ANNUAL REGULATORY BURDEN REPORT

OCTOBER 2019

MGMA

Medical Group Management Association®

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INTRODUCTION

The results of the Medical Group Management Association (MGMA)'s annual Regulatory Burden Survey reveal there is no shortage of opportunities to reduce regulatory burdens on physician practices.

From measuring quality to completing prior authorization requirements, medical practices face mounting regulatory hurdles that interfere with clinical goals and improving patient outcomes. The Annual Regulatory Burden Survey provides MGMA with critical data on the real impact of federal policies and regulations, allowing us to better educate Congress and the Administration about obstacles to delivering high quality patient care.

This year's survey responses demonstrate that there is still much to be done at the federal level to provide regulatory relief for providers and put patients over paperwork. MGMA will continue to play a key role in the policy discussion to ensure that medical practices have a voice in Washington.

About the Respondents

The survey includes responses from executives representing over 400 group practices. 66% of respondents are in practices with less than 20 physicians and 14% are in practices with over 100 physicians. Three-fourths of respondents are in independent practices.

About MGMA

With a membership of more than 45,000 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.

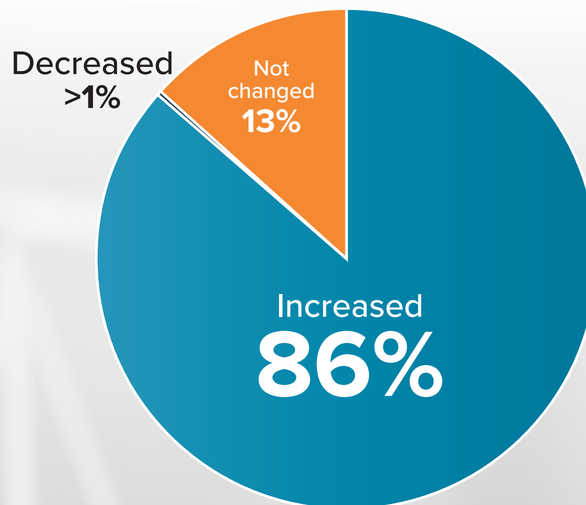
CURRENT STATE OF REGULATORY BURDEN

This survey comes at a time when Congress and the Administration are taking up new efforts to help medical practices deliver quality care to patients while reducing the complexity of the regulatory environment. Despite efforts in Washington to scale back regulatory burden for medical practices, results from the most recent survey tell a different story. As one participant noted...

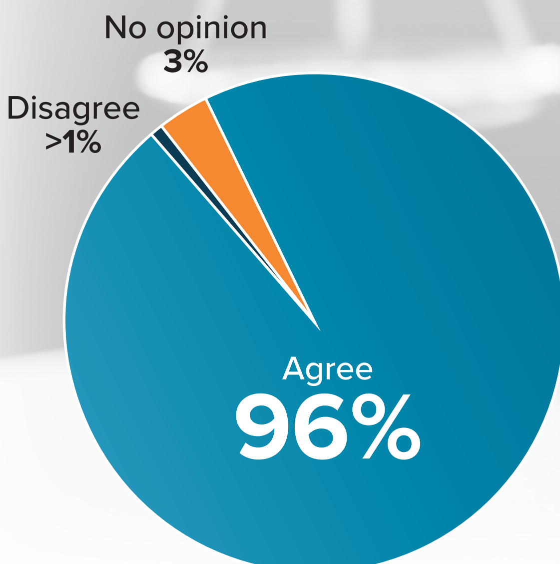
"We used to devote 80% of time to patient care and 20% to regulatory, compliance, insurance, and credentialing issues. Now we spend more time on issues not related to patient care."

Reducing regulatory requirements that do not improve patient care will assist group practices in focusing on patient care and allow them to invest resources in initiatives that improve healthcare delivery, further clinical priorities, and reduce costs.

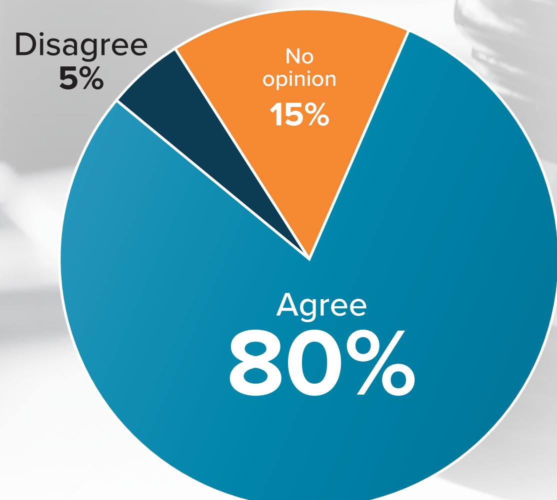
The overall regulatory burden on your medical practice over the past 12 months has:



A reduction in regulatory burden would allow your practice to reallocate resources toward patient care:



A reduction in regulatory burden would allow your practice to invest in new technology:

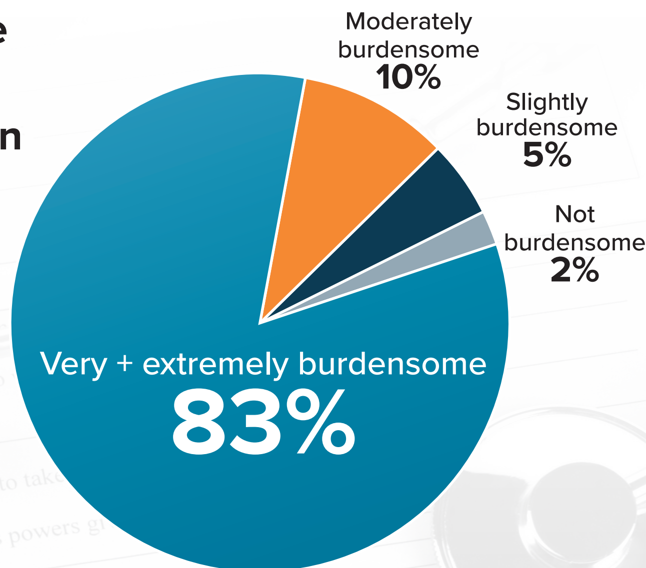


PRIOR AUTHORIZATION

Administrative requirements, such as prior authorization, not only delay patient care but also increase costs and burden. For years, payers have required medical practices to obtain prior authorization before providing certain medical services and prescription drugs to patients. These health plan cost-control mechanisms often delay care unnecessarily at the expense of the patient's health and the practice's resources.

Practices continue to face growing challenges with prior authorization, including issues submitting documentation manually via fax or through the health plan's proprietary web portal, as well as changing medical necessity requirements and appeals processes to meet each health plan's requirements.

How burdensome would you rate prior authorization requirements?



What group practices are saying:

"During the past year we have added 3 new employees to handle just the prior authorization requirements."

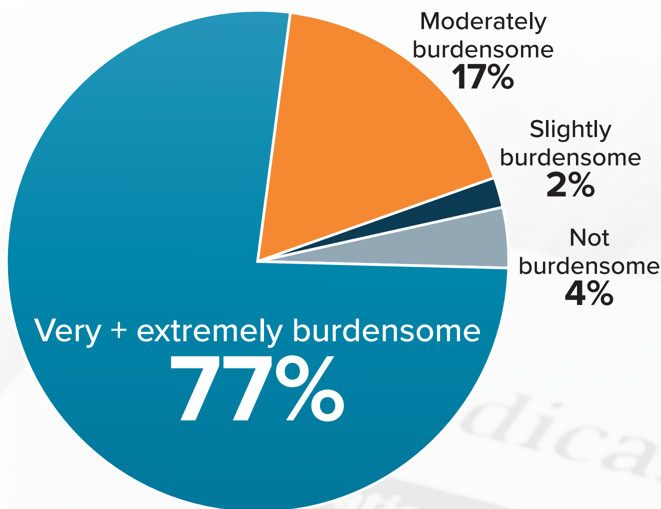
"Loss of payments due to the insurance [plan's] inability to take care of their clients should not be the physician's burden to carry."

"Prior authorization has been out of control for years and it is only getting worse. The insurance companies walk away with record profits and no accountability except to their shareholders. All of burden is placed upon the providers/medical offices who continue to see declining reimbursement and increasing overhead costs."

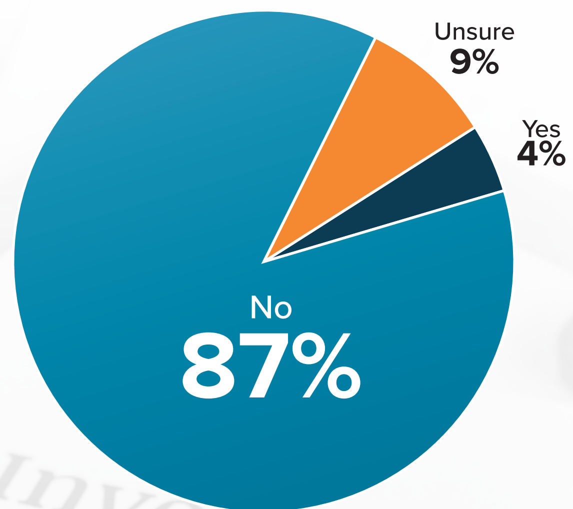
QUALITY PAYMENT PROGRAM

The Merit-based Incentive Payment System (MIPS), which 81% of respondents participate in, continues to present obstacles for those in the program. It is generally seen as a complex compliance program that focuses on reporting requirements rather than an initiative that furthers high-quality patient care. In fact, 84% of respondents reported that the Centers for Medicare and Medicaid Services (CMS) implementation of value-based payment reforms has increased the regulatory burden on their practice.

How burdensome would you rate Medicare Quality Payment Program requirements (including MIPS and APMs)?



Based on your experience in the MIPS program so far, have positive payment adjustments covered the costs of time and resources spent preparing for and reporting under the program?



What group practices are saying:

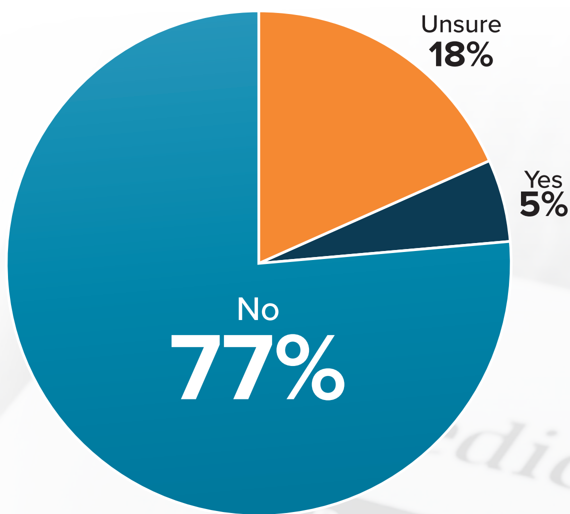
"We have to pay our EHR vendor for a MIPS advisor every month $300. I agree with improving patient care and communication with other physicians. However, the process and amount of information can be reduced and simplified."

"MIPS is getting off the charts intrusive and burdensome."

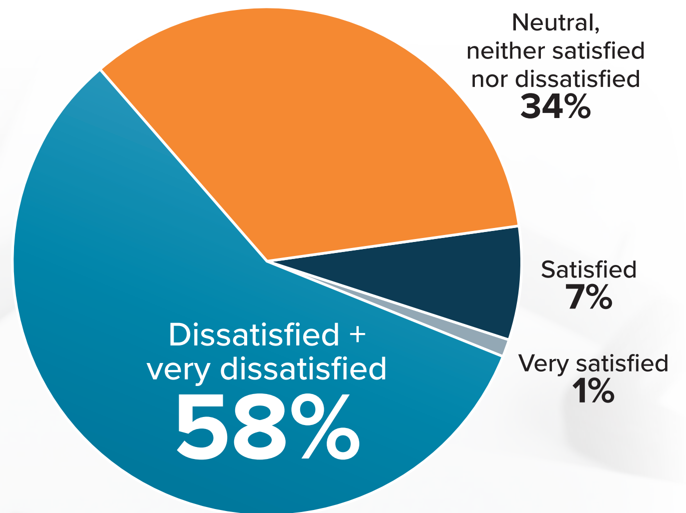
QUALITY PAYMENT PROGRAM

Current quality reporting programs require reporting a large number of measures, but they are often not drivers of meaningful improvements. MGMA has longstanding concerns that MIPS cost measures unfairly penalize clinicians and group practices for costs over which they have no control. MGMA regularly hears from members that clinicians and group practices do not understand how CMS evaluates them on MIPS cost measures and that the lack of actionable, timely information makes this category a “black box” that they have little to no control over.

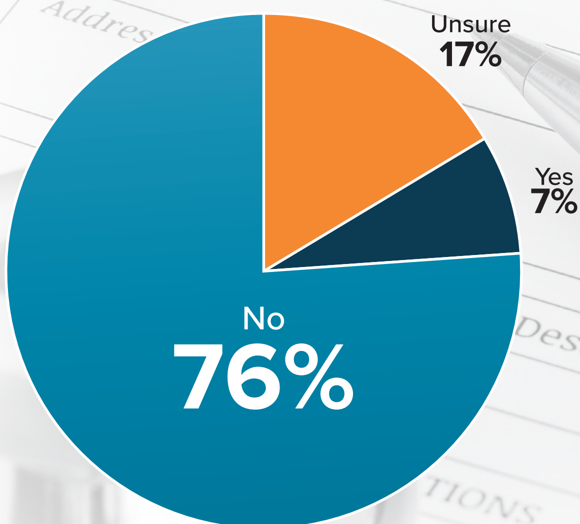
Is CMS’ feedback on MIPS cost measure performance actionable in assisting your practice in reducing costs?



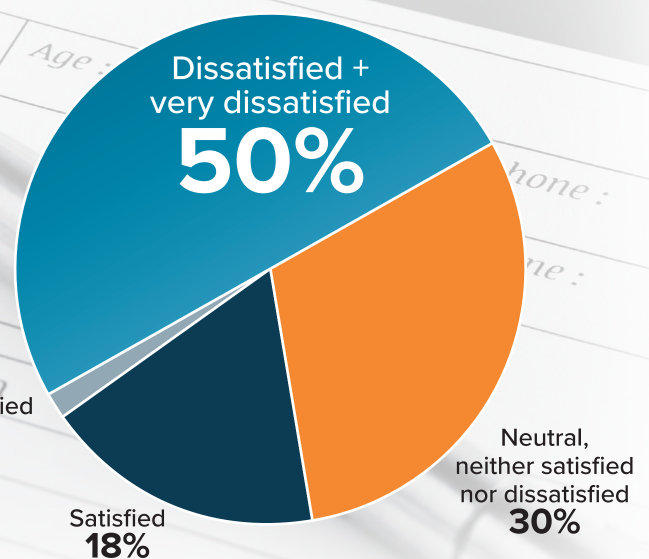
Please rate your level of satisfaction with MIPS cost measures.



Is CMS’ feedback on MIPS quality measure performance actionable in assisting your practice in improving clinical outcomes?



Please rate your level of satisfaction with the availability of applicable MIPS quality measures.



BURDEN LEVEL BY REGULATORY ISSUE

How burdensome would you rate each of the following regulatory issues?

	Not burdensome	Slightly burdensome	Moderately burdensome	Very burdensome	Extremely burdensome	Very + Extremely
Prior authorization	2%	5%	10%	22%	61%	83%
Medicare quality payment program (MIPS/APMs)	4%	2%	17%	30%	47%	77%
Audits and appeals	1%	9%	23%	35%	32%	67%
Lack of EHR interoperability	5%	10%	20%	33%	32%	65%
Medicare Advantage chart audits	6%	10%	23%	26%	35%	61%
Translation and interpretation requirements	8%	14%	24%	26%	28%	54%
Medicare and Medicaid credentialing	4%	18%	31%	24%	23%	47%
HIPAA privacy and security	8%	15%	35%	28%	14%	42%
Federal fraud and abuse law	17%	22%	37%	18%	6%	24%

SURVEY PARTICIPATION DEMOGRAPHICS

How many full-time-equivalent (FTE) physicians are in your organization?	
1-5	30%
6-20	36%
21-50	15%
51-100	5%
100+	14%

Which of the following best describes your organization's specialty focus of care?			
Anesthesiology	3%	Neurosurgery	1%
Cardiac/thoracic surgery	>1%	OB/GYN	4%
Cardiology	4%	Ophthalmology	2%
Dermatology	5%	Oncology	1%
Endocrinology	1%	Orthopedic surgery	9%
Family practice	13%	Otolaryngology	3%
Gastroenterology	4%	Pathology	>1%
General surgery	3%	Pediatric medicine	5%
Infectious disease	>1%	Psychiatry	1%
Internal medicine	4%	Radiology	1%
Multispecialty with primary and specialty care	19%	Rheumatology	2%
Multispecialty with specialty care only	4%	Urology	2%
Nephrology	4%	Other	5%
Neurology	>1%		

Which of the following best describes your organization?	
Independent medical practice	75%
Hospital or integrated delivery system (IDS), or medical practice owned by hospital or IDS	18%
Medical school faculty practice plan or academic clinical science department	2%
Management services organization (MSO)	>1%
Physician practice management company (PPMC)	1%
Independent practice association (IPA)	1%
Other	2%

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