Feb. 10, 2017

The Honorable Thomas Price
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Price,

On behalf of the nation’s medical group practices, I extend my warmest congratulations on your confirmation as Secretary of Health and Human Services (HHS). Given your background as a practicing physician and leader on issues impacting providers while serving in the U.S. House of Representatives, we believe you bring to this role an unprecedented understanding of the onerous regulatory burdens hindering the ability of medical group practices to deliver high quality and efficient patient care. The Medical Group Management Association (MGMA) stands ready to work with you and your colleagues at HHS in creating a new era of innovative, high quality, and efficient care delivery untethered from excessive, one-size-fits-all regulations.

MGMA and its 50 state affiliates comprise more than 33,000 administrators and executives in 18,000 healthcare organizations in which 385,000 physicians practice. MGMA represents physician groups of all sizes, types, structures and specialties, and has members in every major healthcare system in the nation. As the leading association for practice administrators and executives for more than 90 years, MGMA produces the most credible medical practice economic data in the industry and provides the education, advocacy, data and resources that healthcare organizations need to deliver the highest-quality patient care.

As you assume the leadership of the Department, the Association requests your consideration of the following opportunities to significantly reduce the regulatory burden on physician practices and improve the quality and efficiency of healthcare delivery in this country. We have identified additional opportunities to mitigate or eliminate obsolete and burdensome rules in the attached addendum.

**Administrative Simplification**

By some accounts, administrative costs in the U.S. healthcare system total in excess of $300 billion annually, or nearly 15 percent of all healthcare expenditures in the nation.\(^1\) Further, these administrative costs add to clinician frustrations and serve, as in the case of health plan prior authorization mandates and other requirements, as a clear impediment to patient care. When the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996, one of its goals was decreasing the burdensome and costly administrative overhead experienced when providers and health plans interact. While the law required the development of a wide range of national standards for critical electronic transactions including verifying patient insurance eligibility, claim submission, prior authorization, attachments, and

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remittance advice, for various reasons the industry has still not reaped the full benefit of these standards. More than twenty years after the passage of HIPAA, several critical standards have yet to be promulgated by the government, while others have not been updated or are simply not enforced. This has led to a continuation of manual administrative processes that, if corrected, could save the healthcare industry billions of dollars. MGMA urges HHS to engage directly with the leaders of medical groups on the frontlines of the complex healthcare system to identify appropriate administrative standards to reduce excessive costs in the healthcare system and improve coordination among providers and plans.

**The Merit-Based Incentive Payment System (MIPS)**

MGMA recognizes the final rule with comment implementing the Medicare Access and CHIP Reauthorization Act (MACRA) reflected the cooperative relationship CMS forged with the physician and group practice community, and we look forward to building on this relationship to further simplify MIPS to permit practices to prioritize effective improvements to patient care. For instance, one of the principal goals of MACRA was to consolidate three disparate and complex federal quality reporting programs into one. Yet MIPS continues to take a siloed approach to reporting, as it consists of four distinct components under one broad umbrella. This approach is extremely burdensome and incompatible with both the intent of Congress and the Department’s goal of reducing the cost of healthcare. According to a 2016 Health Affairs study, physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion per year on external quality reporting requirements, such as tracking quality measure specifications, developing and implementing data collection processes, entering information into the medical record, and collecting and transmitting data.²

There are many opportunities to reduce the cost and reporting burden of MIPS. For instance, reporting once should count toward the overall MIPS score, rather than merely toward bonus points. Additionally, MIPS should continue to use an “any 90 consecutive day” reporting period to collect data on quality and electronic health record (EHR) metrics and explore sampling and attestation methodologies that ensure statistical validity as an alternative to the onerous data completeness rules. MIPS should not reward the quantity of reporting but the quality of care provided to patients.

**Alternative Payment Models (APMs)**

MACRA incentivizes medical group practices to embrace alternatives to fee-for-service and to incur greater performance risk for clinical outcomes and the cost of care. Unfortunately, physicians have limited opportunities to move into an eligible APM in large part because the regulations establish a restrictive risk standard and the Centers for Medicare and Medicaid Innovation (CMMI) has taken a top-down, government driven approach to developing APMs. We urge a careful review of the eligible APM risk standard and contend there is significant inherent risk in moving from fee-for-service to risk-bearing arrangements, including substantial investment and operational costs, as well as misaligned financial incentives between the payment systems. In a noteworthy analysis of MGMA data from medical groups that transitioned from fee-for-service arrangements to capitation in 1996, groups faced reductions of up to 30% of revenues due to competing incentives in these contracts. Activities that would maximize fee-for-service income cut into profit from risk-bearing payment arrangements, while the reverse occurred when groups attempted to manage utilization.

We also believe the goal of MACRA to support practices in transforming their care delivery models from fee-for-service to value-based is best accomplished by working directly with the physician community to

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design APMs. MACRA does not require a payment model be tested or expanded nationally by CMMI to qualify as an APM. In fact, MACRA created the Physician-Focused Payment Models Technical Advisory Committee (PTAC) to advance innovative physician- and group practice-driven payment models created by providers and practices outside the walls of CMMI. We believe the agency should give substantial deference to PTAC’s recommendations in order to accelerate development of qualifying payment models appropriate for physician practices of all sizes, specialties, and geographic locations.

**Electronic Health Record (EHR) Certification**

The incentives associated with the Medicare and Medicaid Meaningful Use EHR Incentive Program were helpful in facilitating the adoption of EHR technology in physician practices, but excessive regulatory strings have caused extreme frustration for physicians caring for patients. The Office of the National Coordinator for Health Information Technology (ONC) implemented an EHR certification process that required software vendors to divert research and development resources away from implementing physician-friendly design to meeting seemingly arbitrary government requirements. This regulatory environment has resulted in lost productivity and additional cost associated with the current certified EHR technology and the negative impact these systems can have on their interactions with patients. Further, despite widespread use of EHR technology, and the outlay or more than $30 billion dollars in federal incentives, the industry has also not yet achieved the level of interoperability that would result in significant clinical and administrative improvements promised at the outset of the federal incentive programs. We believe ONC should delay any requirement to move to the 2015 CEHRT requirements and provide greater flexibility in the certification standards to match the health information technology needs of physician practices.

**The Stark Physician Self-Referral Law**

No discussion of regulatory burden in the health field would be complete without reference to the Federal Physician Self-Referral Law which has become, over twenty-five years, a regulatory monster of mind-numbing complexity. We doubt, however, that there are adequate regulatory “fixes” to this problem. Thus we encourage you to pursue significant legislative relief on this topic in the context of the new value-based payment landscape, and we pledge our support for serious efforts in this direction.

We look forward to continuing to work with you and others at HHS to advance constructive solutions to improve health and health care in America. Should you have any questions, please contact Anders Gilberg, Senior Vice President, Government Affairs at agilberg@mgma.org or 202-293-3450.

Sincerely,

Halee Fischer-Wright, MD, MMM, FAAP, CMPE
President and CEO
ADDENDUM: OPPORTUNITIES TO PROMOTE EFFICIENCY AND QUALITY IN MEDICAL GROUP PRACTICES THROUGH ADMINISTRATIVE SIMPLICITY AND REGULATORY REDUCTION

Simplify the administration of health care and cut waste in the system by:

- Curbing health plan prior authorization abuses and implement national standards and operating rules to automate prior authorization and standardize it across payers
- Exploring use of clinical decision support software as meeting prior authorization requirements
- Engaging the Workgroup for Electronic Data Interchange, a multi-stakeholder entity named under HIPAA as an HHS advisor, to establish a national standard for electronic attachments and support operating rules
- Establishing national standards for the use of electronic acknowledgements
- Establishing a process to certify health plan compliance with all applicable national electronic data interchange standards and operating rules
- Exploring and supporting opportunities for single capture of all EDI (standard electronic transactions) enrollment information for all health plans
- Delaying implementation of the Social Security Removal Initiative requirement to issue all living and deceased Medicare beneficiaries a new identification number until the proposal has gone through a formal rulemaking process
- Not requiring the unique device identifier to be reported on the CMS 1500 paper claim form or the X12 837 P or X12 837 I claim forms. Rather, require that certified EHRs have the ability to capture and query UDIs
- Lifting the prohibition on HHS working with the private sector on the national patient identifier and/or patient matching approaches
- Making business associates, such as practice management system vendors, subject to the HIPAA standard electronic transactions requirements, in addition to their current responsibilities under the HIPAA privacy and security rules
- Deeming appropriate third party accreditation or certification to meet the HIPAA Security Risk Analysis

Streamline and improve the Merit-Based Incentive Payment System (MIPS) by:

- Preserving “pick your pace” flexibility
- Continuing to use any 90 consecutive day reporting period to collect data on quality and electronic health record (EHR) metrics and exploring sampling and attestation methodologies that ensure statistical validity as an alternative to the onerous data completeness rules
- Harmonizing reporting requirements across all MIPS categories by allowing reporting across categories to count toward performance – not merely toward bonus points
- Providing group practices and eligible clinicians (ECs) the flexibility to report via multiple mechanisms within MIPS categories to facilitate accurate and relevant clinical data collection and analysis
- Continuing the claims-based reporting option
- Publishing the list of approved registries and QCDRs prior to beginning of the reporting year. This would facilitate provider selection and comparison of the clinical capabilities and cost of the registries.
- Requiring only the current ACI “base score” measures for complete fulfillment of the ACI category of MIPS
- Measuring MIPS performance based on quality and cost of care during episodes of care during which ECs have control over the course of treatment
• Ensuring (e.g., through appropriate use of third party assistance) the accuracy of CMS’ MIPS calculations prior to public dissemination
• Providing clear and comprehensive feedback about an EC’s and group practice’s performance in MIPS every calendar quarter
• Making feedback from government available to group practices’ ECs in advance of the virtual group registration deadline
• Improving the informal review processes
• Pilot testing new patient relationship codes (currently proposed as HCPCS modifier) to determine how they will be used to attribute patients for calculating a MIPS score and withdrawing implementation unless the codes are proven effective at patient attribution

Support delivery system improvements and a choice of payment models by:

• Revising the APM risk standard to account for the investment and operational risks inherent in moving from fee-for-service to risk-bearing arrangements and designate Medicare Shared Savings Program Track 1 ACOs as Advanced APMs
• Working directly with the physician community to develop new models of care delivery and episode payments and accelerating the APM approval process
• Making future CMMI demonstration projects voluntary
• Creating waivers from Stark and Anti-Kickback Laws for all APMs

Reduce regulatory burdens on physician practices by:

• Establishing a blanket hardship exception for all eligible professionals (EPs) subject to the 2018 Meaningful Use EHR Incentive Program negative payment adjustment as these clinicians will be transitioning to MIPS/APMs
• Eliminating Stage 3 of the Meaningful Use EHR Incentive Program. If an EP is participating in the Medicaid EHR Incentive Program, he or she would have the option to opt out of participation in MIPS or earn automatic full ACI score.
• Standardizing the provider credentialing process across all payers, including Medicare, all federal programs and Medicaid, to simplify the Medicare enrollment and reenrollment process
• Leveraging existing private sector credentialing databases (i.e., CAQH ProView)
• Streamlining the requirement that providers verify directory information for Medicare Advantage plans quarterly by collecting this information once and disseminating it to the plans
• Stopping "virtual" credit card abuses and limiting fees associated with EFT transactions
• Reducing lab rate reporting burdens under the Protecting Access to Medicare Act of 2014 by using sampling methodologies to collect the private payer rate information
• Withdrawing the proposed mandatory Part B drugs demonstration model
• Expanding coverage of telehealth services by allowing a much broader array of Medicare covered services to be furnished through this convenient and flexible means
• Requiring better coordination between various government and contractor audit and review programs to reduce duplicative, burdensome documentation requests and disruptions in care
• Developing a comprehensive solution to Medicare appeals backlog
• Ensuring data released through Open Payments, Physician Compare and other transparency initiatives is accurate and not misleading to beneficiaries
Modify EHR Certification and interoperability requirements to support high-quality care delivery by:

- Delaying all requirements that providers move to 2015 CEHRT
- Developing a public-private sector initiative to augment and improve the current HIT certification process in line with the requirements of the 21st Century Cures Act
- Ensuring that all FACA advisory bodies include sufficient representation from practicing clinicians and administrative leaders managing group practices
- Including in any new certification effort developer requirements for provider usability, user-centered design, and interoperability
- Developing interoperability “use” cases that have been proven to improve patient care and/or lower costs and incorporate these use cases into certification
- Establishing a public-private sector partnership to advance the deployment of DIRECT solutions for appropriate administrative transactions (i.e., attachments) and clinical interoperability (i.e., sharing summary of care documents)