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PUBLIC COMMENT

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Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Current Procedural Terminology (CPT) Request for Information (RFI)

Comments prepared by Turquoise Health

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Introduction

Turquoise Health (Turquoise) thanks the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (the Departments) for the opportunity to publicly comment on Current Procedural Terminology (CPT) and viable open-license alternatives to national coding sets.

Summary

Turquoise's responses focus on the CPT coding system and the AMA process. Our answers point to the following themes:

1. Proprietary coding standards are a crucial source of the financial complexity plaguing American healthcare billing, and they also stifle innovation. The result is a system that forces claims through multiple overlapping, incompatible code sets (CPT, HCPCS, ICD-10-PCS, ICD-10-CM) never designed with billing in mind.
2. Turquoise built its Standard Service Package (SSP) methodology and Open Payment System specifically to address this fragmentation, and we point to our experiences building and honing an open license code set throughout our responses.
3. **Ultimately, whatever code set or bundling methodology CMS determines will govern physician payment, regardless of who builds or administers it, should be open license**. Closed and gated systems are the root cause of the cost, opacity, and the inability for patients to understand their cost of care.

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H. Current Procedural Terminology (CPT) Request for Information (RFI)

RFI Preamble

> Given these longstanding concerns, we are seeking comment on a number of areas regarding the influence of the CPT® coding system and AMA process on physician payment policy as part of the Secretarial priority to Make America Healthy Again.

Turquoise Response

Turquoise agrees that proprietary coding systems are not a sustainable approach to eliminating the financial complexity of healthcare and contribute to the opacity and confusion that currently plagues providers, payers, employers, and patients alike. As a privatized standard rather than an open one, CPT built a structural flaw into the core of American healthcare billing. When the AMA published CPT in 1966 and it later merged with the government's HCPCS system in 1983, the actual billing code at the heart of every healthcare claim became intellectual property rather than functioning as a shared public utility. That closed-license status meant every software vendor, hospital, and payer had to work within a system no one could freely inspect, improve, or build alternatives to. CPT sits alongside three other overlapping code sets (HCPCS, ICD-10-PCS, and ICD-10-CM), and each covers different elements of a claim. Notably, though, none were designed for billing. ICD in particular was built for population health and mortality tracking, not payment. Thus, claims end up translated through multiple incompatible coding sets before any human or technology can determine what is actually owed. The result is a system that requires an entire licensed profession of medical coders just to navigate. That system is also marked by opaque underlying bill logic, not because healthcare is inherently that complex, but because the code set governing it was closed off from the start.

Turquoise supports open innovation that has the ability to transform healthcare similar to progress in other industries. Our response to the government's previous calls to innovation has been to create a Standard Service Package (SSP) methodology and Open Payment System built specifically because the closed nature of existing code sets and grouping systems makes it structurally difficult for the market to build accurate and scalable patient-facing pricing tools. Those code sets and systems go beyond just CPT and include the broader ecosystem of proprietary episode groupers such as MS-DRG, APR-DRG, EAPG, and others.

Our comments are predicated on our foundational belief that whatever code set or grouping methodology governs healthcare payments going forward, from any developer, existing organization, or new innovation or requirement, should be open license. In our experience, closed licensing and gated, proprietary frameworks are the root cause of the fragmentation, cost, and innovation drag the Departments are seeking to remedy, regardless of which organization holds the license.

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Turquoise Response to RFI Questions

Question 1

> What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA's monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.

We focus our response on the harms and challenges associated with the lack of price transparency caused, in part, by CPT licensure. Patients are often unable to determine the cost of their care, either from their healthcare provider, insurance provider, or acting on their own intending to pay in cash. That price opacity is frequently cited alongside high healthcare costs as a barrier to timely care.

The creation of hospital machine-readable files (MRFs) is another specific challenge. The chargemaster (CDM) that underlies hospital billing already fragments a single encounter into dozens of granular, code-specific line items maintained independently by each hospital. Layering a licensed, closed code set on top of that fragmentation means every entity trying to build an accurate and consumer-friendly patient estimate tool has to separately license CPT before it can even begin normalizing the data. That is a harmful pay-to-play requirement for innovation that adds a cost and legal dependency to the starting line of any new pricing or estimate product.

The ongoing CPT licensing cost is borne by every innovator and startup that touches a CPT code, and **it's a cost with no clinical benefit attached.** CMS can use the ICD-10-PCS and CM code sets as successful alternatives, which are maintained by the WHO as an open standard. Our response to Question 5 includes more detail on this topic. As a result, software developers worldwide have built directly on ICD-10 without a licensing gate, which is part of why ICD adoption has scaled globally in a way CPT has not.

A comprehensive transition from CPT to any open-source alternative must be a meticulous process. The solution is not as simple as a 1:1 switch from a CPT code to an ICD-10-PCS code, given the differences in specificity of the two code sets. Thus, any open-source solution must be built to

1. codify the clinical complexity that exists in patient care, and
2. reliably utilize codes to indicate differences in reimbursement.

CMS should carefully vet any open-source coding system to ensure it is adaptable enough to provide the right level of granularity for care and contracting.

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Question 3

> A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?

This is the core question, and the Turquoise answer is the same regardless of which entity CMS looks to to maintain code sets: **the standard should be open license.** CMS does not necessarily need to name a single successor code set in regulation. Given that 45 CFR § 162.1002(a)(5) is a regulatory designation rather than a statutory mandate, CMS has room to define the requirement at the level of licensing terms (open, royalty-free, freely implementable) rather than naming one proprietary product as the sole legal standard.

An alternative does exist in the Turquoise SSP library as one example of what private-sector competition might resemble. The terms of engagement must be openly published packages compatible with existing transaction standards that any organization can implement without a licensing agreement.

We urge CMS not to read "private competition" as an invitation for a new closed, proprietary code set to simply replace CPT under different ownership. That would exacerbate all of the problems raised in Question 1. The fix is not picking a new winner. Instead, it's requiring whatever code set or bundling methodology CMS relies on for payment purposes be openly licensed, so the market (Turquoise included) can build on it without a toll booth in the middle.

Regarding legal standard, we note that viable alternatives must be HIPAA-compliant solutions that are coded, billed, and adjudicated through the standard electronic data interchange (EDI) process. As the RFI states, "There is no specification in the HIPAA statute regarding the manner in which these national coding sets may be used or how they may be combined, and only HHS interpretation, not the Act itself, mentions CPT®." CMS can and should consider publicly naming their selected open source coding sets to ensure healthcare transactions continue between providers, payers, clearinghouses, EMRs, and patient portals.

Question 4

> What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?

A core structural issue with the RUC committee processes, as the RFI noted, is that specialty societies with a direct financial stake in the outcome are the primary source of the valuation

inputs CMS relies on. The SSP pricing methodology suggests a partial alternative of pricing sub-packages using observed case rates, negotiated rate distributions across a large sample of encounters, and reimbursement variance thresholds.

Sub-variants within an SSP are anchored on clinical similarity and defined in consumer-friendly terms, which we define as the minimum differentiation a patient can reasonably know before receiving care. Our goal is to align reimbursement to those axes and to minimize post-care reimbursement changes beyond those driven by unplanned emergency or adverse events. This approach means we do not need to rely on a single specialty-society survey process.

Any alternative valuation process should be built on a similar transparent, claims-based benchmarking, checked against real-world price variance rather than self-reported time or intensity estimates. An open process is inherently more auditable and less exposed to any legitimate conflict of interest concerns. **Whether administered by CMS directly, by an independent body, or by multiple competing organizations, the key design requirement should once again be transparency. The inputs, methodology, and resulting valuations should be publicly inspectable and not proprietary to whichever committee produces them.**

Question 5

> What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification? What other alternatives exist for bundling or grouping procedural services?

One immediate benefit, which we mentioned in a previous response, is that ICD-10-PCS and CM are maintained by the WHO as open, license-free standards. We believe that is a major reason why global implementation and tooling have successfully scaled.

Historically, prospective payment groupers built on top of open code sets like 3M's MS-DRGs have still ended up privately owned and patent-protected in their grouping logic, even when the underlying codes were open. That is the same problem CPT has, just one layer down. If CMS wants to avoid recreating the fragmentation and licensing-cost issues raised in Question 1, the ICD-10 PCS grouping methodology itself, not just the underlying code set, needs to remain open and license-free as it exists today.

Turquoise's SSP consolidation logic (claims-driven sub-package formation, clinical validation, then open publication) is relevant as a proof of concept that an open, auditable bundling methodology is buildable at scale. We support CMS holding any bundling approach, from any source, to that same openness standard.

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Conclusion

Across all five areas raised in the RFI, Turquoise's answer is consistent: transparent and open license code sets should be the future standard of the healthcare transaction. CMS should not spend time identifying a new winner to replace the AMA and should instead require that any code set, valuation process, or bundling methodology CMS relies on for payment be open, auditable, and free of licensing gates.

We fully support and appreciate CMS's willingness to revisit these longstanding structural questions and welcome the opportunity to provide further detail on the SSP methodology or Open Payment System as CMS considers next steps.

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