HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

January 27, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8013
Baltimore, MD 21244-8013

The Healthcare Business Management Association (HBMA) is pleased to submit this response to the Centers for Medicare and Medicaid Services (CMS) Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P).

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

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

Medicare Advantage (MA) is one of the top sources of administrative burdens for RCM companies and medical practices. Their low reimbursement rates, overzealous prior authorization, and unfair networking practices all add avoidable strain to the healthcare system and disrupt care for patients. Meanwhile, MA plans reap enormous profits while clinicians struggle with inadequate reimbursement rates.

These problems are exacerbated by the fact that MA covers more than half of all Medicare beneficiaries. MA was designed to be a private version of traditional Medicare. However, the current state of MA shows a marked departure from the traditional Medicare program.

HBMA is broadly supportive of CMS' proposals. Our letter further articulates our views on the proposed rule and makes recommendations for how CMS can strengthen key provisions of the proposed rule.

Prior Authorization

HBMA supports CMS' proposals to further limit how MA plans can use prior authorization. We also urge CMS to consider other actions that go beyond what is proposed.

Prior authorization is among the largest administrative burdens for medical practices. MA plans are among the most frequent utilizers of prior authorization. Further, their use of prior authorization does not align with how traditional Medicare uses prior authorization and other program integrity policies.

Traditional Medicare uses prior authorization very selectively with the goal of targeting the highest-risk items and services. MA plans use prior authorization for a huge list of items and services. Most MA prior authorization requests are approved, meaning that MA plans fail to adequately target them to the providers or services where it would be most beneficial. As CMS acknowledges in the proposed rule, over 80% of requests that are not approved are overturned (and therefore approved) after appeal. This is another example of health plans making providers go through unnecessary steps to receive payments for medically necessary services.

What's more, prior authorization is not a guarantee of payment. Health plans frequently still deny payment for the claim even if prior authorization was approved for the item or service. We encourage CMS to collect data from health plans on how often this occurs.

We appreciate CMS reiterating in the proposed rule that MA plans must align with traditional Medicare's national and local coverage policies. We also support CMS' proposal to increase transparency and clarify how MA plans can use internal coverage criteria to set their own coverage policies.

Inconsistent coverage policies among payers, especially among the two types of Medicare coverage, create huge burdens for the RCM industry that must keep track of and implement different coding, documentation and other administrative policies for the same item or service.

We support CMS' proposal to increase transparency around how MA plans use prior authorization. This information will certainly help inform new policymaking.

We urge CMS to go further than what was proposed. MA is intended to be a private version of traditional Medicare. It is essential that MA remain aligned with traditional Medicare on coverage policies. With MA plans covering over half of all Medicare beneficiaries, it is critically important that the Medicare program asserts its control over how MA beneficiaries access care. Therefore, MA plans should be restricted to only requiring prior authorization for the same items and services for which traditional Medicare has a prior authorization requirement.

Provider Directories

HBMA supports CMS' proposal to add MA plan directories to the Medicare Plan Finder website. This will provide important transparency to beneficiaries who are considering choosing an MA plan while also holding MA plans accountable for the accuracy of their networks.

We strongly encourage CMS to aggressively enforce these requirements on health plans.

We also urge CMS to collect data from these directories to track the adequacy of MA plan networks. Many of our members have observed MA plans dropping providers and health systems from their networks. Similarly, we have seen providers not renew contracts with MA plans because of inadequate reimbursement rates and administrative burdens such as prior authorization.

Network transparency is important for beneficiaries. However, we also emphasize the need for CMS to ensure that networks are adequate. MA plans must provide an attractive network option for participating clinicians by paying adequate reimbursement rates and not imposing burdensome administrative requirements such as prior authorization.

Artificial Intelligence

HBMA has major concerns about how MA plans use artificial intelligence (AI) to adjudicate and deny claims and prior authorization requests. CMS allows MA plans to use AI in claim determinations, but those determinations must be based on individual factors and cannot discriminate or create inequitable coverage.

It is clear that AI has led to more denials and more care disruptions for patients. CMS must curtail the ability of health plans to use AI until more stringent guard rails can be created.

Conclusion

Thank you again for your consideration of our recommendations. Please do not hesitate to contact HBMA Director of Government Affairs Matt Reiter (reiterm@capitolassociates.com) or HBMA Executive Director Brad Lund (brad@hbma.org) if you wish to discuss our comments in more detail.

Sincerely,

Krik Reinitz
President
Healthcare Business Management Association