

June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Attention: RFI E.O. 14192
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Administrator Oz:

The Healthcare Financial Management Association (HFMA) would like to thank CMS for the opportunity to submit recommendations pertaining to the Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192)- Request for Information. HFMA is a professional organization of more than 135,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA and our members would like to begin with stating our support of the agency's interests in reducing the costly private healthcare expenditures required to comply with Federal regulations through streamlining regulatory requirements, reducing administrative burden of reporting and documentation, identifying and reducing duplicative requirements and other additional recommendations to reduce administrative burden in healthcare.

On January 31, 2025, President Trump issued Executive Order (EO) 14192 "Unleashing Prosperity Through Deregulation," (<https://www.whitehouse.gov/presidentialactions/2025/01/unleashing-prosperity-through-deregulation/>), which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. The Centers for Medicare & Medicaid Services (CMS) is issuing this Request for Information (RFI) to solicit public feedback for potential changes to Medicare regulations, with the goal of reducing the costly private healthcare expenditures required to comply with Federal regulations.

Through this RFI, CMS seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, Medicare Advantage and Part D plans, and other stakeholders participating in the Medicare program. In line with ongoing efforts to reduce unnecessary administrative burdens and costs, and create a more efficient healthcare system, CMS requests information to better understand any challenges to identify opportunities for deregulation, while also ensuring the continued delivery of high-quality care to beneficiaries. CMS is

seeking specific information from healthcare providers, researchers, stakeholders, health and drug plans, and other members of the public to inform the development and implementation of strategies to support the goals of the Executive Order.

HFMA respectfully submits the following considerations to CMS for consideration under the topics of: Streamlining Regulatory Requirements, Opportunities to Reduce Administrative Burden of Reporting and Documentation, Identification of Duplicative Requirements and Additional Recommendations.

Enforce a Uniform Set of Claim Submission and Information Requirements for Healthcare Payment

HFMA respectfully urges CMS to establish and enforce a modern standardized set of claim submission and information requirements applicable to all payers—including Medicaid and private health insurers—for the payment of healthcare services.

Rationale for Reform

Despite the success and significance of key initiatives and oversight—such as the HIPAA Administrative Simplification standards, electronic data interchange (EDI) standards, the NUBC’s stewardship of the UB-04 claim form and revenue codes for institutional providers, and the NUCC’s maintenance of the CMS-1500 form and associated data elements for professional claims—critical challenges persist:

1. **Inconsistent Adoption Across Payers**
Medicaid programs and private insurers vary widely in their adoption of standardized requirements, leading to manual, duplicative systems, and inconsistent expectations.
2. **Weak Enforcement Mechanisms**
Existing standards lack meaningful enforcement. Inadequate penalties contribute to non-compliance and undermine consistency and interoperability.
3. **Waste and Inefficiency from Multiple Standards**
Providers and payers must navigate different systems, workflows, rules, and payer-specific knowledge to receive payment for the same service—adding administrative burden, delays, and unnecessary cost.
4. **Increased Risk of Improper Payment**
Disparate billing requirements increase the likelihood of errors, unintentional denials, and inappropriate payments due to misunderstanding complex and conflicting payer rules.

Recommendation

We respectfully recommend that CMS update and enforce a single, national standard for claims submission and required information across Medicaid and private payers.

Adopting and enforcing a unified standard would:

- **Reduce administrative burden for providers and payers by simplifying billing systems and reducing manual, duplicative processes.**
- **Improve payment integrity by aligning audit criteria and minimizing opportunities for fraud and abuse.**

- **Enhance patient experience by streamlining prior authorizations, care coordination, and billing—ultimately improving access to timely and affordable care.**

On behalf of HFMA, I respectfully submit this comment urging CMS to modernize and improve the accuracy of the Medicare Disproportionate Share Hospital (DSH) adjustment calculation by eliminating the use of Supplemental Security Income (SSI) eligibility as a factor and replacing it with Medicare-Medicaid crossover data to identify dual-eligible patients.

Current Requirement

Under 42 CFR § 412.106(b)(2), CMS currently uses the percentage of a hospital's Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits to calculate the Medicare DSH adjustment. The formula incorporates:

"...the number of patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits (excluding Medicare Advantage enrollees), divided by the total number of Medicare Part A patient days..."

This SSI ratio is a key input in the "empirical DSH" calculation.

Rationale for Reform

While the original intent of using SSI data was to capture a hospital's burden of caring for low-income Medicare beneficiaries, we believe this method has become increasingly outdated, administratively burdensome, and misaligned with the real patient population hospitals serve. Several challenges justify reconsideration:

1. Inaccurate and Incomplete Proxy for Dual Eligibility

- SSI is a poor proxy for identifying dual-eligible beneficiaries. Many Medicare beneficiaries who qualify for Medicaid do not apply for or receive SSI due to eligibility complexities, state-specific rules, or personal choice.
- As a result, the current methodology underrepresents the actual number of low-income, high-need patients hospitals serve, especially in safety-net and rural communities.

2. Timing and Availability Issues

- Hospitals are not provided their actual SSI ratios at the time of cost report submission, leading to inaccuracies in DSH projections and policy planning.
- This lack of data also contributes to delays in Medicare Administrative Contractor (MAC) final settlements, affecting financial forecasting and operational stability for providers.

3. Crossover Data Offers a More Accurate and Timelier Alternative

- Medicare-Medicaid crossover claims data—available to CMS and state Medicaid agencies—provides a timely and more precise indicator of dual eligibility.
- Crossover status directly reflects a patient's active Medicare and Medicaid entitlement at the time of service, removing the ambiguity of SSI participation and the timing disconnect from annual CMS data releases.

Recommendation

We respectfully request that CMS consider updating the DSH policy under 42 CFR § 412.106 to replace the use of SSI-based ratios with Medicare-Medicaid crossover population data. Doing so would:

- **Improve the accuracy and fairness of the DSH payment methodology.**
- **Reduce administrative delays in cost report finalization.**

- **Better align with current data availability and interoperability goals**
- **Ensure a more equitable distribution of DSH payments that reflects the real-world burden of uncompensated care and social risk.**

Request to Update Capitalization Threshold for Hospitals in Medicare Cost Reporting Regulations

On behalf of the Healthcare Financial Management Association (HFMA), I respectfully submit this comment requesting that CMS update the longstanding capitalization policy threshold set in Medicare cost reporting instructions, raising the allowable minimum capitalization amount from \$5,000 to \$10,000, consistent with more recent updates to federal acquisition guidance issued by the Office of Management and Budget (OMB).

Current CMS Capitalization Policy

Under current CMS policy, hospitals are expected to capitalize assets with an acquisition cost of \$5,000 or more in accordance with Medicare Provider Reimbursement Manual guidance (CMS Pub. 15-1, Chapter 1 §106). This standard is also reflected in cost report instructions and embedded in provider audit practices. Any deviation from this threshold may result in adjustments during audits or require additional disclosures and cost reclassifications.

Additionally, Critical Access Hospitals (CAHs) must report changes in capitalization policy in Worksheet S-2, Part II, Line 27 of CMS Form 2552-10, and Skilled Nursing Facilities (SNFs) may face rate-setting implications due to the capital add-on component in their per diem reimbursement model.

Rationale for Modernization

The current \$5,000 threshold was established decades ago and does not reflect modern market realities, inflationary pressures, or current federal standards. Specifically:

In 2022, OMB revised its Uniform Guidance (2 CFR § 200.1) to reflect a \$10,000 capitalization threshold for equipment purchases in federal awards.

Many hospitals and health systems have already adopted a \$10,000 threshold internally for consistency with OMB guidance, resulting in misalignment with CMS cost reporting rules and potential audit exposure that increase administrative burden on auditors and hospitals.

Requiring providers to track capitalizable items below \$10,000 results in significant administrative burden, including maintaining dual tracking systems, manual reclassifications, and reconciliation efforts during year-end reporting.

For CAHs, failure to align with CMS's outdated threshold can result in the need to adjust reported operating expenses, even when the cost is appropriately expensed under federal accounting standards. These adjustments not only add administrative complexity but also can delay cost report settlement and create inconsistency in audits.

For SNFs, increasing the capitalization threshold could affect the treatment of costs that would otherwise be included in the capital rate component, though this is mitigated by the fact that capital add-ons are not subject to state-set operating cost ceilings.

Request

HFMA urges CMS to consider revising 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 revision would: Reduce unnecessary

administrative and audit burden, promote alignment between CMS and other federal agencies, reflect the inflation-adjusted reality of medical and IT equipment purchases, avoid penalizing providers for following updated federal financial standards, enable CAHs and SNFs to more accurately reflect true operating and capital costs in Medicare cost reports.

Request to suspend Medicare Administrative Contractor (MAC) retroactive recoveries of nursing and allied health education program funding.

On behalf of the Healthcare Financial Management Association (HFMA), I respectfully urge CMS to issue a formal directive instructing all Medicare Administrative Contractors (MACs) to cease and desist from applying increasingly strict and improper interpretations of the qualification requirements for nursing and allied health educational programs.

Recent MAC audit practices have resulted in aggressive and, in many cases, unsupported challenges regarding hospitals' legal authority to operate these programs and the eligibility of pass-through costs. These actions undermine long-standing program integrity and create unnecessary administrative and financial risk for hospitals in clear conflict with established Medicare policy and legal precedent.

Current Environment

MACs are auditing providers for accounting practices that have long been accepted, re-examining cost reports, and seeking to recoup previously approved pass-through payments now deemed ineligible—targeting critical nursing and allied health educational programs at a time when the healthcare workforce faces severe shortages in these fields.

More recently, MACs have begun relying on new or stricter interpretations not clearly defined in regulation. Courts have found such interpretations unreliable in some cases; for example, in *William Beaumont Hosp.-Royal Oak v. Price*, a federal court declined to defer to a MAC's narrower reading of program requirements.

Further compounding the issue, OIG reports have documented instances where MACs have miscoded or improperly reviewed allied health expenses, at times misclassifying costs between nursing and allied health programs—resulting in substantial overpayments and subsequent recoupments that jeopardize the financial stability of these essential educational efforts.

Recommendation

Given the extreme urgency of this issue, particularly in light of the widespread healthcare staffing shortages across many regions of the United States, HFMA strongly urges the agency to take prompt action. We respectfully request that CMS direct all MACs to immediately suspend retroactive recoveries related to nursing and allied health education program funding until further regulatory guidance can be issued to hospitals—ensuring consistent and transparent interpretation of the qualification requirements for these vital programs.

Request to Remove the Contracted Therapy Cap Calculations (Worksheet A83) For Critical Access Hospitals

On behalf of the Healthcare Financial Management Association (HFMA), I respectfully submit this comment requesting that CMS remove the current requirement for Critical Access Hospitals (CAHs) to complete Worksheet A-83, which requires detailed reporting of contracted therapy cap calculations as

part of the Medicare cost report.

Current Requirement

Worksheet A-83, as described in CMS Form 2552-10 (Medicare Cost Report for Hospitals), is used to report therapy services provided under arrangements, specifically to calculate the therapy cap limit for costs associated with contract labor. As detailed in CMS Pub. 15-2 Chapter 40, providers are required to report:

- Total hours worked by contracted therapy staff.
- Weeks worked during the cost reporting period.
- Number of days on-site
- Categorization of services by therapist, therapy assistant, and therapy supervisor
- For multiple therapy disciplines, including Physical Therapy (PT), Occupational Therapy (OT), Speech-Language Pathology (SLP), and Respiratory Therapy (RT)

This requirement is currently applied uniformly to all hospital providers, including CAHs.

Burden on Critical Access Hospitals

While we understand that CMS uses this data to validate the reasonableness of contracted therapy costs and prevent cost report inflation, the requirement imposes a disproportionate administrative burden on CAHs—many of which operate with limited finance and IT resources. In particular:

- CAHs often outsource therapy services through flat-rate or bundled contracts, without day-to-day access to individual therapist-level hours or schedules.
- Reconstructing this data retroactively requires significant manual effort and frequent outreach to third-party vendors, which strains administrative capacity.
- The information collected has limited impact on CMS's ability to assess costs under the CAH cost-based reimbursement model, which already requires direct cost reporting for services under arrangements in Worksheet A, Lines 73–76.

The complexity of Worksheet A-83 not only contributes to delays in cost report completion and final settlement but also diverts resources away from operational improvement and patient care delivery.

Recommendation

HFMA respectfully recommends that CMS eliminate the Worksheet A-83 requirement for CAHs, or, at a minimum, provide a regulatory exemption for CAHs that utilize flat-fee or non-productivity-based therapy contracts. This recommendation aligns with CMS's ongoing efforts to reduce provider burden, as outlined in the "Patients Over Paperwork" initiative and recent rulemaking related to Medicare cost report simplification. This adjustment would not compromise CMS's ability to ensure cost reasonableness but would provide meaningful relief to rural providers, consistent with the agency's commitment to supporting healthcare delivery in underserved communities.

Request to Modernize and Improve the Accuracy of the Medicare Disproportionate Share Hospital Adjustment Calculation

Currently, as per CMS's proposed remedy, hospitals find themselves in a challenging position when it comes to MA plan 340B reimbursement for the period of 2018- September 2022. Hospitals not only have to take matters into their own hands when pursuing the 340B underpayments from MA plans but also face the daunting possibility of having to pay an additional estimated \$7 billion through a proposed

“budget neutrality” offsets on top of the initial unlawful billions that was originally underpaid by FFS and MA combined.

The situation is of utmost importance, and the financial implications are substantial, placing a significant burden on hospitals.

Therefore, it becomes paramount for HHS to address this shortcoming in the final rule.

HHS should assert its MA plan oversight authority and require MA payers to promptly reimburse hospitals and providers for the MA portion of the 340B underpayment covering the period from 2018 to September 2022, in a single comprehensive disbursement. Furthermore, the agency should ensure the exclusion of any "budget-neutrality" adjustment from being transmitted via the outpatient prospective payment reduction, thus preventing its incorporation into private negotiated MA plan contracts spanning from 2025 through 2041.

Sincerely,



Richard L. Gundling, FHFMA, CMA
Senior Vice President, Professional Practice
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 100,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant and consultant.

HFMA is a nonpartisan professional practice organization. As part of its education, information and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices and standards.