April 8, 2013

The Honorable Secretary Kathleen Sebelius  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201


Dear Secretary Sebelius:

The Medical Group Management Association (MGMA) is pleased to provide comments on the proposed rule “Medicare and Medicaid Program; Part II – Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction” as issued in the Federal Register on Feb. 7, 2013. MGMA is strongly in favor of the Department of Health and Human Services’ (HHS’) and the administration’s efforts to identify and eliminate obsolete or burdensome rules. MGMA is pleased that the department recognizes the significant amount of regulatory burdens placed on physicians and practices. However, this regulation misses a critical opportunity to eliminate and streamline a myriad of regulations that pose significant burdens on physicians and medical practices.

Administrative burdens from many different parts of HHS create considerable time and resource constraints for medical practices that should spend their time focusing on providing high-quality patient care rather than focusing their limited resources on complying with administrative requirements posed by the government. We understand that this regulatory relief effort will continue, and as such, we are submitting comments on key areas of concern for medical group practices. While these areas are not specifically addressed in the proposed rule, we urge HHS to consider these changes in the final rule or as part of future regulatory relief rules.

MGMA, founded in 1926, is the nation’s principal voice for medical group practices. The Association’s nearly 22,500 members manage and lead 13,700 organizations, in which 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. MGMA’s core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians’ time and resources.

Suggested regulations for review

MGMA submitted comments in June 2011 on regulatory requirements that the agency should revise, as well as formal comments in December 2011 in response to the proposed part one regulatory relief rule. It is crucial to our nation’s healthcare system that we continually evaluate regulations to ensure quality and cost-effective care through consistent and streamlined requirements. Regulations with inconsistent requirements
create unnecessary burdens on medical groups and other healthcare providers seeking to comply with
government mandates. Such inconsistency ultimately hinders the delivery of healthcare and the
effective performance of medical group practice professionals.

MGMA supports HHS’ and the administration’s efforts to conduct cost/benefit analyses as an
essential part of evaluating regulations. In order to achieve the goals of this regulatory review, we
reiterate our support for HHS to review rules in addition to the proposed changes set forth in the Feb.
7 proposed part II rule. We recommend that HHS make the following changes:

**Medicare enrollment**

- Eliminate the redundant PECOS system and standardize Medicare provider credentialing
  with other public and private payers though adoption of the CAQH UPD. The UPD is the
  industry standard and widely used by commercial payers and state Medicaid programs.

- Do not deactivate physicians for not submitting a Medicare claims for 12 consecutive
  months. CMS previously proposed to change this policy but did not finalize the change. We
  urge the agency to reconsider this policy since some physicians see very few Medicare
  patients and may, through no fault of their own, not have a Medicare claim to submit within a
  year. CMS should exempt physicians who complete the individual enrollment form (855I)
  from being deactivated for this reason.

- Do not require practices and individual practitioners to separately enroll with each Medicare
  Administrative Contractor (MAC) to which the practice or individual bills Medicare.
  Providers should be able to seamlessly submit enrollment information to multiple MACs by
  checking a box for another MAC rather than being required to go through a separate process
  with each MAC.

- Eliminate the requirement for physicians who opt out of Medicare to complete an affidavit
  every two years. These affidavits should be effective until a physician chooses to change his
  or her participation status in Medicare. Requiring opt out physicians to update their affidavit
  every two years is unnecessary and burdensome for physicians and for contractors.

**Medicare quality reporting programs**

- Integrate and align Medicare quality reporting program requirements, including those for the
  Physician Quality Reporting System (PQRS), the Value Based Payment Modifier Program,
  the EHR Incentive Program (meaningful use) and the Electronic Prescribing Incentive
  Program. CMS should deem all physicians that meet meaningful use requirements (and
  therefore electronically prescribe and report clinical quality measures under that program) as
  also successfully meeting all electronic prescribing, PQRS and Value Modifier reporting
  requirements in each corresponding performance year. Eligible professionals (EPs) that
  successfully meet the meaningful use requirements should automatically earn the bonus for
  PQRS and avoid penalties for e-prescribing, PQRS, and the Value Modifier.

- Provide timely and meaningful feedback and assistance with identifying and correcting
  unsatisfactory reporting throughout the year. Receiving feedback reports nine months after
  the completion of the reporting year is not timely. CMS should provide feedback throughout
  the year and then again within eight to 12 weeks of completion of the program year. Timely
feedback is critical to the success of the quality improvement programs implemented by CMS and should be addressed by the agency.

- Review clinical quality measures and align them across HHS programs as well as across sites of service such as physician offices and hospital inpatient and outpatient departments. Ensure the uniform implementation of national standardized measure sets.

- Establish a robust and workable group practice reporting option for meaningful use. Clinicians enter into group arrangements to achieve the efficiencies of the group practice model. Quality reporting and HIT incentive programs should permit physician practices to leverage cost-effective group reporting options and support the team approach to care delivery.

- Where penalties exist, they should be based on actual performance during the time period to which they are applied and should not be based on performance in a previous year.

- Institute adequate hardship exemptions and appeals processes. There are legitimate situations where physicians and group practices are unable to meet program requirements. Exemptions and an appeals process should be available for physicians and group practices to avoid unfair penalties.

- Simplify reporting mechanisms by allowing EPs and groups to utilize all reporting mechanisms across various programs. For instance, a group of 100 or more EPs that participates in the PQRS-EHR incentive pilot program does not qualify to avoid the 2015 Value Modifier penalty because the pilot, which is designed to streamline two overlapping programs, does not count as one of the approved PQRS reporting options for the value-based payment modifier.

- Provide flexibility from “full year” meaningful use reporting. Beginning in the second year of meaningful use, EPs are required to report for a full year. This can be challenging if an issue results in an EHR being shut down for a period of time. For example, environmental issues such as power outages, infrastructure problems (i.e., Internet down, hardware failures), vendor-related problems (i.e., slow response times for updates or repairs), and human resource issues (i.e., key personnel leaving the practice). These could all lead to the EHR being unusable for a period of time during the reporting year. We strongly recommend that CMS adopt a more flexible reporting period. Options for achieving this flexibility could include maintaining a 90-day reporting period beyond year one or having EPs report for a minimum of 200 days a year or allowing 20 percent “down time” during the year.

**Federal healthcare fraud and abuse regulations and overpayments**

- Standardize fraud and abuse exceptions and eliminate numerous conflicting requirements placed on healthcare providers. These changes will reduce physicians’ burden of complying with multiple inconsistent regulatory schemes.

- Create an exception to the overpayment reporting requirement for overpayments below $5 per claim and $100 in the aggregate. Medical practices frequently have adjustments to their payments based on changes in Medicare policy or slight shifts in the Medicare fee schedule. In some instances, these differentials can be pennies per claim. Many, but not all, will be adjusted in the normal course of claims-processing. Where they are not, the administrative
costs associated with reporting and returning these overpayments, both to a practice and to Medicare, would far outweigh any financial benefit of returning funds to the government. By creating a minimum threshold, the government would help prevent wasted resources.

- Harmonize the overpayment reporting requirements across government programs. As CMS adopts a policy for reporting and returning overpayments, it must ensure that the policy does not interfere with other CMS or HHS initiatives to address overpayments, including overpayments caused by potential violations of the physician self-referral ("Stark") law and the federal antikickback statute.

- Utilize a three-year lookback period across government programs and auditors. Additionally, CMS should finalize a standardized form to report overpayments to limit the administrative burden on practices.

**HIPAA privacy**

- Do not require cumbersome new privacy and security requirements. The 2003 privacy and 2005 security regulations have proven sufficient to protect the confidentiality of patient information. Additional onerous and costly requirements serve only to impede the cost-effective provision of quality care.

Specifically, MGMA strongly recommends that the HHS Office for Civil Rights (OCR) withdraws the “HIPAA Privacy Rule Accounting of Disclosures Under the Health Information Technology for Economic and Clinical Health Act” (45 CFR Part 164 RIN 0991–AB62) proposed rule and significantly reevaluate its approach to meeting the HITECH accounting of disclosures provision. In addition, we urge OCR to fully engage impacted stakeholders, including medical groups, patient advocates, electronic health record (EHR) software vendors, and other critical stakeholders, in a formal outreach process prior to release of the next iteration of the regulation. The goal of this outreach should be to ensure that the regulation appropriately balances the patient’s interest in protected health information disclosures in a manner that leverages readily available EHR technology while not overly burdening covered entities and their business associates.

**HIPAA administrative simplification**

- We continue to be concerned with the lack of industry experience prior to national implementation of complex and costly new standards such as the HIPAA Version 5010 standards recently adopted by the industry, the Affordable Care Act (ACA)-mandated operating rules, and the forthcoming ICD-10 diagnosis codes. In the case of 5010, the lack of adequate testing led to significant cash flow disruption for medical groups and the upcoming transition to ICD-10 promises to be even more challenging. We urge that comprehensive pilot testing be conducted prior to any large-scale implementation of any HIPAA or ACA administrative simplification provision where there is not already appropriate industry experience.

**ICD-10**

- Reconsider moving forward with ICD-10. The cost for physician practices to adopt ICD-10 will be substantial. As an example, it is estimated that a 10-physician practice will incur
more than $285,000 in expenses to implement ICD-10. Overall cost to the industry is now estimated at more than $20 billion for this transition.

- CMS should have taken the following actions prior to mandating ICD-10:
  - Conducted a comprehensive cost-benefit analysis
  - Pilot tested ICD-10
  - Fully evaluated alternative approaches

- Should CMS decide to move forward with ICD-10 and on the established timeline, with 18 months to go before the scheduled implementation date, we recommend the agency incorporate the following steps into the current implementation process:
  - Institute a certification program for health plans and clearinghouses to establish ICD-10 readiness. This could be similar to and incorporated into the health plan certification process required under the Affordable Care Act and currently under development at CMS;
  - Financially support a private sector practice management system software certification process;
  - Significantly augment education and outreach to providers—especially small and rural providers and those treating underserved populations; and
  - Leverage the Regional Extension Centers (RECs), established under the American Recovery and Reinvestment Act to assist smaller physician practices achieve meaningful use, to educate providers on ICD-10.

**Medicare contractors including Recovery Audit Contractors**

- Ensure that Medicare contractors perform their duties consistently and transparently to maximize provider understanding and compliance with government requirements. In its attempts to eliminate improper payments, HHS has empowered numerous contractors to audit healthcare providers. MGMA members continue to report inconsistencies in the guidance given by various contractors, delays in contractor correspondence, and continued confusion about the contractors’ specific identity and authority and the relevant timeframes of the audit.

- Strictly oversee all government program auditors. Auditors must be transparent with respect to their identity, their authority and the issues they seek to address. The demands they place on practices must be coordinated and reasonable. The government must exercise strong oversight of its contract auditors and compensate them in a manner that does not create financial incentives that encourage unfair targeting of healthcare providers and increase the potential for contractor abuse.

**Other compliance issues**

- Allow physicians to designate a practice administrator to review information to be reported under the National Physician Payment Transparency Program (also referred to as the Sunshine Rule) before it is made public. CMS’ process requires a physician to log onto its website and review such information within 45 days. Since practice administrators will be integral to tracking reportable payments and ownership interests, they will, in many cases, be best suited to review draft information for accuracy and should be allowed to do so if requested by a physician.
• Review limited English proficiency and hearing impaired translator mandates on practices and consider potential unintended consequences of additional financial and administrative burdens on healthcare providers.

We look forward to working with the agency as it continues its process of reviewing burdensome and outdated requirements. Thank you for the opportunity to comment on these important issues. Should you have any questions regarding our comments please contact Allison Brennan at abrennan@mgma.com or 202-293-3450.

Sincerely,

Susan Turney, MD, MS, FACP, FACMPE
President and CEO