Medical Group Management Association®

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Acting Deputy National Coordinator
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
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Kate Goodrich, MD
Director, Center for Clinical Standards and Quality and
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7500 Security Blvd
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RE: Reducing Clinician Burden

Dear Acting Deputy National Coordinator Gettinger and Director Goodrich:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the Jan. 13, 2018 stakeholder meeting focused on identifying areas of clinical and administrative burden and recommending solutions. We commend you and your teams at the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) for convening this group and for your commitment to reduce the level of administrative burden in medical group practices. We have long been a champion for increased efficiency in the care delivery process and look forward to working closely with you both to achieve this mutual goal.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, advocacy and education, MGMA empowers medical group practices to create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

The following are recommendations to reduce burden on physician practices that we believe could be addressed through regulatory and sub-regulatory action.

Quality Payment Program (QPP)

Repealing the problematic sustainable growth rate and retiring a hodgepodge of quality reporting programs, the Medicare Access and CHIP Reauthorization Act (MACRA) charted a value-based trajectory for the Medicare payment system by valuing innovative, patient-centric and efficient care delivery over check-the-box bureaucracy. However, the final 2018 MIPS rule maintains an overly complex set of rules that reward the quantity of reporting rather than the quality of care

provided to patients. Additionally, the Advanced alternative payment model (APM) pathway is far too narrow. CMS should reset and align the QPP with the original intent of MACRA to support physician practices as they transform the way they deliver care.

According to a recent study of more than 750 MGMA member practices, the QPP is the most burdensome regulatory issue facing group practices in 2018. Although the vast majority of respondents are participating in MIPS, more than 70% of respondents were very or extremely concerned about the lack of clinical relevance to patient care. Articulating a theme we hear regularly across the country, one practice leader wrote: "We are a GI single specialty clinic. I can use the specialty measures for the MDs but not the mid-level providers as they don't apply. I have to have two sets of MIPS requirements and measures. It's extremely burdensome."

Similarly, a 2016 *Health Affairs* study of MGMA member practices found that each year physician practices in four common specialties spend, on average, 785 hours per physician and more than $15.4 billion on quality measure reporting programs. As the study cites, the majority of time spent on quality reporting consists of "entering information into the medical record only for the purpose of reporting for quality measures from external entities," and nearly three-quarters of practices stated their group was being evaluated on quality measures that were not clinically relevant. Congress recognized the pitfalls of these programs in driving clinicians' time away from patients and toward paperwork, and, as a result, replaced them with MIPS.

MGMA is pleased CMS and ONC have signaled a renewed interest in engaging with the physician community to reduce the regulatory burden in MIPS and align it with group practices' ongoing efforts to improve patient care. To further the department's goal to emphasize high-value care and patient outcomes while minimizing burden on eligible clinicians, MGMA offers the following recommendations:

- **Permanently shorten the minimum MIPS reporting period to any 90 consecutive days** using sampling and attestation methodologies that ensure statistical validity. Participants should have the option to report more data as needed.

- **Decrease the number of measures across MIPS.** In 2018, group practices' finite resources are spread across at least 15 measures, including a minimum of six quality measures, two cost measures, five advancing care information (ACI) measures, and two improvement activities (IAs). CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.

- **Simplify MIPS and reduce redundancies by awarding cross-category credit.** As implemented, MIPS reflects a continuation of the agency's historically siloed approach to quality reporting, consisting of four programs under one umbrella. To reduce burden, CMS should award credit in multiple categories for overlapping efforts. For instance, clinicians should receive ACI credit when they report quality measures via end-to-end electronic reporting using certified EHRs.

- **Provide clear and actionable feedback regarding MIPS performance at least every calendar quarter,** as recommended by the statute. Without transparent criteria and timely feedback, MIPS is essentially a reporting exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive clinical improvement.

- **Support the proven group practice model of care delivery and continue to define a group at the tax identification number (TIN) level**. In the working paper entitled, "Issues and Challenges in Measuring and Improving the Quality of Health Care," the Congressional Budget Office recognized the benefits of evaluating quality initiatives at the practice level, writing "systemic changes are made at the practice level, there is greater reliability of quality measurement because of larger sample sizes, and practice-level incentives might facilitate greater cooperation."

- **Refine the low-volume threshold application to group practices**. CMS should mirror its own policy for non-patient facing eligible clinicians (ECs) and scale the low-volume threshold to the group practice level, exempting a group from MIPS if 75% or more of its ECs individually fall below the low-volume threshold or the group's average Medicare allowed charges or Medicare patient population falls below the threshold.

- **Allow MIPS and APM participants the option to use 2014 or 2015 Edition CEHRT through the 2020 reporting year.** Continue to offer MIPS scoring incentives to participants adopting 2015 Edition CEHRT.

- **Release critical MIPS information prior to the start of the performance period**. To participate successfully and, more importantly, implement evidence-based actions at the point of care, groups need time to plan and review key program details, such as the quality measure specifications and benchmarks, qualified vendor lists, and clinician and group practice eligibility determinations.

- **Stabilize the quality performance category** by maintaining current data completeness thresholds for longer than a single performance year. Further improvements to the category include eliminating the outcome or high-priority measure requirement, removing the administrative claims measure, and maintaining "topped out" measures.

- **Avoid adding complexity to the IA performance category** by continuing to allow ECs and groups to attest to completion of activities, not removing any IA activities, and not requiring a future minimum participation threshold. We also strongly urge CMS not to require a threshold reporting requirement for groups attesting to IAs.

- **Streamline the ACI performance category** by deeming ECs and groups using certified EHR technology as meeting the ACI base score requirements and automatically awarding 50% of the full ACI score. CMS should also deem ECs and groups attesting to completing one or more IAs requiring CEHRT to have met the ACI base score requirements and automatically receive 50% of the ACI score.

- **Prioritize methodological improvements to the MIPS cost performance category before increasing its weight.** We urge CMS to extensively test new episode-based measures, reform the patient attribution methodology, and account for social determinants of health through appropriate risk adjustment.

- **Overhaul the Advanced APM criteria and expand the list of qualifying APMs** to include the Centers for Medicare & Medicaid Innovation (CMMI) models such as Medicare Shared Savings Program (MSSP) Track 1 ACOs.

- **Revise the APM risk standard** to account for the investment and operational risks inherent in moving from fee-for-service to risk-bearing arrangements.

- **Work directly with the physician community** to develop new models of care delivery and episode payments and accelerate the APM approval process.

- **Make all CMMI demonstration projects voluntary**. Gaining experience and support from the physician community for new models is essential to their success.

- **Create waivers from Stark and Anti-Kickback Laws for all APMs.** Reducing the burden associated with complying with these regulations is an important incentive for a physician to participate in an APM.

- **Seek opportunities to adopt private sector payment models and patient-centered medical home (PCMH) models as Advanced APMs**. Some of the most innovative and successful APMs are being developed and deployed by the private sector.

- **Establish 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. Do not require them to complete the ACI base score component of MIPS.

- **Eliminate 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.

- **Modify EHR Certification and interoperability requirements to support high-quality care delivery.** Develop 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 and ensure that all FACA advisory bodies include sufficient representation from practicing clinicians and administrative leaders managing group practices.

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. 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 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 health plans.

To achieve administrative simplification, MGMA offers the following recommendations:

- **Curb health plan prior authorization abuses** by fully implementing national standards and operating rules that more effectively automate prior authorization. Ensure that these transactions and operating rules are deployed across all health plans.

- **Explore use of clinical decision support software** as meeting prior authorization requirements.

- **Release the electronic attachments regulation**. Mandated in HIPAA and re-mandated in section 1104 of the Affordable Care Act, this transaction has the potential of reducing burden by supporting claim submissions, meeting clinical documentation requirements for prior authorization transactions, supporting referrals, transitions of care, and care coordination documentation requirements, and other clinical and administrative situations where patient data needs to be shared efficiently and securely.

- **Support opportunities for single capture of all EDI (standard electronic transactions) enrollment information** for all health plans, thus removing the burdensome requirement that clinician enroll separately with each health plan.

- **Standardize the provider credentialing process across all payers, including Medicare, all federal programs and all state Medicaid programs.** This approach would simplify the enrollment and reenrollment process for all clinicians. By leveraging existing private sector credentialing databases (i.e., CAQH ProView), redundant data input requirements would be eliminated.

- **Streamline the data collection process and improve the accuracy of provider directory information** for Medicare Advantage plans by collecting this information centrally and disseminating it to the plans.

- **Do not require 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.

- **Lift the prohibition on HHS working with the private sector on the national patient identifier and/or patient matching approaches.** Effective and safe interoperability is made much more difficult without the establishment of an accurate method of identifying patients.

- **Improve lab rate accuracy and reduce reporting burdens** under the Protecting Access to Medicare Act of 2014 by using sampling methodologies to collect the private payer rate information.

- **Require better coordination between various government and contractor audit and review programs** to reduce duplicative, burdensome documentation requests and disruptions in care.

- **Ensure data released through Open Payments, Physician Compare and other transparency initiatives is accurate** and not misleading to beneficiaries.

- **Establish national standards for the use of electronic acknowledgements**. Standards already exist with some health plans supporting them currently. Requiring all plans to support them would decrease administrative burden.

- **Deem appropriate third-party accreditation or certification to meet the HIPAA Security Risk Analysis**. Data security concerns are growing and by deeming third-party HIPAA security accreditation/certification the government would be encouraging providers to take a proactive approach to conducting a comprehensive risk analysis.

- **Make 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. Adoption of the EDI transactions would be increased if PM vendors were required to support the standards.

- **Support private sector efforts to certify practice management system software**. With PMS software that facilitates use of the HIPAA EDI transactions, practices will achieve increased levels of automation and paper-based burdens will be reduced.

- **Establish a process to certify health plan compliance** with all applicable national electronic data interchange standards and operating rules. To date, CMS has not levied any fines on health plans for non-compliance with the HIPAA electronic transactions and operating rules. In the absence of a federal health plan certification process, we urge the deployment of a random audit process to help ensure health plan compliance.

We appreciate the opportunity to share our comments regarding the many burdens facing physician practices in today's healthcare environment and offer recommendations to improve and simplify quality programs and administrative processes. Addressing these issues will be an important step forward in reducing system inefficiencies and supporting group practices as they seek to transform their organizations and improve the nation's healthcare delivery system. Should you have any questions, please contact me at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
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