June 10, 2025

The Centers for Medicare & Medicaid Services (CMS) Request for Information – Unleashing Prosperity Through Deregulation of the Medicare Program

Streamline Regulatory Requirements

CMS Question: Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements) that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

MGMA Response: On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank CMS for issuing this request for information (RFI) – Unleashing Prosperity Through Deregulation of the Medicare Program. MGMA appreciates the Administration's focus on removing excess and detrimental regulations that impede medical groups' ability to operate effectively. Onerous regulatory burdens have stifled medical groups and caused a myriad of negative impact, ultimately undermining the nation's health system.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

MGMA has long advocated that policymakers scale back regulatory burden for medical practices, arguing that these requirements divert time and resources away from delivering patient care. Reducing regulatory requirements that do not improve patient care will allow group practices to invest in resources and initiatives that improve healthcare delivery, further clinical priorities, and reduce costs.

Many processes under CMS' purview can be simplified and streamlined to alleviate the substantial regulatory burden felt by physician practices – Quality Payment Program (QPP) reporting, prior authorization requirements, provider credentialing, healthcare transactions, documentation requirements, and *No Surprises Act* burdens are just a few of numerous policies that could be reformed.

We consistently hear from MGMA members about the negative impact of these regulatory burdens:

- *"The prior authorization and MIPS requirements are especially burdensome. The good faith estimate requirements have added additional duties, but our Medicare payments keep flat or decrease. This is not sustainable for independent practices. They seem to be a target!"*
- *"As a small, independent, primary care practice, it is very hard to keep up with all the changes. While you can purchase vendors that do credentialing, programs that can reduce your denials, and many other products that can reduce the burden placed on us, we simply cannot afford it."*

- *"The increasing regulatory burdens for MIPS, the No Surprises Act, prior authorization, etc., has not only increased our need for additional staffing, but has also resulted in significant operational losses over the last fiscal year. As an organization, we are now tested with making very difficult decisions regarding staffing and our patient care lines."*

There is ample anecdotal and statistical evidence that heaping regulatory requirements onto physician practices leads to severe negative impacts, such as practice closures, increased consolidation, staffing challenges, and more. We highlight areas ripe for deregulation throughout this RFI and look forward to working with CMS on these issues in more detail.

CMS Question: Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

MGMA Response: CMS has ample opportunity to reduce numerous quality and data reporting requirements related to the Quality Payment Program (QPP).

MIPS Reform

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) replaced the sustainable growth rate formula with the QPP. This was intended to stabilize payment rates in the Medicare fee-for-service (FFS) system and incentivize physicians to transition into value-based payment models. The QPP created two reporting pathways to facilitate the transition to value-based care: the Merit-based Incentive Payment System (MIPS) and advanced alternative payment models (APMs).

Unfortunately, MIPS has been beset with issues. MIPS requires clinicians to report on quality measures that are not clinically relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. Complying with these requirements is a time-consuming and laborious process. Compounding these issues is the lack of adequate and timely feedback by CMS on measuring performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues and improve compliance.

Medical groups report that MIPS requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities. The QPP reporting burden is substantial — 67% of MGMA members surveyed from MGMA's latest annual regulatory burden report found QPP reporting to be extremely or very burdensome. MIPS policies disproportionately impact small practices as they often do not have the same resources, staff, and capital as large systems.

To address these significant concerns, CMS should reform the MIPS program to improve its clinical relevance and reduce the cost and administrative burden of reporting. Specifically, CMS should work to:

- **Reduce reporting burden and better align performance measures with clinical care**. CMS should remove the siloes between the different performance categories; providing multi-category credit for MIPS measures that fulfill multiple categorical functions would avoid the duplicative steps of documenting and reporting on the same activities. The MIPS cost performance category has numerous issues related to measuring costs outside of a provider's control and opaque scoring procedures; it is essential to revise this category significantly.

Additional changes are needed to improve reporting on quality measures and allow providers reporting through clinical data registries to automatically satisfy Promoting Interoperability and Improvement Activities requirements.

- **Improve the performance threshold**. The current MIPS threshold of 75 points results in many providers being unnecessarily penalized. Congress should freeze the threshold at 60 points for three years to allow medical groups to continue recovering from significant events such as COVID-19 and the Change Healthcare cyberattack. Further, the Government Accountability Office (GAO) should submit a report to Congress and the Department of Health and Human Services (HHS) in consultation with physician organizations that details recommendations for a replacement performance threshold.
- **Reform how payment adjustments are calculated.** The current tournament-style model of MIPS needs to be eliminated to stop undermining the financial viability of practices participating in MIPS that receive a negative payment adjustment. A new model with payment adjustments tied to the annual payment update would be more equitable while continuing to incentivize groups to improve their performance. Groups who score below the performance threshold would receive a reduced payment update compared to those at or above the threshold. The penalties would fund bonuses for the high performers and go towards an improvement fund.
- **Ensure timely and actionable feedback from CMS**. Providers do not receive the timely and accurate feedback from CMS needed to understand their performance and be able to make changes to reduce costs or improve scores. A redesigned MIPS program must include this vital feedback, and if quarterly reports are not provided, then medical groups should be held harmless from any penalties.

MIPS Value Pathways (MVPs)

MGMA continues to have significant reservations about CMS repackaging issues in MIPS in the MVP program. MVP reporting should remain voluntary, and the agency should work with physician specialties to design MVPs that are workable and appropriate. CMS should not sunset the MIPS program until MVPs and other value-based care models are mature enough to capture the full spectrum of medical groups.

In order to avoid amplifying the administrative burdens in MIPS through MVPs, CMS should align cost and quality measures, develop MVPS for particular episodes of care/procedures that promote care coordination, address problems with cost measures, and more to alleviate unnecessary reporting obstacles. We continue to oppose mandatory subgroup reporting that will be implemented in 2026, as partitioning practices into subgroups could undermine the advantages of the group practice model. CMS should avoid mandating unworkable reporting requirements in MVPs that hamper the transition to value-based care.

Alternative Payment Models (APMs)

A modernized healthcare system must include value-based care models that are designed to allow physician practices to succeed. The Centers for Medicare & Medicaid Innovation (CMMI) should work to test APM models that facilitate widespread participation from medical groups, as 78% of medical groups report that Medicare does not offer an APM that is clinically relevant to their practice. CMMI has never tested a value-based care model developed by the Physician-Focused Payment Model Technical Advisory Committee (PTAC). We urge the agency to leverage the expertise of PTAC and medical groups to test APM models with minimal unnecessary regulatory and reporting burdens.

In conjunction with a shortage of APMs, 94% of MGMA members reported that moving to value-based care initiatives has not lessened the regulatory burden on their practices. This is exemplified by recently finalized changes that required the use of certified health information technology (CEHRT) utilization in APMs that took effect in 2025. One of the main benefits of joining an APM is the reduced MIPS reporting burden — this policy undermines the success of groups joining value-based care arrangements. CMS should rescind these burdensome CEHRT requirements and look to further incentivize the transition to value-based care arrangements by reducing reporting burdens for participants in APMs.

CMS Question: Are there specific Medicare administrative processes, quality, or data reporting requirements that could be automated or simplified to reduce the administrative burden on facilities and providers?

MGMA Response: See our answers to the questions above. Further, reporting by Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) can be simplified and improved to reduce regulatory burden. MGMA harbors concerns about CMS moving too quickly to all-payer/all-patient digital quality reporting without the proper infrastructure being in place. Requiring ACOs to report all payer/all patient digital measures in the future without significant policy changes is infeasible as ACOs must make changes to operational workflows, secure new technological capabilities, and familiarize themselves with reconfigured measure sets, all of which require the attention of dedicated staff as well as an upfront financial investment for electronic health record (EHR) upgrades.

ACOs often are comprised of multiple group practice taxpayer identification numbers (TINs) that all work in concert to achieve the goals of the ACO, and there may be significant data-sharing limitations that groups will encounter moving to all payer/all patient reporting. There are substantial costs associated with making the technological upgrades needed to report all these measures as well. CMS should allow for flexibility and extend reporting programs that are scheduled to expire to facilitate the development of the necessary infrastructure for all payer/all patient digital reporting.

Recently finalized changes in the 2025 Medicare Physician Fee Schedule (PFS) increased administrative burden for medical groups participating in ACOs by requiring Promoting Interoperability (PI) reporting within MSSP, as well as introducing the APM Performance Pathway (APP) Plus Quality measure set. ACOs having to report the APP Plus Quality measure set will institute a significant administrative burden and require the reporting of quality measures that may not be applicable for certain specialties and medical groups. The phase-in of the 11 APP Plus measures over the next few years, coupled with onerous PI reporting in 2025, will add complexity and burden for ACOs and medical groups participating in the program. Simplifying MSSP reporting by removing these requirements would reduce unnecessary administrative burdens.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

CMS Question: Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?

MGMA Response: There are numerous opportunities to reduce the complexity of reporting for Medicare providers. Provider enrollment and credentialing in Medicare should be streamlined to address a laborious, complex, and cumbersome process. Improving the Provider Enrollment, Chain and Ownership System (PECOS) should be a priority to offer needed relief. MGMA members have consistently ranked

credentialing processes as adding regulatory burden to their practices; aligning requirements across programs while reducing paperwork would help address this longstanding concern.

Additionally, CMS should work to standardize and streamline healthcare transactions, documentation requirements, claims review processes, and audits, to decrease costs associated with inefficient and inconsistent standards.

Identification of Duplicative Requirements

CMS Question: How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

MGMA Response: CMS should collaborate with HHS' Office for Civil Rights (OCR), the Assistant Secretary for Technology Policy (ASTP), and other agencies to reduce duplicative, time-consuming compliance efforts and establish standardized processes while promoting interoperability.

Information Blocking

CMS should coordinate with ASTP to mitigate the complex and punitive provider disincentives associated with information blocking. MGMA members remain committed to utilizing health information technology (IT) to reduce administrative burden and advance the provision of high-quality, cost-effective care. Additional information, education, and simplification are needed surrounding the constantly changing definitions related to information blocking and its exceptions.

We continue to hold significant concerns with recently finalized information-blocking disincentives and their impact on medical groups. CMS and ASTP should undertake the following actions to reduce the negative effects associated with complex information-blocking regulations:

- Utilize corrective action plans and education to effectively remedy information blocking allegations instead of significant financial penalties.
- Rescind finalized disincentives for MIPS and MSSP participants that exacerbate substantial administrative burdens.
- Ensure an accessible appeals process is available for all providers.
- Increase transparency throughout the process and coordinate with other federal agencies to ensure a comprehensive strategy that would best promote information sharing by providing guidance and technical assistance to providers.

Proposed HIPAA Security Rule

OCR recently proposed the Health Insurance Portability and Accountability Act Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information (RIN 0945-AA22). While we appreciate the general intent of this proposal, it is far too burdensome to implement in practice and represents such government overreach that it threatens the very sustainability of medical groups in this country.

This proposed update to the HIPAA Security Rule is a departure from the administration's commitment to reducing burdensome regulations and should not be finalized. Many medical groups do not have the staff to implement the complex proposed requirements. To meet these compliance standards, they would have to significantly increase their investment in internal staffing and third-

party IT experts. CMS should work with OCR to avoid instituting costly additional compliance standards and rescind the proposal.

CMS Question: How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

MGMA Response: CMS can better align its telehealth requirements with industry best practices and ensure beneficiaries have access to vital telehealth services by making common sense policy changes. The agency should safeguard medical groups' ability to leverage telehealth services with minimal administrative burdens. To that end, we offer the following suggestions:

- Congress has extended its waiver of the geographic and originating site restrictions through September 30. These critical waivers are paramount in allowing telehealth to thrive and would be a significant impediment if allowed to expire given a small percentage of beneficiaries were able to utilize telehealth prior to the COVID-19 Public Health Emergency (PHE). CMS should work with Congress and permanently waive these unnecessary barriers to care.
- During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home addresses on their Medicare enrollment forms and allowed billing from their currently enrolled location. The agency extended this policy in the 2025 Medicare PFS until Dec. 31, 2025. Making this policy permanent would appropriately balance protecting providers' need for privacy of their home address with program integrity concerns. Allowing practitioners to provide these services without requiring reporting of their home address and safeguarding their privacy outweighs the potential benefits of having practitioners home addresses listed publicly. We urge CMS to maintain this policy to avoid increasing the administrative reporting burden and potentially putting the security of practitioners at risk.
- CMS should collaborate with the Drug Enforcement Administration (DEA) to extend the current telehealth prescribing policies scheduled to expire at the end of 2025.
- The agency should work to extend the flexibility related to the in-person visit requirement for mental telehealth services. Congress has extended this policy in the most recent Continuing Resolution through September 30; Medicare beneficiaries must be able to continue receiving telemental services, and CMS should permanently eliminate the six-month in-person visit requirement.
- The agency should support improving telehealth coverage by removing administratively burdensome billing requirements, such as collecting patient co-pays for virtual check-ins.

Additional Recommendations

CMS Question: We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

MGMA Response: The following areas under CMS' oversight offer a substantial opportunity to remove regulatory barriers facing medical groups:

Reducing Prior Authorization Burden

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running a practice. Prior authorization requests disrupt workflow, increase practice costs, and result in dangerous denials and delays in care. MGMA is alarmed by reports of rising prior authorization requirements — 89% of medical groups assert that prior authorization requirements are very or extremely burdensome. Ninety-two percent of physician practices reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests. Sixty percent of groups reported that there were at least three different employees involved in completing a single prior authorization request. Physician practices are already facing significant workforce shortage issues — this situation is simply untenable.

Despite feedback from MGMA to multiple administrations and Congress over the years regarding the unnecessary administrative burden, cost, and delay of treatment associated with prior authorization, CMS only recently finalized regulations to mitigate some of these harms. While the agency's actions are a good first step, there is still more work to be done. We urge the administration to explore deregulatory opportunities that would:

- Reduce the overall volume of prior authorizations on medical services and drugs.
- Waive prior authorization requirements for clinicians in risk-based contracts or alternative payment models, which are inherently designed to facilitate cost-effective care delivery and appropriate utilization.
- Require transparency of payer prior authorization policy and establish evidence-based clinical guidelines available at the point of care.
- Increase the automation and efficiency of any remaining prior authorization requirements through adoption of industry-developed electronic standards and operating rules.

No Surprises Act

The *No Surprises Act* (*NSA*) was passed by Congress as part of the *Consolidated Appropriations Act, 2021* and created certain patient protections from surprise medical bills. MGMA applauded Congress for protecting patients' access to necessary care while creating a pathway to ensure physicians and practices receive appropriate payment for out-of-network services. However, since its flawed implementation, certain NSA requirements have increased administrative and financial burden for providers, threatening the financial viability of group practices and access to care.

The Independent Dispute Resolution (IDR) process is full of inefficiencies and delays that make it difficult for providers – who prevail at an 85% success rate according to recent CMS data – to utilize the process. MGMA continues to hear how high administrative fees, lack of insurer engagement during the open negotiation process, and the ongoing backlog in IDR cases has created an imbalance in power between the provider and insurer parties.

Providers struggle with redundancy and administrative burdens in the IDR dispute submission process. The existing process is equally as administratively challenging for larger practices that may have higher volumes of claims under the federal IDR process and smaller practices that do not have the staff and resources available to invest in manually tracking claims through the IDR process. CMS should rectify these issues with the IDR process and align current implementation rules with congressional intent, which was to create a balanced system that did not largely favor one party over

the other.

Regarding the price transparency provisions of the *NSA*, CMS should work to avoid instituting additional regulatory burdens related to unworkable convening provider requirements for Good Faith Estimates (GFEs) and Advanced Explanation of Benefits (AEOBs). The convening provider requirement would lead to an unsustainable increase in the volume of administrative work to meet these new requirements that would necessitate the hiring of additional employees, furthering raising costs for medical groups. In addition, there is no currently available standard industry process for the exchange of information needed to offer an AEOB. Taken together, we caution CMS from moving forward with processes that are untenable and unworkable.

The Stark Law

MGMA has worked with Congress and CMS for over 30 years to reduce burden associated with the *Physician Self-Referral (Stark) Law*. Unfortunately, those efforts have been highly frustrating as with each successive CMS rulemaking, the complexity of the *Stark Law* has grown to the point where it is incomprehensible to the average group practice administrator or physician. The *Stark Law* is a strict liability statute (proof of specific intent is not required to violate the law) with severe penalty provisions that exacerbate these concerns.

CMS should develop policies to provide regulatory relief by standardizing compliance requirements and eliminating the numerous conflicting requirements placed on healthcare providers while maintaining flexibility for the group practice model. Though existing exceptions to the *Stark Law's* prohibitions are numerous, they contain complex criteria and obscure terminology subject to regulatory interpretation and factual determinations that open the door to inadvertent noncompliance.

Further, CMS should work with Congress to make the following long-needed changes:

- Significantly reform the compensation arrangement provision (42 USC 1395nn(a)(2)(B)), as it is not needed under a value-based payment system where overutilization is no longer a problem.
- Enhance the group practice model by significantly simplifying the statutory definition of a group practice.
- Revise penalty provisions to limit fines to situations where the prohibited referrals result in some demonstrable harm to the government or the patients served.

Conclusion:

MGMA appreciates CMS' request for feedback on Medicare deregulatory efforts. We look forward to working with the agency to remove unnecessary barriers that divert critical resources away from patient care and bolster medical groups' ability to operate effectively. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.