May 12, 2025

Russell T. Vought
Director
Executive Office of the President
Office of Management and Budget
725 17th Street NW
Washington, DC 20503

Re: Request for Information: Deregulation (FR. Doc. 2025-06316)

Dear Director Vought:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Office of Management and Budget (OMB) for issuing this request for information (RFI) seeking comment on regulations that are unnecessary, unlawful, burdensome, or unsound. We appreciate President Trump's focus on removing excess and detrimental regulations that undermine medical groups' ability to operate effectively; we write this letter to highlight the alarming state of regulatory burden facing medical groups and examine policies to relieve these hurdles for the betterment of medical groups and their patients.

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.

Government overregulation, coupled with yearly cuts to Medicare reimbursement, undermines the ability of medical groups to remain financially viable. There is ample evidence that heaping regulatory requirements onto physician practices leads to significant negative impacts such as practice closures, increased consolidation, staffing challenges, and more. We appreciate OMB soliciting input on deregulatory efforts and look forward to collaborating with the administration on instituting the following recommendations to support a well-functioning modern healthcare system.

Key Recommendations

- **Reform the Merit-based Incentive Payment System (MIPS**) by making commonsense changes such as alleviating the program's significant reporting burden and moving away from its current tournament-style model.
- **Reduce the reporting burden for practices transitioning to value-based care arrangements** under advanced alternative payment models (APMs).
- **Implement prior authorization reform** to address the top regulatory burden for medical groups.
- **Withdraw the proposal to update the HIPAA Security Rule** that would add substantial costs and administrative complexity to physician practices**.**

- **Continue to promote telehealth by maintaining the Centers for Medicare & Medicaid Services' (CMS) current enrollment policy for practitioners offering telehealth services from home that is set to expire at the end of 2025.**
- **Improve the efficiency of the Independent Dispute Resolution process under the *No Surprises Act*.**
- **Simplify and modernize complex *Stark Law* provisions to better align with value-based care payment reform.**
- **Standardize and streamline healthcare transactions, documentation requirements, claims review processes, and audits**, to decrease the administrative burden and costs associated with inefficient and inconsistent standards.

The Quality Payment Program

MIPS Reform

The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) replaced the sustainable growth rate formula with the Quality Payment Program (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. It is a time-consuming and laborious process to comply with these requirements. Compounding these issues is the lack of adequate and timely feedback by CMS on measure 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 — 67.19% of MGMA members surveyed from MGMA's latest annual regulatory burden report found QPP reporting to be extremely or very burdensome.[1] Small practices are disproportionately impacted by MIPS policies as they often do not have the same resources, staff, and capital as large systems.

In order 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. Specially, 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 fulfil 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 important to significantly revise this category.

[1] MGMA, Annual Regulatory Burden Report, Nov. 2023.

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 myriad 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 who receive a negative payment adjustment. A new model where payment adjustments would be tied to the annual payment update would be more equitable while also 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.

APMs

A modernized healthcare system must include value-based care (VBC) models that are designed to allow physician practices to succeed. 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.[2] This is exemplified by recently finalized changes that added burdensome Promoting Interoperability (PI) reporting requirements in the Medicare Shared Savings Program (MSSP), as well as certified health information technology utilization requirements that took effect in 2025.

One of the main benefits of joining an APM is the reduced MIPS reporting burden — these policies undermine the success of groups joining value-based care arrangements. CMS should rescind these burdensome PI requirements and look to further incentivize the transition to value-based care arrangements by reducing reporting burdens for participants in APMs.

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.[3] 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

[2] *Id.*
[3] *Id.*

percent of groups reported that there were at least three different employees involved in completing a single prior authorization request.[4] 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.

Proposed HIPAA Security Rule

The HHS Office for Civil Rights (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 updates to the HIPAA Security Rule is not only a departure from this administration's commitment to reducing burdensome regulations and should not be finalized.[5] 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 information technology (IT) experts.

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 84% success rate according to recent CMS data – to utilize

[4] MGMA, Spotlight: Prior Authorization in Medicare Advantage, May 2023.
[5] *See* MGMA, Comment on Security Rule to Strengthen the Cybersecurity of Electronic Protected Health Information, March 7, 2025.

the process.[6] 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 are struggling 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.[7]

Telehealth

Access to telehealth services has been a lifeline for Medicare patients over the last five years. CMS should ensure that medical groups are able to effectively leverage telehealth services while facing minimal administrative burdens. During the COVID-19 Public Health Emergency (PHE), CMS has 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 Physician Fee Schedule 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 ensure they maintain this policy to avoid increasing administrative reporting burden and putting the security of practitioners potentially at risk.

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. Further, the complexity and breadth of the law is undercut by the lack of intent requirement and severe penalty provisions.

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 that are 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:

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[6] CMS, Supplemental Background on Federal Independent Dispute Resolution Public Use Files January 1, 2024 – June 30, 2024, March 18, 2025.
[7] *See* MGMA, Comment on Federal Independent Dispute Resolution Operations Proposed Rule (RIN 0938–AV15), Dec. 20, 2023.

- 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.

Standardization Efforts Across CMS

Numerous processes under CMS could be standardized and simplified to avoid diverting critical time and effort from physician practices away from patient care. Provider credentialing, healthcare transactions, documentation requirements, claims review processes, and audits are just a few of numerous policies that could be streamlined to reduce duplicative and unnecessarily time-consuming tasks by medical groups. We look forward to collaborating with CMS to discuss how these procedures would be benefit for standardization in more detail.

Conclusion

MGMA appreciates OMB's request for feedback on its deregulatory efforts. We look forward to working with the administration on policies discussed in this letter and more to ensure medical groups are able to continue providing high-quality patient care without being weighed down by excessive red tape. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs