May 8, 2024

The Honorable Sheldon Whitehouse
Chairman
Senate Committee on Budget
608 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Chuck Grassley
Ranking Member
Senate Committee on Budget
608 Dirksen Senate Office Building
Washington, D.C. 20510

Re: MGMA Testimony — "Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care"

Dear Chairman Whitehouse and Ranking Member Grassley:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Committee for holding this important hearing on alleviating administrative burdens in healthcare. We appreciate the opportunity to provide feedback on this topic as the negative effects of onerous administrative burdens on medical groups are particularly acute.

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 feedback regarding the impact of regulatory burden on small medical group practices.

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. Yet, as indicated in MGMA's annual regulatory burden surveys, the arduous requirements imposed on medical groups continue to rise, further impeding practices' ability to ensure high-quality, timely patient care.

Medical groups constantly face a barrage of administrative and regulatory burdens that divert resources away from patient care. Ninety percent of medical groups said that the overall regulatory burden on their practices had increased over the previous 12 months and 97% of medical groups reported that a reduction in regulatory burden would allow for reallocation of resources toward patient care.

MGMA is encouraged by the Committee's willingness to examine ways to alleviate these regulatory burdens. We support policies that promote innovative, high- quality, and cost-effective care delivery untethered from excessive, one-size-fits-all regulations.

Reducing burden in the Quality Payment Program

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). While MACRA was a step in the right direction, the reporting burden for medical groups under the QPP is substantial — 67.19% of MGMA members surveyed for the 2023 annual regulatory burden report found QPP reporting to be extremely or very burdensome. Both MIPS and APMs contain specific policies that increase administrative burden, without adding value.

MIPS reporting

There are a multitude of factors contributing to increased administrative burden under MIPS. The MIPS program 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.

A study from the Weill Cornell Medical College found that MIPS scores inconsistently relate to performance on process and outcome measures. The study found that physicians treating more medically complex patients were more likely to receive low MIPS scores despite providing high-quality care. Medical groups report that MIPS reporting requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities.

Small practices are disproportionately impacted by MIPS policies as they often do not have the same resources, staff, and capital as large systems. In 2022, the Small, Underserved, and Rural Support (SURS) technical assistance program ended due to a lack of congressional funding. This program was vital in assisting small practices' compliance with the constantly evolving policies in MIPS, and its expiration further
exacerbates small practices' ability to meet program requirements. The *SURS Extension Act* would help rectify this problem by reinstating the program.

CMS proposed to increase the MIPS performance threshold from 75 points in 2023 to 82 points in the 2024 proposed Medicare Physician Fee Schedule (PFS). While we are thankful the agency maintained the current threshold at 75 points, this number is already too high as the mean MIPS score for small groups in 2021 was 73.71, according to the most recent QPP Experience Report. A further increase of the threshold would result in even more small physician practices receiving a negative adjustment.

APM development and reporting

A major barrier medical groups face in transitioning to value-based care is the lack of clinically relevant APMs available to them. Seventy-eight percent of medical groups reported Medicare does not offer an APM that is clinically relevant to their practice, with 56% of MGMA members noting they would be interested in participating in a clinically relevant model. The Centers for Medicare & Medicaid Innovation (CMMI) and private sector entities under the Physician-Focused Payment Model Technical Advisory Committee (PTAC) can develop APMs. Unfortunately, CMMI, who possess the sole responsibility to test and implement the APM, has yet to test any of the models PTAC has recommended.

In conjunction with a shortage of APMs, 94% of MGMA members responded that moving to value-based care initiatives has not lessened the regulatory burden on their practices. This is exemplified by recently finalized changes in the 2024 PFS that added burdensome promoting interoperability reporting requirements in the Medicare Shared Savings Program (MSSP), as well as certified health information technology utilization requirements that are set to take 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.

Small practices find it especially hard to join APMs and need support including investments, resources, and tools to transition to value-based care. Unfortunately, the incentive payment that was meant to help facilitate the transition to APMs has been gradually decreased, first from 5% to 3.5%, then to 1.88% this year, and will cease to exist next year without congressional intervention. These shifting requirements and ambiguous incentives work in concert to add confusion and instability to APM participation. We urge the Committee to support the *Value in Health Care Act* which would extend the APM incentive payment at 5% and make additional changes to facilitate the transition to value-based care.

Supporting medical groups through stabilizing physician reimbursement

While medical groups grapple with administrative burdens stemming from the QPP, they continue to face challenges related to high rates of inflation, staffing shortages, and reimbursement challenges. Physician practices cannot continue to divert financial and staff resources away from patient care to comply with duplicative MIPS requirements. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities. The researchers concluded that if physicians see an average of four patients per hour, then the 53 hours spent on MIPS-related activities could be used to provide care for an additional 212 patients per year. The same study found that MIPS cost practices $12,811 per physician to participate in 2019.

According to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63% from 2013–2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe. Moreover, 89% of medical groups reported an increase in operating costs in 2023. The 2024 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on Medicare participation: "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation … Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term." This echoes what medical

groups are saying, with 87% of groups reporting reimbursement not keeping up with inflation impacts current and future Medicare patient access.

MGMA supports the bipartisan *Strengthening Medicare for Patients and Providers Act*, which would tie Medicare reimbursement to the Medicare Economic Index. This commonsense legislation is needed to not only align with other payment systems, but adequately account for the cost of operating medical groups. Additional modernizing changes are needed to the budget neutrality aspect of Medicare; the *Provider Reimbursement Stability Act would* make welcomed reforms such as increasing the budget neutrality triggering threshold from $20 million to $53 million (while adding an update to keep pace with inflation), and instituting new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates.

Reducing prior authorization requirements and burdens

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running a practice and delivering high-quality care. Increasing prior authorization requirements are detrimental to both practices and the patients they treat. Prior authorization requests disrupt workflow, increase practice costs, and result in dangerous denials and delays in care. In 2018, MGMA partnered with several provider groups and health plans to publish a *Consensus Statement on Improving the Prior Authorization Process*. These organizations agreed that selective application of prior authorization, volume adjustment, greater transparency and communication, and automation were areas of opportunity to improve upon. However, since the time this consensus statement was released, medical groups have reported little progress in any of these areas.

MGMA is increasingly alarmed by reports of rising prior authorization requirements — 89% of medical groups stated 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 has only recently begun to finalize 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 as these requirements disproportionally impact small businesses and medical groups who do not have the resources, infrastructure, and personnel to process these prior authorization requests.

It is critical that Congress step in and provide much-needed relief from these arbitrary requirements. The *Improving Seniors' Timely Access to Care Act*, which we anticipate will soon be reintroduced, and the *GOLD CARD Act* are just a few pieces of legislation that would help alleviate the unnecessary burden of prior authorization.

Improving the *No Suprises Act* independent dispute resolution process

MGMA applauds 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 *No Suprises Act* (NSA) requirements have increased administrative and financial burden for physician practices.

MGMA continues to hear how high administrative fees, overreliance on the qualifying payment amount (QPA), lack of insurer engagement during the open negotiation process, and the ongoing backlog in the independent dispute resolution (IDR) process have created an imbalance in power between the provider and insurer parties, threatening the financial viability of group practices. These ongoing challenges have made it nearly impossible for medical groups with fewer resources to even utilize the IDR process, thereby forcing them to accept lower reimbursements.

A recent Government Accountability Office (GAO) report highlights these challenges medical groups are experiencing with the implementation of the NSA. Unsurprisingly, the report found that initiating parties (mainly providers) prevailed in 77% of disputes initiated between January 1 and June 30, 2023. This further underscores the legitimacy of provider disputes, and the need to ensure that the IDR dispute process is fair. MGMA urges Congress to work with the Administration to rectify these issues 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.

Conclusion

We thank the Committee for its leadership on this critical issue. We look forward to working with you to craft reasonable policies that will allow medical group practices to continue providing high-quality patient care without unnecessary administrative barriers. 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