electronic prior authorization system should rely on accurate and current clinical criteria to make approval or denial decisions. It should also be user-friendly, with straightforward templates and instructions that clearly outlines the items needed for a submission request. CMS should standardize the use of electronic prior authorization processes in Medicare Advantage to include requests for medications. Aligning decision timelines for diagnostic tests or procedures with those for medication approvals will streamline

regulations, reduce administrative burden on providers, and improve patients' timely access to care.

Total Comments Contributing: 6

Total Submissions Contributing: 5

Aggregated Comment Title: ***HCAHPS is No Longer Useful***

Summary: CMS has outcomes data related to hospital-associated infections and readmissions, so patient perspectives on cleanliness and discharge instructions are no longer needed. With objective outcome data readily available today, HCAHPS is no longer relevant or useful, compared to when HCAHPS was introduced two decades ago due to low response rates. CMS should eliminate HCAHPS as a mandated component of the IPPS. Furthermore, the CAHPS survey data should be excluded from the calculation of a Home Health Agency's quality score and focus on objective clinical metrics for a more accurate reflection of care quality.

Total Comments Contributing: 6

Total Submissions Contributing: 5

Organization(s): Florida Hospital Association; NCH Naples Comprehensive Health; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Eliminate Hospital Readmissions Reduction Program (HRRP)***

Summary: Eliminate the Hospital Readmissions Reduction Program (HRRP) because it is topped out and does not provide meaningful or actionable information. There is evidence that the HRRP program and readmission measures lead to negative unintended patient consequences and are no longer capturing the appropriate patient population due to the structure and timeframe of the measures. CMS should rethink its approach to focus on avoidable readmissions.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): American Medical Association; Ascension; Florida Hospital Association; Society of Hospital Medicine

Aggregated Comment Title: ***Pay Claims Timely***

Summary: Startup costs are often excessive for new providers, as are costs for pharmacies. Prompt payment of Medicare claims is crucial to ensure sustainability. Establishing prompt pay requirements in all forms of health care coverage, including Medicare Advantage, would alleviate burden.

Total Comments Contributing: 6

Total Submissions Contributing: 6

- ***Organization(s):*** Alliance of Dedicated Cancer Centers (ADCC); American Pharmacists Association; Booz Allen Hamilton; California Hospital Association; R1 RCM; Shekina Glory Legacy Hospice and Palliative Services

Aggregated Comment Title: ***Revise Direct Supervision Requirements for Infusion and Imaging Contrast***

Summary: The current Medicare requirements for infusion drug and imaging contrast administration are burdensome and do not necessarily improve patient outcomes. The requirement for "direct supervision" imposes staffing constraints, especially for smaller practices, despite the option for virtual supervision. Safety in infusion care can be maintained through protocols and training rather than the physical presence of a physician. CMS should adopt a general supervision standard to align better with clinical operations and ensure access without compromising care quality.

Total Comments Contributing: 6

Total Submissions Contributing: 3

- ***Organization(s):*** National Infusion Center Association; Premier Inc; RadNet

Aggregated Comment Title: ***Smaller Practices Struggle to Keep Up with EHR Requirements***

Summary: Smaller practices, safety-net providers, and rural and mid-sized hospitals face challenges in managing electronic health record requirements. The complexity of keeping up with EHR intensive tasks, such as ensuring compliance with measures and implementing FHIR-based interoperability mandates, strains organizations without large IT or regulatory teams. These issues divert staff from patient care and increase compliance costs without improving outcomes or value.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): American College of Osteopathic Family Physicians (ACOFP); Lumeris Healthcare; National Rural Health Association; ViiV Healthcare

Aggregated Comment Title: ***Improve VBP Programs Targeting SNFs***

Summary: Value-Based Purchasing (VBP) in Skilled Nursing Facilities (SNFs) ties payment to outcome measures without considering social determinants of health or patient complexity, potentially penalizing providers treating complex populations. Refine risk adjustment models and align VBP across post-acute care settings. Simplifying and removing redundant data submission requirements and updating comparative data periods can reduce administrative burden and improve program effectiveness.

Total Comments Contributing: 6

Total Submissions Contributing: 3

- ***Organization(s):*** American Association of Post-Acute Care Nursing (AAPACN); PointClickCare; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Misaligned Agent and Broker Regulations***

Summary: Agent/Broker requirements are conflicting and not aligned with beneficiary needs. For example, the regulation 42 CFR 422.2274(g)(4) contradicts current rules and requirements set by other federal regulatory agencies like the FCC. Initially aligned with the FCC's 1-to-1 consent rule, the recent invalidation of the FCC rule by the 11th Circuit has led to a discrepancy between the two regulations. This misalignment raises concerns about the duplicative nature of 42 CFR 422.2274(g)(4) in the current regulatory landscape. Proposed rule 4208-F adds requires brokers to share a volume of information with beneficiaries that is burdensome.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): Astoria Company; Healthpilot; Memoir, Inc. d/b/a Chapter; Price Services Group, L.L.C.

Aggregated Comment Title: ***Eliminate Consolidated Billing***

Summary: Eliminate consolidated billing in skilled nursing facilities (SNF) to simplify cost determinations, especially for patients who receive certain treatments that are typically not performed in a SNF (e.g., cancer, PET, transfusion). Uniform charges across medical services regardless of the payer source will ensure fairness for both patients and facilities. Simplify the regulation by removing the location specifications and focusing on the services provided. CMS could also expand the SNF consolidated billing chemotherapy exclusion to include oral cancer medications billed through Medicare Part D to ensure patients can access cancer therapy, whether administered orally or through infusion, reducing hospital stays and easing the burden on discharge teams seeking SNF placement.

Total Comments Contributing: 6

Total Submissions Contributing: 4

Aggregated Comment Title: ***Resume Virtual Surveys for Low-Risk Complaints***

Summary: Minimize in-person hospital surveys for low-risk complaints by resuming virtual surveys. Virtual surveys for low-risk complaints would enable more efficient use of survey resources and reduce administrative costs.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): Cleveland Clinic; Georgia Hospital Association; Kansas Hospital Association; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Utilize Risk-Based Reporting Cycles***

Summary: Moving from time-based to risk-based reporting cycles involves tiering survey frequency for hospitals based on compliance risks. Hospitals with low risks could report biennially and undergo less frequent full surveys, reducing administrative burden while maintaining quality standards for facilities with compliance concerns.

Total Comments Contributing: 6

Total Submissions Contributing: 3

- ***Organization(s):*** Health Alliance Plan of Michigan; Price Services Group, L.L.C.; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Modify ICH CAHPS Survey Requirements***

Summary: The ICH CAHPS is one of the most burdensome measures. CMS should explore alternative measures or a simplified version of the ICH CAHPS to reduce financial strain, minimize survey fatigue, and improve the effectiveness of collecting valuable patient feedback, while maintaining patient safety and program integrity. This can be accomplished by implementing a four-month maximum turnaround time for survey vendors to provide results to facilities, ensuring that data is timely and actionable. In addition to this, allow more inclusive sampling, encompassing pediatric, home dialysis, and Medicare Advantage patients to ensure adequate representation in the survey. Also, shorten the survey to a core set of no more than 20 targeted questions that emphasize the most actionable aspects of patient experience. The survey could also be conducted electronically, which could ease the efficiency of delivery, improve response rates, and provide a more adaptive patient experience. Additionally,

administering the survey once a year would better balance administrative and financial burden with the survey's value.

Total Comments Contributing: 6

Total Submissions Contributing: 3

- ***Organization(s):*** Fresenius Medical Care; Nonprofit Kidney Care Alliance; The Renal Healthcare Association

Aggregated Comment Title: ***Implement a Unified System to Streamline Medicare and Medicaid Provider Enrollment***

Summary: The recommendation is for CMS to streamline Medicare and Medicaid provider enrollment by implementing a unified system like PECOS for all State Medicaid programs, which can be layered with state-specific requirements. This would reduce administrative barriers and improve patient care and provider payment efficiency. By standardizing enrollment processes and limiting additional certification requirements for Medicare Advantage and Managed Medicaid payers, resources can be saved while maintaining state autonomy in program oversight. Furthermore, providers and payers face challenges in navigating various systems, workflows, and rules to receive payment for the same service. This leads to administrative burdens, delays, and unnecessary costs.

Total Comments Contributing: 6

Total Submissions Contributing: 5

Aggregated Comment Title: ***Require Expeditious Reviews for LCDs***

Summary: Require Local Coverage Determinations to be completed timely. For example, L33822, regarding coverage of continuous glucose monitoring. MACs should be required to disclose and adhere to a first-in-first-out approach to prioritize their nonurgent backlog of work to ensure timely responses.

Total Comments Contributing: 6

Total Submissions Contributing: 4

- ***Organization(s):*** Castle Biosciences Inc; Quest Diagnostics; The Coalition for 21st Century Medicine; The Helmsley Trust

Aggregated Comment Title: ***Streamline Medicare Overpayment Policies***

Summary: Streamline CMS policies around Medicare overpayment refunds. Suggestions include adopting a de minimis standard for small-dollar overpayments and allowing exceptions to the 180-day refund requirement to accommodate complex investigations, as the current rule creates pressure on healthcare providers.

Total Comments Contributing: 6

Total Submissions Contributing: 5

Organization(s): Emergency Department Practice Management Association (EDPMA); Federation of American Hospitals; Henry Ford Health; Sutter Health

Aggregated Comment Title: ***Simplify the Rules Surrounding 'Incident-to' Billing***

Summary: Simplify 'incident-to' billing rules for non-physician practitioners under physician supervision to reduce confusion and audit risks. One suggestion is to remove the "in the facility setting" language from the Medicare Claims Processing Manual 100-04, Chapter 12: 30.6.18 - Split (or Shared) Visits section. Clarifying supervision requirements and application in various settings can help providers navigate the process more easily, as the current conditions are ambiguous. Additionally, the incident-to framework underestimates pharmacists' contributions, as they can spend significant time with patients. Removing the 7-minute restriction on code 99211 would streamline administrative tasks for physicians and allow other team members to offer more patient care services. Allow these services to bill under higher level of complexity (e.g. 99212-215).

Total Comments Contributing: 6

Total Submissions Contributing: 5

Organization(s): American Pharmacists Association; Mayo Clinic; University of Wisconsin Hospital and Clinics (UW Health); VillageMD

Aggregated Comment Title: ***Support EHR Vendors by Reducing Regulatory Hurdles***

Summary: Ease the regulatory burden on EHR vendors through more transparent and realistic regulatory updates. Help vendors support provider clients with documentation and reporting requirements, especially specialty services like therapies, through rational policy updates. To level the playing field for smaller EHR vendors, CMS should create a regulatory sandbox or modular compliance pathway to help them gradually demonstrate capabilities and reduce duplicative development efforts by offering shared, open-source reference implementations for key requirements. Avoid frequent regulatory changes that have an outsized impact on smaller vendors; allow facilities and vendors to implement existing requirements before adding to them.

Total Comments Contributing: 6

Total Submissions Contributing: 3

Aggregated Comment Title: ***Modernize Use of Occupational Therapy***

Summary: Medicare policies for delivery, documentation, and reimbursement of occupational therapy (OT) and related services fall behind industry standards, hindering access to care, innovation, and adding administrative burden on providers. CMS should allow OTs to stand alone as a qualifying service for Medicare to cover home health.

Total Comments Contributing: 6

Total Submissions Contributing: 3

Organization(s): American Occupational Therapy Association; Vivie

Aggregated Comment Title: ***Revise Multi-Language Insert Requirements***

Summary: CMS updated the Multi-Language Insert (MLI) to the Notice of Availability (NOA), mandating it in English and the top 15 languages spoken in the state by PY 2026. Revert to the prior MLI rules, of including English and the top 15 languages spoken nationally. Alternatively, eliminate the notice or direct beneficiaries to specifically request alternate languages. One commenter notes that CMS should remove the notice of availability of services for individuals with disabilities as well as language access information. Another suggests that CMS should not require plans to include the multi-language insert (and, for 2026, the NOA) with all CMS-required materials, and instead permit plans to provide CMS-required materials only in the languages listed in the Evidence of Coverage and current call center interaction with the enrollee.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** Blue Cross Blue Shield Association; Blue Cross Blue Shield of Massachusetts; Humana; Sanford Health - Sanford Health Plan and Security Health Plan; UnitedHealthcare

Aggregated Comment Title: ***Rethink Reporting of Volunteer Hours***

Summary: Suspend the mandate for hospices and home health agencies to track cost savings from volunteer hours under Hospice Conditions of Participation. This outdated requirement lacks impact on care quality or patient outcomes, diverting staff resources for unnecessary reporting. Remove the requirement for a threshold of volunteer activity. CMS should revise the

CoPs to require only that hospices utilize volunteers, have a recruitment and retention plan for volunteers, and actively recruit volunteers annually.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** Amedisys, Inc.; Home Care Alliance of Massachusetts; National Alliance for Care at Home; Sutter Health; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Hospice Special Focus Program***

Summary: The Hospice Special Focus Program (SFP) in the CY 2024 Home Health Prospective Payment System Final Rule raises concerns about its operational and financial impact on providers and should be withdrawn. Increased survey frequency and loss of deemed status may lead to higher compliance costs and resource diversion from patient care. The program neglects high-risk providers, potentially overlooking fraudulent practices. The "poor performer" label can harm patient trust and organizational reputation. Data inconsistencies and a flawed selection algorithm, including unreliable metrics like HCI and CAHPS data, further complicate fair evaluations, disproportionately affecting larger providers.

Total Comments Contributing: 6

Total Submissions Contributing: 1

- ***Organization(s):*** Texas Association for Home Care and Hospice

Aggregated Comment Title: ***API Requirements are Costly***

Summary: The Interoperability and Patient Access final rule mandates Medicare plans to add three new application programming interfaces (APIs) by January 1, 2027: Payer to Payer, Provider, and Prior Authorization APIs. This rule also demands a significant enhancement to the 2021 Patient Access API. These requirements have led to a surge in demand for API development services, resulting in inflated prices. Further, the exorbitant costs of developing these APIs have yet to be justified by demand for their access.

Total Comments Contributing: 6

Total Submissions Contributing: 1

- ***Organization(s):*** Johns Hopkins Health Plans

Aggregated Comment Title: ***Redundant Workforce Training Requirements***

Summary: Workforce training mandates under 42 CFR 483.35, 483.40, and 483.95 require annual recertification for similar content, leading to redundancies that consume time and resources. CMS should consolidate these requirements into a single competency, allow the use of digital learning management systems or EHR-integrated tools that would cut down redundant training, while ensuring staff readiness, and regulatory alignment.

Total Comments Contributing: 6

Total Submissions Contributing: 4

- ***Organization(s):*** Kingdom Insurance Group; PointClickCare; Price Services Group, L.L.C.; Wellbox

Aggregated Comment Title: ***Reduce Audit Frequency***

Summary: Audit frequency should be reduced, particularly for high-performing plans and organizations and organizations with little infrastructure change over time. CMS should consider making methodological changes to existing audits, where possible, in lieu of creating new audits.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): Booz Allen Hamilton; Lumeris Healthcare; SCAN Health Plan; South Country Health Alliance

Aggregated Comment Title: ***Establish Centralized Audit and Compliance Database to Decrease Redundancy***

Summary: CMS should lead in regulatory coordination by establishing a centralized audit and compliance database accessible to CMS and its regulatory partners. This would reduce duplicate requests and promote uniform standards across agencies.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** Booz Allen Hamilton; CPAC Foundation Center for Regulatory Freedom; Direct Supply, Inc.; Reveleer; SCAN Health Plan

Aggregated Comment Title: ***Integrate Quality Measurements to Reduce Provider Burden***

Summary: Integrate quality measurement across Medicaid, private payers, and quality organizations by aligning metrics, reporting formats, and timelines to streamline data extraction and submission processes for providers while maintaining quality oversight.

Total Comments Contributing: 6

Total Submissions Contributing: 4

Organization(s): American College of Physicians; American Psychiatric Association; Booz Allen Hamilton

Aggregated Comment Title: ***CMS-1500 Claim Form Has Redundancies***

Summary: CMS-1500 claim form requires repetitive entry of static information already stored in CMS databases and the electronic health record, leading to redundant data entry across claims. The form often requires the same patient and service data to be entered multiple times for different payers. One suggestion is to enable APIs or auto-completion in these fields. This would modernize the process, align with current interoperability standards and avoid duplicating existing work to make it more efficient.

Total Comments Contributing: 6

Total Submissions Contributing: 4

Organization(s): Wellbox

Aggregated Comment Title: ***Streamline Part C Technical Specifications and Reporting Requirements with CMS Audit Protocol***

Summary: CMS should simplify regulatory reporting for Part C Technical Specifications and Reporting Requirements by integrating them with the CMS Audit Protocol, as many areas overlap. By aligning these processes, CMS could reduce administrative burden and streamline data reporting for annual Part C and D requirements, ultimately saving time and effort for stakeholders.

Total Comments Contributing: 6

Total Submissions Contributing: 2

Organization(s): Alignment Health Plan

Aggregated Comment Title: ***Allow TRFs as Part of Medical Record***

Summary: Test Requisition Forms (TRFs) are crucial for communicating clinical information to laboratories, yet Medicare Advantage (MA) organizations do not universally recognize them as part of the medical record. This leads to duplicative documentation requests, causing delays and administrative burdens for laboratories and providers. To streamline processes and reduce

paperwork burdens, CMS should formally acknowledge TRFs as part of the patient's medical record, aligning MA documentation policies with those of Medicare Fee-For-Service (FFS).

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** AdvaMed; American Clinical Laboratory Association (ACLA); Castle Biosciences Inc; Guardant Health; Quest Diagnostics

Aggregated Comment Title: ***Define the Term Digital Laboratory Information***

Summary: CMS should consider defining digital laboratory information as digital images or data derived from various laboratory tests, including genetic expression and sequencing data. Amending the definition of laboratory to include patient-specific digital information that can identify the individual would ensure that digital laboratory information is recognized as material derived from the human body for diagnostic and treatment purposes. Make permanent policy changes to formalize the current enforcement discretion and ensure that review of all patient-specific digital laboratory information including histopathology and cytology images is permissible at a remote testing location that operates under a primary site CLIA certificate.

Total Comments Contributing: 6

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Clarify and Consolidate Care Management Codes***

Summary: Clarify and consolidate the various care management codes. Group care management and communication technology services under single codes like the new Advanced Primary Care Management (APCM), Chronic Care Management (CCM), and Transitional Care Management (TCM) codes. This streamlines documentation and billing processes by eliminating the need for separate billing for each service and eases the process for smaller providers to focus on patient care, not identifying the correct billing code.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): Accountable for Health; America's Physician Groups (APG); American College of Osteopathic Family Physicians (ACOFP); Essentia Health; Sanford Health

Aggregated Comment Title: ***Allow Beneficiaries to Indicate Communication Type with Plan***

Summary: Medicare Advantage plans should be allowed to ask beneficiaries to specify if their communication is an appeal, grievance, or coverage determination request, improving member experience and operational efficiency. This empowerment allows for clearer communication and more streamlined plan operations, ultimately benefiting both the members and the plans.

Total Comments Contributing: 6

Total Submissions Contributing: 2

- ***Organization(s):*** DentaQuest; UCare

Aggregated Comment Title: ***Simplify Psychologists' Path to Joining and Working in Medicare HMOs***

Summary: Medicare HMOs often make it difficult for solo psychologists to join their panels, claiming there is already enough coverage in the area, and requiring a lengthy application process with multiple forms and verification steps, often taking months for approval. Coverage for behavioral services under Medicare and Medicare HMOs is also inadequate, with low payments. Additionally, authorization for psychological testing through Medicare HMOs is challenging, requiring extensive administrative work and low reimbursement rates compared to the time involved, along with uncertain payment guarantees.

Total Comments Contributing: 6

Total Submissions Contributing: 1

- ***Organization(s):*** Miami Center for Cognitive Therapy

Aggregated Comment Title: ***Revise Regulations to Reflect Independent Authority of APRNs and NPPs***

Summary: Revising 424.22 and 484.4 would eliminate the need for physician collaboration in states where APRNs and other NPPs can practice independently. These revisions would help reflect the expanded authority of NPPs, allowing them to certify eligibility for Medicare home health services in accordance with applicable state laws. Removing 483.30(e)(4) would reduce workloads for physicians and allow physicians to delegate all tasks to NPPs. CMS should also provide full practice authority for APRNs through federal programs similar to the Veteran Affairs' (VA's) National Standards of Practice, which defines a consistent scope of practice and responsibilities across all VA facilities.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** American Nurses Association; National Council of State Boards of Nursing; National Rural Health Association; OCHIN; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Health Plan Transparency Requirements***

Summary: CMS impacts health plans with costly and overlapping transparency-related regulations like Interoperability 2.0, Interoperability 1.0, Machine-Readable Files for Medical Information, Transparency in Coverage Cost Estimator, and RXDC report.

Total Comments Contributing: 6

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of ACOs (NAACOS); Point32Health

Aggregated Comment Title: ***Promote Interoperability***

Summary: To prevent new administrative burdens, foster innovation, and enhance quality, CMS should prioritize interoperability and coordinate with other federal agencies (OCR, ASTP) instead of imposing additional regulations. To achieve this, provide optional certification programs for technologies such as digital health applications and remote monitoring tools. Data sharing and interoperability across the health care delivery and payment systems are essential. CMS should leverage existing modern interoperability technologies to replace fax, phone, and spreadsheet workflows in several high-burden areas. EHR interoperability, centralized documentation platforms, and simplified compliance processes can remove friction while maintaining oversight.

Total Comments Contributing: 6

Total Submissions Contributing: 6

- ***Organization(s):*** LeadingAge; Massachusetts Health Data Consortium; Medical Group Management Association; Reveleer; Virginia Hospital & Healthcare Association; Wellbox

Aggregated Comment Title: ***Extend MA Appeal Deadlines to Improve Equity***

Summary: Medicare allows stakeholders 120 days to file a redetermination request, while Medicare Advantage (MA) has a shorter 65-day deadline for a first-level appeal. The shorter MA timeline particularly impacts denied claims requiring burdensome medical documentation. CMS should harmonize redetermination timelines within Medicare and extend the Part C deadline for filing a redetermination request to at least 120 days in line with Part B.

Total Comments Contributing: 6

Total Submissions Contributing: 4

- ***Organization(s):*** AdvaMed; American Clinical Laboratory Association (ACLA); Guardant Health; Quest Diagnostics

Aggregated Comment Title: ***Adopt Interoperability Standards***

Summary: Medicare can better align with industry best practices and promote consistency and efficient data exchange by adopting interoperability standards, for instance by leveraging national interoperability standards such as the USCDI and using existing Fast Healthcare Interoperability Resources (FHIR) frameworks. CMS should create open standards for interoperable electronic transmission of clinical data with input from physicians and patients, enabling information exchange across state lines without triggering HIPAA. Streamlining standards at federal and state levels would ensure consistency in definitions and disclosure policies.

Total Comments Contributing: 6

Total Submissions Contributing: 5

- ***Organization(s):*** American Academy of Family Physicians; Lantana Consulting Group; Patient Experience Policy Forum - The Beryl Institute; Physicians Advocacy Institute; Post-Acute and Long-Term Care Medical Association (PALTmed)

Aggregated Comment Title: ***Eliminate SDOH Measures***

Summary: Remove social determinants/drivers and health equity measures to save money and prioritize funds for medical equipment and staffing. A respondent considers these measures unfunded mandates better addressed by public health. Alternatively, CMS should not add any additional new SDOH measures to the Universal Foundation measure set.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Aggregated Comment Title: ***Flexibility in Drug Pricing***

Summary: CMS should prioritize flexibility in negotiations regarding drug prices, considering the impact of price controls on innovation and medication availability. Prices should accurately reflect the costs of drug development. At the same time, CMS should be attentive to risks to providers with invoice pricing and ensure providers are not overburdened with unwieldy processes and consider alternative reimbursement methods.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** American Hospital Association; National Taxpayers Union; Taxpayers Protection Alliance

Aggregated Comment Title: ***Delay or Eliminate Advanced Explanation of Benefits (AEOB) Requirements***

Summary: Implementing Advanced Explanation of Benefits (AEOB) requirements, especially for non-employed providers, is burdensome and challenging to monitor. Provider-payer communication also needs to be near real-time, which adds technical complexity. CMS should continue to delay or not enforce the AEOB requirements. Implementation for health plans is too burdensome and costly, and AEOB overlaps other transparency provisions. CMS is working on data standards for compliance but lacks acknowledgment of the operational processes involved in generating the required data. This could impact patient care and lead to provider burnout. CMS should prevent the AEOB and GFE from becoming additional unfunded burdens on clinician practices.

Total Comments Contributing: 5

Total Submissions Contributing: 5

- ***Organization(s):*** American Academy of Family Physicians; Healthcare Business Management Association; Ohio Hospital Association; Point32Health; WEDI

Aggregated Comment Title: ***Diabetes Equipment Restrictions are Burdensome***

Summary: Medicare sets national and local eligibility requirements for insulin pumps, continuous glucose monitors, and other diabetes management technology. While necessary to

prevent overprescription, these rules involve frequent documentation which can be burdensome for patients and physicians and increase the risks of morbidity and mortality.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Organization(s): American Association for Homecare; Endocrine Society; Joslin Diabetes Center; The Helmsley Trust

Aggregated Comment Title: ***HHVBP is Burdensome***

Summary: Home Health Value Based Purchasing (HHVBP) presents challenges for home health agencies, especially smaller and rural agencies, due to complex reporting demands and limited ability to impact metrics. The rehospitalization penalties are problematic for agencies due to complex medical issues and limited access to follow-up care, despite efforts to front-load visits.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Organization(s): Health Services of the Pacific; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Ease Requirements for Dietary Staffing in Hospice***

Summary: Hospices struggle to comply with the requirement of employing registered dietitians/nutritionists due to infrequent need and difficulty in retention. Recommendations include permitting contract arrangements and implementing a waiver policy to address the challenges in staffing dietary counseling positions.

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** Home Care Alliance of Massachusetts; Illinois HomeCare & Hospice Council; LeadingAge; National Alliance for Care at Home

Aggregated Comment Title: ***Disentangle APMs from MIPS Requirements***

Summary: Increasingly intertwining advanced alternative payment model (APM) requirements with burdensome Medicare MIPS reporting requirements does not reduce burden. CMS should separate advanced APMs from complex MIPS requirements by eliminating the mandatory reporting of the MIPS Promoting Interoperability (PI) performance category for all Qualified Participants (QPs). This change is crucial for small and independent practices that struggle with compliance due to limited resources, especially when compared to larger hospitals and systems.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Aggregated Comment Title: ***Streamline SAFER Guidance Documentation***

Summary: Safety Assurance Factors for Electronic Health Record (EHR) Resilience (SAFER) guidance documentation is redundant, resource-intensive, burdensome, misaligned with other quality measures and lacks clear evidence of direct patient safety benefits.

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** Federation of American Hospitals; Netsmart; Ohio Hospital Association; Piedmont Healthcare

Aggregated Comment Title: ***Translation and Communication Materials Requirement is Overly Complex and Burdensome***

Summary: The translation requirements for marketing and communication materials related to Medicare Advantage, Part D, and Dual Eligible Special Needs Plans (D-SNPs) have become increasingly complex and burdensome without providing clear benefits to beneficiaries. Specifically, the requirements regarding multi-language inserts, translated materials, and national advertising.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Organization(s): Humana; Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***Eliminate Respiratory Illness Reporting Requirements***

Summary: CMS should remove the respiratory illness reporting requirement from conditions of participation for hospitals.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Organization(s): Association of American Medical Colleges; California Hospital Association; Cleveland Clinic; Greater New York Hospital Association

Aggregated Comment Title: ***Eliminate Requirement that a Hospital Operate for Six Months to Convert to CAH Status***

Summary: Remove the prerequisite for hospitals to operate for a minimum of six months under the prospective payment system before transitioning to Critical Access Hospital (CAH) status.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): American Hospital Association; California Hospital Association; Catholic Health Association

Aggregated Comment Title: ***Establish MA Network Adequacy Requirements for Post Acute Care***

Summary: To enhance alignment between Medicare Advantage (MA) and traditional Medicare, implement and enforce network adequacy standards for post-acute and specialty care in MA plans, facilitating prompt access to essential services for patients.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Aggregated Comment Title: ***ACOs and Voluntary Alignment***

Summary: Streamline the process for voluntary alignment of beneficiaries to ACOs and enhance patient choice. For example, permit ACOs to engage with homebound patients about voluntary alignment to prevent any barriers to their participation in ACOs. Additionally, allow ACO providers to discuss voluntary alignment with patients who are homebound or reside in a long-term care facility, which is currently prohibited by the ACO REACH Participation Agreement.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): National Association of ACOs; PSW and MultiCare Connected Care; WellSpan Health

Aggregated Comment Title: ***Overhaul the ACPT for ACOs***

Summary: The Accountable Care Prospective Trend (ACPT) will unfairly reduce benchmarks for Accountable Care Organizations (ACOs) by 1.03 percent, potentially decreasing shared savings revenue by 25 percent for the average ACO, which could significantly underfund ACOs. CMS should overhaul the ACPT for ACOs. Reform ACO performance benchmarks by revising or

eliminating the Accountable Care Prospective Trend (ACPT) from the MSSP, ensuring that the application of ACPT is not worse than prior methods. CMS could also change the weight of the ACPT to 0 percent for the 2024 and 2025 performance years.

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** Aledade; National Association of ACOs; Premier Inc; WellSpan Health

Aggregated Comment Title: ***Medically Unlikely Edit Creates Administrative Burden and Unnecessary Denials***

Summary: The Medically Unlikely Edit (MUE) adds a significant burden and waste of resources. Correcting these edits takes substantial time across clinical and administrative departments, many times the entire line item is denied, and appealing denials for services under the MUE limit does not result in additional payment. This can hinder accurate cost data reporting to CMS, impacting payment calculations and patient-centered care goals. MUE is often triggered with drugs due to weight-based dosing caps, despite many patients being overweight or obese. CMS should accept documentation in the medical record and modifier GD on claims to enable providers to attest to the medical necessity of units exceeding the medically unlikely edits (MUE). It is difficult to comply with the requirements under CMS Manual System Pub. 100-04.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Organization(s): Coalition of State Rheumatology Organizations

Aggregated Comment Title: ***Simplify QRDA Files***

Summary: QRDA files used for quality reporting in MIPS are highly technical and require collaboration between various parties including EHR vendors who charge high fees to access the files. Even with certified systems, manual data validation and adjustments are often necessary before submission. These files pose challenges for FQHCs and solo or small practices without IT support and may overlap with quality reporting requirements in ACO programs or Medicaid. These challenges limit timely quality improvement efforts.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Organization(s): Community Care Cooperative; Piedmont Healthcare

Aggregated Comment Title: ***SNF/LTC Regulations are Excessive***

Summary: Regulation in Skilled Nursing Facilities and Long Term Care is extensive, with facilities allocating a significant portion of staff to compliance tasks rather than patient care, leading to increased costs. CMS should adjust how scope and severity tags are applied to protect LTCs from unnecessary penalties. LTCs should also not be held responsible for unpredictable events but only judged on actions within their control provided they have put all appropriate safeguards in place.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Eventus WholeHealth; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Streamline Medicare Audit for Outpatient Mental Health Services***

Summary: Comprehensive documentation audits on every patient causes excessive burden by draining time and resources from an already strained workforce. CMS should implement targeted audits through statistically valid random sampling for outpatient mental health services to improve the current audit requirements. Random sampling can uphold oversight integrity while easing administrative burdens on clinicians and systems.

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** American Health Care Association (AHCA); Behavioral Wellness Group; Glovan, Pollak and Associates; dba: The Behavioral Wellness Group; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Revise Behavioral Health Network Adequacy Requirements***

Summary: The Contract Year 2025 Medicare Advantage and Part D Final Rule 422.116(b)(2)(xiv)(B) introduces a minimum patient volume requirement for certain behavioral health providers like nurse practitioners, physician assistants, and certified nurse specialists. This provision mandates a minimum number of patients to be treated before providers can be included in network adequacy assessments, potentially excluding qualified professionals. CMS should rescind the 20-patient requirement, because providers should not have to demonstrate a specific patient volume to be considered for network adequacy assessments. Additionally, in Provision 22.116(d)(5), increase in the telehealth credit beyond the current 10 percentage points to better reflect telehealth's importance in expanding access to care, especially in addressing workforce shortages in behavioral health. Furthermore, the network adequacy requirements for MA plans need to be updated to explicitly include LTCHs and IRFs.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Association for Behavioral Health and Wellness (ABHW); National Board for Certified Counselors (NBCC); Select Medical Holdings Corporation

Aggregated Comment Title: ***Revise Behavioral Health Appointment Wait Time Standards***

Summary: Rescind the appointment wait time guidance in the April 2024 and 2025 documents and align wait times for behavioral health services with existing industry standards like the NCQA. For example, CMS could establish a 14-day timeframe for non-emergency behavioral health services instead of the proposed one-week timeframe. This adjustment aims to differentiate non-urgent care from emergency or urgent care, which is typically accessible within 72 hours in the industry. The current standards may hinder the adoption of integrated care models like Collaborative Care by penalizing providers who support these models. CMS should employ a more flexible approach to enforcing wait time requirements.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Association for Behavioral Health and Wellness (ABHW); Blue Cross Blue Shield Association

Aggregated Comment Title: ***Monitor Complaints***

Summary: Monitor calls to complaint hotlines and establish a portal for providers to submit complaints related to insurer practices that limit access to care.

Total Comments Contributing: 5

Total Submissions Contributing: 5

- ***Organization(s):*** American Commitment; Highlands Oncology Group, P.A.; Oak Lane Nursing & Rehab; Piedmont Healthcare; Price Services Group, L.L.C.

Aggregated Comment Title: ***Reduce Frequency and Improve Value of Surveys for Facilities in Good Standing***

Summary: Ease survey burden by reducing frequency and/or improving educational value for facilities in good standing, such as based on Star Quality Ratings. Compliance surveys for long-term care facilities should focus on those with troublesome histories or excessive citations, while homes with good reputations and survey histories should be grandfathered out of surveys. Transitioning from paper to electronic reporting for daily staffing logs would also streamline processes. Prioritizing surveys based on facility history and utilizing electronic tools can improve efficiency and target areas needing the most attention.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Maplewood of Cheshire County; Oak Lane Nursing & Rehab; SCAN Health Plan

Aggregated Comment Title: ***Rescind NCD 40.2***

Summary: Conditions unrelated to diabetes, such as insulinomas, can cause insulin imbalances. CMS should rescind NCD 40.2 and encourage the DME MACs to modify the CGM LCD to permit access by non-diabetic populations to the degree that applicable clinical evidence demonstrates that CGM use would be medically necessary. Remove barriers to care for diabetes technologies that are no longer supported by the latest clinical evidence and standards of care.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Organization(s): Association of Diabetes Care and Education Specialists; Dexcom, Inc.; Diabetes Technology Access Coalition (DTAC); The Helmsley Trust

Aggregated Comment Title: ***Amend the 340B Drug Pricing Program to Enhance Compliance***

Summary: Despite efforts to educate providers and payers on preventing noncompliant discounts and rebates, hundreds of millions of dollars are still identified annually in noncompliance. This suggests that current traditional 340B chargeback solutions are ineffective in preventing drug discount and rebate noncompliance. Review options to cut excessive payments to hospitals. The 340B Drug Pricing Program excludes around 20% of tax-paying community hospitals. This restriction based on tax status undermines the program's original goal of maximizing federal resources to enhance healthcare access for vulnerable populations.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Consumer Action for a Strong Econmy; Federation of American Hospitals; Kalderos, Inc.

Aggregated Comment Title: ***Revise CMS' Bona-Fide Marketing Definition***

Summary: CMS' bona fide marketing standard lacks statutory basis and introduces ambiguity regarding a product's status under price setting regulations. This standard determines whether a reference drug or biologic qualifies as a QSSD and is protected from compulsory price negotiation. The process for a biosimilar to gain market share can be lengthy due to financial incentives favoring reference products, causing delays in meeting regulatory thresholds. The standard's application risks undermining statutory protections for single-source drugs and biosimilars, potentially nullifying intended safeguards. One specific issue is the primary/secondary manufacturer construct, which holds primary manufacturers accountable for third-party manufacturers without contracts, eliminating the bona fide marketing standard. CMS' use of the terms "primary manufacturer" and "secondary manufacturer" improperly ignores and overrides the statutorily adopted manufacturer definition in a manner that exceeds CMS authority. CMS should use the term "marketed" as defined in the statute, emphasizing the introduction of a product into interstate commerce.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Aggregated Comment Title: ***Improve MAC Processes to Streamline Coverage Decisions***

Summary: Policy and technical changes to National Coverage Determinations (NCD) could include removing blanket non-coverage limitations to allow flexibility for Medicare Administrative Contractors (MACs) in determining coverage policies for innovative Next-Generation Sequencing (NGS) tests in cancer. Additionally, establishing clear standards to prevent Medicare Advantage Organizations (MAOs) from avoiding coverage obligations through utilization management, creating a provider-specific electronic reporting form for suspected violations, and prohibiting MAOs from requesting unnecessary medical records for NCD or LCD-covered services can help ensure compliance and streamline the coverage process. Furthermore, requiring MAOs to consider laboratory Test Requisition Forms (TRF) when assessing coverage criteria and eliminating prior authorization for covered services are suggested improvements.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Rethink the REACH ACO Model***

Summary: REACH ACOs are overregulated and not transparent, which adds to administrative burden and detracts from cost savings. This model could be eliminated by adding preferred provider discounts to the MSSP program and increasing quality metric calculation transparency. If maintained, CMS should provide greater insight and transparency into the methodology for calculating ACO REACH Quality Metrics so that ACOs can verify their results.

Total Comments Contributing: 5

Total Submissions Contributing: 2

Organization(s): Lumeris Healthcare

Aggregated Comment Title: ***Streamline the Physician-Owned Hospital Expansion Exception Request Process***

Summary: Automate and streamline the expansion exception request process for physician-owned hospitals at 42 CFR § 411.363. For example, remove discretionary criteria now codified in § 411.363(i)-(j) and implement a transparent, criteria-based system rooted in congressional language. A simplified, web-based application validating hospital eligibility based on objective metrics like Medicaid caseload and bed count would reduce manual work and enhance efficiency. The documentation required under 42 CFR § 411.363(e) is excessive and discourages expansion efforts.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** Doctors Hospital at Renaissance, Ltd. (DHR Health)

Aggregated Comment Title: ***Streamline Requirements for Caregiver Training Services***

Summary: Caregiver training services (CTS) are crucial for safe discharges and care transitions in skilled nursing facilities (SNFs), but face challenges in reporting and billing under Medicare Part B and the MDS system. The recent "Disposition 11" policy change requiring a threshold of time met for CTS billing has caused confusion and denied claims, hindering the delivery of these essential services. Rescind this requirement and reinstate standard timing rules to reduce administrative burden. Also allow CTS minutes to be reported as therapy services on the MDS.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** American Occupational Therapy Association

Aggregated Comment Title: ***Regulatory Actions to Streamline 340B Eligibility and Registration***

Summary: To ensure continuity of care and community benefit, CMS should consider supporting legislative or regulatory actions to grandfather 340B eligibility for hospitals acquired by tax-paying systems, as long as safety-net services and patient demographics remain consistent post-acquisition. This approach would extend cost savings to underserved communities, regardless of tax status, and align with the program's goal of enhancing access and affordability for vulnerable populations. Additionally, streamlining the registration process for 340B child sites by reverting to previous policies would improve efficiency and timeliness in program implementation.

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** America's Essential Hospitals; Federation of American Hospitals; Illinois Health and Hospital Association; National Rural Health Association

Aggregated Comment Title: ***Barriers to Efficient Data Exchange for SNFs***

Summary: Skilled nursing facilities (SNFs), including long-term and post-acute care organizations, have adopted electronic health records (EHRs) to support their clinical and operational needs, but interoperable exchange of health information remains limited. While efforts like the Trusted Exchange Framework and Common Agreement (TEFCA) aim to improve nationwide health information exchange, the interoperability gap for this sector persists due to the lack of standardized health information technology (HIT) and policy support. Only a small percentage of hospitals can routinely exchange interoperable health information with SNFs, highlighting the need for further modernization.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Impact of Forced Downgrades of Star Ratings on Facilities***

Summary: Forced downgrades in star ratings have led to the dissemination of inaccurate and incomplete information about facilities. These downgrades pose a threat to the affected facilities, as they may cause significant revenue losses and closure. Furthermore, these downgrades have impacted facilities by affecting their relationships with consumers, hospitals, and health plans/insurers.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***SPADE Patient Assessment is Burdensome***

Summary: Standardized patient assessment data elements (SPADE) requirements to collect certain MDS data, such as race and ethnicity, are difficult to follow due to inconsistencies across MDS instruments. Remove the inclusion of SPADEs that are not associated with existing SNF QRP measures from the reporting requirements impacting a SNFs Annual Payment Update (APU) determination. Also remove SPADEs that are not utilized for quality measurement or payment purposes and represent a significant time burden on clinicians.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): American Health Care Association (AHCA); American Medical Rehabilitation Providers Association; Encompass Health

Aggregated Comment Title: ***Communicate Clearly on Policy Updates***

Summary: CMS should provide clear guidance and explanations for policy updates. For example, providers and the public could misinterpret the removal of SDOH documentation and modifiers in a way that is not flattering to the administration. A 180-day notice of substantial updates could decrease the complexity of reporting. Additionally, AI can be used to create a cross-manual search tool to assist in providers finding information about Medicare coverage policies or routinely update coverage resources with policy changes.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Aggregated Comment Title: ***Streamline Coding Practices by Removing Excludes Notes from ICD-10-CM Guidelines***

Summary: Modify the ICD-10-CM Guidelines by removing Excludes Notes in Section I.A.12 to alleviate burdens on healthcare providers and laboratories, preventing unnecessary claim denials for essential services. This change aims to streamline coding and reporting processes for improved efficiency and accuracy in healthcare services.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Reconsider Medicare Graduate Medical Education Methodologies***

Summary: The current distribution methodology for Medicare graduate medical education (GME) slots created under Section 126 of the Consolidated Appropriations Act of 2021 prioritizes Health Professional Shortage Areas (HPSA) service and imposes training-time thresholds across all categories, complicating the application process and disadvantaging hospitals. This approach has raised concerns about hindering the efficient allocation of resources critical for ensuring a steady pipeline of highly trained physicians to deliver essential care to Medicare beneficiaries nationwide.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Hackensack Meridian Health; Sutter Health; University Radiology Group, LLC

Aggregated Comment Title: ***Remove SDOH Measure for Home Health Quality Reporting Program (HHQRP)***

Summary: CMS should remove the Social Determinants of Health (SDOH) measure in the Home Health Quality Reporting Program (HHQRP). The requirement creates challenges such as the need to screen patients for social needs, mismatched coding requirements, lack of consistent standards, and duplicative measures already mandated by the Home Health Conditions of Participation.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Health Care Association

Aggregated Comment Title: ***Eliminate 42 CFR 422.2274(g)(4) Regarding TPMOs and Data Sharing***

Summary: 42 CFR 422.2274(g)(4) is burdensome and oriented against compliant organizations. CMS should remove the regulation and allow the industry to self-regulate, including through organizations like the IMC, to establish, follow, and enforce best practices when it comes to lead generation and the associated sharing of Medicare beneficiary data amongst Third-Party Marketing Organizations (TPMOs).

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Astoria Company; Curana Health

Aggregated Comment Title: ***Recredentialing is a Burden***

Summary: The recredentialing process is duplicative, burdensome, and complex. Mistakes made during the process may lead to payment delays until the mistakes are fixed. Further, CMS requires physicians to be recredentialed every five years for Medicare, but some Medicare Advantage plans mandate more frequent recredentialing. CMS should align Medicare Advantage credentialing with the existing 5-year cycle or require Medicare Advantage payers to adopt the standard recredentialing cycle.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): American Society of Anesthesiologists; Point32Health; University Radiology Group

Aggregated Comment Title: ***MOON is Redundant and Overly Complex***

Summary: The Medicare Outpatient Observation Notice (MOON) is redundant, labor-intensive, and confusing for patients.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): Premier Health; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Duplication in Coordination of Benefits Processes***

Summary: Medicare and private insurance coordination of benefits (COB) processes require providers to submit duplicative claims, documents, and reporting to both Medicare and private insurers for dual-covered patients. A single COB system that automatically updates, shares information between payers, and determines which payer is primary would help.

Total Comments Contributing: 5

Total Submissions Contributing: 2

Organization(s): National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Total Beneficiary Cost (TBC) Regulations are Redundant***

Summary: The Total Beneficiary Cost (TBC) regulations governing benefit and cost-sharing changes, which are updated annually, are burdensome for Medicare Advantage plans and CMS reviewers and are unnecessary. These limitations are redundant because market and regulatory protections already exist for beneficiaries. Furthermore, the formula used to implement these regulations is flawed.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Humana; SCAN Health Plan

Aggregated Comment Title: ***Simplify the Medicare Physician Fee Schedule***

Summary: Simplify the Medicare Physician Fee Schedule by consolidating 8,000+ service codes into fewer payment code "families" with similar time and work valuations for related services. It is extremely time consuming for providers to wade through the current volume of codes and modifiers, risking denials if they don't choose the correct code.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP); The Commonwealth Fund

Aggregated Comment Title: ***Network Adequacy Requirements Contribute to Administrative Burden***

Summary: The network adequacy requirements outlined in Title 42 CFR Part 422.116 are burdensome for health plans, especially small rural ones. The updated time and distance

standards, along with the submission timeframe, do not provide enough time for reviewing gaps and completing contracting and credentialing efforts. Providers within the standards are usually in-network, and those outside rarely see members.

Total Comments Contributing: 5

Total Submissions Contributing: 2

Organization(s): Sutter Health

Aggregated Comment Title: ***Remove MIPS CEHRT Attestation Requirements***

Summary: To reduce burdensome requirements aligned with MIPS, suggestions include removing 42 CFR 425.507 from MSSP regulations, simplifying attestation under 42 CFR 425.506(f) and 42 CFR 414.1415(a), revising the definition of Certified Electronic Health Record Technology (CEHRT) under 42 CFR 414.1305, and providing timely compliance guidance. A call to reevaluate numerator/denominator requirements in EHR reporting programs and permit attestation for meaningful use of CEHRT and information exchange is made, aiming to ease reporting burdens and encourage small practices to participate in MSSP.

Total Comments Contributing: 5

Total Submissions Contributing: 5

- ***Organization(s):*** Aledade; College of American Pathologists; Connected Health Initiative; National Association of ACOs; PSW and MultiCare Connected Care

Aggregated Comment Title: ***Shortages of Medical Directors***

Summary: Consider allowing advanced practice providers (APPs) such as nurse practitioners (NPs) or physician assistants (PAs) to qualify as facility medical directors. They enhance care delivery and have extensive medical knowledge. Further, facilities often find it challenging to fill these roles due to onerous requirements; this is especially true in rural areas.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Organization(s): Grafton County Nursing Home

Aggregated Comment Title: ***Regulatory Revisions to Reduce Burden on Drug Manufacturing***

Summary: CMS should make several regulatory changes to reduce burden on drug manufacturers to improve patient access to medicines. CMS should withdraw the Negotiation Data Elements and Drug Price Negotiation Process Information Requests (ICR) due to the

excessive data burden on manufacturers. The price-setting process is arduous, with redundancy in the information requested by CMS. Rescinding these requests could streamline the process and alleviate the burden on manufacturers. To align with statute and safeguard the development of innovative drugs, the definition of a Qualified Single Source Drug (QSSD) should be modified to limit it to products approved by the FDA in a single NDA or BLA. Additionally, CMS should comply with Congress' intent regarding the exclusion of orphan drugs from Medicare's negotiation by applying the 7- or 11-year age requirement from the date of initial approval. Modifying CMS policies, such as the Part D effectuation and primary/secondary manufacturer policies, would ensure continued patient access to critical medicines and reduce administrative burdens on private sector entities.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** Pfizer, Inc.

Aggregated Comment Title: ***Streamline SNF Change of Ownership Process***

Summary: To streamline the change of ownership (CHOW) process for skilled nursing facilities (SNFs), recommendations include allowing new owners to bill Medicare and Medicaid provisionally during Form 855A enrollment updates, maintaining provider agreements during CHOW unless fraud or quality issues are found, aligning state and federal approval timelines, and conducting abbreviated surveys for reputable new owners with strong compliance records. SNFs could input their information into a centralized system like the Provider Enrollment, Chain and Ownership System (PECOS) to improve efficiency and accessibility for federal and state governments, as well as Managed Care Organizations (MAOs) during provider credentialing processes.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Advocating for Seniors; LeadingAge

Aggregated Comment Title: ***Create Standardized Criteria for Prior Authorizations and Concurrent Reviews in MA Plans***

Summary: CMS should create standardized criteria for prior authorizations and concurrent reviews in Medicare Advantage plans, aligning them with Medicare clinical coverage criteria as mandated by current MA rules. Additionally, there is a call to specify the necessary supporting documentation for each of these processes. CMS could require payers to follow standardized

requirements in submission processes, prior authorization forms, or clinical criteria across payer types.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Aggregated Comment Title: ***Establish Uniform Core Quality Metrics Across Medicare Programs***

Summary: Uniformity in core quality metrics across different healthcare programs, providers, and plans, particularly in MA and Medicare, is essential for policymakers to effectively evaluate and compare outcomes and value. By ensuring consistency in both the naming and definitions of these metrics, policymakers can make more informed decisions and assessments regarding the performance of various healthcare entities.

Total Comments Contributing: 5

Total Submissions Contributing: 3

Organization(s): Booz Allen Hamilton; LeadingAge

Aggregated Comment Title: ***Revise Licensure Requirements for Nursing Assistants***

Summary: CMS should revise the licensure requirements for nursing assistants and nurse aides. Recommendations include requiring only a written examination for licensure, standardizing the written examination nationally and establishing a defined passing threshold. Additionally, CMS should remove the skills testing requirement from the licensure process, allowing states to oversee the skills examination within the training program before completion. While licensure requirements are being revised, CMS should defer enforcement of skills testing as a component of licensure. These changes would streamline the licensure process and align it with best practices in similar clinical professions, while maintaining safety.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***Resolve Challenges in Nurse Aide and Nursing Assistant Training Programs***

Summary: Nurse Aides/Nursing Assistants (NA) training programs and testing options are expanding, but federal regulations, such as NA licensure requirements, still pose significant barriers to entry into this essential workforce. Variability in NA written examinations, coursework, and testing providers across states hinders the portability of NA credentials and

creates delays in entering the workforce. The redundancy and inefficiency of high-stakes, stand-alone skills testing for NA licensure can lead to unnecessary delays and increased costs for students and the testing process.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Washington State Board of Nursing

Aggregated Comment Title: ***Streamline DMEPOS Oversight***

Summary: CMS must establish a dependable method to distinguish Part A stays and recoup losses associated with DMEPOS suppliers and provide stricter oversight of DMEPOS suppliers who do not register all locations. Additionally, states should provide DMEPOS oversight through state licensure for enhanced accountability. CMS should require full recognition of CR3959, CR8390, and CR8730 involving all States being required to enact licensure within ones State as initially required by CR 3959 at its inception.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Organization(s): American Association for Homecare; O&P Insight

Aggregated Comment Title: ***Relax Health Equity Requirements***

Summary: Relax or remove requirements around Health Equity. Efforts to address it have not yielded significant opportunities despite resource allocation, and data collection is burdensome. Adjust the specifications to be more realistic.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): Johns Hopkins Health Plans; Kona Community Hospital; UCare

Aggregated Comment Title: ***Simplify Processing of SDRs***

Summary: CMS should simplify the processing of SDRs by increasing the timeline for SDR review from 3 calendar days to 7 calendar days and reduce the number of interdisciplinary team (IDT) members required to participate from 11 to 3, in alignment with the IDT staffing requirements for all other event-based and semi-annual assessments.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** WelbeHealth

Aggregated Comment Title: ***Retain Health Equity and SDOH Reporting to Align with Best Practices***

Summary: Removing certain SDOH reporting requirements to reduce regulatory burdens may negatively impact patient care and perpetuate inequities in healthcare. This is especially true for providers who see geriatric patients with complex conditions. In particular, Medicare should maintain the following elements to align its requirements with best practices: Hospital commitment to health equity; Screening for social drivers of health; Screen positive rate for social drivers of health; Utilities, Living Situation, and Food assessments in the LTCH QRP. Allow relevant social metrics to count toward plan performance scores for MA and D-SNP plans, as these services have demonstrated impact on health outcomes.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): BJC Health System; Center for Medicare Advocacy; Centro De Amigos

Aggregated Comment Title: ***Prior Authorization Audits are Burdensome***

Summary: Prior Authorization audit and appeals processes are complex, slow and resource intensive. They disproportionately impact small and rural providers, who often lack the compliance resources of larger systems. As a result, these providers are penalized for limited administrative capacity rather than care quality or patient outcomes. These audits are often completed long after the service is delivered, where payments are recouped despite their prior approval as covered services.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom; LeadingAge Illinois/Iowa; Ohio Hospital Association; Regulatory Relief Coalition

Aggregated Comment Title: ***Remove Specific Training Requirements for Nursing Home Staff***

Summary: The staff training requirements at 42 CFR 483.95, 483.40, and 483.35 mandate specific training topics, timelines, and minimum hours for nursing home staff annually. This regulation should be revised to eliminate rigid training guidelines and empower nursing home

leadership to tailor training based on staff competencies, resident needs, and operational requirements.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Aggregated Comment Title: ***Consolidate Rebate and Pricing Portals to Establish Interagency Reporting System***

Summary: CMS should work with federal agencies like HHS, FTC, and the Department of Labor to merge rebate and pricing reporting portals and standardize definitions across programs to establish an interagency reporting system. This would minimize redundant submissions, decrease audit expenses, and offer regulators more transparent and consistent access to data.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Part D Reporting Requirements***

Summary: Prioritize streamlining and harmonizing Part D reporting requirements, including across federal agencies.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** AHIP; Pharmaceutical Care Management Association (PCMA); Prime Therapeutics LLC

Aggregated Comment Title: ***Inpatient Psychiatric Facility Documentation Burden***

Summary: Conditions of Participation for Inpatient Psychiatric Facilities impose costly and burdensome documentation requirements on providers, limiting clinical judgment and adding minimal value to care quality. Compliance costs facilities hundreds of millions annually without significant quality improvement.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Psychiatric Association; Henry Ford Health; National Association for Behavioral Healthcare

Aggregated Comment Title: ***Update Requirements for Hospice Continuous Home Care***

Summary: CMS should update the requirements for Hospice Continuous Home Care (CHC) at 42 CFR 418.302 by reducing the minimum duration of care from 8 hours to 4 hours, allowing patients to access CHC in the evening. Additionally, allow hospices to bill and receive payment for CHC if the 4-hour care requirement is met within a 24-hour period, rather than within a single calendar day. CMS should also eliminate the requirement for Continuous Home Care to start at midnight (Subregulation: Medicare Claims Processing Manual Chapter 11, 30.1 - Levels of Care Data Required on the Institutional Claim to A/B MAC (HHH) and Medicare Benefit Policy Manual, Chapter 9, 20.2.1 - Hospice Election).

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Academy of Hospice and Palliative Medicine; LeadingAge; National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Remove Total Beneficiary Cost Test***

Summary: Remove the Total Beneficiary Cost (TBC) test at 42 CFR 422.100 (f) and (j), 42 CFR 422.101(d), 42 CFR 422.254(a)(4), and 42 CFR 422.256(a) to avoid imposing arbitrary limits on benefit changes that may have unintended consequences. The specific regulatory text in 42 CFR 422.256 related to TBC should be repealed to address this issue.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** SCAN Health Plan

Aggregated Comment Title: ***Align Medicare Advantage with Fee for Service***

Summary: Administrative policies between Traditional Medicare and Medicare Advantage (MA) plans need to be aligned. Currently, the variation between the two systems adds complexity and hampers provider efficiency by requiring them to navigate different policies based on the payer. Aligning rules like medical necessity criteria and prior authorization requirements would eliminate duplicative work and create a more consistent process.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** American Osteopathic Association; Highlands Oncology Group, P.A.; Nonprofit Kidney Care Alliance; Ohio Hospital Association

Aggregated Comment Title: ***Simplify the Medicare Change of Status Notice (MCSN)***

Summary: Simplify Medicare Change of Status Notice (MCSN) processes. The current process is complex for patients and challenging for staff to meet deadlines.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Increase Oversight of White Bagging***

Summary: Increase oversight of "white bagging" which can jeopardize access to care in some settings. Prohibit this practice in Critical Access Hospitals. This practice is costly for small providers and potentially impacts timeliness and safety of care delivery. Insurers must be prohibited from unilaterally adopting policies that force providers to use physician-administered drugs provided by the insurer's affiliated pharmacy benefit manager. White bagging practices present a barrier to patients who need infusion medications and can compromise their safety.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): Association for Clinical Oncology; Cleveland Clinic; Ohio Hospital Association

Aggregated Comment Title: ***Change Performance Information Distribution Cadence***

Summary: Provide Medicare claims data and meaningful MIPS information on a more frequent basis, ideally quarterly, to allow for timely performance monitoring and improvement opportunities. The current delay of six to 18 months in receiving feedback leaves physicians unaware of cost measures, patient attribution, and external costs they are being held accountable for, hindering their ability to efficiently improve care and meet MIPS requirements.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Academy of Physical Medicine & Rehabilitation; American Podiatric Medical Association; The American College of Cardiology

Aggregated Comment Title: ***Streamline Interprofessional Consults***

Summary: CMS established six CPT codes for interprofessional consultations to improve access to care and reduce costs by facilitating provider-to-provider interactions and peer-mentored care. CMS can further improve and streamline these services by alleviating barriers to uptake, including: confusion over CPT code 99452 time reporting requirements; allowing the time for these codes to include all activities associated with the interprofessional exchange, including follow-through on the consultant's recommendations; and the coinsurance requirement for codes 99451 and 99452, leading to concerns about patient responsibility for multiple payments.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***Expedite Prior Authorization Decisions for Medicare Advantage Plans***

Summary: Establish stricter timeframes for Medicare Advantage plans to review prior authorizations, with a proposed reduction from 72 to 48 hours for standard requests and 24 hours for urgent cases.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** American Commitment; American Urological Association, Inc.; Association of American Medical Colleges; Johnson & Johnson

Aggregated Comment Title: ***Medicare Prescription Payment Plan and D-SNPs***

Summary: The Medicare Prescription Payment Plan adds little value to Dual Eligible Special Needs Plan (D-SNP) members with small or $0 copays, while imposing costs and burdens on health plans mandated to implement it. CMS should exclude D-SNPs from the M3P since low-income members already have a built-in mechanism to limit their exposure at point of sale.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Organization(s): Minnesota Association of County Health Plans; South Country Health Alliance

Aggregated Comment Title: ***Curb Advantage Plan Requirements for Record Review and RADV***

Summary: Some Advantage plans mandate a comprehensive review of records, which go beyond CMS requirements for Risk Adjustment Data Validation (RADV). These reviews are inefficient and burdensome for both providers and insurers. CMS should establish guardrails on the frequency, scope, and purpose for these plan-initiated reviews.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** Bright Day Psychology PLLC; Coalition of State Rheumatology Organizations; Humana; Reveleer

Aggregated Comment Title: ***Rescind Hospital Drug Invoice Regulations***

Summary: Rescind regulations requiring hospitals to report detailed information about drug invoices on their cost reports. Manufacturers should be required to report the additional pricing information necessary for CMS to create average sales prices (ASPs).

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): Florida Hospital Association; Illinois Health and Hospital Association; University of Vermont Medical Center

Aggregated Comment Title: ***Recognize CCBHCs***

Summary: Certified Community Behavioral Health Clinics (CCBHCs) face challenges in billing Medicare due to the lack of recognition for the service and payment model, leading to increased administrative burdens when providing Medicare-covered services. Including CCBHCs as provider types under Medicare will improve both the quality and efficiency of care.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** National Board for Certified Counselors (NBCC); National Council for Mental Wellbeing

Aggregated Comment Title: ***Expand Oversight of MA Plans on Network Adequacy***

Summary: Expand network adequacy audits for Medicare Advantage (MA) plans, enforcing standards for plans in rural areas, and enhancing transparency to ensure compliance and increase clarity for providers.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Organization(s): American Hospital Association (AHA)

Aggregated Comment Title: ***Standardize Encounter Data Submissions***

Summary: Standardizing encounter data submissions for Medicare Advantage plans, for instance by combining the Encounter Data Submission Performance Report and the Encounter Data Report Card, would significantly reduce burdens on provider systems without compromising data integrity or program oversight.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Organization(s): Health Alliance Plan of Michigan; Humana

Aggregated Comment Title: ***Utilize Specialty-Specific Clinical Data Registries Instead of MIPS***

Summary: Physician-led specialty-specific clinical data registries like the STS National Database offer a more efficient and beneficial alternative to MIPS and should be allowed as an alternative to MIPS. These registries collect detailed data that directly informs quality improvement and patient safety, providing actionable feedback and support for continuous improvement. CMS should rescind MIPS policies that place burdens on these registries.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Physician Clinical Registry Coalition; The Society of Thoracic Surgeons

Aggregated Comment Title: ***Enhance Collaboration Between Regulatory Bodies to Streamline Compliance***

Summary: Regulatory bodies like CMS, Office of Inspector General, state survey agencies, and accrediting organizations should collaborate more effectively to streamline surveys and compliance reviews. All regulatory requirements can be addressed simultaneously by sharing findings, aligning visit schedules, and creating unified corrective action plans

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): American Psychiatric Association; Federation of American Hospitals

Aggregated Comment Title: ***Quality Reporting Incentives and Disincentives***

Summary: CMS's Care Compare and public reporting burden place pressure on facilities to maintain perfect reporting to avoid payment penalties and maintain high public ratings, leading to providers being disincentivized from admitting patients with complex medical histories or non-compliant behaviors. Further, Care Compare does not display useful information for the public.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** American College of Surgeons; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Rescind Ownership/Additional Disclosable Party Disclosure for SNFs***

Summary: CMS should rescind the Final Reporting Rule, November 23, 2023 and related guidance on ownership/additional disclosable party disclosure by SNFs. The requirement places enormous reporting burdens on SNFs and additional processing responsibilities on MACs.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Aggregated Comment Title: ***Combine Auditing Bodies and CMS Contractors***

Summary: To simplify processes and improve efficiency, CMS should combine the four auditing bodies (RAC, SMERC, UPIC, and TPE) that providers receive audits from for Medicare Beneficiaries. Additionally, CMS should combine the four regions and two different contractors (Noridian and CGS) into one agency. By reassessing processes and contractors to minimize the number of entities involved, CMS can ease the administrative workload for providers and enable clinical staff to focus more on patient care. Too many contractors cause unnecessary provider and beneficiary burden and confusion, and it is often unclear where to submit certain claims or who to contact for assistance.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** American College of Surgeons; Diversified Service Options, Inc., dba GuideWell Source (Including First Coast Service Options and Novitas Solutions, Inc.); Michigan Home Health Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***Clarify Eligibility for SSBCI***

Summary: CMS should revise regulatory language regarding eligibility for Special Supplemental Benefits for the Chronically Ill (SSBCI) under 42 CFR §422.102, clarifying what constitutes an "objective method" for MAOs to demonstrate eligibility. Without clarification, MAOs could potentially adopt tools that do not align with CMS objectives. Additionally, consider removing the requirement in 422.102(f)(1)(i)(A)(2) that an enrollee have a high risk of hospitalization or other adverse health outcomes.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Organization(s): Highmark Inc.; The National MLTSS Health Plan Association

Aggregated Comment Title: ***Withdraw the Tukey Outlier Methodology***

Summary: CMS should withdraw the Tukey Outlier methodology to prevent the Star Ratings from penalizing consistently high-performing organizations and to ensure accurate reflection of plan quality. Its inclusion has led to decreased Star ratings without improving cut point stability significantly, potentially affecting beneficiaries' access to high-quality plans.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Aggregated Comment Title: ***Remove Limits on Psychiatric Care***

Summary: Reimburse for intensive outpatient mental health programs as an essential level of care. Further, align Medicare with mental health parity principles and remove the outdated 180-/190-day lifetime limit on inpatient psychiatric hospital care, in line with Executive Order 14192.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): Behavioral Wellness Group; Michigan Health & Hospital Association

Aggregated Comment Title: ***Streamline Reporting for Physicians***

Summary: Overly complex or impractical requirements lead to clinician burnout and reduced adherence to best practices. Streamline physician reporting by consolidating MIPS categories, lengthening performance periods such as a 24-month reporting cycle for clinicians who exceed performance thresholds, eliminating redundant elements in progress notes, and allowing flexibility in documentation.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** Infectious Diseases Society of America; Physicians Advocacy Institute; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Adopt a 'Report-Once, Use-Many' Model to Streamline Data Extraction from EHRs***

Summary: Adopting a "Report-once, use-many" digital model based on eCQMs and HL7 FHIR® involves using electronic clinical quality measures to extract data directly from certified EHRs, reducing the need for manual abstraction. CMS can explicitly align measure definitions, data elements, and file formats across programs, allowing the same digital evidence to satisfy multiple reporting requirements.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** BAYADA Home Health Care; Booz Allen Hamilton; Reveleer; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Mandating Separate NPIs for Each HOPD Creates Unnecessary Complexity and Burden***

Summary: Mandating separate NPIs for each Hospital Outpatient Department (HOPD) would impose redundant Medicare and payer enrollment processes, costly billing and EHR system reconfigurations, and extensive staff retraining. This policy could lead to unnecessary fragmentation, confusion, and risks in clinical care, claims processing delays, and errors, especially for hospitals with multiple off-campus departments, large systems, and rural providers. Furthermore, while the goal of improving data transparency and payment policy

enforcement is understandable, this would lead to operational challenges and administrative burdens for hospitals, payers, and claim clearing houses without clear benefits in payment integrity or transparency. The proposed change may not bring about the desired improvements and could instead create unnecessary complexities in the healthcare system.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Revising the Medicare Capitalization Policy***

Summary: Revise the Medicare capitalization policy to allow hospitals the option to adopt a $10,000 capitalization threshold, consistent with OMB's Uniform Guidance and prevailing accounting practice in the healthcare industry. This change would better reflect equipment costs, align with federal financial standards, and help providers accurately report costs in Medicare. Requiring providers to track capitalizable items below $10,000 results in significant administrative burden.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Data Requirements for the Drug Price Negotiation Plan are Burdensome***

Summary: CMS has requested various negotiation data elements for the drug price negotiation program, raising concerns about the burden of historical data gathering and exceeding necessary information collection. The collection of negotiation data elements fails to comply with the criteria outlined within the PRA. In addition to this, ICRs have required a significant volume of information that is in excess of the statutory requirements needed for the factor analysis, is overly focused on cost factors instead of the data requirements for the evidence required to assess a drug's value over time for the Medicare population, and imposes substantial requirements conflicting with current best business, financial and operational practices, and systems. CMS is requesting unnecessary amounts of data on a number of these resulting in overregulation and administrative burden on the Agency and manufacturers.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Annual Submission is Not Needed for All Measures***

Summary: Annual submission is not needed for all measures. Repetitive reporting adds to workloads with minimal impact on service quality. Other payers have less burdensome reporting requirements. Also, consolidate multiple payment sweeps and submission deadlines into a single, unified schedule.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): MLEM; Waukesha Co DHHS

Aggregated Comment Title: ***CMS Must Recognize Flaws with CPT Code 99024 and Postoperative Visit Reporting***

Summary: CMS relies heavily on flawed studies by RAND to justify continued postoperative visit reporting utilizing CPT code 99024. CMS should not base payment policy on the unsound methodology from the RAND studies because it will harm surgical practice and lead to unjustified payment reductions. Post-operative care by the operating surgeon is an expectation and a clinical imperative. This data collection initiative has proven ineffective, yielding incomplete and misleading information.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** The Society of Thoracic Surgeons

Aggregated Comment Title: ***Simplify Reimbursement Determinations***

Summary: Simplify and stabilize reimbursement determinations to equip providers with more accurate information about how much they will be reimbursed. This could also simplify billing. For instance, CMS should allow each billing provider to submit a good faith estimate (GFE) to the health plan for items and services that they will directly bill.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Aggregated Comment Title: ***Increase Flexibilities for the Administration of Immunizations***

Summary: CMS should approve pharmacy buy-and-bill and other immunizations for administration in clinician offices and reduce variation in where vaccines must be obtained. This would streamline services to beneficiaries and reduce challenges with documentation and duplication. Additionally, allow all vaccines to be administered in the physician's office, regardless of whether they are covered under Medicare Part B or Part D. Consolidating vaccine administration under Medicare Part B, regardless of coverage, would enhance patient access and care by eliminating confusion and barriers.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Aggregated Comment Title: ***Expand Telehealth Flexibilities Permanently***

Summary: Telehealth flexibilities have been extended permanently to include home services for new patients, domiciliary or rest home services for new patients, and initial nursing facility services. These services can now be effectively provided through real-time audio-video telecommunications technology. CMS should allow telehealth services to fulfill regulatory visit requirements for various healthcare needs such as behavioral health, hospice certification, and substance use disorder treatment.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Aggregated Comment Title: ***Patient Attribution in VBC is Burdensome***

Summary: Patient attribution is crucial in value-based care (VBC) models, but the current process is burdensome due to extensive documentation requirements and is often inaccurate. Incorrect attribution is difficult to rectify and complicates outreach to patients for preventive visits. CMS and payers need to share their attribution methodology, which should be transparent, continuous, accurate, and simple.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Hospital Association of Rhode Island; National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Deregulation Harms Patients***

Summary: Deregulation may harm patients and is discouraged. It is critical to distinguish between processes that create unnecessary complexity and those that are essential to patient safety, transparency, and accountability.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***Focus on Inclusion***

Summary: To improve alignment with industry best practices, Medicare should focus on comprehensive and inclusive innovation, considering patients with limited access to technology and language barriers. Transparency tools should be user-friendly for diverse populations to achieve optimal results. Additionally, in data collection efforts, capture and amplify the voice of the patient, especially those managing chronic health conditions.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***Burden from Hybrid Hospital Wide Mortality and Readmission Measure***

Summary: The burden of the Hybrid Hospital wide mortality and readmission measure on quality reporting teams has exceeded previous expectations outlined in final rules. CMS should remove the Hybrid Clinical/Claims-Based Quality Measures.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Aggregated Comment Title: ***Part D Collections for Underpayments***

Summary: Under 42 CFR 423.294(b) and (c)(1), CMS mandates Part D sponsors to refund incorrect premium and cost sharing collections and recover underpayments, excluding de minimis amounts. Sponsors must recover as little as $2, posing challenges due to resource-

intensive efforts for minimal amounts. Revisit the de minimis threshold to balance owed amounts and collection costs efficiently.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** AHIP; Humana; Triton Health Systems

Aggregated Comment Title: ***Expand Methods for C-SNP Verification of Chronic Conditions***

Summary: CMS should revise regulations to allow alternative verification methods for confirming eligibility of C-SNP enrollees with chronic conditions, addressing challenges in obtaining diagnosis confirmation from providers. CMS should amend 422.53(f) and MMCM Chapter 16b - 40.2 to reinstate expanded verification options. Inconsistent C-SNP eligibility verification requirements cause repeated documentation requests and enrollment delays. CMS can improve access by creating a managed hub, enabling data-sharing between carriers, and standardizing proof formats.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Organization(s): Humana

Aggregated Comment Title: ***Eliminate the "48-Hour Rule" for Insurance Agents***

Summary: Eliminate the "48-hour rule" that mandates insurance agents to wait two full days between receiving a signed Scope of Appointment (SOA) form and meeting with a beneficiary to discuss Medicare Advantage (MA) or Prescription Drug Plans (PDPs). This rule causes unnecessary delays in promptly following up with potential MA beneficiaries.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Aggregated Comment Title: ***Regulation 438.208 for ICPs is Ineffective***

Summary: In an effort to reduce administrative burden at 438.208, CMS should eliminate the requirement that MAOs send an Individualized Care Plan (ICP) to members who decline care management or are unable to be contacted. Additionally, sharing the ICP with providers and facilities is crucial for informing all parties about the member's health, but challenges like interoperability issues and low provider uptake lead to inconsistencies and gaps in the

member's care journey, hindering engagement in care management programs. Eliminating the requirement to share the ICP during a care transition could alleviate some burden.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Rescind Methodology for Evaluating Home Health Patient-Driven Grouping Model Budget Neutrality***

Summary: In response to the CY2022 Home Health Final Rule, some commenters believe CMS misinterpreted federal statute 1895(b)(3)(D)(i) of the Social Security Act regarding the evaluation of budget neutrality for the Patient-Driven Grouping Model (PDGM). CMS's methodology for assessing PDGM expenditures in 2020 did not align with the required focus on assumed behavior changes, including therapy thresholds. CMS should rescind this methodology and adhere to a budget neutrality approach based solely on the assumed behavior changes incorporated into the original 2020 rate setting, without additional payment adjustments that could impact home health agencies.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Concerns with Specialty Tier in Medicare Part D***

Summary: CMS should consider rescinding regulations allowing for specialty cost sharing tiers. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 allows Part D enrollees to request exceptions to plan formulary tiering decisions, aiming to ensure access to biotech products. However, the Part D final rule permits plans to exempt certain therapies from this exceptions process, leading to the unauthorized creation of the Specialty Tier. These tiers may discriminate against beneficiaries who require specific therapies, such as those with rare diseases. Furthermore, CMS incorporated this requirement into the final rule without providing an opportunity for public comment, which violated the Administrative Procedure Act. The statute and conference report do not indicate that the exceptions process was intended to be limited to specific therapies, highlighting the need for clarity and potential revision of regulations in this area. This process contradicts the procedure established by Congress and may limit beneficiaries' access to essential treatments.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** BIO

Aggregated Comment Title: ***Medical Necessity for Radiology and Referral-Based Specialties***

Summary: Referral-based specialties, like radiology, should be able to proceed with exams upon receiving a compliant order and authorization, without having to verify medical necessity for payment. A federal court ruled that medical labs do not need to independently verify the medical necessity of tests ordered by physicians for government health-care programs, a decision that may also apply to radiology orders.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reimburse CRNAs Fairly***

Summary: Reimburse CRNAs fairly to promote flexibility. CMS should not use licensure (i.e., CRNA vs. anesthesiologist) or temporary status (i.e., locums) as justifications for decreased or denied payment for the same service.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Organization(s): Excel Anesthesia, LLC

Aggregated Comment Title: ***Billing Process Burdens Providers***

Summary: The current billing process burdens providers, who often question if they will be paid. Providers must engage a billing organization to send bills, follow up, and respond to problems.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Organization(s): Booz Allen Hamilton

Aggregated Comment Title: ***Impact of Prior Authorization Burdens on SNFs***

Summary: Obtaining and maintaining prior authorizations for Medicare Advantage in skilled nursing facilities (SNFs) is burdensome, requiring frequent updates every two to three days and

placing strain on clinical and administrative staff, leading to the need for additional staff to manage the submissions and processes. This disrupts care continuity, contributes to workforce burnout, leads to avoidable hospitalizations, higher downstream costs, and inefficient use of Medicare funds. This can lead to patients staying in hospitals longer, increasing healthcare costs and straining hospital capacity. Similar challenges and risks are present with SNF readmissions. Skilled Nursing Facilities and Home Health Agencies are facing challenges with initial PAs not covering the full duration of required services, requiring multiple subsequent review requests for treatment continuation. This system is not only increasing costs but also causing delays and disruptions in patient care, highlighting the need for a more efficient and compliant approach.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); LeadingAge

Aggregated Comment Title: ***Allow Desk Review for Plans of Correction for Citations***

Summary: CMS should allow surveyors to conduct desk reviews of Plans of Correction (POC) for all citations, including those initially cited at the Immediate Jeopardy (IJ) level, as long as the IJ has been verified as removed and corrective actions have been implemented. This approach aligns with temporary flexibility granted during the pandemic to streamline the compliance process. Specific benefits include improving survey process efficiency, reducing burden on survey teams, maintaining oversight, and optimizing resources. Conducting desk reviews post-IJ removal is seen as a proportionate response for promoting risk-based oversight and decreasing administrative and logistical burdens for state survey agencies and facilities.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Determine and Disclose Cut Points for Star Ratings Before Measurement Period***

Summary: Reintroduce the mandate for CMS to determine and disclose measure-level and pre-determined cut points for Star Ratings measures well before the measurement period. The lack of predictability of performance expectations places a burden on Medicare plans in the form of financial pressure, administrative challenges, changing yet unclear standards, and stressed provider relationships. Setting cut points in advance would enable plans to better manage their

time, resources and efforts on prevention, wellness, and chronic disease and allow for greater Star Ratings methodological transparency.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** AHIP; Johns Hopkins Health Plans; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Expand Ability to Utilize Swing Beds***

Summary: Expand hospitals' ability to utilize swing beds. In 42 C.F.R. 482.58, limitations on swing bed use restrict hospitals from adapting to changing patient volumes and post-acute care demands.

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** American Hospital Association; Ascension; Illinois Health and Hospital Association; Louisiana Rural Health Association

Aggregated Comment Title: ***Use AI Tools to Improve Audit and Validation Processes***

Summary: Enable AI-driven tools to enhance audit readiness by automating chart audits and compliance validation processes. By proactively flagging gaps, summarizing documentation, and auto-generating submission packets for programs like MIPS, these tools reduce preparation time while maintaining human oversight.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Organization(s): Price Services Group, L.L.C.; Reveleer

Aggregated Comment Title: ***Build Organizational Capacity for eCQM Reporting***

Summary: CMS should assist smaller practices in enhancing their capacity to report electronic clinical quality measures (eCQMs), including providing funding to upgrade their technological infrastructure. In this process, CMS should carefully consider which standards to adopt, such as QRDA files versus HL7 Fast Healthcare Interoperability Resources (FHIR), to ensure that ACOs do not invest in technology that may become obsolete and hinder their continued participation.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; Epic Systems

Aggregated Comment Title: ***Relax Interpretation of Director Control***

Summary: CMS' should relax its interpretation of director control and remove the legal operator requirement at 42 C.F.R 413.85(f) to improve collaborations between hospitals and educational institutions, facilitating access to specialized expertise and resources. The current interpretation creates obstacles to partnerships. Reforms would streamline administrative processes, expedite program implementation, and enhance workforce development in nursing and allied health fields.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Hospital Association; Ascension; Illinois Health and Hospital Association

Aggregated Comment Title: ***Reduce CoP Burden to Improve Patient Care and Operations***

Summary: The Conditions of Participation (CoPs) in healthcare includes regulatory complexity, excessive documentation requirements and duplicative surveys that can lead to increased costs without improving care quality. These regulations also divert resources from patient care, operational improvement, and workforce support.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** American Psychiatric Association; Ascension

Aggregated Comment Title: ***Mental Health Documentation and Penalties for SNFs are Duplicative***

Summary: In 2023, CMS initiated schizophrenia audits to detect incorrect coding on MDS assessments. These audits are redundant and impose double penalties on nursing homes. The documentation requirements for mental health diagnoses, such as schizophrenia, place undue burden on nursing homes and duplicate physicians' existing responsibilities. The regulation

expects facilities to acquire or justify diagnoses already provided by licensed physicians, even for patients treated in other settings. This undermines clinical judgment and delays care.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Health Care Association (AHCA); LeadingAge; LeadingAge New York

Aggregated Comment Title: ***Establish a Clear Reporting Process for MA Plan Violations***

Summary: CMS should establish a clear process for providers to escalate suspected violations and resolve disputes between Medicare Advantage (MA) organizations and providers. Additionally, CMS should create a provider-specific electronic form that allows providers to report thousands of claims denied for similar reasons by a single MA plan in one batch, rather than requiring each claim to be submitted individually.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Revise Medicare Advantage Network Adequacy Standards***

Summary: CMS should revise MA regulations at 42 CFR 422.116 to allow greater flexibility in meeting network adequacy requirements through innovative delivery and payment models, including expanded use of telehealth and virtual care. Additionally, broaden the exception criteria to include provider shortages (e.g., behavioral health), non-cooperative provider contracting practices, geographic limitations, and other unique community characteristics. These reforms would modernize the network adequacy framework to reflect evolving care delivery methods and improve access for beneficiaries.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** AHIP; National Organization of Rheumatology Management; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Revise Homebound Status Guidelines***

Summary: Current definitions for Homebound Status exclude many chronically ill patients. This requirement limits access to preventative or less intensive home care services. CMS could remove the Homebound Status Requirement to expand access to appropriate care. Alternatively, CMS could revise the definition to increase the eligible population. Additionally, CMS should clarify guidelines regarding what constitutes reasonable absences from home for home health patients, such as common outings like attending religious services.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Aggregated Comment Title: ***Revise 45-Day Review Period of Medicare Advantage TV Ads***

Summary: The current 45-day review period for Medicare Advantage television advertisements has not effectively prevented misleading advertising and instead is causing delays. CMS should revert to a file-and-use review process with a shortened 10-15 day review period, similar to the process for replacement submissions. This change aims to maintain oversight while enabling compliant organizations to communicate with members more efficiently during critical enrollment periods.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** UCare

Aggregated Comment Title: ***Streamline Compliance and Ethics Program Requirements in LTC***

Summary: Streamline requirements for compliance and ethics programs for SNFs, as they are duplicative. CMS should modify the requirement for review of compliance and ethics programs for Long Term Care (LTC) facilities from annual to periodic reviews.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** DSHS/HCLA/RCS; PointClickCare

Aggregated Comment Title: ***Duplication in Claims and Quality Reporting***

Summary: Streamline quality reporting obligations without compromising oversight or quality measurement. Reduce unnecessary administrative burden by using claims data when possible and minimizing other self-reporting for quality measures.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** National Board for Certified Counselors (NBCC); Reveleer; Riverside Eye Center

Aggregated Comment Title: ***Prior Authorization for Specific Service, Not Specific Provider***

Summary: To improve efficiency and access to care, Medicare Advantage Prior Authorizations should be service-based rather than provider-based. This change would eliminate redundant requests, speed up service initiation, decrease administrative burden, enhance hospital throughput, and empower patients to choose providers once approved. By shifting the focus to clinical necessity, this approach aims to reduce inefficiencies and ensure timely care access for patients.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Psychiatric Association; LeadingAge; LeadingAge PA

Aggregated Comment Title: ***Demonstrating Compliance During Surveys is Complicated***

Summary: Demonstrating compliance during surveys involves extensive internal documentation, such as detailed QAPI records and care planning details, which is a complex preparation process. CMS could adopt interoperable data tools to monitor trends in real-time and reduce reliance on paper-based preparation. The intensive, multi-day survey also requires significant operational spending and diverts staff from their duties or improving care. QAPI and compliance plans demand volumes of paperwork that rarely translate to practical, day-to-day impact.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Aggregated Comment Title: ***Rethink Immediate Jeopardy***

Summary: Standardizing Immediate Jeopardy (IJ) criteria and implementing mandatory annual calibration for surveyors could reduce administrative burdens and improve credibility and equality in enforcement. Further, policies surrounding the timeline for investigation of IJ complaints are burdensome and should be reconsidered. CMS should align graduation criteria regarding IJ with those in the Hospice SFF Program, including that there should be no IJ citations on two consecutive surveys, all citations must be resolved, and there are no pending complaints involving IJ-level issues.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): American Association of Post-Acute Care Nursing (AAPACN); American Health Care Association (AHCA); Henry Ford Health

Aggregated Comment Title: ***Modernize QRP Data Processes***

Summary: CMS should modernize Quality Reporting Program (QRP) data workflows by automating two-way data exchange between certified electronic health record (EHR) systems and CMS using standardized interoperability protocols like Health Level Seven (HL7), Fast Healthcare Interoperability Resources (FHIR), or Direct Secure Messaging. CMS should also ensure better integration of clinical and administrative data.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Microsoft; PointClickCare

Aggregated Comment Title: ***Form-Specific Feedback for CMS-1500 OMB Control Number: 0938-1197***

Summary: CMS Form 1500 (OMB Control Number: 0938-1197) requires billing documentation data elements that are no longer clinically or operationally relevant, such as service location codes and redundant diagnosis linking for each procedure. CMS should simplify and streamline the process by allowing for real-time eligibility verification for Medicare beneficiaries, reducing the need for manual data entry and ensuring that the payer information is accurate before claims are submitted. Other changes that can help reduce redundancies include aligning requirements with documentation in electronic health records (EHRs), reducing the total number of required data points, eliminating low-value measures, and allowing clinicians to attest to specific activities or outcomes instead of documenting each data point in detail.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): American College of Physicians; Microsoft; Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***Revise Medically Unlikely Edits to be Consistent with Current Evidence***

Summary: CMS should make updates to bring Medically Unlikely Edits (MUEs) in line with current evidence including revising MUEs to align with FDA-approved dosing and clinical realities (e.g., J1602 to 400 units) and deleting the daily MUE of 1 to match NCD 270.3 and reduce administrative burden for HCPCS G0465.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** Alliance of Dedicated Cancer Centers (ADCC); Alliance of Wound Care Stakeholders ("Alliance"); National Organization of Rheumatology Management

Aggregated Comment Title: ***Unclear Standards for Psychologists Prior to Medicare Audits***

Summary: Psychologists face frustration due to unclear documentation and billing guidelines, leading to disruptive and financially threatening Medicare audits. The audits divert resources from patient care, penalizing psychologists for minor documentation errors. Varying requirements between Medicare Administrative Contractors and Medicare Advantage plans exacerbate the issue, resulting in recoupments based on undisclosed criteria.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Simplify and Automate Documentation Requirements for Physician Practices***

Summary: Physician practices are facing burdensome documentation requirements for services, hindering the provision of evidence-based care. Automating documentation processes and simplifying requirements could alleviate these challenges.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Aggregated Comment Title: ***Regulations Disproportionately Affect Small EHR Vendors***

Summary: Smaller EHR vendors face challenges due to the cumulative weight of regulatory requirements. The challenges include ONC Certification updates, eCQMs, and annual CMS rule changes. This burden disproportionately impacts smaller organizations that lack resources, which hinders innovation and market competition against larger vendors.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***General Packaging Rule and APC for Drugs***

Summary: CMS should make exceptions to its general packaging rule and Ambulatory Payment Classification (APC) and reimburse separately for certain drugs (especially those with high cost. low utilization) to ensure fair pricing and access for patients, similar to how they handle diagnostic radiopharmaceuticals. This action could decrease costs.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Photocure

Aggregated Comment Title: ***Streamline Plan of Correction Forms***

Summary: Plans of Correction (POC), like the CMS-2567 form, are overly complex and time-consuming and take away from implementing actual solutions and patient care. Further, there are sections of the form that are inaccessible and/or irrelevant, arguing for an update. CMS should create a centralized system with pre-approved corrective actions for common deficiencies to streamline the POC process.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): Amedisys, Inc.; Kona Community Hospital; Oak Lane Nursing & Rehab

Aggregated Comment Title: ***Streamline the Process for Adding Services to the List of Telehealth Services***

Summary: CMS should limit the review requirements for determining whether a service can be provided using an interactive, two-way audio-visual telecommunications system to streamline

the process for adding services to the List of Telehealth Services. Additionally, removing the distinction between provisional and permanent services would further streamline the process.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Intersocietal Accreditation Commission

Aggregated Comment Title: ***Utilize ESRD Networks to Oversee EQRS Data***

Summary: To improve oversight of EQRS data, CMS should utilize ESRD Networks in managing and accessing the data, while leveraging ESRD QIP to monitor program quality. By consolidating data across ESRD Programs, CMS could eliminate redundant programs, streamlining operations and enhancing efficiency in the management of ESRD. Additionally, dialysis facilities should report directly into EQRS so CMS has the data needed, and Networks should use data within the EQRS system to eliminate any additional reporting.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Berkshire Medical Center

Aggregated Comment Title: ***Reduce Burden of Dialysis Facility Core Survey Data Requirements***

Summary: Core Survey requirements place significant burden on dialysis facilities. Specifically, burdensome requirements include retaining three months of lab data for all patients, including outliers, and providing it within three hours of the survey's commencement' maintaining patient hospitalization records for six months; and requiring the initial comprehensive assessment and care plan within 30 days of a patient starting dialysis.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Berkshire Medical Center

Aggregated Comment Title: ***Duplicative Oversight***

Summary: Medicare providers face duplicative oversight from various entities, leading to inefficiencies, legal violations, over-reporting, audit fatigue, data conflicts, and reduced provider participation in federal programs. This situation highlights structural issues and regulatory challenges within the system.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** BAYADA Home Health Care; CPAC Foundation Center for Regulatory Freedom; Kingdom Insurance Group

Aggregated Comment Title: ***Review Agent/Broker Requirements to Educate Members***

Summary: Regarding CY2026 Medicare Advantage (MA) Proposed Rule (CMS-4208-F), CMS should provide additional clarity on these new requirements: specifically, the requirement that agents/brokers "pause" to allow customers to seek additional clarity. CMS should refine and update requirements for agents and brokers to provide education on the value and effect of integrated care options. CMS should review current requirements and look for opportunities to streamline and shorten them to avoid overwhelming and burdening beneficiaries.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): NABIP, HAFA,; Price Services Group, L.L.C.

Aggregated Comment Title: ***Eliminate Enrollment "Seasons"***

Summary: Eliminate enrollment periods, also known as "seasons," both from CMS oversight and all together. These time restrictions are burdensome.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Kingdom Insurance Group; WelbeHealth

Aggregated Comment Title: ***Waive Requirements for Billing for Advanced Primary Care Management***

Summary: CMS should waive requirements associated with billing for advanced primary care management (APCM) for all providers in ACO arrangements.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Accountable for Health; America's Physician Groups (APG); American Academy of Family Physicians

Aggregated Comment Title: ***Ongoing Communication and Coordinating Services for APCM Should be Optional***

Summary: 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 should be optional (not required) with community-based social services providers.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Allow Annual Wellness Visits on Calendar Year and Waive Requirement for ACOs***

Summary: Annual Wellness Visits (AWVs) should be scheduled based on a calendar year schedule that resets on January 1st each year to allow providers to bill for one AWV per calendar year, eliminating the requirement for visits to be more than 365 days apart. This would reduce administrative burdens and improve care quality. Additionally, CMS could waive the one-per-year requirement for ACO participants who are accountable for patient quality and total cost of care and do not rely on this metric.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Accountable for Health; America's Physician Groups (APG); PSW and MultiCare Connected Care

Aggregated Comment Title: ***Allow Verbal Election of Hospice Care in Special Circumstances***

Summary: CMS should allow representatives to verbally elect hospice care when they are unable to physically sign the Medicare hospice election statement or when administrative changes are needed. This should only apply when the beneficiary cannot make healthcare decisions and the legal representative is unavailable to sign, and such circumstances should be documented in the medical record. To ensure the process's integrity, CMS should require the representative's signature within a reasonable timeframe, such as 10 days, after the verbal election or administrative change, unless the beneficiary dies, revokes, or is discharged.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** National Alliance for Care at Home

Aggregated Comment Title: ***Diagnosis Code Limit on Inpatient Claims Causes Burden***

Summary: The current limit of reporting 25 diagnosis codes on hospital inpatient claims poses challenges for hospital staff who must manually select and prioritize which codes to report. The manual approach remains inefficient, time-consuming, and resource-intensive for hospitals, and the current limit may inadvertently penalize institutions caring for more medically complex patients. CMS should consider significantly increasing the 25-diagnosis code limit submitted with claims.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Vizient, Inc.

Aggregated Comment Title: ***Allow Medicare Beneficiaries to Opt-In to All Digital Communications***

Summary: Allow Medicare beneficiaries to opt-in to all digital communications at once, rather than requiring individual opt-ins for each communication from health plans. This change would streamline the process for both beneficiaries and plans, potentially saving government money by reducing administrative costs associated with physical mailings. By implementing an umbrella digital opt-in option, CMS could simplify Medicare communications and improve efficiency in delivering important information to members.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** America's Physician Groups (APG); SCAN Health Plan

Aggregated Comment Title: ***Increase Flexibilities Around Opting Out***

Summary: The MACRA statute of 2015 aimed to reduce regulatory burdens on physicians who opted out of Medicare, but corresponding regulations impacting patients' private contracts with

opted-out physicians were not properly revised. CMS should revise 42 C.F.R. § 405.415(h) and revoke (o) to provide flexibility for patients and physicians in contract length, aligning with deregulation efforts. Further, providers should not be required to opt out in order to accept cash payments from Medicare patients.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Association of American Physicians and Surgeons; Essentia Health; Prosper DPC

Aggregated Comment Title: ***Reconsider S-10 Audit Requirements***

Summary: CMS initially indicated that S-10 audits would not be conducted annually, but providers continue to experience yearly audits. Additionally, some MACs prefer the old methodology for S-10 Audits and are not utilizing the Charity Care and Bad Debt exhibits 3B/3C. If a MAC is going to use the old methodology to perform their audit, then providers should not have to put unnecessary effort into schedules that are rendered meaningless. Simplify the formula for DSH/S-10 to reduce complexity.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Ohio Hospital Association; Tampa General Hospital - Tampa, FL; The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Eliminate SNF Recertification Requirement***

Summary: CMS should eliminate the SNF recertification requirement on day 20. The requirement adds administrative load without improving care quality.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Reduce Frequency of Changes to Risk Score Analyses and Adjustments***

Summary: Reduce the frequency of conducting and implementing changes to risk score analyses and adjustments under the Medicare Advantage program to alleviate administrative burden. The modifications to risk adjustment models, coding patterns, and benchmarks have created challenges for providers and take time away from patient care.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Booz Allen Hamilton; Sutter Health; The American College of Cardiology

Aggregated Comment Title: ***Standardize CPT and HCPCS Code Sets Across All Payers***

Summary: Standardizing CPT and HCPCS code sets across payers would simplify reporting, improve data consistency, and reduce claim denials caused by coding errors.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Ascension; Healthcare Association of New York State; University of Vermont Medical Center

Aggregated Comment Title: ***Burdensome Outpatient Surgery Measures***

Summary: Hospitals face significant burdens with quality reporting requirements. Candidates for elimination include Patient Understanding of Key Information Related to Recovery After Outpatient Surgery (PRO-PM) and OP-36: Hospital Visits after Outpatient Surgery. These measures are challenging to collect.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Florida Hospital Association

Aggregated Comment Title: ***Suspend Hospital Star Ratings***

Summary: CMS should suspend the Hospital Star Ratings program and initiate a transparent, collaborative process to develop a more accurate and equitable model.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Federation of American Hospitals; Florida Hospital Association

Aggregated Comment Title: ***Improve Medicare Advantage Oversight***

Summary: CMS should improve oversight of Medicare Advantage to align payment and compliance requirements. For instance, regarding the Two-Midnight Rule and the SNF 3-Day Rule, some MA plans routinely second-guess providers' clinical judgment, demanding extensive documentation to justify inpatient stays and SNF transfers.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** AVIA-Leavitt Partners Nexus Collaborative; Kansas Hospital Association; LeadingAge

Aggregated Comment Title: ***Create Parity Between Marketing Rules for ACOs and Medicare Advantage (MA)***

Summary: Create parity between marketing rules for ACOs and Medicare Advantage (MA) by modifying the definition of Marketing materials and activities for ACOs at 42 CFR 425.20 to align with the intent and content standards for MA plans under the definition of Marketing at 42 CFR 422.2260. This would enable ACOs to create more educational resources for beneficiaries.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): National Association of ACOs; PSW and MultiCare Connected Care

Aggregated Comment Title: ***Challenges with Physician Certification Statement for Ambulance Services***

Summary: Obtaining a Physician Certification Statement (PCS) for ambulance services from CMS can be challenging due to the lack of specific requirements or a mandated form. Contractors have the discretion to determine if the provided PCS contains the necessary information to support a claim, sometimes offering vague guidance. Signatures may be rejected if they do not meet subjective requirements, creating a burdensome review process for healthcare providers. This ambiguity can lead to frustration and uncertainty for those seeking reimbursement from Medicare. 42 CFR § 410.40(e)(2)(i) should be revised to remove a physician certification

statement as a condition of payment for nonemergency, scheduled, repetitive ambulance services.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Ease Restrictions on Registered Dietitians***

Summary: Registered Dietitians face challenges in participating in Medicare Advantage (MA) networks due to credentialing denials, despite recognition for Medical Nutrition Therapy (MNT) under Part B. MA plans' unclear denial processes and lack of patient notification on financial liability create barriers for RDs to deliver MNT services, impacting both providers and beneficiaries.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Academy of Nutrition and Dietetics

Aggregated Comment Title: ***Reduce Restrictions on Behavioral Health Services***

Summary: Partial Hospitalization and Intensive Outpatient Programs (IOPs) for behavioral health services face billing limitations under Medicare, restricting access for beneficiaries. The current billing structure only allows for group therapy reimbursement per day, while the typical program runs at least 3 hours per day. This limitation hinders sustainability for IOP providers and prevents Medicare beneficiaries from accessing crucial care, potentially leading to more costly treatment options like inpatient hospitalization.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Ease Requirements for Patients with Psychiatric Conditions***

Summary: Requirements for patients with psychiatric conditions are often burdensome and/or unclear, as in the case of regulations surrounding ligature risk. Further, hospitals face financial strain due to the mandatory one-on-one sitters for patients with suicidal ideations, often requiring RNs to fill this role. Moreover, some requirements may not be suitable for all patient populations. For example, the requirement for a one-hour face-to-face evaluation is not

appropriate for a patient who has been placed in violent restraint due to non-psychiatric factors, such as substance abuse or developmental delays. Suggestions include the use technology to monitor patients; or allow one sitter to cover two rooms with a clear line of sight; and waive or modify the one-hour face-to-face requirement for violent restraints in cases where the evaluation will not provide therapeutic benefit. These solutions aim to address staffing challenges and reduce costs while ensuring patient safety.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Auditors Should be Accountable for Review Rate***

Summary: CMS should monitor and publicly report denial and overturn rates to enhance oversight, which would lessen the administrative burden on hospitals, especially during discharge planning and post-acute transitions, while maintaining safety and fiscal accountability. If an auditor consistently fails claims in the initial review that are later overturned in the redetermination phase, then the auditor should be held accountable for their mistakes.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): American College of Surgeons; CrownQuest Inc

Aggregated Comment Title: ***Allow Same-Day Billing and Expand Bundled Payments***

Summary: Allow same-day billing and expand bundled payments for behavioral health and psychiatric care. Simplifying coding and removing restrictions would support better coordination, reduce provider burden, and improve patient outcomes.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Allow Advanced Practice Providers to Certify SNF Stays***

Summary: Current process mandates that an MD or DO certify a SNF stay, potentially placing patients' care in the hands of providers who may not be familiar with their needs. This is particularly critical in rural areas with limited MD/DO availability, where Advanced Practice Providers (APPs) often play a vital role in community healthcare. Additionally, authorize NPs to perform all mandatory SNF assessments as a permanent Medicare policy.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** American Association of Nurse Practitioners; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Allow NPPs to Conduct Required Visits in Skilled Nursing Facilities***

Summary: Revise the guidance in 42 CFR 483.30(b)-(c) to allow non-physician practitioners (NPPs) to conduct required visits and sign orders under physician supervision in nursing and skilled nursing facilities, regardless of their employment status. Currently, physicians are mandated to visit residents every 30 days for the first 90 days post-admission and every 60 days thereafter, but this proposal aims to expand the scope of practitioners who can fulfill these requirements.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); LeadingAge PA

Aggregated Comment Title: ***Remove Burdensome Quality Measures***

Summary: CMS should repeal quality measures that impose excessive burdens, especially on Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs).

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Highlands Oncology Group, P.A.; Pennsylvania Health Care Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***Direct MA to Approve Authorizations for Care Permitted Under Medicare***

Summary: Medicare Advantage Organizations (MAOs) must offer all Traditional Medicare benefits to beneficiaries, but they often use authorization requirements to deny access to Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs), causing delays in necessary care and burdening healthcare providers with repeated authorization requests and

appeals. CMS should revise its rules to require Medicare Advantage Organizations (MAOs) to authorize admissions to LTCHs and IRFs in line with Traditional Medicare guidelines. This change aims to ensure consistent access to care across different Medicare plans.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Eliminate MDS A1250 for SNFs***

Summary: MDS A1250 questions regarding transportation should not apply to nursing homes. It is unnecessary and burdensome as patients' responses do not change throughout their admission.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Maplewood of Cheshire County; Select Medical Holdings Corporation

Aggregated Comment Title: ***Redundant FIDE-SNP Application Processes***

Summary: The enrollee application process for Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) necessitates separate applications and approvals from Medicare and Medicaid. This duplication causes confusion and frustration for beneficiaries, particularly those with complex needs, and leads to wasted administrative resources due to misaligned timelines and redundant processes.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Antibiotic Stewardship Program Needs Overhaul***

Summary: While antibiotic stewardship remains crucial, CMS should overhaul the program to address challenges and ensure appropriate care for residents. Providers may hesitate to prescribe necessary treatments due to administrative burdens and fear of legal liabilities, impacting antibiotic stewardship efforts. Balancing regulatory requirements with effective treatment decisions is essential to improve patient outcomes and combat unnecessary medication use.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Maplewood of Cheshire County; Oak Lane Nursing & Rehab

Aggregated Comment Title: ***Eliminate Physician Oversight Requirements for APPs***

Summary: Eliminate the requirement for Advance Practice Providers (APPs) to have collaborative agreements with and/or note sign-off from physicians, since they are allowed to practice independently under state law. Requiring physician visits, such as for LTC residents, incurs added cost.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): American Nurses Association; Eventus WholeHealth

Aggregated Comment Title: ***Enrolling in Medicare is Overly Complex***

Summary: Enrolling in and opting out of Medicare are convoluted and poorly explained processes, resulting in high costs for organizations to complete the process. Required tasks take substantial time and response times for correspondence are excessive.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Sanford Health

Aggregated Comment Title: ***Implement Universal Billing Code Sets***

Summary: Implementing universal and up-to-date billing code sets across payers can help reduce billing errors and costs.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Medicare Must Recognize and Support Modern Standards***

Summary: Medicare needs to shift from a compliance-driven model to a capability-enabling model, particularly in ambulatory settings. Clinicians in outpatient environments are already adopting modern standards like virtual visits and coordinated care teams, but Medicare's recognition and support for these practices needs to improve to streamline documentation and enhance care delivery. CMS can issue guidance for integrated care systems by offering flexible interpretations of existing Conditions of Participation (CoPs) to support innovative care models.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Streamline Promoting Interoperability Program's Health Information Exchange Objective***

Summary: CMS should make targeted changes to Promoting Interoperability Program's Health Information Exchange (HIE) Objective by eliminating the TEFCA Manner Exception in the information blocking regulations. This aims to prevent regulatory preference for one exchange model and reduce the risk of vendor lock-in within the health information technology ecosystem. Reframing the HIE Objective to prioritize real-world, outcome-based metrics over rigid models directing participation in specific interoperability frameworks would offer more flexibility.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Datavant

Aggregated Comment Title: ***Adopt Concurrent Validation Surveys***

Summary: Validation surveys cause rework and disruption for hospitals. CMS should eliminate lookback surveys and use concurrent validation surveys for direct observation of AO performance.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Ascension; Georgia Hospital Association; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Allow Accrediting Organizations to Provide Same-Day Notification for Surveys.***

Summary: Remove the restriction on accrediting organizations giving same-day notification for survey conducting. This will maintain survey quality while ensuring adequate staffing and resources during surveys.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Illinois Health and Hospital Association

Aggregated Comment Title: ***OQR Reporting is Overly Complex***

Summary: Documentation and reporting requirements for the Outpatient Quality Report (OQR), OMB Control Number 0938-1203, are overly complex.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Microsoft; Ohio Hospital Association; Piedmont Healthcare

Aggregated Comment Title: ***Outdated CMS Thresholds Create Cost Reporting Challenges***

Summary: Failure of CAHs to align with outdated thresholds set by the CMS may require adjustments to reported operating expenses, causing administrative complexity, delays in cost report settlement and inconsistencies in audits. Similarly, raising the capitalization threshold for SNFs could impact cost treatment within the capital rate component, but this is offset by the exemption of capital add-ons from state-set operating cost limits.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Data Collection Requirement Burdens Resource Limited CAHs***

Summary: The CMS requirement to report detailed therapist-level data places a disproportionate administrative burden on Critical Access Hospitals (CAHs), which often lack the financial and IT resources to comply. Because therapy services are typically outsourced under flat-rate or bundled contracts, CAHs do not have routine access to individual therapist schedules. Reconstructing this data retroactively is labor-intensive and provides minimal value under the existing cost-based reimbursement model, which already requires direct cost reporting for services under arrangements in Worksheet A, Lines 7376. Additionally, CMS should remove the requirement for Worksheet A-83, as its complexity delays cost report completion and diverts resources from patient care and operational improvements.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Streamline Reporting of Negotiation Data Elements for Drug Price Negotiation Program***

Summary: Streamline the reporting process for the Negotiation Data Elements in the Drug Price Negotiation Program by eliminating redundant data submissions and reducing unnecessary reporting burdens that go beyond statutory requirements. CMS could simplify R&D reporting requirements by allowing Primary Manufacturers to attest when R&D costs have been fully recouped for a drug. In cases where costs have not been recouped, manufacturers should have flexibility in their responses to align with financial practices, reducing unnecessary information collection. This approach aims to minimize the burden of data submission while meeting statutory requirements.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Johnson & Johnson; PhRMA

Aggregated Comment Title: ***Revise Risk Adjustment Model for Medicare Advantage***

Summary: The current CMS risk adjustment model relies solely on FFS Medicare data, which is not suitable for Medicare Advantage plans and allows insurance companies to exploit upcoding, leading to challenges for providers and patients. Shift to a risk adjustment model based on Medicare Advantage data to address these issues. Making this shift would enhance program integrity by mitigating insurers' coding abuses, lessening administrative burdens for providers, and alleviating financial strain on patients due to upcoding.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Codify NCDs and LCDs in Interoperable Format***

Summary: Technical solutions for systematic consumption and implementation of guidelines is lacking.
CMS should codify National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) in a standardized, interoperable format (FHIR-based) and make them

publicly available. This would ensure consistency across payers, reduce duplicative efforts, and support the broader goals of interoperability, provider burden reduction, and patient-centered care.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Eliminate Redundant Documentation Requirements in Risk Adjustment and Value-Based Care Programs***

Summary: In the risk adjustment and value-based care space, a major administrative challenge is the need for physicians to continuously resubmit documentation for conditions already present in claims data.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** National Association of ACOs (NAACOS); Reveleer; Society of General Internal Medicine

Aggregated Comment Title: ***Refine Standards for Inpatient Bed Designation Under 42 CFR 485.620***

Summary: 42 CFR 485.620 limits Critical Access Hospitals (CAH) to 25 inpatient beds, but SOM associates how beds are counted based on their use. Recommendations suggest that surveyors should focus on the actual use of inpatient beds at any given time, rather than how they are designated or deployed as an OBS (or other outpatient) bed.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate QW Modifier for Laboratory Billing for CLIA-Waived Tests***

Summary: Eliminate the requirement for laboratory providers to use the QW modifier when billing for tests that have been waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The process causes delays and burden for labs. Medicare is the only payer that blanket-requires the QW modifier. Certificate of Waiver laboratories are unable to bill Medicare

for "waived" tests until CMS updates its list with the necessary information, including the test name and associated CPT code requiring a -QW modifier.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** AdvaMed; Biomerieux; Danaher Diagnostics

Aggregated Comment Title: ***Streamline CEHRT Updates for MIPS***

Summary: CEHRT requires health IT vendors to apply multiple updates to their certified products, including for MIPS reporting. This adds to the already intense process of maintaining certified electronic health technology products, necessitating more work hours. Some providers report that vendors pass these compliance costs onto providers. Streamlining the CEHRT process could enhance user-friendly platforms while maintaining effectiveness.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Net Health; Physicians Advocacy Institute; VillageMD

Aggregated Comment Title: ***Eliminate Duplicate Penalties Under HRRP, VBP, and Other Programs***

Summary: Certain occurrences are penalized for the same readmission event or incident/violation under multiple programs, undermining fairness and disproportionately impacting low-volume providers. Specifically, 42 CFR 488.430 contains authority to impose duplicative penalties for nursing homes. These policies threaten facility viability and do not adequately weigh provider intent, compliance history, or severity of harm. CMS should rescind the FY 2025 changes and instead adopt a sliding-scale penalty model, safe-harbor mitigation for prompt self-correction, and greater transparency.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Advocating for Seniors; LeadingAge New York

Aggregated Comment Title: ***Challenges to Critical Care Reimbursement***

Summary: Providers encounter challenges like limited billing codes, underpayment for services, and regulatory hurdles, making it hard to receive reimbursement for critical care under Medicare.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Simplify Billing for FQHCs/CHCs***

Summary: Billing policies for Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs) require them to report detailed HCPCS coding for all services provided during an encounter, including identifying the qualifying visit and line-item charges. Manuals guiding this process are outdated. This adds administrative complexity. Further, some Medicare Administrative Contractors require separate claims for medical and behavioral health services. Certain behavioral health, telehealth, and procedure-only visits, especially when these services are clinically appropriate and independently billable in other settings, should be included in the qualifying visit list. This would solve the billing complexity for CHCs that do not exist for other providers.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Align Health Center Fee Schedule with Medicare Physician Fee Schedule***

Summary: Updating the health center Prospective Payment System (PPS) to match the Medicare Physician Fee Schedule (MPFS) can ensure that Community Health Centers (CHCs) receive full reimbursement for the affordable and high-quality services offered to Medicare beneficiaries.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Streamline Guidance for Providers and Medicare Administrative Contractors (MACs)***

Summary: Streamline guidance for providers and Medicare Administrative Contractors (MACs) to ensure health centers receive timely wrap-around payments, including removing the restriction on hospitals choosing a different MAC.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Complying with 340B Policies is Burdensome***

Summary: Health centers find complying with 340B policies burdensome. Identifying prescriptions eligible for 340B drugs is complex and data-intensive, often impossible at the point of sale. Implementing point-of-sale identification for 340B drugs is challenging due to the need to correct misclassified claims, adding to administrative workload. Health centers are also concerned about the lack of any agency as a clear arbiter for 340B claims verifications and request that CMS clarify how it will arbitrate the enforcement of such verifications.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of Community Health Centers (NACHC); The Wright Centers for Community Health and Graduate Medical Education

Aggregated Comment Title: ***Align Advanced Practitioners in Specialty Categories***

Summary: CMS should align its approach for advanced practitioners with AMA guidelines by categorizing them within specific specialties rather than as general providers. This alignment would be consistent with existing CMS policies like Split/Shared billing rules. CMS should further streamline extensive documentation requirements to bill split/shared visits under a physician rather than an advanced practice provider.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Cleveland Clinic; Healthcare Business Management Association; Sanford Health

Aggregated Comment Title: ***Update Insulin Pump Coverage Policy***

Summary: CMS must update the insulin pump coverage policy to align with current evidence, as the existing criteria, last updated over 20 years ago, poses barriers for individuals with Type 2 diabetes who are insulin-dependent. CMS should quickly update this policy, as the request was submitted over three years ago, highlighting the need to remove the C-peptide testing requirement.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Diabetes Technology Access Coalition (DTAC); The Helmsley Trust

Aggregated Comment Title: ***Transition to an eCQM to Reduce SEP-1 Administrative Burden***

Summary: There are opportunities to simplify and improve reporting for Medicare providers in sepsis care by transitioning from the resource-intensive SEP-1 measure to a more streamlined electronic process measure, such as the "ID to IV" measure. This new measure focuses on timely antibiotic administration for patients with hypotension, aligning with the Surviving Sepsis Campaign's recommendations and showing improved patient outcomes. By utilizing existing EHR data and vital signs, this approach reduces administrative burden, allows for real-time process improvement, and can be applied to all sepsis patients, regardless of when sepsis develops. Transitioning to electronic, high-impact measures like ID to IV can enhance patient care while alleviating provider burden.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Hartford Healthcare; Providence Health and Servicess

Aggregated Comment Title: ***Non-integrated Data Systems Create Burden***

Summary: Non-integrated data systems require manual data entry into multiple non-communicating portals, leading to burnout, missed information, communication gaps, and reduced provider-patient interaction. CMS should consider how to integrate enrollment and certification data systems and processes between HHS agencies and subagencies that maintain data utilized by CMS programs to evaluate provider eligibility for specific programs.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** BJC Health System; Healthpilot; Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***High-Cost Disposable Supplies***

Summary: High-cost disposable supplies in the Medicare Physician Fee Schedule often do not cover the actual purchase and service delivery costs and should be removed from the MPFS and assigned their own HCPCS codes. Budget neutrality requirements lead to reduced reimbursement for all providers, causing unfair cuts for some specialties like occupational therapy.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Occupational Therapy Association

Aggregated Comment Title: ***Low Vision Exclusions Limit Care***

Summary: The 2008 CMS "Low Vision Aid Exclusion" restricts Medicare coverage for vision aids using lenses, causing denial of medically necessary low vision aids prescribed by qualified clinicians for functional use and increased administrative burden. The lack of proper support for individuals with low vision leads to poorer health outcomes and strain on the health system.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Occupational Therapy Association; Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition's Low Vision Subgroup

Aggregated Comment Title: ***Unintended Consequences of HITECH***

Summary: The Health Information Technology for Economic and Clinical Health (HITECH) Act encouraged physicians to adopt EHRs, improving legibility and access to medical records. However, strict regulations have led to unintended consequences, with providers using subpar and cumbersome CEHRT products focused on meeting CMS requirements rather than adopting more beneficial technology. The needs of some niche providers, such as occupational therapists, are not met by health IT vendors.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP); American Occupational Therapy Association; Connected Health Initiative

Aggregated Comment Title: ***Implement Electronic Standardization to Reduce Prior Authorization Burden***

Summary: Standardizing the prior authorization (PA) process across health plans can be streamlined by electronically exchanging information, reducing the complexity and time required for PA approvals. Efforts are being made to streamline and automate the prior authorization process by integrating a centralized record for all relevant information into electronic health records.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** America's Essential Hospitals; American Association of Orthopaedic Surgeons; American College of Osteopathic Family Physicians (ACOFP); Association of American Medical Colleges; Society for Gynecologic Oncology

Aggregated Comment Title: ***Eliminate the Meaningful Use Program***

Summary: Eliminate the Meaningful Use program as it has outlived its usefulness. Return to a model that provides financial incentives and technical support for rural hospitals to comply rather than penalizing non-compliance for meaningful use of certified EHR technology to receive Medicare reimbursements.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Illinois Health and Hospital Association; Louisiana Rural Health Association

Aggregated Comment Title: ***Remove Contracted Provider Telehealth Requirement for Medicare Advantage***

Summary: CMS should remove the contracted provider telehealth requirement for Medicare Advantage plans that mandates that additional telehealth benefits can only be offered through contracted providers, with coverage by non-contracted providers allowed as a supplemental benefit. This policy imposes administrative and contracting burdens without improving patient safety or care quality.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Devoted Health

Aggregated Comment Title: ***Remove C-SNP Plan Enrollment Requirement for Provider Attestation in 42 CFR 422.52(f)(1)***

Summary: Enrolling individuals in Chronic Special Needs Plans (C-SNPs) requires MA organizations to confirm qualifying conditions with the applicant's healthcare provider, causing a burden and potential disenrollment. Furthermore, this rule necessitates plans to verify member eligibility with a provider-signed form, which puts members at risk of disenrollment for those who may struggle to secure a provider signature promptly. A recommendation to update regulations suggests using existing data like claim records or medical charts to validate chronic conditions, reducing provider burden and beneficiary disenrollment due to non-response.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Devoted Health; UnitedHealthcare

Aggregated Comment Title: ***Use Risk-Stratified Model for Individualized Care Plan (ICP) for SNP Members***

Summary: Implementing a risk-stratified model for Individualized Care Plan (ICP) planning in SNP would ensure that resources are allocated efficiently by allowing lower-risk members to engage at a suitable level while focusing more resources on higher-risk members. This approach prevents burdening lower-risk members and ensures that those with greater needs receive the necessary support and attention.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enable MA Plans to Use Electronic Communication for Timely and Accurate Member Outreach***

Summary: Allowing MA plans to use electronic communication, like email and secure messaging through member portals, are more likely to reach members promptly and accurately. CMS should clearly define when electronic means of communication from payer to member/provider can be used in place of US Mail or fax. By shifting to electronic communications as the default,

Medicare plans lower overhead costs and allocate those savings towards enhancing member services and improving quality. This shift is crucial as Medicare plans are increasingly expected to do more with limited administrative budgets.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Agadia Systems; DentaQuest

Aggregated Comment Title: ***Give MAOs Flexibility in Providing Translated Materials and Alternative Material Formats***

Summary: Revise 422.2267 and 423.2267 (Translated Materials) to enhance flexibility for Medicare Advantage Organizations (MAOs) in offering translated materials and accessible formats, like screen readers and real-time verbal translations, to beneficiaries. This adjustment seeks to improve service timeliness, reduce costs, and administrative burdens while ensuring beneficiary needs are met effectively.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Home Care Alliance of Massachusetts; Humana; UnitedHealthcare

Aggregated Comment Title: ***Modernize Medicare Claims Processing System***

Summary: The billing and claims processing infrastructure, specifically regarding Medicare's refusal to accept CPT Modifier 33 for preventive services, creates unnecessary complexity for providers. By modernizing Medicare's claims processing systems to recognize Modifier 33, thousands of hours of administrative time spent on differential billing could be eliminated.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Alabama Hospital Association; Health Alliance Plan of Michigan

Aggregated Comment Title: ***Difficulties with Part C & D Contracting***

Summary: The Part D contracting process is fundamentally flawed. Bids for Part C and D contracts are time-consuming and could be streamlined. CMS should offer multi-year contracts with contract amendments to reduce big submission burdens.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Senior Care Pharmacy Coalition: SCPC

Aggregated Comment Title: ***Restrictions on Assessments Delay Care and Increase Provider Burden***

Summary: According to the staffing requirements outlined in 484.55(a)(2) and (b)(3), only nurses are permitted to conduct initial and comprehensive assessments. This restriction creates an unnecessary burden on providers and can delay the start of care for patients due to nursing shortages. Further, CMS should extend the timeframe for completing the recertification assessment to 7 days (or 5 business days) to allow for more flexibility.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Adara Home Health; LeadingAge

Aggregated Comment Title: ***Streamline Requirements When Radiology Report is Required for Payment***

Summary: To streamline the process of providing necessary clinical documentation for payment, CMS should establish standards for electronic attachments and identify payment requirements before conducting the study to avoid withholding payment. Payors should accept electronic claims with attached radiology reports or other forms of electronic messaging to ensure timely payment without burdening providers with excessive documentation costs.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***Rethink the IRMAA Process***

Summary: Streamline the Income-Related Monthly Adjustment Amount (IRMAA) process to be less onerous and more thoughtful in the application of adjustments. Form SSA-44 is a lengthy document that is overly complex or burdensome.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Honor MA Prior Authorization Decisions***

Summary: MA plans conduct retroactive audits that recoup payments from previously authorized admissions. This disruptive practice penalizes providers after securing authorization, which creates financial instability for and undermines the integrity of the authorization process. CMS should require MA plans to honor prior authorization decisions. This would significantly reduce administrative strain on providers, improve efficiency within our healthcare system, and promote consistency and fairness in reimbursement policies.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Reliable Medical Supply

Aggregated Comment Title: ***Withdraw Cybersecurity Rule for PHI***

Summary: Withdraw the proposed HHS OCR HIPAA Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information. Instead, initiate a stakeholder process to create a new cybersecurity regulatory framework. HHS explicitly declined to include considerations or flexibilities for rural hospitals and clinics despite acknowledging that they will have a more difficult time complying with the proposed regulations.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Modify the MDS to Capture more Clinically Meaningful Data for Antipsychotic Use***

Summary: The Minimum Data Set (MDS) needs modifications to include more clinically relevant information on antipsychotic use, such as distinguishing appropriate from inappropriate prescribing, specifying the drug, dose, and clinical rationale. Specifically, expand the reasons for why gradual dose reduction has not been attempted to include a new category stating: "documented use of the drug and dose as clinically appropriate;" and require that in cases where gradual dose reduction has not been attempted, both a physician and a pharmacist must independently document that gradual dose reduction is either clinically contraindicated or that the use of the drug and dose are clinically appropriate. CMS should also incorporate real-time data capture mechanisms to reduce the reliance on retrospective reporting, which often fails to reflect the nuanced clinical decisions involved in caring for patients with complex neuropsychiatric needs.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness)/Alliance for Aging Research

Aggregated Comment Title: ***Strengthen Support for Rural EMS Agencies***

Summary: Stabilize rural EMS agencies and ensure access to care by allowing for cost-based reimbursement for CAH-owned providers and removing arbitrary mileage caps.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Revise Conditions of Coverage for Dialysis***

Summary: CMS should collaborate with dialysis facilities, physicians, and healthcare providers to introduce more flexibility in developing and updating care plans required by the Conditions for Coverage, along with more flexibility in staffing requirements. The current requirements are burdensome, lack an evidence base, and do not align with patient care needs. Additionally, eliminating the time spent on machine reporting requirement for dialysis facilities would reduce the burden placed on facilities, patient care, and the ESRD PPS payment system.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Berkshire Medical Center; Kidney Care Council

Aggregated Comment Title: ***Eliminate Requirement for Quality Information on ESRD Claims***

Summary: Remove the mandatory inclusion of certain quality information on ESRD claims each month, as these data elements are redundant and already covered by existing ESRD quality programs. CMS could alleviate the burden of reporting on claims forms, which may result in claim denials if not completed, by relying on the EQRS system as the primary quality data reporting mechanism.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Kidney Care Council; Kidney Care Partners

Aggregated Comment Title: ***Replace Strict Liability Standard for SNF Citations***

Summary: Skilled Nursing Facilities (SNFs) are subject to a strict liability standard for citations under 42 CFR 483.12 (CMS), which can lead to penalties even if they followed all regulations, but an adverse event occurred. CMS should replace this strict liability concept with a non-compliance standard to align SNFs with other provider types and ensure fair treatment in deficiency citations under the Requirements of Participation (ROPs). CMS could discontinue strict liability by making modifications to guidance in Appendix PP, specifically to F600 and F689.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); Ohio Health Care Association

Aggregated Comment Title: ***Ensure Timely Revisit Scheduling for DPNAs***

Summary: The State Survey Agency is facing challenges in scheduling revisit surveys to avoid Denial of Payment for New Admissions (DPNA), leading to providers nationwide encountering DPNA issues. SSAs should schedule revisits for denials of payment for new admissions (DPNA) in a timely and adequate manner. SSAs should schedule the revisit at least ten days before the revisit date, provided the facility has met DPNA compliance. However, if the DPNA is pending, the agency should plan the revisit after the facility meets compliance and at least ten days before the scheduled revisit. Additionally, CMS should include these changes in updates to the revisit guidelines in Chapter 7 of the State Operations Manual.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Suspend HOPD Prior Authorization Programs***

Summary: CMS should suspend and repeal the active Hospital Outpatient Department (HOPD) prior authorization program, for which it has never provided adequate statutory or policy justification and which has imposed unnecessary paperwork and processing burdens on providers, patients and Medicare Administrative Contractors (MACs).

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Florida Hospital Association; Medical Device Manufacturers Association (MDMA)

Aggregated Comment Title: ***Clarify Definitions of Rural Health Clinics***

Summary: CMS statutory language restricts Rural Health Clinics (RHCs) to offer up to 49% of their services as behavioral health. CMS should define facilities primarily for mental health care, suggesting Certified Community Behavioral Health Clinics (CCBHCs), Community Mental Health Centers (CMHCs), standalone Opioid Treatment Programs (OTPs), or those providing intensive outpatient services. If a facility offers primary care and does not fall under mental health care or rehabilitation agencies, it should be eligible for RHC provisions. Clarifying these definitions would align with statutory intent and reduce administrative burdens on providers.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Louisiana Rural Health Association; National Association of Rural Health Clinics; OCHIN

Aggregated Comment Title: ***Records Retention Rules***

Summary: The regulations regarding record retention results in ongoing costs in storage, maintenance, compliance, and staffing. For small agencies, these recurring expenses reduce funds for education, training, and service enhancements, potentially limiting competition and beneficiary access to personalized support. A more proportional approach would reserve the most intensive oversight tools for scenarios where indicators of risk are present, such as patterns of complaints, anomalous enrollment activity, or prior compliance issues.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Price Services Group, L.L.C.

Aggregated Comment Title: ***Implement FHIR API for EHR Interoperability***

Summary: Implementing Fast Healthcare Interoperability Resources (FHIR) API can streamline data exchange between EHR systems and CMS platforms, automating reporting processes. Requiring EHR interoperability can save time by standardizing data exchange protocols.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP); Booz Allen Hamilton; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Automate Eligibility Verification Process***

Summary: CMS should automate the eligibility verification process to decrease claim denials, reduce errors, and enhance payment timeliness.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Nationalize and Simplify the Credentialing Process***

Summary: CMS should establish a national credentialing system and simplify the recredentialing process for providers with clean records to reduce administrative burdens.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Highlands Oncology Group, P.A.; National Nurse Practitioner Entrepreneur Network; Reveleer

Aggregated Comment Title: ***Allow NPPs to Refer for Pulmonary and Cardiac Rehab***

Summary: Allow non-physician practitioners (NPPs) to refer patients to pulmonary rehabilitation (PR), intensive cardiac rehabilitation (ICR), and cardiac rehabilitation (CR) services. This change aligns with Congressional intent, removes barriers to care, and enhances patient access to these vital services. Currently, NPPs are restricted from making referrals to these programs, limiting access, especially in rural areas. Updating CMS policy to permit NPP referrals would not only improve access but also align with legislative reforms and statutory intent.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)

Aggregated Comment Title: ***Employ Attestation-Based Measures***

Summary: CMS could introduce attestation-based reporting for specific measures, enabling providers to verify compliance without detailed documentation. This shift aims to help physicians prioritize patient care while upholding Medicare program standards.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Infectious Diseases Society of America; Reveleer; WEDI

Aggregated Comment Title: ***Improve Provider Directories***

Summary: Improving the accuracy and efficiency of provider directories is beneficial for both health plans and providers. CMS should establish a comprehensive solution to provider directory accuracy that includes, aligning the data elements required under PECOS and MAO provider directories, ensuring provider submission of data to PECOS is accurate and updated timely when provider circumstances change through use of financial incentives and penalties, and allowing access to relevant PECOS data by MAOs for purposes of maintaining an accurate provider directory.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Alignment Health Plan; SCAN Health Plan; WEDI

Aggregated Comment Title: ***Regulate Royalties for Use of CPT Code Set***

Summary: HIPAA code set regulations require covered entities to use a privately-owned code set for submitting health care claims to third party payors without regulating the royalties that the owner can charge covered entities to use the mandated code set. For example, the AMA holds copyright for the CPT code set, but HHS has not regulated royalties that AMA can charge for its use.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***Use the Plan Benefit Package (PBP) to Pre-Populate Model Letters***

Summary: Use the Plan Benefit Package (PBP) to automatically pre-populate model letters with benefit and rate information. This will improve content accuracy and management of various letter versions. In order to give plans enough time to incorporate information, pre-populated letter templates must be made available by July 1st annually. To ensure the success and fairness of this implementation, safeguards need to be included for Medicare Advantage (MA) plans. If any errors arise from the pre-populated data, CMS should be responsible for correcting those errors and covering all associated costs, including reprinting inventory and mailing errata notices.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** UCare

Aggregated Comment Title: ***Remove Network Adequacy Requirements for Network Contract Attestations***

Summary: CMS should remove unnecessary network adequacy requirements at (422.116(a)(1)) to submit network contract attestations as part of the application process for new and expanding service areas. This requirement is onerous for health plans which would need a full network in place a year ahead of the actual contract.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Concerns With ICD-10***

Summary: ICD-10 acts as a barrier to care, is burdensome, and should be revised or eliminated due to increased costs, complexity, and potential for insurance claim denials.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Quest Diagnostics

Aggregated Comment Title: ***Streamline Documentation for SNF Discharges***

Summary: Streamline skilled nursing facility (SNF) discharges by reducing the number and complexity of associated documents. This will improve family compliance, enhance efficiency, and increase satisfaction for both families and staff involved in the discharge process. One example is removing the requirement the SNF to specify the exact discharge location when a resident is being discharged due to non-payment. Furthermore, CMS could accept standardized hospital transition records in lieu of the SNF admission MDS when comprehensive hospital discharge information is available.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Require EHR Vendors to Align Data Structure***

Summary: Instead of requiring each hospital to create their own mapping logic and custom builds, a more efficient approach would be to mandate EHR vendors to standardize data structures across all hospitals and submit the data at the vendor level. This would streamline reporting processes and ensure consistency in data management while reducing administrative burden and costs. Also require EMR vendors to backfit data collection requirements into older versions of their platforms.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): American Psychiatric Association; Lumeris Healthcare

Aggregated Comment Title: ***Standardize Clinician Signature and Attestation Requirements***

Summary: It is burdensome for clinicians to have to review federal regulation, state statute, individual NCDs, and LCDs to determine whether their signature is required since it is not standardized across all forms. CMS should create and encourage a standard for signature and attestation requirements. Specifically, CMS should create a universal compliance attestation for healthcare organizations to simplify the annual attestation process.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): BAYADA Home Health Care; Cleveland Clinic

Aggregated Comment Title: ***Establish Centralized Screening of Providers Against Exclusion Lists***

Summary: CMS should implement an internal, centralized screening process that matches Medicare and Medicaid enrollment data against the OIG and General Services Administration's

System for Award Management exclusion lists on a recurring basis. At a minimum, such a system should apply to all currently enrolled providers. Establishing a centralized federal screening system would significantly reduce the administrative and financial burden currently managed by healthcare providers and suppliers, all of whom must independently contract with vendors to perform the same monthly screening tasks. It would also enhance program integrity by allowing CMS to proactively identify and remove excluded individuals and entities from participation in federal healthcare programs.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Simplify Patient Consent***

Summary: The current patient consent requirement hinders service delivery by causing delays and limiting providers' ability to manage or coordinate on patients with chronic conditions. Streamlining the requirement with opt-out mechanisms or simplified consent models could improve engagement without sacrificing patient autonomy.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Psychiatric Association; Wellbox

Aggregated Comment Title: ***Documentation Burden for CAH Swing Bed Patients***

Summary: The documentation burden for critical access hospital (CAH) swing bed patients closely mirrors SNF-level MDS reporting, which is not appropriate for CAHs. These facilities are not structured or staffed like traditional SNFs. CMS should adopt a simplified format with a reduced data set focused on essential clinical indicators.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Kansas Hospital Association; National Rural Health Association

Aggregated Comment Title: ***Review and Scale Back Conditions of Participation***

Summary: The current Conditions of Participation (CoPs) are overly restrictive and burdensome on healthcare providers without significant benefits for patient care. CMS should revise,

simplify, and potentially remove some of the most burdensome CoPs. Unnecessary, duplicative, and outdated CoPs create additional administrative work, drive inefficiencies, and reduce the time providers spend with patients.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** AVIA-Leavitt Partners Nexus Collaborative; Cleveland Clinic; Highlands Oncology Group, P.A.

Aggregated Comment Title: ***Revise DMEPOS Quality Standards for CPAP Access***

Summary: CMS should revise the DMEPOS Quality Standards for respiratory equipment, clarifying that CPAP devices do not need 24/7 service as stated in Item #3 on Page 10 of the Final DMEPOS Quality Standards Appendix A. Requiring 24/7 availability of CPAP for sleep apnea imposes unnecessary costs and administrative burdens on suppliers without improving patient outcomes or safety.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Aeroflow Health; American Association for Homecare

Aggregated Comment Title: ***Streamline CLIA Regulations for PPM***

Summary: Applying CLIA to provider-performed microscopy (PPM) imposes a significant financial burden on healthcare providers, especially solo and small practices, due to compliance costs and time spent on documentation, diverting attention from patient care and practice management with little proven benefit in outcomes or quality improvement. CMS should re-assess how the standard for CLIA waiver has been implemented and focus on study design based on a demonstration of accuracy. CMS should also remove mandates for annual competency assessments, detailed quality control documentation, and personnel files from CLIA.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Limitations of Claim Forms***

Summary: Medicare inpatient claims forms like UB-04 and CMS-1500 allow up to 25 diagnostic codes, creating a challenge for reporting codes that reflect the resources used for complex patients. This limitation can hinder accurate documentation and create competing interests for providers. CMS should redesign the claim forms to allow for supplementary codes to be recorded separately and consider paperwork reforms such as increasing the cap of reportable codes.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Streamline NHSN Reporting for HAIs***

Summary: Streamline NHSN reporting by simplifying complex case definitions for certain HAIs and allowing facilities with strong outcome data to attest for process measures, reducing reporting burden.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Increase the Use of API-Based Reporting***

Summary: Increase the use of API-based reporting, which can automate some data submissions.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Modernize VBP Data Processes***

Summary: CMS should modernize the Value-Based Purchasing Program (VBP) data workflows by automating two-way data exchange between certified electronic health record (EHR) systems and CMS using standardized interoperability protocols like Health Level Seven (HL7), Healthcare Interoperability Resources (FHIR), or Direct Secure Messaging. CMS should also better integrate clinical and administrative data.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** PointClickCare

Aggregated Comment Title: ***Rescind Provisions for Laboratory Staff Qualifications***

Summary: CMS should revise certain provisions related to laboratory director and technical supervisor qualifications for laboratories conducting moderate and high complexity testing, including 493.1405(b)(2)(ii)(A), 493.1443, and 493.1449(d) standards. These changes would streamline regulations and improve efficiency in laboratory operations.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** College of American Pathologists

Aggregated Comment Title: ***Eliminate Star Ratings***

Summary: Eliminate star rating calculations. The methodology is inadequate, including distorted comparisons of hospital performance and significant time lag.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Kingdom Insurance Group

Aggregated Comment Title: ***Eliminate Hospice Caps***

Summary: Remove the hospice cap process, as the annual payment from Medicare is lower than the cost of an ED visit, hospital admission, or ICU stay. Despite their good-faith efforts, agencies face paperwork burdens and financial risks from potential repayments due to Cap requirements.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Aaryn Hospice LLC; All Star Hospice Inc

Aggregated Comment Title: ***Streamline Documentation for Cognitive Services***

Summary: Streamline cognitive services documentation to address the following which contribute to burden: varying MAC interpretations; shared visit rules; excessive documentation to justify billing.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Include All Observation Hours for C-APC***

Summary: All observation hours should contribute to meeting the Comprehensive Ambulatory Payment Classification (C-APC) to ensure fair beneficiary cost-sharing, especially with the removal of separate payment for most services during the C-APC period. It is unnecessary and cumbersome to separate observation hours from other therapeutic services during the observation period. Removing this requirement will not impact APC rates, as the perceived rise in observation hourly charges will actually lead to lower cost-to-charge ratios and create consistency in cost-sharing regardless of individual hospital practices.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Delay Implementing the HOPE Tool***

Summary: CMS should postpone the implementation of the HOPE (Hospice Outcomes & Patient Evaluation) tool until necessary communication, education, and technical specifications are provided to ensure successful implementation by providers and vendors. There should be at least a 6 to 12-month grace period for the implementation of the HOPE assessments before it counts.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): National Partnership for Healthcare and Hospice Innovation; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Increase the Use of EHRs***

Summary: Increase the use of electronic health records (EHRs), which can automate some data submissions. By allowing reporting from both EHR and traditional claims data, CMS can ensure that these providers are not excluded from participating in quality initiatives. This dual approach not only facilitates broader participation but also enhances the completeness and accuracy of data collected from various reporting entities. Recognizing EHR limitations and accepting alternative formats containing required clinical information would accommodate practice variations.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** National Board for Certified Counselors (NBCC); Sanford Health - Good Samaritan Society; ViiV Healthcare

Aggregated Comment Title: ***CED and Its Impact on Access to Alzheimer's Treatments***

Summary: Coverage with Evidence Development (CED) have sometimes hindered therapies by trapping them in regulatory uncertainty. This delay can limit Medicare access to promising therapies, such as anti-amyloid drugs, and prolong reliance on less effective, costlier Alzheimer's treatments. CED for Alzheimer's therapies duplicates efforts with FDA's authority in evaluating safety and effectiveness. The lack of clear linkage between the evidence needed under CED requirements and registry data collection on providers adds complexity to the situation. The FDA's expertise in assessing therapeutics' safety and effectiveness is a unique advantage that could be undermined by CMS's NCD for Alzheimer's therapies.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): National Taxpayers Union

Aggregated Comment Title: ***Rethink Regulations for Restraints***

Summary: CMS regulations under 42 CFR 482.13(e) aim to safeguard patient rights and safety during restraint use. However, in the current healthcare landscape with staffing shortages and evolving care models, these regulations are overly complex and burdensome. Prohibiting restraints for fall prevention may not be practical for patients who cannot ensure their safety or follow instructions. Sitters are expensive and not always feasible. Allow clinical discretion to use restraints as a last resort when other interventions fail and the patient lacks capacity. Additionally, 482.13(e)(7), eliminating the requirement for attending physician notification even if another licensed practitioner orders the restraint would streamline processes and improve efficiency.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Expand Medical Necessity Criteria for Psychotherapy Services***

Summary: CMS should broaden the medical necessity criteria for psychotherapy services in Medicare and Medicaid to enable early intervention and prevention services. Presently, individuals who do not meet full diagnostic criteria for a mental disorder are unable to access behavioral health services due to the requirement of a diagnosis for medical necessity. By including specific Z codes in the criteria, behavioral health providers could intervene sooner, potentially averting the onset of behavioral health disorders. Additionally, needing to provide

rationale for the frequency and durations of sessions creates burden given the scrutiny applied to reviewing these claims. CMS should also accept clinical inference that reasonably supports medical necessity even when documentation doesn't precisely match coverage determination language.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Organization Determinations and Laboratory Services***

Summary: CMS should enhance and clarify the Organization Determination (OD) process to protect laboratories from financial liabilities. Medicare Advantage (MA) beneficiaries should have the same rights as Traditional Medicare beneficiaries to access laboratory testing without delays caused by the OD processes, which can lead to wasted time and resources due to additional specimen collections.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Require MAOs to Publish List of Payable Diagnosis Codes***

Summary: CMS should mandate MA organizations or their contracted laboratory benefit managers to disclose a list of payable diagnosis codes publicly. This move aims to enhance transparency and streamline processes within the system.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Provide Beneficiaries an Alternative for Aligning their MSSP/ACO PCP***

Summary: Provide an alternative option for beneficiaries to align with their MSSP/ACO PCP, like the ACO REACH program, to simplify the administrative process and cater to varying levels of computer skills among Medicare beneficiaries.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Simplify Timeframe Requirements for Mailed Letter Auditing***

Summary: Streamline the timeframe for mailing audit protocol letters, focusing on timely notification, such as within three calendar days, rather than the exact time organizations mail the letters. Harmonizing regulations across state regulators, NCQA, and CMS will reduce the workload and reporting burdens.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Physicians Advocacy Institute

Aggregated Comment Title: ***Rethink Rules on Advisory Meetings for Medicare Carriers***

Summary: CMS should eliminate or simplify the rules on the advisory meetings for the Medicare carriers on policies, including suggestions that 3 articles/studies are needed. The rules stifle physician input to policy.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Rethink CERT Audits for DME Claims***

Summary: CMS should reconsider Comprehensive Error Rate Testing (CERT) audits for durable medical equipment (DME) claims, as they cannot reliably detect fraud. CERT auditors are perceived as hostile, with error rates based only on paperwork review and no chance for appeal within the program. Despite claiming to be educational, individuals audited do not feel more competent afterward.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Confusion in Medicare Secondary Payer Rules***

Summary: The last sentence of 42 CFR 422.108(f) has caused confusion and issues in coordinating benefits with primary plans in Medicare Advantage. The regulation's implementation challenges, misinterpretation by courts, and concerns about double liability to Medicare Advantage Organizations have hindered Medicare beneficiaries from settling claims

effectively. The provisions in subparts B through D of Part 411 are noted to be unrelated to the Secretary, further complicating the situation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Health Alliance Plan of Michigan

Aggregated Comment Title: ***Wasteful and Inappropriate Service Reduction (WISeR) Model***

Summary: The Wasteful and Inappropriate Service Reduction (WISeR) model, which imposes prior authorization in Medicare fee-for-service and pays organizations based on savings from denied services, will increase physicians' administrative burden and create misaligned incentives. CMS should halt or pause its implementation until these issues are resolved.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Osteopathic Association

Aggregated Comment Title: ***Physicians Should Not be Penalized for Not Meeting Quality Metrics***

Summary: Patients have the right to make decisions about their healthcare, and physicians should not face penalties for not meeting quality metrics if a patient chooses not to receive a specific treatment. If a physician has made every effort to provide care but the patient refuses, the physician should not be held accountable for unmet patient needs.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): American College of Osteopathic Family Physicians (ACOFP)

Aggregated Comment Title: ***Use HL7 FHIR APIs to Eliminate Duplicative Efforts***

Summary: Improving data quality and interoperability through the use of HL7 FHIR APIs can help eliminate duplicative efforts in reporting and administrative tasks. Mandating this technology will enable seamless data exchange across different healthcare systems and providers can meet reporting requirements more efficiently, leading to improved accuracy and consistency in data used for care delivery and policy evaluation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Massachusetts Health Data Consortium

Aggregated Comment Title: ***Rethink What Care Must be Provided by a Physician***

Summary: CMS should rethink what care requires physician supervision or delivery versus care that can be provided by independent professionals or by virtual supervision of a practitioner. An example is the Medicare Diabetes Prevention Program (MDPP), which has shown success with community-based health coaches who do not require physician supervision.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Mandatory One-Star Penalties on Care Compare is Burdensome***

Summary: CMS should remove the automatic one-star penalty for audit findings. The mandatory one-star penalties on the Care Compare Five Star Quality Rating System cause issues for nursing homes because they are penalized regardless of actual staffing levels or performance on quality measures. This creates a burden for nursing homes as they must explain these inaccurate ratings to potential residents, families, and referral sources like hospitals or social service agencies.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; LeadingAge PA

Aggregated Comment Title: ***Rescind Enhanced Facilities Assessment Requirements***

Summary: The Enhanced Facility Assessment requirements (42 CFR 483.25) have caused excessive administrative burden on nursing homes. This document is seen as a checkbox exercise by providers and regulators and diverts staff time and resources away from resident care. CMS should remove these requirements to alleviate unnecessary paperwork and allow nursing homes to focus on ensuring resident safety and well-being as mandated by existing regulations.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; LeadingAge PA

Aggregated Comment Title: ***Form-Specific Feedback for CMS-802***

Summary: CMS should review form CMS-802 to eliminate unnecessary items, simplify the form, and extend the deadline for nursing homes to submit the information to alleviate administrative burden.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; LeadingAge PA

Aggregated Comment Title: ***Promoting Interoperability Measures are Without Patient Benefit***

Summary: Promoting Interoperability measures often prioritize checkbox compliance over meaningful patient outcomes, especially with fragmented health information exchange (HIE) systems.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Academy of Family Physicians; Ohio Hospital Association

Aggregated Comment Title: ***Optimize the CMS Batch Eligibility Query***

Summary: To enhance health plans' operational efficiency, CMS should include the following data elements in the CMS Batch Eligibility Query (BEQ): billing information such as address, out-of-area (OOA) status, state/county codes, health status codes, late enrollment penalty (LEP) amount, premium payment option, premium start/end dates, prescription payment plan (Yes/No), Social Security Administration (SSA)/Railroad Retirement Board (RRB) accepted month, and Medicare Advantage Open Enrollment Period (MA OEP) last used date.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** BAYADA Home Health Care; UnitedHealthcare

Aggregated Comment Title: ***Reduce Burden in Prescription Drug Event Analysis***

Summary: The Prescription Drug Event (PDE) analysis involves nine types of analyses and requires numerous data downloads and uploads, leading to a time-consuming process for health plans. To streamline operations, consider conducting PDE analysis at a Plan and/or Submitter ID level instead of by Contract, which would reduce administrative time for Medicare Advantage organizations and CMS contractors while enabling quicker responses to inquiries. Alternatively, provide health plans additional time to address questions during the process because of the time needed for data processing and analysis.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Waivers Applied Inconsistently***

Summary: Current Medicare programs use waivers to enhance participation and care coordination. However, the slight variations in waiver application across programs can lead to confusion and administrative challenges for participants and patients. CMS should prioritize consistency in waiver policies to simplify regulations and reduce burdens on providers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** America's Physician Groups (APG)

Aggregated Comment Title: ***Standardize the ADR Process***

Summary: CMS should standardize the Additional Documentation Request (ADR) process among Medicare contractors. The current lack of uniformity in ADR procedures and documentation requirements creates a significant administrative burden for physical therapists, occupational therapists, and speech-language pathologists, especially those in private practice and smaller outpatient clinics. Standardizing ADR protocols would reduce operational and technical challenges, lower costs, and improve efficiency for both Medicare and healthcare providers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of Rehabilitation Providers and Agencies (NARA); Net Health

Aggregated Comment Title: ***Allow Enrollees to Disenroll by Phone***

Summary: Regarding 422.66(b)(1), 422.74, and 423.36, allow enrollees for Medicare Advantage, MAPD and PDP to voluntarily disenroll through phone contact with their plan, instead of requiring a written request or contacting CMS. This adjustment would align the disenrollment process with the current enrollment process and improve efficiency for beneficiaries. The current process causes member abrasion and discrepancies between plan systems and CMS regarding member status.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts; Humana

Aggregated Comment Title: ***Streamline Billing for Hospice Transfers***

Summary: Under current Medicare billing policy for patients transferring between hospices, the receiving hospice must wait for the transferring hospice to submit their final claim before billing their first claim, causing financial burden on the receiving hospice, administrative burdens, and care coordination disruptions.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Enable APPs for Hospice Services***

Summary: Hospices cannot bill for advanced practice provider (APPs) services (such as NPs or PAs) under Part A unless they are the attending physician, causing burdens and limiting flexibility in staffing and service contracting.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Remove Call Center Measures from Star Ratings***

Summary: CMS should remove the Call Center Foreign Language Interpreter and TTY Availability Measures (C30 and D01) for the CY 2027 Star Ratings and beyond to simplify the program and reduce administrative burden. These measures complicate the Star Ratings program and eliminating them would benefit CMS by streamlining operations.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** SCAN Health Plan

Aggregated Comment Title: ***Reinstate the Reward Factor for CY 2027 Star Ratings***

Summary: CMS should reinstate the Reward Factor for the CY 2027 Star Ratings (42 CFR 422.166(f)(1)), as its elimination would unfairly penalize high-performing plans that invest quality bonus payments in benefits to prevent and manage chronic diseases. Coupling the implementation of the EHO4all reward with restoring the Reward Factor would ensure that plans are not burdened by the loss of this incentive.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Point32Health; SCAN Health Plan

Aggregated Comment Title: ***Changes to Policies Adds to Burden***

Summary: The constantly changing measure requirements (e.g. weights, categories, available measures), thresholds, and performance targets contributes to increasing confusion with the system and undermines accurate annual comparisons of policies and clinician performance. Practices struggle to keep up with the program's demands, which diverts resources from patient care to collecting irrelevant data.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Alliance of Specialty Medicine

Aggregated Comment Title: ***Adjust Provider Availability Reporting Requirements***

Summary: For regulations requiring updated healthcare provider availability information every 90 days, assume no changes unless indicated by the healthcare provider, or offer a simple "Have there been any changes" with a "no" option. The current process is burdensome.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Admission Documentation is Complex***

Summary: Complex admission documentation creates confusion for patients and inefficiency for hospitals.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Psychiatric Association; Ohio Hospital Association

Aggregated Comment Title: ***Streamline Outdated Administrative Policies***

Summary: CMS should simplify and streamline outdated processes and remove punitive requirements such as timely filing edits without adequate appeal pathways. CMS should focus on areas where the current rules add cost but yield little benefit to Medicare beneficiaries.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Eliminate Ground Ambulance Data Collection System***

Summary: Special CMS initiatives, such as the Ground Ambulance Data Collection System project, are too complex and labor-intensive. Explore more efficient data collection methods to reduce paperwork and streamline processes, as this system adds minimal value.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***Update Transplant-Related Policies***

Summary: Ensure transplant-related policies and guidelines are consistent with current clinical guidelines from accrediting bodies.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Houston Methodist; Ohio Hospital Association

Aggregated Comment Title: ***Medicare Cost Report Audits are Often Inefficient***

Summary: Medicare Cost Report Audits: Audit requirements under CMS Provider Reimbursement Manual 15-1, Chapter 29 create significant burden due to inconsistent standards applied between MACs. Hospitals report that different MACs apply varying audit standards, making compliance unpredictable. Documentation requirements to support certain costs can be so extreme that costs are disallowed due to over-burdensome documentation standards rather than actual compliance issues. Additionally, MACs often proceed with full Medicare Cost Report Audits despite clean desk reviews which increases administrative workload and raise concerns about the efficiency and purpose of the audit process.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Ohio Hospital Association

Aggregated Comment Title: ***Chronic Care Management Creates Burden***

Summary: Documentation requirements for Chronic Care Management create significant administrative burden for providers. The requirement can create challenges, particularly for remote or asynchronous care models, as it adds complexity and delays patient engagement. Simplifying the consent process by implementing eligibility-based or opt-out consent models could help eliminate a common barrier in onboarding patients into valuable care programs, making it easier for patients to access the care they need.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; Wellbox

Aggregated Comment Title: ***Transitional Care Management Creates Burden***

Summary: Documentation requirements for Transitional Care Management (TCM) creates significant administrative burden for providers. TCM services should be billable for new and existing patients, but there is a lack of a specific code for new patients, causing confusion.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of Community Health Centers (NACHC); Ohio Hospital Association

Aggregated Comment Title: ***Outdated 90-Day Recertification Rule is a Burden***

Summary: The regulation at 42 C.F.R. 424.24(c)(4)(i) mandates recertification for physical or occupational therapy by a physician every 90 days. Chronic care items, such as diabetic shoes, also require frequent physician signatures. This is outdated, burdensome, and unnecessary due to improved monitoring tools by CMS. This requirement is seen as a hindrance to therapy providers who must allocate time to obtain recertifications from physicians instead of focusing on patient care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***Eliminate Algorithm-Driven Denials***

Summary: Managed care organizations should not use proprietary algorithms to automatically deny emergency or inpatient care, as this practice unfairly places the burden on providers to prove medical necessity.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; Premier Health

Aggregated Comment Title: ***Sepsis Definitions are Inconsistent Across Medicare***

Summary: Inconsistencies in sepsis definitions and criteria, such as those between Medicare's SEP-1 requirements and clinical coding guidance, create confusion for healthcare providers and documentation teams. Defining sepsis-related organ dysfunction, temperature thresholds, and lactate levels differently across programs lead to inefficiencies and potential errors in patient

care documentation. Aligning definitions and criteria would reduce administrative burden, improve clinical accuracy, and enhance reporting efficiency for better patient care outcomes.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; Providence Health and Servicess

Aggregated Comment Title: ***Technology-Driven Burdens Without Patient Benefit***

Summary: The costs of technology required to participate in Medicare is substantial and draws resources away from patient care. Constant EHR system upgrades, driven more by compliance needs (e.g., USCDI v3, HT-1, public health reporting) than clinical care are disruptive.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Johns Hopkins Health Plans; Ohio Hospital Association

Aggregated Comment Title: ***NCCI is Burdensome***

Summary: The National Correct Coding Initiative (NCCI) edits are becoming burdensome due to the increasing volume of code pairs and versions. Commenter suggests a reduced reliance on NCCI when payment systems already incorporate bundling mechanisms. CMS should also eliminate Example #2 regarding use of the 59 Modifier.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Podiatric Medical Association; Panacea Healthcare Solutions

Aggregated Comment Title: ***Delay Sunsetting of Web Interface and MIPS CQM Reporting Options***

Summary: CMS should delay the sunsetting of the Web Interface and MIPS CQM reporting options until at least 2028 and assure ACOs that the Medicare CQM option will remain available for the foreseeable future until digital quality measure reporting is feasible and successful. This would alleviate burden for ACOs participating in the MSSP.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Association of American Medical Colleges; Cleveland Clinic

Aggregated Comment Title: ***Base Payment Adjustments on Medicare Economic Index***

Summary: MIPS model design should be replaced with payment adjustments that are based on the Medicare Economic Index to account for inflation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Association of American Medical Colleges; National Organization of Rheumatology Management

Aggregated Comment Title: ***Provide Physicians and Patients Reasoning for Prior Authorization Denials***

Summary: Medicare Advantage plans should provide physicians and patients specific reasons for prior authorizations denials. Along with the reasoning for the denials patients and physicians should also be informed about appeal rights and offer alternative covered options. Transparency in rules and criteria for prior authorization is crucial to ensure medically necessary care is not denied due to complex processes.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Prohibit MA Plans From Imposing More Restrictions or Cost-Sharing Than FFS***

Summary: CMS should prohibit Medicare Advantage (MA) plans from charging higher in-network cost sharing for behavioral health services and MA inpatient hospital readmissions policies from being stricter than those of fee-for-service Medicare. Additionally, prohibit MA plans from using these policies for technical claims denials without providing appeal rights or recourse for providers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Association of New York State

Aggregated Comment Title: ***Implement a Unified Reporting System for Hospital Quality Measures***

Summary: CMS could implement a unified reporting system where hospitals can submit all quality measures to a single entity.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Florida Hospital Association; National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Limit Inappropriate Denials of PAC from MA Plans***

Summary: Enforce existing Medicare Advantage (MA) rules to minimize inappropriate denials for post-acute care (PAC) and reduce discharge delays and administrative burdens associated with appealing denials or finding alternative discharge options. Enforce stricter oversight of denial practices as recommended by the OIG.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Florida Hospital Association; LeadingAge

Aggregated Comment Title: ***Adopt a Voluntary CMMI Model***

Summary: Making CMMI models voluntary would help alleviate burden on providers. End mandatory models.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Florida Hospital Association; PhRMA

Aggregated Comment Title: ***Expand and Support G0552 Code Devices***

Summary: CMS should broaden the G0552 code to encompass devices treating physical conditions with a mental health aspect and others not meeting current DMHT device criteria. The FDA may introduce new device categories for evolving technologies. Manufacturers face substantial costs in developing DMHT devices, and MACs should receive CMS guidance when setting rates for G0552 devices. Recommendations include providing guidance on covered devices, valuation considerations, and establishing a transparent claims review process for G0552 devices.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** ATA Action

Aggregated Comment Title: ***Eliminate Redundant Beneficiary Communications in MSSP***

Summary: To support deregulation, reduce regulatory burdens in the Medicare Shared Savings Program (MSSP) by eliminating redundant beneficiary communications. In addition to this, organizations should publicly display only the eCQMs used for scoring.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of ACOs; Piedmont Healthcare

Aggregated Comment Title: ***Cover Additional Services From Registered Dietitians***

Summary: Consider additional services aligned with the Registered Dietitian (RD) scope of practice, such as self-management training (98960, 98962) and online digital evaluations (98970, 98972). Clarifying coverage to include these types of services would modernize Medicare policy, more closely reflect the full capabilities of the RD workforce, and improve access to timely, cost-effective care for beneficiaries with complex nutrition needs.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Academy of Nutrition and Dietetics

Aggregated Comment Title: ***Expand Access to Intensive Behavioral Therapy for Obesity***

Summary: Medicare does not cover Medical Nutrition Therapy (MNT) for obesity unless the beneficiary has diabetes or renal disease. The Intensive Behavioral Therapy (IBT) for Obesity benefit, established in 2011, lacks updates to reflect modern evidence or care models. Revisiting NCD 210.12 could modernize coverage components, provider eligibility, supervision requirements, and care delivery settings, align the benefit with current clinical standards and expanding access to evidence-based behavioral interventions. Additionally, enabling Medicare Diabetes Prevention Programs to independently offer and bill for IBT services would enhance treatment accessibility and effectiveness.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Revise Requirement that Providers Must Remain Opted Out of Medicare for Two Years***

Summary: CMS should eliminate or create exceptions to the requirement that providers must remain opted out of the Medicare system for two years. Flexibility is crucial for providers to meet the system's demands effectively. Updating these rules would enable providers to adjust their service delivery methods and locations more efficiently, aligning with the dynamic nature of healthcare.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Cover More Mental Health Professionals***

Summary: Master level psychologists are highly qualified and provide psychotherapy for private insurance, meeting or exceeding the requirements of MFTs and MHCs. Including master level psychologists, along with MFTs and MHCs, in Medicare would enhance care for underserved populations and reduce disease burden.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** CEPD Psychological Services; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Increase Oversight of Inpatient Rehabilitation***

Summary: Inpatient rehabilitation facilities require more oversight to address issues like poor diet, lack of activity, medication practices, and neglect of patient requests. Closer scrutiny is necessary to prevent deceptive practices and ensure proper care for patients, as reported from personal experience.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Cost of Vendors to Support Mandatory Reporting***

Summary: Providers and facilities incur significant costs by relying on multiple third-party vendors to collect and submit necessary data such as NHSN, IQR, OQR, and PI requirements. This expense highlights the financial burden for providers and hospitals in managing and reporting essential healthcare data through external vendors. CMS should keep these costs in mind with every new regulatory requirement.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Lumeris Healthcare

Aggregated Comment Title: ***Revise Requirement to Post Daily Nursing Staff***

Summary: The daily nursing staff posting should be available on request instead of being displayed publicly. Staffing needs vary across facilities based on resident care requirements and population. Visitors care that their loved ones' needs are being met, regardless of the number of hours nursing staff are present. It serves no other purpose than to be described as a deficiency and does not inform or educate consumers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Make the Prior Authorization Requirements, Documentation, and Decision (PARDD) API Mandatory***

Summary: The Prior Authorization Requirements, Documentation, and Decision (PARDD) API should be mandatory and apply to all services and drugs. Automated, API-driven prior authorization systems like the Prior Authorization Requirements, Documentation, and Decision (PARDD) API simplify prior authorization processes by improving efficiency and reducing obstacles in the current prior authorization process. The adoption of the prior authorization API

requirement could automate tasks for providers, allow queries to determine authorization needs, and facilitate the compilation of necessary data elements for HIPAA-compliant transactions. Embedding these APIs into EHR workflows would reduce the need for separate portals, streamlining the prior authorization process.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Urological Association, Inc.; Large Urology Group Practice Association (LUGPA)

Aggregated Comment Title: ***Update Requirements for Nurse Aide Instructors***

Summary: Update Nurse Aide Training and Competency Evaluation Program (NATCEP) instructor qualifications to allow experienced RNs and LPNs to serve as instructors, addressing workforce shortages and expanding training capacity to meet the needs of long-term care residents. Additionally, rescind the requirement at 483.152(5)(i) of "at least 1 year of which must be in the provision of long term care facility services." These changes would expand eligibility criteria, which would enable more training programs to increase the number of individuals entering the nurse aide profession.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge PA; Pennsylvania Health Care Association

Aggregated Comment Title: ***Allow MedPAC to Use the Same Information for MA and Traditional Medicare***

Summary: Allow MedPAC to use enhanced encounter data to assess provider payment adequacy in Medicare Advantage, as is done for traditional Medicare.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; LeadingAge PA

Aggregated Comment Title: ***Reduce and Rescind Prior Authorization in OPPS***

Summary: CMS should reduce the overall volume of prior authorization (PA) in CMS-regulated plans by refraining from introducing new PA requirements under the OPPS and rescinding those currently imposed.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Medical Association; Association of American Medical Colleges

Aggregated Comment Title: ***Allow PTAs and OTAs to Establish Therapy POC***

Summary: The regulation at 42 C.F.R. 410.61(b) restricts the list of practitioners who can establish therapy Plans of Care (POCs), excluding PTAs and OTAs despite their qualifications. This exclusion is burdensome and impractical, as it forces physical therapists and occupational therapists to spend more time on POCs without the support of PTAs and OTAs. By allowing PTAs and OTAs to create the POC, providers could enhance outpatient therapy services for beneficiaries, especially in rural and medically underserved areas.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Payment Differential for PTAs and OTAs Limits Therapy Access in Rural Areas***

Summary: CMS pays for PT and OT services provided by PTAs and OTAs at 85% of the standard payment amount. Despite stakeholder objections, CMS stated it lacks the authority to exempt PTAs and OTAs from this payment differential, potentially impacting therapy service availability in underserved regions. CMS must replace its rules 42 C.F.R. 410.59(a)(4)(ii) and 410.60(a)(4)(ii) that applies the 15% payment differential to PTA and OTA services to better reach underserved areas.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Burdens of IRF Regulations Outweigh the Benefits***

Summary: The IRF regulations, outlined in 42 C.F.R. 412.622(a)(3), (4), include detailed coverage criteria and documentation requirements that are often seen as overly administrative and redundant, lacking clinical value or patient safety improvement. The burden on IRFs is further intensified by MACs and other CMS contractors scrutinizing minor violations to deny payment, leading to high compliance costs that outweigh the benefits of these detailed regulations. Repeal and replace IRF regulation with less burdensome coverage and documentation requirements. By reducing technical elements, compliance processes for IRFs would be streamlined, provider burden eased, and care delivery improved. CMS should replace the IRF coverage and documentation requirements with a regulation that contains fewer technical elements.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Implement 90-Day Limit on Therapy Orders and Referrals***

Summary: CMS sought feedback on imposing a 90-day limit on therapy orders or referrals for exceptions to physician signature requirements but ultimately did not implement this rule. The absence of a time limit on orders or referrals for therapy is considered outdated and inconsistent with recent changes to physician certification requirements, highlighting the need for an updated policy. There is a suggestion to establish a 90-day limit (or longer if permitted by state law) for completing the initial therapy evaluation after the order or referral is written.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Replace LTCH and IRF QRP Data Thresholds with Fairer Standards***

Summary: Regulations for LTCH QRP and IRF QRP data completion thresholds are being reconsidered for lower and fairer thresholds. Currently, LTCHs and IRFs must meet specific completion thresholds to comply with QRP requirements. The proposal suggests adopting lower, more reasonable thresholds, with exceptions for certain issues beyond the provider's control, and treating all data reported to NHSN as delivered to CMS.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Medical Rehabilitation Providers Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***Change In Mobility Measure Imposes Burden on LTCH***

Summary: The change in mobility quality measure for long-term care hospital patients requiring ventilator support in the LTCH QRP is unsound and overly burdensome. The measure is deemed unsound due to its flawed measurement of patient progression, and burdensome as it necessitates LTCHs to gather irrelevant information for their patients. This results in a significant data collection burden for LTCHs with minimal benefit to CMS from the non-Medicare information.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Repeal the 30-Day Readmission Measure from LTCH and IRF Quality Reporting Programs***

Summary: Repeal the potentially preventable 30-day post-discharge readmission measure from the LTCH QRP and the IRF QRP.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Financial Impact of Site-Neutral Payment Rule***

Summary: The LTCH patient criteria and site neutral payment rate rules have led to the closure of 22% of LTCHs and 28% of LTCH beds, disproportionately affecting hospitals in underserved areas with labor shortages and lower wage index amounts. CMS has not utilized its authority to increase payments for medically complex patients, despite evidence that site neutral payment harms LTCHs and impairs beneficiary access to care, resulting in declining margins and bankruptcies.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***60% Rule (42 C.F.R. 412.29(b)(1)) Suppresses Patient Access to Intensive Rehabilitation***

Summary: In order to remain exempt from the IPPS, IRFs must adhere to the 60% Rule, which requires that at least 60% of their inpatients are admitted for rehabilitation treatment for specific conditions. Failure to meet this threshold results in the loss of IRF classification. The 60% Rule is a major administrative challenge for IRFs as it limits admissions for patients in need of intensive rehabilitation. CMS should consider reevaluating the qualifying diagnoses and codes for the 60% rule.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Physical Therapy Association; Select Medical Holdings Corporation

Aggregated Comment Title: ***Revert to Previous Outlier Reconciliation Criteria***

Summary: CMS issued Transmittal 12594 (CR 13566) on April 26, 2024, updating outlier reconciliation policies for LTCHs. These changes are unnecessary, unlawful, burdensome, and unsound, as CMS failed to comply with the Medicare Act's rulemaking requirements. The adjustments may exacerbate payment reductions for HCO patients, who are the sickest and resource-intensive to treat, by increasing the FLA that LTCHs must absorb. The transmittal revised the CCR criteria for outlier reconciliation, changing the threshold to 20% or more for cost reporting periods starting on or after October 1, 2024. CMS should revert to the previous criteria in effect before October 1, 2024.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***IRF-PAI Schedule is Overly Demanding and Redundant***

Summary: Inpatient Rehabilitation Facilities (IRFs) are mandated to conduct two assessments for each patient and record them in the IRF-PAI. However, the IRF-PAI schedule is overly demanding and redundant since the admission assessment is not sent to the Internet Quality Improvement & Evaluation System (iQIES) until the patient is discharged.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Claim Review Process is Burdensome***

Summary: CMS's claim review processes are burdensome for providers due to the involvement of multiple overlapping contractors reviewing claims for compliance with coverage criteria and documentation requirements. This is burdensome for providers without benefiting patients or improving patient care.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Ineffective Use of Collected QRP Data***

Summary: A small portion of the QRP data, particularly from the LCDS and IRF-PAI, is utilized by CMS for evaluating hospital quality. The requirement for extensive data collection seems unjustified when the information gathered is not effectively utilized in assessing hospital quality. Furthermore, a small portion of the QRP data, particularly from the LCDS and IRF-PAI, is utilized by CMS for evaluating hospital quality, leading to concerns about the burden of data collection on providers. The requirement for providers to gather this data is burdensome when it is not used in assessing hospital quality.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***LCDS Requirements Increase Administrative Burden on Staff***

Summary: The LCDS contains 23 pages of clinical questions for staff to complete, adding to the burden of already strained healthcare staffing due to industry-wide shortages. CMS should look for opportunities to reduce the burden of LCDS reporting, including by removing unnecessary items such as mood, mobility, and health conditions.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Prohibit Prior Authorization From Deterring Care and Adding Burden***

Summary: CMS should institute rules that forbid Medicare Advantage plans from utilizing prior authorization simply for the purposes of adding administrative burden and deterring care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Select Medical Holdings Corporation; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***MA Plans Exclude LTCHs and IRFs from Networks***

Summary: Network-based Medicare Advantage (MA) plans must meet network adequacy standards, but the current regulation does not require them to include Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs) in their networks. MAOs are denying LTCH and IRF authorization requests based on reviews by professionals who lack experience in the LTCH and IRF settings. As a result, LTCHs and IRFs are burdened by improper decisions reached by these inexperienced reviewers. This loophole has allowed MA plans to exclude these providers, making it difficult for beneficiaries to access them. This oversight not only limits patient access but also creates challenges for hospitals by causing backups in acute care beds and restricting post-acute care providers from operating in areas where they are needed.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Allow Exception for CMO Requirement for Hospital-Within-Hospital***

Summary: The hospital-within-hospital regulation at 42 C.F.R. 412.22(e)(1)(ii) mandates a separate Chief Medical Officer (CMO) for hospital-within-hospital setups, independent of the host hospital or any controlling third party. CMS should create an exception for hospitals in non-large urban areas from this requirement to alleviate the burden. It is difficult outside of large urban areas to find a well-qualified CMO who is not employed by the host hospital or a third entity that controls both hospitals.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Prohibit Prior Authorization for Certain Cancer Care***

Summary: To reduce costs and improve patient access to timely treatment, consider prohibiting prior authorization for cancer care aligned with NCCN guidelines levels 1 and 2A in Medicare Part C. This approach would streamline administrative processes without compromising care quality, reserving prior authorization for cases lacking consensus on treatment options.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Highlands Oncology Group, P.A.; Memorial Sloan Kettering Cancer Center

Aggregated Comment Title: ***EP and QAPI Requirements are Duplicative***

Summary: Many of the EP (Emergency Preparedness) and QAPI (Quality Assessment and Performance Improvement) requirements overlap. To streamline, check Emergency Preparedness and QAPI during desk review.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Expand Locum Tenens Designation***

Summary: CMS current limits locum tenens to physicians which is hindering facility staffing, exacerbating the nationwide clinician shortage, and impacting 24/7 Emergency Department coverage. This is especially impactful in rural areas. CMS should expand the designation beyond physicians.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): VillageMD

Aggregated Comment Title: ***Automate High-Burden Forms with Data CMS Already Owns***

Summary: By utilizing the data already owned by CMS, pre-populating high-burden forms with information such as wage-index days, bad-debt claims, and charity-care charges could streamline the process for hospitals. This automation would allow hospitals to easily attest or correct the information, streamlining HCAHPS vendor extracts.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Remove Requirements for Outdated Information Sharing***

Summary: Eliminate the requirement for health plans to share information using outdated formats as outlined in 45 CFR 164.524.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Consolidate Reporting by Using Direct Data Submission Portals***

Summary: The Joint Commission's Direct Data Submission Platform (DDSP) allows hospitals to upload, validate, and correct eCQM files online, reducing manual processes. CMS could adopt a similar web-service for IQR, Hospital Value Based Purchasing (HVBP and Hospital Acquired Conditions Reduction Program (HACRP) to streamline data submission in a single portal and eliminate the need for multiple vendor gateways.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Standardize Insurance-Related Administrative Transactions***

Summary: Standardize insurance-related administrative transactions.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Replace Using SSI-Based Ratios with Medicare-Medicaid Crossover Population Data***

Summary: Update the Disproportionate Share Hospital (DSH) policy under 42 CFR 412.106 to replace SSI-based ratios with Medicare-Medicaid crossover population data. This change would reduce administrative delays, align with current data availability and interoperability goals, and ensure a more equitable distribution of DSH payments that reflects the actual burden of uncompensated care and social risk.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Increase the Frequency of NTAP Application Reviews***

Summary: The current legislation does not prohibit CMS from approving New Medical Services and New Technologies (NTAP) applications or adding new diagnosis or procedure codes more than once a year. To enhance the NTAP Program and streamline the process for drugs approved with Breakthrough Therapy Designation, CMS should increase the frequency of NTAP application reviews beyond once a year to help distribute the workload more evenly throughout the year and provide flexibility for applicants who miss FDA approval timing requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** BIO; Johnson & Johnson

Aggregated Comment Title: ***Improve Transparency and Timeliness of Updates to CMS Technical Files***

Summary: CMS should increase transparency and timeliness in updating CMS technical files such as J Codes, ASP Pricing Files, OPPS Addendum B files, and NCCI MUE files. Issuing J Codes promptly would reduce reimbursement delays, minimizing lag in ASP reporting, and modernizing publication processes to streamline updates would enhance operational efficiency for providers and ensure quicker access to care for patients. These interconnected files impact provider reimbursement and patient access to treatments, making changes or delays in updating them critical issues.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Data Issues in Discarded Drug Refund Program***

Summary: The Discarded Drug Refund Program's data reports have revealed missing data, inconsistencies, and errors, such as discontinued drugs being included in the invoice report while some products with shared HCPCS codes were missing. Manufacturers spend significant time verifying refunds owed and entering dispute resolution for more complete data files. These discrepancies hinder manufacturers' ability to reduce wastage effectively when data is incomplete or presented in an unusable format. CMS should simplify the process by providing complete and consistent files at the outset, standardizing formats and data elements, and including either total allowed units or total allowed amounts to enable manufacturer verification of report data.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Unintended Consequences of Medicare Laboratory Policy 42 CFR 414.510***

Summary: The Medicare laboratory date of service (DOS) policy at 42 CFR 414.510 has led to unintended consequences for laboratories, hospitals, clinicians, and Medicare Administrative Contractors (MACs). The regulation created issues for independent laboratories performing tests on specimens collected from hospital patients, as the DOS being the date of specimen

collection caused confusion in billing for services. To address these challenges, CMS has introduced exceptions over the years, resulting in a complex and confusing regulation that hinders innovative testing utilization due to billing complexities.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Establish Medicare Advantage Access Standards for Contracting with Providers***

Summary: Establishing access standards for contracting with healthcare providers in Medicare Advantage plans would simplify the process and reduce hurdles for providers. Offering a certified "provider-friendly" or "open-network" option alongside more restrictive plans could maintain flexibility while ensuring clarity for both providers and enrollees. Currently, the absence of clear access standards in the administrative process creates burdens for willing providers, especially home health and SNFs, highlighting the need for a more transparent and straightforward system.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Deregulation Will Maximize Cost Savings and Improve Quality***

Summary: The focus of all CMMI programs should be maximizing cost savings while improving quality. Deregulation will go a long way to meet this objective. Overly stringent, burdensome requirements strain resources and shift the focus from actual care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Simplify Contracts Between ACO and Providers***

Summary: To streamline the contract process between ACOs and providers, CMS could provide templated examples prior to the start of the year to simplify the necessary agreements and reduce the need for extensive audits.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): America's Physician Groups (APG)

Aggregated Comment Title: ***Documentation Burden for Critical Care***

Summary: CMS finalized a change to CPT code 99292 in the CY 2022 Physician Fee Schedule, requiring 104 cumulative minutes for billing critical care. This change adds to documentation burden and inconsistency with Medicare rules, as critical care codes do not adhere to the "median time" rule. CMS should rescind this policy and return to a 75-minute threshold for reporting the 99292 code.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Emergency Department Practice Management Association (EDPMA)

Aggregated Comment Title: ***Remove Mandatory Participation in Medicare Transaction Facilitator Data Module***

Summary: Mandatory participation in the Medicare Transaction Facilitator Data Module (MTF DM) may cause financial strain on pharmacies, leading to closures and worsening access issues. CMS has indicated it cannot protect pharmacies from underpayments by PBMs due to the noninterference clause, but is requiring pharmacy enrollment in the MTF DM, contradicting its stance. Therefore, CMS should make MTF DM participation voluntary or use its discretion to stop PBMs from paying pharmacies below acquisition costs under Medicare Part D.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Split/Shared Billing is Burdensome***

Summary: Current rules on split/shared billing between Advanced Practice Providers (APPs) and physicians create challenges for team-based care, with time-based documentation adding administrative burden and confusion. This complexity can reduce patient interaction time and discourage collaborative care models. Additionally, the rules obscure the distinct contributions of APPs, limiting recognition of their clinical value and reinforcing outdated hierarchies.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Integrated Care Plan Requirements***

Summary: CMS should clarify regulatory language requiring integrated care plans to include CHCs in their provider network, and that the plans should not have reimbursement rates lower than those set by the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS).

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Allow Radiologists to Order Diagnostic Tests***

Summary: Current CMS guidance restricts radiologists from ordering medically necessary tests directly, causing disruptions in patient care. Revising the treating physician rule to allow radiologists to order tests without needing to bill an E&M service as a treating physician would enable them to utilize their expertise effectively, support patients and other physicians, and reduce the data burden on primary care providers and non-physician providers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Review Choice Demonstration for Home Health Services is a Burden***

Summary: The Review Choice Demonstration for Home Health Services (HH RCD) places a heavy paperwork burden on home health agencies (HHAs) without proven benefits to Medicare or patient care. Evolving technology could provide CMS with more efficient tools to detect fraud and abuse, offering a better alternative to the current burdensome HH RCD process for providers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Occupational Therapy Association; Illinois HomeCare & Hospice Council

Aggregated Comment Title: ***Eliminate Prior Authorization for Therapy Services***

Summary: Prior Authorization for therapy provides no benefit and should be limited or eliminated entirely to reduce care barriers, reduce burden, and improve patient outcomes. CMS should align MA plan requirements with traditional Medicare by removing prior authorization for therapy services, but if retained, CMS should require electronic requests to be processed within 48 hours to ensure timely care and appeals.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Occupational Therapy Association; PointClickCare

Aggregated Comment Title: ***Eliminate One-to-One Monitoring Requirement for Patients at Risk of Suicide***

Summary: Enable Inpatient Psychiatric Facilities (IPFs) to provide appropriate monitoring for patients at risk of suicide by removing the requirement for one-to-one monitoring. This change would allow IPFs to implement more efficient monitoring strategies while still ensuring patient safety without overburdening the workforce and reducing unnecessary costs.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Limit Requirement to Purchase Supplies Through CMS-Approved Vendors***

Summary: Enable hospitals to reduce costs by limiting the requirement to purchase supplies through CMS-approved vendors to only medical devices and other aspects of direct patient care and exempting non-clinical items such as office furniture and supplies.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Florida Hospital Association; Illinois Health and Hospital Association

Aggregated Comment Title: ***Eliminate eCQMs Requirement to Report on All Patients Across All Payers***

Summary: CMS should eliminate the electronic clinical quality measures (eCQMs) requirement under 42 CFR 425.512(a)(4) to report on all patients across all payers. This requirement forces Accountable Care Organizations to collect and report data on non-Medicare patients, creating significant administrative burden that extends beyond the scope of the MSSP.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): America's Physician Groups (APG)

Aggregated Comment Title: ***Limit on D-SNP Plans Restricts Beneficiary Choice***

Summary: The 422.514(h)(1)(i) rule restricts parent companies with D-SNPs and affiliated Medicaid managed care organizations to offer only one D-SNP in a service area, which limits beneficiary choice. While there is an exception for HMOs and PPOs, they cannot accept new enrollments, leading to concerns about unnecessary restrictions on beneficiary options.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Special Needs Plan Alliance; The National MLTSS Health Plan Association

Aggregated Comment Title: ***Allow MAOs to Determine Coverage***

Summary: The 2024 and 2025 Final Rules restrict Medicare Advantage Organizations (MAOs) from using internal clinical criteria when determining coverage for basic Medicare benefits. Rescinding this policy will maintain MAO flexibility in member care management.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Christian Science Provider Network; The National MLTSS Health Plan Association

Aggregated Comment Title: ***Expand Definition to Ease FIDE-SNP Requirements***

Summary: CMS should expand the definition of "under a single entity" at 422.2 to encompass cases where a parent company oversees two managed care entities holding contracts for MA and Medicaid managed care. This adjustment would alleviate the administrative complexities

related to legal restructuring necessary for establishing Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP).

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Special Needs Plan Alliance; The National MLTSS Health Plan Association

Aggregated Comment Title: ***Continue Improvement Measure Hold Harmless for MA Plan Star Ratings***

Summary: In 42 CFR 422.166 and 42 CFR 423.186, CMS's should continue to maintain the Improvement Measure hold harmless provision for Medicare Advantage plans rated 4 or more Stars, as altering the threshold to 5 Stars could negatively impact high-performing plans by reducing incentives for quality enhancement and introducing instability in Star Ratings. If CMS proceeds with changes to the provision (proposed rule 87 FR 79632), this could result in significant reductions in benefits for Medicare Advantage enrollees.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** SCAN Health Plan; The National MLTSS Health Plan Association

Aggregated Comment Title: ***Coverage for Non-Participating DME Suppliers***

Summary: CMS should clarify their policies on beneficiary liability for non-participating DME suppliers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Globe Life Insurance Company

Aggregated Comment Title: ***Limiting Charge Provision for DME Suppliers***

Summary: To protect Medicare beneficiaries and carriers from unregulated costs, CMS should implement parallel limiting charge rules for DME suppliers. This would prevent open-ended expenses and provide clarity on the application of the 15% limiting charge provision to non-

participating DME suppliers. Revisiting the 2022 interpretation and affirming this provision would help ensure fair and transparent pricing for all parties involved.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Globe Life Insurance Company

Aggregated Comment Title: ***Access to Medicare's Payment Rules and Fraud Indicators Will Decrease Billing Errors***

Summary: Understanding Medicare's payment rules and potential fraud indicators can help Medigap carriers process claims more accurately and efficiently, reducing the number of erroneous bills sent to beneficiaries.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow MA Plans to Use Opt-Out Frameworks***

Summary: Allow MA plans to use an opt-out framework for electronic communications, rather than opt-in. Opt-in systems can lead to low enrollment in electronic communication due to inertia or lack of awareness, not necessarily because members prefer paper mail.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** DentaQuest

Aggregated Comment Title: ***Improve IRE Processes***

Summary: CMS should require more consistent and thorough member identification and responses from Independent Review Entities (IREs) to align with requirements. Improved regulatory oversight and bidirectional discussion channels would increase clarity, decrease appeals, and expedite member services.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): DentaQuest

Aggregated Comment Title: ***Align D-SNP Requirements***

Summary: States are customizing requirements for D-SNP plans beyond federal standards, leading to administrative challenges for plans managing varying processes. These additional processes, often operational and not beneficial to members, result in inconsistent experiences for dual eligible individuals. Despite CMS efforts to align D-SNPs, states continue to impose extra requirements, increasing costs and burdens for plans.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Eliminate Star Rating from Past Performance Methodology***

Summary: CMS should eliminate the inclusion of Star Ratings from the past performance methodology at 422.502(b)(1)(D) and 423.503(b)(1)(D).

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Allow Sales Agents to Perform Enrollment Verification***

Summary: Medicare Advantage Organizations must conduct enrollment verification outreach within 15 days of agent/broker assisted enrollments, as per MCMG and 422.2272(b) and 423.2272(b) regulations. However, agents/brokers are not allowed to participate in this process to avoid conflicts of interest. While the intent is understood, CMS could allow a different sales agent to handle the verification to provide expertise and help enrollees understand their plan benefits better.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Healthpilot; Humana

Aggregated Comment Title: ***Revisit Coverage Requirement for Protected Drug Classes***

Summary: CMS should reconsider the "all or substantially all" coverage requirement in the Medicare Part D Six Protected Classes to allow plans more flexibility in limiting coverage within these classes if their formularies align with clinical guidelines for the relevant disease states. This adjustment would streamline administrative processes, decrease program costs, and enhance the ability of plans to negotiate formulary coverage effectively.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Eliminate Targeted Probe and Educate Program***

Summary: CMS should eliminate the Targeted Probe and Educate (TPE) program for nursing facilities and HHAs in the Review Choice Demonstration for Home Health Services program. These reviews may utilize pre-claim review to streamline audits and reduce duplicative efforts but are burdensome and apply standards inconsistently.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Greater New York Hospital Association; Humana

Aggregated Comment Title: ***Eliminate Unnecessary National Coverage Determinations***

Summary: Eliminate the need to perform National Coverage Determinations (NCDs) for preventive services that have already been thoroughly reviewed by the U.S. Preventive Services Task Force. CMS possesses clear statutory authority under Section 4105 of the Affordable Care Act to streamline this process without any Congressional action.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Exempt LTC Pharmacies from Certain Medicare Payment Plan Program Requirements***

Summary: Exempt long-term care (LTC) pharmacies from beneficiary notice requirements in the Medicare Prescription Payment Plan program, especially the "likely to benefit" notice

requirement, as most LTC facility beneficiaries have zero copayments and would not benefit from the Medicare Prescription Payment Plan program.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Senior Care Pharmacy Coalition: SCPC

Aggregated Comment Title: ***Concerns with the ESRD PPS Bundled Payment***

Summary: The inclusion of oral-only drugs in the ESRD PPS bundled payment is concerning for the potential to negatively impact patient care and overall costs. Rescinding the regulation that includes oral-only drugs would prevent disruptions in treatment regimens, provide more care choices, improve health outcomes, and encourage medical innovation for Chronic Kidney Disease (CKD)/ESRD patients, potentially reducing healthcare costs associated with suboptimal therapeutics for CKD/ESRD complications.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** BIO

Aggregated Comment Title: ***Adopt "Market Date" Reported Under Medicare Drug Rebate Program***

Summary: CMS should adopt the "market date" reported under Medicare Drug Rebate Program (MDRP) as its standard for identifying the date a generic or biosimilar is marketed. This alignment would ensure consistency across programs and prevent potential delays in market entry due to discrepancies in determination dates. Failing to synchronize these dates could significantly impact the development of generic drugs and biosimilars, potentially extending market exclusivity periods and hindering competition.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** BIO

Aggregated Comment Title: ***Low-Volume High-Cost Therapies***

Summary: Challenges in reimbursement hinder access to low-volume, high-cost therapies for rare diseases. This is due to the difficulty of accurately reflecting these cases in the MS-DRG payment system and can lead to significant reimbursement shortfalls, limiting patient access to treatments. CMS should continue exploring ways to address access challenges for low-volume, high-cost therapies.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** BIO

Aggregated Comment Title: ***Waive Signature for In-Person Supplier Pickup***

Summary: CMS should waive the signature requirement for in-person supplier pick-ups, as it places an unnecessary burden on suppliers. Since a signature is not required for home deliveries, it is inconsistent to maintain this requirement for in-person pickups. Moreover, suppliers can provide alternative documentation as proof of pickup, such as electronic records of sales transactions.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of Chain Drug Stores; National Community Pharmacists Association

Aggregated Comment Title: ***Ease MA Prior Authorization Regulations***

Summary: Reverse regulations on Medicare Advantage (MA) prior authorization decisions under 422.138 due to their excessive burden on MA plans, hindering fraud detection efforts and limiting patient care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Curana Health; University Radiology Group, LLC

Aggregated Comment Title: ***Eliminate Inefficiencies in OASIS by Regularly Streamlining Assessment Items***

Summary: The OASIS Tool System faces systemic inefficiencies due to the lack of regular pruning or streamlining of items, resulting in inefficiencies and increased costs for agencies and payers. This will ensure that the document is efficient and effective. Data-driven reform emphasizes the need to retain only clinically relevant and outcome-impacting items.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Physician Narrative Requirement is Redundant***

Summary: The requirement for physicians to provide a narrative justifying the need for management and evaluation of a care plan is burdensome, as the service is already based on established clinical standards and monitored by home health agencies. This additional requirement may discourage providers from ordering essential services, leading to potential barriers to care access and higher claim denials.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Price Services Group, L.L.C.; Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Extend 180-Day Overpayment Investigation Timeline***

Summary: The 180-day suspension period for the report and return of Medicare Parts A and B overpayments, as outlined in the Affordable Care Act, is often insufficient for hospitals conducting good-faith investigations involving complex legal and factual issues. Without a longer suspension period, providers may be forced to adopt a piecemeal approach to overpayment reporting.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Federation of American Hospitals; Illinois Health and Hospital Association

Aggregated Comment Title: ***Allow Grace Period When Replacing Essential Staff in Nursing Homes***

Summary: CMS should allow long-term care facilities a grace period when replacing essential staff. Hiring infection preventionists and activity directors in nursing home settings can take time, and allowing a six-month period would allow for proper qualifications and training to be met without strict turnover deadlines.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge Illinois/Iowa

Aggregated Comment Title: ***Eliminate Observation Hours Carve-Out Policy for Diagnostic or Therapeutic Services***

Summary: The CMS Medicare Claims Processing Manual, Chapter 4 - Part B Hospital, 290.2.2 for Observation Services currently requires hospitals to carve out observation hours for diagnostic or therapeutic services, adding administrative burden and confusion. This policy necessitates manual tracking of time for each service, disrupting hospital workflow and increasing paperwork. Eliminating this carve-out policy would streamline processes and reduce unnecessary administrative burden.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Hospital Association; MaineHealth

Aggregated Comment Title: ***Use AI for Medical Necessity Evaluations***

Summary: Use AI-driven tools to extract context-specific patient information to expedite the evaluation of medical necessity. These specialized models can efficiently handle complex workflows, achieving automation rates exceeding 85 percent.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Reveleer

Aggregated Comment Title: ***Prioritize SNF and Part B Prior Authorization Approvals***

Summary: Ensure seniors have timely access to SNF and Part B therapy services by treating these prior authorizations with urgency. Prioritizing SNF prior authorizations as emergent prevents unnecessary hospital stays and ensure timely initiation of skilled services.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Suggestions for Improving SNF Data Automation***

Summary: CMS should involve stakeholders in developing a strategic plan for transitioning skilled nursing facilities (SNFs) to automated health information reporting, leveraging technology to streamline data submission and reduce administrative burden. Automating data reporting could enhance information exchange, improve efficiency, and provide timely insights to regulators, providers, and consumers. Additionally, CMS should create tools, such as a digital app, to collect data on beneficiaries' demographics, goals, and priorities. This data could then be automated to populate the SNF electronic health record (EHR) or shared with CMS primarily through automated processes, supplemented by updates from SNF assessors. This approach would eliminate the need for repetitive, time-consuming assessments at each transition of care.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Allow Nurse Practitioners to Work Independently***

Summary: CMS should eliminate practice limitations on nurse practitioners (NPs) that are more restrictive under CMS rules than state rules. This is crucial for improving access to care, especially in underserved areas. By aligning federal regulations with state laws that grant NPs full practice authority, clinicians can provide care to the full extent of their education and licensure, addressing workforce challenges and improving healthcare access in rural and underserved communities.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); Premier Inc

Aggregated Comment Title: ***Support In-House Training Programs for Certified Nursing Assistants***

Summary: CMS should support rules that allow skilled nursing facilities (SNFs) to restart or establish in-house nurse aide training programs after addressing deficiencies and meeting patient safety criteria. These programs not only provide on-the-job experience but also contribute to workforce development by creating job opportunities and career advancement for certified nursing assistants. By enabling SNFs to offer in-house training, particularly in rural and underserved areas, the workforce pipeline can be strengthened.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Impact of the Two-Year Ban on Nurse Aide Training Programs in SNFs***

Summary: Current federal laws impose a two-year ban on nurse aide training programs (NATPs) in SNFs if civil monetary penalties (CMPs) exceeding $12,924 are issued, regardless of the reason. This restriction hinders many facilities from initiating or continuing in-house nurse aide training programs. Exercise greater enforcement discretion to allow nursing homes cited with deficiencies to continue their NATPs at 42 CFR 483.151(b)(2) and (c) and SSA 1819(f)(2).

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); LeadingAge New York

Aggregated Comment Title: ***Streamline SNF Validation Processes***

Summary: Many Skilled Nursing Facilities (SNFs) face challenges with revalidations due to unclear guidance from CMS, leading to delays in submission. Eliminate the validation process for the SNF Quality Reporting Program (QRP) to reduce duplication and burden on facilities.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Association of Post-Acute Care Nursing (AAPACN); American Health Care Association (AHCA)

Aggregated Comment Title: ***Medicare Star Ratings Favor Larger Medicare Plans***

Summary: Medicare Star Ratings tend to favor larger Medicare plans over smaller ones due to the smaller number of beneficiaries in smaller plans, which leaves less room for error. This favoritism leads to potential disparate impact on plans that are at a competitive disadvantage compared to larger insurers dominating the market.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Provide Quality Measure and Performance Scores in a Timely Manner***

Summary: Current systems like iQIES report quality measures and performance score data with significant delays of 3 to 12 months, limiting providers' ability to engage in timely, data-driven process improvement efforts that could directly enhance patient care. Implementing a centralized system for real-time or near-real-time data could empower facilities to proactively identify and resolve issues, enhancing patient care through timely interventions rather than reacting to outdated information months later.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Eventus WholeHealth; The American College of Cardiology

Aggregated Comment Title: ***Increase Funding to Help Physicians Promote Data Interoperability***

Summary: CMS should increase funding opportunities to help physicians promote data interoperability, which would reduce burden on independent provider practices.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***LCDs Create Confusion***

Summary: Medicare Administrative Contractors (MACs) regularly use local coverage determinations (LCDs) instead of national coverage determinations (NCDs), causing confusion for billing staff who must navigate varying coverage policies across jurisdictions. A unified NCD approach would streamline coverage consistency across all jurisdictions, aligning with Medicare's national scope. Replacing LCDs with NCDs could simplify billing processes and reduce administrative burden for healthcare providers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; Healthcare Business Management Association

Aggregated Comment Title: ***Documentation Requirements for MA and Part D are Overly Complex***

Summary: Medicare Advantage and Part D documentation requirements are overly rigid and confusing for beneficiaries. Instead of utilizing standardized templates, CMS should permit plans to adapt these documents in more user-friendly ways and only publish the minimum requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Pharmaceutical Care Management Association (PCMA); Reveleer

Aggregated Comment Title: ***Streamline E/M Documentation***

Summary: Simplify and streamline the documentation requirements for evaluation and management services, especially for inpatient care. The current regulations force infectious disease physicians to spend too much time on redundant or low-value documentation, taking away from patient care and leading to physician burnout.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Highlands Oncology Group, P.A.; Infectious Diseases Society of America

Aggregated Comment Title: ***Revise Hospice Discharge Order Requirements***

Summary: CMS should revise the Hospice Condition of Participation 418.26 (b) to permit any employed or contracted physician to issue a hospice patient's discharge order, rather than solely the hospice medical director, to ease administrative burden.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Oregon Hospice & Palliative Care Association and Washington State Hospice & Palliative Care Organization

Aggregated Comment Title: ***Eliminate Nursing Home "Pass Through" Regulation for Dually-Eligible***

Summary: Eliminate the Nursing Home "pass through" regulation, which currently requires Medicaid to pay hospices for room and board rates for Medicaid beneficiaries in nursing homes, rather than paying the nursing home directly. This change would streamline the payment process and potentially benefit dually-eligible or Medicaid hospice beneficiaries by removing unnecessary administrative steps.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Home Care Alliance of Massachusetts; Oregon Hospice & Palliative Care Association and Washington State Hospice & Palliative Care Organization

Aggregated Comment Title: ***Offer Flexibilities in ACO Reporting***

Summary: Specialists face challenges in complying with reporting requirements for certain quality measures, leading to their exclusion from ACO participation. CMS should offer flexibility in reporting based on provider type to maintain specialist engagement and ensure effective care coordination within ACOs.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ascension; Sutter Health

Aggregated Comment Title: ***Medicare EFT Enrollment Process is Burdensome***

Summary: The EFT enrollment process in Medicare, as outlined in 42 CFR 424.510(e)(1), is outdated, burdensome, and inefficient. Despite CMS requiring EFT enrollment for modernization

purposes, the current regulations do not permit the automated reuse of EFT information for providers with multiple enrollments. This leads to unnecessary verification through costly and duplicative administrative processes.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** CGI Federal Inc.

Aggregated Comment Title: ***Automate Fraud, Waste, and Abuse Screening***

Summary: CMS should coordinate with OIG and implement modern tools to automate the Medicare screening process for fraud, waste, and abuse (FWA). Automating the screening of provider applications will speed up the process and help CMS better distinguish between well-intentioned providers and those acting in bad faith. Additionally, this approach will streamline the policy framework for application processing, which is currently impacted by differing interpretations across various Medicare Administrative Contractor (MAC) jurisdictions.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** CGI Federal Inc.; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Streamline Documentation Requirements for Medications***

Summary: CMS should streamline medication-related documentation across providers, enabling qualified entities, such as pharmacies, to meet requirements for multiple programs. Non-prescribing providers in particular face burdensome medication requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): AnewHealth

Aggregated Comment Title: ***Do Not Require Rebasing for ACOs Participating in the Prepaid Shared Savings Option***

Summary: CMS should not require rebasing for ACOs participating in the Prepaid Shared Savings option. Denying established ACOs access to prepaid savings hinders progress, as CMS can accurately predict savings for these ACOs. Requiring rebasing forces ACOs to restart, slowing program improvements and hindering timely funding for initiatives. By eliminating the rebasing

requirement, CMS can support ACOs and encourage program adoption without penalizing those who did not renew participation, ultimately fostering program growth and success.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Aledade

Aggregated Comment Title: ***Develop a Standardized Online Portal to Automate SNP MOC Training Attestations***

Summary: Automate SNP Model of Care (MOC) training attestations by developing a standard online learning portal for SNP MOC Training accessible to providers and staff.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Empower 340B Entities to Independently Purchase MFP Drugs at or Below the Maximum Fair Price***

Summary: Create a regulatory guidance that allows 340B entities to purchase MFP drugs at their discretion, rather than relying on individual manufacturer discretion. This ensures that the price paid by the dispensing entity for the drug does not exceed the MFP.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of Community Health Centers (NACHC); The Wright Centers for Community Health and Graduate Medical Education

Aggregated Comment Title: ***Revise Definition of "Laboratory" to Limit CLIA Regulations to Patient-Specific Information***

Summary: The definition of 'laboratory' in 42 CFR § 493.2 needs to change, with an emphasis on the importance of the 'patient-specific' modifier to ensure that only examination of patient-specific digital laboratory information falls under CLIA regulation. Entities analyzing deidentified information to support a clinical laboratory's examination of patient specimens, like third parties handling deidentified genetic variant information, should not be subject to CLIA regulation as clinical laboratories.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***Transition to Automatic Payments for GUIDE Program Billing***

Summary: Transition the GUIDE program billing process from manual to automatic payments. This will reduce administrative burden for participants and streamline operations efficiently.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** AdventHealth

Aggregated Comment Title: ***Eliminate Patient Signature Requirement on Notice of Privacy Practices***

Summary: Eliminate the requirement for patients to sign the Notice of Privacy Practices to reduce front-desk burden and streamline the registration process without compromising transparency. It is an outdated formality that is well understood by patients.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** AdventHealth

Aggregated Comment Title: ***Simplify Requirements for Dialysis Staff***

Summary: Dialysis providers are facing challenges in expanding access to home dialysis due to strict nurse staffing requirements outlined in 42 CFR 494.140. These regulations mandate specific experience levels for home dialysis nurses and managers, leading to significant staffing shortages, particularly in rural and pediatric facilities. CMS should modify these requirements to focus on clinical competency rather than time served.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** The Renal Healthcare Association

Aggregated Comment Title: ***Timely Release of Plan Closure Model***

Summary: Releasing the Plan Closure model alongside the ANOC and EOC models by the end of May each year is crucial for maintaining consistency, reducing administrative workload, and enabling accurate customization, review, and production of materials. Timely access to all related models, particularly the Plan Closure model, is essential for these processes to run smoothly.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** UCare

Aggregated Comment Title: ***Eliminate Star Measures with 100% Thresholds***

Summary: CMS should remove 100% thresholds as a requirement for a 5-star Medicare Advantage plan rating, as they do not consider statistical variability and discourage continuous improvement, particularly for plans already performing well. These thresholds also unfairly penalize plans serving complex or vulnerable populations where achieving perfection is unrealistic and not a true measure of quality. Removing these thresholds would provide a more accurate assessment of plan performance and incentivize ongoing quality enhancements.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan; UCare

Aggregated Comment Title: ***Rescind FY 2025 SNF Payment Rule***

Summary: CMS should rescind the FY 2025 SNF payment rule that expanded civil monetary penalties (CMP) on SNFs beyond the statutory framework. CMS had implemented CMPs for survey citations as per statutory instruction but then used the annual Medicare payment rule to further expand these penalties.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge PA; Ohio Health Care Association

Aggregated Comment Title: ***Simplify Dialysis While Traveling***

Summary: CMS should simplify the process to help patients who need dialysis while traveling. Creating a standardized "Patient Passport" document for dialysis patients could streamline transfer procedures. Patients could input their dialysis prescription and recent lab values, sending them directly to the destination clinic. This system would simplify the process for both patients and clinic staff, reducing the burden of manual transfer requests.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***More Coordination and Support for CPT-4 and HCPCS Needed***

Summary: The coordination between the HCPCS Level II Workgroup and CMS payment systems groups, such as MPFS, OPPS, and DMEPOS, needs improvement to provide timely updates for new, deleted, or revised HCPCS Level II and AMA CPT-4 codes. Further, CMS needs to synchronize with the updates. While the AMA offers educational resources like CPT Changes, users struggle to integrate information from various sources for quarterly updates. Providers require 60-90 days to update systems, making late transmittals and MLN updates from payment systems unhelpful. Release summary updates within a week of Final Rule publication and post data releases at least 60 days before their effective dates.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Panacea Healthcare Solutions

Aggregated Comment Title: ***Retire Disposal of Garbage and Refuse Measure***

Summary: Retire certain measures that do not or no longer apply. For example, F814 §483.60(i)(4) Disposal of Garbage and Refuse, applies only to food and nutrition services, while many facility services contribute to the generation of refuse.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** CCL Hospitality Group; Compass Community Living

Aggregated Comment Title: ***Data from the OASIS Home Health All Payer Rule will not be Useful***

Summary: The CMS Home Health OASIS All Payer rule effective July 1, 2025, lacks comparison between Medicare-eligible and non-Medicare eligible groups, which will reduce the usefulness of the data.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Compassion Home Health; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Improve Usability of NHSN Reporting***

Summary: Enhance usability of NHSN Acute Respiratory Illness Reporting by simplifying login and data correction processes, as outlined in QSO-25-11-NH / 483.80(g). Additionally, allow multiple administrators per facility to streamline access.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Place of Service Requirements Prevent Care in Certain Settings***

Summary: Medicare's Place of Service requirements can hinder optimal patient care as certain procedures are only reimbursed when performed in specific settings like hospitals or ambulatory surgical facilities, not in physician's offices. For instance, a physician may be able to safely perform a procedure like removing cancer from the nose and covering the defect with a flap in their office, but Medicare may not cover the flap procedure in that setting, impacting patient care options. Older patients who do not have transportation to and from the hospital often must settle for lesser procedures that can be performed in office.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Eich Plastic Surgery, PC

Aggregated Comment Title: ***Eliminate Recertification for Established Conditions***

Summary: Once a chronic condition has been established, eliminate recertification requirements. The annual recertification requirements for chronic conditions are a waste of resources.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline DME Claims Processes***

Summary: Real-time eligibility and coverage validation for DME claims can reduce billing errors, denials, and improve compliance, leading to a decrease in improper payments and audit burden. This streamlined process enhances operational and financial efficiency in the healthcare industry. Pharmacies can adjudicate in real-time through NCPDP standards, but DME cannot.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Medical Arts Chemists & Surgicals

Aggregated Comment Title: ***Set Time Limit for Third-Party Audits***

Summary: CMS should require that Medicare Advantage third-party audits occur within six months to a year of the patient's discharge date.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Ascension

Aggregated Comment Title: ***Simplify Navigating Across Portals***

Summary: Navigating portals for information is complex due to numerous commercial HMOs, some following CMS guidelines while others do not. Simplifying the ability to navigate across portals would make it easier to access information.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Require OIG and SAM Checks Annually***

Summary: Require only annual OIG and SAM checks; monthly checks are time-consuming and burdensome. Also consider only requiring screenings of healthcare providers, not for individuals who have no direct contact with beneficiaries.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Lumeris Healthcare; Maplewood of Cheshire County

Aggregated Comment Title: ***Remove FDR Definition and Requirements***

Summary: CMS should remove the definition and requirements related to First Tier, Downstream, and Related Entities (FDRs). Instead, focus on including Medicare compliance language in contracts, conducting risk assessments of key areas and vendors, and determining oversight activities. Eliminating the FDR/provider compliance program education and attestation requirements while maintaining publicizing Compliance Programs and overseeing FDRs through auditing and monitoring based on risk assessment would alleviate burden.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Rescind Provider Availability Requirement for Rural Health Clinics***

Summary: Rescind the provision in 42 CFR § 491.8(a)(6), which describes Staffing and Staff Responsibilities related to the Rural Health Clinics, which requires a provider to be available to furnish patient care services at all times the center operates. Based on this requirement, care by nurses must stop if the sole provider is called out for an emergency, and staff cannot pre-room patients to complete vitals and triage before the provider arrives. Additionally, rescind the 2006 memo requiring surveyors to enforce this requirement.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Rural Health Clinics

Aggregated Comment Title: ***Simplify e-Consults***

Summary: Simplify and streamline e-consults, such as easing restrictions on billing for e-consults based on subsequent visits. Further, regulations requiring patient consent for electronic consults create a barrier to improving care and reducing healthcare costs.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** University of Vermont Medical Center

Aggregated Comment Title: ***Adverse Outcomes of Accelerated eCQM and ECDS Implementation***

Summary: The hasty adoption of electronic Clinical Quality Measures (eCQMs) and Electronic Clinical Data Systems (ECDS) without proper infrastructure has resulted in higher costs, reporting challenges, and misaligned incentives for healthcare providers. This rushed transition compromises the reliability and effectiveness of quality measurement. CMS should extend the MSSP eCQM submission deadline to accommodate unexpected technical issues and ensure participants have adequate time to complete their submissions without penalty.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Piedmont Healthcare; The U.S. Chamber of Commerce

Aggregated Comment Title: ***COPs Affect Rural Hospitals Negatively***

Summary: CMS imposed new Conditions of Participation (COPs) for emergency services readiness and obstetric services without considering the challenges faced by rural hospitals. The additional provisions are redundant and may negatively impact rural hospitals' ability to comply, potentially leading to more closures of units providing obstetric services.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Rural Health Association

Aggregated Comment Title: ***The Medicare IPO List***

Summary: The Medicare Inpatient Only (IPO) List has had changes and then reversals over the last few administrations. This causes confusion and errors for hospitals, as the list complicates procedures and billing processes. Stakeholders find the list burdensome and prefer a focus on patient care based on health status rather than administrative requirements. CMS could conduct a comprehensive review of IPO-listed services to determine subsets for removal and improve the process for future changes. Establishing clear, evidence-based criteria for IPO list inclusion would simplify and clarify the process, reducing confusion and complexity.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): AVIA-Leavitt Partners Nexus Collaborative

Aggregated Comment Title: ***Rethink SCH Reporting Requirements***

Summary: Medicare reimburses sole community hospitals (SCHs) based on the higher of hospital-specific or federal payments. SCHs with higher hospital-specific payments may not receive DSH or UCP but must comply with audit and reporting requirements for these programs.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Citizens Memorial Hospital; Illinois Health and Hospital Association

Aggregated Comment Title: ***Do Not Reinstate Competitive Bidding Program for DMEPOS***

Summary: CMS should not reinstate the Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Further reductions in reimbursement rates could harm patient care and the stability of the supplier network. The program has already achieved its price discovery goal, and pushing rates lower may force suppliers out of the market, reducing access to necessary equipment and potentially compromising quality, especially in underserved areas.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Aeroflow Health; American Association for Homecare

Aggregated Comment Title: ***Eliminate Coding Requirements for Psychiatric Care***

Summary: Eliminate billing and coding requirements for psychiatric care at 42 CFR 483.102 as they are overly stringent and not based on medical criteria.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** MaineHealth

Aggregated Comment Title: ***Patient Consent for CAHPS Creates Challenges for Providers***

Summary: Patients must provide consent before CAHPS survey vendors can share patient-level encounter data with outpatient facilities or ambulatory surgical centers, hindering providers' ability to analyze survey results for improving patient experiences.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Supporting FHIR-Based PROM Standards Reduce Reporting Burden***

Summary: Supporting FHIR-based implementation guides for patient-reported outcome measures (PROMs) can help reduce reporting burden. It is recommended to certify APIs and digital platforms that adhere to FHIR PROM standards. In addition to this, using HL7 FHIR resources would allow for automated data collection, visualization, and exchange.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** International Consortium for Health Outcome Measurement (ICHOM)

Aggregated Comment Title: ***Integrate Standardized Outcome Tools Into EHR Systems***

Summary: Integrating standardized outcome tools into electronic health record (EHR) systems can help reduce reporting burden for healthcare providers. Recommendations include funding the integration of PROMs into EHRs through grants or pilot programs.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** International Consortium for Health Outcome Measurement (ICHOM); Price Services Group, L.L.C.

Aggregated Comment Title: ***Initial Certification Process Demands Significant Time and Resources***

Summary: The CMS Initial Certification process places a heavy administrative burden on hospitals and other certified facilities due to the extensive upfront work required to ensure compliance with all Conditions of Participation before the initial survey. This process demands significant resources and time. Moreover, the burden of potential delays in achieving certification due to deficiencies can create financial uncertainty and impact the timely generation of Medicare revenue, making program entry a significant administrative challenge, particularly for new facilities.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Survey Administration***

Summary: CMS should explore new forms of survey administrative, including AI and digital platforms, which would better support respondents and providers while providing timely and continuous results.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Patient Experience Policy Forum - The Beryl Institute; Piedmont Healthcare

Aggregated Comment Title: ***HVBP Reporting Is Duplicative and Overly Complex***

Summary: Documentation and reporting requirements for the Hospital Value-Based Purchasing (HVBP) Program are overly complex and duplicate measures from the Hospital Inpatient Quality Reporting (IQR) Program. Low-Value Structural Measures should be removed from programs as they impose a significant reporting burden with little utility for hospital performance differentiation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Federation of American Hospitals; Ohio Hospital Association

Aggregated Comment Title: ***Narrow the Focus of Emergency CoPs***

Summary: CMS should narrow the focus of new Conditions of Participation (CoPs) issued in late 2024 for hospital emergency services, focusing on emergency readiness, including staff training on the emergency protocols and a call-in system for each patient in the emergency services treatment area.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Federation of American Hospitals; Mayo Clinic

Aggregated Comment Title: ***Duplicate Billing and Claims Submission for Repeat Procedures***

Summary: Providers often encounter issues with duplicate billing, where the same service is billed more than once for the same patient and date of service, resulting in denials and administrative rework and the use modifiers to distinguish repeat procedures from duplicate claims. CMS should develop an online solution to streamline communication and address instances of multiple claims submitted for the same patient within the same timeframe.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Premier Inc

Aggregated Comment Title: ***Specialty Specific Registries Are Essential to Improving Data-Driven Healthcare***

Summary: Specialty-specific registries with long-term follow-up are crucial for clinicians to track and monitor their outcomes. These registries serve as vital data repositories for developing and testing measures and can be audited to ensure accuracy. With improved data portability, these registries will play an increasingly important role.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Quality and Performance Measures Committee of the Society for Vascualr Surgery; University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Burdensome Requirements for Independent Practices***

Summary: Prior authorization, MIPS/MSSP, and good faith estimate requirements place significant administrative burdens on providers, while Medicare reimbursement remains flat or declines with disincentives—posing sustainability challenges for independent practices.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Medical Group Management Association

Aggregated Comment Title: ***Eliminate Electronic Visit Verification for Home Health***

Summary: Eliminate the Electronic Visit Verification (EVV) mandate for home health. It was aimed at reducing fraud and improving accountability, but causes technical, operational, and privacy challenges. Rural providers encounter connectivity issues and device limitations, disrupting care workflows. EVV's intrusive monitoring strains provider-patient trust without enhancing quality or efficiency.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Illinois HomeCare & Hospice Council; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Replace Medicare's 8-Minute Rule Relevant Authority***

Summary: CMS should replace the confusing and time-consuming 8-minute rule with the AMA's Midpoint rule, a similar, but administratively simpler standard. The current rule is Medicare Claims Processing Manual, Ch. 5, Sec. 20.3(B), "Reporting of Service Units With HCPCS: Timed and Untimed Codes"; CMS, Transmittal 747, Dec. 1999).

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Deter Part C Plans from Denying Covered Services***

Summary: CMS should use its enforcement authority to prevent Part C plans from denying essential Medicare services and strengthen the 2024 MA alignment regulations which will alleviate burdens within the Medicare system.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Physical Therapy Association

Aggregated Comment Title: ***Revise Cost Reporting Requirements for Community Mental Health Center (CMHCs)***

Summary: Use abbreviated reporting in place of detailed annual cost reports for Community Mental Health Centers (CMHCs) paid on a Prospective Payment System (PPS). Full cost reporting could be used when a rebate is anticipated.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Council for Mental Wellbeing

Aggregated Comment Title: ***Replace the Word "Grievance" in the CMS SOM***

Summary: The word "grievance" can be confusing for many elderly residents in long-term care facilities, leading to difficulties in reporting concerns. CMS should replace the word "grievance" with "complaint" or "concern" in the State Operations Manual (SOM).

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Maplewood of Cheshire County

Aggregated Comment Title: ***Reimbursement Requirements***

Summary: Reimbursement requirements are burdensome. A commenter suggests CMS remove these requirements from oversight.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Virtual Appeals Hearings Enhancement***

Summary: Enhancing virtual appeals hearings could modernize the paper-centric appeals documentation processes by implementing fully digital workflows. A digital appeals workflow could include digital evidence presentation for real-time sharing of health data, interactive documentation review for examining EHR data during proceedings, and mobile accessibility through mobile-optimized interfaces for providers using tablet-based telemedicine systems. By mirroring successful telemedicine platforms, these enhancements seek to streamline and improve the efficiency of appeals hearings.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Form-Specific Feedback for CMS-485 OMB Control Number: 0938-0365***

Summary: Form CMS-485 (OMB Control Number: 0938-0357), which providers use for home health certification and care planning, is overly complex, redundant, and burdensome. The form requests information that providers have collected during the initial assessment, often from multiple systems. It is also excessively long and delays timely access to home health services, disproportionately affecting seniors and individuals with chronic diseases. CMS should utilize EHR systems to automatically update patient care plans and reduce the need for duplicate entries.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Eliminate One-Size-Fits-All Regulations***

Summary: CMS should eliminate regulations that apply to all entities because of regional variation and resource limitations of smaller providers. For example, pharmacies should not be held to the same standards as large health systems. Additionally, if an organization appears out of compliance, audit them directly without requiring all entities to do burdensome tasks like electronic visit verification.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Hands of Wellness; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Revise Sections of the IRA***

Summary: To remove ineffective policies and improve patient outcomes, CMS should focus on revising the health sections of the Inflation Reduction Act (IRA) that hinder progress towards breakthrough cures, limit patient access to care, and waste resources.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Survivors for Solutions; Taxpayers Protection Alliance

Aggregated Comment Title: ***Duplicative Wound Assessment Documentation Requirements***

Summary: Duplicative wound assessment forms are a common requirement during transitions of care, leading to repeated measurements, photos, and descriptions by providers for different payers, electronic medical records, and levels of care due to lack of interoperability. Different payers also have different coverage standards. This redundancy in documentation across paper and electronic systems results in clinicians having to re-enter data multiple times for various purposes like charts, billing, quality reporting, and device manufacturers. To streamline this process and reduce errors, a carry-forward continuity record that updates only the latest visit, recent treatment, effectiveness, and any plan changes could alleviate the burden on clinicians and improve efficiency.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance")

Aggregated Comment Title: ***Concerns with CED Policy***

Summary: Of the 27 Coverage with Evidence Development (CED) decisions, only seven have been finalized, leaving the rest unresolved for years without set time limits. Recommendations include establishing clear timelines and endpoints, ensuring adequate reimbursement post-National Coverage Determination (NCD), and streamlining the complex 30+ step process to prevent hindering innovation and patient access.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance"); PhRMA

Aggregated Comment Title: ***Consider Administrative Challenges Experienced by Smaller Medical Practices***

Summary: Small and medium-sized medical practices face a significant administrative burden due to the challenges of managing multiple quality reporting programs without dedicated staff, advanced IT systems, or financial flexibility. Unlike larger health systems that have centralized teams and scalable infrastructure, smaller practices often have to divert clinical or administrative staff to handle reporting tasks. The cost of compliance is higher for these practices because the time and money it takes extracting data, meeting divergent specifications and submitting reports strains the limited resources. This strain on resources not only increases financial pressure but also detracts from patient care and quality improvement efforts, potentially widening disparities in provider capacity and outcomes.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Lantana Consulting Group; Massachusetts Health Data Consortium

Aggregated Comment Title: ***Mandate the Use of Recognized Data Standards***

Summary: Mandating the use of recognized data standards to support CMS functions can streamline data flow, reduce manual tasks, and cut administrative costs. This approach enhances interoperability, improves efficiency, and allows providers to concentrate on delivering quality patient care by eliminating redundant submissions and reformatting efforts. CMS should mandate that plans report accurate, timely MA network adequacy and provider data in standardized, accessible, and regularly updated formats that providers can easily use.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Massachusetts Health Data Consortium; National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Incentivize Data-Exchange by Requiring FHIR in Programs***

Summary: CMS should incorporate FHIR-based capabilities as a fundamental requirement in programs like the Medicare Shared Savings Program and ACO REACH. Offering preferential scoring, bonus points, or financial incentives would reward organizations that exhibit real-time data exchange and automated electronic quality measure submission.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Psychiatric Association; Massachusetts Health Data Consortium

Aggregated Comment Title: ***SNF Attachment is Overly Burdensome***

Summary: The new SNF Attachment process is overly intrusive, especially for organizations like 501(c)3 facilities that already report annually. Key staff must contact various businesses to gather and report detailed information, diverting time from patient care. One member reported it took nearly a year to complete the form, involving executives, boards, and stakeholders. The complexity led CMS to issue multiple updates and deadline extensions, indicating the challenges faced by nursing homes in complying with the requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Greater New York Hospital Association

Aggregated Comment Title: ***Mandate Reimbursement for Services from Advanced Psychology Trainees***

Summary: CMS should mandate MACs and state Medicaid programs to reimburse for services delivered by advanced psychology trainees under the supervision of licensed psychologists. These trainees have completed doctoral-level coursework and are in the final phase of their clinical internship before licensure. By expanding the pool of supervised providers, CMS could ease the burden on the psychology workforce and improve access to care. Currently, 29 state Medicaid programs cover services by advanced psychology trainees, and some commercial plans are starting to provide reimbursement. Standardizing coverage for these trainees could help support the psychology workforce pipeline and enhance access to mental health services.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** The American Psychological Association Services, Inc.; University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Clarify Provider Rights with Medicare Advantage Plans***

Summary: Providers who have not agreed to cover non-covered services under their agreement with a Medicare Advantage Organization (MAO) should have the same appeal and review rights as non-participating providers. CMS should specify that unless the MAO has a contract with the provider to assume financial responsibility, the MAO should be responsible for the costs of plan-directed care.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Streamline MA Approval with Revision in Program Integrity Manual***

Summary: CMS should revise the Program Integrity Manual, Pub. No. 100-08, Ch. 3, Sec. 3.3.2.1, Documents on Which to Base a Determination, by adding a provision stating: "When requisition forms include complete information validating medical necessity, such as qualifying clinical information that demonstrates test coverage criteria are met, the test requisition form is sufficient to determine whether a service is reasonable and necessary for Medicare beneficiaries without other medical information from the ordering provider." Communicate this update to the MACs through written communication and to MA plans through a Health Plan Management System (HPMS) memo.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Address Administrative Barriers Imposed by MA Plans***

Summary: CMS can tackle the various administrative obstacles imposed by Medicare Advantage (MA) plans, such as the inconsistencies across plans in quality measures, definitions, documentation standards, and reporting platforms, which greatly increase provider burden.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Psychiatric Association; Quest Diagnostics

Aggregated Comment Title: ***HCC Coding is Overly Complex***

Summary: Finding, submitting, and resubmitting the appropriate codes for hierarchical condition category (HCC) coding can be a challenging task due to the specificity and duplication required. This process can be tedious and time-consuming. When a patient's chart includes multiple diagnostic codes that are related to the same medical issue, it can create confusion about the correct coding. Significant time must be invested in resolving these coding issues. CMS should simplify the HCC coding process.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Gritman Medical Center Kendrick Family Care; Hospital Association of Rhode Island

Aggregated Comment Title: ***Revise Home Health Authorization and CoPs for Chronically Complex Pediatric Patients***

Summary: Children’s hospitals have identified the Chronically Complex Pediatric Patients CoP-related regulations as particularly burdensome at 42 CFR 484.50.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Children's Hospital Association; Premier Health

Aggregated Comment Title: ***Consolidate PPS Rule with a Broad Framework***

Summary: Simplifying administrative compliance in the PPS rule by replacing provider-specific rules with a more coherent framework would enhance program effectiveness and reduce system complexity.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Commercial Medicare HMO Advantage Plans Delay Care with Low Reimbursements and High Denials***

Summary: Commercial Medicare HMO Advantage plans have poor reimbursement rates and high denial rates for claims, poor follow-ups, and delays in patient care implementation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Streamline Health Plan Mailings***

Summary: Remove envelope requirements for health plan mailings.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Call Monitoring is Burdensome for MA Plans***

Summary: Monitoring calls and volume is time-consuming and burdensome for Medicare Advantage plans. Streamline requirements so plans can focus on assisting enrollees effectively. Plans can automate call recording by using metadata and tagging to distinguish call purposes, reducing unnecessary recordings, protecting privacy, and adapting documentation methods as conversations move beyond marketing topics.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Price Services Group, L.L.C.

Aggregated Comment Title: ***Modify PACE Marketing Guidelines***

Summary: Modify PACE marketing guidelines to allow proactive solicitation of potential participants. Aligning marketing guidelines with Medicare Advantage plans would increase awareness and access to PACE programs. Also by lifting restrictions on door-to-door marketing, PACE organizations can reach more individuals who would benefit from their services. Restrictions on PACE organizations' direct marketing efforts, as they are not currently listed on the Medicare Plan Finder, limits Medicare beneficiaries who could benefit from PACE because they don't know about the program.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Catholic Health Association; InnovAge

Aggregated Comment Title: ***MIPS Participation Costs Physician Practices More Time and Money***

Summary: Physician practices spend significantly more time and money on MIPS participation than estimated by CMS. A study revealed that practices devote over 200 hours per physician and more than $12,000 annually, contrasting with CMS's estimates of 38 hours and $7,800. The Administration reviews and adjusts these burden estimates to accurately reflect the impact on small and rural GI practices for informed policy decisions.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Gastroenterology (ACG)

Aggregated Comment Title: ***Medicare Cost Reports are Inaccurate***

Summary: CMS must rectify inaccurate cost reports to ensure fair reimbursement rates for Medicare-covered services. For example, approximately $28m in patient servicing costs by DMEPOS suppliers in HHA and SNFs is unaccounted for, necessitating inclusion in cost report calculations for sustainable patient care and precise Medicare funding. Hospitals are not provided with all applicable data at the time of report submission, such as SSI ratios.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Association for Homecare; Healthcare Financial Management Association

Aggregated Comment Title: ***Establish Presumptive Eligibility for Post-Acute Care Services***

Summary: To streamline access to post-acute care (PAC) services and reduce administrative burden, CMS could implement a presumptive eligibility model where providers can initiate services without prior authorization when a physician certifies the need for PAC. This approach aims to provide timely care while maintaining oversight and could benefit both providers and plans by lowering administrative costs and reducing delays.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; LeadingAge PA

Aggregated Comment Title: ***Automate Medication Review Process***

Summary: CMS should automate the medication review process through Medicare reaching out to patients or providers to verify accurate medication lists. The current level of scrutiny is excessive and should be automated or managed by a more suitable group or setting within the healthcare system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Budget Neutrality in Physician Fee Schedule***

Summary: Applying budget neutrality solely to the physician fee schedule in the US has led to distortions within the payment system. This approach, which is not extended to other parts of the budget, has created an imbalance in healthcare reimbursement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Increase Efficiency for CMS Payments to Prevent Providers Cutting Corners***

Summary: Efficiency reduction for procedures leads to physicians cutting corners to manage overall payment reductions from CMS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate MedPac and Use the Same Conversion Factor***

Summary: Eliminate MedPac and establish a level playing field for hospitals and physicians by implementing the same conversion factor. While the Relative Value Units (RVUs) may vary, equalizing the conversion factor and applying identical rules to both parties would improve fairness and consistency in reimbursement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Rethink Approach to Bad Actors in the DMEPOS Space***

Summary: CMS and its contractors' response to recent DOJ investigations and indictments has led to increased audits, intense credentialing scrutiny, and slow processing times for National Supplier Clearinghouse applications. There are bad actors in the industry, but CMS's measures lack a focus on preventing or promptly detecting such bad actors. MAC auditors are applying outdated processes and imposing financial and administrative burdens on compliant companies. More targeted approaches are needed to address the issue effectively.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require Only Necessary Information for the ESRD 2728 Form***

Summary: ESRD (End-Stage Renal Disease) 2728 form should be as brief as possible only requiring necessary information.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Berkshire Medical Center

Aggregated Comment Title: ***Standardize Electronic Health Record Software***

Summary: Standardizing Electronic Health Record software to ensure a more uniform protocol for computer systems, enabling reliable and equal data access across facilities of all sizes. This standardization would promote equity in healthcare by providing all hospitals with the same level of access and functionality in their software programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Repeal the CEHRT Requirements for ACOs***

Summary: Repeal the CEHRT requirements for ACOs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***Remove Enhanced Communications Services from Interprofessional Referral Services***

Summary: CMS should exclude interprofessional telephone/internet/EHR referral services from Enhanced Communication Services due to their focus on patient-care team communication. Interprofessional referrals (CPT codes 99446-99449) are mainly reported by specialties other than primary care within this service element.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***Clarify Requirements and Process for APCM Service Consent***

Summary: CMS should clarify the process for obtaining consent for APCM services from established patients through various methods like face-to-face encounters, telephone conversations, and written consent. CMS should provide specific and descriptive guidance and optional templates for practices to use in obtaining consent to reduce the administrative burden of implementing APCM codes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***Reinterpret Definition of Incurred Costs***

Summary: CMS should revise the definition of "incurred costs" under 42 C.F.R. 423.308 to exclude supplemental benefits, except for Employer Group Waiver Plans. This would streamline

bid development, decrease reconciliation complexities, and better adhere to Congress's intentions as stated in the Inflation Reduction Act.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Prime Therapeutics LLC

Aggregated Comment Title: ***Automate Part D Eligibility Determination***

Summary: Automating Part D eligibility determination would enhance efficiency, allowing plans to focus care management resources on beneficiaries who are most likely to benefit.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Prime Therapeutics LLC

Aggregated Comment Title: ***Simplify Medicare Advantage Bid Documentation***

Summary: CMS can simplify the bid documentation for Medicare Advantage plans by removing the "Instructions for Completing the Medicare Advantage Bid Pricing Tools, Appendix B: Supporting Documentation."

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Single Written Notice to Reduce Notification Burden***

Summary: The notification burden may be reduced to a single written notice, which can be delivered electronically based on the beneficiary’s preference.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Payer to Payer API***

Summary: New regulations governing Payer-to-Payer API for patient data exchange may make access more challenging, due to the requirement for payers to share data only within five years of the date of service request, and a patient opt-in process that CMS has not yet finalized.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** America's Physician Groups (APG)

Aggregated Comment Title: ***Revise Procedure for Involuntary Disenrollment for Part B***

Summary: Under current procedures related to involuntary disenrollment for loss of Part B or erroneous disenrollment due to a member's death, the member is responsible for notifying the Medicare Advantage plan. This process is unnecessary, confusing, and adds work for the enrollee.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Procedures for Undeliverable Mail Cause Complaints and Burden***

Summary: The current procedures for undeliverable mail lead to complaints from members regarding excessive paperwork. The process increases administrative burden on plans without providing commensurate benefit to enrollees.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Part B Coinsurance Rates Should Change Less Frequently***

Summary: CMS should streamline current allowable Part B coinsurance rates by allowing less frequent updates, but with more meaningful changes to the rates.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Medicare Advantage Pricing and Code Change Updates Occur Too Frequently***

Summary: CMS sends MA plans pricing and code changes frequently and on an ad hoc basis throughout the year, which require a significant amount of operational work to implement and result in confusion for providers. CMS should instead aggregate pricing and code changes into annual or semiannual updates.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Plans Should Only Send Explanation of Benefits When Beneficiary Has Financial Liability***

Summary: CMS should require that plans send Explanations of Benefits (EOBs) to enrollees (whether on a per claim basis or monthly) only when the EOB describes financial liability on the part of the enrollee. The current requirement that an EOB be sent regardless of liability on the part of the enrollee results in excessive paperwork that does not benefit the enrollee.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Grievance Procedures for Members are Unnecessarily Broad***

Summary: Current procedures for member grievances are overly broad, diverting attention from significant issues related to accessing quality care. Streamlining these processes could improve efficiency and focus on addressing meaningful challenges in healthcare access.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Eliminate PA Employer Restrictions on Hospice Medication Orders***

Summary: Physician assistants (PAs) are currently allowed to prescribe medications for their hospice patients only if they are designated as the attending physician and are not employed by or contracted with the hospice. This restriction creates limitations and burdens for providers, ultimately affecting patient care. CMS should allow PAs to order medications for their hospice patients, regardless of their employment status with the hospice.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Alliance for Care at Home

Aggregated Comment Title: ***Repeal the Packaged Laboratory Services Rule***

Summary: CMS should repeal the laboratory test packaging-2013 OPPS final rule, effective in 2014.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AdvaMed

Aggregated Comment Title: ***Varying Hospice Change of Provider/Transfer Notice Statements***

Summary: Hospices face challenges in creating Change of Provider/Transfer Notice due to lack of CMS guidance, resulting in varying formats causing administrative burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***OQR Measure OP18, Median Time from ED Arrival to ED Departure Causes is Manual and Unreliable***

Summary: Data collection for the Hospital Outpatient Quality Reporting (OQR) Program measure OP18, Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients, involves manual entry of time stamps by abstractors, which can introduce human errors and result in unreliable data that may not accurately represent hospital performance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Vizient, Inc.

Aggregated Comment Title: ***Do Not Use Health Outcomes Survey Measures in Star Ratings***

Summary: CMS should not use Health Outcomes Survey (HOS) measures for plan star ratings as survey results may not be properly interpreted. Instead, CMS should re-add Physical and Mental Health measures from HOS, emphasizing their importance with a weight of 1 for 2026 and 3 for 2027 ratings.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** SCAN Health Plan

Aggregated Comment Title: ***End the Option to Opt-Out***

Summary: Eliminate the option for providers to opt out of Medicare.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Prosper DPC

Aggregated Comment Title: ***Eliminate ASCQA***

Summary: Eliminating ASCQA will simplify Medicare reporting and documentation requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Clarify Dentists Covered by Supplemental Dental Do Not Need to Enroll in Medicare***

Summary: CMS should clarify that dentists providing care covered by supplemental dental benefits in Medicare Advantage plans do not need to enroll in Medicare. CMS should also confirm that dentists who have opted out of Medicare can still provide care and receive reimbursement under these supplemental benefits. Since dental services are not typically covered by Medicare, requiring dentists to enroll would create unnecessary administrative burdens, as they have already undergone credentialing to be in-network with Medicare Advantage plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Dental Association

Aggregated Comment Title: ***Establish Uniform Guidelines for MA Dental Prior Authorization***

Summary: There needs to be enhanced transparency and uniformity in prior authorization processes for dental services covered by supplemental benefits in Medicare Advantage. Despite the relatively small cost of these benefits compared to hospitalization visits, the process lacks consistency and clarity. Strengthening these requirements would offer dentists clearer guidelines for creating treatment plans, ensuring patients receive care without disruptions or modifications based on their specific supplemental dental coverage.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Dental Association

Aggregated Comment Title: ***Medicare Advantage Cards Should Include Dental Plan Information***

Summary: Billing for Medicare Advantage supplemental dental benefits is complex due to the diverse plans and changing parameters, and dental offices have difficulty determining patient cost-sharing. To simplify the process, Medicare Advantage cards should include detailed information on supplemental dental benefits, including annual limits, covered services, cost-

sharing responsibilities, and co-pays. This would streamline billing procedures and improve transparency for both providers and patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Dental Association

Aggregated Comment Title: ***Automate Administrative Transactions for Dental***

Summary: The current HIPAA-mandated electronic transactions in dentistry do not support fully automated processes due to dental-specific data elements, leading to increased costs for providers and insurers. Adopting ADA/ANSI standards could save the healthcare system $2.1 billion annually and save dental providers an average of 31 minutes per patient by automating administrative transactions. Aligning Medicare with these industry best practices for dental transactions would bring efficiency and cost savings to the healthcare system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Dental Association

Aggregated Comment Title: ***Waiver of Liability is Problematic***

Summary: Non-contracted providers can file a standard appeal for denied claims by submitting a Waiver of Liability statement, waiving payment collection rights. Concerns arise regarding providers who sign this waiver for supplemental dental services, potentially discouraging provider participation. This impacts network adequacy and patient access to Medicare Advantage supplemental benefits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Dental Association

Aggregated Comment Title: ***Unclear Process and Guidance for Patient Financial Liability in Medicare Advantage***

Summary: Providers are facing challenges in shifting financial liability to Medicare Advantage plan enrollees due to restrictions on using ABNs or HINNs, except for HINN 10. The lack of guidance from CMS leaves providers unsure of how to hold patients accountable for their financial responsibilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Develop National Set of Services Requiring Prior Authorization***

Summary: The complex maze of prior authorization and appeals could be streamlined by promoting the development of a national, standardized set of services requiring prior authorization, with clear, evidence-based criteria, uniform documentation requirements, and timelines, regardless of payer.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***FDA Laboratory Testing Rule is Burdensome***

Summary: The FDA's laboratory testing rule is costly and administratively burden for hospital labs while adding little benefit. It has been challenged in court but is still unresolved.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***Simplify Therapy Regulations Around Site-of-Service***

Summary: CMS should relax site-of-service rules for therapy services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***MIPS Should Exclude Pediatric Providers***

Summary: MIPS should exclude pediatric providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***Adjustment for Cost Measures***

Summary: All cost measures used in the MIPS program should be appropriately adjusted to account for clinical complexity and economic risk factors.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association of American Medical Colleges

Aggregated Comment Title: ***Permit Promoting Interoperability Reporting Through Attestation***

Summary: CMS should use the HITECH Act's authority to enable reporting of Promoting Interoperability (PI) through yes/no attestations, with each "yes" carrying a specific point value. This approach would reduce reporting burdens, encourage EHR development to better meet patient and physician needs, and identify gaps in health IT functionality for prioritization.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association of American Medical Colleges

Aggregated Comment Title: ***Requiring Staff to be Present for Billing***

Summary: CMS mandates hospital staff providing care management services to be present in the hospital, even if the patient is no longer there. Because some hospitals contract for care management staff, this is a burdensome requirement. CMS should make exceptions for hospitals, similar to those in the OPPS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association of American Medical Colleges

Aggregated Comment Title: ***Ensure Parity Between Remote Mental Health Services and Care Management***

Summary: To ensure parity between remote mental health services and care management services provided remotely, CMS can revise 42 CFR § 410.27(a)(1)(iii) to add the following language after the words "communication technology:" "and care management services when the patient is not physically present in the hospital."

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association of American Medical Colleges

Aggregated Comment Title: ***Reverse Requirement for ACOs to Report QPP PI Data***

Summary: CMS should make adjustments to regulations for ACOs in the SSP to reduce burden and maintain participation in the primary value-based care model for Medicare providers. CMS should reverse the policy that mandates ACOs to report QPP PI data, irrespective of their QP status, as outlined in 42 C.F.R. § 425.507.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association of American Medical Colleges

Aggregated Comment Title: ***Streamline Prior-Authorization Requirements***

Summary: It is crucial for Medicare Advantage plans to streamline prior-authorization requirements by simplifying processes and coverage criteria. To ensure prior-authorization requirements do not limit patients' access to care, it is important to streamline processes and coverage criteria.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association of American Medical Colleges

Aggregated Comment Title: ***Clarify Guidance Related to APM Participation***

Summary: CMS should consolidate and clarify guidance related to APM participation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American College of Cardiology

Aggregated Comment Title: ***Regulatory Relief Should Maintain Oversight***

Summary: Regulatory relief in Medicare should prioritize maintaining core integrity, quality, and accountability while reducing burden and supporting patient-centered care. CMS should focus on implementing quality programs that uphold accountability and equity without compromising the foundational oversight that Medicare offers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American College of Cardiology

Aggregated Comment Title: ***MA Should Not Request Extra Documentation for Test Requisition Forms***

Summary: When Test Requisition Forms (TRF) contain required information for coverage criteria as per LCD or NCD, MA organizations should not request extra documentation unless a clearly documented deficiency can be provided.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Castle Biosciences Inc

Aggregated Comment Title: ***Eliminate Auto-Forwarding of Coverage Determinations in Part D***

Summary: Initial/first-pass coverage determinations in Medicare Part D involves plans automatically forwarding cases to the Part D IRE, as there is no unfavorable decision for the enrollee to appeal in the case of a coverage determination approval, leading to no benefit for enrollees. The IRE has little incentive to review the case due to its favorable outcome. Unlike Part C, there is no requirement for auto-forwarding untimely determinations, prompting a suggestion to align Part D requirements with those of Part C.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kaiser Permanente

Aggregated Comment Title: ***Automate MA Reinstatement in MARx***

Summary: When a beneficiary is disenrolled from a Medicare Advantage (MA) plan due to a loss of entitlement for Part A or Part B, or because incorrect information has been entered in their records—such as being mistakenly labeled as incarcerated or unlawfully present in the United States—MA plans encounter time-consuming manual processes to reinstate their enrollment and process retrospective adjustments. Reinstating enrollees in these situations is more complex than for other types of errors, such as those involving death. Implementing automatic reinstatement in the Medicare Advantage/Prescription Drug (MARx) system when these errors are corrected would help alleviate the administrative burden on MA plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kaiser Permanente

Aggregated Comment Title: ***Eliminate Quality Measures When Adding New Measures***

Summary: CMS should implement a "one in, one out" policy for quality measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Hospital Association

Aggregated Comment Title: ***Modernize Ghost Claims Reporting***

Summary: The current 1500 claim form limits providers to 12 diagnostic codes per claim, requiring multiple submissions for full reporting. CMS should modernize the ghost claims reporting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Hospital Association

Aggregated Comment Title: ***Allow Bundling of Recurring Service ABNs***

Summary: Allow bundling of recurring service Advanced Beneficiary Notices (ABNs) to reduce redundant paperwork and administrative costs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Hospital Association

Aggregated Comment Title: ***Modify Definition of Applicable Manufacturer in OPP***

Summary: Modify the definition of "applicable manufacturer" in the Open Payments Program (OPP) to exclude wholesalers and distributors of pharmaceutical products and medical devices from reporting requirements. This is consistent with plain language of the statue.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Distribution Alliance

Aggregated Comment Title: ***Standardize Waivers and Simplify Implementation for MSSP***

Summary: Reduce regulatory burdens in the Medicare Shared Savings Program (MSSP) by standardizing waivers and simplifying implementation requirements to foster innovation within the healthcare system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of ACOs

Aggregated Comment Title: ***Streamline Voluntary Alignment***

Summary: Streamline the approach for voluntary alignment to make it a more useful tool for increasing beneficiary engagement and fostering patient choice. This includes aligning the MSSP approach with signed voluntary alignment in REACH by removing the language at 42 CFR 425.402(e) that restricts voluntary alignment to an electronic designation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of ACOs

Aggregated Comment Title: ***Restore Prior Benchmark Approaches in MSSP***

Summary: Reduce regulatory burdens in the Medicare Shared Savings Program (MSSP) by restoring previous benchmark approaches.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of ACOs

Aggregated Comment Title: ***Prohibit Prior Authorization for Medications Without Alternative***

Summary: CMS should replace or amend 42 CFR 422.138, 42 CFR 422.122, and 42 CFR 423.120 and eliminate the use of prior authorization for medications that do not have an equally effective alternative.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Rheumatology

Aggregated Comment Title: ***Review Definition of Chronic Renal Insufficiency***

Summary: CMS should examine whether updates to the regulatory definition of 'chronic renal insufficiency' under 410.130 could reduce confusion, close the current coverage gap, and improve care continuity for patients with progressive kidney disease.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Academy of Nutrition and Dietetics

Aggregated Comment Title: ***Pricing Transparency Requires Billing Standardization***

Summary: Pricing transparency is ineffective without standardized billing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Use AI for Billing and Coding***

Summary: Use AI for billing and coding.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Lack of Available Measures for Anesthesia***

Summary: Anesthesia-specific quality measures are scarce, with many already "topped out" which makes it challenging to improve scores and avoid penalties despite mandatory reporting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Remove the M1800 OASIS Items***

Summary: The M1800 items should be removed from the next revision to the OASIS instrument.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Aegis Therapies

Aggregated Comment Title: ***Allow Advance Notice for Surveys***

Summary: Accreditation Organizations (AOs) should provide hospitals 24 hours' advance notice of a survey. Brief advance notice would allow the hospital to resolve simple scheduling issues that could ensure maximum access to hospital leadership and other staff, making the survey results more useful and reflective of the care the hospital provides for the facility, public, and CMS' consideration.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Federation of American Hospitals

Aggregated Comment Title: ***Clarify "Fee-Based Consulting Services" Definition***

Summary: CMS is considering restricting Accreditation Organizations (AOs) from offering fee-based consulting services to providers before initial surveys and during the 12 months before reaccreditation surveys. CMS should clarify that this restriction would not apply to subscription-based generic consultative tools, as these tools are essential for hospitals to generate self-assessment reports, meet Conditions of Participation (CoPs), and prepare for surveys. Limiting the use of these resources could have a negative impact on hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Federation of American Hospitals

Aggregated Comment Title: ***Minor Administrative Errors Result in Penalties***

Summary: Facilities face penalties for minor administrative errors, like using a "Doing Business As" (DBA) name instead of the legal business name.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Keep Measures Focused on Beneficiaries***

Summary: Provider costs of measurement should be a secondary consideration in removal of measures and never dwarf the rightful place of Medicare beneficiaries as the top concern. CMS

is the agency responsible for paying providers on behalf of beneficiaries, and proper stewardship of that mission requires that patient needs and risks be the first and foremost concern.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Leapfrog Group

Aggregated Comment Title: ***Publish List of ICD-10 Codes Ineligible for Reimbursement***

Summary: Medicare should share a list of ICD-10 codes that are ineligible for reimbursement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Consolidate Nursing Home Reporting into a Single Dashboard***

Summary: Conduct an evaluation of existing reporting requirements and digital platforms to assess how to consolidate nursing home reporting into a single, unified dashboard. This centralized system would allow both CMS and state agencies to access the same data from one location, using a single sign-on for all reporting needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge PA

Aggregated Comment Title: ***Burdensome ED Protocols***

Summary: Protocols targeting delirium in elderly ED patients may strain resources due to diverse high-priority cases. Age-based prioritization may neglect younger patients at risk of deterioration, as cognitive status varies widely among older adults.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Northwestern Medicine

Aggregated Comment Title: ***Perform Age Friendly Social Vulnerability Assessments at Admission***

Summary: Performing social vulnerability assessments (Age Friendly Hospital Measure Domain 4: Social Vulnerability) for patients aged 65 and older at admission, rather than at discharge, is more efficient as vulnerabilities are unlikely to change significantly during a hospital stay. Early assessment enables care teams to arrange timely support and interventions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Northwestern Medicine

Aggregated Comment Title: ***Eliminating MIPS CQM Reporting Is Difficult and Wasteful***

Summary: CMS' current plans to eliminate MIPS clinical quality measure (CQM) reporting (and potentially Medicare CQM) by the 2026 performance period/2028 payment year will be nearly impossible. Additionally, current investments in reporting infrastructure may be wasted as ACOs will soon be required to adopt the HL7 FHIR standard.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Replace LTCH and IRF QRP Penalties with New Regulations to Include 'Cure' Period***

Summary: Repeal the LTCH QRP and the IRF QRP regulations on penalties for noncompliance and replace them with new regulations that include a "cure" period for hospitals receiving a notice of noncompliance. Currently, failing to meet QRP requirements results in a two percent payment reduction across all Medicare payments for LTCHs and IRFs. The new regulations aim to provide providers with an opportunity to rectify minor errors before facing payment penalties, ultimately improving the accuracy of reported quality data and reducing the burden and punitive nature of the QRPs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***TPE Review Policy Grants Unlimited Discretion to MACs***

Summary: CMS regulatory policy allows MACs to perform targeted probe and educate (TPE) reviews on Medicare providers, particularly focusing on IRFs for inpatient issues. These reviews can occur post-payment or even lead to pre-payment claim reviews and potential payment withholding. The policy grants MACs unlimited discretion in selecting providers for reviews, lacking valid criteria and overlapping with other claim review programs, making it burdensome and redundant.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Mandatory Data Completion Thresholds for QRP Compliance***

Summary: Regulations require LTCHs and IRFs to meet data completion thresholds for QRP compliance, but these rules are overly complex and burdensome. Providers are penalized for minor errors like typos in non-quality data, rather than deficient quality data submission. Issues with government reporting systems also contribute to noncompliance. Penalizing providers for non-quality data errors hinders the efficient collection and publication of quality information.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Implement a Deadline for Making Changes to a Therapy Plan of Care***

Summary: The regulation at 42 C.F.R. 410.61(d) allows physicians to modify a therapy plan of care (POC) for outpatient therapy at any point, creating challenges for therapists due to the lack of a deadline for changes. This process can be burdensome as therapists must confirm with physicians for any alterations, leading to potential delays and adjustments in planned therapy sessions, especially when patients have already undergone sessions. Physicians' administrative burdens often result in delays of weeks before evaluating and communicating changes to therapists, further complicating the therapy process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Implement Time Constraints on Physician Modifications to Therapy POCs***

Summary: Repeal and replace regulation [42 C.F.R. 410.61(d)] to include a time limit on physician changes to a therapy POC. Last year, CMS considered limiting physicians to 10 business days to modify the POC but did not implement the change, which CMS should make this change now.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***QRP Non-Compliance Triggers 2% Payment Cut Without "Cure" Period***

Summary: LTCHs and IRFs facing non-compliance with QRP requirements risk a two percent payment reduction on all Medicare payments without a cure period to rectify data issues. The current regulations are burdensome to providers and costs exceed the benefits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Concerns with Medicare Spending Per Beneficiary Post-Acute Care Measure***

Summary: The Medicare Spending Per Beneficiary Post-Acute Care (PAC) measure in the LTCH and IRF QRPs is burdensome and hinders care coordination. Patients and families struggle to interpret its impact on care quality and safety, leading to unintended consequences favoring certain PAC facilities over others. This measure disproportionately affects LTCHs and IRFs, potentially limiting patient choice and lacking timely and representative public reporting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***CMS Policy Prevents Eligible Patients From Qualifying for LTCH***

Summary: CMS regulations restrict LTCH patient criteria to those directly admitted from "subsection (d)" hospitals, excluding patients from CAHs and REHs. This unsound limitation excludes beneficiaries from these facilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Create Payment Adjustments for Medically Complex Patients in LTC***

Summary: CMS should consider adopting payment adjustments for certain medically complex patients in Long-Term Care Hospitals (LTCHs) who do not currently qualify for standard payment rates. These adjustments would increase payments for patients with high acuity, severe wounds, non-ventilator respiratory conditions, complex infections, cancer, spinal cord injuries, brain injuries, transplants, congestive heart failure/advanced heart failure, and pulmonary hypertension. The proposed adjustments aim to bridge the gap between site-neutral and full standard Federal payment rates for these specific patient populations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Add More Qualifying Conditions to IRF Payment Classification Rule***

Summary: Modify the 60% Rule at 42 C.F.R. 412.29(b)(1) for Inpatient Rehabilitation Facilities (IRFs) by expanding the list of qualifying conditions to include cardiac, cancer, and transplant patients. The current rule allows CMS to specify qualifying diagnoses, but the list has not been updated in over 20 years. Updating the rule could reduce the burden on IRFs, hospitals, and beneficiaries, making IRFs a more beneficial care setting for a wider range of patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Rule No.93-1 Disregards Medical Judgment of Treating Physician***

Summary: Over 30 years ago, the Health Care Financing Administration (now CMS) ruled against giving "presumptive weight" to a treating physician's opinion in medical necessity determinations. While the treating physician's certification is necessary for coverage, it does not guarantee coverage of recommended care. Many claims for LTCH and IRF services are denied as medically unnecessary by Medicare contractors, who may consider the care treatable at previous short-term care hospitals or other settings. This rule disregarding the professional medical opinion of treating physicians is criticized as unsound, as they are better equipped to assess a patient's clinical need for LTCH services compared to Medicare contractors or appeal bodies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Repeal Rule Preventing Deference to Treating Physician's Medical Judgment***

Summary: Repeal the rule preventing deference to a treating physician's medical judgment regarding the reasonableness and necessity of Medicare services, replacing it with a regulation that presumes the physician's judgment is correct. This change would protect patient access to hospitals, such as LTCHs and IRFs, by ensuring reliance on treating physicians' opinions for patient admissions and treatment costs, preventing second-guessing by Medicare contractors or appeal reviewers that could harm providers and patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Repeal Requirement for Individual Overall Plan of Care at IRF***

Summary: CMS should repeal the regulation requiring an IRF individualized overall plan of care (IOPC) to be completed within four days of a patient's admission and the rule specifying elements in the IOPC, as outlined in 42 C.F.R. 412.622(a)(4)(ii)(A). This requirement is duplicative of the multidisciplinary assessments conducted during the admission assessment process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***TPE Reviews Lack True Targeting and Educational Value***

Summary: CMS allows MACs to perform targeted probe and educate (TPE) reviews on providers. However, critics argue that the TPE program lacks true targeting and educational value. CMS should approve for each issue MACs want to review under the TPE program in advance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Dual Rate Program for New LTCHs***

Summary: New long-term care hospitals (LTCHs) are required to adhere to the dual rate payment system after a 6-month qualifying period, despite facing distinct challenges as new facilities. This policy is unsound as the site neutral payment rate places a heavy financial burden on new LTCHs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Revise Transfer Policy to Exempt Patients Who Meet LTCH Criteria***

Summary: Repeal and replace the CMS regulation that applies the IPPS post-acute transfer policy to patients who meet LTCH criteria. To reduce administrative burden on providers and enhance access to care for beneficiaries, the post-acute care transfer policy should be replaced with a rule that exempts LTCH criteria patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Implement a Real-Time Authorization Process for High-Acuity Patients***

Summary: CMS is recommended to implement a real-time authorization process for high-acuity patients, like those in LTCHs with severe conditions, to replace current regulations and reduce burdens on healthcare providers and beneficiaries by enabling providers to receive immediate decisions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Repeal MA Prior Authorization Processes to Exempt High-Acuity LTCH Patients Meeting Criteria***

Summary: Repeal and replace MA regulations on prior authorization processes to exempt high acuity LTCH patients that meet specific criteria set by Congress. It argues that patients meeting these criteria are inherently high acuity cases and should not be denied admission to LTCHs by Medicare Advantage Organizations MAOs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Repeal MA Prior Authorization Rules with Shorter Request and Appeal Timeframes***

Summary: Repeal and replace current MA prior authorization rules with shorter request and appeal timeframes to reduce harm from denied care by MAOs. The recommendation is for up to 72 hours for standard requests and up to 24 hours for expedited requests.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Repeal Regulations That Mandate Redundant Validation Surveys***

Summary: The recommendation is to repeal the regulation that mandates redundant validation surveys for compliance with Conditions of Participation (COPs) and to find alternative monitoring methods for state survey agencies and accrediting organizations that are less burdensome for providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Time Study Requirements***

Summary: CMS should revise physician time study requirements at 2313.2 of CMS publication 15-1 to reduce administrative burden on hospitals and clinicians. Eliminating the need for time studies and allowing certification of time allocation would streamline processes and enable clinicians to focus on patient care rather than administrative tasks.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Memorial Sloan Kettering Cancer Center

Aggregated Comment Title: ***Revise Medicare Part C Prior Authorization Requirements***

Summary: Prohibit Medicare Part C providers from imposing prior authorization requirements on care that complies with evidence-based, nationally recognized clinical guidelines.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Memorial Sloan Kettering Cancer Center

Aggregated Comment Title: ***Streamline Processes for Adjusting Rate Increase Ceilings***

Summary: CMS should simplify procedures in 42 CFR 413.40 for adjusting rate increase ceilings on target amounts per discharge for hospitals under reasonable cost basis, like PPS-exempt cancer hospitals. Streamlining these processes would enhance efficiency and effectiveness in managing rate adjustments for these healthcare facilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Memorial Sloan Kettering Cancer Center

Aggregated Comment Title: ***Remove Free-Text Field from MOON***

Summary: CMS should revise the Medicare Outpatient Observation Notice (MOON) to remove the mandatory free text field for hospital staff to describe patient-specific clinical considerations. The section is burdensome and not beneficial to patients. CMS could replace this field with CMS-prepared standard language explaining the reasons physicians order observation services for patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Hospital Association

Aggregated Comment Title: ***Rescind Delayed Safe Harbor for Drug Rebates Rule***

Summary: The Department of Health and Human Services Office of Inspector General previously issued a final rule in November 2020 to remove safe harbor protection for prescription drug rebates and replace it with a new protection for certain discounts offered at the point of sale (85 FR 76666). This rule has been delayed multiple times, most recently in the Inflation Reduction Act of 2022 (P.L. 117-169) until 2032. Given the rule has already been delayed multiple times, it should be formally rescinded.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield Association

Aggregated Comment Title: ***Exclude Concurrent and Post-Service Requests from Expedited UM Requests***

Summary: Medicare Advantage (MA) plans must handle expedited utilization management requests, even for beneficiaries already receiving or completed services, causing inefficiencies and administrative challenges. This process may not benefit beneficiaries who have already accessed care and can delay urgent request resolutions, diverting resources. Excluding concurrent and post-service requests from expedited processing could streamline operations for plans and providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield Association

Aggregated Comment Title: ***Add Data Request and Attestation to Initial Agreement***

Summary: CMMI should incorporate the Data Request and Attestation (DRA) directly into the initial participation agreement, thereby eliminating the need for multiple contract vehicles and accelerating data availability.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Denials for Injectable Drugs***

Summary: Medicare is denying a significant number of infusions and J-code drugs, leading to increased workloads, appeals, and payment delays for hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health

Aggregated Comment Title: ***Allow ePRO Capture Through EHR Portals or Texting Platforms***

Summary: Allowing electronic patient-reported outcome (ePRO) capture through EHR portals or texting platforms would reduce vendor fees and mailing costs while increasing response rates.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Raise Reimbursement Threshold for Reporting Requirements***

Summary: CMS should increase the reimbursement threshold from $90,000.00 to $150,000.00 for providers who must participate in reporting requirements. $90,000 is no longer the right threshold with inflation in medical practice costs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Modify the Depression Screening ESRD QIP Measure***

Summary: The Depression Screening ESRD QIP measure burdens dialysis clinic social workers with rigid reporting requirements which penalize clinics for uncontrollable patient circumstances. CMS should consider modifying the Depression Screening measure to account for uncontrollable patient circumstances.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Fresenius Medical Care

Aggregated Comment Title: ***Reduce Administrative Burden and Costs by Standardizing Translation Requirements***

Summary: The evolving requirements and lack of consistent definitions for essential languages in translation have created a complex and costly process for plan sponsors and vendors. Adapting to changing federal and state standards necessitates frequent adjustments to processes and materials, leading to administrative burdens and increased complexity in implementation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***Simplify Reporting from MA Organizations***

Summary: The 2024 Final Rule mandates MAOs to disclose internal criteria publicly, necessitating new infrastructure for data storage. Requesting annual reports on this is redundant, costly, and labor-intensive due to the manual effort required to extract narrative data from various systems, despite much of this information being already known or accessible elsewhere.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***Remove Time Requirement on Interprofessional e-Consults***

Summary: CMS should remove time constraints for CPT code 99452, Interprofessional Telephone/Internet/Electronic Health Record Consultations. The current minimum requirement of 16 minutes is challenging for providers, as e-consults average less than 10 minutes. Removing these time restrictions would alleviate the burden of documenting time and align reimbursement with the actual time spent on e-consults.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance for Connected Care

Aggregated Comment Title: ***Remove Patient Consent for Interprofessional Consultations***

Summary: CMS should eliminate the requirement for patient consent for interprofessional consultations as it is an unnecessary regulatory burden. Patients reasonably expect their healthcare provider to seek input from other professionals as needed during a care visit, making explicit consent unnecessary for such consultations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance for Connected Care

Aggregated Comment Title: ***Automate Hospital OQR Data Processes to Reduce Manual Burden***

Summary: Hospital OQR involves manual data collection and validation processes. However, transitioning to automated data submission and validation could greatly decrease this burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Delay in Enforcement of Payer-to-Payer Data Exchange Provisions***

Summary: Payer-to-payer data exchange provisions have been deemed burdensome, leading CMS to postpone enforcement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Overly Restrictive Qualification Criteria for Nursing and Allied Health Educational Programs***

Summary: [Health System] urges CMS to issue a formal directive instructing Medicare Administrative Contractors (MACs) to halt the use of increasingly restrictive and inconsistent interpretations of qualification requirements for nursing and allied health educational programs. Recent MAC audits have challenged hospitals' long-accepted authority to operate these programs and questioned the eligibility of pass-through costs, despite established Medicare policy and legal precedent. These actions pose significant financial and administrative risks, particularly amid critical workforce shortages. MACs have also relied on interpretations not clearly defined in regulation, which courts have found unreliable, and OIG reports have identified errors in MAC reviews that have led to costly misclassifications and unjustified recoupments.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Simplify Payer Rules***

Summary: Disparate billing requirements can lead to errors, denials, and incorrect payments due to misunderstanding complex and conflicting payer rules.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Crossover Claims Data Identifies Dual Eligibility More Precisely***

Summary: Medicare-Medicaid crossover claims data offers CMS and state Medicaid agencies a timely and more accurate measure of dual eligibility by directly indicating a patient's active enrollment in both programs at the time of service. This data eliminates the uncertainty associated with SSI participation and the delays in annual CMS data releases.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Remove Prohibition on Dual Listing Providers Across Specialties***

Summary: CMS should rescind Provision: 422.116(b)(2) in CMS's Contract Year 2025 Medicare Advantage and Part D Final Rule. It prohibits a single provider from being listed in multiple network adequacy specialty categories, which increases administrative burden and limits recognition of providers' expertise.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Outdated Prior Authorization Submission Methods Cause Delays and Inefficiencies***

Summary: Providers often use outdated methods like fax or phone to submit prior authorization requests, leading to delays and inefficiencies due to limited visibility into approval status and

required documentation. This manual process is especially problematic in high-volume clinical settings.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Rescind Guidance on Manufacturer Accountability for Secondary Manufacturers***

Summary: CMS should rescind burdensome guidance that hold primary manufacturers accountable for secondary or third-party manufacturers with whom they have no contracts. The terms 'primary manufacturer' and 'secondary manufacturer' are not mentioned in the Inflation Reduction Act, and their use in CMS guidance goes beyond their authority by overriding the statutorily adopted manufacturer definition. OMB should collaborate with CMS to align the definition of a manufacturer with the statute to prevent primary manufacturers from being held responsible for unrelated corporate entities' information or actions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Streamline Adoption of ePA across Fee-For-Service Medicare***

Summary: CMS should accelerate the adoption of ePA [Electronic Prior Authorization] across Fee-for-Service Medicare.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Integrate ePA with Electronic Health Records***

Summary: Integrating ePA with electronic health records would streamline provider workflows and reduce redundant data entry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Use of Standardized ePA***

Summary: Encouraging the use of standardized electronic prior authorizations (ePA) is essential as proprietary health plan portals often lack efficiency and automation, as they necessitate healthcare providers to juggle multiple unique logins for each plan.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Delayed FRF Updates Postpone Patient Access to New Part D Drugs***

Summary: Part D plans typically delay coverage for new Part D drugs until they are listed on the Formulary Reference File (FRF), which can take months to update. This leads to delayed access for patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Improve Timeliness of Part D Formulary Reference File Updates***

Summary: CMS should improve the timeliness of updates to the Part D Formulary Reference File (FRF) to reduce access delays for patients. Currently, the process can take months, impacting patients' ability to obtain necessary medications in a timely manner.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Remove NCD Non-Coverage Language in Favor of MAC Discretion***

Summary: Well-supported policy and technical changes that could be made to a National Coverage Determination (NCD) include removing non-coverage language in favor of Medicare Administrative Contractor (MAC) discretion.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Final LCDs Revisions When Expanding Coverage***

Summary: CMS should clarify that a Final LCD may be revised without notice and comment if the revision expands coverage of an item or service.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Use of Prior Authorization to Enforce Coverage and Documentation Requirements***

Summary: Medicare Advantage organizations heavily rely on pre-service utilization reviews, such as prior authorization, to enforce internal coverage criteria and demanding documentation requirements for tests covered by Medicare NCD or LCD.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Add New NHSN Reporting Questions to the Automated Reporting***

Summary: NHSN should include new reporting questions in the automated reporting function. Issues have arisen when new data elements are required but cannot be completed through automated reporting methods, causing delays and inconsistencies in reporting essential information.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Encompass Health

Aggregated Comment Title: ***Face to Face Encounters and DME***

Summary: Face-to-face encounter and documentation requirements for DMEPOS are burdensome and divert resources from patient care. These protocols are redundant, overly prescriptive, and add unnecessary administrative tasks, impacting the delivery of medical equipment and supplies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AMGA

Aggregated Comment Title: ***Corroboration of Suspect Conditions in HHAs***

Summary: The regulation (42 CFR 424.22(c)(1)) mandating physician corroboration of home health agency (HHA) documentation for suspect conditions imposes excessive administrative burden on providers without proven benefits for program integrity or patient outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AMGA

Aggregated Comment Title: ***Insurer-PBM Drug Rebates Should Not Be Exempt from Anti-Kickback Statute***

Summary: The exemption of insurer-PBM drug rebates from the federal Anti-Kickback Statute (AKS) has led to misaligned incentives in Medicare drug plans, where purchasers are incentivized to negotiate higher list prices to increase rebates, ultimately harming seniors. This arrangement diverts funds to corporate entities and profits, contrary to the AKS's purpose of preventing inflated pricing in federal spending programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Reform Quality Bonus Program***

Summary: To reduce waste, fraud, and abuse in the Medicare Advantage program, CMS should reform the Quality Bonus Program established by the Patient Protection and Affordable Care Act to reduce scoring abuses.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Require Clearer Disclosures of Narrow Network Plan Designs***

Summary: CMS should require clearer upfront disclosures of narrow network plan designs, making sure seniors understand the tradeoff when they select a lower cost plan that restricts specialty care (e.g., oncology, cardiology) via network, benefit, and utilization management designs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Enhance Competition and Allow Switching Between MA and Traditional Medicare***

Summary: Enhance competition between Medicare Advantage (MA) and traditional fee-for-service (FFS) Medicare by requiring new beneficiaries to actively choose between the two options at enrollment, rather than defaulting to FFS. Additionally, eliminate regulations that hinder MA enrollees from switching to FFS and simplify the process for seniors to switch between the two programs, aiming to reduce bureaucratic obstacles and provide more flexibility for beneficiaries in their healthcare choices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Life Safety Standards are Burdensome***

Summary: The requirement for existing facilities to comply with the highest Life Safety Standards due to a change in ownership is burdensome and costly, as it can amount to $1,000,000 for compliance. Adding a service or changing ownership should not lead to such financial hardship.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Seaford Endoscopy Center

Aggregated Comment Title: ***Sharing Data is Expensive***

Summary: Participating in the local Health Information Network involves costly implementation fees, monthly charges, and membership costs. The burden of sharing patient information falls on physicians and providers, creating financial strain due to lack of reimbursement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Seaford Endoscopy Center

Aggregated Comment Title: ***Training Certification is Burdensome***

Summary: CMS' required annual training certification is burdensome.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow Certified Rehab Agencies to Participate in MIPS***

Summary: If MIPS relevance is enhanced, all therapists in Certified Rehab Agencies (CRAs) should be allowed to participate in the program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance for Physical Therapy Quality and Innovation

Aggregated Comment Title: ***CMS Complex Accounting and Auditing in IRIS is Burdensome***

Summary: CMS utilizes a detailed accounting system in IRIS to enforce audit policies for Medicare Cost Reports. Failure to comply restarts the process for all parties involved. Disputes between hospitals and auditors can result in withheld reimbursements. Secondary audits consume significant time, energy, and resources for all parties involved with minimal benefits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** BJC Health System

Aggregated Comment Title: ***Burdens in Medicare Stemming from Its Five-Part Structure***

Summary: The administrative burdens in Medicare stem from its complexity, divided into five parts. The interactions between these parts create incongruities in coverage, billing, and payment, leading to significant administrative costs for the Agency, providers, and beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***The ABPM Testing Process is Burdensome***

Summary: The Medicare administrative process for testing ambulatory blood pressure monitoring (ABPM) devices in a physician's office burdens providers and patients. Outdated in-office requirements for ABPM setup and monitoring create unnecessary strain on healthcare providers, limiting patient access, especially in rural or underserved areas.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Biobeat USA Inc.

Aggregated Comment Title: ***Allow Nurse Practitioners to Admit Patients***

Summary: Amend Medicare regulations to allow certified nurse practitioners to admit patients in hospital settings, conduct assessments in skilled nursing facilities, and certify patients for

hospice care. These adjustments would streamline processes, enhance patient access to care, and improve quality outcomes by leveraging the expertise of nurse practitioners. These revisions are needed at: 42 CFR 482.12(c)(1) (2) and 482.12(c)(4); 42 CFR 483; and 42 CFR 418.22.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Council of State Boards of Nursing

Aggregated Comment Title: ***Dispensing Entity Funding Limitation Challenges***

Summary: CMS does not advance funds to dispensing entities for future MFP payments. Alternative payment options are available, but they create additional administrative burdens for pharmacies with cash flow concerns.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Pharmacists Association

Aggregated Comment Title: ***Streamline Value-Based Payment***

Summary: The 18-month delay in value-based payment poses a significant challenge for smaller providers and health care systems. This delay hinders investment in infrastructure and quality improvement initiatives, straining resources and discouraging adoption of innovative care models

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** VillageMD

Aggregated Comment Title: ***Improve Infectious Disease Diagnosis Reporting***

Summary: CMS should streamline interoperability regulations to improve the accuracy of infectious disease diagnosis reporting. The current data transfer process results in information loss between test collection, laboratory analysis, storage in EHR systems, and reporting to public health agencies. This lack of interoperability hampers data quality and completeness, potentially

leading to incorrect reporting and hindering the ability to derive clinical value for appropriate antibiotic usage. Simplifying these regulations is crucial for enhancing the overall effectiveness of the data reporting process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Danaher Diagnostics

Aggregated Comment Title: ***Create Exception for Clinical Laboratory Test to Support Antibiotic Stewardship***

Summary: To improve appropriate antibiotic prescribing practices and patient outcomes, CMS should establish a new exception from the OPPS packaging rules for clinical diagnostic laboratory tests that aid in antibiotic stewardship, particularly in distinguishing between bacterial and viral infections. By implementing reimbursement policies that encourage the adoption of these technologies, it aligns with the goal of improving public health and reducing inappropriate antibiotic use, ultimately leading to better patient outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Danaher Diagnostics

Aggregated Comment Title: ***Increase Medication Regimen Reviews to 90 Days***

Summary: CMS should increase the Medication Regimen Reviews (MRR) timeframe to 90 days for long-term nursing home residents in the State Operations Manual Appendix PP, 42 CFR ¤ 483.45(c). This change would allow pharmacists and other team members to concentrate on residents requiring more frequent or immediate medication reviews, potentially enhancing overall care quality in long-term care facilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge New York

Aggregated Comment Title: ***Amend Definition of a Medical Visit***

Summary: CMS should amend the definition of a medical visit to eliminate confusion and billing complexities for Community Health Centers (CHCs). Amending the definition of a medical visit creates parity with the revised definition of mental health visits, updated at 405.2463 b(3) in the CY2023 PFS Final Rule.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***CHCs and Payment for Telehealth***

Summary: CMS does not include telehealth in updated payment schemes for CHCs, causing financial strain on health centers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish Clear Guidelines for Unbundled Service***

Summary: Auditing unbundled services is complicated, and clarification is needed for what should be included in a bundled service versus what should be billed separately.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Failure to Define Maximum Fair Price Professional Dispensing Fees***

Summary: There are concerns about the negative economic effects of not defining the MFP professional dispensing fees on independent pharmacies, especially those in health centers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Expand Access to Behavioral Health Codes***

Summary: Certain new behavioral health codes and services do not automatically include Community Health Centers (CHCs), leading to financial strain as Medicare does not adequately reimburse these centers for providing essential health services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Allow Postoperative Pain Medication Without Surgeon Order***

Summary: CMS should allow anesthesiologists to administer postoperative pain blocks without requiring a surgeon's order or surgeon documentation. Under current CMS and payer guidance, the surgeon must request and document the medical necessity of the block in the surgeon's postoperative note, a process that is repetitive and delays care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Society of Anesthesiologists

Aggregated Comment Title: ***Restore the CEHRT Utilization Threshold***

Summary: CMS should restore the 75 percent CEHRT utilization threshold for Advanced APM participants. Requiring all participants to utilize CEHRT is overly burdensome and discourages participation in APMs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Neurology

Aggregated Comment Title: ***Remove Additional PA Requirements for Botulinum Toxin Injections***

Summary: CMS should remove the finalized requirement for additional PA requirements for botulinum toxin injections and facet joint interventions in the hospital outpatient setting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Neurology

Aggregated Comment Title: ***Cost Attribution Methods are Flawed***

Summary: Inaccurate cost attribution methodologies can lead to misallocation of costs for patient care to individual providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Neurology

Aggregated Comment Title: ***Burden Associated With Quality Measure 438: Statin Therapy for the Prevention and Treatment of CVD***

Summary: Quality measure #438, Statin Therapy for the Prevention and Treatment of CVD is an opportunity to reduce burden. Patients often report not taking statins as prescribed due to side effects; therefore, they may have unopened statin bottles in the home due to the automatic delivery system of mail-order pharmacies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Exempt Onsite Direct Supervision Requirements in Rural Areas***

Summary: CMS should exempt onsite direct supervision requirements in rural areas to improve healthcare access.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Advanced Medical Software Solutions Inc

Aggregated Comment Title: ***Automatically Reweight OTPs in the Promoting Interoperability Category***

Summary: Occupational therapy practitioners (OTPs) should be granted automatic reweighting for the Promoting Interoperability (PI) category in the Merit-based Incentive Payment System (MIPS) due to limited EHR access and control. This adjustment aims to reduce administrative burden, acknowledge technological barriers, and ensure fair performance evaluations across provider types.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Occupational Therapy Association

Aggregated Comment Title: ***DME Payments for Compression Garments***

Summary: Under Part B, the DME rate for compression garments includes payment for measuring and fitting. Therapists often provide these services, but DME suppliers may not reimburse therapists or serve Medicare beneficiaries, leading to delays and administrative challenges, particularly in rural areas with limited DME access.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Occupational Therapy Association

Aggregated Comment Title: ***Expand ePA Rules to Include Medications***

Summary: The current electronic prior authorization (ePA) rules do not cover medications, leaving a significant administrative burden unaddressed in the field of rheumatology.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Hospital Drug Cost Survey***

Summary: CMS's planned survey of hospital acquisition costs for outpatient drugs raises concerns about significant administrative burdens and questionable accuracy. Mandated by EO 14273, the survey's methodology must be published, but ongoing drug pricing fluctuations and supply chain uncertainties from proposed reforms may further complicate data reliability and increase provider challenges.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** America's Essential Hospitals

Aggregated Comment Title: ***Sequestration Adds Burden***

Summary: Medicare sequestration, a result of the Congressional Budget Control Act of 2011, is burdensome. It imposes a 2% reduction in Medicare payments for SNF providers. Additional reductions of up to 4% may occur due to other programs, including penalties for noncompliance with quality reporting and funding for value-based purchasing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Add a Fatal Error for PPS Assessment Submissions***

Summary: The manual deletion process for PPS assessments in Skilled Nursing Facilities involves contacting the state Medicaid automation coordinator, completing a paper form, and returning it via mail. To simplify this process, a fatal error (e.g., If the assessment is a PPS 5-Day [A0310B = 01] or a PPS Part A Discharge [A0310H = 1] and this stay is not coded as a Medicare-covered stay [A2400A = 0]) could be added for assessments that do not meet specific criteria, preventing the need for manual deletion.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association of Post-Acute Care Nursing (AAPACN)

Aggregated Comment Title: ***Extended Surveys are Burdensome***

Summary: Extended surveys for corrected deficiencies, as interpreted from section 488.720, are burdensome for facility staff and operations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association of Post-Acute Care Nursing (AAPACN)

Aggregated Comment Title: ***Medicare Only HCPCS Codes Create Complex Billing***

Summary: Medicare-only HCPCS codes and government plan coding rules under Chapter 23 of the Medicare Claims Processing Manual are burdensome processes for hospitals. These non-standard processes create complex billing procedures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Tie Provider Level Balance (PLB) Codes to Related Claims***

Summary: Tying each PLB code to related claims would improve clarity, facilitate easier tracking, and simplify reconciliation processes, potentially allowing for automated reconciliation systems.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Remove the 24-Month Physician Visit Requirement for Patient Attribution***

Summary: CMS should remove the 24-month physician visit requirement for patient attribution under 42 CFR 425, allowing Nurse Practitioners and other qualified providers to maintain MSSP patient attribution, particularly vital in rural areas with physician shortages.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve the Hospital Quality Reporting Website***

Summary: The Hospital Quality Reporting Website (hqr.cms.gov) website needs improvements to simplify the process of adding new users and roles. While recent changes have enhanced report accessibility, requesting new roles and adding users remains challenging. Clearer information on role-function associations is necessary for better usability.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Eliminate Graduate Medical Education Overlap Reporting***

Summary: Eliminate Graduate Medical Education overlap reporting and audits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Eliminate Patient-Specific Data Required for Bad Debt and Charity Worksheets***

Summary: Eliminate the patient-specific data required for bad debt and charity worksheets

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Administrative Burdens Faced by C-SNPs During MOC Approvals***

Summary: C-SNPs face a disadvantage as they are limited to a one-year MOC approval period regardless of their performance score, unlike D-SNPs and I-SNPs which can receive longer approvals based on their performance. This creates an unfair administrative burden for C-SNPs, even when they consistently meet or exceed CMS's quality expectations for MOC.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Devoted Health

Aggregated Comment Title: ***Care Planning Through Risk Stratification for Low and High-Risk Enrollees***

Summary: Risk stratification involves categorizing individuals based on their risk levels. High-risk individuals may benefit from comprehensive frameworks like the "Geriatrics 5Ms," while lower-risk individuals may benefit more from preventive screenings and PCP engagement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Devoted Health

Aggregated Comment Title: ***Limit Additional Information for Beneficiaries During Enrollment***

Summary: The increasing amount of information Brokers must provide to beneficiaries during enrollment could lead to potential negative impacts on the enrollment process. Callers are already frustrated with the current lengthy reviews, and additional requirements could deter beneficiaries from enrolling altogether.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The National MLTSS Health Plan Association

Aggregated Comment Title: ***Misleading and Fraudulent Claims***

Summary: CMS transmits Medicare claims data to Medigap carriers, inaccurately showing fraudulent claims as paid, leading carriers to believe they are legitimate. This misinformation results in overpayments, consumer confusion, and increased costs within the system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Globe Life Insurance Company

Aggregated Comment Title: ***Improve Fee Schedule Transparency for Medigap Carriers***

Summary: CMS should modify the Fee Schedule to include the standard Medicare allowable amounts for common services, general guidelines on the typical frequency of covered services, and clear summaries of Medicare's coverage rules for specific services that are often targets of fraud.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Globe Life Insurance Company

Aggregated Comment Title: ***Misleading Prior Authorization Notices***

Summary: Providers may update treatment plans during an enrollee's treatment, leading to changes in authorizations requested from the MA organization. This can cause confusion for enrollees who may mistakenly perceive a denial of services. Sending withdrawal notifications without clear explanations can create unnecessary confusion and waste in the system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***UM Withdrawal Requirements***

Summary: CMS should remove the requirement for member notifications and appeal rights in cases where a provider withdraws an authorization request, as per UM Withdrawal Requirements - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance - 40.14.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Establish Compensation Cap for TPMOs***

Summary: CMS should set a compensation cap on payments to Third Party Marketing Organizations (TPMOs), including independent agents and brokers, to prevent excessive payments for various services. This is similar to the Agent and Broker Compensation cap at 422.2274(a). The proposed cap would cover commissions, administrative costs, marketing, lead generation, and post-enrollment member services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reconsider National Advertising Rules***

Summary: Allowing benefits to be advertised nationally, as long as they are available to a certain percentage of eligible beneficiaries, would help Medicare Advantage plans reach more

individuals and provide them with information about coverage options. This change could empower beneficiaries to make more informed decisions about their healthcare choices by expanding the reach of plan advertisements beyond specific counties.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Allow Unlimited Edits to Claims and Encounters Before Deadline***

Summary: Allow unlimited edits to claims and encounters before the submission deadline to decrease reliance on chart reviews, enhance data accuracy, and align with the Reducing Provider and Health Plan Burden initiative for streamlined RADV validations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Allow MAOs Access to Risk Adjustment Data***

Summary: To enhance care coordination and data integrity, CMS should grant Medicare Advantage Organizations (MAOs) access to validated historical Hierarchical Condition Category (HCC) data for new enrollees upon enrollment. This access would enable MAOs to better assess clinical needs, coordinate care promptly, and ensure service continuity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Ensure Counties in MARx Align with USPS Verified Addresses***

Summary: To address discrepancies in county verification between USPS and MARx, CMS should ensure that counties in MARx align with USPS verified addresses for accurate out-of-service area moves.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Revise Rebate Reallocation Instructions***

Summary: CMS should revisit the Rebate Reallocation guidance in MA Plan Instructions for CY 2026: Appendix E, Section II and 423.286. The current process creates excessive burden with exception requests, and removing or modifying Appendix E, Section II, A.10.3.1 in future MA Instructions would streamline the rebate reallocation process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Remove County Test Requirements for MA and Part D Plans***

Summary: The regulations 422.4(c)(1), 423.100, and 422.114(a)(3) establish criteria for geographic access to services by MA and Part D plans. CMS should eliminate these requirements or specify that MA coordinated care plans from the same parent company satisfy the criteria outlined in 422.4(c)(1).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Revise Medicare Bid Audit Instructions***

Summary: For the CY 2026 Medicare Bid Audits, CMS should revise bid instructions to require correction of audit findings from two years prior, instead of just the most recent year, to allow plans more time to address deficiencies. CMS could conduct audits no more than once every two years to provide plans with a predictable audit schedule while maintaining audit effectiveness. This approach aims to balance CMS' auditing rights with plans' need for adequate time to rectify issues, ensuring a fair and efficient audit process for all parties involved.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Modernize Manual Medicare Processes to Improve Access and Reduce Burden***

Summary: Medicare maintains entirely manual processes for implementing evidence-based preventive services recommended by USPSTF [U.S. Preventive Services Task Force]. This represents a profound missed opportunity for administrative modernization that could simultaneously reduce burden, improve accuracy, and accelerate beneficiary access to preventive care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Implement Automated Electronic Notification System for USPSTF Recommendations***

Summary: Creating an electronic notification and implementation system for USPSTF Grade A recommendations presents a significant automation opportunity. Currently, the process of translating these recommendations into Medicare coverage is manual and time-consuming, involving initiating NCD requests and compiling documentation. Automating this process through a system that monitors USPSTF publications, triggers coverage workflows, and notifies stakeholders could streamline operations. This system would integrate with Medicare systems to activate billing codes, set reimbursement rates, and update provider manuals and beneficiary communications automatically.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Automate Tracking of Preventive Services***

Summary: Automation could potentially eliminate the need for quality reporting requirements for evidence-based preventive services, which currently burdens providers with manual reporting tasks. By implementing an automated system to track the delivery of USPSTF-recommended services, providers could focus on delivering effective preventive care while still enabling population health monitoring.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Adopt Standardized Implementation Protocols for Common Service Categories***

Summary: To simplify preventive services coverage, Medicare could create standard protocols for common categories like laboratory-based screening tests and counseling services. By establishing templated coverage rules based on service categories, Medicare could automate implementation processes for new screening tests recommended by the USPSTF.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Prepare Medicare Systems Now to Support Automated Digital Preventive Services***

Summary: Medicare needs to be ready for the automated implementation of digital health and telemedicine-based preventive services as the USPSTF evaluates and recommends digitally delivered interventions. This requires building flexibility into automated systems now to accommodate future innovations in preventive care delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Use Retrospective Analytics to Strengthen Program Integrity and Reduce Provider Burden***

Summary: Integrity concerns can be tackled effectively by utilizing backend analytics instead of imposing upfront documentation requirements on every provider. By leveraging sophisticated data systems, Medicare can detect outlier billing patterns and potential fraud without necessitating extensive documentation for evidence-based services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reinterpret CMS Authority Under Section 4105 of the ACA***

Summary: CMS should issue immediate sub-regulatory guidance to reinterpret its authority under Section 4105 of the ACA. The current conservative interpretation of "may" in the statute allows CMS to choose whether to cover U.S. Preventive Services Task Force-recommended services. An alternative interpretation suggests CMS has broad discretion in implementing coverage, potentially establishing streamlined processes. By presumptively meeting the "reasonable and necessary" standard for Grade A recommendations, this guidance could shift the burden of proof against coverage opponents, aligning with the ACA's intent to enhance preventive care access within CMS's legal boundaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Patient Notices Increased with Medicare Patients***

Summary: Hospitals that provide mandatory patient notices are tasked with providing an increasing number of notices to Medicare patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***PDPs and PBMs Misuse Quality Measures to Withold Payments***

Summary: Prescription Drug Plans and Pharmacy Benefit Managers sometimes use deceptive "quality measures" to withhold payments from Long Term Care pharmacies, leading to financial burdens on providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Senior Care Pharmacy Coalition: SCPC

Aggregated Comment Title: ***Requirement for Beneficiary Signed Authorization to Bill Medicare is Outdated***

Summary: The requirement for a beneficiary's signature on reimbursement claims, as outlined in 42 C.F.R. 424.32 and 42 C.F.R. 424.36, is outdated due to the prevalence of electronic claim submission. The administrative burden of capturing signatures, both on paper and electronically, is ineffective in deterring fraud and abuse. These rules add significant administrative burden on pharmacies, leading to delays in patient care, without clear benefits in protecting the Medicare program from fraud.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Community Pharmacists Association

Aggregated Comment Title: ***Clinical Record Turnaround Timeline is Challenging***

Summary: The current four-day timeline for clinical record delivery under 42 CFR 484.110(e) is challenging. One recommendation is to reinstate a 10-business-day record delivery timeframe, used during the PHE.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Home Care Alliance of Massachusetts

Aggregated Comment Title: ***Remove HCBS Care Plan Dissemination and Signature Mandates***

Summary: The Home and Community-Based Services person-centered care plan signatures requirement that all providers sign and receive the full care plan is excessive and may violate privacy. CMS should remove dissemination/signature mandates at 42 CFR 441.301(c)(2)(ix).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Home Care Alliance of Massachusetts

Aggregated Comment Title: ***Assess All Reporting Mandates***

Summary: CMS should conduct a comprehensive audit of its reporting mandates, following the guidelines of the Regulatory Flexibility Act and Paperwork Reduction Act. The audit should aim to eliminate any requirements that do not demonstrate a clear and measurable necessity, ensuring efficiency and reducing unnecessary burdens on stakeholders.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom

Aggregated Comment Title: ***Reimburse Providers for Additional Duties Imposed by Medicare Advantage***

Summary: Medicare Advantage plans and managed Medicaid and Medicare insurance products should adhere to the same rules as traditional Medicare to avoid added administrative costs. When these plans create new administrative processes, providers should be reimbursed for the extra work.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***Medicare Advantage Should Follow ABN Guidelines***

Summary: CMS should require Medicare Advantage programs to accept and follow identical Advance Beneficiary Notice (ABN) guidelines as CMS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***CMS Should Manage Ordering Physician Enrollment Status***

Summary: CMS, not imaging providers, should enforce the Medicare enrollment requirement for ordering/referring clinicians. Rather than denying the referral-based provider's claim for services rendered to Medicare beneficiaries, CMS should contact the ordering clinician directly about his/her Medicare enrollment status and pay claims on a conditional basis.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***MPFS Cuts Impact Radiology and Other Specialties***

Summary: The Medicare Physician Fee Schedule (MPFS) has created an unbalanced playing field that disproportionately affects radiology and other specialties, as funds have been shifted to primary care providers, resulting in reduced reimbursement for specialists under Traditional Medicare, Medicare Advantage, and related commercial contracts linked to Traditional Medicare indexes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** University Radiology Group, LLC

Aggregated Comment Title: ***Allow Direct Billing for SNF Patients***

Summary: Some specialty practices that treat SNF patients must bill Medicare first and have the money retracted before billing the SNF for medication, causing unnecessary administrative burden. Direct billing to the SNF could streamline the process and save time and energy for both parties involved.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Retina-Vitreous Surgeons of Central New York

Aggregated Comment Title: ***QMB Policy Changes***

Summary: CMS should institute a policy to waive the Part B deductible for QMB patients, as Medicaid typically does not reimburse providers for this deductible, to they must absorb the cost.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Modify Readmission Measures***

Summary: Modify readmission measures to focus on specific conditions treated, rather than "all cause readmissions," for a more equitable accountability measure for hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Hartford Healthcare

Aggregated Comment Title: ***Lack of Standardization for Determinations Creates Financial Burden***

Summary: Complexity and lack of standardization in determinations decisions creates challenges that could lead to financial penalties and reimbursement discrepancies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Evidence for Survey Effectiveness is Lacking***

Summary: CMS cannot evaluate the effectiveness of the nursing home survey process due to the lack of a control group, as they have regulated all facilities with the same process since inception. This raises concerns about the process's ability to enhance quality in nursing homes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Incorporate a Grace Period for the Transition Between Hospice Assessment Tools***

Summary: Hospice providers are required to switch from using the Hospice Item Set (HIS) to the new Hospice Outcomes and Patient Evaluation (HOPE) assessment tool. One of the operational challenges they face is the lack of a grace period for this transition.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Texas Association for Home Care and Hospice

Aggregated Comment Title: ***Inconsistent Nursing Home Pre-Admission Assessment Requirements***

Summary: Nursing home regulations mandate a pre-admission assessment for mental illness and developmental/intellectual disabilities to determine appropriate care levels. However, these assessments vary in consistency and interpretation across states.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge Illinois/Iowa

Aggregated Comment Title: ***Gradual Dose Reduction Policy Disrupts Care and Adds Administrative Burden***

Summary: The current GDR policy for antipsychotic medications is disruptive and burdensome as it mandates dose reduction regardless of patient stability or clinical need. This approach can destabilize residents, leading to a harmful cycle of withdrawal and reinstatement, especially impacting those who have been stable on antipsychotics for years. Forcing dose reduction in such cases introduces unnecessary risk and undermines continuity of care, while also adding administrative burden without clear quality benefits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Project PAUSE (Psychoactive Appropriate Use for Safety and Effectiveness)/Alliance for Aging Research

Aggregated Comment Title: ***Eliminate the Good Faith Price Estimate Convening Provider Requirement***

Summary: Eliminate the convening provider requirement as part of good faith price estimates given to patients because there is no technical solution to operationalize it.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***CHC Restrictions Create Challenging Care Schedules***

Summary: CHC restrictions on hours and timing is a challenge because the requirement is for care to be provided from midnight to midnight.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Home Care and Hospice Association of New Jersey

Aggregated Comment Title: ***Barriers to Efficient Data Exchange***

Summary: Efforts to achieve full interoperability with Electronic Medical Records (EMRs) are hindered by the prevalent use of fax machines in many healthcare organizations, especially smaller independent physician practices in urban and rural areas. This reliance on outdated technology leads to provider frustration and inefficiency.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Challenges Due to Current Clinical Guidelines***

Summary: Current clinical guideline development creates challenges for providers, leading to administrative burdens due to outdate or conflicting guidelines. This leads to increased appeals when submitting authorizations for services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Absence of Standardized National Medical Policies***

Summary: The lack of standardized national medical policies leads to inconsistencies in guidelines across payers, requiring healthcare providers to navigate varying clinical criteria and interpretations. This discrepancy requires processes and efforts to ensure compliance with different guidelines.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Align Medicare Advantage Prior Authorization with CMS Interoperability Standards***

Summary: Align the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), which includes implementing electronic prior authorization capabilities and ensuring timely responses to authorization requests.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Align MDS Item Reporting with Automation Friendly Processes***

Summary: To support automated data reporting, consider aligning the current rigid MDS item reporting requirements and schedules with more flexible, automation-friendly processes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Long-Term and Post Acute Care Not Included in HITECH Act***

Summary: The HITECH Act of 2009 and subsequent value-based payment models have not specifically addressed the needs of long term and post-acute care providers in terms of facilitating electronic exchange of patient information. Despite advancements in coordinated care, bundled care, and integrated care models, federal resources and administrative support for seamless and secure interoperability between providers, patients, and CMS during transitions of care remain limited for these providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Strict Liability Policies in Nursing Homes***

Summary: Strict liability policies in nursing homes penalize facilities for incidents even when they have taken appropriate measures and could not have reasonably prevented the incident. This approach contrasts with other healthcare settings that do not take the same enforcement approach, leading to concerns about regulatory inconsistencies within CMS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Implement Balanced Regulatory Strategy to Attract and Retain Staff***

Summary: Facilities are cited for incidents beyond their control and unpreventable. The strict liability approach deters skilled caregivers from working in nursing homes due to fear of unfair consequences. A more balanced regulatory strategy is needed to retain experienced staff and attract new professionals to the field.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Standardize Prior Authorization to Reduce Denials from Insufficient Documentation***

Summary: Standardizing prior authorization processes to reduce denials due to insufficient documentation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Mandating Timely ALJ Decisions in SNF/NF Appeals***

Summary: To ensure timeliness in SNF/NF appeals, ALJs will be required to issue written decisions within 180 days of the record closure. Failure to meet this deadline will result in a 50% discount on any imposed Civil Monetary Penalty (CMP) and the forfeited CMP proceeds held in escrow returned to the nursing facility.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Require CMS to Meet Burden of Proof***

Summary: CMS should adopt a new regulation requiring that section 556(d) of the Administrative Procedure Act be the standard, and CMS would be required to meet for the burden of proof.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Use of Competent Evidence to Prove Violations***

Summary: A new regulation should clarify that a Statement of Deficiencies (SOD) does not serve as evidence to prove violations; instead, there must be competent evidence to support the alleged violations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Shorten the CMS-855A Enrollment Form***

Summary: The SNF Provider Enrollment Disclosure includes the CMS-855A provider enrollment form, a lengthy SNF-specific attachment,

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Clarify Guidance and Simplify Requirements for SNF Revalidation***

Summary: Less than half of Skilled Nursing Facilities (SNFs) have completed their revalidations due to the complex reporting requirements and lack of clear guidance from the Centers for Medicare & Medicaid Services (CMS).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish Minimum Threshold for Disclosure***

Summary: The SNF provider enrollment disclosure process lacks a minimum threshold for reporting, leading to excessive burden on providers. This means that even temporary employees or consultants working for just one day require multiple change of information (COI) transactions, creating unnecessary administrative work. The requirement to disclose individuals with no financial interest or operational responsibility further complicates the process, as these individuals do not significantly impact SNF operations. Providers find this system irrational.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Adverse Outcomes Associated with Missed Enrollment Deadlines***

Summary: The SNF Provider Enrollment Disclosure highlights the importance of meeting the August 1 submission deadline to avoid potential suspension or revocation of Medicare enrollment, which would prevent providers from admitting Medicare/Medicaid patients. This could lead to the relocation of current residents, who are typically frail older adults with multiple conditions, potentially causing a crisis in access to care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline MAC Ceiling Adjustment Processes***

Summary: Simplify the rate of increase ceiling adjustment process for MACs by automating approvals for adjustment requests for changes that were previously identified and validated by the MAC in a prior year. This streamlining could significantly expedite the resolution of adjustment requests.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Dedicated Cancer Centers (ADCC)

Aggregated Comment Title: ***Allow Hospice Respite Care at Home***

Summary: CMS could revise regulations to permit respite care to be provided at home by hospice interdisciplinary teams, similar to Continuous Home Care (CHC), but with a focus on alleviating caregiver burden. The proposed model would have a set number of days for services, a payment structure reflecting the care's intensity, and safeguards to ensure clinical justification and documented caregiver relief needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Provide Clarity Around Risk Adjustment Models***

Summary: Opaque risk adjustment models result in years of financial losses for provider-sponsored plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johns Hopkins Health Plans

Aggregated Comment Title: ***Reduce Financial Burden on Medicare Plans by Accounting for APIS Development Costs***

Summary: To reduce the financial burden on Medicare plans to develop APIS, it is recommended to consider the costs incurred, especially by smaller plans, in creating and maintaining technology solutions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Clarity in Star Ratings Expectations***

Summary: The lack of clarity in Star Ratings expectations can lead to increased provider workload as they try to align their activities with ambiguous goals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johns Hopkins Health Plans

Aggregated Comment Title: ***Remove Medical Policy Requirement for Hip and Knee Surgeries***

Summary: CMS should remove the medical policy requirement for hip and knee joint arthroplasty/replacements, as patients typically meet surgery criteria. Eliminating this policy would streamline processes, reduce administrative workload, and lessen the need for medical policy reviews in hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Adjust Oversight of Appeals of Survey Findings***

Summary: The current structure where CMS oversees both enforcement and appeals processes raises concerns about a conflict of interest. To enhance fairness and transparency, appeals of survey findings should be handled by independent administrative law judges not affiliated with CMS. This change would help build trust among stakeholders in the regulatory system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Eventus WholeHealth

Aggregated Comment Title: ***Permit Involvement of Third-Party Certified Medical Directors in Survey Disputes***

Summary: CMS should consider allowing third-party Certified Medical Directors (CMDs) to participate in resolving survey disputes, especially when clinical judgment is at issue. CMDs possess the expertise to evaluate care standards in complex medical cases and should be acknowledged as key clinical arbitrators in these situations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Eventus WholeHealth

Aggregated Comment Title: ***Ease the Deadline for Submission of SNF Data***

Summary: Proposed revision of the final data submission deadline for Skilled Nursing Facilities (SNFs) from 4.5 months to 45 days may pose challenges for Tribal SNFs due to staffing shortages, lack of electronic infrastructure, and limited resources. CMS should afford special exemptions and investments in IT systems to support these facilities in rural and remote areas.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Tribal Technical Advisory Group

Aggregated Comment Title: ***Accelerate Medicare Access to FDA-Approved Technologies Through New Coverage Pathways***

Summary: Efforts are being made to expedite Medicare beneficiaries' access to new, safe, and effective medical technologies following FDA approval. There is a push to enhance the CED pathway and establish a new accelerated pathway for emerging technologies, distinct from the current coverage determination pathways.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Exempt Proven Evidence-Based Treatments from Prior Authorization Process***

Summary: Exempt treatments and services from the prior authorization process that have a proven track record of success or follow recognized standards and guidelines.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Society for Gynecologic Oncology

Aggregated Comment Title: ***Electronic Health Record Compliance Rules Create Burden***

Summary: CMS should rescind or modify certain Medicare regulations that impose excessive burdens on rural healthcare providers, particularly in relation to electronic health record compliance. These rules create significant administrative and financial burden without providing substantial benefits to patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Louisiana Rural Health Association

Aggregated Comment Title: ***Allow Rural Health Clinics in Non-Urban Areas***

Summary: Before 2020, Rural Health Clinics (RHCs) could be situated in non-urbanized areas, but the Census Bureau now only distinguishes between rural (less than 5,000) and urban (5,000 or more) areas. This change leaves RHCs in areas with populations between 5,000 and 50,000 in uncertain eligibility status due to outdated language in the RHC statute. CMS should maintain the current eligibility criteria, allowing RHCs to be located in areas not classified as urban with populations of 50,000 or more.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Louisiana Rural Health Association

Aggregated Comment Title: ***Allow Rural Health Clinics to Treat Mental Health***

Summary: Rural Health Clinics (RHCs) are facing a growing demand for mental health services due to a shortage of providers and facilities, particularly in rural areas. Remove the restrictions on RHCs from primarily treating mental diseases in Section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)), as they increasingly serve patients in need of both physical and mental health care. By striking this provision, RHCs would have the flexibility to provide comprehensive outpatient care to all patients without limitations on the types of services offered.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Louisiana Rural Health Association

Aggregated Comment Title: ***Quality Measure Templates Do Not Align with the Quality Measure Manual***

Summary: The Quality Measures (QM) order in the five-star reports differs from the QM manual, which makes it difficult to find points promptly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Inconsistencies in the Medicare Beneficiary Spending Report***

Summary: CMS should waive, modify, or streamline the Medicare beneficiary spending report. While it aims to be a "cross-setting measure," inconsistencies exist in item definitions and look back/observation times.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Difficulty Understanding CMS Factors for Assessment***

Summary: It is difficult to determine what factors CMS uses to assess certain measurements such as, "CMS expected discharge function score."

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***COVID Reporting on the MDS***

Summary: COVID reporting for patients on the Minimal Data Set only allows for "yes" or "no" answers and does not allow for further explanation of the answer.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Medicare Approvals Should Carry Over to Other Groups***

Summary: Providers approved under Medicare should have their approval carried over to any group they work for. Given that companies have unique identifiers, linking provider's NPI to new companies should distinguish billing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Excel Anesthesia, LLC

Aggregated Comment Title: ***Streamline EHR Billing Add-On***

Summary: Building out the electronic health record (EHR) within each health system before billing for new add-on codes is a burden. This process could be streamlined through EHR automation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Infectious Diseases Society of America

Aggregated Comment Title: ***Develop More Infectious Disease Related Quality Measures***

Summary: Develop more infectious disease specific quality measures that reflect the value of infection prevention, antimicrobial stewardship and management of complex infections.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Infectious Diseases Society of America

Aggregated Comment Title: ***Deregulate Payment Models***

Summary: Deregulating payment models in healthcare is essential for improving efficiency, transparency, and patient-centered care. Simplifying reimbursement processes and reducing regulations would help providers focus more on patient care, promote innovation in payment arrangements, and control costs effectively.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Eliminate EDAC Measures***

Summary: Rescind the Emergency Department Admit, Discharge, and Transfer (EDAC) measures, which do not provide actionable insights.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Simplify the Extraordinary Circumstances Exceptions (ECEs) Process***

Summary: Simplify the Extraordinary Circumstances Exceptions (ECEs) process by combining IQR and PI program requests. Since CMS systems can identify qualifying submissions, a unified request should suffice, reducing administrative complexity and allowing hospitals to focus on patient care during emergencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Eliminate MBI Requirement for Shadow Billing***

Summary: Eliminating the Medicare Beneficiary Identifier (MBI) requirement for shadow billing would streamline the process, leading to more efficient and accurate claims processing by removing complexity and redundancy.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Repeal Critical Access Hospital Cost-Based Ambulance Reimbursement Requirement***

Summary: Repeal the requirement for Critical Access Hospital-based ambulance services receive cost-based reimbursement only if they are the sole provider within a 35-mile radius. This distance limitation is seen as arbitrary and does not consider the crucial services these ambulances provide in rural and underserved areas, regardless of other providers in the vicinity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Lift Restrictions on Providers that Limit Discussions about Traditional Medicare and MA***

Summary: The restrictions under 42 CFR 422.2262 limit provider discussions on Medicare Advantage (MA) versus Traditional Medicare, acting as a gag rule. Lifting this restriction would enable transparent, fact-based conversations using publicly available MA plan data, empowering providers to inform patients fully about coverage options. CMS should remove this barrier to support patient-centered decision-making and ensures beneficiaries can choose coverage that aligns with their medical and financial needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Expedite Medicare Prior Authorization Process to Improve Access and Trust***

Summary: The Medicare Prior Authorization process is slow and manual, often taking over 30 days for approval. This delay leads to poor access to care and erodes trust in the program. To address this issue, CMS should prioritize electronic standardization to reduce administrative burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CGI Federal Inc.

Aggregated Comment Title: ***Lack of Centralized Medicare FFS Requirements Results in Provider Billing Errors***

Summary: Medicare FFS requirements are dispersed across multiple digital platforms, making them difficult to interpret. As a result, providers frequently misapply these regulations, leading to billing inaccuracies and unintentional non-billable services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CGI Federal Inc.

Aggregated Comment Title: ***Simplify Billing Requirements for Self-Administered Medications***

Summary: Simplify self-administered medication billing requirements to preserve safety, prevent waste and reduce administrative burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish Standardized List of Procedures That Require Authorization***

Summary: Establish a standardized list of procedures that require authorization for all plans. Such standardization would reduce administrative burden and reduce delays in care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Rehab Rule Prevents Coverage for Some Patients***

Summary: The 3-hour rehab rule requires patients to actively engage in therapy for a minimum of three hours daily, which prevents coverage for patients with consciousness disorders who are unlikely to meet this requirement. Evidence-based rehabilitation for such patients does not necessitate active participation, but Medicare's rule hinders their admission to Inpatient Rehabilitation Facilities (IRFs).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Form-Specific Feedback for CMS-10261 OMB Control Number: 0938-1051***

Summary: This process requires back and forth documentation for MA and Part D appeals and grievances, delaying access to care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate Guidance That Places Financial Burden on Providers***

Summary: The guidance issued in response to the Executive Order on Lawful Governance imposes high costs on providers without demonstrating clear public benefits. It is recommended that CMS revoke these burdensome changes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Revise and Reinstate Experience-Based Pathway for Food Service Directors***

Summary: CMS should revise 42 CFR §483.60 to reinstate the experience-based pathway for qualifying food service directors. This would aim to combat workforce shortages and retain skilled staff.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Revise Safe Use of Opioids eCQM***

Summary: The Safe Use of Opioids eCQM should focus on monitoring the co-prescription of two or more opioids at discharge in the acute care setting, rather than opioid-opioid or opioid-benzo combinations. Monitoring patients on opioids and benzodiazepines should be done in the office setting with the primary care physician, as discontinuation of benzodiazepines is not usually appropriate for inpatients. Consider revising the approach to align with these suggestions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Inpatient vs Observation Status***

Summary: The 2026 Final Rule on inpatient versus observation status creates operational and financial challenges for health plans, offering little benefit to beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alignment Health Plan

Aggregated Comment Title: ***Streamline Disaster Aid Impact Mitigation***

Summary: To streamline disaster aid impact mitigation, CMS should eliminate the requirement for the HHS Secretary to certify a disaster area and instead rely on a presidential declaration for health plans to provide Medicare coverage. This change would expedite relief efforts, ensure transparency with a set threshold, and prevent rural markets from being neglected, ultimately reducing administrative burden while maintaining oversight.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alignment Health Plan

Aggregated Comment Title: ***PRO Measures Hold Hospitals Financially Responsible for Patients' Non-Response***

Summary: Patient-reported outcome (PRO) measures are essential for healthcare quality assessment, but many patients are hesitant to complete surveys, making it challenging for hospitals to collect data. Holding hospitals financially responsible for patient non-response is problematic as patient participation is beyond their control. CMS should recognize patients' reluctance to engage in data collection, as patients have the right to decline answering questions or following recommendations, which can burden hospitals and impact performance outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alabama Hospital Association

Aggregated Comment Title: ***Rigorous and Costly Testing Standards for New QCDR Measures***

Summary: CMS does not offer financial assistance to external measure developers, but it enforces rigorous and excessive testing standards for new QCDR measures to be approved, even though these measures undergo rigorous development and vetting processes. These requirements surpass those for QPP measures and are costly, with developing and testing a single quality measure ranging from $250,000 to $1 million, making running a QCDR a financial burden for many organizations. These current testing requirements run counter to the intent of MACRA, which aims to promote the use of QCDRs in quality reporting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Redundant Regulations Contribute to Inefficient Resource Allocation***

Summary: Review redundant regulations that are causing Community Health Centers (CHCs) to allocate resources inefficiently, detracting from patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Wright Centers for Community Health and Graduate Medical Education

Aggregated Comment Title: ***Expand Home and Community Based Setting***

Summary: Amend 42 CFR ¤ 441.530(a)(2)(v) to broaden the definition of home and community-based settings to include assisted living residences connected to nursing facilities without requiring additional scrutiny. The current language is overly restrictive and could limit viable options for seniors and individuals with disabilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pennsylvania Health Care Association

Aggregated Comment Title: ***Revise 120-Day Requirement for Nurse Aide Certification***

Summary: CMS should extend or waive the 120-day requirement for nurse aide certification due to ongoing workforce shortages in nursing homes. By allowing extended flexibility, it could enhance staffing stability, continuity of care, ease certification bottlenecks, support workforce development, and promote long-term retention in the industry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pennsylvania Health Care Association

Aggregated Comment Title: ***Eliminate Laboratory Claims Denials Based on Excludes Type Notes***

Summary: Patients may need various diagnostic laboratory services, leading providers to include multiple ICD-10 diagnosis codes on test requisitions. However, due to Excludes Type Notes, claims for these services may be denied entirely for administrative reasons. This denial poses a significant financial burden on laboratories, as they would not receive payment for the services rendered, impacting their operations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***65-Day Redetermination Deadline Leads to Inappropriate Denials***

Summary: For redetermination requests, MA plans have a 65-day deadline for the first level appeal, but to prevent inappropriate denials, CMS requires MA plans to accept appeals filed within 120 days, aligning with Medicare Fee-for-Service rules.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***Revise the ADLT Definition to Prevent Confusion***

Summary: A revised definition for Advanced Diagnostic Laboratory Test (ADLT) to prevent confusion specifies that an ADLT is a clinical diagnostic laboratory test covered by Medicare Part B, offered exclusively by a single laboratory, and not intended for use by other laboratories. The test must analyze multiple biomarkers of DNA, RNA, or proteins, predict individual patient will develop a certain condition, and be FDA cleared or approved.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***Enable ACOs to Use TINs or NPIs***

Summary: Enabling ACOs to use either Tax Identification Numbers (TINs) or National Provider Identifiers (NPIs) could significantly improve provider participation, especially in rural areas where coverage thresholds pose a challenge.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AdventHealth

Aggregated Comment Title: ***Increase Resources to Improve Dialysis***

Summary: Increase Medicare funding and reimbursement for service delivery (especially pediatrics), and research and development of technologies and procedures to improve dialysis effectiveness and accessibility for patients needing treatment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Renal Healthcare Association

Aggregated Comment Title: ***Allow Plans to Address Non-Payment***

Summary: CMS should allow plans to place members in delinquency status and terminate coverage if premium payments are not received within a set timeframe. This approach is crucial for ensuring plan financial stability and responsible enrollment management. Addressing non-payment promptly helps minimize disruptions for both the plan and the member, while also encouraging members to keep up with their premium payments.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UCare

Aggregated Comment Title: ***Rescind Revision of Long-Term Care Surveyor Guidance***

Summary: CMS should rescind the revision of QSO-25-14-NH (CMS) Long-Term Care Surveyor Guidance. The revision exceeds long-standing guidance on many aspects of the Medicare/Medicaid requirements of participation for SNFs, adding more requirements even though the text of the rules hasn't changed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Revise NCD 20.4 on Defibrillators***

Summary: Documenting shared decision-making tools for defibrillator claims is burdensome. It should not be the hospital's responsibility, since these discussions often happen in ambulatory settings. NCD 20.4 has unclear language, leading to denied claims and time-consuming appeals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Simplify Clinical Trial Billing***

Summary: CMS should simplify clinical trial billing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Contractors Create Unnecessary Layers and Burdens on Home Health***

Summary: Medicare contractors like Palmetto impose additional layers of complexity and administrative burdens on home health agencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Compassion Home Health

Aggregated Comment Title: ***Include Community Providers in Data Sharing***

Summary: Community-based providers, like Social Adult Day Care programs, face challenges due to the lack of streamlined data sharing processes. Despite daily interactions with individuals, community-based providers cannot readily share critical observations with Medicare providers, which impacts health outcomes and care plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Centro De Amigos

Aggregated Comment Title: ***Reporting Burden on Nursing Homes***

Summary: The various reporting requirements for nursing homes are excessive and create significant burden for providers. The requirements require input from multiple disciplines and take away from patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Meals on Wheels of Northwest Indiana

Aggregated Comment Title: ***Streamline Ombudsman Notification***

Summary: To streamline Ombudsman notification for planned discharges, utilize batch reporting or automated alerts as per Discharge Notices regulations (483.15(c)(3) - F628).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Clarify No-Pay Claims***

Summary: Clarify billing regulations (42CFR Part 400-499) related to no-pay claims by simplifying documentation to prevent denials due to technical errors.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Provide Real-Time Access to the Common Working File***

Summary: CMS should improve eligibility tracking by providing real-time access to the Common Working File.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Allow Single Claim Per Stay or Per Month***

Summary: Unify claims by allowing a single claim per stay or per month, not both.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Combine Initial and Continuing Stay Prior Authorizations***

Summary: Simplify authorizations by combining initial and continuing stay notifications.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Sending a Summary of Care Measure is Irrelevant***

Summary: The Sending a Summary of Care measure in the MIPS program generates lengthy documents, ranging from 10 to 40 pages, with mostly irrelevant information. This excess of unnecessary data is a hindrance to providing effective patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Eich Plastic Surgery, PC

Aggregated Comment Title: ***Remove Multiple Levels of Codes***

Summary: Remove multiple levels of codes to simplify coding and allow for reliable and stable income practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***IRIS Duplicate Requests***

Summary: Providers routinely receive duplicate IRIS requests, and they have little to no value as many providers are over their caps. CMS should eliminate these requests or at the very least verify that it will have an impact prior to the request.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Tampa General Hospital - Tampa, FL

Aggregated Comment Title: ***Allow Hospitals to Choose From Additional Base Year for Payment Calculations***

Summary: Strengthen Medicare-dependent and Sole Community Hospitals by allowing participating hospitals to choose from an additional base year when calculating payments.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Hospital Association

Aggregated Comment Title: ***Allow Rural Health Clinics to Provide Group Services***

Summary: The Medicare Benefit Policy Manual Chapter 13 restricts group services for Rural Health Clinics (RHCs), limiting the utilization of Marriage and Family Therapists and Mental Health Counselors in providing group, family, and couples therapy. CMS should reconsider this guidance to allow these practitioners to bill for their services at RHCs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Rural Health Clinics

Aggregated Comment Title: ***Rescind OPO Final Rule***

Summary: CMS should rescind the OPO Final Rule, published in the Federal Register on December 2, 2020, due to concerns that it could disrupt the organ procurement system and negatively impact patients awaiting transplants. While aiming to enhance accountability and transparency, the rule's administrative complexity may disproportionately affect lower-resourced Organ Procurement Organizations (OPOs), potentially leading to the elimination of

those showing consistent improvement. The rule could hinder industry progress and harm patients in need of life-saving transplants.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mississippi Organ Recovery Agency

Aggregated Comment Title: ***Allow ACOs to Exclude Patient Records Not Stored in QRDA-Capable EHRs***

Summary: In the short term, CMS should permit ACOs to exclude patients without records in QRDA-capable EHRs, as long as they meet the overall reporting requirement of 75% of patients. This strategy would enable ACOs to report quality measures for the majority of patients while accommodating smaller practices that may struggle with reporting capabilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Epic Systems

Aggregated Comment Title: ***Allow Carveout for CAHs Exceeding 16-Bed Threshold***

Summary: CMS should revise regulations to allow carveouts for CAHs and other rural facilities, enabling them to receive Medicaid reimbursement for psychiatric services even if they exceed the 16-bed threshold. Doing so would reduce administrative complexity and strengthen behavioral health infrastructure in rural communities without compromising program integrity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Rural Health Association

Aggregated Comment Title: ***Support Waivers for Accountable Care Entity DME***

Summary: CMS should support waivers for Accountable Care Entities operating under global risk arrangements, allowing flexibility to provide Durable Medical Equipment (DME) that may fall outside current National Coverage Determinations when it demonstrably supports a beneficiary's safe transition to, or ability to remain in, the home setting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Aeroflow Health

Aggregated Comment Title: ***Expand Regulatory Jurisdiction in Prior Authorization***

Summary: Expanding regulatory jurisdiction in prior authorization can help streamline healthcare processes and reduce administrative burdens. By implementing regulatory additions, CMS can simplify the regulatory landscape it oversees.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** R1 RCM

Aggregated Comment Title: ***Make Internet-Only Manuals (IOMs) More User-Friendly***

Summary: The Internet-Only Manuals (IOMs) would be a more useful resource if CMS updated the manuals to be more user-friendly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** R1 RCM

Aggregated Comment Title: ***Develop Prompt Payment Tracking***

Summary: Tracking prompt payment activity from payers would be immensely beneficial.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** R1 RCM

Aggregated Comment Title: ***Enrolling in Internet Quality Improvement & Evaluation System (iQIES) is Burdensome***

Summary: To enroll in Internet Quality Improvement & Evaluation System (iQIES), a hospice provider must have a privacy security official, and staff apply for iQIES access and undergo background checks.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Alliance for Care at Home

Aggregated Comment Title: ***Update the Governing Body Requirements***

Summary: The governing body requirements limit collaboration between facilities and make it more difficult for healthcare organizations to work together to improve patient care across the continuum. Updating the governing body requirements will permit greater flexibility for organizations to function as a system, independent of the provider agreement specificity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Rigid Interpretation of 42 CFR 418.22(b)(3)(iii) Leads to Denials***

Summary: The language in 42 CFR 418.22(b)(3)(iii) is causing denials for hospice services due to strict interpretation by Medicare Administrative Contractors (MACs) during audits. The regulation's requirement for physician signature placement is leading to retrospective denials based on technical criteria, such as the signature's location relative to the clinical narrative. This prescriptive approach allows MACs to deny coverage based on technicalities rather than focusing on patient care or clinical necessity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Allow Multiple Physician Visits to Same Specialty Occurring on Same Day***

Summary: The current payment policy in PUB 100-04 CH 12 30.6.7 limits patients to one evaluation and management visit per specialty per day, hindering efficient and patient-centric care. This policy penalizes physicians who aim to provide comprehensive care by restricting the involvement of sub-subspecialists and hindering the delivery of care at specialized medical centers. This policy change would support improved patient outcomes and efficient healthcare delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Eliminate CPAP Payment Prohibition***

Summary: CMS should eliminate the regulation 42 CFR 424.57(f) which prohibits Medicare reimbursement for CPAP devices provided by an organization or its affiliate after conducting a home sleep study for a Medicare Fee-for-Service patient. This prohibition disrupts continuity of care for clinics and hospitals enrolled as DME suppliers, hindering their ability to dispense CPAP equipment and supplies. It also limits patient choice, particularly affecting Medicare patients in rural areas who require CPAP devices and supplies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Clarify that Medicare Advantage Plans Must Comply with SNF Presumption of Coverage***

Summary: CMS should clarify that 42 CFR 409.30 requires Medicare Advantage (MA) plans to follow the SNF Presumption of Coverage. While MA plans should provide the same Medicare benefits as traditional plans, some MA plans are imposing prior authorization for SNF placement after a 3-day qualifying stay, causing delays and denials for beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Repeal Unnecessary Signed Attestation Forms***

Summary: Required signed attestations do not protect reproductive health care records more than existing laws and regulations and only add additional administrative burden. CMS should repeal these unnecessary attestation forms.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Essentia Health

Aggregated Comment Title: ***Survey Requirements Create Financial and Administrative Burden for ASCs***

Summary: The burden on ASCs to collect extensive data is financially challenging and administratively burdensome. While facilities are willing to report easily collectible data like falls or wrong-site incidents, the mandated survey is costly, lengthy, and contains irrelevant questions beyond the center's control. Patient follow-up surveys are conducted to gather feedback, but the current survey requirements pose significant challenges for ASCs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Gulf Coast Outpatient Surgery Center, Laurel Surgery & Endoscopy Center

Aggregated Comment Title: ***90-Day Post Cataract Complications Measure is Not Relevant to ASCs***

Summary: The 90-day post-cataract complications follow-up is currently voluntary but expected to become mandatory. The ASC manages patient care efficiently within hours, but this measure primarily concerns physicians, not the ASC facility, and poses an additional administrative challenge.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Gulf Coast Outpatient Surgery Center, Laurel Surgery & Endoscopy Center

Aggregated Comment Title: ***Measurement-Based Care is Problematic***

Summary: Measurement-based care requirements are burdensome due to excessive administrative tasks and limited usefulness of collected data. Patient progress is largely self-driven, questioning the necessity of linking practitioner payments to these metrics.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Place of Peace Counseling Center

Aggregated Comment Title: ***Streamline Medicare Advantage Plan Wait Time Surveys***

Summary: The MA plan wait time survey requirement created in 2025 is an administrative burden on plans to independently submit data and survey results. A centralized survey process would enhance consistency, reduce duplicative reporting, and alleviate administrative burdens for both plans and providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***MA Benchmarks Penalize Efficient Markets and Lead to Fewer Choices for Beneficiaries***

Summary: Medicare Advantage (MA) benchmarks, as outlined in 42 CFR § 422.258, can penalize historically efficient but high-cost areas like Northern California, known for being both efficient and expensive in healthcare. The lower benchmark rates in such regions reduce plan profitability, making them less appealing to MA plans, leading to lower MA penetration and fewer choices for Medicare beneficiaries in the area.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Time and Distance Standards Hinder Collaboration Between Hospitals and Health Plans***

Summary: Time and distance standards for Medicare Advantage plans hinder collaboration between hospitals and health plans to improve access to care, especially in underserved areas or rapidly changing markets.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***CMS Interpretation of HIPAA Restriction on Administrative Business Functions***

Summary: CMS should allow willing trading partners to use multiple alternative standards without cumbersome exception approval processes to promote innovation, competition and efficiency. The CMS interpretation of the Health Insurance Portability and Accountability Act (HIPAA) restricting each administrative business function to one and only one regulatory adopted standard and implementation guide at a time, is erroneous.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Managing Supplier Lists is Burdensome***

Summary: Managing supplier lists is burdensome due to manual work needed to aggregate changes from different systems and stakeholders, leading to errors.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Henry Ford Health

Aggregated Comment Title: ***Coinsurance Notice at Every Visit is Wasteful and Burdensome***

Summary: Requiring providers to give a Coinsurance Notice to every Medicare patient at every visit is wasteful and burdensome, leading to confusion and frustration for patients, particularly those with frequent visits. This practice creates unnecessary administrative work for providers

and may not effectively communicate important information to patients, especially when multiple visits occur in a short timeframe.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Henry Ford Health

Aggregated Comment Title: ***Use AI and Natural Language Processing to Automate Care Summaries***

Summary: The development of natural language processing and Artificial Intelligence tools to produce summations of care that would prompt codes connecting to quality measure modules would send the necessary data to CMS instantly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quality and Performance Measures Committee of the Society for Vascualr Surgery

Aggregated Comment Title: ***Align Marketing Rules for MA and ACOs***

Summary: CMS marketing rules for ACOs are more stringent than for Medicare Advantage, limiting the ability to inform beneficiaries about ACO benefits. Parity in marketing rules between MA and ACOs could enhance beneficiary understanding and choice.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Curana Health

Aggregated Comment Title: ***Ease Requirements for MA Organizational Determinations***

Summary: Reverse regulations concerning Medicare Advantage (MA) organizational determinations under 422.566 to alleviate burdens on MA plans and enhance fraud detection efforts.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Curana Health

Aggregated Comment Title: ***Maintain Consistent SNP Audit Protocols for a Set Period of Time***

Summary: CMS's rapid changes to SNP audit protocols create challenges for plans to adapt. Maintaining consistent protocols for a set period of time (e.g., 3 years), unless significant legislative or regulatory changes occur, would provide stability and allow plans to adjust effectively.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Curana Health

Aggregated Comment Title: ***Increased Regulatory Burdens Drive Staffing Challenges and Operational Strain***

Summary: Challenges due to rising regulatory burdens like MIPS and the No Surprises Act result in increased operational losses and the need for more staff. Tough decisions regarding staffing and patient care are now being considered to address these challenges.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Medical Group Management Association

Aggregated Comment Title: ***Streamline Hospice Room-and-Board Pass-Through Process***

Summary: To improve Medicaid beneficiaries' access to hospice care and alleviate financial strain on providers, CMS should issue standardized guidance and enhance payment timeliness for the room-and-board pass-through process. Inconsistent state interpretations and slow payment cycles currently disrupt the current system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Illinois HomeCare & Hospice Council

Aggregated Comment Title: ***Scale QAPI Requirements***

Summary: 42 CFR 483.75 mandates uniform QAPI protocols for all SNFs, creating disproportionate administrative burdens for smaller facilities. Flexibility based on size, acuity, and EHR capabilities could reduce manual documentation and enhance focus on measurable quality outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** PointClickCare

Aggregated Comment Title: ***Centralize Compliance Program Oversight for SNFs***

Summary: CMS should centralize compliance program oversight by using integrated electronic health record (EHR) tools for real-time tracking, auditing, and reporting for skilled nursing facilities (SNFs) within the same healthcare system. Doing so would enhance the integrity and efficiency of the compliance programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** PointClickCare

Aggregated Comment Title: ***Incentives Accelerate TEFCA and QHIN Integration to Advance Health Information Exchange***

Summary: Incentivizing TEFCA and QHIN integration to leverage the existing exchange framework can enhance the exchange of electronic health information among providers and entities, facilitating quality improvement, care coordination, and response to public health events. Leveraging the trusted exchange framework and designated QHINs can advance interoperability, align with CMS goals, and reduce administrative burdens for Medicare stakeholders.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Health Information Network, Inc. dba KONZA

Aggregated Comment Title: ***Waive the Use of "Unlisted" and "Non-HIPAA" Codes***

Summary: Medicare Administrative Contractors (MACs) should stop directing physicians/providers to report "unlisted" codes when specific AMA Current Procedural Terminology (CPT) codes are available. Additionally, federal contractors should not mandate the use of additional "non-HIPAA" codes to report their services as it adds unnecessary complexity to claims for medically necessary services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** College of American Pathologists

Aggregated Comment Title: ***Update Scoring Policy to be Applied to All Quality Measures***

Summary: Rescind 42 CFR 414.1380(b)(1)(ii)(A) and instead apply the scoring policy indicated in 42 CFR 414.1380(b)(1)(ii)(E) to all quality measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** College of American Pathologists

Aggregated Comment Title: ***Overlapping and Complex Rules for Price Transparency and Estimates Risk Patient Harm***

Summary: There are concerns that overlapping requirements and increasing complexity around price transparency and good faith estimates for pathology services may cause delays that risk patient harm, especially given the difficulty in determining pathology costs in advance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** College of American Pathologists

Aggregated Comment Title: ***Integrate Medicare Reporting Systems with Provider Systems***

Summary: Integrating Medicare reporting systems with provider systems will increase data accuracy as well as simplify provider burden for reporting and documenting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Local Long Term Care Ombudsman (NALLTCO)

Aggregated Comment Title: ***Revise the Five-Day Reassessment Window to Reduce Agency Burden***

Summary: Clients must be reassessed within a 5-day window to qualify for continued services, even if their skilled need only requires weekly or monthly visits. This tight timeframe places an additional burden on agencies, as they must provide unbillable visits to complete the assessment on time, impacting their planning and resources.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Clarify in Regulation Medicare Enrollment is Not Needed for Medicaid Reimbursement***

Summary: Behavioral health providers are enrolling clinicians in Medicare to receive payment for Medicaid services, believing it is necessary. However, CMS clarified that providers do not need Medicare enrollment to bill Medicaid for services covered by both programs. Stakeholders recommend CMS formalize this clarification in regulations to streamline processes and reduce bureaucratic redundancy.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Council for Mental Wellbeing

Aggregated Comment Title: ***Streamline Government Performance and Results Act (GPRA) Reporting Requirements***

Summary: Data reporting requirements under the Government Performance and Results Act (GPRA) create a large burden and should be streamlined.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Council for Mental Wellbeing

Aggregated Comment Title: ***Eliminate Beneficiary Signature on Reimbursement Claims***

Summary: CMS should eliminate the requirement for a beneficiary's signature on reimbursement claims, as it is no longer applicable for pharmacies that utilize real-time electronic claims submissions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Chain Drug Stores

Aggregated Comment Title: ***HCPCS Codes for Biosimilars***

Summary: CMS should return to timelier issuance of HCPCS codes for biosimilars. This will lead to lower administrative burden on CMS and providers, and patients will have more timely access to lower-cost products. The current uncertainty associated with miscellaneous HCPCS codes presents a serious disincentive for providers to adopt lower-cost biosimilars at launch.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Biosimilars Forum

Aggregated Comment Title: ***Reimburse for Medical Necessity Certifications***

Summary: Medicare requires the referring physician's certification of medical necessity but does not reimburse for providers who assess another provider's orders. Standardize certification forms and shift responsibility to the furnishing provider for certifying their own plan of care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Surgeons

Aggregated Comment Title: ***Remove Provision for Billing Outpatient Drugs Administered in the ER as Non-Covered***

Summary: Eliminate the provision (Medicare Benefit Policy Manual, Chapter 6 Hospital Services Covered Under Part B) enabling hospitals to categorize outpatient drugs administered during ER visits or observation stays as "non-covered," requiring Medicare beneficiaries to pay upfront and seek reimbursement through Part D.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Repeal the Excellent Health Outcomes for All Index***

Summary: CMS should repeal the Excellent Health Outcomes for All Index (422.166(f)(3)).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Cap Medicare Prescription Payment Plan Eligibility***

Summary: Medicare Prescription Payment Plan requirements should apply if Part D monthly cost exceeds $167 to reduce administrative burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Eliminate Annual In-Person Encounter Requirement for Health Plans***

Summary: Remove the annual in-person encounter reporting requirement for health plans, as it often does not provide valuable information. Plans should have flexibility in using different modalities like telephonic or audio/visual methods, with exceptions for members who cannot be reached or decline interaction.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Remove Requirements of New True Out of Pocket Eligible Costs***

Summary: CMS should remove requirements from PDBM Chapter 14 of new True Out of Pocket (TrOOP) eligible costs such as Non-covered Plan Paid amounts, Other Health Insurance and Group Health Plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Re-Assessment for Skilled Nursing Services***

Summary: A client must be seen within a 5-day window to complete their re-assessment for services, but the client's skilled need may only require services every 7, 14, or 30 days. Allow clinicians to complete these re-assessments when the client requires skilled care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Excessive LTCF Recertifications Waste Resources***

Summary: For stable residents of long-term care facilities (LTCF), the required frequency of physician recertifications is not an effective use of healthcare dollars.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Maplewood of Cheshire County

Aggregated Comment Title: ***Eliminate 90-Day Notice for Department Head Changes***

Summary: CMS should remove the requirement to provide notice within 90 days of changes to department heads in the online Medicare enrollment management system, PECOS. PECOS is challenging to navigate, so regularly updating department head positions is burdensome.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Maplewood of Cheshire County

Aggregated Comment Title: ***Automation Causes More Work***

Summary: Automation increases administrative burden for tasks that were previously simple, like filling out forms. Instead of automating existing rules, CMS should reduce or eliminate unnecessary rules to streamline processes and reduce workload.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***MDS Language is Outdated and Not Aligned with Person-Centered Care***

Summary: The Minimum Data Set (MDS) language is outdated and does not align with person-centered care directives.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Automate CAHPS Surveys***

Summary: Automating the collection and submission of CAHPS survey results directly from patients via email or text messaging would simplify the process. Another option is to use existing electronic communication systems (e.g., EHR or specialized vendors).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Implement Pre-Audit Documentation Check***

Summary: Providers can streamline audit and medical review processes by utilizing automation tools to conduct pre-audit documentation checks to flag incomplete or inconsistent documentation before submitting claims.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Form-Specific Feedback for CMS-10415 OMB Control Number: 0938-1154***

Summary: Use EHR data to auto-populate relevant sections of the form, minimizing the need for manual data entry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Form-Specific Feedback for CMS-2552-10 OMB Control Number: 0938-1197***

Summary: CMS-2552-10 OMB Control Number 0938-1197 can be streamlined by allowing automated data extraction from internal accounting systems (e.g., general ledger, billing systems) to streamline the completion of the cost report.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Form-Specific Feedback for CMS-64 OMB Control Number: 0938-0763***

Summary: Use predictive analytics and EHR integration to automatically track and report readmission data without requiring providers to submit additional forms or data sets.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Prioritize CNAs Over SDOH Reporting***

Summary: Collecting social determinants of health (SDOH) data can create administrative burdens for individual healthcare providers. To alleviate this burden, CMS should consider eliminating or deprioritizing SDOH reporting. Emphasis should be placed on community needs assessments (CNAs), which address systemic issues and the empowerment of local communities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Burden Can Contribute to Fraud***

Summary: Companies are fraudulently billing under QZ codes to comply with government regulations, given the administrative burden to bill under the medical direction code.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Amend Policy to Remove Face-to-Face Requirement for Certifying Practitioners***

Summary: An amendment to § 424.22 aims to remove the requirement for the certifying practitioner to personally conduct the face-to-face encounter.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Automate Hospital Inpatient Quality Reporting (IQR) and Hospital Outpatient Quality Reporting (OQR)***

Summary: Automate abstraction measures for the Hospital Inpatient Quality Reporting (IQR) and the Hospital Outpatient Quality Reporting (OQR) programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Extend Time for Initial Assessments***

Summary: Allow more than 5 days for disciplines such as MSW and spiritual care to do their initial assessments under 42 C.F.R. § 418.54(c)). Often families are so exhausted from all the nursing visits in the first few days that they do not want to have other disciplines in the home.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enable Hospice Exceptions***

Summary: Enable an exclusion for hospice visits in the last few days of life when a hospice patient completes medical aid in dying, so families can spend quality time with loved ones.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Limit Annual Medicare Records Audit to Sample of Patient Records***

Summary: To streamline the annual Medicare records audit process, CMS should only audit a sample of notes from each provider instead of reviewing every patient record.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Glovan, Pollak and Associates; dba: The Behavioral Wellness Group

Aggregated Comment Title: ***Extend Virtual Supervision for E/M Services***

Summary: CMS should permanently authorize virtual supervision for evaluation and management (E/M) services. During the COVID-19 pandemic, this accommodation allowed oncology practices to maintain continuity of care and operational efficiency, fostering greater flexibility while preserving necessary oversight.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Oncology Nursing Society

Aggregated Comment Title: ***Duplicative Training Requirements for Principal Illness Navigation (PIN) Services***

Summary: Certified oncology nurses with the necessary licensure, training, and competencies to meet CMS's expectations for Principal Illness Navigation (PIN) services are required to undergo redundant training or acquire extra credentials. This duplicative training misallocates educational resources and delays the provision of essential patient navigation services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Oncology Nursing Society

Aggregated Comment Title: ***CED Reform Advances Drug Availability***

Summary: CED reform can accelerate the availability of drugs to the market, enabling testing and evaluation by patients simultaneously, thus potentially addressing the financial burden caused by health issues, such as Alzheimer's and obesity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Pricing Data Analysis and Coding (PDAC) Applications***

Summary: Requiring a full PDAC resubmission and product sample for non-clinical changes such as stock-keeping-unit (SKU) updates is burdensome and unnecessary. CMS should create a streamlined pathway for administrative updates when product function is unchanged.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance")

Aggregated Comment Title: ***Contingency Fee for RACs Incentivizes Aggressive Denials***

Summary: Recovery Audit Contractors (RACs) receive contingency fees, leading to aggressive denials often overturned on appeal. Providers bear the cost and time of appeals. CMS should consider penalties for high denial reversals, transparent audit criteria, and identifying clinicians making medical-necessity decisions to address issues like non-clinical staff making judgments.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance")

Aggregated Comment Title: ***Adopt AMA Data-Driven Performance Payment System to Reduce MIPS Burden***

Summary: The AMA's Data-Driven Performance Payment System, supported by numerous medical societies, aims to lessen MIPS burden by offering multicategory credit, streamlining measure reporting, correcting cost-measure inaccuracies, and providing timely claims data. CMS should adopt this proposal and push it forward in Congress to improve the current system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance")

Aggregated Comment Title: ***Permit Suppliers to Upload Proof-of-Delivery and Provider-Signed Orders at Claim Submission***

Summary: CMS should allow suppliers to upload proof-of-delivery and provider-signed orders during claim submission to prevent fraud. This would enable front-end verification and AI review of digital documents, reducing manual workloads. In wound care, errors in documentation could be reduced by allowing suppliers to send standardized forms with all required fields for providers to sign, decreasing error rates and audit volume caused by missing debridement elements in EHR templates.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance")

Aggregated Comment Title: ***Empower Plans to Re-Evaluate Patient Recovery Milestones***

Summary: Health plans should have the authority to reassess patients who achieve certain recovery milestones in order to facilitate prompt evaluations and enhance the allocation of resources for Home and Community Based Services (HCBS).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Prescription Drug Labeling Rules***

Summary: State and federal regulations mandate detailed prescribing information, patient labeling, and carton/container labeling for prescription drugs. Some of these requirements are excessive; limiting these requirements as well as rules that mandate the widespread distribution of paper prescription notifications would streamline the process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Point32Health

Aggregated Comment Title: ***Rescind Guidance on Plans' Abilities to Review Inpatient Admissions***

Summary: CMS should rescind the guidance in the CY2026 Medicare Advantage Final Rule that restricts plans from reviewing inpatient admissions. It is inefficient for the healthcare system to pay inpatient rates for patients with observation-only stays in hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Point32Health

Aggregated Comment Title: ***Challenges Posed by CED Requirements***

Summary: CED requirements are burdensome for patients and providers by limiting access to certain medical products due to clinical study availability or registry participation. This results in added administrative burden for providers and restricted clinical autonomy when prescribing products with limited Medicare coverage under CED requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** PhRMA

Aggregated Comment Title: ***Rescind CMMI Model Regulations***

Summary: CMS should rescind all CMMI models regulations, end current mandatory models, and avoid introducing new mandatory models due to the participation demands and limited cost savings. The additional rules of CMMI models compound the burden on providers, especially those forced to partake in involuntary models.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** PhRMA

Aggregated Comment Title: ***Revise Part D Effectuation Policy***

Summary: CMS should revise its Part D effectuation policy to maintain patient access to essential medications. Concerns were raised about potential errors in the implementation approach for the IRA, as well as the creation of a new system for MFP effectuation that could lead to delays in pharmacy reimbursement. CMS should reconsider its current approach to MFP effectuation for IPAY 2027 and beyond to address these issues.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** PhRMA

Aggregated Comment Title: ***Enhance Access to Mental Health Services by Streamlining Processes***

Summary: By simplifying rules and streamlining processes, healthcare providers are more likely to accept Medicare, improving access to needed mental health services for beneficiaries. This allows providers to spend more time on direct patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Reduce Administrative Burden to Enhance Psychologist Participation***

Summary: Reducing administrative burdens is critical for increasing psychologist participation in Medicare, as psychologists spend significant time and resources on obtaining prior authorizations. This process disrupts care delivery, leading to delays in treatment for patients in need, potentially worsening their symptoms or causing crises.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow Same-Day Billing of Assessment and Psychotherapy***

Summary: Allow same-day billing of emotional/behavioral assessments (CPT code 96127) and psychotherapy codes. This change would facilitate data-sharing and clarify roles among oversight entities, ultimately improving patient care and outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Allow Psychologists Reimbursement for E/M Services for Medication Management***

Summary: Psychologists with prescriptive authority are legally permitted to prescribe medications for mental and behavioral health conditions, but Medicare does not currently recognize them for evaluation and management (E/M) services when treating Medicare beneficiaries. This limits access to medication management for patients transitioning from private insurance to Medicare and contradicts CMS's goal of allowing healthcare providers to practice to the full extent of their licensure. Revising internal policies to acknowledge prescribing psychologists and allowing them to report E/M services for medication management under Medicare would improve access to care for Medicare beneficiaries and align with the intent of ensuring all healthcare providers can operate within their scope of practice.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Adjust Work RVUs for Psychological and Neuropsychological Testing Services***

Summary: In response to the CY 2024 Medicare PFS final rule indicating CMS was open to feedback on the valuation of psychological and neuropsychological testing services for updates in future rulemaking: CMS should increase work RVUs for these services in 2025 to align with the rise in work RVUs for psychotherapy services, aiming to reduce barriers for psychologists providing testing. It is important to adjust work RVUs for time-based services like psychological and neuropsychological testing to better reflect practitioner time inputs, in line with CMS's rationale for enhancing their value.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Unclear Criteria for Mental Health and Substance Use Services***

Summary: Providers and beneficiaries encounter challenges due to unclear and inaccessible criteria for mental health and substance use disorder (SUD) services, leading to confusion and administrative burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Medicare Advantage Should Pay for Non-Participating Laboratory Services***

Summary: Referrals for laboratory services from participating ordering practitioners should be considered favorable organization determinations (OD), regardless of the lab's participation status. Medicare Advantage Organizations (MAOs) should pay laboratories for these services even if the lab is not participating.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Public Dashboard Enables Real-Time Tracking of LCD Requests and Review Statuses***

Summary: To enhance transparency and accountability, CMS should direct MACs to create a publicly accessible dashboard for LCD including requests that are under consideration, along with the submission date. Ideally, the LCD dashboard would display when a policy is actively under review as opposed to waiting in the queue after being accepted.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Publicly Share Waitlist Topics***

Summary: Publicly sharing waitlist topics can prevent duplicate requests and provide applicants with insight into their application's position in the queue based on submission date.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Increase Transparency by Publishing LCD Requests and Submission Dates***

Summary: Making LCD requests and their submission dates public will help Medicare beneficiaries and policymakers gain insight into the actual timeframe for coverage of new services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow Labs to Directly Request Prior Authorization***

Summary: Allowing labs to request prior authorization directly before billing for services, even if the ordering provider did not request it, can improve efficiency.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***MA Enrollees Experience Challenges Navigating Claims and Appeals***

Summary: Providers serving MA enrollees face challenges in navigating the claims filing process and appeals pathway to receive comparable coverage rates to traditional Medicare for most claims.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Streamline MA Claim Denial Reporting***

Summary: CMS should develop a provider-specific electronic form for reporting systemic MA violations, enabling providers to submit multiple denied claims from a single MA plan in a batch, streamlining the reporting process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quest Diagnostics

Aggregated Comment Title: ***Allow Rehab Therapy Providers Option to Open Cases***

Summary: During the COVID-19 pandemic, CMS allowed rehab therapy providers to open cases if both therapy and nursing were on the physician's order, which streamlined patient care. CMS should make this option permanent to benefit both specialties and improve efficiency in delivering care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** ADVION (formerly National Association for the Support of Long-Term Care [NASL])

Aggregated Comment Title: ***Complexity in Billing for Outpatient Therapy***

Summary: Outpatient therapy providers under Medicare Fee-for-Service Part B, whether billing through a skilled nursing facility or outpatient clinic, encounter substantial administrative challenges due to the intricate and inconsistent application of Local Coverage Determinations (LCDs) Medicare Administrative Contractors (MACs). These guidelines often link numerous ICD-10 diagnosis codes to specific CPT codes, adding complexity to billing processes for Physical Therapy, Occupational Therapy, and Speech-Language Pathology services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** ADVION (formerly National Association for the Support of Long-Term Care [NASL])

Aggregated Comment Title: ***NOMNC and DENC Notifications***

Summary: NOMNC and DENC notifications should be sent during standard business hours or via electronic systems with real-time acknowledgment and secure receipt tracking, especially on weekends and holidays. This approach safeguards patients' due process rights, streamlines coordination, and lessens administrative workload for home health and skilled nursing staff.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** ADVION (formerly National Association for the Support of Long-Term Care [NASL])

Aggregated Comment Title: ***Simplify HIPAA Rules and Expand Education***

Summary: To enhance care coordination and reduce confusion, simplify HIPAA Rules and increase education. This would encourage participation in care models while considering the associated costs and burdens. CMS should adjust the rules to promote accurate and timely exchange of PHI to patients, physicians, and providers, ultimately improving care decisions and service delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Physicians Advocacy Institute

Aggregated Comment Title: ***Low Reimbursement for Certain Drugs at SNFs***

Summary: Skilled Nursing Facilities (SNFs) are required to cover the cost of medications for their residents, which can sometimes exceed the reimbursement they receive.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Limit Readmission Penalties for MA to Align with FFS***

Summary: CMS should limit readmission reviews and penalties by Medicare Advantage (MA) plans to the same diagnoses for Fee For Service (FFS) beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Children's Hospitals Face Burdens from CoP-Related Regulations.***

Summary: Children's hospitals face burdens from CoP-related regulations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Children's Hospital Association

Aggregated Comment Title: ***Ensure the Comments on Claims are Being Processed***

Summary: Ensure the system is reading and appropriately processing the comments on claims for unlisted procedures when they are billed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Waive Requirement for Social Security Numbers of Board Members***

Summary: CMS requires nonprofit and charitable organizations to disclose the Social Security numbers of all Board of Directors members, a stipulation that deters many from seeking Medicare provider status.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Diabetes Advocacy Alliance

Aggregated Comment Title: ***Outdated Quality Measures***

Summary: Outdated quality and data reporting requirements in the Quality Payment Program (QPP) lead to provider fatigue.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** WEDI

Aggregated Comment Title: ***Modify Process for Adoption of HIPAA-Mandated Administrative Transactions***

Summary: The regulatory process for adopting new and updated versions of HIPAA-mandated administrative transactions is lengthy and burdensome. CMS should modify the process to establish a more predictable schedule while maintaining a designated public review and feedback process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** WEDI

Aggregated Comment Title: ***Modify Process for Adoption of CAQH Core Operating Rules***

Summary: The regulatory process for adopting new or updated CAQH CORE operating rules is excessively long and burdensome. CMS should modify the process to establish a more predictable timeline while still incorporating a designated public review and feedback mechanism.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** WEDI

Aggregated Comment Title: ***Provide Transitional Pathways for Automation***

Summary: While some data may require manual extraction due to clinical nuances, CMS should offer clear pathways for providers to transition to automation. Investments in health-IT infrastructure and support for smaller providers are crucial to prevent disparities in adopting these technologies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lantana Consulting Group

Aggregated Comment Title: ***Meeting Patient Access Goals Increases Documentation***

Summary: Meeting Medicare's goals around patient access often result in added documentation tasks.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Use Digital Reporting for HEDIS Measures***

Summary: Providers face numerous record requests from health plans for Healthcare Effectiveness Data and Information Set (HEDIS®) measures. There is support for using digital reporting to collect clinical quality measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Finalize Model Materials Sooner for Part C and Part D Plans***

Summary: To streamline the process for Part C/Part D plans, CMS should set a deadline of August 1st each year for finalizing model materials without allowing any changes thereafter. This would prevent the need for rushed printing and save resources by avoiding last-minute updates after materials have been sent for printing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Complex Patients and Upcoding***

Summary: Evaluate the practice of paying higher rates for "complex" patients to address issues like upcoding and up billing, which result in significant financial losses for Medicare and patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Create More Realistic Timeframe for Home Health Comprehensive Assessment***

Summary: Under 484.55(d), when an agency recertifies a patient for another 60 days of home health, they must complete a new comprehensive assessment within 5 days. This requirement aims to ensure timely and accurate assessment of the patient's needs, but it sometimes difficult to meet the timeframe.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Adara Home Health

Aggregated Comment Title: ***Standardize Practitioner Term***

Summary: To simplify administrative burdens without compromising patient safety, standardizing terms is crucial. In the 2024 Physician Fee Schedule proposed rule, CMS suggested using the term "practitioner" instead of distinguishing between provider types, explicitly including Advanced Practice Registered Nurses (APRNs). This change was later finalized in the rule, but not all federal agencies have adopted this terminology, creating inconsistency within HHS' subagencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Nurses Association

Aggregated Comment Title: ***Clarify "Practitioners" as Inclusive of APRNs***

Summary: In the 2024 Physician Fee Schedule rule, CMS proposed using the term "practitioner" instead of distinguishing provider types, explicitly including APRNs. While CMS finalized this change, not all federal agencies have adopted it, causing confusion in determining authorized healthcare providers and potentially delaying patient treatment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Nurses Association

Aggregated Comment Title: ***Negative Outcomes of CMS Survey of Hospitals' Outpatient Drug Acquisition Costs***

Summary: CMS will conduct a survey of hospitals' outpatient drug costs following an Executive Order on drug pricing. This survey will place unnecessary administrative burden on 340B hospitals and serve as a foundation for future payment cuts to Part B drugs, negatively impacting patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** 340B Health

Aggregated Comment Title: ***Hospice Prognosis Requirements***

Summary: The requirement for a six-month prognosis in hospice patients creates administrative and clinical burdens, leading to premature discharges and delayed enrollment for patients with chronic progressive illnesses, hindering early palliative care involvement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Amedisys, Inc.

Aggregated Comment Title: ***Allow Special Enrollment Period When Moving Between Settings***

Summary: CMS should grant beneficiaries moving between care settings and requesting disenrollment a limited special enrollment period to facilitate timely access to new coverage, while also reducing the burden on the skilled nursing facility (SNF).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Advocating for Seniors

Aggregated Comment Title: ***Resident-Initiated MA Disenrollment***

Summary: The 2021 CMS guidance on resident-initiated Medicare Advantage disenrollment imposes burdensome requirements on SNFs, including detailed explanations, signed acknowledgments, and staff attestations, leading to staff time diversion, care transition delays, and a quasi-broker role. CMS should revise the guidance to reduce compliance burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Advocating for Seniors

Aggregated Comment Title: ***Establish Prior Authorization Process for Part B Drugs***

Summary: CMS should establish an electronic prior authorization process for Part B drugs as soon as possible.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association for Clinical Oncology

Aggregated Comment Title: ***Issue Guidance Reiterating Supplemental Benefit Inclusion in MLR***

Summary: There is uncertainty surrounding the treatment of payments for supplemental services in the MLR that has led to potential inconsistencies in reporting. The Medicare Program CY 2021 Policy and Technical Changes final rule clarified that payments for supplemental benefits and SSBCI should be included in the MLR numerator, regardless of the payment recipient being a provider or another entity. CMS should issue guidance reaffirming its policy that supplemental benefits and SSBCI should be included in the numerator of the MLR.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Food Is Medicine Coalition

Aggregated Comment Title: ***Allow a Flexible DOS for DMEPOS***

Summary: For purposes of consolidated billing, allow a flexible Date of Service (DOS) window for DMEPOS items to align with the date of utilization rather than shipment or delivery, ensuring accurate reimbursement for supplies used by beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Standardize DMEPOS Site Inspections***

Summary: Standardize DMEPOS enrollment and revalidation site inspections and subject them to meaningful oversight. Additionally, establish stronger quality controls and accountability measures for site inspectors, as well as a formal process for supplier input before revocation decisions are made.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Evidence of Continued Medical Need for DME***

Summary: CMS should review and revise the documentation requirements for Durable Medical Equipment (DME) suppliers, particularly in cases where patients have a lifetime prescription and a chronic, progressively worsening condition. The current obligation for suppliers to provide ongoing evidence of continued medical need within the past 12 months may not be necessary or practical in such situations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Repeal Primary Payer's Notice of Primary Payment Responsibility***

Summary: CMS should repeal 42 C.F.R. 411.25, Primary Payer's Notice of Primary Payment Responsibility. This 1990s reporting requirement was overtaken by the 2007 enactment of Section 111 of the MMSEA and no longer has meaning or effect.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Confusion Over Authority to Bill Primary Payer for Full Charges***

Summary: The 42 CFR 411.31 billing requirement from the 1990s has led to confusion in the Medicare Secondary Payer community, with stakeholders misinterpreting it as allowing

recoveries for 100% of the billed amount, even if Medicare paid only a fraction. There are calls for the regulation to be repealed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Rethink ORM Processes***

Summary: ORM (Ongoing Responsibility for Medicals) requires Responsible Reporting Entities to report certain claims to CMS. The presence of the ORM flag on the Common Working File can causes known problems in claims processing and hinders unrelated care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Medicare Set Aside Reporting is Burdensome and Unnecessary***

Summary: CMS now mandates that Responsible Reporting Entities (RREs) include Medicare Set Aside (MSA) data in Section 111 Reporting for workers' compensation. This new requirement is burdensome and redundant, as it duplicates information already held by CMS. Stakeholders and beneficiaries managing MSAs are facing unnecessary reporting obligations, leading to calls for the elimination of MSA reporting as an onerous manual requirement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Raise Collection Threshold Under SMART Act***

Summary: In 2013, Congress mandated CMS to exclude claims below a certain threshold to prevent excessive collection costs. The current threshold is $750, but some industry experts suggest raising it to $2,000 to align with actual collection expenses and reduce administrative burdens on the program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Modernize "Grouper" to Improve Claims Identification and Recovery***

Summary: CMS and its contractors struggle to efficiently identify Medicare payments related to accidents or injuries, with studies showing less than five percent accuracy in identifying conditional payments. This inefficiency results in 95% of claims sought for recovery being ineligible. The outdated "Grouper" system used by CMS contributes to this problem. CMS should

modernize the Grouper to improve the matching process between claims paid by CMS and those reported by the reporting entity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***ICD Codes and Health Plan Recovery***

Summary: ICD code matching for non-group health claims in the non-group health plan recovery program is flawed due to the unavailability of ICD codes in those claims and the outdated CMS Grouper, which often misidentifies claims related to chronic conditions as accident or injury claims.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Codify Clarification on Interrupted Stays***

Summary: CMS should codify a clarification on interrupted stays from a February 6, 2024 guidance that instructs Medicare Advantage (MA) plans to follow the Medicare interrupted stay policy and prohibits MA plans from requiring skilled nursing facilities (SNFs) request another, duplicative prior authorization for the same episode of care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Medicare Advantage Processes Are Complex***

Summary: Over half of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans, with an average of 43 plans available per county. Providers face challenges navigating the unique prior authorization, concurrent review, and claims processes of multiple MA plans, leading to delays, duplicative reviews, and administrative errors. The communication of requests and plan responses through various channels further complicates the process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Implement a Centralized API to Streamline Prior Authorizations and Reduce Burden***

Summary: Implement a single portal or API for PAs following specific parameters, allowing providers to check if a PA is needed, submit requests, check status, and receive plan responses. Plan decisions on the PAs and CRs [concurrent reviews] should also be saved here for future reference for pursuing payment. This centralized system would streamline the process, reduce administrative burden and costs for Medicare Advantage plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Obtain Approval for Internal Coverage Criteria to Ensure Compliance***

Summary: MA plans should obtain approval for any internal coverage criteria, as its use should be rare. This approach would ensure appropriate interpretation of and compliance with Medicare regulations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Enable Access to Patient Cost-Sharing Information***

Summary: Post-acute care (PAC) providers lack information on patient cost-sharing, making collection of co-pays and coinsurance challenging. This is especially true with Medicare Advantage plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Digitize Procurement, Maintenance, Infection Control Compliance Documentation***

Summary: Digitize compliance documentation for procurement, maintenance, and infection control by accepting secure digital logs and third-party systems. Transition life safety surveyors to digital means for building walkthroughs with automation on creating the CMS Form 2567. This would enable immediate review and response to citations and digital creation of corrective action plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Direct Supply, Inc.

Aggregated Comment Title: ***Decrease Reporting Frequency of Measures***

Summary: Transition from quarterly to annual or biennial reporting for some or all measures to lessen administrative burdens and restore focus on patient care. Metrics with typically low variance (e.g., staffing, care plan reviews) can be reduced from monthly to quarterly or semi-annual reporting frequency. This will reduce workload while maintaining visibility. CMS may also consider event-triggered reporting, activated only by specific quality events or performance thresholds; practice size adjustments that establish reporting frequency based on practice size, performance, risk profile, and complexity; and exception reporting to allow providers to report only when performance varies significantly from established baselines. Alternatively, reporting deadlines may be adjusted to align with natural practice workflows and avoid peak seasons. CMS should also consider automation, risk-based adjustments, and the elimination of redundant data collection.

Total Comments Contributing: 26

Total Submissions Contributing: 16

Organization(s): American College of Physicians; BAYADA Home Health Care; Dale Medical Center; Infectious Diseases Society of America; Lantana Consulting Group; Lumeris Healthcare; Microsoft; National Board for Certified Counselors (NBCC); PACE Southeast Michigan; Sutter Health; The Ohio State University Wexner Medical Center; WelbeHealth

Aggregated Comment Title: ***Reduce Reporting Burden for High Performing Providers***

Summary: Reduce the reporting burden for high-performing providers through less frequent and simplified reporting or other flexibility, similar to a "trusted provider" status. Alternatively, implement a "deemed status" for high-performing providers with low denial rates. This approach rewards consistent compliance and quality outcomes, allowing regulators to focus on outliers. This rewards high performance with reduced oversight which eliminates unnecessary work.

Total Comments Contributing: 20

Total Submissions Contributing: 15

Organization(s): Booz Allen Hamilton; Health Alliance Plan of Michigan; Highlands Oncology Group, P.A.; Lantana Consulting Group; National Board for Certified Counselors (NBCC); Reveleer; Virginia Hospital & Healthcare Association; Wellbox

Aggregated Comment Title: ***Reduce Duplicative Submission Requirements Across Agencies***

Summary: Regulations should be modified to streamline processes. For instance, if certain documentation is already required by one regulatory body, such as CMS, it should not need to be duplicated for submission to another entity like a state administering agency (SAA).

Total Comments Contributing: 14

Total Submissions Contributing: 5

- ***Organization(s):*** BAYADA Home Health Care; Booz Allen Hamilton; InnovAge; National PACE Association; WelbeHealth

Aggregated Comment Title: ***Focus on Health Outcomes, Not Compliance and Technicalities***

Summary: To reduce burden while maintaining integrity, CMS should prioritize outcomes over processes and technicalities by considering intent, effort, and context, not just adverse events. Shifting focus from process compliance to measuring clinical outcomes and resident satisfaction can prevent facilities from being penalized for minor technical issues when patient care is appropriate and timely. This approach ensures a more balanced and fair assessment of healthcare quality.

Total Comments Contributing: 13

Total Submissions Contributing: 11

Aggregated Comment Title: ***Regulatory Consistency Across Federal and State Entities***

Summary: To improve alignment with best practices and industry standards, Medicare should ensure consistency between Federal and State regulations, especially related to licensure, scope of practice, workforce requirements, data sharing for health care operations, care coordination, and payment. For example, prohibiting states from imposing stricter requirements than federal requirements, such as CMS COPs and HIPAA, can eliminate unnecessary barriers to timely care coordination and administrative efficiency, ultimately enhancing the delivery of high-quality, integrated care. Additionally, a process for reviewing and eliminating outdated or redundant

requirements should be developed and uniformly applied across state and federal entities (for example, between CMS and OSHA). There should also be greater consistency and coordination between CMS staff working on different quality programs.

Total Comments Contributing: 13

Total Submissions Contributing: 13

Organization(s): Booz Allen Hamilton; Kingdom Insurance Group; Microsoft; National Board for Certified Counselors (NBCC); PointClickCare; Sutter Health; The American Association of Nurse Anesthesiology; Vivie

Aggregated Comment Title: ***Explore Ways to Reduce Overlapping Quality Reporting Requirements***

Summary: Similar clinical metrics, such as blood pressure, post-surgical complications, and diabetes management, are frequently requested across quality improvement programs, and there is often a misalignment between these requirements. Programs like the Hospital Readmission Reduction Program, the Value-Based Purchasing Program, the Medicare Shared Savings Program, the Merit-Based Incentive Payment System, and the Hospital Inpatient Quality Reporting Program require separate submissions for overlapping measures, forcing providers to repeatedly gather the same data and report it through different systems with varying specifications and timelines. This results in unnecessary administrative burdens, inefficiencies, increased costs, and a diversion of time from more impactful quality improvement efforts. These quality reporting requirements significantly disadvantage smaller and rural facilities due to their limited staffing and technological resources, making it difficult for them to comply. CMS should explore methods to reduce duplication in reporting for quality improvement programs.

Total Comments Contributing: 12

Total Submissions Contributing: 9

Organization(s): Alabama Hospital Association; American College of Surgeons; AnewHealth; Ohio Hospital Association; Premier Health; The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Make Transparency Meaningful for Patients***

Summary: Standardizing expectations for transparency in healthcare across payers is crucial to ensure patients receive consistent and readable information on cost and coverage. However, simply providing transparent information is not enough; it must also be easily accessible to patients. Tools like clear pricing calculators should be user-friendly and prominently displayed to be truly beneficial, especially for patients who may not have assistance navigating complex healthcare systems. Prioritizing usability and accessibility in healthcare transparency efforts is essential for empowering patients to make informed decisions about their care. Best practices

include clarity, patient education, real-time data, leveraging existing tools, avoiding duplicative regulation and incentivizing use.

Total Comments Contributing: 12

Total Submissions Contributing: 4

Organization(s): Massachusetts Health Data Consortium; National Association of ACOs (NAACOS); Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Modify QRP for Low-Volume Facilities***

Summary: The Skilled Nursing Facility Quality Reporting Program (QRP) faces challenges with certain facilities, particularly in rural areas, due to reporting requirements that are burdensome for those with a low volume of Medicare Part A SNF residents. Suggestions include: exclude facilities with 25 or fewer Medicare Part A stays from reporting and APU penalties, aligning with volume exceptions in other programs; increase transparency and the value of reported metrics; and allow exceptions to SNF QRP APU reporting requirements for all resident interview items when a provider completes both a 5-day PPS assessment and an unplanned discharge assessment.

Total Comments Contributing: 10

Total Submissions Contributing: 2

- ***Organization(s):*** American Association of Post-Acute Care Nursing (AAPACN); American Health Care Association (AHCA)

Aggregated Comment Title: ***Patient Safety Structural Measure is Critical***

Summary: The Patient Safety Structural Measure (PSSM) and Age Friendly Structural Measures are a critical component of improving quality and outcomes of care while reducing errors and costs and should not be waived or eliminated. Of particular value are elements related to job descriptions and patient and family advisory councils. Additionally, public reporting of actual responses and more granular data could enhance these measures.

Total Comments Contributing: 9

Total Submissions Contributing: 5

- ***Organization(s):*** Institute for Healthcare Improvement; Massachusetts Coalition for the Prevention of Medical Errors; National Association of Healthcare Quality; Patient Experience Policy Forum - The Beryl Institute; Patients For Patient Safety US

Aggregated Comment Title: ***Duplication in M1800 and Outcome and Assessment Information Set (OASIS)***

Summary: Providers complete the Outcome and Assessment Information Set (OASIS) for patients entering home health care, which includes Section GG items to assess functional abilities in self-care and mobility. Providers also complete the M1800 items that assessed these abilities previously. This requires providers to complete duplicative information, eliminating the M1800 items would eliminate this redundancy.

Total Comments Contributing: 8

Total Submissions Contributing: 7

Organization(s): ADVION (formerly National Association for the Support of Long-Term Care [NASL]); Adara Home Health; Aegis Therapies; American Physical Therapy Association

Aggregated Comment Title: ***Expand Use of AI Through Innovation and Incentives***

Summary: Medicare needs transparent pathways for assessing coverage of new technologies like artificial intelligence to support their adoption. A sustainable market environment that encourages investment in AI and rewards its implementation is crucial for its success. Along with investments and incentives CMS should offer technical assistance to help practices with limited resources, such as those in rural areas, adopt AI tools. Technologies proving clinical value should receive additional Medicare reimbursement incentives to further incentivize their use.

Total Comments Contributing: 8

Total Submissions Contributing: 4

Organization(s): Bipartisan Policy Center; RadNet; Reveleer

Aggregated Comment Title: ***Explore Ways to Eliminate Redundancies in the Appeals Process***

Summary: The appeals process involves redundancies. Providers must adhere to distinct documentation requirements for Medicare Advantage appeals (CMS-10260: OMB Control Number 0938-0932) compared to Traditional Medicare appeals, which have separate processes for appealing the same services. Furthermore, integrated care appeals require navigating multiple appeals systems. At each appeal level, including redetermination, reconsideration, and the Administrative Law Judge (ALJ) level, providers must submit duplicate medical records. This often leads to multiple identical submissions for a disputed claim. Furthermore, to request a hearing with an ALJ, providers must completely restate their appeal rationale, regardless of any previous submissions made during the redetermination and reconsideration levels. The ALJ Procedures could be streamlined through expanded pre-hearing resolution options and allowing designated practice representatives to appear without requiring provider presence for administrative billing disputes. Prescription drug appeals (Part D) also have a distinct

documentation process (CMS-10148: OMB Control Number: 0938-0975) separate from medical appeals, despite clinical similarities. CMS should establish a "one-time submission" rule that allows documentation submitted at any appeal level to be automatically forwarded to subsequent levels, thus eliminating redundant paperwork.

Total Comments Contributing: 8

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Leverage Technology to Streamline Processes***

Summary: Medicare can implement industry best practices and modern standards without adding more regulations. By utilizing existing technology, transparent communication, and digital health integration, Medicare can streamline operations and support modern care delivery models. Emphasizing interoperable digital health platforms and user-friendly interfaces will simplify referrals, documentation, data collection, and reporting, ultimately improving efficiency and effectiveness in claims appeals. For instance, requiring practitioners to download remittance statements on their Medicare website rather than receive them in the mail would cut costs.

Total Comments Contributing: 8

Total Submissions Contributing: 8

Organization(s): Johns Hopkins Health Plans; Lantana Consulting Group; National Board for Certified Counselors (NBCC); Ohio Hospital Association; Patients For Patient Safety US; Premier Health; Solventum

Aggregated Comment Title: ***Transition to Electronic Reporting***

Summary: CMS should provide support and resources that facilitate the transition to electronic reporting, ensuring that all healthcare entities, regardless of their technological capabilities, can participate effectively in quality measurement initiatives.

Total Comments Contributing: 8

Total Submissions Contributing: 3

Aggregated Comment Title: ***Simplify SNF Provider Enrollment Disclosure Requirements***

Summary: The SNH Provider Enrollment Disclosure requirements currently exceed what is required in statute. CMS should require currently enrolled SNFs to provide disclosures during their next regularly scheduled five-year provider enrollment revalidation, work with SNF stakeholders to remove excessive disclosure requirements from sub-regulatory guidance and disseminate and regularly update guidance on the CMS website and via interactive activities.

Total Comments Contributing: 8

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Streamline Current Peer-to-Peer Processes and Expand Consultations***

Summary: Standardizing peer-to-peer appeal and review processes across payers could reduce administrative burdens, and reforms such as permitting peer-to-peer reviews for pre-service denials under Medicare Advantage plans could improve patient care and outcomes. Additionally, expanding the use of peer-to-peer consultations could ensure appropriate and safe clinical care, such as for second opinions. Encouraging peer-to-peer consultation would align with industry best practices and enhance patient safety by ensuring the application of the most current clinical protocols, particularly in remote settings.

Total Comments Contributing: 7

Total Submissions Contributing: 5

Organization(s): Cleveland Clinic; National Board for Certified Counselors (NBCC); Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Streamline CMS and State Emergency Preparedness Standards***

Summary: Streamline Emergency Preparedness Standards and eliminate redundant surveys by combining CMS and state requirements. Further, reduce the number of required exercises to one annually by revisiting 42 CFR 482.15(d). Simplify the Emergency Preparedness requirements for smaller agencies and allow virtual drills and mobile-first communication plans.

Total Comments Contributing: 7

Total Submissions Contributing: 7

Organization(s): LeadingAge; Vivie

Aggregated Comment Title: ***Simplify Reporting Language and Requirements***

Summary: Navigating complex language, technologies, and requirements for regulations and reporting can be challenging. Simplification, provider education, and improved accessibility will improve understanding, consistency, and usability.

Total Comments Contributing: 7

Total Submissions Contributing: 7

Organization(s): American Academy of Neurology; Price Services Group, L.L.C.; Shekina Glory Legacy Hospice and Palliative Services

Aggregated Comment Title: ***Increase Utilization of PROM Technology***

Summary: Investing in technology to support clinical systems for centralized patient-reported outcome measures (PROMs) collection and data visualization can provide valuable insights for clinical decision-making. Collaborating with health IT vendors to enable plug-and-play functionality for outcome collection can make PROM data readily usable for clinicians and regulators. Replacing outdated Medicare forms and surveys with condition-specific, interoperable PROM tools can better reflect personalized outcomes that patients care about, improving response rates and serving both clinical and quality goals effectively. CMS could adopt open-access ICHOM Patient-centered Sets as default templates for outcomes data collection.

Total Comments Contributing: 7

Total Submissions Contributing: 1

- ***Organization(s):*** International Consortium for Health Outcome Measurement (ICHOM)

Aggregated Comment Title: ***OASIS is Overly Complex and Burdensome***

Summary: Although the Outcome and Assessment Information Set (OASIS) is vital for home health payment and quality reporting, it is time-consuming and burdensome. It requires extensive staff training, which diverts resources away from patient care. Additionally, redundant data elements further complicate the process.

Total Comments Contributing: 6

Total Submissions Contributing: 4

Aggregated Comment Title: ***Technology Enhancements to Improve Appeals Processes***

Summary: Efforts to enhance technology solutions for appeals processes should prioritize developing integrated platforms to streamline portal management complexities, such as by creating electronic document repositories with a one-time submission with automatic forwarding; standardizing digital workflows through the creation of a universal appeals portal; and automating outcome tracking. Additionally, implementing feedback loops for appeals outcomes can proactively detect and rectify systematic denial trends, preventing the escalation of administrative challenges.

Total Comments Contributing: 6

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Replace Sepsis Bundle Measure at 79 FR 50241 and 88 FR 59801 with Sepsis Outcomes Measure***

Summary: The recommendation is to replace the sepsis bundle measure with a measure of sepsis outcomes in hospital quality reporting programs to reduce administrative burden and improve patient care. This shift towards outcome-based measures is seen as a more effective and administratively efficient approach to improving patient safety programs and reducing abstraction burdens for hospitals.

Total Comments Contributing: 6

Total Submissions Contributing: 6

Organization(s): Cleveland Clinic; Illinois Health and Hospital Association; MaineHealth; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Align Assessment Requirements to Reduce Duplicate Documentation***

Summary: Skilled Nursing Facilities complete multiple assessment forms for each patient, some of which overlap in the information they require and occur more frequently than necessary. Assessment requirements should be aligned across Medicare, Medicare Advantage, and Medicaid to streamline the assessment process.

Total Comments Contributing: 6

Total Submissions Contributing: 5

Organization(s): BAYADA Home Health Care; LeadingAge PA; Price Services Group, L.L.C.

Aggregated Comment Title: ***Simplify and Improve the MDS Reporting Process***

Summary: The Minimum Data Set (MDS) reporting process is overly complex, which causes some facilities to struggle with completing all required documentation. Additionally, limitations in electronic medical records (EMRs) can hinder healthcare providers from capturing the necessary fields while completing the documentation. If a provider neglects to fill in a minor detail, such as whether the assessment was performed while the patient was wearing glasses, the quality reporting program standard for the MDS cannot be met. This can result in payment denials. While CMS uses MDS reporting for payment determinations, the data points often lack relevance to quality outcomes. CMS should reopen the MDS help desk.

Total Comments Contributing: 6

Total Submissions Contributing: 4

Organization(s): American Health Care Association (AHCA); Booz Allen Hamilton; Vivie

Aggregated Comment Title: ***Align with USPSTF Recommended Services***

Summary: The lack of CMS alignment with USPSTF-recommended services creates inefficiencies and confusion. Medicare's requirement for different G codes compared to the rest of the healthcare system leads to parallel coding systems, duplicate provider education, and separate claims processing logic. There is a patchwork of coverage timelines for identical preventive services. The duplicative public comment process between USPSTF and CMS further adds to regulatory excess, hindering consistent implementation and creating challenges for providers in tracking preventive service coverage. CMS should also adopt HEDIS measures aligned with USPSTF instead of maintaining separate specifications.

Total Comments Contributing: 6

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reform and Target Hospice Audits***

Summary: Reform hospice audits and use risk-adjusted benchmarks for accurate targeting or randomly sample new hospices for compliance.

Total Comments Contributing: 6

Total Submissions Contributing: 3

Aggregated Comment Title: ***Reconsider Definition of Marketing Materials***

Summary: CMS should reconsider the December 2024 proposal to expand the definition of marketing materials. Comments recommend maintaining the current two-part standard. This standard offers a clearer and more balanced framework for distinguishing marketing materials from general communications, ensuring appropriate oversight and operational efficiency. The

expansion could limit beneficiaries' access to crucial information, create barriers to effective communication, strain CMS's review capacity, increase administrative burdens on plans, and lead to a significant rise in submissions for review.

Total Comments Contributing: 6

Total Submissions Contributing: 1

- ***Organization(s):*** UCare

Aggregated Comment Title: ***Rethink Quality Reporting for Orthotic and Prosthetic Providers***

Summary: Current CMS quality reporting programs like MIPS and QPP are not well-suited for orthotic and prosthetic (O&P) providers, leading to disproportionate penalties for non-participation, limited ability to demonstrate value-based care, and/or failure to meet thresholds due to limited applicability of the requirements to this specific healthcare sector. Develop specific quality measures for these providers and streamline reporting requirements.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** O&P Insight

Aggregated Comment Title: ***Streamline MIPS Data Collection Requirements***

Summary: CMS could streamline the MIPS data collection requirements by allowing clinicians to attest to certain activities or outcomes rather than document each data point in detail, eliminating low-value measures, and reducing the total number of required data points.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** American College of Physicians; American Osteopathic Association; Blue Cross Blue Shield Association

Aggregated Comment Title: ***Adopt Real-Time Status Tracking for Appeals***

Summary: CMS can enhance efficiency by adopting real-time status tracking for appeals, similar to patient portals. Implementing comprehensive appeals tracking systems with features like automated updates, AI-powered timeline projections, and interactive case dashboards would

streamline processes and improve transparency without requiring new regulations. CMS could also integrate appeals tracking with a single system for all Medicare appeals types.

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** Booz Allen Hamilton; National Association of ACOs (NAACOS); National Board for Certified Counselors (NBCC); Regulatory Relief Coalition

Aggregated Comment Title: ***Align NCCI Policy Manual with AMA's CPT Code Set for Laboratory Services***

Summary: The coding guidance in the NCCI Policy Manual conflicts with AMA CPT codes for certain services, including laboratory procedures, causing compliance issues and reimbursement denials. Resolving this conflict is crucial for accurate coding and reimbursement. Suggestions include addressing these contradictions by removing or modifying the guidance that states, "In the case of tests for infectious agents, methodologies include detection by immunofluorescence, immunoassay, or nucleic acid probe techniques," and "CMS may adopt NCCI edits that are not consistent with CPT Assistant."

Total Comments Contributing: 5

Total Submissions Contributing: 4

- ***Organization(s):*** AdvaMed; American Clinical Laboratory Association (ACLA); College of American Pathologists; Quest Diagnostics

Aggregated Comment Title: ***Standardize Language for Denials***

Summary: To improve appeals processing and increase transparency require standard language for denials. Transparent decision criteria would address the current gap of generic denial reasons without specific guidance for resolution. Best practice involves providing detailed, actionable feedback similar to clinical decision support systems through implementation that develops AI-powered systems generating specific documentation recommendations based on denial reasons. CMS should require MACs to provide these specific and actionable denial reasons rather than generic codes. Smart denial code translation systems can convert generic denial codes into specific, actionable guidance for providers.

Total Comments Contributing: 5

Total Submissions Contributing: 2

Organization(s): National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***IMM is Redundant and Overly Complex***

Summary: The Important Message from Medicare (IMM) notification requirement is redundant, labor-intensive, and confusing for patients.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Premier Health; The Ohio State University Wexner Medical Center; University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Delays and Dissatisfaction With Equipment Repair Processes***

Summary: Administrative delays and beneficiary dissatisfaction plague repair processes for Complex Rehabilitation Technologies (CRT) and Assistive Technology (AT) devices, and durable medical equipment (DME) due to requirements such as obtaining a physician's signature for each transaction, lengthy evaluation and validation processes for repairs, and cost analyses not exceeding 60% of the replacement cost. Even after physicians sign orders, the repair process can take weeks or months. Eliminating prior authorization for repair claims would prevent unreasonable delays for consumers who have already met coverage requirements upon initial issue of the technology.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** American Association for Homecare; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services); Wheelchair Clinic Inc

Aggregated Comment Title: ***Baseline Care Plan Requirement is Duplicative***

Summary: The Baseline Care Plan (BCP) requirement, mandated within 48 hours of admission by 42 CFR §483.21, is redundant and burdensome. Facilities already must create a comprehensive person-centered care plan that covers all essential clinical and psychosocial information. The additional BCP within a short timeframe adds administrative complexity without clear benefits. The baseline care plan requirement should be eliminated.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Organization(s): BAYADA Home Health Care; LeadingAge PA; Select Medical Holdings Corporation; Special Needs Plan Alliance

Aggregated Comment Title: ***Support Remote Patient Monitoring***

Summary: CMS should update regulations to support remote patient monitoring as billable services, including aligning its definition of remote patient monitoring in the HHPPS with that captured in relevant CPT codes.

Total Comments Contributing: 5

Total Submissions Contributing: 5

- ***Organization(s):*** Cleveland Clinic; Connected Health Initiative; Illinois Health and Hospital Association; Microsoft; Sutter Health

Aggregated Comment Title: ***Physician-Owned Hospital Expansion Policies are Redundant***

Summary: The documentation and quality reporting requirements for physician-owned hospital expansions contain redundancies. The documents mandated by 42 CFR § 411.363(e) require justifications for projected future needs, details about the usage of previously approved expansions, and an analysis of community demand; however, none of these requirements are statutorily mandated. Additionally, the quality and community needs assessments outlined in 42 CFR § 411.363(i) are unnecessary in the context of expansion eligibility and replicate elements already assessed under hospital participation conditions and Medicare enrollment standards, resulting in redundant evaluations.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** Doctors Hospital at Renaissance, Ltd. (DHR Health)

Aggregated Comment Title: ***USPSTF Quality Reporting is Redundant and Overly Complex***

Summary: The reporting requirements for the United States Preventive Services Task Force (USPSTF) recommended services under the current Merit-based Incentive Payment System (MIPS) are overly complex and redundant. Providers are required to document detailed process and outcome measures for preventive services that have already been validated through systematic evidence review. For example, when offering depression screening, providers must report specific details beyond the occurrence of the screening, including the type of screening tool used, the score achieved, and the follow-up plan. This creates administrative inefficiencies

for services with established effectiveness. While such detailed reporting may be appropriate for experimental interventions, it is excessive and wasteful for established preventive services. Quality measurement should focus on whether eligible beneficiaries received recommended services, not on documenting processes that have already been validated through systematic evidence review.

Total Comments Contributing: 5

Total Submissions Contributing: 1

Aggregated Comment Title: ***Universal Use of HCPCS Codes***

Summary: The coordination between the HCPCS Level II Workgroup and CMS payment systems groups, such as MPFS, OPPS, and DMEPOS, needs improvement to provide timely updates for new, deleted, or revised HCPCS Level II and AMA CPT-4 codes. CMS should establish a more reasoned policy that allows for more HCPCS codes, along with more specifications within the codes. Further, CMS needs to synchronize with the updates. While the AMA offers educational resources like CPT Changes, users struggle to integrate information from various sources for quarterly updates. Providers require 60-90 days to update systems, making late transmittals and MLN updates from payment systems unhelpful. Release summary updates within a week of Final Rule publication and post data releases at least 60 days before their effective dates.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Alliance of Dedicated Cancer Centers (ADCC); American Association for Homecare

Aggregated Comment Title: ***Establish More Structured and Transparent Timelines for Regulatory Changes***

Summary: CMS should establish more structured and transparent timelines for implementing changes to Medicare policies, especially when updates impact electronic health record systems and billing platforms used by rehabilitation providers. The current rushed process by CMS in releasing final rules with minimal time for implementation increases the risk of errors, omissions, and compliance failures, particularly for small to mid-sized practices lacking dedicated IT or compliance departments. Partnering closely with software vendors to create a product roadmap that aligns with the regulatory framework would ensure that providers can comply with the regulation. Limiting the frequency of regulatory changes would alleviate burdens.

Total Comments Contributing: 5

Total Submissions Contributing: 5

Aggregated Comment Title: ***Certification and Recertification Forms are Overly Complex and Redundant***

Summary: Certification and recertification forms, including for transitions from Medicare Part A to Part B and Medicare Advantage, and Part D, are overly complex and redundant.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Aggregated Comment Title: ***Improve Quality Measurement***

Summary: Government policy relief and alignment from private partners could replace the current quality measurement patchwork with a more targeted landscape. Measures should be optimized by ensuring quality frameworks align with CMS coverage policies to support timely adoption of clinically appropriate innovations that can improve care.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Aggregated Comment Title: ***Eliminate Redundancies in Documentation for MTM and eCare Plans***

Summary: Pharmacists face challenges with complex and redundant documentation requirements for submitting medication therapy management (MTM) and eCare Plans, as different CMS programs do not recognize standard formats like NCPDP SCRIPT or HL7 FHIR. This leads to the need for manual extraction and reformatting of information into PDFs or program-specific platforms. An MTM intervention or PGx consultation often must be documented three different ways: for billing, for a PBM audit, and for the patient's record. CMS should align MTM reporting with current adherence and quality methodologies.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** Prime Therapeutics LLC; Sanford Health - Sanford Health Plan and Security Health Plan; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Batch Submission of Appeals***

Summary: CMS should allow batch submission of similar appeals and integrate with existing practice management systems through dedicated provider portals. This will be particularly beneficial for practices experiencing pattern denials of routine services. Batch submission could also be complemented by establishing a "provider advocate" program with specialized Medicare staff familiar with mental health billing practices to guide providers through complex appeals.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***Consider Reporting Accommodations for Low-Volume Providers***

Summary: Expand exemptions, adjust thresholds, or suppress results for low-volume or specialty providers where certain measures are not or no longer applicable. For example, procedures related to hips and knees are now mostly completed as outpatient services and related metrics should be retired from inpatient reporting. This will minimize unnecessary administrative effort.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Aggregated Comment Title: ***Revise Survey Deficiency Tags and Descriptions***

Summary: Revise survey deficiency tags to reduce redundancies and complexity and increase flexibility. On Statements of Deficiency, ensure findings are described clearly, such as whether a finding of abuse is facility-reported. Multiple F-tags should not be assigned to a single deficiency.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): American Association of Post-Acute Care Nursing (AAPACN); LeadingAge

Aggregated Comment Title: ***Reimburse SNFs via Grants Rather Than Billing***

Summary: Pay SNFs via grants (similar to HRSA) instead of via billing. Alternatively, move oversight for nursing homes to HRSA entirely.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Standardize Hospice Benefit Documents***

Summary: Standardizing required hospice benefit documents can alleviate administrative and financial burdens for hospice providers. Technical denials due to signature location errors or missing dates on forms can lead to delayed payments. Implementing standardized forms could help prevent these issues, ensuring data elements are correctly placed and reducing claim review complications. Suggested standardized forms include the Election Statement, Certification of Terminal Illness (CTI), and Notice of Election and Claim Form (CMS-1450).

Total Comments Contributing: 4

Total Submissions Contributing: 2

Aggregated Comment Title: ***Adopt Existing Industry Standards Over New Regulatory Frameworks***

Summary: CMS should adopt established industry standards instead of developing new regulations, particularly for cardiovascular imaging and for religious non-healthcare institutions. By utilizing existing appropriateness criteria, quality standards, and innovative care models, CMS can improve patient access to high-quality imaging, reduce administrative burden, enhance outcomes for Medicare beneficiaries, and ensure the sustainability healthcare services. CMS can also align with countries already using patient-reported outcome measures (PROM)-based models (e.g., Netherlands, UK, Brazil).

Total Comments Contributing: 4

Total Submissions Contributing: 4

- ***Organization(s):*** Booz Allen Hamilton; Christian Science Provider Network; International Consortium for Health Outcome Measurement (ICHOM); UltraSight Inc.

Aggregated Comment Title: ***Limit Changes to Formularies***

Summary: Ensure that plans cannot remove or reduce coverage for medications listed on the Part D formulary at the start or renewal of a policy. Also ensure consistent patient access by preventing mid-year formulary or coverage changes and increasing transparency for review processes.

Total Comments Contributing: 4

Total Submissions Contributing: 3

Aggregated Comment Title: ***Permit Health Plans to Report Beneficiary Deaths upon Receipt of Death Certificate***

Summary: CMS should permit health plans to report beneficiary deaths once they have received a copy of the official death certificate, as it helps maintain up-to-date enrollment information crucial for plan operations and member services, minimizes administrative discrepancies, supports effective beneficiary record management, and ensures accuracy and timeliness while reducing reliance on potentially delayed or inconsistent external data sources.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** UCare

Aggregated Comment Title: ***Digitize Physical Beneficiary Notice and Coverage Mailings***

Summary: CMS should modernize physical notice requirements such as the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) and as found in 42 CFR ¤ 482.13 [...] by allowing digital alternatives, consolidating duplicative postings, and prioritizing clarity and accessibility for patients and families, reflecting how beneficiaries consume health information in the digital age.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Association for Homecare; Children's Hospital Association; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Delimit Number of Authorized Users for RADV***

Summary: CMS should remove the user limitation for RADV as it poses operational challenges for MAOs managing large volumes of audit-related data.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Health Alliance Plan of Michigan; Humana

Aggregated Comment Title: ***Establish Single Clinical Standard for Traditional Medicare and Medicare Advantage***

Summary: To streamline the claims adjudication process, it is proposed to implement a unified clinical standard for both Traditional Medicare and Medicare Advantage plans. This would eliminate the need for providers to navigate various criteria used by different plans, ultimately saving time and improving efficiency in claim processing.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Cleveland Clinic; Illinois Health and Hospital Association; Kentucky Hospital Association

Aggregated Comment Title: ***Remove Some SNF QRP Measures***

Summary: Remove SNF QRP measures that do not result in better resident outcomes and focus more on metrics that matter to patients.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); National Association of Rehabilitation Providers and Agencies (NARA)

Aggregated Comment Title: ***Decrease Burden Associated with the Promoting Interoperability Program***

Summary: Documentation and reporting requirements for the Promoting Interoperability Program (OMB Control Number 0938-1174) are overly complex. For example, generating reports for the query of the Prescription Drug Monitoring Program, a component of the Promoting Interoperability Program, requires a manual process. This requirement can be particularly challenging for small, rural, and critical access hospitals, which often lack adequate staffing to collect the necessary data.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Ohio Hospital Association; Sanford Health

Aggregated Comment Title: ***Streamline the Hospital Wage Index Survey***

Summary: Completing the Hospital Wage Index Occupational Mix Survey is resource-intensive. Streamlining this form by consolidating and simplifying or decreasing the frequency of wage index data reporting could reduce the response burden without compromising Medicare's integrity.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Ohio Hospital Association; The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Quality Dashboards Improve Performance***

Summary: CMS should prioritize the development of real-time quality dashboards for providers to monitor and improve quality metrics promptly. Emphasizing response time to improvement as a key metric could drive timely enhancements. Integrating performance dashboards can automate the display of appeals metrics, denial patterns, and comparative performance data, aiding quality improvement efforts.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** National Board for Certified Counselors (NBCC); Price Services Group, L.L.C.; Quality and Performance Measures Committee of the Society for Vascualr Surgery

Aggregated Comment Title: ***Misalignment Between Appeals Deadlines and Audit Timelines***

Summary: Appeals deadlines do not coincide with audit timelines, leading to conflicting submission requirements. This necessitates that providers manage multiple tracking systems for related issues. The forms impacted include OMHA-700, CMS-10265, and CMS-20027.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Variability in MAC Electronic Submission Requirements***

Summary: The requirements for electronic submission differ among Medicare Administrative Contractors (MACs) and across various appeal levels. This variation requires providers to convert

documentation into various electronic formats for OMB 0938-1017, 0938-1048, and 0938-1053. Additionally, the absence of standardized requirements for organizing and submitting medical records across MACs necessitates that providers format their submission information differently for all CMS-200XX series medical record request forms based on the MAC jurisdiction. This variability requires multi-state practices to implement different procedures for managing appeals documentation.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Minimize Changes to Reporting Platforms and Specifications***

Summary: Minimize frequent changes to reporting specifications and platforms and supply clear guidance and adequate lead times for updates. This will help providers manage complex reporting more effectively.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Suggestion for Medicare Certification Process***

Summary: The Medicare certification process should be altered to include 14 days for the initial certification and every 30 days thereafter and may be extended to no more than 100 days depending on the provider. CMS should also address licensure separately from certification/accreditation, as they serve different purposes.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Healthpilot; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Focus Post-Payment Review Resources on Problem Areas***

Summary: CMS should focus post-payment review resources (like RAC and MAC audits) more sharply on patterns indicating significant potential for fraud, waste, or abuse, rather than pursuing minor, inadvertent errors that impose disproportionate administrative burdens for minimal recoveries. Improving the consistency and transparency of audit processes remains important.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): LeadingAge PA; National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Streamline Infection Control Protocols and Reporting***

Summary: CMS should streamline and clarify infection control protocols, and ensure they reflect current risks and realities. CMS should also optimize and streamline reporting for infection preventionists, avoiding semi-automated and manual reporting processes.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): LeadingAge PA

Aggregated Comment Title: ***Publish D-SNP and MA-PD Data Reporting Requirements***

Summary: Publish a comprehensive and regularly updated inventory of the full scope of D-SNP and MA-PD data reporting requirements. This will help stakeholders identify gaps in MA data collection and reporting.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Association for Community Affiliated Plans (ACAP)

Aggregated Comment Title: ***CAHPS Survey Complexities for Patients in USIT***

Summary: Patients in the U.S. Island Territory of Guam face significant challenges in completing Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Due to the absence of home mail delivery or pickup, patients must travel to a post office to receive and return their surveys. For homebound patients, this requires assistance from friends or family, creating an additional obstacle. Furthermore, many patients struggle with understanding certain words in the survey, such as "gentle" and "medicine." These issues contribute to a low response rate. On average, patients in Guam score slightly lower (between 7 and 9) than the required scores of 9 or 10 on the survey, resulting in the exclusion of their scores. This negatively affects providers' Home Health Value-Based Purchasing Model (HHVP) scores. CMS should consider incorporating visuals into the CAHPS survey to aid individuals with literacy difficulties or allowing providers to conduct it as a brief phone survey.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Health Services of the Pacific

Aggregated Comment Title: ***Technological Streamlining of Electronic Visit Verification***

Summary: Recommendations to improve technical complexity, formatting errors, and connectivity issues for Electronic Visit Verification (EVV) include providing grants for alternative EVV adoption, simplifying error correction processes, and allowing offline verification methods to address these issues effectively.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Home Care Alliance of Massachusetts

Aggregated Comment Title: ***Rethink SNF Surveys Using HRSA's Approach as a Model***

Summary: Consider HRSA's approach to surveys and apply that flexibility to SNF surveys to alleviate burden and rancor while assuring quality. CMS could test the effectiveness in a pilot that compares outcomes of SNFs surveyed by each process.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Simplify Patient Screening Process***

Summary: CMS should consider simplifying current CPT codes for basic screenings to reduce physician time spent on coding rather than patient care. Hospitals are required to screen for various risks and social determinants of health, which can be burdensome for nursing staff and detract from patient care. While some screenings are necessary for patient well-being, others may not be as relevant. Streamlining these requirements could help healthcare providers focus more on direct patient care and less on administrative tasks.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): American College of Osteopathic Family Physicians (ACOFP); Oklahoma Hospital Association

Aggregated Comment Title: ***Prohibit Claim Denial for Prior Authorized Services***

Summary: CMS should prohibit Medicare Advantage plans from denying claims for which they have provided prior authorization. This would reduce duplicate work for providers. CMS can identify services that require prior authorization but are frequently overturned on appeal. CMS should designate these services as prior authorization prohibited, preventing MA plans from requiring prior authorization for services with low denial rates and rarely disputed medical necessity.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Booz Allen Hamilton; College of American Pathologists; Georgia Hospital Association

Aggregated Comment Title: ***Consolidate or Sunset Overlapping Value-Based Care Components***

Summary: CMS should consolidate, align, or eliminate redundant programs and establish a standardized national framework for value-based care components like risk adjustment, attribution, and quality measures. This streamlining effort could enhance program transparency, focus fraud prevention efforts on impactful system reform, and ultimately improve the efficiency and effectiveness of value-based care initiatives.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Booz Allen Hamilton; Patients For Patient Safety US; The Wright Centers for Community Health and Graduate Medical Education

Aggregated Comment Title: ***Use Outcomes as Meaningful Stars Measures***

Summary: Star measures should be based on care outcomes instead of many of the currently used measures such as medication adherence.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Aledade

Aggregated Comment Title: ***Standardize Policies for SNF, Rehabilitation, and LTACH Care***

Summary: It is essential to align rules for SNF, rehabilitation, and LTACH so authorizations and patient status determinations apply across these settings. End-of-life care rules between SNFs and hospitals should be aligned, including the process of calling off heroic measures in a SNF.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Martha T. Berry Medical Care Facility, Macomb County Michigan; Ohio Hospital Association; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Empower Laboratories to Comply with PAMA Reporting Requirements***

Summary: Hospital outreach laboratories were not initially included in educational strategies regarding laboratory reporting obligations. CMS must conduct aggressive outreach to hospital outreach laboratories and others that need information and assistance to comply with the data reporting requirements under the PAMA.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***Facilitate an Efficient Non-Clinical Documentation Process***

Summary: CMS should develop a user-friendly data submission process with reduced frequency and complexity of reporting for non-clinical providers. Current processes are fragmented, duplicative, and inefficient. One such tool could include dropdown fields and structured check-ins to capture essential information without the need for complex clinical documentation or PDF uploads, ultimately improving care coordination and outcomes.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Centro De Amigos

Aggregated Comment Title: ***Standardize Billing***

Summary: Standardize and simplify billing methodology across hospitals and other providers to reduce burden and improve outcomes.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Standardize USCDI Plus Quality Elements***

Summary: CMS and ONC should collaborate to standardize USCDI and USCDI Plus Quality elements for inclusion in APIs as part of the Interoperability and Prior Authorization rule.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Lantana Consulting Group; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Reduce Documentation Duplication for Dual-Eligible Programs***

Summary: Providers operating in both Medicaid and Medicare-adjacent systems face duplicative requirements, particularly in person-centered service planning and documentation for dual-eligible individuals. Providers must repeat processes across Medicare Advantage, Medicaid Managed Care Plans, care management agencies, and state-required systems, leading to manual re-entry of the same information due to slight formatting differences. The lack of integration wastes time, increases miscommunication risk, and fragments care for individuals. A shared digital care plan platform for duals accessible to both Medicare and Medicaid stakeholders could streamline documentation processes and improve care coordination, ultimately allowing providers to focus more on supporting seniors and less on redundant paperwork.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Centro De Amigos; R1 RCM

Aggregated Comment Title: ***Provide Additional Reimbursement for Integration of Digital Health Tools***

Summary: Integrating digital health into the healthcare system can improve information flow to providers, reduce delays in patient care, and decrease emergency room visits and

hospitalizations. CMS should offer providers additional reimbursement or subsidies to incentivize integration of digital health tools.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): American College of Surgeons

Aggregated Comment Title: ***Modify Required MA Materials and Content***

Summary: Modify the required MA materials and content by removing the 'Star Ratings Disclaimer', the 'Accommodations Disclaimer' requirement for events, and the confusing and unnecessary consumer notification when leaving the MA organization's Medicare site.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Establish Reporting for Chaplain Services in HQRP and Claims***

Summary: CMS has introduced three new HCPCS Level II codes for chaplain services in hospices: Q9001 for assessment, Q9002 for individual counseling, and Q9003 for group counseling. However, it is uncertain when these codes will be used in hospice claims or the Hospice Quality Reporting Program (HQRP). There is a call to include chaplain visits in the HQRP.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Hospice and Palliative Medicine

Aggregated Comment Title: ***Incorporate Hospice Services Furnished Via Telecommunications Technology into HQRP***

Summary: The proposal suggests incorporating telehealth visits into the Hospice Quality Reporting Program (HQRP) to improve data collection for process measures like Timely Follow-up for Pain Impact and Timely Follow-up for Non-Pain Symptom Impact. CMS may modify these measures to include visits via telecommunications technology, even audio-only, for patients unable or unwilling to use audio-video capabilities.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Hospice and Palliative Medicine

Aggregated Comment Title: ***Use Collected Data Efficiently, Rely on Facilities Only for Missing Information***

Summary: Use the data that are already collected by Medicare and only require providers and facilities to supply missing information for smart forms or templates. This will minimize redundancy and errors.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Hands of Wellness; WEDI

Aggregated Comment Title: ***Align Reporting With Clinical Workflows***

Summary: To reduce provider burden while maintaining program integrity, align reporting, such as for MIPS, with actionable metrics and established clinical workflows.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Allow Therapists to Conduct Home Health Assessments***

Summary: The requirements of 42 CFR §484.55(a)(2) and §484.55(b)(2) should be amended to allow speech-language pathologists, physical therapists, and occupational therapists to perform initial and comprehensive assessments when therapy services are ordered, regardless of whether nursing services are included in the plan of care. Currently, only registered nurses are allowed to complete initial assessments if nursing is an ordered service. However, during the COVID-19 pandemic, therapists were able to conduct home health initial assessments and initiate care more quickly, providing greater flexibility in the healthcare system.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Uniform Clinical and Documentation Standards***

Summary: CMS should develop and enforce uniform clinical and documentation standards across all contractors to reduce subjectivity and variability in claim reviews.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Sanford Health - Good Samaritan Society; The Coalition for 21st Century Medicine

Aggregated Comment Title: ***Removal of Admission Schedule Requirements***

Summary: The completion deadlines and encoding requirements in the Admission Schedule requirements at 42 CFR 412.610(d), 42 CFR 412.610((c)(1)(i)(C), and 42 CFR 412.610(c)(2)(i)(B) should be removed.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate Redundant SRAs***

Summary: Eliminate redundant SRA (security risk assessment) requirements, which are resource-intensive without clear benefit. Establish a multi-year reporting schedule and only require them when certain system changes or risks occur.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): Greater New York Hospital Association

Aggregated Comment Title: ***e-Prescribing for DMEPOS***

Summary: CMS should issue guidance clarifying that e-Prescribing applications are considered an extension of the prescriber's medical records. If CMS required ePrescribing for all DMEPOS orders, suppliers would adopt ePrescribing platforms with clear CMS support. The oxygen clinical data elements (CDE) that were developed by the Mettles pilot should be publicly available and recognized as sufficient to meet medical record requirements.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow Contracted Pharmacy Partners to Complete Medication Management Requirements***

Summary: CMS should acknowledge via regulation or subregulatory guidance that medication reviews and medication management requirements under various Medicare and Medicaid program requirements can be met by contracted comprehensive pharmacy partners. This would allow CMS to streamline duplicative requirements for Home Health OASIS agency reporting, Part D plans, and care management providers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): AnewHealth

Aggregated Comment Title: ***Timelines of Proposed Changes to MS-DRGs***

Summary: CMS should release changes to MS-DRG codes no later than August 1st of each year, and limit retrospective changes to the rule to avoid delays, rework, and burden on providers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Remove Transitions of Care Measures***

Summary: It is suggested to eliminate two Transitions of Care indicators to reduce the burden on providers and payers, as these measures rely solely on chart collection. The addition of the Transitions of Care measure in the 2022 MA and Part D Technical Rule should be reconsidered.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Good Cause Appeals Process is Redundant***

Summary: The current procedures for good cause appeals involve redundant workflows that lead to delays for enrollees. The plan must first review and approve appeals for involuntary

disenrollment due to good cause and then submit the decision to a Retroactive Processing Center. Notably, the vast majority of these appeals (99%) are approved, making this step largely unnecessary.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts; UnitedHealthcare

Aggregated Comment Title: ***Form-Specific Feedback for CMS-2567 OMB Control Number: 0938-0351***

Summary: Form CMS-2567 (OMB Control Number 0938-0351), the Statement of Deficiencies, is problematic because it overlaps with existing accreditation and nursing documentation requirements. CMS should update the form to differentiate when a citation for abuse is based on a Facility-Reported Incident.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Notify Health Plans of Changes***

Summary: CMS should give providers a one-stop-shop to change their information such as open for new enrollees, address or phone numbers changes, etc. Furthermore, CMS should distinguish between urgent material changes that require immediate reporting and minor administrative updates, reducing the 30-day reporting burden on providers for non-critical enrollment changes.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Booz Allen Hamilton

Aggregated Comment Title: ***APM and MIPS Reporting is Redundant***

Summary: Submitting similar quality measures to both Alternative Payment Models (APMs) entities and CMS through the Merit-Based Incentive Payment System (MIPS) APM pathways creates redundancies and undermines the goals of care alignment. The measures used in APMs do not necessarily align with individual physician measures. CMS should allow qualified APM participants to report quality measures and data elements via existing registries.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** College of American Pathologists; The American College of Cardiology

Aggregated Comment Title: ***Reduce Redundant Documentation Requested During Validation Surveys***

Summary: Surveyors conducting validation surveys of accrediting organizations (AOs) are required by the State Operations Manual, Appendix A, to make photocopies of all necessary documents that support their findings. Surveyors will often request multiple copies of the same document, such as hospital policies and procedures, during the survey process.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** California Hospital Association; Health Alliance Plan of Michigan

Aggregated Comment Title: ***Simplify Ambulance Enrollment Form***

Summary: CMS should simplify the 855B Ambulance Enrollment Form by eliminating the patient signature on the claim requirement in order to pay for ambulance services, removing the vehicle section of the form, and removing the "extra" practice locations for EMS section, which requires ambulance services to list all substations. These requirements are unnecessary and duplicative, as the information is already required elsewhere.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Ambulance Association

Aggregated Comment Title: ***Modify CMHC CoPs to Apply Only to Patients Where Clinically Appropriate***

Summary: CMS should modify the Community Mental Health Center (CMHC) CoP-related regulations to only apply to patients where clinically appropriate in order to reduce administrative burden and strengthen provider participation in services able to be furnished at CMHCs.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Form-Specific Feedback for CMS-20027 OMB Control Number: 0938-0033***

Summary: Form CMS-20027 (OMB Control Number: 0938-0033) for Medicare redetermination requests does not accommodate common appeal scenarios, such as coding corrections or duplicate denials. It also requires extensive narrative explanations, even for simple billing corrections.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Integrate Value-Based Care Reporting***

Summary: CMS should integrate value-based care reporting as it can consolidate Medicare Shared Savings Program, Next Generation ACO, and other alternative payment model reporting into unified frameworks that reduce duplicate submissions.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Urological Association, Inc.; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Leverage AI for Appeals Optimization***

Summary: The integration of artificial intelligence in healthcare appeals offers various opportunities for optimization, such as utilizing AI for document analysis to review appeals documentation, predicting outcomes through machine learning models to suggest effective appeals strategies, and automating the identification of systematic denial issues through pattern recognition. These applications can enhance the efficiency and effectiveness of the appeals process by leveraging AI technologies already in use in healthcare.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Incorporate Automated Risk Assessment Tools into Risk Stratification***

Summary: Risk stratification can utilize automated risk assessment tools to identify providers requiring enhanced oversight without broad-based reporting increases.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** MLEM; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Avoid New Classifications for Digital Health***

Summary: Expand coverage of new digital health offerings via existing technology categories, like remote patient monitoring, based on clinical benefit, avoiding new classifications.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Premier Health; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Validation Survey Redundancy***

Summary: Hospitals selected for the validation survey sample in a given year, in accordance with 42 CFR § 488.9, must complete redundant surveys from CMS, the state, and their accrediting organization.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Select Medical Holdings Corporation; Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Provider Directory Requirements are Redundant***

Summary: Medicare Advantage requires providers to submit and maintain accurate directory information across multiple plans. This results in redundant and inconsistent reporting, as plans dedicate substantial resources to ensure compliance. MAOs are further required to contract their network contracted providers on a quarterly basis to update the information that appears in the provider directory. The plan is already in regular contact with contracted providers and provides updates that way as well as through the provider portal.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): DentaQuest

Aggregated Comment Title: ***Simplify HIPAA Reporting***

Summary: Rethink the HIPAA breach notification threshold to avoid burdensome protocols for minor incidents.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Illinois Health and Hospital Association

Aggregated Comment Title: ***Provide Clear Documentation Standards for Audits/Medical Reviews***

Summary: CMS should provide clear documentation standards (e.g., across E/M codes) for audits and medical reviews.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Extend the CHNA Cycle to Five Years***

Summary: Extend the Community Health Needs Assessment (CHNA) cycle from 3 to 5 years to alleviate the burden on small rural facilities with relatively stable community demographics, allow hospitals to fully implement interventions from the previous cycle, and align with planning cycles of county public health agencies.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Form-Specific Feedback for CMS-10079 OMB Control Number: 0938-0907***

Summary: No new data is included in uploads of the Data Accuracy & Completeness Acknowledgement for Hospital IQR (CMS-10079, OMB 0938-0907), as providers already transmit the data file through the QualityNet Secure Portal. It serves only as confirmation of existing records. Consequently, the form could be eliminated with no loss of quality.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Restrictions on Audits***

Summary: The number of audits that can be completed should be restricted.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): CrownQuest Inc

Aggregated Comment Title: ***Dialysis Data Validation Activities***

Summary: Reward dialysis facilities that participate with data validation activities, rather than penalizing those that do not. Reduce burden by reducing the frequency of these studies to every five years.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Fresenius Medical Care

Aggregated Comment Title: ***Exclude Employer Group Waiver Programs (EGWPs) from Supplemental Benefits Reporting***

Summary: The recommendation is to exclude supplemental benefits from incurred costs under the statute, with the exception of Employer Group Waiver Programs (EGWPs), suggesting that EGWPs should be exempt from supplemental benefit reporting requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Humana; Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***Eliminate CAUTI Reporting in NHSN***

Summary: Eliminate the Catheter-Associated Urinary Tract Infections (CAUTI) Outcomes Measure from Quality Reporting Programs, as commenters believe the costs associated with reporting outweigh the benefits. This measure requires patient-level and monthly provider-level reporting in the CDC National Healthcare Safety Network [NHSN] system.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Medical Rehabilitation Providers Association; Encompass Health

Aggregated Comment Title: ***Reduce Redundancy Through REMS Integration***

Summary: Reduce redundancy via thoughtful REMS Integration. For example, provider documentation that meets safety criteria in a REMS system could automatically fulfill CMS PA requirements, significantly reducing treatment timelines for critical therapies.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Standardize Reporting Frameworks Across Provider Types***

Summary: Standardize reporting frameworks across all provider types to avoid duplicative efforts. Currently, pharmacists, physicians, and care coordinators must format outcome measures differently for various programs, which is inefficient and unsustainable.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Recognize Digital Therapeutics and Precision Medicine Tools***

Summary: To align with best practices and industry standards, CMS must recognize that digital therapeutics and precision medicine tools are essential components of the healthcare ecosystem. CMS should work with innovators to define what data elements are necessary instead of having providers translate innovations into outdated documentation to comply with CMS requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Reporting Burden on CHCs***

Summary: Community health centers (CHCs) allocate significant resources to comply with Medicare documentation and reporting requirements. These efforts often involve navigating complex and redundant compliance requirements that do not enhance patient outcomes or generate cost savings.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Require Full Cost Reporting Every Five Years***

Summary: Interpretation discrepancies in cost reporting rules among Medicare Administrative Contractors (MACs) result in inconsistent audits, settlement delays, and disputes. Errors in cost reports may lead to reimbursement delays, audits, penalties, and disruptions in cash flow and service delivery. A simplified cost reporting process, such as requiring full cost reporting every 5 years with interim skeletal reporting by facilities, could enhance efficiency and compliance. CMS should also enforce timeliness requirements on MACs to settle cost reports within 1 year.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Illinois Health and Hospital Association; National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Finalize Recent Proposed Rules***

Summary: CMS should finalize the 2023 No Suprises Act and Independent Dispute Resolution rule to address many of the administrative burdens and regulation challenges.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American College of Radiology; Healthcare Business Management Association

Aggregated Comment Title: ***Challenging PHQ Questions Can Result in Misdiagnosis***

Summary: SNF residents often struggle with PHQ 2 and 9 questions, especially when diagnosed with dementia or a BIMS score below 10. This confusion leads to many residents answering inaccurately, potentially resulting in underdiagnosis and undertreatment of depression.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Maplewood of Cheshire County

Aggregated Comment Title: ***Allow CRRs to be Linked to Supplemental Services***

Summary: CMS should remove the limitation that chart review records (CRRs) cannot be linked to encounters where all service lines contained supplemental benefit services, and allow CRRs to be linked to claims or procedures associated with supplemental benefits given they are an eligible procedure code are provided by an approved provider specialty type, and occur in an approved setting, consistent with the requirements for submitting other claims that are allowed for risk adjustment purposes.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Annual Documentation Requirement for Lifelong Conditions***

Summary: Under 42 CFR 422.310, Medicare Advantage organizations must submit annual diagnoses for CMS' Risk Adjustment Data Validation program. CMS should create a list of "permanent HCCs" that can be documented once and carried forward unless otherwise changed for lifelong diagnoses, eliminating the annual requirement. CMS can reduce audit and oversight costs by removing the need for recertification of verified chronic conditions.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Humana

Aggregated Comment Title: ***Remove Requirement for Medicaid Cost Sharing in D-SNP Materials in MMCM Chapter 16b - 20.2.4.2.1.***

Summary: The request is to remove the requirement for Dual-Eligible Special Needs Plans (D-SNPs) to include nominal Medicaid cost sharing in their materials, as this information is already available through other sources like integrated plans, Medicaid managed care plans, and state Medicaid agencies, making it duplicative. This change aims to streamline information dissemination to D-SNP enrollees.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Eliminate Prior Authorization for Preventive Services***

Summary: Medicare's prior authorization process for preventive services lags behind industry standards. Medicare could improve by establishing safe harbors for U.S. Preventive Services Task Force (USPSTF)-recommended services eliminating prior authorization for Grade A or B recommended services. No additional clinical justification or review should be required.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish a Small-Provider Exemption Process***

Summary: CMS should lead in regulatory coordination by establishing a formal small-provider exemption process, drawing on input from the Small Business Administration's Office of Advocacy and the National Ombudsman.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Administrative Complexity Creates Barriers to DME and Home Health Access***

Summary: Patients who are homebound or have chronic illnesses often need referrals for durable medical equipment (DME) and home health services. However, strict documentation requirements complicate the process. These include redundant provider attestations, detailed notes from face-to-face visits, and varying certification processes that differ among vendors and service types.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Eventus WholeHealth

Aggregated Comment Title: ***Pilot Demonstration Projects***

Summary: CMS should consider piloting demonstration projects that test streamlined documentation and reporting requirements for ID physicians.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Infectious Diseases Society of America; Price Services Group, L.L.C.

Aggregated Comment Title: ***Audits Must Be Thorough and Complete***

Summary: Medicare audits should thoroughly assess all provider-reported data. For example, a targeted approach to audit-related documentation, requesting records only in response to specific complaints, risk indicators, or anomalies, can reduce administrative workload and enhance the relevance and effectiveness of audits.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of Local Long Term Care Ombudsman (NALLTCO); Price Services Group, L.L.C.

Aggregated Comment Title: ***Strengthen Requirements for Certified Health Record Technology in CMS Programs***

Summary: CMS should strengthen and consistently enforce the requirement to use ONC certified health information technology across all applicable Medicare and Medicaid quality reporting programs. Certified health IT should demonstrate patient engagement tools, real time access to data, and seamless extraction of reportable information for programs such as HEDIS, MIPS, and ACO performance reporting.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Massachusetts Health Data Consortium; Price Services Group, L.L.C.

Aggregated Comment Title: ***Many Programs Test the Same Concepts Resulting in "Pilot Fatigue"***

Summary: There are duplicative, outdated, and obstructive practices in pharmacy access and patient medication promptness. Many providers are experiencing "pilot fatigue" because programs repeatedly test the same concepts across various states or plans but lack clear paths for scaling up, wasting resources and staff trust.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Price Services Group, L.L.C.; Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Suspend Retroactive Recoveries Related to Nursing and Allied Health Education Funding***

Summary: CMS should suspend retroactive recoveries for nursing and allied health education program funding due to healthcare staffing shortages. CMS should provide consistent and transparent regulatory guidance to ensure qualification requirements are interpreted uniformly across hospitals.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Healthcare Financial Management Association; Price Services Group, L.L.C.

Aggregated Comment Title: ***Grant Safe-Harbor Protections to Providers***

Summary: CMS should lead in regulatory coordination by granting safe-harbor protections to providers audited or deemed compliant by other programs like Medicaid or private insurance carriers under federal standards.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Use HL7 Da Vinci Implementation Guide to Standardize Prior Authorization***

Summary: Standardization of prior authorization (PA) requirements can be achieved through the HL7 Da Vinci Implementation Guide, which aims to minimize variation and streamline the approval process for treatments that align with established clinical guidelines.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Medical Informatics Association; Booz Allen Hamilton

Aggregated Comment Title: ***Simplify Medicare Credit Balance Reporting***

Summary: The requirement for quarterly Medicare credit balance reporting (CMS-838) is unnecessary. CMS should simplify this process by establishing a policy that mandates providers to promptly return overpayments, without the need for separate reporting of outstanding credits, as this would create redundancy.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Henry Ford Health; Reveleer

Aggregated Comment Title: ***Require Single Interoperability Standard***

Summary: Integrated care relies on integrated data, emphasizing the importance of interoperability to ensure information follows the patient seamlessly across platforms. Setting a universal standard for vendors and platforms is crucial to prevent data silos. This standard should encompass not only clinical data but also social determinants of health, such as food insecurity and housing, as they significantly impact health outcomes. By prioritizing interoperability and including social determinants in data sharing, healthcare systems can better address the holistic needs of patients and improve overall care quality.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Reveleer

Aggregated Comment Title: ***Streamline Referrals***

Summary: CMS should streamline referral orders by allowing referring providers to include important information without providing an attestation of their exact role in the patient's care. Eliminate requirements for a follow-up signature from the referring physician.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Diabetes Advocacy Alliance; The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Resolve TRF Policy Discrepancy Between MACs Using and Not Using MolDX***

Summary: The MolDX program, used by various Medicare Administrative Contractors, allows the Test Requisition Form (TRF) to determine the medical necessity of a test. However, there is a discrepancy in medical documentation policy between MACs that do not use the MolDX program and those that do. CMS should resolve this discrepant policy.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Quest Diagnostics

Aggregated Comment Title: ***Stop Classifying SNF SRIs as Complaints***

Summary: CMS should stop classifying SNF self-reported incidents (SRIs) as complaints as this inflates reported data on complaints against SNFs. SNFs report allegations or suspicions of abuse, neglect, or misappropriation, which are not complaints.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Health Care Association

Aggregated Comment Title: ***Streamline CPAP Compliance Documentation***

Summary: Eliminate the need for CPAP/Bi-Pap compliance documentation in physician notes by allowing physicians to submit a download summary page with their signature and date as proof of compliance, avoiding the need for an extra visit.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** F B Thomas Drug Store Inc.

Aggregated Comment Title: ***Expand the DMEPOS Code Set***

Summary: The current DMEPOS HCPCS code set groups diverse products under the same code, hindering innovation and leading to payment discrepancies. Recommendations include expanding the code set for distinct product groups, utilizing an NDC-style code structure, allowing beneficiaries to upgrade within a code, introducing Q codes for cellular and tissue-based products, streamlining PDAC resubmissions, making LCD coding changes in Local Coverage Articles, adopting real-world evidence for coverage support, and refining the Transitional Coverage for Emerging Technologies pathway with clear timelines and expanded eligibility criteria. These changes could improve coding accuracy, payment fairness, and access to innovative technologies in healthcare.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Alliance of Wound Care Stakeholders ("Alliance"); Medical Arts Chemists & Surgicals

Aggregated Comment Title: ***Reduce Redundancy of Long Term Care Ombudsman***

Summary: Enhance communication, data-sharing, and role clarity among oversight entities to improve cross-agency collaboration. From the perspective of the Long-Term Care Ombudsman, reduce duplicative efforts in auditing, reporting, and compliance monitoring to enhance operational efficiency and minimize disruption to residents' daily lives.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): National Association of Local Long Term Care Ombudsman (NALLTCO)

Aggregated Comment Title: ***Payer-to-Payer Data Exchange Implementation Support***

Summary: Implement requirements for payer-to-payer data exchange and ensure that new healthcare plans respect existing authorizations from previous payers during a designated continuity-of-care grace period.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Benefits of Coordinating Across Payers***

Summary: Coordination among Medicare, Medicaid, and private payers regarding readmissions and condition codes would minimize redundancy and reduce confusion.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of ACOs (NAACOS); Ohio Hospital Association

Aggregated Comment Title: ***Coordinate Health Risk Assessments***

Summary: Medicare and Medicare Advantage each have regulations regarding health risk assessments (HRAs), which can overlap for dual eligible beneficiaries. CMS should review and coordinate these assessments to enhance effectiveness, reduce duplication, and improve beneficiary outcomes while cutting costs.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Implement Common Clinical Data Set***

Summary: CMS should implement a common clinical data set based on FHIR standards and create a centralized submission portal that can route data appropriately based on provider type and participation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** CGI Federal Inc.; National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Establish Benchmarks Based on NPIs to Encourage Reporting on More Meaningful Measures***

Summary: Currently, benchmarks are set based on the number of provider Taxpayer Identification Numbers (TINs) reporting on a measure, disadvantaging specialties with fewer reporters. This leads to clinicians avoiding specialty measures to meet scoring requirements. To address this, benchmarks should be established using National Provider Identifiers (NPIs) instead of TINs. This change would enable providers to access more relevant measures, reduce burdens, and encourage reporting on measures that are meaningful to both providers and patients, ultimately improving the quality of care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Association of ACOs (NAACOS); The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Redundant Prior Authorization Requirements***

Summary: There is redundancy in the prior authorization health equity analysis requirements specified in 42 CFR 422.137, the Improving Seniors Timely Access to Care Act of 2025, and the proposed CMS-10913. This includes the requirement to submit lists of items and services that need prior authorization to CMS, as well as to make publicly accessible prior authorization metrics.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Inefficiencies in the DMEPOS Prior Authorization Process***

Summary: The prior authorization process for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as outlined in CMS-10110 (OMB Control No. 0938-0953), requires providers and suppliers to submit repetitive documentation. Prior authorization should only be applied to high-cost items such as complex rehab technology (CRT) and non-invasive ventilators (NIVs).

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Nursing Care Plans are Outdated***

Summary: The current requirements for nursing care plans under 42 CFR 482.23 are outdated and do not align with the needs of multidisciplinary care planning. CMS should not implement specific nurse-to-patient ration in regulation or sub-regulatory guidance. Moreover, the static nature of nursing care plans in a dynamic healthcare environment leads to inefficiencies, requiring frequent updates that do not necessarily enhance the quality of care. Technological advancements in electronic health records provide more effective communication within care teams, making traditional nursing care plan practices obsolete.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***CMS Should Collect Patient Data Directly***

Summary: Clinicians can indicate recommended patient assessments, but CMS should assume responsibility for the burden of collecting certain data (such as SDOH/Health Equity metrics) from patients.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Adherence to CDC "Safer" Guidelines***

Summary: Eliminate mandatory adoption of CDC 'Safer' guidelines unless CMS codifies them into CoPs. These guidelines are valuable, but they are not legally binding regulations.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Piedmont Healthcare

Aggregated Comment Title: ***Streamline Documentation Requirements in Risk-Adjustment Methodologies***

Summary: Reduce unnecessary and administratively burdensome documentation requirements in risk-adjustment methodologies.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): American Academy of Family Physicians

Aggregated Comment Title: ***Revisit Review Process for Non-Formulary Generics and Biosimilars***

Summary: CMS should consider whether different review processes are needed when an enrollee is attempting to access a generic or biosimilar drug that is non-formulary. The formulary exceptions process creates hurdles for Part D plans to promote generic and biosimilar uptake because it allows enrollees to bypass a plan formulary's preference for a generic or biosimilar alternative over the brand drug.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Humana

Aggregated Comment Title: ***Require Transparency from Payers on Prior Authorization Policy***

Summary: CMS is encouraged to consider deregulatory measures that focus on transparency of payer prior authorization policies and the availability of evidence-based clinical guidelines at the point of care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Medical Group Management Association; Physicians Advocacy Institute

Aggregated Comment Title: ***NHSN Reporting Criteria Inflate Reported Neglect and Abuse Cases***

Summary: The NHSN definitions for required neglect and abuse reporting in nursing homes have gotten more specific, leading to an increase in reported incidents such as falls and abuse. This can result in skewed data and potentially overreporting incidents that did not formally meet the criteria, stemming from resident misunderstandings, benign interactions, or minor accidents. Changes in definitions can affect how neglect and abuse issues in nursing homes are perceived.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Maplewood of Cheshire County

Aggregated Comment Title: ***Streamline Adverse Event Follow Up***

Summary: Streamline adverse event follow-ups by eliminating redundant root cause reports and multiple system follow-ups to reduce unnecessary work and improve care outcomes. Adopt reporting models for additional provider types.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Vivie

Aggregated Comment Title: ***Enact Risk Triggers for Logging of Resident Data***

Summary: Require mandatory daily/weekly logs only when triggered by certain events or for at-risk residents. By scaling or triaging reporting requirements based on risk and event frequency, CMS can maintain integrity while lessening the burden of excessive documentation that can detract from resident-centered care.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate Marketing Material Approval***

Summary: Eliminate marketing material review and approval from CMS oversight and all together, which is duplicative and resource intensive.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Healthpilot; Kingdom Insurance Group

Aggregated Comment Title: ***Extend Quality Reporting Timelines***

Summary: Extend deadlines for quality reporting in general, and especially in cases of unusual circumstances.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***CNAs Should Reflect Regional Priorities***

Summary: Community needs assessments (CNAs) are essential for identifying and addressing challenges faced by a population through targeted interventions. By collaborating with public health departments, community leaders, and local organizations, CNAs can accurately reflect regional priorities and streamline resource allocation. This shift towards collaborative initiatives led by community organizations and local governments reduces the administrative burden on healthcare providers, making the process more efficient and effective in addressing community needs.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Incentivize Use of EHRs***

Summary: Incentivize the use of electronic health records (EHRs) by all medical providers. In particular, support psychologists to engage in meaningful use of EHRs through financial incentives, technical assistance, and guidance for the adoption of EHR systems.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Timely Adjudication of IDR Payments***

Summary: CMS should ensure timely adjudication and full enforcement of the independent dispute resolution (IDR) process established by the No Surprises Act (NSA) to adjudicate surprise medical bills. CMS should take steps to ensure that claims are processed in a timely manner and provide for additional enforcement to ensure payment in an appropriate timeframe.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Federation of American Hospitals; Physicians Advocacy Institute

Aggregated Comment Title: ***Standardize EDI Enrollment***

Summary: CMS should standardize and centralize the process for electronic data interchange (EDI) enrollment for federal government payers so that one form can be used across all payers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** WEDI

Aggregated Comment Title: ***Streamline Data Collection for FWA***

Summary: CMS should ensure that data collected is actionable and relevant for preventing fraud, waste, and abuse.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Lantana Consulting Group

Aggregated Comment Title: ***Maintain Consistent Program Audit Protocols for a Set Period***

Summary: Regarding OMB Approval 0938-1395, Medicare Part C and Part D Program Audit and Industry-Wide Part C Timeliness Monitoring Project (TMP) Protocols, CMS should maintain consistent protocols for a specified period, such as three years, for the SNP program unless there are significant changes due to legislation or regulations. By setting protocols for a set time, both CMS and health plans can benefit from a more streamlined process and focus on enhancing the program effectively.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Lantana Consulting Group; Special Needs Plan Alliance

Aggregated Comment Title: ***Streamline Attestation for MIPS Improvement Activities***

Summary: Streamline the attestation process for MIPS Improvement Activities. Some activities are subjective, vague, or redundant with existing clinical workflows, such as patient education tools or integrated behavioral health. Forms could be pre-filled based on information from EHRs or PCMH participation.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Extend the Timeframe for ESRD Assessments***

Summary: Extend the ESRD Core Survey time frame to 60 days to allow dialysis facilities to complete a thorough initial assessment and care plan, ensuring proper attention and time with patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Berkshire Medical Center

Aggregated Comment Title: ***Simplify Model Documents Including EOBs and MPPPs***

Summary: CMS should simplify model documents such as EOBs and MPPP templates to allow plans more flexibility in formatting and language. This change would enable the use of real-world examples, plain language, and tailored messaging to enhance member understanding.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Prime Therapeutics LLC

Aggregated Comment Title: ***Eliminate the Organization Replacement Report***

Summary: 42 CFR 422.506(a)(2)(ii)(A) should be revised to remove the list of alternative enrollment options from the Medicare Advantage organization non-renewal notice and refer beneficiaries to Medicare.gov instead. This would reduce the burden for CMS, as the Organization Replacement Report would no longer need to be produced.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Make Determination that Drugs are Always Part B or D***

Summary: It is recommended that CMS make the determination that a drug is either always Part B or always Part D (similar to what was done for HIV PrEP). The Part B vs. Part D determination is a cumbersome process, and in some cases cannot be determined when providers do not respond timely to requests. Implementing this proposed change would eliminate confusion, dissatisfaction, and access challenges.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reverse Addition of POLY-ACH and COB in the 2025 MA and Part D Technical Rule***

Summary: It is suggested that CMS reverse the addition of POLY-ACH and COB measures in the 2025 MA and Part D Technical Rule, as these measures may penalize necessary treatments for beneficiaries with complex clinical conditions. This would make the Star Ratings requirements less burdensome for CMS, MA plans, and providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Reverse Changes to MTM Program Completion Rate for CMR Measure***

Summary: It is suggested that CMS reverse the burdensome changes to the Medication Therapy Management Program Completion Rate for Comprehensive Medication Review measure, as the expansion fails to target beneficiaries most in need of medication reviews, diminishing the program's effectiveness. This reversal would help alleviate burdensome components of the Star Ratings program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Reverse Sociodemographic Risk Adjustment to Medication Adherence Measures***

Summary: CMS should reverse adding the risk adjustment based on sociodemographic status to the medication adherence measures in the 2024 MA and Part D Technical Rule. Risk adjusting these measures is so burdensome and complicated that CMS is only able to calculate the measures once a year after the measurement period, compared to monthly reports with the current specifications that allow plans to measure their progress.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Remove Improving or Maintaining Physical and Mental Health Measures***

Summary: CMS should remove the 2-year Improving or Maintaining Physical Health measure and Improving or Maintaining Mental Health measure.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Report all Star Ratings at Contract Level Rather than PBP Level***

Summary: It is advised to report all Star Ratings measures at the contract level instead of the Plan Benefit Package (PBP) level for consistency. Currently, only three Star measures related to Special Needs Plans are reported at the PBP level, while all other measures are reported at the contract level. Aligning all measures to the contract level would streamline the system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Simplify CAHPS Star Assignment Rules in 42 CFR 422.166(a)(3)***

Summary: It is suggested to streamline the CAHPS Star assignment rules in 42 CFR 422.166(a)(3) by eliminating relative distribution and significance testing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Provider Education and Support***

Summary: CMS should require contractors to provide consistent education and support to providers on documentation expectations for therapy services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Fast-track Credentialing and Contracting Processes***

Summary: Credential/contracting processes are excessively lengthy, with a commercial payer offering a Medicare Advantage plan can take anywhere from 90 to 180 days, which affects beneficiaries. CMS should direct MAOs to process credentialing and contracting applications for Medicare providers timelier and to make the effective dates retroactive in line with CMS's established processes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Rehabilitation Providers and Agencies (NARA)

Aggregated Comment Title: ***Exempt SNFs from Collecting SDOH Information upon Admission***

Summary: SDOH information collected by hospitals can be shared with post-acute care providers such as SNFs if incentivized or mandated to do so. SNFs should not have to collect this information upon admission but rather upon discharge for discharge planning.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Rehabilitation Providers and Agencies (NARA)

Aggregated Comment Title: ***Replace PSI 90 with Specific Individual Patient Safety Indicators***

Summary: CMS should consider replacing the PSI 90 composite with specific individual patient safety indicators in order to offer hospitals more targeted and actionable data for quality improvement. CMS should also work with stakeholders to evaluate and refine the weighting of these individual patient safety indicators if this recommendation is adopted.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Vizient, Inc.

Aggregated Comment Title: ***Redundant Reporting of Data is Resource Intensive for Hospitals***

Summary: Hospitals submit data quarterly and annually for the same measures, leading to increased reliance on contracted vendors for compliance and guidance due to the complexity of reporting requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Franciscan Missionaries of Our Lady Health System (FMOL Health)

Aggregated Comment Title: ***Asking for CMS/OMB Form Numbers Adds Complexity***

Summary: Respondent opines that requesting healthcare professionals to include OMB Control Number or CMS form numbers is, in itself, overly complex as they primarily focus on providing healthcare services rather than dealing with form numbers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Coordination of Dental Benefits Through Form 837D***

Summary: Allow FQHCs to use the 837D form for Medicare claims for certain dental services, streamlining the claims process and improving data accuracy and coordination between CMS and state Medicaid agencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Dental Association

Aggregated Comment Title: ***Allow Email or Text Dual Factor Identification***

Summary: Instruct Medicare Advantage (MA) plan administrators to allow email- or text-based dual factor verification, not authenticator apps, which are numerous, inconsistent, and each require time-consuming set-up processes on the fiscal intermediary's website.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Form-Specific Feedback for CMS 10415 OMB Control Number: 0938-0738***

Summary: Form 10415 re: Medicare Secondary Payer is confusing and redundant for patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***Keep Eligibility Requirements Stable***

Summary: CMS should ensure eligibility requirements remain stable for multiple years to limit program complexity and allow for more accurate year-to-year comparisons of clinician and program performance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Podiatric Medical Association

Aggregated Comment Title: ***Reduce Diagnostic Laboratory Test Reporting***

Summary: CMS should reduce Advanced Diagnostic Laboratory Tests (ADLT) reporting to every 3 years in line with the Clinical Diagnostic Laboratory Test (CDLT) general standard.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Castle Biosciences Inc

Aggregated Comment Title: ***Remove Verification Requirement for Retiree Drug Subsidy***

Summary: The verification requirement of CY 2025 Medicare Advantage and Part D Enrollment and Disenrollment Guidance (50.7) Other Qualified Prescription Drug Coverage Through an Employer or Union Retiree Drug Subsidy (RDS) Plan Sponsor should be removed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kaiser Permanente

Aggregated Comment Title: ***Digitize Validation Surveys of AOs***

Summary: CMS should implement electronic processes to improve validation surveys of accrediting organizations (AOs), including by developing an electronic platform that would enable hospitals to upload relevant documents once and allow the survey team electronic access to all documents necessary for the survey.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** California Hospital Association

Aggregated Comment Title: ***Enhance MAC Accountability***

Summary: Enhance MAC accountability by implementing quality metrics for MACs based on overturn rates and resolution times.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Form-Specific Feedback for CMS-20032 OMB Control Number: 0938-1053***

Summary: In form CMS-20032 (OMB Control Number: 0938-1053), Additional Documentation Request, CMS requests additional documentation without specifying what information is needed to resolve a denial.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Inconsistent Documentation Requirements Across QICs***

Summary: Inconsistent formatting requirements across Qualified Independent Contractors (QICs) force providers to fully re-document submissions instead of simply updating existing information.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Form-Specific Feedback for CMS-10265 OMB Control Number: 0938-1015***

Summary: In the CMS-10265 Form (OMB Control Number: 0938-1015), CMS requires Recovery Audit Contractors (RACs) to submit documentation through separate systems, despite the overlap with standard appeals processes. As a result, plans must submit the same clinical records for various types of audits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Redundant ZPIC Documentation Requirements***

Summary: Documentation requirements for Zone Program Integrity Contractors (ZPICs) require separate documentation for appeals processes, even for identical claims. Additionally, the submission timelines and requirements differ from those of standard appeals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Apply Tiered Response Deadlines***

Summary: CMS should tier response deadlines based on practice size, thereby allowing smaller practices additional time to gather documentation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Simplify Improvement Activities***

Summary: CMS should simplify improvement activities, which can reduce the current 100+ improvement activities to 20 to 30 high-impact, evidence-based options with clear implementation guidance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Consolidate Patient Safety Events***

Summary: CMS should consolidate patient safety events, which can merge multiple patient safety reporting systems including Hospital-Acquired Condition Reporting and Patient Safety Indicators into a single comprehensive platform.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Streamline Financial Reporting Requirements***

Summary: CMS should streamline complex financial reporting requirements by simplifying financial reconciliation though automated claims-based calculations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Utilize Focus Groups to Enhance Rulemaking Engagement***

Summary: Utilize focus groups of providers, patients and industry experts prior to implementing new rules to ensure that policies align with frontline realities and patient needs, avoiding impractical or punitive regulations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Premier Health

Aggregated Comment Title: ***Remove AFHS From ED Attestations***

Summary: Remove AFHS (Age Friendly Health System) from ED attestations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** WKHS

Aggregated Comment Title: ***Provide Funding for the Transition to Electronic Quality Measures***

Summary: Providing funding to improve the efficiency of meeting quality mandates, such as via electronic quality measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Keystone ACO

Aggregated Comment Title: ***Some Quality Measure Elements Are Difficult to Capture Electronically***

Summary: Capturing measures with multiple elements, such as depression screening and follow-up plans, poses challenges due to increased provider burden, especially for the follow-up components which are cumbersome to capture electronically.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Clinicians Should Not Be Penalized by Patient Refusals***

Summary: CMS should not hold clinicians accountable for measures that patients refuse to answer.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Keystone ACO

Aggregated Comment Title: ***Increase Program Integrity***

Summary: Increase integrity of programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Mandate Portals for esMD***

Summary: The Medicare Claims Review process burdens providers due to inefficient processes, including electronic submission of medical documentation (esMD). Requiring requestors to implement an online portal for submitting esMD securely and easily, with updates on review results, could streamline the process and reduce complexity and expenses associated with third-party entities providing gateway services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Aegis Therapies

Aggregated Comment Title: ***ED Throughput Measures Lack Relevance***

Summary: ED throughput measures lack significance due to the absence of patient stratification based on illness severity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Shift Breastfeeding Reporting to Public Health***

Summary: Public health systems should focus on addressing breastfeeding rates rather than acute care hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Risk-adjust Outcomes***

Summary: CMS should consider risk-adjusting outcomes more robustly to account for high-acuity populations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***TPE Reviews are Redundant***

Summary: Medicare Administrative Contractor (MAC) targeted probe and education (TPE) reviews have redundancies with other claim reviews.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Rethink BMI Thresholds***

Summary: Current Body Mass Index (BMI) classifications in the Minimum Data Set (MDS) for older adults may not accurately reflect mortality risk, with evidence suggesting increased risk below 23 and above 31. To better align with health outcomes, CMS should revise MDS BMI thresholds or eliminate them to reduce administrative burden

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Data Collection from MA Plans***

Summary: CMS should reduce its collection of data from MA plans as collecting such a large amount of data from plans creates an unnecessary burden on providers and plans and does not necessarily improve patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***NHSN Reporting is Overly Complex***

Summary: The CDC's National Healthcare Safety Network (NHSN) portal for Medicare-required quality reporting has new security measures, including Secure Access Management Services (SAMS) card verification. Further, hospitals must restrict access to the portal to limit exposure to personally identifiable information. Its unique structure for departments and hospitals differs from other reporting systems, making non-infection-related measure submissions complex. CMS should use NHSN solely for infection-related measures and maintain a separate portal for other reporting needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health

Aggregated Comment Title: ***Form-Specific Feedback for CMS-10218 OMB Control Number: 0938-1066***

Summary: The form for HCAHPS Patient-Experience Survey (CMS-10218, OMB 0938-1066) could be collected through electronic means instead of through paper.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Form-Specific Feedback for CMS-1450/UB-04 OMB Control Number: 0938-0050***

Summary: Providers who qualify for an electronic submission waiver must still complete the UB-04 Form (OMB Control Number: 0938-0050), even though the hospital includes all necessary information in the 837I electronic claim that CMS receives.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Requiring MAOs to Summarize CMS Guidance is Redundant***

Summary: The requirement under CMS-10913 for Medicare Advantage Organizations (MAOs) to document whether the list of targeted services is flexible and based on applicable CMS guidance is redundant, inefficient, and a waste of resources. This requirement fails to evaluate compliance with regulatory standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***Accessibility Marketing Requirement is Overly Complex and Burdensome***

Summary: The accessibility requirements for marketing and communication materials related to Medicare Advantage, Part D, and Dual Eligible Special Needs Plans (D-SNPs) have become increasingly complex and burdensome without providing clear benefits to beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***OQR Reporting is Redundant***

Summary: Hospital Outpatient Quality Reporting (OQR) is a cumbersome process that requires manual data collection and validation. The reporting involves redundancies between CMS and other agencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Interoperability and Patient Access Rule is Overly Complex***

Summary: The CMS Interoperability and Patient Access Final Rule (CMS-9115-F) is complex, both technically and administratively, which has led to delays in implementing data sharing between patients and payers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Coordination of Benefits Rules are Overly Complex***

Summary: Medicare's rules for coordination of benefits are complex and vary depending on a beneficiary's other insurance coverage, such as employer coverage, Medicaid, COBRA, TRICARE, or Veterans Affairs benefits. This complexity can result in billing errors, delayed payments, and confusion for providers and beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***NTAP Inefficiencies for Pharmaceutical Drugs***

Summary: Pharmaceutical drugs, unlike medical devices, have not been given a breakthrough designation that would allow manufacturers to bypass the need to repeatedly demonstrate

significant clinical improvement over existing drugs when submitting a New Technology Add-on Payment (NTAP) program application. This lack of exemption for drugs has led to inefficiencies and redundancies within the NTAP program and for pharmaceutical manufacturers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Independent Pharmacies are Essential Providers***

Summary: Acknowledge frontline and independent pharmacies as essential providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Facilitate Access to Data Dictionaries and Templates to Promote Sharing***

Summary: Open data dictionaries and templates enable independent and specialty providers to participate in data sharing without the need for third-party compliance vendors, reducing costs and complexity for those without large IT departments.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Mandate Real-Time Pricing from Part D Sponsors***

Summary: Require Part D sponsors to offer pricing and formulary APIs directly into pharmacy and EHR systems to simplify reporting and documentation. This change would improve the process for providers and patients and reduce abandoned prescriptions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***DIR Reporting Requirements are Opaque***

Summary: Pharmacies face challenges with complex and redundant direct and indirect remuneration (DIR) fee reconciliation reporting, lacking clear metrics to challenge or understand retroactive adjustments. Providers operate in a reporting 'blind spot', hindering their ability to forecast and manage these adjustments effectively.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Replace ASC 12 With A More Valid Measure for ASCs***

Summary: End the ASC-12 measure due to measurement flaws and lack of variability in results. An example of a more valid measure of quality of care is post-polypectomy bleeding.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Seaford Endoscopy Center

Aggregated Comment Title: ***UHC/Optum Platinum Program is a Model for Medicare***

Summary: United Healthcare/Optum utilizes claims data to monitor quality and outcomes in their commercial insurance sector through their Platinum program, which incentivizes providers to meet benchmarks and decrease utilization review. This model could be beneficial for Medicare.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Waukesha Co DHHS

Aggregated Comment Title: ***Promote Continuity of Care Through Common Systems***

Summary: Promote continuity of care by maintaining a common documentation system or repository. This would help patients who may need to change providers and/or therapies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Align Part B and Part C Coverage Determination Processes***

Summary: Alignment between Medicare Part B and Part C of multiple policies pertaining to the Medicare coverage determination process would reduce administrative burden for providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Guardant Health

Aggregated Comment Title: ***Allow Claims Data to Support Medical Complexity Coding***

Summary: Allowing claims data to support medical complexity coding would significantly reduce redundant documentation and administrative workload.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Society of General Internal Medicine

Aggregated Comment Title: ***Reevaluate Anti-Markup Rule 42 CFR 414.50***

Summary: The Medicare anti-markup rule (42 CFR 414.50) should be re-evaluated considering its administrative impact and limited utility in today's care environment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Unclear Standards for Schizophrenia Audits***

Summary: The criteria for assessing documentation in schizophrenia audits is unclear. CMS should discontinue schizophrenia audits in nursing homes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge New York

Aggregated Comment Title: ***Simplify Form CMS-224-14***

Summary: Streamline the Medicare cost reporting process for health centers by simplifying the CMS-224-14 form by removing redundant data fields. The current form requires detailed documentation of allowable costs, visit counts, allocation methods, and regulatory compliance, which can be time-consuming and complex. This process often requires dedicated finance staff or external consultants due to its demanding nature. Simplifying the form and reducing unnecessary data fields would help save time and resources, making the reporting process more efficient for health centers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Update PPS Qualifying Visit List***

Summary: Update the PPS qualifying visit list (G0466 and G0467) for new and established patients to prevent billing complexities, reimbursement loss, and provider errors due to confusion.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Easier Designation of Third-Party Documentation Processers***

Summary: CMS should make the process of designating a third-party data documentation processing entities easier, such as the use of an RCM company to process quality reporting and program integrity initiatives.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Clarify the Dispute Resolution Process***

Summary: The lack of specificity in the NSA statute regarding the individual dispute resolution (IDR) process creates challenges for healthcare providers to comply. CMS's insufficient enforcement exacerbates the issue, leading to frustration in the industry. Standardizing and automating the IDR process could alleviate burdens for providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Business Management Association

Aggregated Comment Title: ***G2025 Code Complicates FQHC/RHC Telehealth Billing***

Summary: The G2025 telehealth billing code for federally qualified health centers (FQHC) and rural health clinics (RHC) is overly complex. CMS should align the code with standard billing practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** OCHIN

Aggregated Comment Title: ***Streamline OIG Investigations***

Summary: HHS should leverage its enforcement discretion to focus the HHS OIF investigations and application of provider disincentives on clearly intentional, repetitive, and objectively anti-competitive 'bad faith' behaviors by major actors.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Radiology

Aggregated Comment Title: ***Estimate APC Payment Rates Using Single Diagnostic Radiology Cost Center***

Summary: Since 2021, CMS has set the imaging APC payment rates at 100 percent of the payment rate using the standard payment methodology. CMS should estimate cost using a single diagnostic radiology cost center rather than CT and MRI-specific cost centers. The benefits of this approach include consistent reporting across hospitals, proper accounting of high-cost medical equipment, simplification and standardization of cost reporting within the diagnostic radiology cost center, elimination of partial allocation of costs to CT and MR cost centers, and reduced reporting burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Radiology

Aggregated Comment Title: ***Simplification Must Preserve Patient Voice***

Summary: CMS must ensure that its efforts to simplify preserve tools that capture the patient voice and maintain patient-centeredness alongside efficiency.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***Expand Quality Measure Calculation***

Summary: CMS should expand quality measure calculation for certain measures to include both electronic clinical quality measures (eCQMs) and clinical quality measures (CQMs) in order to accommodate a diverse range of healthcare entities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** ViiV Healthcare

Aggregated Comment Title: ***Ensure Home Health Care Data is Eligible for Inclusion in Risk Adjustment Calculations***

Summary: Remove "home health care" from the list of non-covered facilities for sources of diagnostic data for risk adjustment so that data from the OASIS is eligible for inclusion in risk

adjustment calculations when the form is completed by a clinician permitted to submit risk adjustment diagnoses.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Digitize Provider Directories***

Summary: CMS should permit plans to provide the provider directory electronically without prior authorization from the enrollee.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Review Changes to Maternal Care CoPs***

Summary: CMS should review the changes recently made to the Maternal Care CoPs with an eye to reducing the burden placed on hospitals by releasing some of the more prescriptive requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UHS, Inc.

Aggregated Comment Title: ***Use 1115 Waiver to Pilot a New SNF Survey Model***

Summary: Use the 1115 Medicaid Waiver for nursing homes, groups of nursing homes, or states to opt out of the CMS contract and test a different survey model while still receiving Medicaid/Medicare reimbursement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Extensive Billing Requirements***

Summary: Medicare requires extensive narratives and other documentation to ensure proper billing codes are submitted.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Endocrine Society

Aggregated Comment Title: ***Maintain Patient Safety Structural Measures***

Summary: The AHRQ's Making Healthcare Safer IV report highlights that the main obstacles to safety improvement are gaps in leadership accountability, resourcing, and clear implementation protocols, rather than a lack of will or evidence. Structural measures, such as whether an organization participates in a Patient Safety Organization or using validated teamwork protocols, are crucial for assessing if institutions have the necessary foundations for safe care. These measures provide insight into an institution's readiness to improve and should not be removed without a clear justification and improved alternative, as they represent foundational commitments to safety and better treatment outcomes for all patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Patients For Patient Safety US

Aggregated Comment Title: ***Eliminate Modifier Codes***

Summary: Eliminate modifier codes. Allow practitioners to see patients without modifiers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reverse Program Level UM Audit Protocols in SSA 1857(d) and 42 CFR 422.516(a)***

Summary: Recommendation to CMS to reverse recent program level UM audit protocols due to the significant burden it poses on both plans and CMS, as outlined in SSA 1857(d) and 42 CFR 422.516(a).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Special Needs Plan Alliance

Aggregated Comment Title: ***Prior Authorization Processes are Misaligned with Best Practices***

Summary: The current approach to prior authorization primarily focuses on managing a large number of codes rather than pinpointing instances of inappropriate utilization, which can result in authorizations that do not align with the latest evidence or best practices. This inefficiency diverts resources from direct patient care and contributes to systemic waste in the healthcare system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Leverage Prior Authorization Data for Provider Performance Analysis***

Summary: CMS should utilize PA data to differentiate between high and low value providers in order to facilitate interventions that enhance practice patterns without adding burdensome requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require Transparency for Beneficiary Out-of-Pocket Liability***

Summary: Payers should be required to publish rates for services rendered and beneficiary out of pocket liability instead of providers sharing those rates. Payers are better equipped to provide actionable and comprehensive information to patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Dedicated Cancer Centers (ADCC)

Aggregated Comment Title: ***Streamline Paperwork for Mental Health Services***

Summary: Streamline paperwork processes in ambulatory mental health settings to reduce client burden and improve timely access to services. Reducing redundant paperwork, involving clinician input for review, and making the experience more trauma-informed could lead to faster implementation of interventions, potentially preventing hospitalizations and improving client well-being.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Display Individual Scores Within Hospice Care Index in Hospice Compare***

Summary: Hospice Compare's current practice of only displaying the total score for the Hospice Care Index is criticized for lacking transparency and value for hospice beneficiaries and their families. To make informed decisions, consumers need access to individual scores for each of the 10 measures within the index, such as Skilled Nursing Visits and Skilled Nursing Care Minutes. This detailed information allows consumers to assess a hospice's performance accurately and choose a program that meets their specific needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Oregon Hospice & Palliative Care Association and Washington State Hospice & Palliative Care Organization

Aggregated Comment Title: ***Tracking Long-Term Patient-Reported Outcomes is Challenging***

Summary: CMS should reconsider the measurements for Patient-Reported Outcomes (PROs), particularly those that require follow-up for up to a year after surgery. Hospitals face challenges in maintaining ongoing clinical relationships with patients for extended periods, which complicates data collection. The existing reporting structure places excessive accountability on hospitals, overloading them with the responsibility of tracking patients long after their care episode has ended, resulting in incomplete data.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Limit Medicare EFT Reverification***

Summary: Medicare EFTs should only be re-verified during revalidation or upon the submission of a new EFT.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CGI Federal Inc.

Aggregated Comment Title: ***Accept Range of Codes in Prior Authorization Requests***

Summary: Accept broader ranges of procedure codes in prior authorization requests to allow for intra-procedure adjustments, eliminating the need for new approvals or extra documentation, simplifying the process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***CDA is Not Appropriate for Clinical Lab Orders***

Summary: CDA is a document-based standard within HL7, ideal for transmitting final laboratory results but not designed for high-volume transactional exchanges required for clinical laboratory orders.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Clinical Laboratory Association (ACLA)

Aggregated Comment Title: ***Single Unlimited License for CPT Codes in Laboratories***

Summary: HHS should purchase a single, unlimited license to allow all covered entities conducting HIPAA standard transactions to use the mandated CPT code set without charge or establish a reasonable limit on licensing fees for use of the code set.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Provide Timely Access to CMS System Updates***

Summary: Provide timely access to validated CMS payment and coding system update master files and transmittals. This will reduce administrative challenges for providers related to upkeep.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Panacea Healthcare Solutions

Aggregated Comment Title: ***Adopt a Tiered Reporting Structure for Community-Based Programs***

Summary: Adopting a tiered reporting structure based on the provider's scope of work could reduce burden for community-based programs. Semi-annual reporting through streamlined tools focusing on key indicators like participation trends and SDOH impacts would offer valuable insights to CMS and health plans without the need for frequent, detailed documentation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Centro De Amigos

Aggregated Comment Title: ***Quality Benchmarks Should Reflect Impact***

Summary: Revise quality benchmarks of community-based care to reflect actual impact.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Centro De Amigos

Aggregated Comment Title: ***Standardize Reporting Requirements for EHRs***

Summary: CMS should consider standardizing reporting requirements for EHRs to reduce time spent on them.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP)

Aggregated Comment Title: ***Eliminate Unique HCPCS Codes***

Summary: Eliminate unique HCPCS codes for generic drugs, which adds burden by complicating the billing process

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** University of Vermont Medical Center

Aggregated Comment Title: ***Streamline the OAS CAHPS***

Summary: The Outpatient and Ambulatory Surgery CAHPS survey logic is challenging to implement and maintain, with results deemed unhelpful. Revert to unit-based surveying, allowing hospitals to share data by CPT code for better unit management and improvements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Allow Flexibility in Timeline Requirements for Grievance Responses***

Summary: Permit flexibility in the timeline for responding pertinent to 482.13(a)(2)(ii).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** MaineHealth

Aggregated Comment Title: ***Overlapping HVBP and HACRP Requirements***

Summary: Both the Hospital Value-Based Purchasing Program (HVBP) and the Hospital-Acquired Conditions Reduction Program (HACRP) include CMS Patient Safety and Adverse Events Composite (PSI-90) measures, as well as measures for healthcare-associated infections (HAIs). This unnecessary overlap can lead to increased penalties and administrative workload without enhancing patient outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** MaineHealth

Aggregated Comment Title: ***Hospital Physical Environment CoPs***

Summary: CMS should reconsider the applicability of the hospital physical environment CoPs to outpatient locations and rather consider a risk-based approach to setting safety standards in outpatient settings. Support staff and patient time spent in the facility differ in the outpatient setting, and thus certain physical environment requirements, such as ligature risk mitigation and stringent life safety codes, may not be necessary.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Enforce MA PA and Medical Necessity Reforms***

Summary: CMS should enforce recent MA [Medicare Advantage] prior authorization and medical necessity reforms designed to ensure equitable access to health care by traditional Medicare and MA beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Limit Standards and Measures for "Deemed Status" Providers***

Summary: Further limits should be placed on standards and measures for deemed status providers beyond what is set by CMS, especially if they have not been shown to improve care significantly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Allow "Collect Once, Report Many" Model***

Summary: Allow a “collect once, report many” model across Medicare programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** International Consortium for Health Outcome Measurement (ICHOM)

Aggregated Comment Title: ***Ensure that States Cover the Costs of Mandated Benefits that Exceed the Federally-Defined Scope***

Summary: CMS should enforce the ACA requirement that states cover costs for mandated benefits that exceed federally-defined Essential Health Benefits, impacting QHP issuers with added administrative complexity and increased costs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Delay Effective Date***

Summary: Delay the effective date of CMS' proposals to change processes and procedures, electronic measures, and ongoing data analysis that require significant technological investments and human resources to implement and maintain.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Henry Ford Health

Aggregated Comment Title: ***Make EHRs Accessible Across Healthcare Systems***

Summary: Universal accessibility of Electronic Health Records (EHRs) across healthcare systems, with patient permission, is crucial to streamline care and reduce inefficiencies. This requirement would save time and eliminate redundancies associated with acquiring medical records from various institutions, benefiting both providers and patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Quality and Performance Measures Committee of the Society for Vascualr Surgery

Aggregated Comment Title: ***Create Distinct KX Modifier Thresholds for Physical Therapy and Speech-Language Pathology Services***

Summary: Creating separate KX modifier thresholds for Physical Therapy (PT) and Speech-Language Pathology (SLP) services enhances patient access and outcomes, especially in neurological diagnoses, by allowing concurrent necessary services without interruptions or limitations, simplifying billing and tracking for providers, and promoting consistency across rehabilitation services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Confluent Health

Aggregated Comment Title: ***Adopt Mid-Point Rule for Applying CPT Coding***

Summary: The current 8-minute rule for CPT coding is complex and burdensome, requiring extensive training and compliance efforts. Adopting the mid-point rule used by other payers would simplify coding and improve efficiency for therapists.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Confluent Health

Aggregated Comment Title: ***Standardize Operational Policies Across Plans***

Summary: CMS allows plans significant discretion in their operational policies, which leads to inconsistent documentation and modifier requirements and creates inefficiency. Standardize these requirements across plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** PointClickCare

Aggregated Comment Title: ***Quarterly Data Reporting is Ideal***

Summary: Provider-reported data should be submitted at least quarterly, due to staff turnover. This frequency would uncover fraudulent use of funds and allow CMS to react quickly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Standardize Patient Assessment Items Across Medicare***

Summary: Standardize patient assessments to allow facilities to compare outcomes across all patients, not just traditional Medicare patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Physical Therapy Association

Aggregated Comment Title: ***Ease AOR Requirements***

Summary: Remove the requirement for an Appointment of Representation (AOR) form to process a claim submitted on behalf of a member.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Repeal Health Outcomes Survey***

Summary: Repeal/sunset the Health Outcomes Survey.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Ease Record Retention Requirements***

Summary: Reduce record retention requirements, as outlined in Chapter 7 of the Contract Administrative Requirements Record Retention and Disposal Schedule (Medicare General Information 100-01).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Eliminate Standard Format for Medication Therapy Management***

Summary: CMS should eliminate the standard format for medication list, action plan, and cover letter (CMS Form 10396).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Specialty Impact Data and Physician Fee Schedule***

Summary: Specialty Impact Data for Hospice and Palliative Medicine Physicians, specifically specialty code 17, is crucial for informed comments on Medicare Physician Fee Schedule rules. Its absence hinders the ability to provide comprehensive feedback to CMS proposals, impacting hospices in the long term.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Hospice and Palliative Medicine

Aggregated Comment Title: ***Reduce HEDIS Requests to Liberate Resources for Patient Care***

Summary: Reducing HEDIS requests can improve patient care by freeing up staff and resources for direct patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Only Require Documentation of Vaccines Administered to Patients***

Summary: Rather than requiring documentation when staff offer vaccinations to residents, CMS should rely only on documentation of confirmed vaccine administration.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Maplewood of Cheshire County

Aggregated Comment Title: ***MDS B1300 Rarely Applies in SNFs***

Summary: In a nursing home setting, the MDS question B1300 about how often someone needs help reading instructions from a doctor or pharmacist is often irrelevant, as residents typically require assistance with managing their medications.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Maplewood of Cheshire County

Aggregated Comment Title: ***Facility Staffing and Characteristics Reports Are Redundant***

Summary: Documentation and reporting requirements in the Facility Staffing and Characteristics Reports (CMS-672 & CMS-671 Forms), are often redundant and complex, requiring facilities to submit duplicative information available through other systems like Payroll-Based Journal (PBJ). This results in unnecessary burden for facilities to comply with slightly different formatting or wording requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Self-Reported Incident Follow Up***

Summary: Documentation and reporting requirements for self-reported incidents and follow-up are often complex and redundant, leading to inefficiencies, burnout, and a shift away from resident care. Streamlining and integrating these processes, especially with EHR systems, could significantly enhance compliance and care quality.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Shift Approval of Marketing Materials to State Departments of Insurance or Carriers***

Summary: Shift oversight of marketing material review and approval from CMS to state departments of insurance and/or insurance carriers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Shift Oversight for Member Communication Management to State Departments of Insurance or Carriers***

Summary: Shift oversight for member communications recording and storage from CMS to state departments of insurance and/or insurance carriers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Shift Oversight of HEDIS Scoring to State Departments of Insurance or Carriers***

Summary: Shift oversight of HEDIS scoring from CMS to state departments of insurance and/or insurance carriers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Eliminate HEDIS Scoring***

Summary: Eliminate HEDIS scoring from CMS oversight and all together.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Shift Oversight of Star Ratings to State Departments of Insurance or Carriers***

Summary: Shift oversight for calculating star ratings from CMS to state departments of insurance and/or insurance carriers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Shift Oversight of Enrollment "Seasons" to State Departments of Insurance or Carriers***

Summary: Shift oversight for enrollment periods, also known as “seasons,” from CMS to state departments of insurance and/or insurance carriers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Empower State Departments of Insurance and Carriers to Oversee Reimbursement***

Summary: Shift oversight for reimbursement requirements from CMS to state departments of insurance and/or insurance carriers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Empower Patients Through Administrative Simplification***

Summary: Empower patients to manage their healthcare effectively by simplifying, modernizing, and automating reimbursement and billing procedures for all Medicare-covered services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kingdom Insurance Group

Aggregated Comment Title: ***Adjust Medicare Recertification Cadence***

Summary: Change Medicare recertification from 60 days to 6 months.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Medicare Should Manage PRO-PMs to Alleviate Burden***

Summary: Patient surveys are overwhelming. Medicare should manage the PRO-PMs, send surveys directly to patients, and maintain a centralized database, reducing reconciliation efforts and hospital workload.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Psychiatric Work Sheets***

Summary: Streamline OMB Control Number 0938-0391 for CMS Form Number CMS-437 by simplifying reassessment frequency to focus on major changes in patient status rather than frequent updates that may not reflect changes in care needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Provide Funding and Technical Assistance For CNAs***

Summary: Community needs assessments (CNAs) are essential for identifying challenges and developing targeted interventions. To facilitate this process, CMS should provide funding and technical support to rural hospitals, Critical Access Hospitals, Health Departments, and communities to conduct CNAs regularly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enact Flexible Polices for Responding to CNAs***

Summary: Community needs assessments (CNAs) help identify challenges faced by a population and guide interventions. To aid this process, CMS should create flexible policies enabling rural hospitals and Critical Access Hospitals to allocate resources according to CNA results.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***CNAs Take a Holistic Approach***

Summary: Community needs assessments (CNAs) provide a holistic perspective by considering various factors like healthcare infrastructure, transportation systems, economic development, and access to nutritious food. This approach helps policymakers address systemic barriers rather than isolated symptoms.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***CNAs Drive Coordinated Solutioning***

Summary: Community needs assessments (CNAs) provide actionable insights by focusing on community-level data, allowing stakeholders to prioritize resources effectively and address the most pressing needs with coordinated and impactful solutions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Standardize Payment for Anesthesia Services***

Summary: Per the GAO report of 1992, CMS should standardize payment for anesthesia services, regardless of who performs the care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Advance Hybrid Payments for PCPs***

Summary: CMS should advance hybrid payments for PCPs to lessen burden rather than add more codes to the MPFS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Commonwealth Fund

Aggregated Comment Title: ***Redundancies in Payment Models***

Summary: CMS has various payment models, such as the Value-Based Purchasing (VBP) Program and the Transforming Episode Accountability Model (TEAM), that track identical metrics, including infections and post-surgical complications. Combining these programs into one would allow for a more streamlined focus on key indicators of value.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Extend the Notice of Election for Hospice Time Limit***

Summary: Extend the Notice of Election (NOE) for hospice time limit to 7 days or 5 business days to avoid burden when holidays fall near a weekend.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Differentiate Among APRNs***

Summary: CMS should establish APRN taxonomy or specialty codes to differentiate among APRNs with distinct clinical specialties. This will improve the granularity of provider-level data,

enable better performance measurement, and support future efforts to identify and address workforce gaps and benchmark quality.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Oncology Nursing Society

Aggregated Comment Title: ***Create Single Restraint Protocol***

Summary: The categorization of restraint protocols as "violent" and "non-violent" can be confusing for patients with fluctuating behaviors like dementia or head trauma. To address this issue, it is suggested to consolidate restraint standards into a single, behavior-neutral protocol that prioritizes patient condition and clinical judgment over strict behavioral classifications.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Standardize Definition of "Invasive Procedure"***

Summary: CMS should provide a clear and standardized definition of the term "invasive procedure" within the Conditions of Participation (CoPs) for hospitals. Include examples and exclusions to guide implementation, align the definition with current clinical practices and technological advancements, and publish a formal, comprehensive definition of "invasive procedure" in the Conditions of Participation or associated interpretive guidelines

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require PBMs to Submit Drug and Rebate Information Under RxDC***

Summary: The annual Prescription Drug Data Collection (RxDC) reporting submission mandates health plans to provide data on prescription drug spending, rebates, medical services spending, and premiums. However, this process is time-consuming and lacks value in addressing drug price increases. Instead, PBMs should be responsible for submitting drug and rebate information under RxDC.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Point32Health

Aggregated Comment Title: ***Medicare Revalidation Process is Redundant and Overly Complex***

Summary: Providers, including psychologists, find the Medicare revalidation process overly complex and redundant. The reporting and documentation requirements necessary to maintain billing status lead to significant delays.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Admission Schedule Requirements are Redundant and Overly Complex***

Summary: The admission schedule requirements in regulatory text at 412.610 are outdated, overly complex, redundant, and inconsistent with current practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Rehabilitation Providers Association

Aggregated Comment Title: ***Use Either HRSA or BPC For Data Collection***

Summary: Streamline data collection by choosing either HRSA or the Bureau of Primary Care, noting the latter is inefficient and overstaffed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Processing of No Pay Claims***

Summary: The delay in processing No Pay claims in sequential order causes payment hold-ups. CMS needs a more efficient billing practice to enable CMS to track residents' admissions, discharges, and 60-day breaks accurately, while also allowing facilities to bill when necessary.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enact Flexible Data Standards That Acknowledge Resource Limitations***

Summary: Enact flexible, patient-centered data standards that assure transparency and quality while accommodating providers with fewer informatics resources.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Expand Hardship Exceptions and Bonus Scoring in MIPS***

Summary: Support smaller practices by expanding hardship exceptions and bonus scoring in MIPS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Cut Duplicative OASIS BIMS Reporting***

Summary: The Brief Interview for Mental Status (BIMS; C0200-C0500) in the Home Health OASIS is duplicative of M1700 and M1710, with no added benefit. CMS should eliminate M1700 and M1710 to reduce duplication in the assessment process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Adara Home Health

Aggregated Comment Title: ***Establish a Shared Federal Data Platform***

Summary: A shared federal health data interoperability platform using APIs and cloud-based services with FHIR-standardized datasets can modernize CMS and streamline agency-wide integration for effective data-driven policy and technology implementation. This would enable efficient sharing of claims, enrollment, audit, and provider data for monitoring and reporting.

Total Comments Contributing: 10

Total Submissions Contributing: 8

Organization(s): American Psychiatric Association; CGI Federal Inc.; Kingdom Insurance Group; Ohio Hospital Association; PointClickCare; Reveleer; Wellbox

Aggregated Comment Title: ***Partner With Stakeholders on New Regulations***

Summary: Involve stakeholders such as patients, clinicians, hospitals, and trade organizations in the design and review of new regulations and measures to ensure practical, evidence-based requirements without unnecessary administrative burdens, and to promote sustainable, high-quality care. CMS should preserve and enhance opportunities for patients to participate in policy development, including through the public comment process, listening sessions, and public meetings.

Total Comments Contributing: 9

Total Submissions Contributing: 8

Organization(s): Alliance for Person-Centered Care; Gulf Coast Outpatient Surgery Center, Laurel Surgery & Endoscopy Center; Infectious Diseases Society of America; Lantana Consulting Group; Ohio Hospital Association; Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***Streamlining Oversight Through Cross-Agency Collaboration While Ensuring Legal and Policy Mandates***

Summary: CMS must streamline its oversight by coordinating with agencies like CDC, OSHA, DOJ, and state licensure bodies to avoid conflicting regulations and duplicative enforcement, as mandated by law and upheld by courts. Enhanced cross-agency collaboration, including mutual recognition of compliance findings and aligned legal interpretations, would reduce redundancy, improve efficiency, and maintain program integrity. Establishing an inter-agency council with senior leaders for regular strategic planning and performance monitoring is essential for effective coordination and burden reduction.

Total Comments Contributing: 9

Total Submissions Contributing: 4

- ***Organization(s):*** BAYADA Home Health Care; CPAC Foundation Center for Regulatory Freedom; National Board for Certified Counselors (NBCC); Vivie

Aggregated Comment Title: ***Formally Recognize Community-Based Organizations as Part of Care Team***

Summary: Community-Based Organizations (CBOs) play a crucial role in care coordination and improving outcomes for seniors with complex needs and multiple providers and managed care plans, yet they are not formally recognized as part of the care team in Medicare or Medicaid systems. CMS can enhance care coordination and advance person-centered care for vulnerable populations by formally allowing CBOs to document and coordinate care for beneficiaries across programs.

Total Comments Contributing: 8

Total Submissions Contributing: 1

- ***Organization(s):*** Centro De Amigos

Aggregated Comment Title: ***Allow Payment for Asynchronous Care and Consider Billing Codes Not Tied to Time***

Summary: Medicare's reliance on time-based CPT codes for billing asynchronous care services like Diabetes Self-Management Training (DSMT) presents challenges for providers because these codes do not account for asynchronous delivery. Establishing standards for claims submission that do not mandate specific amounts of synchronous time could address this issue. Asynchronous digital DSMT programs offer real-time support using tools like digital glucose monitors, but the lack of visibility in claims data for asynchronous services hinders understanding of their effectiveness. Shifting away from time-based billing requirements towards outcome-based models could better incentivize quality care delivery and leverage digital health infrastructure to ensure program integrity without relying on time measurements.

Total Comments Contributing: 7

Total Submissions Contributing: 1

- ***Organization(s):*** Omada Health, Inc.

Aggregated Comment Title: ***Opportunities for Federal Oversight to Pass to States to Reduce Duplication***

Summary: CMS could streamline efforts and reduce duplication by "deeming" state agencies who meet or exceed federal requirements outlined in 42 CFR Part 483. State licensing surveys conducted by "deemed" state agencies could be recognized by CMS as meeting federal regulatory standards. If a state agency demonstrates efficient and effective CHOW, CHOI, & new provider application/licensing systems, that meet or exceed federal regulations, CMS could permit the use of these systems without federal oversight.

Total Comments Contributing: 6

Total Submissions Contributing: 4

Aggregated Comment Title: ***Medicare and Other Payers Lack Cross-Payer Collaboration***

Summary: Medicare and secondary payers like Medigap or Medicaid are designed to work in tandem, but the absence of collaboration between payers burdens providers with duplicate billing and preventable claim denials. Medicaid programs often reject crossover claims from Medicare due to formatting discrepancies, place-of-service errors, or incorrect routing to managed Medicaid policies, causing manual effort to resubmit and appeal claims. Additionally, providers often must produce the same documentation for Medicaid and Medicare program eligibility determinations including income and resource verification and medical necessity.

Total Comments Contributing: 6

Total Submissions Contributing: 3

Organization(s): Globe Life Insurance Company; University Radiology Group

Aggregated Comment Title: ***Duplication in Medicare and Medicaid Programs for Behavioral Health and Home Health***

Summary: Providers of behavioral health and home health services often face duplication when submitting documentation to both Medicare and state Medicaid programs. Providers must submit extensive treatment plans and progress reports to both programs and complete duplicate patient assessments and care plans for patients eligible for both programs, but CMS could create standardized assessment and reporting tool could meet the requirements of both programs.

Total Comments Contributing: 6

Total Submissions Contributing: 3

Organization(s): American Psychiatric Association; BAYADA Home Health Care

Aggregated Comment Title: ***Implement Solutions to Chronic Disease Management***

Summary: CMS should promote self-management and self-direction for chronic conditions where appropriate, including by prioritizing research and innovation in developing technology-assisted means of patient self-care. CMS should also support an integrated approach to preventing and managing multiple chronic conditions and widely disseminate and implement proven multi-condition treatments such as the TEAMcare intervention. Furthermore, eliminate patient cost-sharing for integrated, multi-condition chronic disease management in primary care to enhance access, engagement, and continuity of care for patients.

Total Comments Contributing: 5

Total Submissions Contributing: 1

Aggregated Comment Title: ***Include Technology Readiness Assessments in Regulatory Planning***

Summary: To improve alignment and reduce unnecessary burden, CMS and its contractors should include technology readiness assessments in CMS's regulatory planning process to ensure stakeholders are adequately prepared before go-live dates. CMS should furnish vendors with comprehensive implementation guidelines concurrently with policy updates, including code sets and data reporting formats, and allow optional pilot testing periods before full implementation. Additionally, CMS should give a minimum 180-day advance notification period for any regulatory or policy modifications necessitating system adjustments or billing updates.

Total Comments Contributing: 5

Total Submissions Contributing: 2

Aggregated Comment Title: ***Duplicative Obstetric Requirements***

Summary: The upcoming Medicare conditions of participation for hospitals and critical access hospitals regarding obstetric (OB) care are duplicative and unnecessary. The Emergency Medical Treatment and Labor Act (EMTALA) governs OB care, and existing hospital and state regulations inform staff training, equipment access, and quality monitoring standards. Anticipated requirements, such as those related to staff training and obstetric emergency preparedness, duplicate or misalign with accreditor or state standards, adding burden without improving care quality or outcomes.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): Alliance of Safety-Net Hospitals (ASH); Henry Ford Health; OCHIN

Aggregated Comment Title: ***Collaborate with HRSA to Reduce Burden on Health Centers***

Summary: Collaborate with HRSA on data sharing and administrative processes. For example, interoperability between HRSA and CMS reporting processes can enhance health center participation by reducing data reporting burdens and accurately attributing patient outcomes to the primary care provider, addressing administrative and financial challenges faced by health centers. Further, simplifying the Medicare site registration process for health centers under ¤ 424.510 is crucial for streamlining operations and supporting the new Administration for a Healthy America.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** America's Essential Hospitals; National Association of Community Health Centers (NACHC); Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Barriers to AI Technologies in Healthcare***

Summary: The lack of Medicare Physician Fee Schedule (MPFS) reimbursement for Category III codes hinders the adoption of AI technologies in healthcare. A study revealed underutilization of Category III codes for AI technologies, affecting their transition to Category I status and access to traditional MPFS payments. Fast-tracking the MAC consideration process for successful AI technologies could benefit developers, providers, and patients. Currently, outpatient hospitals under the Hospital Outpatient Prospective Payment System (HOPPS) receive reimbursement for AI services, while MPFS-based facilities may require patients to pay out-of-pocket. AI-enabled healthcare services can qualify for Category III codes, but their pricing is carrier-based.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***Transitioning From Medicaid to Medicare***

Summary: The transition from Medicaid to Medicare is confusing, with little in the way of communication or resources.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Hospital Association of Rhode Island; Johns Hopkins Health Plans

Aggregated Comment Title: ***Incentivize Adoption of Evidence-Based Care Coordination Models***

Summary: CMS can further support best practices by incentivizing the adoption of evidence-based care coordination models, EHRs, and clinical decision support tools. By aligning requirements with best practices and industry standards, emphasizing flexibility, interoperability, and outcome-based approaches, Medicare can enhance care coordination.

Total Comments Contributing: 5

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reassess Conflict of Interest Rules***

Summary: CMS should reassess its conflict of interest rules for contractor selection to enhance administrative efficiency, technology utilization, and adherence to best practices. Current provisions may hinder competition and limit access to innovative technologies, impacting program integrity and efficiency. By revising these regulations, CMS and states could foster competition, adopt cutting-edge technologies, and optimize the use of government resources while ensuring fair contractor selection processes. The Federal Acquisition Regulation allows contracting officers discretion to determine whether a possible conflict of interest can be avoided or mitigated. It recognizes that not every business relationship causes a conflict that should prevent an otherwise preferable vendor from receiving a contract.

Total Comments Contributing: 5

Total Submissions Contributing: 1

Aggregated Comment Title: ***Collaborate with ONC/ASTP***

Summary: CMS and ASTP/ONC should collaborate to promote alignment and drive industry implementation of interoperability standards and technology for the benefit of both healthcare facilities and patients.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Direct Supply, Inc.; Health Level Seven International (HL7); WEDI

Aggregated Comment Title: ***Modify MA Utilization Management Data Submission Requirements***

Summary: CMS should withdraw the Medicare Part C Utilization Management (UM) Annual Data Submission and Audit Protocol Data Request (CMS-10913, 89 FR 104547)) as existing audit and reporting initiatives provide sufficient means for CMS to monitor Medicare Advantage internal coverage criteria and utilization management. The proposed formatting criteria are burdensome and redundant.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American Clinical Laboratory Association (ACLA); Pharmaceutical Care Management Association (PCMA); UnitedHealthcare

Aggregated Comment Title: ***Duplicative Processes in Beneficiary Enrollment***

Summary: Sending three enrollment verification letters (outbound enrollment verification, enrollment acknowledgment, and confirmation of enrollment) within ten days is duplicative and results in unnecessary expenses, as all three letters contain identical information. Additionally, beneficiary enrollment documentation is duplicative across multiple platforms.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts; Price Services Group, L.L.C.

Aggregated Comment Title: ***Harmonize Quality Definitions***

Summary: Cross-agency collaboration is crucial for harmonizing quality measure definitions and data requirements across programs. Recommendations include forming multi-agency working groups involving CMS, CDC, ASTP, state Medicaid agencies, and private-sector stakeholders to align reporting protocols and minimize conflicting definitions, ultimately streamlining processes and reducing duplication.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** International Consortium for Health Outcome Measurement (ICHOM); Lantana Consulting Group; Ohio Hospital Association

Aggregated Comment Title: ***Aligning with Value-Based Care Appeal Processes***

Summary: Value-based care appeals processes address the current challenge where traditional fee-for-service appeals processes don't align with value-based care models, while industry evolution shows healthcare increasingly operates under bundled payments and shared risk arrangements. Medicare alignment opportunities include prevention services in appeals decisions, outcome-focused documentation that accepts quality metrics, and episode-based appeals that group related claims for coordinated appeals review.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Care Area Assessment Duplicates MDS***

Summary: The Care Area Assessment (CAA) process, mandated by 42 CFR §483.20, was intended to aid in creating personalized care plans but has become redundant within the Resident Assessment Instrument (RAI) process. Facilities already complete the comprehensive Minimum Data Set (MDS) and develop care plans based on resident-specific data. CMS should consider eliminating the CAA requirement to streamline and improve efficiency in care planning.

Total Comments Contributing: 4

Total Submissions Contributing: 4

Organization(s): American Health Care Association (AHCA); CCL Hospitality Group; Compass Community Living

Aggregated Comment Title: ***Use CMMI Models to Test Digital Health Reimbursement***

Summary: Use Centers for Medicare & Medicaid Innovation (CMMI) models to test digital health reimbursement models before broader rollout and align digital health initiatives with existing clinical workflows to minimize disruption. Facilitate partnerships between payers, health systems, and community organizations by simplifying participation in CMMI models.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Ohio Hospital Association; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Best Practices in Healthcare Communications***

Summary: Multi-channel communication follows the best practice where modern healthcare communications use multiple channels to reach providers effectively through implementation that expands beyond traditional mail to include secure messaging, mobile apps, and API notifications while allowing providers to select preferred communication methods without additional compliance requirements.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** National Board for Certified Counselors (NBCC); Quest Diagnostics

Aggregated Comment Title: ***Enhance Communication Between CMS and Industry Organizations***

Summary: Communication between CMS and industry organizations could enhance transparency in addressing fraud, abuse, or over-utilization.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Globe Life Insurance Company; MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services)

Aggregated Comment Title: ***Best Practices in Integrated Service Models***

Summary: Integrated service models include key elements such as a single point of contact for care coordination and individualized service plans that are site agnostic. These components aim to streamline care delivery and improve outcomes by providing personalized support and guidance to individuals navigating the healthcare system.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** LeadingAge; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Establish Registration System for Virtual Prescribers***

Summary: Eliminate the need for in-person visits before prescribing controlled substances by implementing a unique registration system for virtual prescribers. Clarify that hospice providers, in particular, are not subject to in-person requirements.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Cleveland Clinic; Michigan Health & Hospital Association; Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Adopt Telehealth E/M Codes***

Summary: CMS should implement the new AMA CPT codes (99202;99215) for telehealth office-based Evaluation and Management (E/M) services. This change would replace existing in-person E/M codes with modifiers, creating a unified national code set. The adoption of these codes could streamline billing processes, reduce administrative waste, and simplify education and

claims processing across various payer types, ultimately improving claims accuracy and reducing the risk of fraud and abuse in healthcare services.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Organization(s): National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Increase Collaboration Between CMS and Social Security Administration***

Summary: Cooperation and collaboration between the Social Security Administration (SSA) and CMS are essential to assist retirees effectively. Instead of agents from each agency pointing fingers and redirecting individuals back and forth, a unified approach would streamline the process and reduce confusion for those seeking assistance with their benefits.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Make National Medical Policies Open-Source***

Summary: CMS should strive for standardization of all national policies in an open-source, public-good setting wherein medical specialty societies and physicians can weigh in on the appropriateness of care. This would establish a singular, consistent source of information, thereby reducing the need for multiple, disparate efforts driven by content organizations.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Evaluate Outcomes, Try Alternatives, and Focus on Continuous Improvement***

Summary: CMS should learn from outcomes and foster innovation. If metrics show a policy is not achieving desired results, CMS can test alternative approaches in a structured and systematic manner. A focus on evaluation fosters a culture of learning and continuous improvement

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** American Health Care Association (AHCA); Vivie

Aggregated Comment Title: ***Reimbursement Parity for Virtual Services***

Summary: CMS should prioritize reimbursement parity for virtual healthcare services, including audio-only or digital chat options, to ensure equitable access for Medicare beneficiaries, especially individuals with limited digital literacy or broadband access.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Organization(s): Infectious Diseases Society of America; Wellbox

Aggregated Comment Title: ***Collaborate on Preemption for MA and Part D Programs***

Summary: CMS should collaborate with stakeholders like AHIP and NAIC to provide clear guidance on federal preemption for MA and Part D programs, enhancing coordination between federal and state regulators. This will reduce duplication, ensure regulatory consistency, and improve program efficiency for beneficiaries and plans.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** AHIP; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Mandate and Adopt Existing Industry Standards for Interoperability***

Summary: To enhance interoperability and safety without increasing regulatory burden, CMS should adopt established industry standards like HL7, NCQA, or NCPDP instead of creating new Medicare-specific requirements. By leveraging existing consensus standards, such as HL7's FHIR implementation guides, digital health tools can ensure compatibility and streamline compliance processes, ultimately benefiting both healthcare providers and patients.

Total Comments Contributing: 3

Total Submissions Contributing: 3

- ***Organization(s):*** Health Level Seven International (HL7); Massachusetts Health Data Consortium; National Association of ACOs (NAACOS)

Aggregated Comment Title: ***Recognize Participation in Certified Models for Integrated Care Systems***

Summary: Integrated Care Systems face challenges in proving care coordination for Medicare programs, which often require documentation already present in models like ACOs and PCMHs. To streamline this process, CMS should recognize participation in certified care models as evidence of integration, eliminating the need for additional tracking. Leveraging resources like FHIR CarePlan and CareTeam can help document multidisciplinary collaboration, while supporting real-time data exchange through TEFCA or state HIEs can ensure efficient information sharing without redundant provider attestations.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Develop a Patient-Centered Quality Measure for Chronic Disease Management Programs***

Summary: CMS should develop an advanced patient-centeredness quality measure for use in chronic disease management programs and include key indicators such as patient quality of life, patient continuity of care, patient cost of care, and patient pain interference.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Interagency Data Sharing to Prevent Redundant Audits***

Summary: Current processes require duplicate collection and submission of the same information. Federal, state, and healthcare entities need to better communicate and share information when patients consent to data sharing and utilize existing data whenever possible. Basic patient demographics and surgical and medical history forms should be one and done. One suggestion to streamline data collection is to implement a secure identification system like those used in banking or social security to tie all information to an individual so it does not need to be duplicated by each provider. By enhancing data-sharing initiatives and adopting secure, interoperable standards like APIs and FHIR, regulatory frameworks can be more efficient, reduce provider burden, and improve coordination between providers, payers, and digital health platforms.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Duplication Between Joint Commission and CMS Requirements***

Summary: Submitting electronic Clinical Quality Measures (eCQMs) to both CMS and The Joint Commission (TJC) is redundant. If eCQMs are submitted to CMS, there should be no need to submit them to TJC.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Franciscan Missionaries of Our Lady Health System (FMOL Health)

Aggregated Comment Title: ***Leverage Specialty Society Data Registries***

Summary: To streamline Medicare processes, automation and enhanced data interoperability are key. CMS can simplify data submission procedures by utilizing specialty society registries that gather reliable data. Robust specialty-specific registries with long-term follow-up are essential for clinicians seeking to improve outcomes.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Quality and Performance Measures Committee of the Society for Vascualr Surgery; The American College of Cardiology

Aggregated Comment Title: ***Standardize Electronic Submission of Medical Records Over Fax***

Summary: CMS should standardize for all plans the ability to accept electronic submission of medical records. A standardized claims attachment would allow plans to request and providers to transmit necessary medical records via a safe electronic transmission standard. Even with the broad utilization of electronic medical records, some administrative processes have not technologically evolved, especially the requirement from many plans that medical records be submitted via fax machine.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Michigan Health & Hospital Association; The American College of Cardiology

Aggregated Comment Title: ***Redundancy Between OIG and CMS***

Summary: Redundancy between the Office of Inspector General (OIG) and CMS oversight arises when investigations overlap, leading providers to address multiple federal agencies seeking the same information on claims or practices. This duplication creates compliance burdens due to varying reporting timelines and requirements for similar oversight functions.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Technology-Neutral Coverage Decisions***

Summary: Industry best practices increasingly recognize that many preventive services, particularly counseling and behavioral interventions, can be effectively delivered via telemedicine. Industry standard would be technology-neutral coverage: if a service is covered, it should be covered regardless of delivery method, subject only to appropriate quality and privacy safeguards.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***ACA-Related Coverage Forms are Duplicative***

Summary: IRS Forms 1094-B, 1095-B, 1094-C, and 1095-C are used for ACA-related coverage reporting. These forms often duplicate information already provided to CMS or state Medicaid programs. Additionally, IRS Section 6055/6056 requires providers offering minimum essential coverage to report information to both the IRS and CMS, and many times providers also must submit the same information to Medicaid and private insurers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Develop and Implement Data Sharing Agreements***

Summary: Formal data sharing agreements are crucial for agencies to access and utilize shared datasets efficiently, minimizing redundant data collection. Establishing clear protocols for data privacy and ethical use is vital, and agencies need to document and communicate these standards to all stakeholders. Data agreements are particularly useful for public health reporting, SDOH, and insights tied to USCDI.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Require Access to Medical Records for Information Exchange***

Summary: CMS should require hospitals and providers to ensure patient and public health access to medical records and facilitate information exchange during care transitions, aligning with industry best practices for transparency and patient-centered care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Cost Sharing and Dual Eligibility***

Summary: Providers who serve beneficiaries with Medicare and Medicaid encounter complex and repetitive cost-sharing and eligibility verification processes. CMS should create integrated eligibility and benefits platforms for dual-eligible beneficiaries under both Medicare and Medicaid.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Allow Registered Dietitian Nutritionists to Document in MDS***

Summary: Update the Minimum Data Set (MDS) Section I documentation requirements to include Registered Dietitian Nutritionists (RDNs) as valid sources for coding malnutrition or risk of malnutrition, specifically for the I5600 code. This change would streamline the documentation process, reduce redundant documentation for physicians, and ensure accurate and timely resident care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Compass Community Living

Aggregated Comment Title: ***Streamline Patient Privacy Regulations***

Summary: Streamline patient privacy regulations and reduce administrative burden by coordinating the multiple federal agencies within the Department of Health and Human Services that govern patient privacy, such as the Office of Civil Rights, the Centers for Medicare and Medicaid Services, and the Substance Abuse and Mental Health Services Administration.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Federation of American Hospitals; Georgia Hospital Association

Aggregated Comment Title: ***Establish Unified Post-Acute Care Framework***

Summary: CMS should establish a unified post-acute care payment framework that streamlines documentation and billing requirements for inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals, and home health agencies. By harmonizing documentation, quality reporting, and payment methodologies under a single, site-neutral framework, providers can focus on delivering the most appropriate care based on patient needs rather than care setting. This approach would enhance care coordination, reduce duplicative data collection, eliminate inefficiencies, and ultimately improve patient outcomes.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): AMGA

Aggregated Comment Title: ***Align Coverage Policies with CPT Guidelines***

Summary: Aligning CMS coverage policies with CPT codes, informed by physician input through the RUC process, can reduce regulatory burdens by accurately reflecting the cost and operational requirements of healthcare services. While Medicare is not required to follow CPT guidelines, its influence as a coverage policy leader can encourage commercial payers to adopt similar policies, streamlining processes and reducing burdens on the healthcare system overall.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP); Healthcare Business Management Association

Aggregated Comment Title: ***G Codes are Unnecessary***

Summary: The addition of new G codes in 2025 has led to confusion and potential coding errors. Some believe these codes serve more for data collection than improving care, suggesting that existing CPT and ICD-10 codes could suffice for the same purpose, urging CMS to reconsider their use.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Business Management Association

Aggregated Comment Title: ***CMS and DOGE Collaboration to Reduce Regulatory Burdens***

Summary: Collaboration between CMS and DOGE is essential to significantly decrease regulatory burdens. By eliminating unnecessary bureaucracy, this partnership can enhance patient care and save time and resources. By focusing on integrating with DOGE-led reviews, CMS ensures internal Medicare compliance efforts are evaluated for necessity and overlap before implementation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom; Consumer Action for a Strong Econmy

Aggregated Comment Title: ***Collaborate with SBA***

Summary: CMS should collaborate with the Small Business Administration (SBA) on vetting new policies to avoid harming small healthcare providers. Additionally, they should establish a memorandum of understanding to address grievances from healthcare providers facing duplicative audits or conflicting compliance requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom

Aggregated Comment Title: ***Enhance Coordination Among Federal Agencies to Increase Efficiency***

Summary: Enhanced coordination among federal agencies for interoperability initiatives can lead to improved outcomes, increased system efficiency, and smoother provider workflows. By focusing on these efforts, CMS can reduce data reporting inconsistencies and lessen administrative burdens on providers. CMS should collaborate with federal, as well as state agencies, to align audit objectives, share data, and prevent redundant penalties.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Reform Medicare FFS to Resemble MA to Capture Savings for the Program***

Summary: Adopting an approach for Medicare FFS that more closely resembles the approach in MA would be an effective way for CMS to capture savings for the program, identify inappropriateness and abuse patterns across the delivery system, and ensure patient safety and appropriate clinical care. This will significantly reduce confusion and abrasion amongst providers who submit for both MA and FFS.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Utilize AI for Prior Authorizations***

Summary: AI-powered review platforms offer evidence-based and collaborative processes for prior authorization determination, promoting transparency and patient-centric evaluation. Additionally, smart PA technologies enable a patient-centric approach by mapping longitudinal patient journeys for various conditions, streamlining the authorization process by bundling services instead of requiring multiple disconnected requests from providers for a single patient.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Use AI to Identify Waste and Recommend Services***

Summary: Prior authorization data can be strategically leveraged to identify patterns of inappropriate care, waste, and abuse. AI and technology can detect behavior indicative of "gamification," such as unexplained alterations within duplicate submissions. AI can also anticipate physician behavior and proactively recommend other timely services along a patient's care journey.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Replace State RAIs with a National Center***

Summary: There is uncertainty in coding accuracy and conflicting guidance re: MDS. A proposed national center could replace individual State Resident Assessment Instrument (RAI) Coordinators, enhancing efficiency in the RAI/MDS process for CMS and nursing homes. Inconsistencies in state coordinators' experience levels and responsiveness lead to delays in MDS corrections and timely completion.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Modernize Safe Harbor to Supply Patients with Internet and Devices***

Summary: Modernizing Medicare's safe harbor provisions to permit healthcare providers to provide patients with internet access and smart devices without fear of penalties would enhance access to telehealth and improve healthcare outcomes. By eliminating complex technical restrictions on device use and simplifying inducement rules, vulnerable populations would have better tools to navigate the evolving healthcare landscape, ultimately benefiting both patients and health systems.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Alliance for Connected Care; Johns Hopkins Health System

Aggregated Comment Title: ***Publish New eCQMs in FHIR and Traditional Formats***

Summary: CMS should publish new eCQMs using FHIR formats as well as traditional formats to drive standardization of quality reporting.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Booz Allen Hamilton; Microsoft

Aggregated Comment Title: ***Collaborate with the FDA***

Summary: CMS should collaborate with the FDA to address supply chain issues and expedite approval of devices and equipment to lower costs, improve supply chain resilience, and enhance patient access.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Infectious Diseases Society of America; The Renal Healthcare Association

Aggregated Comment Title: ***Eliminate Duplicative Staffing Rules for CAHs***

Summary: Eliminate duplicative staffing rules for Critical Access Hospitals (CAHs) under 42 CFR 485.608(d) to reduce administrative complexity and improve patient care in rural and underserved areas. Defer to state authority through standing waivers, streamlining compliance and allowing CAHs to focus on care delivery.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ascension; Premier Inc

Aggregated Comment Title: ***Identify Methods to Reduce the Overreliance on CEHRT***

Summary: CMS should identify methods to reduce the overreliance on CEHRT in its programs. Allow for physician and patient choice to drive the adoption and use of health IT products, such as by leveraging the value of connected health technology innovations that build on CEHRT. The situation where CEHRT is implemented but its interoperability capabilities are underutilized or not used at all primarily due to cost considerations--should be addressed with appropriate policy and incentives.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Connected Health Initiative; Health Level Seven International (HL7)

Aggregated Comment Title: ***STARS and ACTS Reporting is Duplicative***

Summary: STARS is a database in Washington State that monitors facility certifications, investigations, and survey activities for nursing homes and assisted living facilities. Entering and tracking intake allegations in both ACTS and STARS is redundant. CMS could "deem" state agencies that demonstrate efficient and effective complaint reporting hotline and investigation processes as meeting federal reporting and investigation requirements.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** DSHS/HCLA/RCS

Aggregated Comment Title: ***Reduce Prescriptive Regulatory and Implementation Requirements***

Summary: Overly prescriptive regulations inhibit innovation of alternative effective processes among the industry, particularly among smaller and provider-sponsored Medicare plans.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** BAYADA Home Health Care; Johns Hopkins Health Plans

Aggregated Comment Title: ***Engage with Key Stakeholders to Ensure Alignment with Industry Standards***

Summary: To ensure alignment with industry standards, ongoing engagement with key stakeholders across the healthcare continuum is crucial, including providers, payers, patient advocates, and technology developers. By actively seeking and incorporating input from these diverse perspectives, Medicare can drive innovation, support patient-centered care, and enhance the quality of outcomes.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Academy of Family Physicians; MCG Health, part of the Hearst Health network

Aggregated Comment Title: ***Strengthen Requirements for Hospice Visits***

Summary: CMS should review requirements for hospice visit reimbursement, such as documentation of time spent with patients. Hospice also sometimes "double dips" by performing and charging for services that have already been performed by skilled nursing or assisted living, such as bathing. These duplicate services cost taxpayers unnecessarily.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Standardize Fraud, Waste, and Abuse Compliance Training***

Summary: Fraud, Waste, and Abuse and Compliance requirements create challenges for staff and clinicians. Currently, the burden of finding resources for training falls to each organization or provider, leading to inefficiencies. Providing standardized training materials for everyone would ensure compliance and reduce time wasted on resource searching or creation.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Highlands Oncology Group, P.A.

Aggregated Comment Title: ***Technology-Driven Utilization Management***

Summary: Eliminate utilization management (UM) for hospitals utilizing technology to avoid duplication and reduce burden, especially for those engaged in population health efforts to ensure patients receive quality and efficient care.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Premier Inc; Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***DEA Special Registration Rule and Hospice***

Summary: Revise the DEA Special Registration Rule to improve medication access for hospice patients by streamlining registration processes and expanding prescriber allowances in end-of-life care settings. CMS should exempt hospice providers from these regulations to ensure continued high-quality care for patients at the end of life. CMS and the DEA should collaborate to address the risks posed to hospice patients and providers by the proposed rule.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Illinois HomeCare & Hospice Council; National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Incentivize TEFCA Participation***

Summary: Incenting providers and other stakeholders to participate in TEFCA can significantly reduce the administrative burden of health data exchange by reducing disparate and duplicative point to point connections to exchange health data.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Health Information Network, Inc. dba KONZA

Aggregated Comment Title: ***TEFCA and Provider Directories***

Summary: States should utilize or enhance provider directories from TEFCA-participating health information exchanges instead of creating separate directories, to avoid duplication and promote interoperability.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Health Information Network, Inc. dba KONZA

Aggregated Comment Title: ***Cross Train Staff Across Agencies***

Summary: Cross-training staff from different agencies and developing shared protocols can enhance collaboration, prevent duplication, and ensure efficient responses to concerns, particularly those related to resident safety. This approach fosters better understanding of each agency's roles, limitations, and data policies, ultimately improving overall effectiveness and coordination.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Local Long Term Care Ombudsman (NALLTCO)

Aggregated Comment Title: ***Enhance Oversight and Penalties for Contractors Inconsistent with CMS Policy***

Summary: CMS should create a robust oversight system with penalties for contractors that exhibit high rates of improper denials or patterns of inconsistent application of CMS policy.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Collaborate on Provider Education for Compliance***

Summary: CMS should enhance cross-agency collaboration, particularly in provider education, to help reduce duplicative efforts in reporting and compliance monitoring. This streamlining will enable providers to dedicate more time and resources to direct patient care, while ensuring effective program oversight in the healthcare system.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** The American Psychological Association Services, Inc.

Aggregated Comment Title: ***Develop Common Quality Measure Sets and Risk Adjustment Methodologies***

Summary: Public-private partnerships should be pursued to develop common quality measure sets and align risk adjustment methodologies, particularly for clinicians participating in multiple value-based care arrangements.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American College of Physicians; Connected Health Initiative

Aggregated Comment Title: ***Enhance Audit Effectiveness Through Contractor and Payer Coordination***

Summary: Efficient coordination between contractors and payers is necessary for audits in Medicare Part C and Medicaid programs to avoid duplication, conflicting audits, and to decrease administrative burdens on suppliers. The lack of alignment leads to repeated audits, inconsistent determinations, and challenges in maintaining program integrity and patient access to care. Enhanced coordination would streamline oversight and alleviate burdens on suppliers. Collaborate with trustworthy providers and expand audits beyond the current MAC contractors to develop a new audit framework that protects Medicare funds while minimizing the impact on compliant providers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Expand Inflation Considerations***

Summary: CMS should recommend updates in line with inflation rather than introducing efficiency reductions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improving Immunization Data Sharing via Interagency Coordination***

Summary: CMS partnering with the CDC, ASTP/ONC, and other federal partners would advance reliable, interoperable sharing of immunization data across the health care system.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***Support Payer-Agnostic Data Aggregation Platforms***

Summary: Support payer-agnostic data aggregation platforms, like regional health data utilities (HDUs), that enable multidirectional exchange of clinical and nonclinical data.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***IODN and D-SNPs***

Summary: CMS should eliminate the Integrated Organization Determination Notice (IODN) for Advance Investment Payments (AIPs) requirement in 42 CFR 422.631(d) and use the existing denial notice for all MA plans to avoid confusion for beneficiaries in AIP plans who may receive notices that do not affect them.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Revise Low Utilization Payment Adjustment Methodology***

Summary: CMS should revise the Low Utilization Payment Adjustment (LUPA) methodology to reflect clinical need, not arbitrary visit counts, and recognize telehealth as a qualifying contact.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Trial Reimbursement for IDE Studies***

Summary: The process for FDA-approved Investigational Device Exemption (IDE) studies involves redundancies between the CMS and FDA approval processes, leading to delays in trial access. To improve efficiency, it is suggested that coding, coverage, and payment assignment be consolidated into a single process, possibly at the same time as FDA approval. This streamlining would reduce administrative burden and allow timely trial access.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AdvaMed

Aggregated Comment Title: ***Hospice Ownership Transparency in Data Dictionary***

Summary: CMS should eliminate the ownership type "Other" from the hospice data dictionary due to lack of clarity and consistency in categorization. There are no specific IRS designations for this category, making it confusing for the public to understand the nature of hospice providers.

With over 400 hospices currently identified under "Other," the change would improve transparency and aid public understanding of hospice agencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Quality Measures Retired by CMS Remain Active with Joint Commission***

Summary: CMS frequently discontinues quality measures, but they remain in use by The Joint Commission (TJC), such as the PC01 measure.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Franciscan Missionaries of Our Lady Health System (FMOL Health)

Aggregated Comment Title: ***Waive Reporting Requirements for Hospitals with HIMSS Level 6 or 7***

Summary: CMS could waive additional reporting requirements for hospitals that achieve HIMSS level 6 or 7 and allow attestation instead. Organizations who achieve HIMSS level 6 or 7 demonstrate high interoperability for telemedicine, transparency, digital health, and integration, meeting rigorous standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***PASRR is Duplicative with Other Assessments***

Summary: Preadmission Screening and Resident Review (PASRR) is duplicative with other medical assessments.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***Coordinate Accreditation Between Federal and State Agencies***

Summary: Coordinate accreditation between federal and state agencies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Permit Registry or Vendor Data in MIPS***

Summary: CMS should permit the use of validated registry or third-party vendor data where appropriate, especially when it enhances the accuracy and utility of performance measurement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The American College of Cardiology

Aggregated Comment Title: ***Expand the Use of HQR Dashboards***

Summary: Expand the use of HQR dashboards to all hospital types.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kansas Hospital Association

Aggregated Comment Title: ***PTAN Acquisition***

Summary: Suppliers of unique products face challenges in obtaining PTAN numbers when their offerings do not align with existing Medicare benefit categories. To address this, CMS should lift restrictions on PTAN acquisition for providers billing non-Medicare payors with non-payable codes and DMEPOS-accredited providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** ATA Action

Aggregated Comment Title: ***Integrate Medication Reviews in Part C***

Summary: Integrate reconciliation and comprehensive medication review in Part C measures to enhance efficiency and focus on vulnerable patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Agadia Systems

Aggregated Comment Title: ***Reduce Duplication by PDMPs***

Summary: State Prescription Drug Monitoring Programs (PDMPs) often have duplicative regulatory policies for monitoring controlled substance abuse, which overlap with existing measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Agadia Systems

Aggregated Comment Title: ***Embed Appeals Guidance into EHR Workflows to Improve Documentation***

Summary: To align with best practices, clinical decision support can embed appeals guidance directly into EHR workflows, alerting providers to potential coverage issues during documentation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Form-Specific Feedback for CMS-10337 OMB Control Number: 0938-1140***

Summary: Quality Reporting During Appeals CMS-10337 (Appeals Outcome Reporting) OMB Control Number: 0938-1140 mandates providers to report appeals outcomes and timelines for

quality measurement, despite CMS having access to this data through MAC reporting systems, resulting in redundant reporting requirements for the same information.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Coordination with Workers' Compensation***

Summary: Workers' compensation coordination can lead to duplications in cases where work-related injuries necessitate separate appeals to Medicare and workers' compensation systems, resulting in redundant submission of clinical information through uncoordinated processes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Streamline ESRD Appeals***

Summary: End-Stage Renal Disease programs submit appeals to both standard Medicare appeals and ESRD-specific review processes, leading to duplication of dialysis treatment documentation across various channels.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***DME Appeals are Duplicative***

Summary: Appealing Durable Medical Equipment denials may involve navigating both Medicare and supplier appeals processes, leading to multiple appeals for a single denial.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Mental Health Parity Appeals***

Summary: Mental health parity appeals may require both Medicare appeals and compliance reviews for mental health parity, involving duplicative documentation to various review bodies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***FHIR Compliant APIs for Appeals Could Improve Efficiency and Accuracy***

Summary: API connectivity for seamless data exchange, with a focus on developing Fast Healthcare Interoperability Resources (FHIR) compliant APIs for appeals processes, is best practice in modern healthcare systems. By integrating these APIs with existing EHR systems, benefits such as automated submission of appeals documentation, real-time validation, and reduced manual processing through automated data extraction and formatting can be achieved, improving efficiency and accuracy in the appeals process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Cloud-Based Platforms for Care Coordination***

Summary: Healthcare organizations are adopting cloud-based collaboration platforms for care coordination, with a focus on secure appeals management systems. These systems enable multi-party collaboration by providing secure platforms for provider coordination, real-time access to appeals documentation, and automatic tracking of updates and revisions. Implementing these features can enhance efficiency and communication within care teams.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Multidisciplinary Care Team Documentation is Best Practice***

Summary: Best practice care team documentation in modern healthcare emphasizes multidisciplinary collaboration by allowing any qualified care team member to contribute, not just the billing provider. This approach is supported by technology that enables all team members to participate in appeals documentation through shared platforms, ensuring comprehensive and inclusive record-keeping practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Enhance Processes Through Operational Guidance***

Summary: Guidance-based improvements can lead to sub-regulatory implementation by leveraging CMS's flexibility to enhance processes through operational guidance. This strategy involves issuing appeals process guidance that integrates best practices, offering the advantage of swift implementation without the need for lengthy rulemaking procedures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Align CCBHC CoPs with Existing Requirements***

Summary: CMS should align future Medicare Certified Community Behavioral Health Clinics (CCBHCs) Conditions of Participation (CoP) with current Medicaid and state certification requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Suggestions for Development of Policies and Coverages***

Summary: When developing policies and coverages, CMS should involve organizations that have established Standards of Practice, a Code of Ethics, and Repair Best Practices early in the discussion. By including these organizations from the outset, CMS can ensure that the policies and coverages being developed are aligned with industry best practices and ethical standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services)

Aggregated Comment Title: ***Risk Adjustment Data Submissions Overlap for Medicare Advantage***

Summary: Medicare Advantage plans submit both Risk Adjustment Processing System (RAPS) data and encounter data for risk adjustment purposes. While these datasets overlap, plans must submit similar information through two separate systems, increasing administrative burden and the risk of inconsistency.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Duplicate Payments Across Federal Programs***

Summary: Improper duplicate payments have occurred involving both Medicare and the Veterans Community Care Program (VCCP), where both programs have paid for the same services. Despite regulations in place to prevent Medicare from covering services already paid for by another government entity, instances of duplicate payments persist between these federal programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Leverage Existing Community and Cross-Sector Partnerships***

Summary: Utilizing established community partnerships like Health Equity Zones and interagency councils can accelerate the implementation of joint initiatives and minimize redundancy.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Adopt Best Practices for Data Mapping and Extraction***

Summary: CMS should recognize and implement best practices for data mapping and extraction in healthcare to streamline the process of sharing and utilizing health information, ultimately reducing costs and improving efficiency for providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish Shared Priorities and Leadership Commitment***

Summary: Executive leaders should establish shared priorities across agencies to align goals and reduce siloed efforts. Successful state-level initiatives have shown that governors or high-level officials mandate collaboration and mutual responsibility, such as during the COVID-19 response.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow FQHCs to Submit UDS Data to CMS***

Summary: CMS should permit FQHCs to use their existing UDS data submission to CMS for HRSA Health Center Program reporting as a substitute for duplicate reporting for MSSP and ACO REACH. This streamlined approach would alleviate administrative burdens for FQHCs and incentivize their participation in value-based care models, ultimately enhancing quality and cost-effectiveness in healthcare delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Community Care Cooperative

Aggregated Comment Title: ***Expand Existing Value-Based Models Before Launching New Programs***

Summary: Scale up existing value-based models (e.g., ACO REACH, Primary Care First) rather than launch new programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Improve Quality Metric Selection and Assessment***

Summary: Promote outcome-based metrics over process-heavy reporting. When residents have documented non-compliance or refusal of care, remove from consideration for quality metrics

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Good Samaritan Society

Aggregated Comment Title: ***Adopt Quality Measure for Blood Culture Contamination Rate***

Summary: Blood culture contamination in sepsis tests costs Medicare a significant amount annually, leading to unnecessary treatments, patient harm, and exacerbating antimicrobial resistance. CMS should adopt a quality measure for blood culture contamination rate based on an allowable standard of 1 percent or less, such as the CDC's NQF-endorsed formal Adult Blood Culture Contamination Rate measure, to the Medicare HAC program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Magnolia Medical Technologies

Aggregated Comment Title: ***Update Telehealth Regulations for Therapy to Require In-Person***

Summary: Having an in-person therapy session before transitioning to telehealth can provide significant benefits to patients, ensuring they understand the therapy process and can actively participate. Updating Medicare telehealth regulations to require an initial in-person session for physical therapy and occupational therapy services before transitioning to telehealth could enhance the quality of care for Medicare beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Revise Registered Dietitian Requirements and Allow Transition Period***

Summary: CMS should revise 483.60(a)(1) to state registered by the Commission on Dietetic Registration (CDR) or its successor organization; and is licensed or certified as a dietitian or nutrition professional in the state where services are provided, if such licensure or certification exists. CMS should also allow a transition period of up to five years for individuals to meet these new qualifications. This change aims to streamline regulations, adhere to national credentialing standards, promote workforce development, and uphold quality resident care standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Contract State Surveyors to Educate Providers***

Summary: Contracting state surveyors to educate providers would better align Medicare requirements with best practices and industry standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Adopt AASM Sleep Apnea Diagnostic Standards***

Summary: CMS should adopt the American Academy of Sleep Medicine's (AASM) sleep apnea diagnostic standards, as the current thresholds used by CMS are outdated and can misclassify patients, leading to reduced access to CPAP treatment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Physician Supervision for Incident-To is Duplicative***

Summary: Physician supervision requirements for incident-to and diagnostic services are redundant.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Reexamine Use of Informal Guidance***

Summary: CMS should reexamine its use of informal guidance such as Medicare Learning Network (MLN) articles as an implicit enforcement mechanism for compliance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Transform Price Transparency from Duplicate Uploads***

Summary: A single FHIR-based endpoint, validated once, then queried by consumers, states, and private plans, could tighten data integrity and align with emerging APCD Council formats, all without expanding the universe of mandatory fields. In addition, Health Plan Transparency files should be integrated into the file to ensure consistent, reliable information.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Utilize Established Care Delivery Frameworks Instead of New Mandates***

Summary: Utilize established care-delivery frameworks like NCQA's Patient-Centered Medical Home (PCMH) model instead of new CMS mandates. PCMH offers integrated, team-based primary care with proven benefits of higher quality, improved patient experience, and lower costs. By referencing PCMH or similar certifications, value-based models like ACO REACH can promote cross-continuum coordination without additional paperwork, aligning with existing successful structures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Use Third-Party Certification and Voluntary Attestation Rather Than Rulemaking***

Summary: Utilize third-party certification and voluntary attestation for digital-health tools instead of prescriptive rulemaking. By accepting existing certifications like the FDA's software-as-a-medical-device guidance, CMS could streamline the process, focusing on outcome tracking rather than duplicative pre-market reviews for products like remote-patient-monitoring dashboards and AI-enabled clinical-decision support. This approach would leverage industry-led validation pathways to ensure safety and efficacy.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Virginia Hospital & Healthcare Association

Aggregated Comment Title: ***Enhancing Coordination Between Drug Discount and Rebate Programs***

Summary: Efficient coordination between drug discount and rebate programs is crucial for program integrity. However, concerns remain about potential duplicate discounts with the Maximum Fair Price, as CMS have not outlined specific measures to prevent such occurrences.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Confidential Computing***

Summary: Confidential computing and federated learning enable secure analysis of sensitive data without exposing it, facilitating multi-agency collaboration while upholding privacy standards. Federated learning models can share insights across agencies without compromising data security.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Implement DOGE-Style Oversight to Medicare Advantage via CMS and DOGE Collaboration***

Summary: If CMS and DOGE worked together, they would jointly reduce waste, fraud, and abuse in Medicare Advantage by introducing DOGE-style accountability, competition, and transparency into the program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Reconsider Definition of Dose for Allergen Immunotherapy Under CPT Code 95165***

Summary: CMS should reconsider the definition of a "dose" for allergen immunotherapy under CPT code 95165, which has been set as a 1cc aliquot since 2001. This definition differs from the standard clinical practice and the AMA's CPT book, causing challenges for allergy practices, especially smaller ones. The current definition is seen as arbitrary and creates administrative and economic burdens for healthcare providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Allergy, Asthma and Immunology

Aggregated Comment Title: ***Duplicative Pharmacy Performance Standards***

Summary: Pharmacies face Direct and Indirect Remuneration (DIR) fees under Medicare Part D and then PBMs audit plans on the same metrics. Despite originating from the same claims data, this duplication leads to redundant compliance workflows. Varying performance standards across plans create additional burdens for pharmacies, despite the same outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Synerio and CodeX and GenomeX Use / NCPDP Task Group Lead

Aggregated Comment Title: ***Medicare Coverage of Innovative Technologies***

Summary: Reinstate the rescinded MCIT final rule or establish a new expedited voluntary pathway for Medicare coverage of FDA-authorized innovative medical devices, including IVDs.

This pathway, similar to the MCIT program or the Ensuring Patient Access to Critical Breakthrough Products Act of 2023, would provide automatic national temporary coverage for breakthrough technologies, relieving CMS of duplicative efforts and ensuring FDA oversight for safety and efficacy.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Danaher Diagnostics

Aggregated Comment Title: ***Implement 'Deemed Status' to Simplify Survey Processes in State Veterans Homes***

Summary: State Veterans Homes offering nursing home care undergo survey inspections by various agencies. To streamline the process, it is suggested that "deemed status" be implemented, to replace the VA survey process for the redundant CMS/state survey process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Simplify Beneficiary ID Cards***

Summary: Have a single member ID card for patients enrolled in both Medicare and Medicaid managed care plans to streamline administrative processes for providers and provide clarity on coverage and costs. This simplification can enhance patient care management, leading to better outcomes and potentially lowering healthcare expenses.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Align Patient Attribution Requirements***

Summary: Health centers require clear and consistent patient attribution numbers and a straightforward process for entering value-based care agreements. Collaboration between CMS, payers, and agencies like CMMI is crucial to align patient attribution requirements and streamline processes across payers. Incorrect attribution can lead to administrative challenges for providers, hindering access to vital patient data and impacting care coordination efforts.

Ensuring accurate patient attribution is essential for maintaining value-based care arrangements and improving overall healthcare delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Align CMS Payment Processes With Industry Standards to Resolve Billing Disparities***

Summary: Medicare does not recognize or pay additional units for ASA Physical Status modifiers, creating disparities in billing requirements compared to private payers. Anesthesiologists and clinical stakeholders face challenges in navigating different policies and procedures for billing. CMS should accept and track the use of anesthesia physical status modifiers, as used by many private payers. Aligning CMS processes with industry standards could reduce burdens for physicians and billing companies, improve cost identification, and enhance care for complex patients. Compensating care for patients with co-morbidities appropriately would reflect the increased level of service provided by anesthesiologists, benefiting both providers and patients across payers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Society of Anesthesiologists

Aggregated Comment Title: ***Emergency CoPs and EMTALA***

Summary: Emergency Conditions of Participation duplicate compliance requirements in EMTALA.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** OCHIN

Aggregated Comment Title: ***Clinical Integrated Networks Could Become Outcomes Network***

Summary: Clinical Integrated Networks (CINs) can function as outcomes networks by allowing health systems to partner with insurance companies to improve health outcomes. This collaboration could lead to advancements in clinical research, faster introduction of new therapies, and better drug options with improved compliance and adherence. By leveraging technologies like AI and working together, CINs have the potential to enhance outcomes, particularly in areas such as rare diseases, cardiovascular health, COPD, and oncology, while also optimizing cost savings.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Medicare Policy Lags Behind Industry Standards***

Summary: Medicare policy often lags behind industry standards and best practices in how occupational therapy is delivered, documented, and reimbursed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Occupational Therapy Association

Aggregated Comment Title: ***Reduce Redundant Documentation Through CMS and ASTP Collaboration***

Summary: CMS should coordinate with the Assistant Secretary for Technology Policy (ASTP) to standardize utilization management and ePA systems, minimizing redundant documentation across programs and EHRs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Organization of Rheumatology Management

Aggregated Comment Title: ***Burden of State Imposed Documentation Mandates***

Summary: States often impose extra documentation requirements in addition to the federally mandated OBRA MDS assessment, altering the original purpose of the assessment and removing national standardization of the data. These additional state requirements can contradict RAI User's Manual, adversely impacting the data integrity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association of Post-Acute Care Nursing (AAPACN)

Aggregated Comment Title: ***Use the Universal Foundation Framework to Reduce Quality Data Reporting Burden***

Summary: The Universal Foundation is a guiding framework for unified quality measurement that addressing leading drivers of disease in the US. By implementing this framework consistently across programs, providers, payers, and patients can align towards common goals and standardized metrics. This approach will reduce the burden of reporting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** NCQA

Aggregated Comment Title: ***Appeals with No Enrollee Liability***

Summary: CMS recently finalized changes to 42 C.F.R. 422.562(c) to limit the dismissal of appeals with no enrollee liability, sparking concerns about the impact on the Medicare administrative appeals process. The delineation between enrollee interests and provider disputes is crucial to ensure the system functions as intended, avoiding wasteful redundancy and confusion among stakeholders.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***International Examples of Collaboration***

Summary: International examples from the UK and Canada showcase successful collaboration between agencies in implementing healthcare recommendations. By directly aligning coverage with evidence-based guidelines, these systems improve coordination and efficiency while reducing administrative costs. CMS could benefit from studying and adapting these models to enhance their own federal structure.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***OIRA Collaboration***

Summary: CMS, specifically the Office of Management and Budget, must collaborate with OIRA to address both proposed rules and the cumulative impact of interlocking oversight regimes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish an Interagency Oversight Alignment Council***

Summary: CMS can lead regulatory coordination by establishing an Interagency Oversight Alignment Council, with participation from DOGE, SBA Advocacy, OIRA, and relevant divisions within the Department of Health and Human Services HHS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom

Aggregated Comment Title: ***Establish Duplication Checks***

Summary: CMS should lead cross-agency collaboration by implementing duplication checks for all new audit and reporting policies, with the results being publicly disclosed.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Cross-Agency Coordination to Elevate Small and Rural Provider Voices***

Summary: Cross-agency coordination would aim to elevate the perspectives of small and rural providers during the development of regulations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom

Aggregated Comment Title: ***Implement Preclearance Procedures to Prevent Audit Redundancy***

Summary: OIRA and the Office of Management and Budget should implement preclearance procedures to prevent redundant audits by CMS or burden healthcare providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom

Aggregated Comment Title: ***Modernize Medicare to Encourage Innovation and Adoption***

Summary: Medicare lacks coverage and payment pathways that encourage innovation and adoption.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***Crosswalk Technical Component Payments to HOPPS***

Summary: To ensure fairness between Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Prospective Payment System (HOPPS) sites, it is crucial to align Technical Component (TC) payments with HOPPS guidelines as per CMS standards. This alignment supports the industry's goal of utilizing outpatient centers to alleviate hospital capacity constraints, emphasizing the importance of a balanced reimbursement system for different service locations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** RadNet

Aggregated Comment Title: ***Quality Data Capture for Incentive Payments***

Summary: Medicare utilizes eCQM algorithms mapped in EHRs to demonstrate quality performance for MIPS reporting. In contrast, insurance payers pay real-time incentive payments

for quality performance, necessitating the billing of CPT II Codes with a $0.01 charge on the bill, which are currently not approved for use.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Adams Health

Aggregated Comment Title: ***Duplication in Record Requests***

Summary: Health plans and IPAs related to the same health plans regularly request the same patient records separately, causing duplicate work.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Routine Physician Visit Requirements in Long-Term Care***

Summary: CMS should consider reducing routine physician visits to quarterly intervals or allowing primary care physicians to determine visit frequency based on individual patient acuity. Tailoring the frequency of visits to each patient's specific requirements may optimize healthcare resources and improve patient outcomes by ensuring timely and appropriate care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge Illinois/Iowa

Aggregated Comment Title: ***Leverage Prior Authorization Data for FWA***

Summary: Leverage prior authorization data to help identify inappropriate care, waste, and abuse in the healthcare system. Analyzing this data can lead to more targeted compliance monitoring and reduce the need for broad audits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Encourage Policies Against Information-Blocking***

Summary: Interoperability is paramount for modernizing processes like prior authorization. CMS should also vigorously encourage policies that terminate information-blocking practices by

Electronic Medical Record (EMR)/Electronic Health Record (EHR) vendors and legacy technology companies to foster robust interoperability.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Many HIOs May Not Participate in TEFCA***

Summary: Many current Health Information Organizations (HIOs) may not participate in the Trusted Exchange Framework and Common Agreement (TEFCA) for nationwide health information exchange. CMS may need to collaborate with stakeholders to attract these HIOs or provide alternative participation options for their providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Health Care Association (AHCA)

Aggregated Comment Title: ***Create New Billing Code for Telehealth Visits to Monitor Utilization***

Summary: Telehealth visits in hospice care should be viewed as supplementary to in-person visits rather than a complete replacement. It is crucial to establish a billing code for telehealth visits to track their usage and assess their effects on patient outcomes and costs. By monitoring and analyzing the balance between in-person and telehealth visits, CMS can identify opportunities to streamline care delivery, like minimizing unnecessary in-person visits for specific assessments, such as the two-question Symptom Follow Up Visit for HOPE.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Partnership for Healthcare and Hospice Innovation

Aggregated Comment Title: ***Discontinue the Provider Directory API***

Summary: Discontinue the Provider Directory API due to the availability of more efficient methods for external parties to access provider directory data without the need for API technology.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johns Hopkins Health Plans

Aggregated Comment Title: ***Hospice CoP Social Worker Requirement Creates Staffing Issues***

Summary: The 2008 revisions to the Hospice Conditions of Participation (CoPs) mandate that hospice social workers must have a master's degree in social work (MSW) or be supervised by someone with an MSW, unless hired before December 2, 2008. This requirement poses challenges for hospices in finding and retaining qualified social workers, as many states do not mandate an MSW for social work licensure. Consequently, states with limited MSW availability face difficulties in meeting the supervision requirements set by the CoPs, which surpass typical state licensure laws.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Alliance for Care at Home

Aggregated Comment Title: ***Inpatient Orders***

Summary: CMS should review the necessity of an inpatient order for Inpatient Only codes to avoid redundant requirements in registration and admissions processes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** University of Wisconsin Hospital and Clinics (UW Health)

Aggregated Comment Title: ***Investigational Device Exemption Processes***

Summary: Enhance transparency in the Investigational Device Exemption (IDE) review process by providing a status dashboard for companies, offering visibility into review status and potential delays, enabling better planning, reducing unnecessary follow-ups, and improving operational efficiency for both CMS and submitting companies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Medical Device Manufacturers Association (MDMA)

Aggregated Comment Title: ***Create Documentation Template for Provision of Supplemental Oxygen***

Summary: CMS CERT contractor data reveals minimal medical necessity issues with supplemental oxygen provision, but a high medical documentation error rate exceeding 60%, reaching 90% in some years. To address this, implementing a CMS template for prescribers to answer specific questions could streamline Medicare processes, enhance accuracy, and reduce administrative burden, benefiting Medicare, physicians, suppliers, and patients, ultimately improving the Medicare fraud and abuse program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Council for Quality Respiratory Care

Aggregated Comment Title: ***Coordination Across Agencies to Address FWA***

Summary: CMS, MedPAC, and the OIG lack coordination in addressing fraud and abuse. Improved collaboration through timely audits and reports is essential to combat these issues effectively.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Oregon Hospice & Palliative Care Association and Washington State Hospice & Palliative Care Organization

Aggregated Comment Title: ***Remove Manual Review Requirements***

Summary: The review requirements at 42 CFR 482.1(a)(3) and 482.30 for hospitals utilizing technology to verify medical necessity should be removed. With the increasing adoption of automated tools for reviews, these regulations are redundant and burdensome.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate Redundant Medication Reconciliation***

Summary: Eliminate redundant mandates for various healthcare providers like home health agencies, primary care practices, LTC pharmacies, and Medicare Part D plans to conduct and document similar medication-related tasks independently, such as medication reconciliation and drug utilization reviews.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AnewHealth

Aggregated Comment Title: ***Conflict of Interest Provisions***

Summary: States can better address conflicts of interest by interpreting provisions appropriately, enabling them to decide on necessary mitigation measures and enhancing their ability to serve citizens with greater efficiency and effectiveness.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Streamline Care Coordination Reporting***

Summary: Some states collect quarterly member-level data extractions for care coordination reporting, including risk assessments, care plans, and related documentation. In contrast, CMS collects similar data annually, leading to redundant data pulls, reconciliation cycles, and governance workflows due to differing frequencies and definitions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alignment Health Plan

Aggregated Comment Title: ***Duplication of Claims and Roster Files for SNFs***

Summary: Providers transmit claims and roster updates to meet CMS requirements, but plans must duplicate the submission process for state SNF utilization files, diverting resources from patient care. This duplication creates additional workload and inefficiencies in managing enrollment attestations and inpatient SNF utilization data.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***MAO Reporting Through HPMS***

Summary: CMS requires MAOs to report provider payment arrangements like shared risk, bonuses, and fee-for-service models, despite overlapping data captured through MLR reporting, risk adjustment submissions, and HPMS financial management modules.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alignment Health Plan

Aggregated Comment Title: ***Work with NCQA on Hybrid Reporting***

Summary: To improve the implementation of digital quality measures, CMS should collaborate with NCQA to establish guidelines for hybrid reporting and allow adequate transition periods for quality measures, especially in the QHP Quality Rating System. Additionally, CMS should partner with NCQA to ensure the public release of ECDS data, benchmarks, and national performance of ECDS-reported measures for evaluation purposes. This collaboration will help address ongoing implementation challenges and enhance the effectiveness of quality measurement in healthcare.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AHIP

Aggregated Comment Title: ***Streamline EQRS Support***

Summary: Integrating EQRS-related support within the EQRS program instead of splitting it between Networks and the EQRS help desk can enhance efficiency, reduce confusion for providers, minimize duplicative reporting requirements, lower administrative burdens, and align with CMS's goal of eliminating redundancy and focusing regulatory efforts effectively to alleviate provider fatigue.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Renal Healthcare Association

Aggregated Comment Title: ***Map All Related Regulatory and Payment Resources***

Summary: Federal regulatory materials for SNFs are in various locations and formats. Consolidating these resources by topic would enhance practice accuracy, especially during staff turnover. CMS already provides some mapping of regulatory and payment resources on CMS.gov.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** DSHS/HCLA/RCS

Aggregated Comment Title: ***Require Managed Care Organizations to Fulfill Obligation to Honor Person-Centered Care Plans***

Summary: Medicare can improve alignment with industry standards by enforcing existing regulations, particularly in holding Managed Care Organizations (MCOs) accountable for fulfilling their contractual obligations. Many MCOs are denying access to community-based services, like Social Adult Day Care, leading to increased hospitalization and costs for Medicare.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate Disconnect Between Medicaid and Medicare Authorizations***

Summary: CMS should bridge the gap between Medicaid and Medicare authorizations to streamline processes for providers, ensuring services are seamlessly integrated into care plans. For example, when Medicaid authorizes a service like SADC, it should automatically be integrated into the individual's Medicare care plan, which would reduce paperwork and force plans to work together, as originally intended under integrated care models.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Centro De Amigos

Aggregated Comment Title: ***Telehealth as a Supplement to In-Person Care***

Summary: In-person care is the gold standard and telehealth as a supplementary tool rather than a complete solution. Telehealth's growth may disrupt physician-patient relationships and care coordination, potentially leading to worsened medical conditions and health outcomes. Telehealth should be used for established patients, with primary care physicians overseeing care coordination.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP)

Aggregated Comment Title: ***Form-Specific Feedback for Part C Reporting Requirements OMB: 0938-1054***

Summary: The recent inclusion of supplemental benefits in Part C Reporting Requirements, along with CMS's request for their submission via encounter data, creates redundant work for plan sponsors, adding significant burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Use Independent, Evidence-Based Care Guidelines***

Summary: To enhance alignment with best practices and industry standards, Medicare should promote the adoption of independent, evidence-based care guidelines throughout the agency. These guidelines provide a validated framework for decision-making in various specialties, promoting consistency and accountability while reducing regulatory burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** MCG Health, part of the Hearst Health network

Aggregated Comment Title: ***Eliminate Copays and Deductibles in CCM, PCM, and APCM***

Summary: Eliminating copays and deductibles in CCM, PCM, and APCM would align policy with industry standards focused on prevention, engagement, and population health. CMS can set the pace by simplifying the path for providers to adopt best practices without adding burdens that reduce access or slow innovation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Wellbox

Aggregated Comment Title: ***Increase Audit Transparency and Accessibility***

Summary: Healthcare providers are calling for a reduction in audit burden by suggesting a collaborative approach between the government and payers to share audit outcomes transparently. This would make audit results accessible to all parties and potentially lead to fewer audits for positive outcomes and more targeted audits for negative ones.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Aeroflow Health

Aggregated Comment Title: ***Modernize T Code Processes to Keep Pace with Technological Advancements***

Summary: The use of T Codes for emerging therapies involves working with the FDA to increase resources and survey stakeholders to ensure approval and reimbursement processes are up to date with technological advancements. Emphasis is placed on modernizing approaches to align with evolving care delivery standards in the application of AI, flexible care delivery models and spaces, as well as virtual/ambient tools and technologies.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Off-Label Drug Restrictions Create Access Barriers***

Summary: The exclusion of off-label medications from Medicare reimbursement under 42 CFR 423.100 Part D drug access creates access barriers for patients in hematology and oncology. Off-label medications sold by a pharmacy should not be excluded, aligning with the original congressional intent and standard medical practice. CMS should change its regulation to allow coverage of off-label prescriptions under Medicare Part D for medically accepted indications.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Cost-Sharing Collection Duties***

Summary: Transfer cost-sharing collection duties to insurers. This will allow hospitals and healthcare providers to streamline billing processes, reduce duplication, and lower costs associated with managing multiple billing infrastructures, ultimately improving efficiency and reducing financial burden on patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Duplicative Patient Event Notifications***

Summary: Patient event notifications are duplicative. Hospitals must comply with CoPs by sending electronic ADT notifications to providers, while payers generate their own notifications for Transition of Care measures. This leads to redundant notifications, increasing communication volume between entities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Cleveland Clinic

Aggregated Comment Title: ***Remove Provision of Additional Prescription Drugs as Part of Essential Health Benefits Package***

Summary: CMS should remove the provision at 45 CFR § 156.122(f) that automatically deems additional prescription drugs covered by a health plan as part of the Essential Health Benefits (EHB) package, which burdens issuers. This change would give plans and states more flexibility in determining necessary drug coverage for beneficiaries, rather than being constrained by the current policy that expands the list of EHB drugs based on state mandates.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Reconsider Special Enrollment Period Rules***

Summary: Non-traditional SEPs, SEPs not tied to predictable, verifiable circumstances, raise significant concerns regarding adverse selection. Most non-traditional SEPs are limited to the exchange, prompting a need for CMS to reassess SEP eligibility criteria to align better with state initiatives and minimize variability.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***USCDI Annual Updates Present Challenges***

Summary: The annual updates to the United States Core Data for Interoperability (USCDI) present challenges for Standards Development Organizations (SDOs) and hinder the pace of change adoption in the industry. It is crucial for the rate of USCDI changes to align with the industry's ability to implement them effectively. Acknowledging the time required for integrating USCDI changes and achieving successful implementation is essential for developing rational policies in this context.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Health Level Seven International (HL7)

Aggregated Comment Title: ***Maintain EHI Export Regulatory Requirements***

Summary: Electronic Health Information (EHI) Export is an important capability for better enabling patients to access their health data. As such, EHI Export regulatory requirements should be maintained.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Health Level Seven International (HL7)

Aggregated Comment Title: ***Support Implementation of HL7 FHIR Bulk Data Exchange***

Summary: The HL7 FHIR bulk data exchange capability is still developing, along with the related implementation experience. To support future scalable use, there is a need for more specific documentation and consistent implementation practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Health Level Seven International (HL7)

Aggregated Comment Title: ***Continue Promoting Innovation in Patient Surveys***

Summary: CMS has been actively promoting innovative survey administration methods like digital platforms and multilingual versions to boost response rates, enhance representativeness, and lower survey expenses. CMS should maintain its leadership in innovation of survey efforts, particularly in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which offer crucial insights into healthcare delivery for patients and the public, beyond just CMS evaluation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Institute for Healthcare Improvement

Aggregated Comment Title: ***Support Patient-Centered Applications***

Summary: Support patient-centered applications (e.g., digital therapeutics) especially in the areas of behavioral health and sleep medicine, promoting wellness through behavior modification training instead of strictly through medications.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Henry Ford Health

Aggregated Comment Title: ***Reporting Exemptions***

Summary: Simplify the exemption process for hospitals facing challenges in reporting eCQM data due to extraordinary circumstances like natural disasters. CMS should accept a single exemption request for both the Inpatient Quality Reporting (IQR) and Promoting Interoperability (PI) Programs. This would eliminate the duplicative and burdensome task of submitting separate applications through different portals, streamlining the process for hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Premier Inc

Aggregated Comment Title: ***Focus Collaboration on Resident Impact***

Summary: Collaboration among agencies should prioritize resident protection and well-being without compromising oversight quality. Effective communication, mutual understanding, and shared tools can reduce inefficiencies and improve care for long-term care residents.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Local Long Term Care Ombudsman (NALLTCO)

Aggregated Comment Title: ***Ensure Affordable Out-of-Network Access to In-Office Visits***

Summary: Medicare beneficiaries, especially those in long term care facilities, should have the option to use telehealth services without being mandated to do so. Telehealth can improve access to healthcare providers in communities with limited resources, but lack of devices or internet access can hinder its effectiveness. Medicare Advantage plan beneficiaries should have affordable out-of-network access to medical specialists through traditional office visits or telehealth to enhance healthcare access and reduce costs associated with delayed treatment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Local Long Term Care Ombudsman (NALLTCO)

Aggregated Comment Title: ***Collaborate with CDC NSSP***

Summary: Aligning CMS with CDC's National Syndromic Surveillance Program (NSSP) is crucial for enhancing coordination and efficiency in health data reporting. Integrating NSSP with state and local Public Health Agencies (PHAs) will reduce the burden of dual reporting, streamline data sharing, and improve overall surveillance capabilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Review Rule on Observation Determinations***

Summary: CMS should review the existing rule (412.3(c), 412.3(d)(3) that mandates that the inpatient and outpatient observation determinations be made at the start of hospital admissions to better align with industry standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Part D Denial Letters***

Summary: Beneficiaries find Part D denial letters confusing as they highlight denial upfront instead of Part B approval, suggesting the removal of this requirement to improve clarity and understanding for recipients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sanford Health - Sanford Health Plan and Security Health Plan

Aggregated Comment Title: ***Combine and Simplify OIG and SAMS Lists***

Summary: For nursing homes, the OIG and SAMS lists are administrative burdens because of the duplication and monthly requirement. CMS should combine them into one list and make them simpler by allowing multiple names to be added to one inquiry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Simplify Adverse Event Follow-Up***

Summary: When an incident is already documented in a self-report, requiring additional, often duplicative root cause reports or follow-ups across multiple systems adds layers of work without improving care outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Cross-Agency Collaboration Already Occurs***

Summary: Cross-agency collaboration already occurs to reduce duplicative compliance efforts.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate 30 Day Deadline for OASIS Transmittal***

Summary: The Notice of Admissions (NOA) and 30 day Outcome and Assessment Information Set (OASIS) transmittal is duplication. If the NOA is done timely, as required for payment, a timeliness standard for the OASIS is unnecessary.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Hands of Wellness

Aggregated Comment Title: ***Prioritize Cost-Effective Telehealth Services***

Summary: CMS should create a list of healthcare services that would be more cost-effective than in person care and prioritize the list of services for telehealth coverage in upcoming PFS rulemaking.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Taxpayers Protection Alliance

Aggregated Comment Title: ***Promote Reimbursement of Principal Illness Navigation Services***

Summary: CMS should advocate for the inclusion and proper reimbursement of Principal Illness Navigation (PIN) services within Medicare Advantage and state Medicaid programs through education and outreach. Some plans may claim to cover PIN services but fail to provide separate payment, instead bundling them with other services. This bundling practice could hinder the utilization of PIN services by not adequately supporting the staffing and resources required for their effective delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Oncology Nursing Society

Aggregated Comment Title: ***Regulatory Reform for Biosimilar Approvals***

Summary: Leverage cross-pollination with other CMS and FDA programs like CMMI and generic/biosimilar approvals for regulatory reform. There are in-depth analyses on these areas that consider the taxpayer's viewpoint.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Taxpayers Union

Aggregated Comment Title: ***Cybersecurity Rules and Industry Standards***

Summary: There is concern about federal agencies issuing cybersecurity rules that deviate from industry standards like the NIST Cybersecurity Framework, despite supporting strong cybersecurity standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Point32Health

Aggregated Comment Title: ***Engage with Multi-Stakeholder Collaboratives***

Summary: CMS should collaborate with local health data collaboratives to inform national policy. By engaging with these groups, CMS can learn from their governance structures and explore ways to scale effective regional models, such as standardized data exchange and reduced administrative burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Massachusetts Health Data Consortium

Aggregated Comment Title: ***Population Health Metrics to Improve Health***

Summary: Effective systems of care extend beyond individual clinicians and utilize administrative data to analyze risk-adjusted rates of preventable hospitalizations, ER visits, and complications. By focusing on population performance measures that encompass a wide range of conditions, opportunities for improvement in cost and quality can be identified. This approach enhances the overall effectiveness of the care system, benefiting providers, Medicare beneficiaries, and taxpayers by aligning services with their needs and optimizing resource allocation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Solventum

Aggregated Comment Title: ***Cover Services From Therapy Aides***

Summary: State licensing laws govern the services that physical therapists and occupational therapists can delegate to support personnel, including aides. Medicare does not cover services provided by aides, leading to limited appointment availability, delayed access, disrupted care plans, worse outcomes, unnecessary services, and increased costs for beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Duplication Between PDPM and SNF QRP***

Summary: In the SNF setting, providers face duplicative tasks with the Minimum Data Set (MDS) required for quality measurement and payment determination under the SNF Quality Reporting Program and Patient Driven Payment Model (PDPM). These requirements, while serving similar purposes, lack full harmonization and may necessitate redundant documentation of clinical events in varying formats.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lantana Consulting Group

Aggregated Comment Title: ***Hypoglycemia eCQM***

Summary: The hypoglycemia eCQM differs between CMS and CDC, with CMS focusing on adult patients and CDC including all ages. Providers face challenges in collecting, transforming, and submitting data due to nuanced differences, leading to errors and diverting resources from clinical care to administrative tasks for health-system quality teams.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Duplication in FQHC Uniform Data Collection Submissions***

Summary: FQHCs must submit Uniform Data collection within 45 days of each fiscal year's end, reporting to both HRSA and the Bureau of Primary Health Care, resulting in unnecessary costs for duplicate data collection.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Part C Audits are Burdensome***

Summary: Streamline Part C audits for organization determinations, appeals, and grievances (ODAG) to reduce burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Align State and Federal Network Adequacy Standards and Processes***

Summary: CMS should align network adequacy, monitoring and reporting requirements, and auditing for states and CMS. CMS could delegate network adequacy assessments to states, leveraging their local knowledge to set appropriate standards, or at the very least align state and federal standards.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Encourage Participation from EHR Vendors in Digital Transformation***

Summary: To reduce administrative friction and accelerate digital transformation in Medicare, CMS should encourage or require participation from electronic health record (EHR) vendors and clearinghouses to ensure full interoperability in the authorization lifecycle.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Revise Ambulatory Payment Classification to Ensure Payment for High Cost Drugs***

Summary: The regulation 42 C.F.R. 419.31 outlines the structure for the Medicare Hospital Outpatient Prospective Payment APC system. CMS should align this system with integrated health system standards by separately reimbursing high-cost, low-utilization drugs currently bundled into procedure payments, ensuring fair compensation for these medications within the Medicare program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Photocure

Aggregated Comment Title: ***Align FDA Food Code and USDA FSIS Temperature Discrepancies***

Summary: The 2022 FDA Food Code sets 135°F as the minimum hot holding temperature for food, while USDA Food Safety and Inspection Service (FSIS) advises 140°F, causing regulatory discrepancies among states. To reduce confusion, federal agencies should harmonize their food safety guidelines to facilitate consistent standards nationwide, based on current scientific knowledge.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Compass Community Living

Aggregated Comment Title: ***Improve Coordination Between Medicare FFS and Medicare Part C***

Summary: Medicare FFS and Medicare Part C must coordinate more effectively to ensure consistent policy implementation, oversight, and beneficiary experience.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Improve Medicare Part C Plans***

Summary: CMS should mandate Medicare Part C plans to establish dedicated budgets and develop comprehensive Provider Outreach and Education departments similar to those in the Medicare FFS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Improve Internal Coordination at CMS***

Summary: The division within CMS that regulates Medicare Advantage (MA) plans is separate from the division that regulates Medicare providers like skilled nursing facilities (SNFs) and home health agencies (HHAs). Better coordination between these branches would help identify conflicting policies that hinder care delivery and providers' financial sustainability, such as discrepancies in regulatory obligations like safe discharges and assessment results. CMS should improve coordination between the MA and provider regulatory oversight divisions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Improve Integrated Service Models***

Summary: Core elements that have been proven to work in creating effective integrated service models include pooled funding with risk sharing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Timely Initiation of Hospice and Palliative Care***

Summary: Timely initiation of hospice and palliative care can reduce end of life care costs and preserve quality of life.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Engage Long-Term Care Providers in Value-Based Care***

Summary: CMS should look at the recommendations on how to better engage long term care providers in value-based care models like Accountable Care Organizations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Increase Medicare Reimbursement Rates***

Summary: Increase Medicare reimbursement to professionals and agencies to keep up with inflation. Many are opting out due to poor reimbursement rates and experiences (e.g., audits, paperwork). This limits patient choice, often leading to subpar care.

Total Comments Contributing: 9

Total Submissions Contributing: 9

Organization(s): LeadingAge Illinois/Iowa; Shekina Glory Legacy Hospice and Palliative Services; University Radiology Group, LLC

Aggregated Comment Title: ***NTAP and Medicare Advantage***

Summary: Medicare Advantage (MA) plans do not include New Technology Add-on Payment (NTAP) rates, potentially limiting access to innovative technologies for a growing number of MA enrollees. Failure to provide comparable payments as traditional Medicare may create financial barriers, impacting beneficiary access to critical treatments supported by the NTAP program. Requiring MA plans to adhere to the NTAP program is crucial for ensuring beneficiary access to innovative technologies and addressing discrepancies in reimbursement between MA plans and Traditional Medicare.

Total Comments Contributing: 8

Total Submissions Contributing: 2

- ***Organization(s):*** Abbott; Philips

Aggregated Comment Title: ***Align Standards Before Integrating Dental Care into Diabetes Management***

Summary: Establishing clear guidelines, definitions, and regulatory alignment are essential for effective implementation and integration into the broader healthcare and dental care framework. These issues need to be addressed before proposing potential integration of dental services into diabetes management under Medicare. Clear guidance is needed on how newly covered dental services for diabetes will be integrated into this regulatory framework to ensure compliance and streamline operations. Furthermore, failure to provide clear guidelines may lead to difficulties in care coordination when integrating dental care with diabetes management while maintaining effective coordination between dental and medical services. Appropriate service delivery in dental care involves covering only dental services directly linked to diabetes management. It is necessary to specify critical dental services for diabetes management to avoid potential issues arising from lack of clarity.

Total Comments Contributing: 7

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Proposed Revisions to 340B Guidance to Align with Statutory Intent***

Summary: HHS is urged to rescind various guidelines and notices related to the 340B Drug Pricing Program to ensure program integrity and align with statutory intent. Recommendations include restricting the 340B Prime Vendor Program to its defined function, clarifying Apexus's authority, rescinding guidance on in-kind contributions, limiting contract pharmacy services, revising manufacturer audit guidelines, and addressing eligibility criteria for outpatient facilities. These actions aim to reduce unjustified markups, enhance transparency, and lower drug costs for patients, aligning with the Administration's goals of improving pricing systems and program integrity.

Total Comments Contributing: 6

Total Submissions Contributing: 1

- ***Organization(s):*** Pfizer, Inc.

Aggregated Comment Title: ***Streamline Regulations for Pediatric Beneficiaries***

Summary: CMS should carefully consider coverage and benefit regulations with respect to the unique needs of children with Medicare. Accessing pediatric specialists and services can be challenging due to limited acceptance of Medicare. It is especially crucial for Medicare policies to consider the unique needs of dually eligible children to ensure optimal health outcomes. CMS should mandate pediatric expertise for prior authorization reviews and coverage of compounded medications for pediatric patients to improve access to essential treatments.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** American Society of Pediatric Nephrology

Aggregated Comment Title: ***Facilitate Medicare Enrollment***

Summary: Make it easier for beneficiaries to enroll in Medicare through agencies and agents.

Total Comments Contributing: 5

Total Submissions Contributing: 3

- ***Organization(s):*** Astoria Company; Healthpilot; National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Incentivize Use of the ACC Tool***

Summary: To improve facility culture, enact the Artifacts of Culture Change (ACC) Tool as an incentive for quality ratings and reimbursement. CMS could further support this effort by creating a database to store the required reports.

Total Comments Contributing: 5

Total Submissions Contributing: 1

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Leverage Patient-Reported Outcome Measures (PROMS)***

Summary: Patient-Reported Outcome Measures (PROMs) play a crucial role in identifying patients in need of additional support, ultimately leading to reduced follow-up costs and hospital utilization. As CMS transitions its measurement programs to evaluate overall well-being, it is important to understand patient perspectives and defining well-being from their point of view is essential for person-centered care. By focusing on PROMs, healthcare providers can enhance outcomes, build trust, increase satisfaction, alleviate workforce burnout, and optimize resource utilization by minimizing unnecessary testing, medication, and interventions, while also helping doctors tailor care to meet patient preferences and potentially prevent avoidable emergency department visits.

Total Comments Contributing: 5

Total Submissions Contributing: 2

- ***Organization(s):*** Alliance for Person-Centered Care; International Consortium for Health Outcome Measurement (ICHOM)

Aggregated Comment Title: ***Ensure Transparency and Avoid Duplicate Discounts in 340B Sales***

Summary: Issue guidance on implementing alternative mechanisms like a rebate model to deliver 340B ceiling prices. Requiring the use of 340B claims modifiers and establishing a neutral clearinghouse could ensure accurate claim identification. Additionally, CMS should allow manufacturers to define 340B patients clearly through the rebate model to prevent duplicate discounts and diversion. These actions would offer manufacturers transparency to ensure compliance with rules against diversion and duplicate discounts, ultimately ensuring that the 340B program benefits eligible patients effectively.

Total Comments Contributing: 5

Total Submissions Contributing: 4

Organization(s): America's Essential Hospitals; Illinois Health and Hospital Association; Pfizer, Inc.

Aggregated Comment Title: ***Revise Surveys to be Less Punitive***

Summary: The current survey environment is punitive and disheartening to staff, with an excessive focus on deficiencies. Facilities facing findings of noncompliance and financial hardship may have to suspend certain valuable services and programs, such as nursing aide training, resident programs, and admissions. Instead, CMS should shift towards collaboration, sharing best practices, and a more flexible and supportive approach from surveyors to remediate deficiencies and improve the overall care environment.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** LeadingAge; Maplewood of Cheshire County; The Meth-Wick Community

Aggregated Comment Title: ***Preemptively Approve Nutrition Supports and Offer National Coverage***

Summary: The development and release of preemptively approved nutrition supports by CMS would bring various benefits to plans, enrollees, and the cost and quality of care. Plans could offer programs incentivizing healthy food purchases, improving health outcomes. Providing a pre-approved list of evidence-based nutrition supports would guide plans in implementing CMS's clarification on healthy food benefits. Classifying medically tailored meals, groceries, and produce prescriptions as health-related supplemental benefits could enhance their use in GLP-1 therapy. Poor nutrition's direct impact on health justifies nutrition interventions as primarily health-related treatments. Establishing a National Coverage Determination (NCD) to formalize the integration of medically tailored meals, medically tailored groceries, and produce prescriptions aligns with CMS's strategy to include prevention services and activities promoting good nutrition and could produce cost savings.

Total Comments Contributing: 4

Total Submissions Contributing: 1

Aggregated Comment Title: ***Strengthen Oversight of PBMs***

Summary: Reform PBM policies to enhance transparency in rebate arrangements, curb practices like spread pricing and formulary steering, and ensure fulfillment of network adequacy standards. Address PBM rebate impacts on medical practices, especially concerning biosimilars.

Total Comments Contributing: 4

Total Submissions Contributing: 2

- ***Organization(s):*** American College of Rheumatology; National Organization of Rheumatology Management

Aggregated Comment Title: ***Deregulate Measure Development and Integration***

Summary: CMS should explore ways to deregulate the pipeline for developing and integrating new performance measures into federal programs to encourage innovation while reducing measurement burden. Replacing numerous quality measures with fewer, more impactful measures like PRO-PMs could alleviate provider burden and enhance healthcare outcomes. CMS has already reduced Medicare quality measures by 18% through the Meaningful Measures 2.0 Framework, but challenges persist in fully utilizing meaningful measures, including PRO-PMs. Simplify the integration of high-impact quality measures by leveraging CMMI models to test new measures and innovative data collection methods.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance for Person-Centered Care

Aggregated Comment Title: ***Allow Retroactive Authorization of Services***

Summary: Allow retroactive authorization of completed services to align Medicare and Medicare Advantage requirements, such as preventive services. Additionally, increase transparency and awareness of the processes related to retroactive authorizations to reduce administrative burden and support timely claims processing.

Total Comments Contributing: 4

Total Submissions Contributing: 2

Aggregated Comment Title: ***Addressing Underreported Harm***

Summary: Medicare currently lacks infrastructure for patient reporting of harm, hindering transparency and learning opportunities compared to systems like VAERS and FAERS operated by the FDA. To combat underreporting of harm, CMS should create audit triggers using prevalence data, rather than reported incidents. Additionally, promoting AI tools for detecting unreported harm in health records, and incorporating patient harm reports into fraud detection and post-payment reviews could identify issues. Non-reporting of serious harm should be treated as a billing integrity concern to align policy and enforcement. Implementing these changes can improve safety reporting and prevent improper payments in healthcare.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Patients For Patient Safety US

Aggregated Comment Title: ***Cautions for Using AI in Healthcare***

Summary: Physicians must oversee AI to prevent inappropriate denials, misrepresentation, and bias in patient care. Cost barriers hinder AI adoption for small practices, prompting the need for policies ensuring equal access to AI tools for all physicians, regardless of practice size or location.

Total Comments Contributing: 4

Total Submissions Contributing: 3

- ***Organization(s):*** American College of Osteopathic Family Physicians (ACOFP); Cleveland Clinic; Reveleer

Aggregated Comment Title: ***Mandate Board Certification to Ensure Healthcare Professional Qualification and Patient Safety***

Summary: Requiring physician chart notes for prosthetic and orthotic services is a burden. If Medicare mandated certification by the American Board for Certification in Orthotics and Prosthetics, it would guarantee that healthcare professionals are qualified to create and execute treatment plans for Medicare beneficiaries, enhancing the quality of care provided. Restricting services to trained professionals helps prevent fraud, waste, and abuse by unqualified providers, safeguarding beneficiaries from receiving inappropriate care that could harm their health.

Total Comments Contributing: 4

Total Submissions Contributing: 1

- ***Organization(s):*** Eastern Michigan University

Aggregated Comment Title: ***Virtual Research Data Center Process is Burdensome and Expensive***

Summary: The Virtual Research Data Center (VRDC) enables registries to access Medicare claims data for research purposes. However, the process is slow, cumbersome, and costly, which limits its usability. The center releases a limited amount of data for specific projects, and requests can take years to process, without a guarantee of approval. Eliminating VRDC fees and enhancing cost-effective data access could empower clinician-led registries to improve clinical outcomes and advance quality of care.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Rheumatology

Aggregated Comment Title: ***Strengthen Nutrition-Related Quality Measurement***

Summary: Enhance nutrition-related measures in healthcare quality programs like MA Stars Ratings, CMS Core Measures, and QPP by emphasizing timely access to Medical Nutrition Therapy (MNT) and recognizing Registered Dietitians (RDs) as key contributors in chronic care management and care coordination. CMS should standardize metrics across programs to elevate the visibility of nutrition care in various healthcare settings.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Academy of Nutrition and Dietetics

Aggregated Comment Title: ***Rethink Informal Guidance for Compliance***

Summary: CMS should review its reliance on informal guidance like FAQs and sub-regulatory transmittals as a means of enforcing compliance.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Standardize Coverage, Coding, and Billing Criteria Among MACs***

Summary: To streamline processes for providers, CMS should standardize coverage, coding, and billing criteria across Medicare Administrative Contractors (MACs), using clinical and specialty society guidelines. Currently, if a service lacks a National Coverage Determination (NCD), each MAC establishes its own criteria, leading to complexities for providers operating in multiple MAC jurisdictions.

Total Comments Contributing: 3

Total Submissions Contributing: 3

Aggregated Comment Title: ***Best Practices for Deploying Automation***

Summary: Technology advancements streamline workflows, enhancing operational efficiency and reallocating resources to direct patient care. Employing a proprietary evaluation harness to rigorously tests AI models against hand-labeled datasets can ensure quality and safety standards pre-deployment. Require rule simulation during testing before any model deployment to ensure forecasted behavior and impact are thoroughly understood. Predictive models are closely monitored for efficiency and quality in decision-making, supported by bi-weekly code reviews and ongoing change management.

Total Comments Contributing: 3

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enhance Nursing Home Surveys***

Summary: CMS should use objective quality measures (QMs) and Payroll-Based Journal data to enhance nursing home surveys. Publicly reported and Minimum Data Set (MDS) measures, such as pressure ulcer rates, hospitalization rates, functional improvement scores, staffing levels, and turnover rates, should be included in the data. CMS could link survey focus areas to QM outliers, like investigating rehabilitation care for poor mobility improvement or dining services for notable weight loss. Additionally, quality measure thresholds could elevate a facility to Tier 1 status, resulting in fewer surveys due to higher staffing levels and lower turnover rates. In contrast, facilities with declining performance could be placed in Tier 3 status, requiring more frequent and thorough reviews.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Post-Acute and Long-Term Care Medical Association (PALTmed)

Aggregated Comment Title: ***Increase Collaboration with Facilities***

Summary: CMS should increase collaboration with facilities when making changes to regulations. Better education and communication between entities, such as MAOs and care facilities, can foster this increased collaboration.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Provide Clear Guidance and Helpdesk Support for Facilities***

Summary: Clear guidance and helpdesk support should be provided for facilities to ensure effective training and support, particularly for claims coding, prior authorization processes, and coverage criteria.

Total Comments Contributing: 3

Total Submissions Contributing: 2

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions; Committee on Publication, U.S. Federal Office - The First Church of Christ, Scientist

Aggregated Comment Title: ***Support Participation and Subsidize Obtaining QCDR Status***

Summary: Given the importance of registries to the QPP, CMS should financially support participation and subsidize their obtaining QCDR status. Quality improvement should more than cover the cost of such subsidies over time.

Total Comments Contributing: 3

Total Submissions Contributing: 2

Aggregated Comment Title: ***Support HL7 FHIR Directories***

Summary: Support HL7 FHIR Accelerators to advance healthcare industry standards effectively. Promote easy access to HL7 FHIR endpoints in a secure and consistent manner with a national directory of validated endpoints to enhance interoperability in healthcare systems.

Total Comments Contributing: 3

Total Submissions Contributing: 1

- ***Organization(s):*** Health Level Seven International (HL7)

Aggregated Comment Title: ***Define Medically Necessary Care and Coordinate Systems to Support Expansion***

Summary: Establishing clear definitions of medically necessary care, developing structured guidelines for service inclusion, and fostering thoughtful coordination across healthcare systems are crucial foundational elements for expansion. Without these, there is a risk of confusion, inefficiencies, and unintended consequences.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Establish Clear Guidelines to Coordinate Dental Benefits with Medicare Services***

Summary: The proposed expansion could impact how dental benefits coordinate with other Medicare services. Since dental plans often use separate fee schedules, clear guidelines are necessary to prevent coordination challenges. Expanded coverage may lead to increased demand and higher costs for dental plans, necessitating clear guidelines for effective management of resources.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Make CMS Regulations Requirements Evidence-Based***

Summary: CMS measures and regulations should be evidence based by science, patient-centered, and focused on areas where providers and facilities can directly influence improvement.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Berkshire Medical Center; Price Services Group, L.L.C.

Aggregated Comment Title: ***D-SNPs and Impact Analyses***

Summary: CMS should separate the process of impact reporting for D-SNPs and integrated D-SNPs to analyze policy impacts and ensure accurate payment systems for specialized MA-PD plans. This approach would allow CMS and stakeholders to assess potential consequences and make informed decisions prior to policy implementation.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** South Country Health Alliance

Aggregated Comment Title: ***Consider Hybrid Approach Combining HL7/FHIR and NCPDP SCRIPT***

Summary: CMS should consider a universal hybrid approach combining HL7/FHIR and NCPDP SCRIPT standards for seamless clinical data sharing between EHR providers and payers.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Agadia Systems

Aggregated Comment Title: ***Encourage QCDR Measure Development and Modify Scoring Policies***

Summary: CMS's policy of assigning zero points to clinicians for reporting on a Qualified Clinical Data Registry (QCDR) measure that lacks a benchmark under 42 CFR § 414.1380(b)(1)(i)(A)(1) discourages clinicians from participating in QCDR measure reporting. CMS should promote the development and use of specialty QCDR measures by rescinding 42 CFR § 414.1380(b)(1)(i)(A)(1) and collaborating with stakeholders to create a more suitable scoring policy. Further, approve QCDR measures for two years, with submission of reliability and validity data in year three.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Rheumatology

Aggregated Comment Title: ***Develop Multi-Lingual Enrollment Materials***

Summary: CMS should create enrollment materials for dual-eligibles in multiple languages and at appropriate literacy levels to ensure accessibility and understanding.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Create a Single Payer System***

Summary: Create a single payer system, such as Medicare for All, to decrease costs and administrative burden.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Organization(s): Eastern Virginia Medical School

Aggregated Comment Title: ***Support Innovative Approaches to Reducing Reporting Burden***

Summary: Support innovative pilot programs and electronic quality measurement methods to simplify and reduce administrative burdens in integrated care reporting. For example, implement a one-year, penalty-free test of new electronic measures.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Empower Patients via Transparency***

Summary: Transparency in pricing, treatment plans, and outcomes can empower patients to take control of their healthcare decisions. Suggestions include building on the Blue Button 2.0 initiative and increasing regulations to promote transparency from private insurance.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Enable Practitioners to Work at the Top of Their Licensure***

Summary: Allow practitioners to practice at the top of their license, aligning with team-based care trends. States can oversee discipline-specific clinical practices to ensure patient safety. Removing restrictions for APRNs would enhance care quality, and legislation like the ICAN Act aims to eliminate barriers.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** American Nurses Association; Sutter Health

Aggregated Comment Title: ***Create Reciprocal Paths to Coverage and Treatment Approvals***

Summary: CMS should establish a more responsive process for coverage policymaking. For example, by adopting more reciprocal paths for coverage and treatment approvals, as proposed in the RESULT Act by Senator Ted Cruz. This legislation aimed to establish an expedited approval process for drugs, biologics, or medical devices already authorized in select countries, and potentially offers a framework for executive branch action.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** National Taxpayers Union; Sutter Health

Aggregated Comment Title: ***Streamline Communication via CMS Liaison or Website for Hospitals***

Summary: A point of contact or liaison internally at CMS/Medicare would be extremely beneficial and reduce an immense amount of administrative burden and communication for hospitals. Currently, all communication is at the program level which is not ideal given that most questions can be and usually are applicable to multiple programs. Additionally, a single website for submitting questions with the ability to select multiple agencies/programs from which a response is warranted or needed would assist in addressing this longstanding issue. A clear point of contact for stakeholders to address issues such as prior authorizations, updates to CMS Technical Files, or updates to the Part D Formulary Reference File could enable more prompt communication when patient treatment is affected.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Johnson & Johnson; The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Enhance Provider Informal Dispute Resolution Process***

Summary: CMS should update regulations for facility IDR processes. For example, allow for the presence of facility legal counsel at any meeting; ensure independence of reviewers; and offer flexibility for in-person or virtual meetings.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge New York

Aggregated Comment Title: ***Challenges with OPPS in Radiology***

Summary: CMS should consolidate all costs and charges under the OPPS to a single diagnostic radiology cost center instead of using CT and MRI-specific cost centers. Further, the DRA of 2005 capped payment for screening CT colonography under APC 5523, with technical component reimbursement at $528 under the PFS but capped at the OPPS rate of $241.72. Excluding screening and diagnostic mammography from the cap raises concerns about the impact on breast cancer identification services, suggesting the need to eliminate the DRA cap for imaging.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Radiology

Aggregated Comment Title: ***Eliminate Automatic Removal of Deemed Status***

Summary: CMS should eliminate automatic removal of deemed status under 42 CFR Parts 401, 488, and 489 when a hospital receives one or more condition-level citations during a validation survey. Oversight is important, but punitive measures often create operational and financial strain that hinders corrective action and detracts from quality improvement.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ascension; Illinois Health and Hospital Association

Aggregated Comment Title: ***Medical Liability Reform***

Summary: Cap non-economic and punitive damages via medical liability reform, reducing unnecessary costs and ultimately streamlining the system and promoting efficiency.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Illinois Health and Hospital Association

Aggregated Comment Title: ***Allow Market Entry and Innovation Without Federal Preclearance***

Summary: Simplify the process for new technologies to enter Medicare by deferring, where appropriate, to private sector evaluations and FDA determinations, rather than requiring federal preclearance. This change would promote innovation and prevent delays caused by preclearance regulations.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** CPAC Foundation Center for Regulatory Freedom

Aggregated Comment Title: ***Eliminate Ineffective Safety Programs***

Summary: CMS should revamp or eliminate outdated safety reporting programs like CMS's Serious Reportable Events list, Quality Improvement Organizations (QIOs) and Patient Safety Organizations (PSOs) due to their ineffectiveness in reducing preventable harm. These systems are siloed, retrospective, and underutilized by clinicians and patients. QIOs are unresponsive to patient safety reports and often face hospital resistance to transparency, while PSOs are used primarily to conceal harm rather than drive improvement.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Preserve and Improve HCAHPS***

Summary: HCAHPS remains the only CMS mechanism capturing patients' lived experience of care. It must be preserved and updated to reflect what patients value, including safety. Patient experience surveys (like CAHPS), when implemented thoughtfully, give insight into gaps in communication, trust, and outcomes - especially for marginalized communities.

Total Comments Contributing: 2

Total Submissions Contributing: 2

Aggregated Comment Title: ***Enhance Support for MVP Reporting***

Summary: CMS should enhance support for MIPS Value Pathway (MVP) reporting by streamlining tools, such as embedding automated data capture into EHRs, and providing targeted assistance to under-resourced settings. These supports can reduce the burden on providers and increase participation in the MVP program.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Post-Acute and Long-Term Care Medical Association (PALTmed)

Aggregated Comment Title: ***Strengthen Support for Rural Integrated Care Models***

Summary: CMS should simplify participation in integrated care models for rural providers by streamlining billing and compliance requirements, enabling a focus on care coordination rather than administrative obstacles.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Post-Acute and Long-Term Care Medical Association (PALTmed)

Aggregated Comment Title: ***Extend Rural Floor Protections***

Summary: Extend rural floor protections to Skilled Nursing Facilities and post-acute care providers to ensure access to care and workforce stability in rural counties.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Make the Full Medicare Dataset Available to All APMs***

Summary: Making the full Medicare dataset at 42 C.F.R. 425.660 available to all APMs is essential for supporting accurate benchmarking, provider performance evaluation, and data-driven care improvements. The application process and associated costs are prohibitive for many APM participants, limiting their ability to access the comprehensive information needed to manage population health effectively. Providing unrestricted access to the full dataset would level the playing field, enhance transparency, and enable all APMs regardless of size or resources to analyze trends, identify care gaps, and tailor interventions more precisely.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Ascension; PSW and MultiCare Connected Care

Aggregated Comment Title: ***Allow Providers to Delegate Certain Documentation and Reporting Requirements***

Summary: CMS should allow providers to delegate documentation and reporting tasks to other provider types and contracted entities such as pharmacies providing home-based care services. This would streamline processes by enabling entities already performing clinical services to handle related documentation, such as medication reviews and drug utilization reviews. By counting pharmacy-conducted time and documentation towards clinician billing requirements, these changes aim to reduce duplicative data entry, eliminate overlapping attestations, and enhance care coordination efficiency.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** AnewHealth

Aggregated Comment Title: ***Lack of Data Transparency During Star Rating Preview Periods***

Summary: During Star Ratings preview periods, CMS offers limited data and summary information, hindering plans' ability to fully grasp their performance metrics and calculations. This lack of transparency makes it challenging for plans to validate their data accurately and identify areas for improvement before final ratings are published. Consequently, plans end up duplicating data collection efforts, wasting time and resources that could be better utilized for

quality improvement initiatives. CMS should share more information, such as data and methodology changes, with plans during the initial preview period to reduce confusion and minimize the need for repetitive communication between CMS and individual plans to validate methodologies and address data issues. Revise regulations at 42 CFR 422.166(h)(2) and 423.186(h)(2) to require CMS to provide more data during the preview periods.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** AHIP; The U.S. Chamber of Commerce

Aggregated Comment Title: ***Publish Impact Analyses of Rate Changes and Star Ratings***

Summary: Publish impact analyses of Medicare Parts C and D rate changes and Star Ratings separately by plan profit status and for D-SNPs and integrated D-SNPs. This approach would provide a more detailed assessment of policy impacts on different types of MA plans, helping CMS and stakeholders understand potential consequences and adjust payment systems to better suit specialized plans for high-need populations.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Association for Community Affiliated Plans (ACAP)

Aggregated Comment Title: ***Better Data Standards Will Improve Coordination with Public Health***

Summary: Public health agencies face challenges in receiving data. Evolving standards and organizational implementation in this area requires further maturity and support.

Total Comments Contributing: 2

Total Submissions Contributing: 2

- ***Organization(s):*** Health Level Seven International (HL7); Lantana Consulting Group

Aggregated Comment Title: ***Review Age and BMI Qualifications for THA and TKA***

Summary: CMS should alleviate the age and BMI qualifications for THA and TKA at 42 CFR 412.29(b)(2)(xiii). These qualifications ensure patients with less rehabilitation potential are

accepted, and with these characteristics are unable to tolerate the higher level of therapy provided in the IRF setting.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Physical Therapy Association

Aggregated Comment Title: ***Increase Use of Indemnity Insurance***

Summary: Increase indemnity insurance (rather than Medicare Advantage) to enable flexibilities for providers and transparency for patients.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reform Organ Cost Attribution to Sustain Pediatric Transplant Services***

Summary: CMS should exempt children's hospitals from Medicare-only attribution requirements at 42 CFR 413 and 419 and establish pediatric-specific cost reporting rules for organ procurement. CMS should allow allocation of organ acquisition costs across all payer types for pediatric centers and delay enforcement while updated guidance is developed.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Children's Hospital Association

Aggregated Comment Title: ***Authorize Certified Professionals to Provide Footwear for Diabetic Patients***

Summary: Allow certified individuals to provide footwear for patients with a documented diabetic diagnosis would improve patient outcome and reduce costs for CMS by providing proactive care to the beneficiaries before they have wounds, callouses, or amputations. Furthermore, limiting diabetic footwear care to ABC-certified orthotists and pedorthists helps prevent fraud, waste, and abuse.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** Eastern Michigan University

Aggregated Comment Title: ***Prohibit Piecemeal Prior Authorization and Reimburse Providers for Time Spent***

Summary: Prior authorization should not be necessary for care that aligns with established pathways or guidelines. Prohibiting payers from requiring separate authorizations for individual components of a larger procedure, such as medications or services, would streamline the process. Payers who require prior authorization in these situations but ultimately approve it should reimburse practices for the time spent obtaining approval.

Total Comments Contributing: 2

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require MA Documentation Requirements to Align with Medicare Fee-For-Service***

Summary: CMS should provide clear guidance to Medicare Advantage (MA) plans to align their coverage and documentation requirements with Medicare Fee-for-Service (FFS) and ensure equitable access to care. Consistent application of FFS policies across MA plans is crucial for regulatory consistency and patient care.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Offer Appeals and Grievances Process for DMEPOS Suppliers***

Summary: CMS should offer a Medicare Advantage appeals and grievances process for all DMEPOS suppliers. DMEPOS suppliers should have the opportunity to escalate concerns to CMS. The current methodology of outreach through the Division of Policy, Analysis, and Planning (DPAP) Mailbox has no required response times and does not offer the ability to follow up when the issue has not been addressed.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Prior Authorization Length Should Align With Need***

Summary: A prior authorization length should be consistent with the length of need ordered by the physician, and a length of need of 99 should be considered a lifetime need.

Total Comments Contributing: 2

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare

Aggregated Comment Title: ***Prioritize Patient Self-Care Through Advanced Primary Care Management***

Summary: Prioritize patient self-care strategies and activities to deliver high-quality, patient-centered care through Advanced Primary Care Management (APCM).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Medicare's Dental Coverage Expansion May Impact Dental Benefits***

Summary: The proposed Medicare coverage expansion for dental services related to diabetes treatment is not included in the physician fee schedule, but it is a noteworthy development with potential impacts on beneficiaries and the dental benefits industry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Improve Diabetes Definitions to Help Determine Medically Necessary Dental Care***

Summary: The lack of a clear framework for defining diabetes—such as "controlled" vs. "uncontrolled"—makes it difficult to determine which dental services are medically necessary. Clarifying these definitions is crucial.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Align Coverage with Clinical Standards for Diabetic Periodontal Care***

Summary: Ensure coverage aligns with clinical practices for managing periodontal disease in diabetic patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Establish Guidelines to Prevent Billing Issues for New Services***

Summary: Lack of guidelines may lead to challenges in payment and billing, including navigating complexities in reimbursement processes for new covered services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Dental Plans

Aggregated Comment Title: ***Create a Level Playing Field for Hospitals and Physicians***

Summary: To create a level playing field, hospitals and physicians should have the same conversion factor while allowing for different RVUs and applying consistent rules to both entities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Prohibit Hospitals from Employing Physicians***

Summary: The recommendation is to prohibit hospitals from employing physicians and restoring equal footing between hospitals and doctors, as was the case 30 years ago. This will help reduce CMS costs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Collaborate with Drug Manufacturers on Pricing***

Summary: CMS should collaborate with drug manufacturers to facilitate the reporting of Average Sales Prices (ASP) for new drugs or biologicals (per the CY 2024 Outpatient Prospective Payment System final rule), enabling separate payment based on ASP in upcoming years.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Hospital Association

Aggregated Comment Title: ***Identify and Track Distinct Facility Survey Triggers***

Summary: Distinguish between surveys based on facility-reported incidents or complaints on the Care Compare website.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge

Aggregated Comment Title: ***Modify Personnel Qualifications Under 42 CFR 460.64***

Summary: 42 CFR 460.64 personnel qualifications for direct participant contact may need adjustment to exclude transportation service providers like Uber/Lyft. Excluding them could improve access to health care providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** InnovAge

Aggregated Comment Title: ***Modify PACE Level of Care (LOC) Determination Process***

Summary: Modify the level of care (LOC) determination process from being a State developed process to that of a single model. A singular model creates efficiency and prevents delays in participant access to services by shifting the process from the State to the PACE organization.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** InnovAge

Aggregated Comment Title: ***Do Not Add the Preventive Care and Wellness Composite Measure to MIPS***

Summary: The Preventive Care and Wellness composite measure (QID 497) is not supported and should not be included in traditional MIPS or any Primary Care MIPS Value Pathway (MVP).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***Eliminate Qualified Participants (QPs) Requirements in MIPS***

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

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Academy of Family Physicians

Aggregated Comment Title: ***Permit Customized Intervention Models***

Summary: CMS should permit customized intervention models to enhance efficiency, allowing plans to focus care management resources on beneficiaries who are most likely to benefit, especially in Part D plans.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Prime Therapeutics LLC

Aggregated Comment Title: ***Establish National Standard Health Risk Assessment Tool***

Summary: CMS should establish a national standard Health Risk Assessment (HRA) tool to prevent duplication and avoid conflict between state and federal requirements, especially given the integration requirements in the CY26 Final Rule for applicable integrated plan D-SNPs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UnitedHealthcare

Aggregated Comment Title: ***Provide Guidance for 2026 Participating Group Decisions***

Summary: CMS should provide timely and explicit instructions for 2026 participating group decisions and show flexibility towards ACOs in 2025 and beyond regarding CEHRT compliance, including avoiding all impacts on shared savings and losses.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** America's Physician Groups (APG)

Aggregated Comment Title: ***Provide Detailed Information About HCC Risk Adjustment Model Using MA Encounter Data***

Summary: CMS should provide detailed information on the proposed approach for HCC risk adjustment model using MA encounter data through white papers, diagnosis mapping, and impact simulation models to allow for meaningful feedback and refinement before implementation. Additionally, CMS should begin early sharing of information to provide ample time for review and feedback, rather than waiting for the next year's Advance Notice.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** America's Physician Groups (APG)

Aggregated Comment Title: ***Modify Promoting Interoperability to Provide Positive Incentives***

Summary: CMS should adjust the Promoting Interoperability payment system to reward providers who demonstrate true interoperability by sharing data with public Health Information Exchanges (HIEs) and utilizing high-performance APIs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Extend the Expedited Prescription Determination Review Time***

Summary: Extend the time that plans are permitted to review an expedited prescription determination to the next business day, rather than 24 hours.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield of Massachusetts

Aggregated Comment Title: ***Realign FIDE SNP Policies With State Laws***

Summary: In the 2019 rule, CMS finalized policies that align the requirements for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) with state laws and Medicare-Medicaid coverage integration requirements for Dual Special Needs Plans (D-SNPs). This alignment was emphasized by Congress for D-SNPs, ensuring that benefits are covered, in line with state policies. CMS should rescind the requirement in the 2023 rule and revert to the statute-driven approach of the 2019 rule regarding FIND SNP and state policy alignment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** SCAN Health Plan

Aggregated Comment Title: ***Reinstate Medicaid Behavioral Health Carve-Outs for FIDE SNPs***

Summary: CMS should reinstate its previous policy of allowing Medicaid behavioral health carve-outs for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) in accordance with state policies, as specified in 42 CFR 422.107.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** SCAN Health Plan

Aggregated Comment Title: ***CMS Effectiveness is Questionable***

Summary: A respondent doubts the effectiveness of CMS' practice of utilizing a carrot and stick approach to quality and best practice, offering either penalty protection or reimbursement incentives.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate Measures Under Consideration (MUCs)***

Summary: Eliminate Measures Under Consideration (MUCs).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Eliminate EHRs***

Summary: Eliminate EHRs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Collection of Pediatric Dialysis Information***

Summary: CMS should collaborate with stakeholders to create a more efficient method for gathering precise hospital-based pediatric dialysis data. It is important to gather accurate data for the Transitional Pediatric End-Stage Renal Disease Add-on Payment Adjustment (TPEAPA) to ensure continued financial support for children's hospitals and pediatric dialysis units.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Society of Pediatric Nephrology

Aggregated Comment Title: ***Streamline Therapy Regulations***

Summary: Streamline therapy regulations to permit outpatient visits for homebound patients with non-overlapping care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ohio Hospital Association

Aggregated Comment Title: ***Improve Coordination with SSA***

Summary: Communication issues between CMS and SSA lead to delays in resolving member entitlement and premium issues, potentially leaving them without coverage. Hold plans harmless for governmental issues beyond their control to ensure timely resolution.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Collect and Publish Plan Performance Metrics on Claims Processing***

Summary: CMS should also collect and publish performance metrics such as backlog statistics, average processing times, and denial rates for PA and claims reviews. Standardizing interpretation and enforcement of coverage criteria will promote equity and reduce inefficiencies caused by inconsistent policy implementation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Castle Biosciences Inc

Aggregated Comment Title: ***Publish Review Criteria for MACs***

Summary: CMS should publish clear and comprehensive review criteria for commonly reviewed services that MACs are required to follow.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Castle Biosciences Inc

Aggregated Comment Title: ***Incentivize Comprehensive Medication Review***

Summary: CMS should consider ways to incentivize the provision of the Comprehensive Medication Review (CMR), such as allowing plans to provide gifts in the form of a gift card to patients who complete a CMR each year.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Agadia Systems

Aggregated Comment Title: ***Furnish Standard APIs or Files for Coverage Determination***

Summary: Managing NCD/LCD/MCD policies is a complex and time-consuming task for stakeholders. To streamline this process, providing standard APIs or downloadable tables that can be easily integrated into software platforms is essential. This approach would help reduce costs and manual efforts associated with managing these policies, making the process more efficient and less burdensome for all parties involved.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Agadia Systems

Aggregated Comment Title: ***Medicare Savings Programs***

Summary: Align effective dates for Medicare Savings Programs with Medicare coverage to prevent beneficiaries from experiencing unexpected out-of-pocket costs during transitional periods.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Board for Certified Counselors (NBCC)

Aggregated Comment Title: ***Eliminate Regulations on Sales of Hospice***

Summary: Eliminate restrictions on when a hospice agency can be sold.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Curtail Greed and Waste***

Summary: Curtail corporate greed and focus on improving care while reducing waste.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Expand Scope of Coverage for Mobility Devices***

Summary: Medicare lacks updated policies for younger individuals with mobility deficits. Expand scope to include consideration of functional and community needs for both prosthetics and mobility devices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** MATTERS (Mobility and Assistive Technology: Time for Essential Rights and Services)

Aggregated Comment Title: ***Solicit Input from NCQA on Quality Measures***

Summary: Include consultation from NCQA to promote the efficiency and effectiveness of quality measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Keystone ACO

Aggregated Comment Title: ***Reimburse for Individualized Preventive Services***

Summary: Medicare reimbursement for preventive services, such as individualized social work plans, can enhance patient care by focusing on holistic (rather than acute) health needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Faith Regional

Aggregated Comment Title: ***Enact Compensation Limits***

Summary: Enact compensation limits for medical staffing, such as nurses. This would especially impact high costs due to utilization of travel nursing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Faith Regional

Aggregated Comment Title: ***Require Low Volume CAHs to Convert to REHs***

Summary: Require Critical Access Hospitals (CAHs) with low inpatient volume to transition to Rural Emergency Hospitals (REHs), retaining 2-3 swing beds for patient overflow. This shift would optimize resources by consolidating staff and supplies, potentially reducing healthcare system costs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Faith Regional

Aggregated Comment Title: ***Urinary Drug Testing***

Summary: Remove G0480-G0483 codes and add a single HCPCS code for all drug classes tested during urinary drug testing. Mandate electronic reporting of positive drug tests per beneficiary, per date of service, providing CMS with accurate data to combat over-utilization of higher G codes and improve monitoring of tested beneficiaries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Three Rivers Diagnostics

Aggregated Comment Title: ***Hold Software Companies Financially Accountable for Updates***

Summary: Software companies, not healthcare providers, should bear the cost of updates for software and interoperability in the healthcare industry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Restore MU for Other Healthcare Sectors***

Summary: Restore meaningful use and certifications for various healthcare sectors, including public health, skilled nursing facilities, school clinics, mental health providers, and community-based organizations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Mandate and Fund State-Based Health Data Utilities***

Summary: Mandate and fund the creation of all payors claims databases managed by Health Data Utilities in each state.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Costs of Meaningless Data Submission***

Summary: Reducing the expenses involved in submitting meaningless data would save hospitals, especially rural hospitals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enhance Encounter Claims Data to Reflect More Detail***

Summary: CMS could streamline MA administrative processes by enhancing encounter claims data to capture more detailed information on amounts paid, denied, and recouped by MA plans, as well as more granular service-level data for oversight and audits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** LeadingAge PA

Aggregated Comment Title: ***Explore Opportunities to Use Clearinghouses and Vendors to Connect Systems***

Summary: Explore opportunities to allow clearinghouses and vendors who already have the underlying real-time data to create a new pipeline between a provider's workflow, their claims information, and the government systems.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Availity

Aggregated Comment Title: ***Require Standardized Templates and Timeframes for MA Audits***

Summary: CMS should require MA plans and their vendors to use standardized audit documentation request templates and uniform, reasonable timeframes that provide sufficient time for practices to respond. A more consistent and predictable approach would allow for better workflow integration and reduce unnecessary administrative complexity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Proposed Rule for Electronic Exchange of Data Creates Different Set of Standards***

Summary: The 2022 proposed rule CMS-0053-P would adopt standards to facilitate electronic exchange of clinical data for processing prior authorizations (PAs) and claims adjudication. This rule creates potential duplication with another rule, CMS-0057-F, which mandates different

standards for electronic PAs. If finalized, this could lead to varying standards and workflows for completing the PA process based on health plan types.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Subversive Use of Local Coverage Articles***

Summary: Between 2016 and 2018, regulatory changes enabled coding modifications through local coverage articles (LCAs) instead of local coverage determinations (LCD), which have stricter criteria. This shift has allowed Medicare Administrative Contractors (MACs) to bypass formal LCD processes, implementing coding changes with major implications on Medicare payment and coverage policies without transparency or public notice. Some updates take effect within one business day, imposing burdens on physician practices and potentially compromising patient safety due to lack of clinical oversight for administering complex drugs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Focus on Transition to FHIR dQMs***

Summary: CMS should focus on the transition to FHIR dQMs rather than initially just FHIR eCQMs. This will move everyone further in the journey to digital data and reduced data collection and reporting burden than the proposed phased approach.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Guarantee Uniform Appeal Rights and Suspend Penalties***

Summary: Guarantee uniform, timely appeal rights. Suspend penalties until final adjudication so that physicians are not forced to close doors while contesting allegations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Monitor MA Risk Adjustment Data Validation Program Record Collection***

Summary: CMS should monitor how MA plans delegate Risk Adjustment Data Validation Program related record collection responsibilities to providers. Plans should ensure that record requests align with network agreements and be transparent about the use of third-party vendors.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish Best Practices or Guardrails to Ease Burden***

Summary: CMS should consider establishing best practices or guardrails (e.g., limiting repeated documentation requests for the same patient within a defined audit window, monitoring overall request volumes to individual providers, etc.) to reduce unnecessary administrative burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Association

Aggregated Comment Title: ***Many Measures Are Not Endorsed by Consensus-Based Entity***

Summary: The Secretary is required to select quality measures endorsed by a consensus-based (CBE) entity under section 1886 of the SSA, with exceptions for areas where endorsed measures are not available. However, many quality measures proposed by CMS are not endorsed by the CBE, contrary to congressional intent that this should be the exception rather than the norm.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Select Medical Holdings Corporation

Aggregated Comment Title: ***Mental Health Coding Definitions are Confusing***

Summary: The definitions of Place of Service coding for outpatient mental health are confusing and should be more specific for 02 and 10.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Remove Mandate for X12 275 Standard***

Summary: The CMS-0053 rule finalized in 2024 emphasizes the importance of claims attachments and supporting documentation in healthcare workflows. However, the requirement to adopt a specific standard like X12 275 may hinder progress due to evolving technology and industry practices. By allowing multi-use solutions instead of a one-off standard, CMS can reduce provider burden, lower costs, and support healthcare IT modernization in line with broader goals of administrative simplification and value-based care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Blue Cross Blue Shield Association

Aggregated Comment Title: ***Empower Front Line Staff With Technology***

Summary: Utilizing technology like telemedicine, AI, and LLMs and empowering front-line care teams to bill directly for chronic disease services allows clinicians to work at their full capacity, reducing burden and improving patient care by involving various healthcare professionals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Helmsley Trust

Aggregated Comment Title: ***Embrace Direct Contracting***

Summary: CMS should embrace direct contracting, which empowers physicians to assume risk, manage care efficiently, and enhance access by minimizing payer involvement, ultimately streamlining healthcare delivery.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Helmsley Trust

Aggregated Comment Title: ***Align Performance Measures with Current Standards of Care***

Summary: Performance measures for chronic disease in value-based care models should align with standard of care technologies like continuous glucose monitoring (CGM).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Shift Responsibility for Interoperability Compliance to EHR Vendors***

Summary: Shift interoperability compliance responsibility to EHR vendors, rather than hospitals and providers, as they create interfaces and should handle regulatory obligations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Prohibit "Deny and Delay" Tactics***

Summary: Prohibit inappropriate “deny and delay” tactics by payers. These practices harm patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require Payers to Share Quality Data***

Summary: Require payers to share quality data with facilities to facilitate population health efforts.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***CMS Should Approve Marketing Materials***

Summary: CMS should manage approvals for marketing materials and online plan information for brokers and technology companies, bypassing the need for individual Medicare Advantage carriers' approval. The current process essentially grants carriers veto power over the content.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Memoir, Inc. d/b/a Chapter

Aggregated Comment Title: ***Allow Part D Plans and PBMs to Use Formularies to Control Costs***

Summary: CMS should, wherever possible, remove restrictions that hamper the ability of Part D plans and their PBMs to fully utilize formularies to control drug costs and promote more cost-effective drug utilization.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Pharmaceutical Care Management Association (PCMA)

Aggregated Comment Title: ***Prioritize FHIR-Based Data Exchange for Public Health Reporting***

Summary: CMS should prioritize and support the adoption of FHIR-based data exchange at state level public health reporting, health information exchange (HIE) systems for real-time, API-based data exchange. This will reduce custom/legacy formats for different systems and drive the national adoption of interoperable data exchange for quality measurements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Adopt Monitor, Evaluate, Assess, Treat Framework for HCC Documentation***

Summary: Adopt Monitor, Evaluate, Assess, Treat (MEAT) framework universally for Hierarchical Condition Category (HCC) documentation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Ban Ambiguous Shorthand***

Summary: CMS should ban ambiguous shorthand. Require full-text entries for diagnoses and procedures to avoid misinterpretation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Microsoft

Aggregated Comment Title: ***Existing Standards and Simplification Efforts Lack Meaningful Enforcement***

Summary: Key healthcare initiatives like HIPAA Administrative Simplification and standards such as EDI, UB-04, and CMS-1500 forms have been successful, but challenges remain due to the lack of enforcement and inadequate penalties for non-compliance. This hinders consistency and interoperability in the healthcare industry.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Using SSI to Identify Dual-Eligible Beneficiaries is Flawed***

Summary: Using Supplemental Security Income (SSI) as a measure to identify dual-eligible beneficiaries is flawed as many Medicare beneficiaries eligible for Medicaid do not receive SSI due to eligibility complexities, state-specific rules, or personal choice. This leads to an underrepresentation of low-income, high-need patients in hospitals, particularly in safety-net and rural areas. The current methodology fails to accurately capture the true extent of the population in need of assistance.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Healthcare Financial Management Association

Aggregated Comment Title: ***Provide Report for All Drug Products to Aid in Post-Market Optimization***

Summary: CMS should offer an annual, detailed report covering all products, including those not eligible for refunds under the discarded drug program or with zero refund amounts, to assist manufacturers in making informed decisions regarding post-market optimization of drug vials or packaging in line with the Program's objectives.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johnson & Johnson

Aggregated Comment Title: ***Adjust Medicare Advantage Coding Requirements***

Summary: Require Medicare Advantage plans to provide home visit and consultation reports documenting any coding adjustments or medical determinations to both patients and primary care providers to reduce the administrative burden on providers who run into coding adjustments they were not made aware of. Additionally, this transparency would reduce overpayments resulting from upcoding.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require MA Plans to Pay Providers within 30 Days***

Summary: Medicare Advantage payments to providers should be subject to a 30-day payment requirement to prevent delays.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Medicare Advantage is Unsustainable***

Summary: Medicare Advantage is a vital program, but it is unsustainable without proactive reforms to rein in overpayments while boosting transparency, competition, and choice.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Patient Access to Data***

Summary: Develop a system that allows patients to access their own health information data (e.g., claims, prior authorization decisions).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Commitment

Aggregated Comment Title: ***Eliminate Transplant Waitlist Measures***

Summary: Remove transplant waitlist measures from End Stage Renal Disease (ESRD) quality programs as they better reflect transplant centers than dialysis facilities, which lack control over hospital waitlist criteria.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Kidney Care Partners

Aggregated Comment Title: ***Do Not Rescind NCD 40.2***

Summary: NCD 40.2 is a necessary regulation, as it constrains unnecessary device prescriptions that would drive up costs without proven benefits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Enact Positive Pay Adjustments for Reporting***

Summary: Enact positive (rather than negative) pay adjustments for compliance and/or achievement in reporting, especially for Ambulatory Surgical Centers (ASCs).

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Seaford Endoscopy Center

Aggregated Comment Title: ***Increase Access to Information on Diagnostic Testing***

Summary: Enable access to MolDx evaluation, which provides information on a lab's location, region-specific LCD guidelines, standard costs, and approved test details, which can be unclear from test names that may change frequently, such as genetic tests.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Increase Flexibilities for Healthy Benefit Awards***

Summary: Allow plan members to use their Healthy Benefit Awards for fresh produce, in addition to OTC items.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Permit Services From Clinicians Outside of the US & Territories***

Summary: Permit clinicians trained and credentialed in the United States (US) to provide Medicare services for procedures performed in the US, even if they are located outside the US Territories, as long as they meet the same standards. For example, radiologists who trained and credentialed in the US, but reside outside of the US.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** University Radiology Group

Aggregated Comment Title: ***Promote Deinstitutionalization***

Summary: Promote deinstitutionalization of nursing homes to align with CMS regulations and National Quality Strategy Goals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Redesign the QIO Program***

Summary: Redesign QIOs (Quality Improvement Organizations) to educate nursing homes on compliance practices that improve health outcomes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Edu-Catering: Catering Education for Compliance and Culture Change

Aggregated Comment Title: ***Enhance Customer Service for Providers***

Summary: Provide customer service support by phone, so providers can get their questions answered.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Include All Screening Tests in CRC Measure***

Summary: CMS and NCQA should collaborate to include all FDA-authorized, Medicare-covered screening tests in Colorectal Cancer (CRC) quality measures for CMS programs, ensuring comprehensive CRC screening coverage.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Guardant Health

Aggregated Comment Title: ***Publicize Medicare Advantage Coverage Criteria***

Summary: CMS should require MA organizations to publicly display coverage criteria in standardized, machine-readable formats that are easily accessible to clinicians and providers, including integration into claims documents.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Medical Informatics Association

Aggregated Comment Title: ***Tactics to Address Nationwide Shortage of Caregivers***

Summary: CMS should work with states to establish national standards for non-physician practitioners and invest in medical training to address the nationwide shortage of caregivers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** BJC Health System

Aggregated Comment Title: ***Delay Mandatory eCQM Reporting for ACOs***

Summary: There is support for H.R. 483, the Health Care Efficiency Through Flexibility Act, which would delay mandatory eCQM reporting for Accountable Care Organizations (ACOs) until January 1, 2030. Until these standards are finalized and implemented, ACOs should be allowed to continue using existing reporting mechanisms without penalty.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** VillageMD

Aggregated Comment Title: ***Reward Early Adopters of Digital Reporting Standards***

Summary: It is crucial to reward early adopters who have invested resources in complying with digital reporting standards to encourage innovation and ensure a smooth transition to more efficient and equitable quality reporting systems. Recognizing and incentivizing these providers will help drive progress and support the development of scalable and fair reporting practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** VillageMD

Aggregated Comment Title: ***Create Master List of Required Data Elements***

Summary: CMS should create a "master list" of required data elements so that hospitals can avoid duplication of efforts in data extraction and formatting data to meet the various reporting requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Danaher Diagnostics

Aggregated Comment Title: ***Retroactive Process for Entities to Identify 340B Drugs***

Summary: To enhance flexibility, consider allowing retroactive identification of 340B drugs. The current process of determining if a prescription should be filled with a 340B drug is complex and data-heavy, often impossible at the point of sale. Implementing point-of-sale identification for 340B drugs is challenging as it would necessitate pharmacies to resubmit incorrectly classified claims, resulting in heightened administrative tasks.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Lack of Mechanism for Professional Dispensing Fee***

Summary: The lack of a defined mechanism for setting a fair professional dispensing fee (PDF) in statutes, regulations, or guidance raises concerns about the economic impact on independent pharmacies, especially those within health centers. This absence of clarity could have detrimental effects on these businesses. CMS should pursue regulations setting fair PDFs, reflecting the cost of dispensing, or adding to the Drug Price Negotiation Program Complaint and Dispute Intake Form a section allowing the dispensers to file grievances related to unfairly low PDFs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Community Health Centers (NACHC)

Aggregated Comment Title: ***Adopt the Improving Seniors' Timely Access to Care Act***

Summary: CMS should adopt key provisions of the Improving Seniors' Timely Access to Care Act, such as real-time automated approvals and enhanced transparency reporting.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** UltraSight Inc.

Aggregated Comment Title: ***Clarify Distinction Between CoPs and AO-Specific Standards***

Summary: CMS can alleviate burden on physicians and their practices by assisting Accreditation Organizations (AOs) in applying the conditions of participation (CoPs) as intended. By clearly distinguishing between CoPs and standards specific to AOs, CMS can reduce confusion among providers, allowing them to focus on meeting patient needs rather than on requirements that exceed Medicare's standards and do not enhance patient care. Furthermore, the CoPs should be finalized as the baseline standards for accreditation and ensure AOs clearly separate any additional requirements that go beyond Medicare's conditions when seeking approval for deeming authority.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Society of Anesthesiologists

Aggregated Comment Title: ***Give CMS Clinical Outcomes Data to Clinical Data Registries***

Summary: CMS should provide clinical data registries with access to cloud-based CMS data on clinical outcomes and other measures at little to no cost. Such an action would provide clinical data registries with the data necessary to develop robust risk-adjusted outcome metrics which will improve clinical care and ensure prioritization of measures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Society of Anesthesiologists

Aggregated Comment Title: ***Expand the Scope of HHA Staffing***

Summary: Expand the scope of staffing in home health agencies (HHAs) by including other licensed para-professionals like EMTs and non-licensed clinical personnel such as Medical Assistants in the billable clinical team, with an aim to increase staffing options and patient access to care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Health Services of the Pacific

Aggregated Comment Title: ***Involve Clinical Staff in Reporting Activities***

Summary: Involve clinical staff (e.g., CRNAs) in committees and boards that oversee reporting and documentation activities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Mechanical Lifts and Teen Workers***

Summary: OSHA's restriction on 16- and 17-year-old workers operating mechanical lifts causes scheduling inefficiencies and delays in care, as providers need 18+ staff to operate lifts. This impacts resident mobility assistance and highlights the importance of teenage workers in addressing staffing shortages.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Vivie

Aggregated Comment Title: ***Review Guidance Processes for Clarity and Statutory Authority***

Summary: CMS should review its use of informal guidance like MLN articles and FAQs as an enforcement tool for compliance which may venture beyond statutory authority. CMS should clarify policies that have legal force, establish transparent procedures for incorporating informal guidance, and ensure consistency to protect providers from retroactive enforcement of new interpretations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Sutter Health

Aggregated Comment Title: ***Add Qualitative Data to Patient Experience Surveys***

Summary: Adding narrative item sets to CAHPS surveys enhances patient feedback by incorporating qualitative comments alongside quantitative data. CMS should expand this approach to all patient experience surveys for a more comprehensive understanding of healthcare quality.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Patient Experience Policy Forum - The Beryl Institute

Aggregated Comment Title: ***Enable Retrospective Adjustments***

Summary: Utilize retrospective adjustments to budget neutrality offsets and prevent unjustified fee schedule cuts by CMS due to overestimated utilization. This will ensure fairness for services like Transitional Care Management (TCM) or G2211.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Organization of Rheumatology Management

Aggregated Comment Title: ***Reimbursement for Biosimilars***

Summary: Reimburse for biosimilars under WAC+3% until ASPs stabilize and exclude rebates from ASP calculations to address pricing issues and ensure sustainable levels for biosimilar products.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Organization of Rheumatology Management

Aggregated Comment Title: ***Allow Hospitals to Choose a MAC***

Summary: Allow hospitals to choose a different MAC.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Illinois Health and Hospital Association

Aggregated Comment Title: ***Require Price Information from Manufacturers***

Summary: Manufacturers must disclose pricing details to enable CMS to calculate average sales prices accurately.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Illinois Health and Hospital Association

Aggregated Comment Title: ***Avoid Redundancies with OSHA***

Summary: Create alignment between OSHA, State laws, and CMS requirements. Avoid implementing redundant Occupational Safety and Health Administration workplace violence regulations for hospitals to prevent additional administrative burdens due to existing rigorous accreditation requirements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Varying Denial and Appeals Processes Create Burden***

Summary: Chapter 13 of the Medicare Managed Care Manual governing denial and appeals processes creates administrative burden due to inconsistencies and lack of transparency. Claim denial standards differ between Medicare fee-for-service and Medicare Advantage, creating confusion for providers and unequal access for beneficiaries receiving the same Medicare benefit.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Update Critical Access Hospital Criteria to Reflect Current Rural Healthcare Delivery***

Summary: Update the Critical Access Hospital (CAH) criteria established under Section 402 of the Balanced Budget Act of 1997 to better align with modern rural healthcare needs. The current standards do not account for changes in demographics, technology, telemedicine, and patient care models. By making the criteria more flexible, community-oriented, and responsive to current healthcare practices, rural hospitals can maintain essential services and improve financial sustainability.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Automation Adoption Considerations***

Summary: Automating processes to reduce administrative burden is crucial, but adoption will vary among facilities based on factors like facility type, such as academic medical center versus a free-standing rural hospital. CMS should support both manual and automated processes during the transition period to ensure smooth implementation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Require Universal Access to Payer Portals***

Summary: Non-contracted providers face challenges accessing the provider portals for certain Medicare Advantage plans, hindering efficiency and patient care. CMS should require universal access to payer portals, even for non-contracted providers, to streamline administrative processes and improve patient clearance procedures.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The University of Texas MD Anderson Cancer Center

Aggregated Comment Title: ***Approve C-SNP MOCs for Three-Year Period***

Summary: The federal government pays the National Committee for Quality Assurance (NCQA) to review all Models of Care (MOCs). If C-SNP MOCs were approved for a three-year period, the NCQA would review fewer MOCs, and the government would pay for fewer reviews.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Devoted Health

Aggregated Comment Title: ***Extend Termination Period for Out-of-Service Area Moves***

Summary: Currently, plans must terminate a member at the end of the month they report an out-of-service area address change, leading to a tight timeframe for submitting a new application and causing gaps in coverage. To address this issue, CMS should extend the termination period to the end of the second month, providing members with more time to secure coverage and reducing the burden of acting quickly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Delay Implementation of the Health Equity Index for Star Ratings***

Summary: CMS should delay the implementation of the Health Equity Index (HEI) for the 2027 Star Ratings due to concerns about the rushed timeline and lack of critical information provided to plans. Pausing implementation until at least two years of plan-level data are available would allow plans to adequately respond and prepare. A delay would give CMS and plans time to assess the impact of HEI on plans and beneficiaries and ensure alignment with policy objectives.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Humana

Aggregated Comment Title: ***Revisit TBC and OOPC Model Timing***

Summary: The timing of the parameter release for Total Beneficiary Costs (TBC) / Out-of-Pocket Cost (OOPC) Model is unduly burdensome and should be revisited by CMS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Launch USPSTF Pilot Program Focused on HIV/STI Prevention***

Summary: CMS should initiate a pilot program for automatic U.S. Preventive Services Task Force (USPSTF) Grade A adoption, focusing on HIV/STI prevention services to streamline implementation and address critical public health needs promptly. The pilot aims would automatically implement Grade A recommendations within 60 days, measuring success through reduced administrative costs, improved beneficiary access, provider satisfaction, and program integrity. If successful, this approach could potentially extend to other preventive service areas.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Impacts of Removing Requirements for Collecting Demographic Data***

Summary: If CMS removes the requirement for collecting demographic data, consider also removing the screening for geriatric-specific social vulnerabilities, such as economic insecurity, caregiver stress, and elder abuse.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Limit Homecare Agencies***

Summary: Limit the number of home health or hospice agencies that can operate within a given geographic area.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Create New Modern Safety Requirements***

Summary: CMS should enhance existing Conditions of Participation (CoPs) by introducing a new requirement for hospitals and health systems to implement advanced safety detection systems, such as real-time AI surveillance of clinical data and patient-accessible harm reporting systems. By incorporating patient-reported data into root cause analyses and harm response protocols, this approach would improve awareness, response time, and accountability without adding administrative burden.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Patients For Patient Safety US

Aggregated Comment Title: ***Overarching Goal of Reducing Preventable Patient Harm***

Summary: CMS should align deregulatory strategies with the overarching goal of reducing preventable patient harm. Modernize regulations to reduce inefficiencies, not by cutting essential programs but by reinvesting in tools that improve patient safety and system performance, emphasizing patient involvement and data transparency in all CMS reforms.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Patients For Patient Safety US

Aggregated Comment Title: ***Maintain the Hospital Readmissions Reduction Program***

Summary: Performance in the Readmissions Reduction Program (HRRP) has not “topped out.” The measure should be improved, for example, by adding Excess Days in Acute Care (EDAC) to better address gaming through observation status.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Patients For Patient Safety US

Aggregated Comment Title: ***Revisit Burdensome AI Transparency Provisions***

Summary: CMS and HHS should review the AI transparency provisions outlined in the ONC/ASTP's final rule (89 FR 3910, Jan. 2024), because of concerns about premature and burdensome reporting requirements that do not align with current standards or follow a risk-based framework. These provisions may duplicate existing federal and state oversight efforts, prompting a need for reassessment by HHS and CMS.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Special Needs Plan Alliance

Aggregated Comment Title: ***Automate Medical Necessity Evaluation***

Summary: Automate medical necessity evaluation using rigorous development and testing with in-house clinical experts. Utilize comprehensive longitudinal patient profiles and a combination of deterministic and predictive models to enhance accuracy and efficiency in evaluating medical necessity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Strategies for Bias Identification and Mitigation in Automation***

Summary: To identify and mitigate bias, regular manual audits and a monitoring system are implemented to flag irregularities within specific groups for investigation by data scientists, clinical experts, and compliance teams. This approach ensures that potential biases related to high-risk cohorts or protected classes are promptly addressed through thorough analysis and corrective actions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Performance Monitoring Recommendations for Machine Learning***

Summary: Real-time performance monitoring is crucial for high-volume, low-latency machine learning systems to maintain reliability and scalability. By regularly scanning models for data availability, drift, bias, and irregular performance indicators, this monitoring system ensures prompt investigation and correction of any issues, such as out-of-class or out-of-distribution data.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Concentrate Prior Authorizations on Areas of Inappropriate Utilization***

Summary: Rather than exclusively focusing on limiting the number of codes on a prior authorization list, a more substantial opportunity exists. The most effective method to mitigate provider abrasion involves concentrating oversight on areas within the code set where inappropriate utilization most frequently occurs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Limit New Regulations to Replacement of Existing Rules***

Summary: Limit new regulations to only replacement of existing rules, maintaining a capitalist approach in their implementation, and considering the impact on smaller, provider-sponsored Medicare plans facing significant financial burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Johns Hopkins Health Plans

Aggregated Comment Title: ***Grant Specialty Societies and QCDRs Greater Access to Medicare Claims Data***

Summary: Collaborating with Congress to grant specialty societies and Qualified Clinical Data Registries (QCDRs) enhanced access to Medicare claims data, as outlined in MACRA, will enable these organizations to support CMS in achieving MIPS objectives more effectively. This will also lead to a streamlined administration of the program.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Alliance of Specialty Medicine

Aggregated Comment Title: ***Notice of Proposed Rulemaking Enables Input***

Summary: When CMS proposals impact various stakeholders and could be contentious, a Notice of Proposed Rulemaking is ideal for soliciting extensive public feedback and ensuring transparency.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Costly Impacts Due to Fragmented A/B MAC Model***

Summary: The fragmented A/B MAC model creates costly impacts that didn't exist when identifying questionable provider behavior and implementing suspensions for continued payments was consolidated under the former Medicare FI/Carrier contracts.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Diversified Service Options, Inc., dba GuideWell Source (Including First Coast Service Options and Novitas Solutions, Inc.)

Aggregated Comment Title: ***Centralize LCD Development for Consistency and Engagement***

Summary: CMS should establish a centralized, standardized process for developing LCDs across multiple MACs. This would ensure consistency in policy implementation and claim processing through utilization of a centralized Fraud Prevention System and creating a collaborative platform for stakeholder engagement.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Ensure Fair Hospital Wage Data Reporting***

Summary: Hospital wage data plays a crucial role in post-acute care reimbursement, but hospitals' ability to reclassify can lead to inaccuracies that disadvantage SNFs, hospice, and home health agencies. CMS should implement safeguards to ensure accurate wage data reflects true local labor costs for fair payments to all providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Remove Limitations on Reporting for Smaller Practices***

Summary: Remove limitations so that quality measure reporting is inclusive to allow full participation and credit for all practices, including smaller, specialized ones.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***End MIPS Penalties for Past Deficits***

Summary: Stop penalizing groups in MIPS due to issues such as lacking a reporting track record; or past failures under different management. This change would ensure fair evaluation and prevent unwarranted penalties.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Excel Anesthesia, LLC

Aggregated Comment Title: ***MA Plans Should be Transparent About Contract Negotiations***

Summary: CMS should require that Medicare Advantage (MA) programs notify members of ongoing negotiations with hospitals and other providers during open enrollment to ensure continuity of care. This would enable beneficiaries to make an informed decision.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Halt the Use of Patient Safety Indicators Derived From Claims Data***

Summary: Halt use of Patient Safety Indicators (PSIs) derived from administrative claims data, which are often inaccurate, poorly risk-adjusted, and prone to penalizing appropriate care. Many PSIs reflect documentation practices or case mix complexity rather than actual safety events, making them unfit for regulatory use. If not removed entirely, their use should be restricted to well-validated indicators that clearly represent preventable harm.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Ascension

Aggregated Comment Title: ***Small and Rural Providers Struggle to Meet Data Reporting Requirements***

Summary: Small and rural providers, Federally Qualified Health Centers (FQHCs) and Critical Access Hospitals (CAHs) often lack the staff and infrastructure to meet complex data reporting requirements. While CMS has provided some hardship exceptions, these are temporary and require repeat applications for continued coverage.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CGI Federal Inc.

Aggregated Comment Title: ***Revise Level 3 Appeals Process to Improve Efficiency***

Summary: CMS should revert level 3 appeals back to Medicare Appeals System (MAS) from Electronic Case Adjudication and Processing Environment (ECAPE) to enhance efficiency, centralize reporting, reduce processing times, benefit Medicare beneficiaries and providers, and save $5.3M annually in redundant ECAPE-related costs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CGI Federal Inc.

Aggregated Comment Title: ***Streamline Medicare Advantage Plan-Specific Trainings***

Summary: Explore replacing multiple managed care plan-specific trainings with a single standardized training module that providers can attest to completing.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The Ohio State University Wexner Medical Center

Aggregated Comment Title: ***Waive MSSP Telehealth Requirements for Risk Models***

Summary: CMS should waive Medicare Shared Savings Program payment and program requirements to allow for one-sided and two-sided risk models under a waiver of telehealth restrictions.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Increase Transparency for MA Enrollment***

Summary: Medicare Advantage (MA) plans should offer transparency comparable to Medicare fee-for-service (FFS) for dialysis patients. CMS should publish detailed MA ESRD enrollment data to support patients and providers to make informed healthcare choices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Nonprofit Kidney Care Alliance

Aggregated Comment Title: ***Require CMS to Offer Notice and Comment Opportunity***

Summary: CMS could offer a notice and comment period for any proposals outlined in the 2026 MA and Part D proposed rule that CMS plans to finalize.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AHIP

Aggregated Comment Title: ***Mandate Separate NPIs for Off-Campus Provider-Based Outpatient Departments***

Summary: Hospitals billing for services under the Outpatient Prospective Payment System as provider-based departments must adhere to 42 CFR 413.65 to receive higher Medicare reimbursement. To improve monitoring and transparency, CMS should mandate separate National Provider Identifiers (NPIs) for off-campus provider-based outpatient departments. This approach simplifies compliance monitoring for CMS and private payers, enhances cost transparency for patients, and empowers them to make informed decisions about their care providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** AHIP

Aggregated Comment Title: ***HPSA-Based Prioritization***

Summary: CMS should remove the additional HPSA-based prioritization in all categories and adopt a more straightforward, statute-based system going forward

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Hackensack Meridian Health

Aggregated Comment Title: ***Reverse Clinical Labor Cuts***

Summary: Reverse the clinical labor cuts enacted in 2022, as they were financially devastating for many practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Retractions and Corrections to Datafiles and Transmittals***

Summary: Accurate data files from CMS are crucial for informing the provider community about payment and coding systems. Recent upticks in corrections and retractions cause rework for vendors and providers. It is important for CMS to prioritize accuracy, clearly note changes, and avoid backdating updates to prevent confusion and ensure stakeholders can stay current with policy documentation.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Panacea Healthcare Solutions

Aggregated Comment Title: ***Align Employment Definitions with ACA***

Summary: Define full-time employment as 30 hours or more per week and part-time employment as fewer than 30 hours per week under §483.60(a)(1)–(2). This change aims to align CMS definitions with ACA standards, provide consistency in federal regulations, and offer long-term care facilities flexibility in addressing staffing challenges.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** CCL Hospitality Group

Aggregated Comment Title: ***Do Not Use Commercial Insurance Data for Determining HHA Reimbursement***

Summary: CMS should not use commercial insurance data on length of stay and utilization for home health agencies to justify reimbursement reductions for Medicare patients. This is not an equivalent comparison.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Compassion Home Health

Aggregated Comment Title: ***Compensate Providers for Time Spent on Medicare Advantage Appeals***

Summary: Medicare Advantage plans should compensate healthcare providers for time spent on prior authorizations and fighting denials.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Riverside Eye Center

Aggregated Comment Title: ***Reward High-Quality Care to Outweigh Sequestration***

Summary: Reward for high-quality care should equal or exceed reductions from sequestration.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Riverside Eye Center

Aggregated Comment Title: ***Revise 3-Day Rule to Allow SNF Stays After Observation***

Summary: Revise the 3-day rule, aligning Medicare with managed care policies to allow skilled nursing facility (SNF) stays following observation periods.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***Create a More User-Friendly CMS Portal***

Summary: Redesign CMS portals to be more user-friendly by creating intuitive navigation and improving error handling.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Christian Living Communities / Cappella Living Solutions

Aggregated Comment Title: ***The Red Hand Discourages Reporting of Abuse Allegation***

Summary: The Red Hand currently is a disincentive to report allegations. As a result, many choose not to report. A recent study found that facilities reported only 14% of over 8,000 abuse citations nationwide leaving 86% of abuse allegations discovered by surveyors were not reported by the facilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Incentivize Facilities that Appropriately Report Abuse or Neglect***

Summary: The Red Hand should be reserved for facilities that fail to report abuse or neglect. Facilities that report and address issues appropriately should have their plans reviewed by surveyors, be acknowledged, and thanked for handling the situation correctly.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Martha T. Berry Medical Care Facility, Macomb County Michigan

Aggregated Comment Title: ***Invest in Developing Block Chain Technology to Enhance Fraud Detection***

Summary: To combat fraud, CMA should invest in developing its own blockchain technology and fraud detection systems.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Maintain Three Year Accreditation Frequency to Reduce Employee Burden***

Summary: Changing the accreditation frequency from every 3 years to every year will significantly increase the workload for providers, requiring more time and effort to prepare forms and evaluations for approval by the accreditation agency before their in-person survey. This adjustment will place a heavy demand on already overworked employees.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** F B Thomas Drug Store Inc.

Aggregated Comment Title: ***Reduce Burden by Reducing Beneficiary Scams***

Summary: Reducing call centers and regulating unethical agents or brokers would significantly decrease administrative burdens and excessive data entry caused by frequent beneficiary scams, particularly in which a beneficiary undergoes the onerous enrollment process multiple times.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Physician Input is Critical in Prior Authorizations***

Summary: AI can assist in reviewing prior authorizations, but physician input is crucial for decision-making. This process needs guardrails to ensure physicians remain the primary decision-makers in patient care. CMS should mandate that physicians maintain clinical oversight of prior authorizations.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Expand Part B Cost Sharing Waivers***

Summary: Primary care services play a crucial role in maintaining health and reducing healthcare costs. The Part B cost-sharing waiver in ACO REACH is a valuable tool to improve access to primary care, especially for those lacking support for Part B coinsurance. CMS should make this waiver a permanent feature across their programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Expand In-Home Care***

Summary: CMS should expand care beyond traditional home health services. Facilitating direct in-home patient visits for preventive and primary care services will improve access for all patients, especially those with transportation challenges.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Applicability of TCPA to Text Messages***

Summary: It is uncertain whether the Telephone Consumer Protection Act (TCPA) applies to text messages from healthcare providers to patients. CMS should offer clear guidance stating that the TCPA does not apply in this context to address this lack of clarity.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Centralize Data Collection and Validation***

Summary: CMS should centralize data collection and validation for Medicare to enhance efficiency.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Lumeris Healthcare

Aggregated Comment Title: ***Allow HIDE SNPs to Offer one Plan Benefit Package***

Summary: MA organizations with HIDE SNPs should be allowed to offer a single Plan Benefit Package for full-benefit duals in Medicaid FFS to ensure care coordination and continuity. Concerns exist that restricting enrollment to beneficiaries in companion Medicaid MCOs may hinder dually eligible beneficiaries from joining HIDE SNPs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Association for Community Affiliated Plans (ACAP)

Aggregated Comment Title: ***Reconsider Burdensome 2026 MA and Part D Rules***

Summary: The proposed 2026 Medicare Advantage and Part D rule introduces new policies such as expanded prior authorization requirements, enhanced oversight of AI applications, and revisions to the Star Ratings program, which could significantly burden plans and providers. The lack of comprehensive analysis on the practical impact raises concerns about potential barriers to care delivery and innovation. To address these issues, CMS should delay finalizing these proposals and conducts a detailed regulatory analysis to assess the operational and financial implications for all stakeholders involved.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** The U.S. Chamber of Commerce

Aggregated Comment Title: ***Waive MSSP and CMMI Models to Increase APM Participation***

Summary: The Medicare Shared Savings Program (MSSP) and CMMI models should also make use of waivers, both to enhance care quality and to provide further incentives for providers to participate in advanced alternative payment models (A-APMs).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Pilot and Support Innovative DME Delivery Models***

Summary: CMS should pilot and support innovative models of Durable Medical Equipment (DME) delivery that prioritize person-centered care, reduce avoidable institutionalization, and align with the goals of value-based care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Aeroflow Health

Aggregated Comment Title: ***Allow APPs to Satisfy Hospital On-Call Obligations***

Summary: Under 42 CFR 489.20, hospitals must maintain an on-call list of physicians available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions. Allowing advanced practice providers (APPs) to also satisfy a hospital's on-call obligations would allow greater availability of specialty services, particularly when physician resources are limited within communities or specialties.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Provide Flexibility for Interhospital Transfer Under EMTALA***

Summary: EMTALA regulations limit health systems from triaging patients based on acuity and complexity among different hospitals, leading to capacity issues. Allow hospitals to transfer stable patients within the same system for better resource management and care allocation, benefiting patients with various medical needs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Mayo Clinic

Aggregated Comment Title: ***Eliminate Hospice Carve-Out for Medicare Advantage***

Summary: CMS should eliminate the MA carve-out for hospice benefits.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Essentia Health

Aggregated Comment Title: ***Support Therapies for Maximum Recovery***

Summary: CMS should allow for continuation of therapies until the patient achieves maximum recovery, particularly post-stroke. Encouraging and supporting patients as long as they show improvement is essential.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Make Enrolling in Medicare More Attractive to Providers***

Summary: Medicare lacks sufficient provider participation, leading to inadequate care for beneficiaries. Redirect funds to private insurance companies for better administration and care access and leverage existing provider networks and rates. This will reduce burden and improve the experience for provider experience.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Place of Peace Counseling Center

Aggregated Comment Title: ***Implement Fixed Inflation Adjustments to Payments***

Summary: To avoid the need for frequent votes on inflation adjustments to Medicare rates, implement a fixed inflation adjustment based on official economic calculations. This will ensure stability and prevent payment cuts to providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Place of Peace Counseling Center

Aggregated Comment Title: ***Provide IRFs with Flexible Payment Options***

Summary: CMS should offer Independent Rehabilitation Facilities (IRFs) the choice of a discount to standard payment or increased risk assumption for cases discharged from acute care hospitals in CMMI bundling programs.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Federation of American Hospitals

Aggregated Comment Title: ***Offer IRFs Access to PRRB***

Summary: CMS should allow Inpatient Rehabilitation Facilities (IRFs) access to the Provider Reimbursement Review Board (PRRB) process for Low-Income Patient (LIP) appeals.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Federation of American Hospitals

Aggregated Comment Title: ***Disseminate Information on Interoperability***

Summary: Government agencies, including CMS, need to enhance the communication of public information on interoperability requirements, like transmitting electronic summaries during care transitions, to improve accessibility and understanding for stakeholders.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Health Level Seven International (HL7)

Aggregated Comment Title: ***Send QPP Incentives Directly to the NPI***

Summary: CMS sends QPP payments for providers as a lump sum to the billing organization closest to the APM Entity Group, causing administrative burden. Payments should go directly to the NPI earning the incentive to streamline the process.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Henry Ford Health

Aggregated Comment Title: ***Allow Hospital Staff to Provide Services Outside of the Hospital***

Summary: Extending Medicare regulations to permit hospital and contracted staff to deliver care management services outside of the hospital setting, similar to the exception for tele-mental health services provided from providers' homes.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Premier Inc

Aggregated Comment Title: ***Medicare Processes and Reporting Are Necessary***

Summary: All Medicare required administrative process and reporting requirements are necessary to ensure that providers are supplying American taxpayers, the federal government and beneficiaries with high quality services without waste, fraud and abuse.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** National Association of Local Long Term Care Ombudsman (NALLTCO)

Aggregated Comment Title: ***End Blanket CMS Reimbursements for Non-Payment***

Summary: Hospitals are under scrutiny for exploiting Medicare reimbursements for charitable assistance and patient non-payment. Ending blanket CMS reimbursements for non-payment and tying reimbursements to hospitals' charitable care provision could ensure funds go to charitable providers for actual care and incentivize hospitals to offer more charitable services to vulnerable patients.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Consumer Action for a Strong Econmy

Aggregated Comment Title: ***Limit Impact of Price Control Program***

Summary: The CMS price controls are set to reduce funding incentives by removing the ability to generate revenue. CMS should find ways to pause this program or mitigate its negative effects on our innovation pipeline.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Consumer Action for a Strong Econmy

Aggregated Comment Title: ***Exemption to the 60-Day Claims Processing Requirement***

Summary: CMS should allow an exemption to the 60-day claim processing requirement for alleged fraud, waste or abuse.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Revise Staff Turnover Measure***

Summary: Revise the staff turnover measure to accommodate extended leave periods exceeding 12 weeks, including FMLA and Maternity Leave, to ensure accurate tracking of turnover rates.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Prohibit MA from Publicly Traded Insurance Companies***

Summary: Prohibit Medicare Advantage plans from companies that are publicly traded.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Hands of Wellness

Aggregated Comment Title: ***Revise Rules on Coverage Gap Discount Programs for Small Businesses***

Summary: CMS has introduced the Medicare Part D Manufacturer Discount Program in compliance with the Inflation Reduction Act, but its implementation poses challenges for small innovative companies. The program's guidelines create obstacles for companies that acquire others with existing agreements, leading to the revocation of small manufacturer status. This policy contradicts the program's intent and unfairly impacts small biotech innovators.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Impacts of Mergers and Acquisitions on Medicare Participation***

Summary: In terms of participation, Medicare should enhance its understanding of corporate merger and acquisition transactions, particularly in the biotech and pharmaceutical industries, considering factors like simultaneous acquisitions and the impact on companies without Medicare agreements acquiring those with existing agreements.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Do Not Require Participation in Clinical Trials or Registries***

Summary: In accordance with federal law, do not require Medicare beneficiaries to participate in clinical trials or registries.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Add Additional Restraint Exemptions to Death Reporting***

Summary: Current death reporting rules exempt two-point soft restraints. CMS should expand the exemption to include all non-restrictive, non-lethal restraint types that pose no increased risk, such as mittens and enclosure beds.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Redirecting Non-Emergent Chronic Conditions***

Summary: Hospitals need clearer guidance on referring stable chronic disease cases to urgent care or primary care after an appropriate medical screening examination (MSE).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Global Discrimination Against Americans in Drug Pricing***

Summary: Address global discrimination against Americans in drug pricing by viewing it as unfair trade practices that affect pharmaceutical costs in government programs like Medicare and employer-based coverage.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Allow Plans to Conduct Prior Authorization for Out-of-Network Services***

Summary: Allow plans to conduct prior authorization for PPO members when seeking care from an out-of-network provider. Prior authorization allows plans to ensure members receive necessary, high-quality care likely to improve their condition.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Point32Health

Aggregated Comment Title: ***Allow Health Plans Exceptions to Continue Without Meaningful Change***

Summary: Once CMS approves an exception, health plans should be allowed to maintain it as long as there are no significant changes in their network or provider market. This approach would cut down on administrative costs for insurers and the federal government, ultimately lowering the total cost of care. Additionally, it would ensure that members do not lose access to their current health plan.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Point32Health

Aggregated Comment Title: ***Adopt a Flexible, Outcomes Based Approach***

Summary: To improve healthcare outcomes, a flexible, outcomes-based approach is recommended over rigid rules by focusing on patient results rather than strict compliance. This strategy allows providers to choose the most effective technologies and processes to achieve desired outcomes. For example, in telemedicine, CMS could prioritize access and quality measures like patient satisfaction and reduced hospitalizations, rather than specific platform requirements or usage quotas.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Massachusetts Health Data Consortium

Aggregated Comment Title: ***Increase Funding to Help Physicians Adopt Telehealth***

Summary: CMS should increase funding opportunities to help physicians embrace telehealth platforms, which would reduce burden on independent provider practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Physicians Advocacy Institute

Aggregated Comment Title: ***Increase Funding to Help Physicians Expand Operational Capabilities***

Summary: CMS should increase funding opportunities to help physicians expand operational capabilities, which would reduce burden on independent provider practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Physicians Advocacy Institute

Aggregated Comment Title: ***Prioritize Payment Reform to Prevent Physician Attrition***

Summary: Research indicates payment cuts drive physicians from private practice. CMS, Congress, and DOJ should prioritize payment reforms to protect physician-led practices in Medicare, particularly in urban and rural areas facing access challenges.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Physicians Advocacy Institute

Aggregated Comment Title: ***Conditions of Participation and Pediatric Care***

Summary: Children's hospitals adhere to the Medicare Conditions of Participation (CoPs) at 42 CFR 482 to maintain safe and high-quality care standards, but these requirements are primarily designed for adult hospitals. CoPs may not fully address the unique clinical, operational, and developmental needs of pediatric care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Children's Hospital Association

Aggregated Comment Title: ***Align Standards for Non-Covered Services***

Summary: To improve alignment between Medicare and Medicare Advantage plan requirements, align standards for non-covered services.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Policy-Related Technology Infrastructure***

Summary: Improving CMS's technology infrastructure is essential, as current systems do not promptly reflect new policy implementations. This delay hampers staff's ability to complete necessary tasks, extends time on tasks, and diverts time away from patient care.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Improve Workflows for TPE Audits***

Summary: Improve workflows for Targeted Probe and Educate (TPE) audits by ensuring the process is consistent, structured, and provides adequate follow-up education to facilitate improvements. These changes can help reduce administrative burdens.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Maintain Consistent Criteria for Inpatient-Only Rules***

Summary: To improve alignment between Medicare and Medicare Advantage plan requirements, CMS should maintain consistent criteria for inpatient-only rules.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Require Code First Notes for IPF Claims***

Summary: To improve alignment between Medicare and Medicare Advantage requirements, CMS should require Medicare Advantage plans to utilize code first notes for inpatient psychiatric facility (IPF) claims paid under the Inpatient Prospective Payment System (IPPS).

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Establish an Emergency Process for Electronic Data Interchange Enrollment***

Summary: CMS should establish an emergency process that can be deployed during a significant cyberattack or other debilitating event and expedite EDI enrollment.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** WEDI

Aggregated Comment Title: ***Professional Organizations Set Standards of Care for Persons with Disabilities***

Summary: Collaborating with professional organizations like The Clinician Task Force, APTA, AOTA, NCART, NRRTS, and RESNA can help in setting standards for providing the best care to individuals with disabilities.

Total Comments Contributing: 1

Total Submissions Contributing: 1

Aggregated Comment Title: ***Reduce Provider and Patient Burden with Certified O&P Professionals***

Summary: Certified prosthetists and orthotists managing evaluations and treatment plans reduce the workload for providers, patients, and physicians.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** Eastern Michigan University

Aggregated Comment Title: ***Limit Data Collection From Manufacturers to Prevent Duplication for Part D***

Summary: CMS should collect the least amount of data required to prevent duplication, focusing on Part D claims-level data elements for non-340B dispensers. Manufacturers should not require additional data from 340B covered entities, as individual de-duplication plans could burden hospitals and hinder access to lower prices. Allowing retrospective submission of 340B claims data to the Medicare Transaction Facilitator (MTF) and utilizing it to prevent duplication could streamline processes and reduce barriers for providers.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** 340B Health

Aggregated Comment Title: ***Consolidate ASC Four Sub-Safe Harbors***

Summary: CMS should streamline the ASC safe-harbor regulations at 42 CFR 1001.952(r) by consolidating the four sub-safe harbors into a single safe harbor for investment returns paid to referral-source investors in ASCs. A single structure would simplify compliance and still protect against fraud and abuse.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Gastroenterology (ACG)

Aggregated Comment Title: ***Update Cost Assumptions for Promoting Interoperability***

Summary: CMS estimates the Promoting Interoperability cost at $287 per clinician, but small practices face higher expenses for electronic health record implementation and upkeep. Cloud-based systems range from $100 to $600 per provider monthly, while on-premises solutions demand significant upfront payments. CMS should revise its cost projections to reflect the actual financial burden on small practices.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American College of Gastroenterology (ACG)

Aggregated Comment Title: ***MA Plans Should Establish "Same and Similar" Portal for DMEPOS***

Summary: CMS should require Medicare Advantage plans to create a "same and similar" portal for DMEPOS suppliers to check MA enrollees' eligibility for specific items, aligning with traditional Medicare standards. This system would prevent duplicate orders and ensure coverage for newly requested DMEPOS items.

Total Comments Contributing: 1

Total Submissions Contributing: 1

- ***Organization(s):*** American Association for Homecare