ANNUAL REGULATORY BURDEN REPORT

OCTOBER 2022

CONTENTS

INTRODUCTION

The results of the Medical Group Management Association's (MGMA) Annual Regulatory Burden survey reveal that medical practices continue to face overwhelming regulatory challenges. In many cases, the burden has increased year over year. This year's annual report highlights the ongoing burden associated with prior authorization and the Medicare Quality Payment Program, but also challenges related to newer policies, such as the good faith estimates included in the No Surprises Act.

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 medical groups. 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 500 group practices. 64% of respondents are in practices with less than 20 physicians and 15% are in practices with over 100 physicians. Over 75% of respondents are in independent practices.

About MGMA

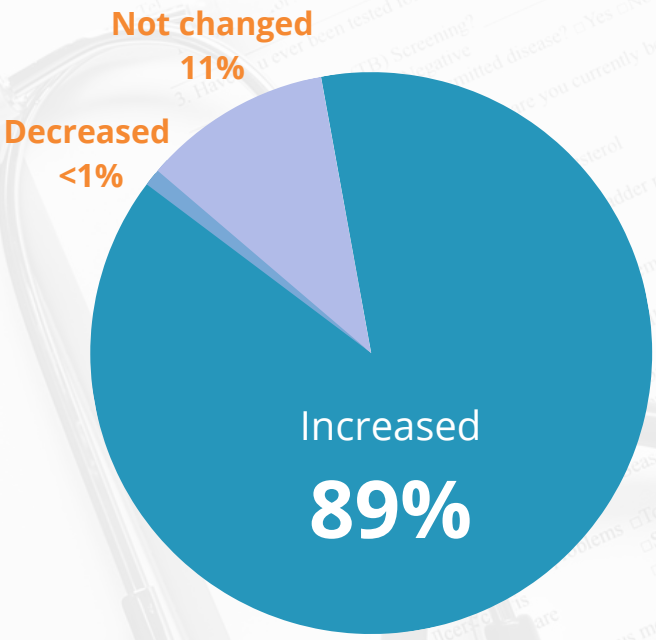
With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties. For more information on how MGMA is advocating for medical practices in Washington, please visit mgma.com/advocacy or contact us at govaff@mgma.org.

CURRENT STATE OF REGULATORY BURDEN

MGMA has long advocated that policymakers in Washington scale back regulatory burden for medical practices, arguing that these requirements divert time and resources away from delivering patient care. Yet, as indicated in this year's report, regulatory burden continues to rise.

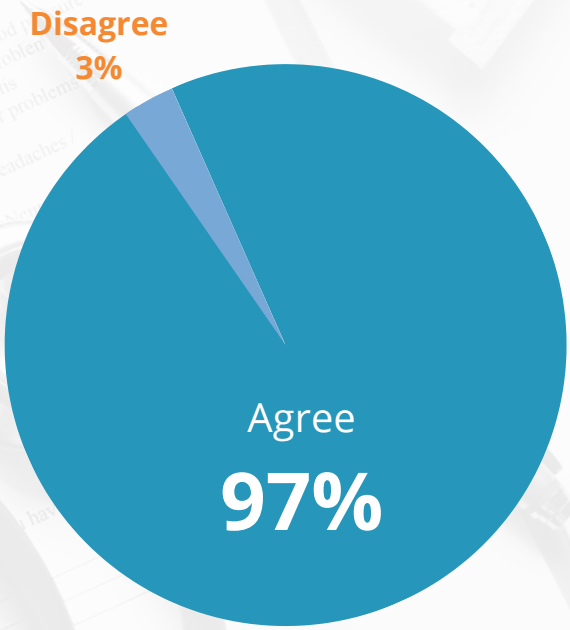
Reducing regulatory requirements that do not improve patient care will assist group practices in focusing on patient care and allow them to invest resources in initiatives that improve healthcare delivery, further clinical priorities, and reduce costs.

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



*Totals do not equal 100% due to rounding

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



What group practices are saying:

"We face staffing issues, and all the regulatory requirements means we cannot actually see as many patients."

"Extremely burdensome to the private practice when resources are already maximized, and all of the responsibilities fall on the administrator. There are no other practice resources available."

"Physician offices are being squeezed from all sides. Regulatory requirements continue to increase, costs of staffing and medical supplies continue to increase, and what physicians are reimbursed for services provided continues to decrease. This can't continue. Something has got to give."

BURDEN LEVEL BY REGULATORY ISSUE

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

	Not burdensome	Slightly burdensome	Moderately burdensome	Very or extremely burdensome
Prior Authorization	2.20%	4.41%	11.45%	81.93%
Surprise billing & good faith estimate requirements	2.57%	8.57%	18.42%	70.45%
Medicare Quality Payment Program (MIPS/APMs)	7.00%	7.66%	20.79%	64.56%
Audits and appeals	2.34%	6.49%	27.27%	63.90%
Medicare Advantage chart audits	7.28%	11.04%	20.75%	60.93%
Translation and interpretation requirements	7.96%	17.42%	23.87%	50.75%
Lack of EHR interoperability	8.30%	14.85%	26.42%	50.44%
COVID-19 Provider Relief Fund reporting requirements	10.60%	13.02%	34.00%	42.38%
Medicare & Medicaid credentialing	7.33%	18.97%	32.54%	41.17%

What group practices are saying:

"All these items have significant impact on our resources; patients typically take the brunt of this. Patient care has been lost in all these requirements."

"We are being slowly strangled financially because of the cost increase associated with complying with regulatory requirements while reimbursements remain the same or are being cut."

"Constant burden and fear we are not doing enough despite measures in place. Increases employee and provider burnout as it takes away from quality of care."

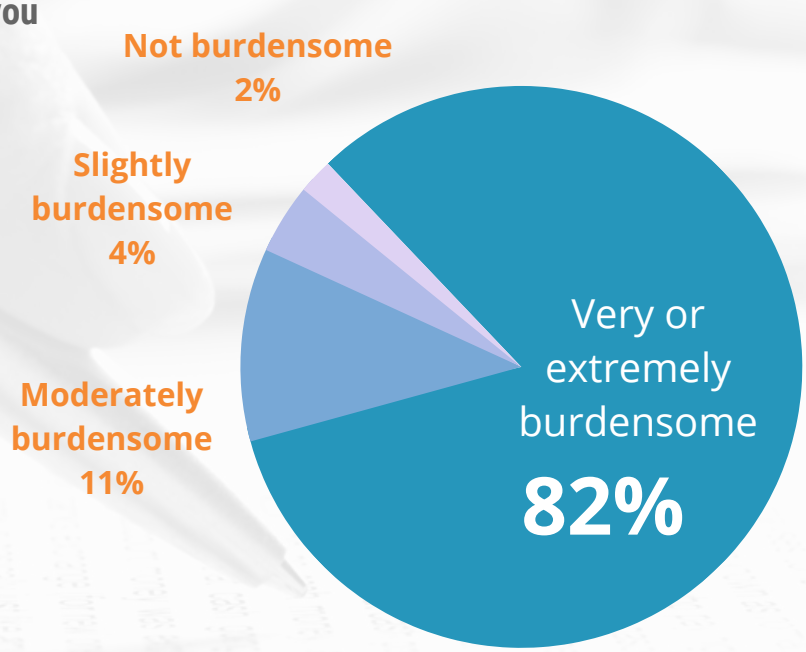
"With the increased challenges of staffing due to COVID, we are seeing burnout at all levels of the organization due to the increased load of work duties from regulatory issues. We continue to see coders, providers, managers, and other clinical and administrative staff leaving the healthcare field to look for jobs in fields with less stress and more appropriate workloads."

PRIOR AUTHORIZATION

Administrative requirements, such as prior authorization, not only delay patient care but also increase provider 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:

"We have a prior authorization approval rate of 99.87%. The fact that we've had to hire 3 additional FTE's this year to manage PA's that always get approved is very frustrating and only adds to the cost of medical care."

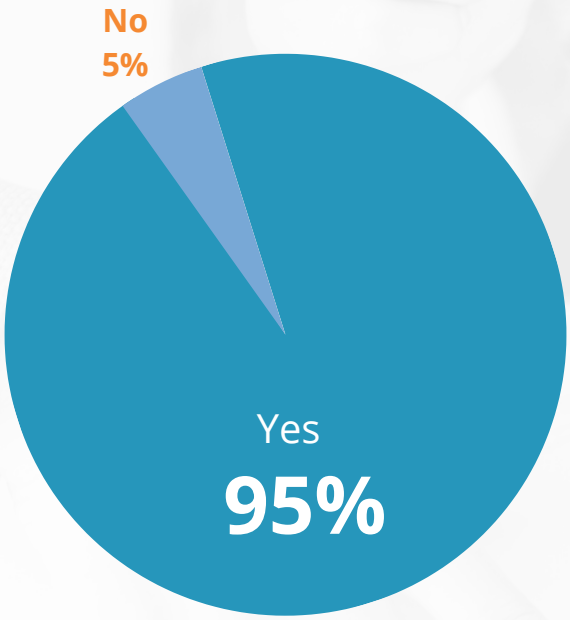
"In my over 15 years in practice management, we went from 1 FTE handling prior authorization and all audits we now employee 12 FTEs while our practice has grown 20%."

"The prior authorization process, specifically with commercial payers, has become increasingly burdensome for our staff and expensive for us. Most importantly, it unnecessarily delays care for our patients. At this point in time, we have a patient who needs a procedure and has been waiting for three weeks for prior authorization."

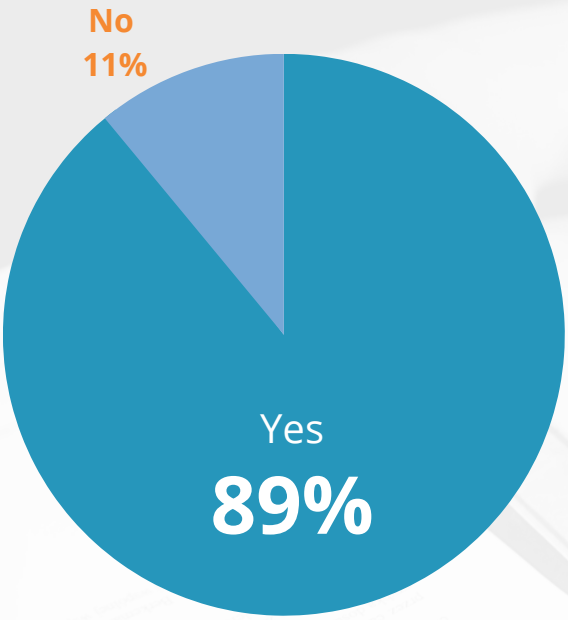
PRIOR AUTHORIZATION (CONT.)

With an increase in utilization of prior authorization across both commercial payers and Medicare Advantage, practices are struggling to ensure patients continue to maintain access to medically necessary care. Prior authorization processes can vary greatly across payers, resulting in a convoluted and overly burdensome process. 89% of practices have had to hire additional staff or redistribute current staffing resources to process prior authorizations due to the increased number of requests.

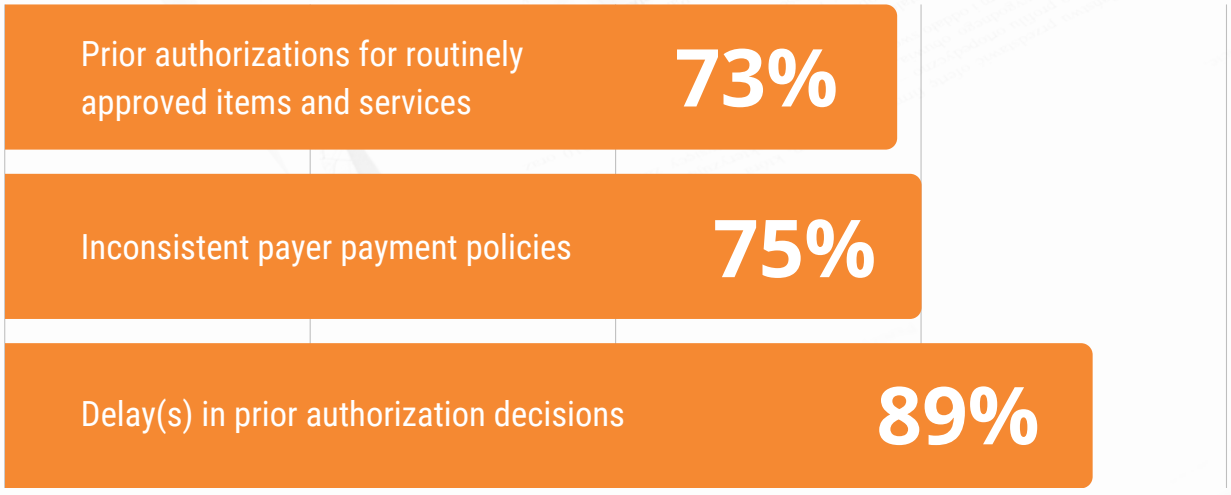
Have your patients experienced delays or denials for medically necessary care due to prior authorization requirements?



Has your practice hired or redistributed staff to work on prior authorizations due to the increase in requests?



Top Challenges with Prior Authorization

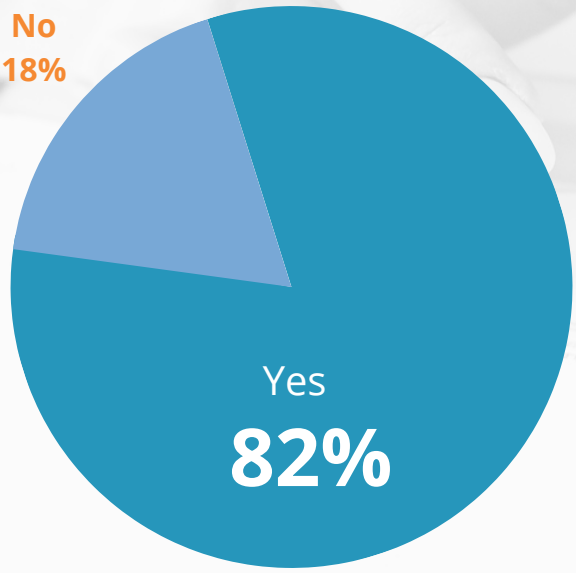


SURPRISE BILLING

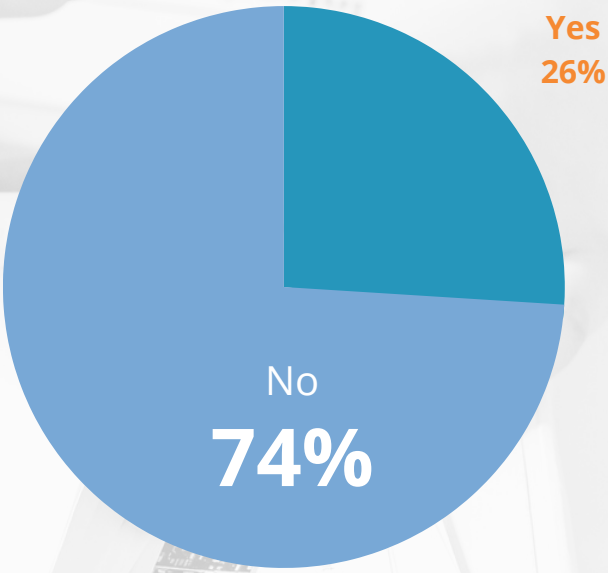
The No Surprises Act prohibited balance billing practices for certain out-of-network care and established several new patient transparency protections, such as the uninsured or self-pay good faith estimate (GFE) process, provider directory requirements, and continuity of care protections. These newly enacted mandates created significant burden for practices upon their implementation on Jan. 1, 2022.

While supportive of ensuring patients are protected from malicious balance billing practices and have the cost estimate information necessary to make informed decisions about their care, MGMA remains concerned that these policies, as implemented, create undue burden without improving care.

Has the uninsured or self-pay good faith estimate (GFE) requirement increased administrative burden on your practice?



Does your practice have the technical infrastructure to comply with convening/co-provider requirements beginning Jan. 1, 2023?



What group practices are saying:

"The new No Surprise/GFE process has been EXTREMELY burdensome. Our staff spend much more time working on this administrative process and less time taking care of patients."

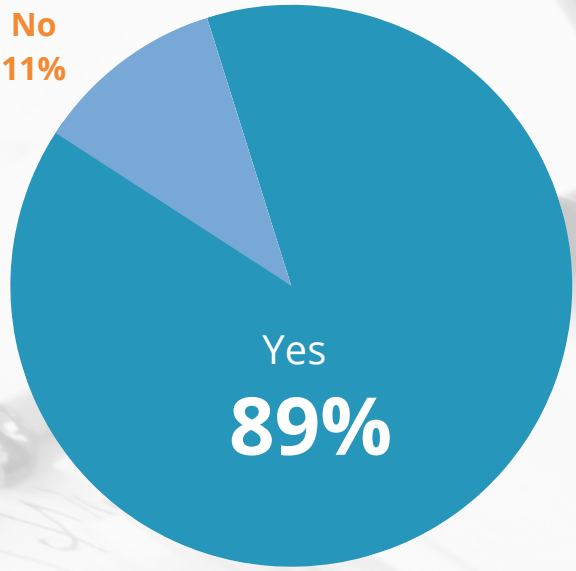
"The good faith estimates in combination with prior authorizations have become so burdensome that our staff can barely keep up. The changes planned for next year, requiring authorizations for every patient, may very well break us."

SURPRISE BILLING (CONT.)

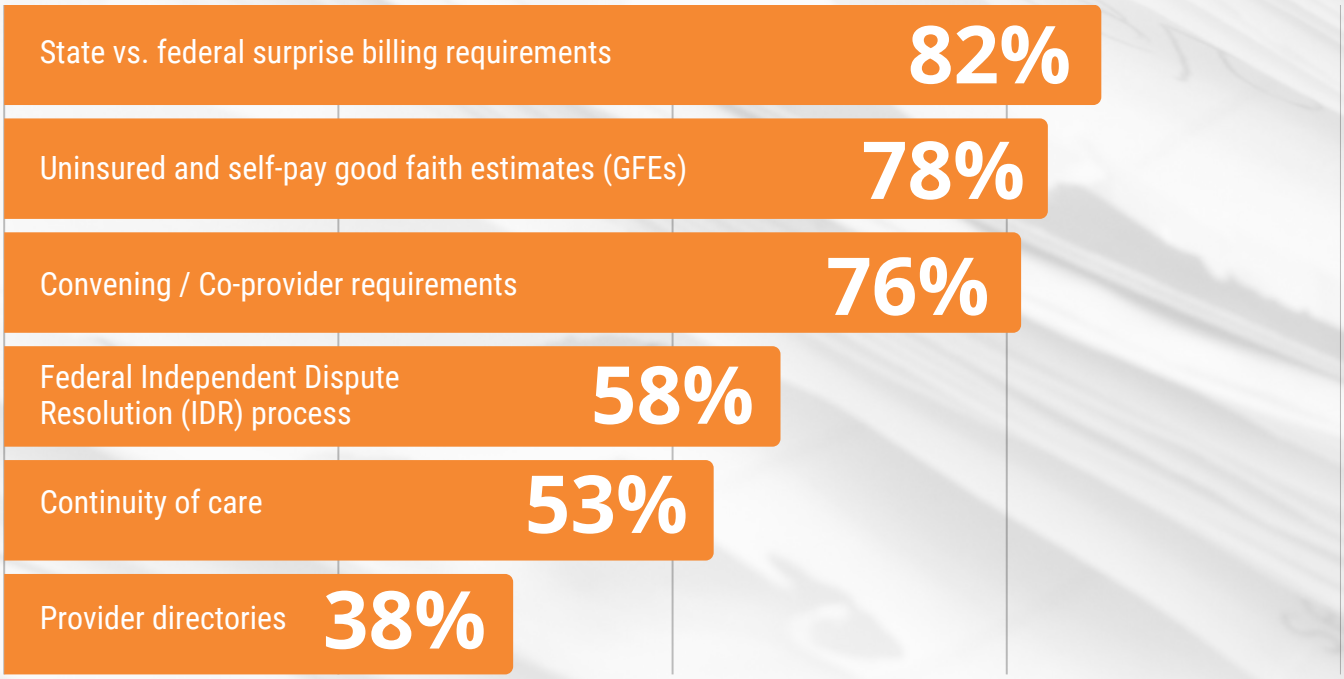
Many of the provisions under the No Surprises Act have already taken effect, however, confusion and misunderstanding of the requirements remain. The GFE process for uninsured and self-pay patients went into effect on Jan. 1, 2022, yet 78% still require additional guidance from the Centers for Medicare and Medicaid Services (CMS) to fully understand this new policy.

Looking ahead to 2023, additional requirements are scheduled to take effect. However, group practices still require appropriate guidance from the Administration and time to implement these new complex policies, if they are to be enacted.

Is your practice concerned with additional administrative burden related to the implementation of the advanced explanation of benefits (AEOB) requirement?



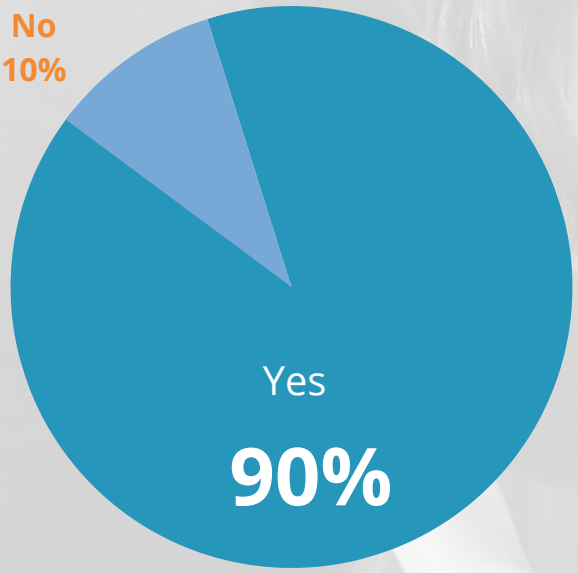
Is additional guidance from CMS necessary to fully understand the following policies under the No Surprises Act? (Yes)



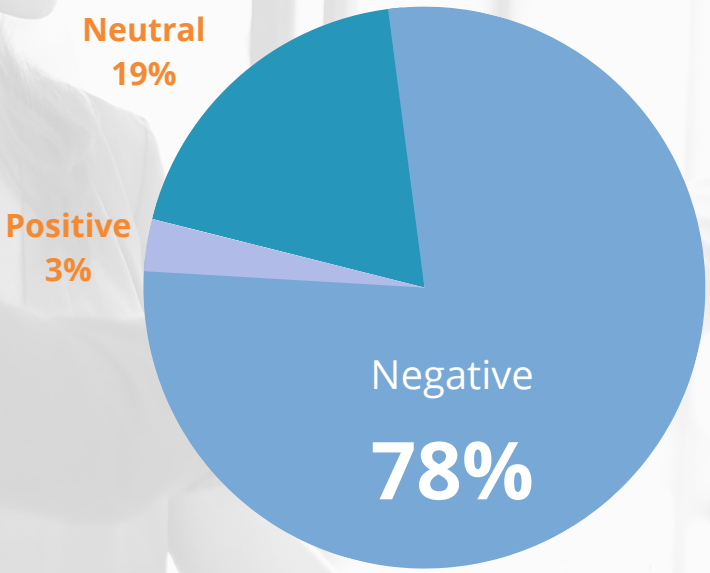
HEALTHCARE CONSOLIDATION

In recent years, there has been an increase in the number of mergers and acquisitions in the healthcare industry, and with this business trend, there has simultaneously been an increase in scrutiny from the federal government. There are many drivers of consolidation across the U.S. healthcare system. Physician practices that merge with larger groups or hospitals may experience access to greater financial and staffing resources. 76% of medical groups indicate that increasing regulatory burden has been a major contributor to the increasing rate of consolidation in healthcare.

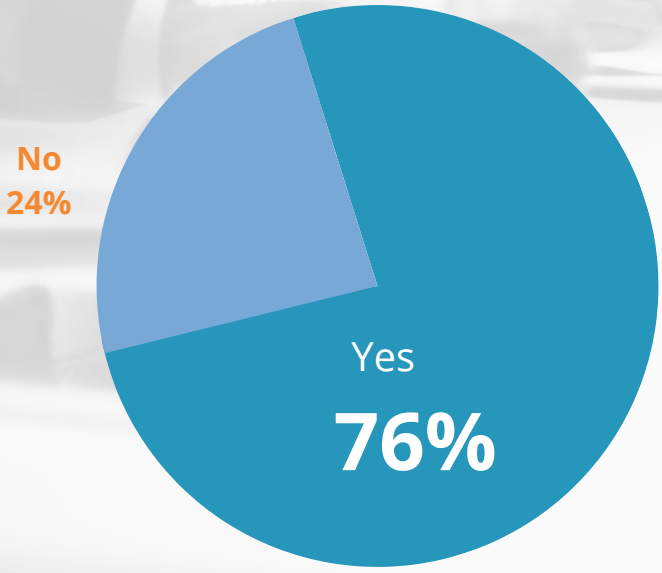
In your opinion, is healthcare consolidation increasing?



How would you describe the overall impact of consolidation on the U.S. healthcare system?



Are increases in regulatory requirements a significant driver of healthcare consolidation?

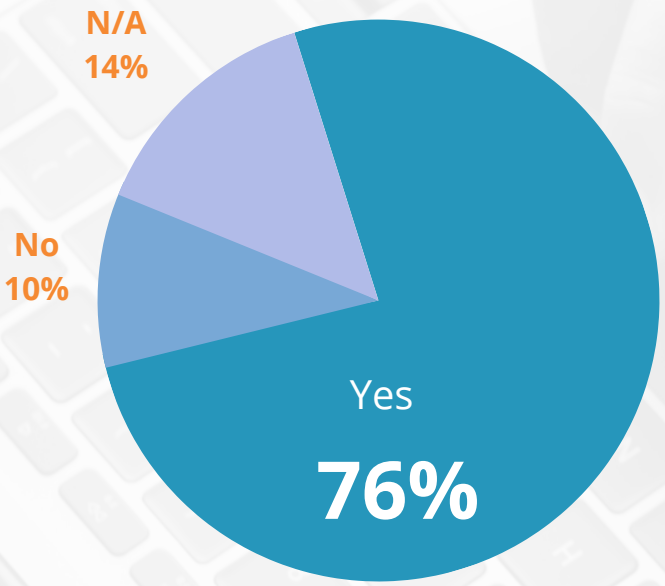


QUALITY PAYMENT PROGRAM

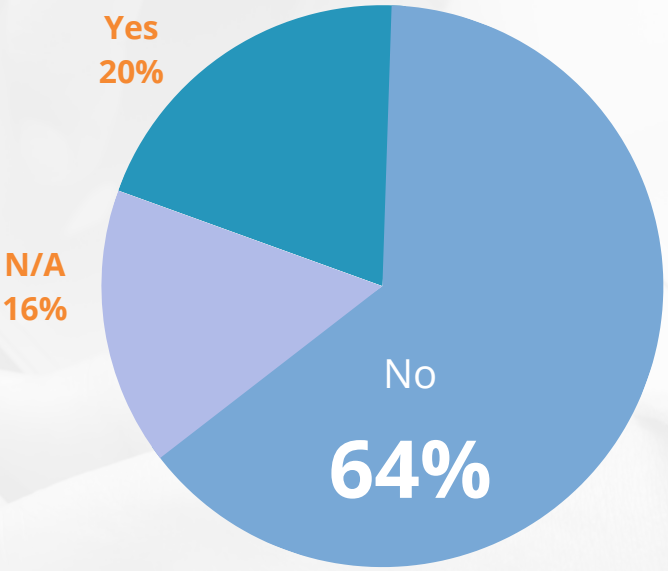
The Quality Payment Program (QPP) created two new reporting pathways to transform care delivery for Medicare beneficiaries by incentivizing the highest quality care, the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

In 2022, 73% of respondents are participating in MIPS. 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, 76% of respondents reported that the CMS implementation of value-based payment reforms has increased the regulatory burden on their practice.

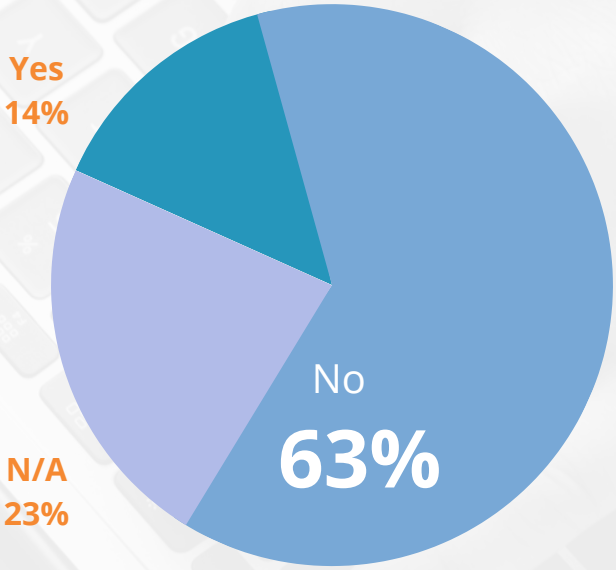
Has the move toward value-based payment (in Medicare/Medicaid) increased the regulatory burden on your practice



Has the move toward value-based payment (in Medicare/Medicaid) improved the quality of care for your patients?



Overall, has the move toward paying physicians based on value been successful to date?

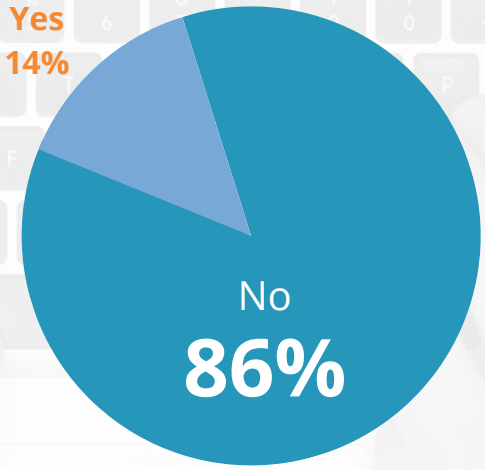


QUALITY PAYMENT PROGRAM: MIPS

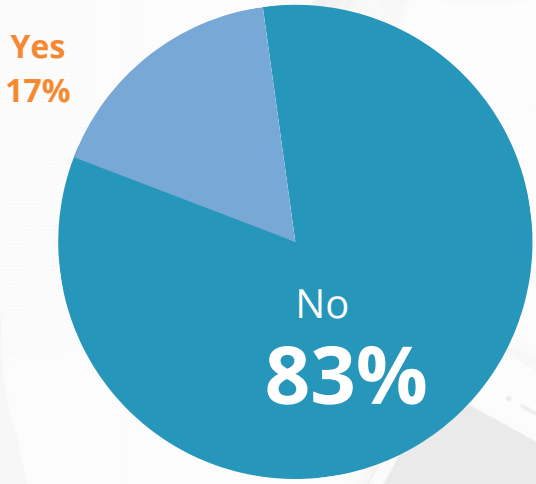
Current quality reporting programs require reporting a large number of measures, but they are often not drivers of meaningful improvements. MGMA has longstanding concerns that MIPS cost measures unfairly penalize clinicians and group practices for costs over which they have no control. MGMA regularly 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 actionable in assisting your practice in improving clinical outcomes or reducing healthcare costs related to the...

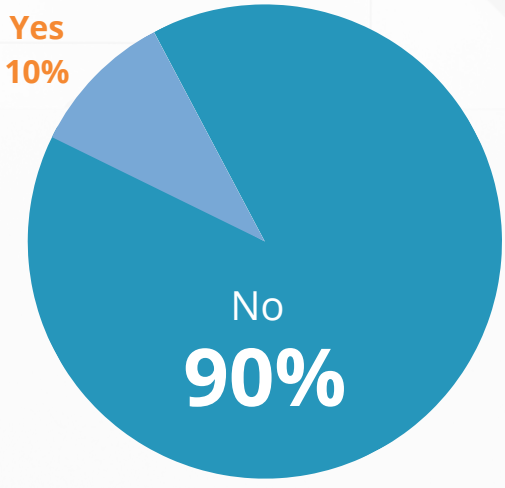
...cost performance category?



...quality performance category?



Do positive payment adjustments cover the costs of time and resources spent preparing for and reporting under the MIPS program?



What group practices are saying:

"MIPS/APMs create a significant burden on the practice; we are measuring things that truly don't improve care in a specialty practice. The measures are very primary care driven and work well for a healthcare system, not a standalone independent single specialty practice."

"MIPS is getting harder to achieve no penalty. Countless hours are spent training staff, especially difficult with staffing shortages and high turnover rates. These requirements mean we cannot focus time and money on the patient care that matters most."

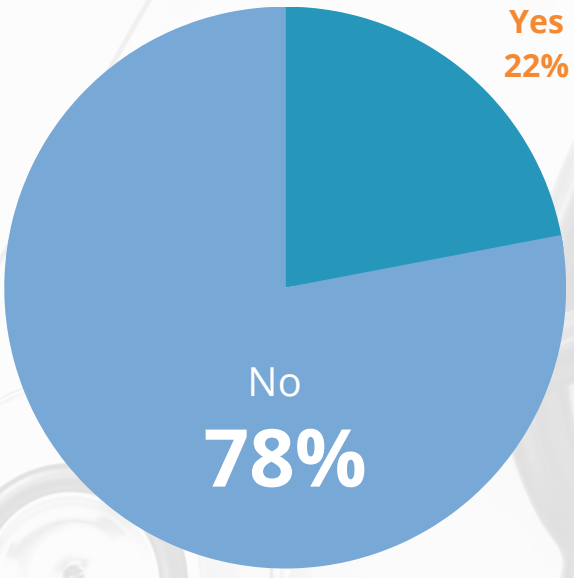
"MIPS is difficult due to measures not applying to our specialty and our EHR can't seem to track them."

QUALITY PAYMENT PROGRAM: APMs

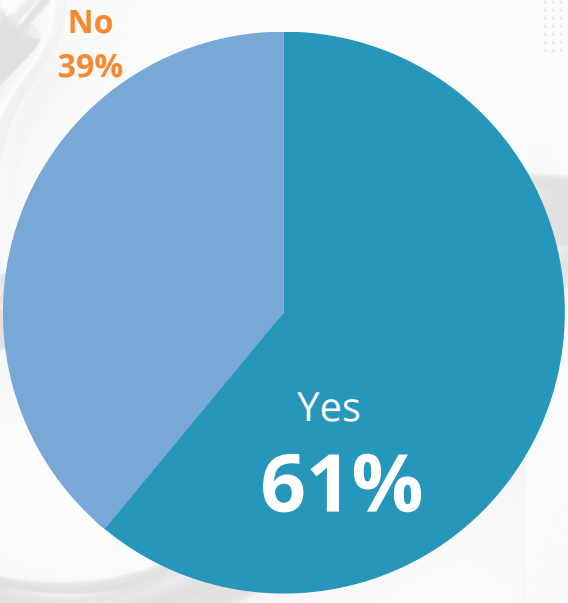
The goal of Advanced Alternative Payment Models (APMs) is to improve quality of care or patient outcomes without increasing spending. The Medicare Access and CHIP Reauthorization Act (MACRA) was passed to incentivize participation in APMs. This landmark legislation also created MIPS as an alternative quality pathway, which was intended to be an on-ramp to APM participation.

MGMA has expressed concerns to the Center for Medicare and Medicaid Innovation (CMMI) in response to its recent proposal to create a more streamlined and condensed portfolio of APMs. There is no single approach to APMs that will work for all practices or specialties. Different specialties are responsible for the provision of different types of care, and thus there is no one-size-fits-all approach to APM design. Within the current portfolio of APM offerings, a majority of MGMA practices do not have a clinically appropriate model in which to participate. Therefore, consolidating the CMMI portfolio of APMs, focusing on primary care and episodes of care, will continue to make widespread APM participation a challenge.

Does Medicare offer an Advanced APM that is clinically relevant to your practice?



Would your practice be interested in participating in an Advanced APM if it was clinically relevant and aligned with your quality goals?



SURVEY PARTICIPANT DEMOGRAPHICS

How many full-time-equivalent (FTE) physicians are in your organization?	
1-20	30%
21-50	34%
51-100	15%
101+	7%

Which of the following best describes your organization's specialty focus of care?			
Allergy/immunology	<1%	Neurology	2%
Anesthesiology	1%	Neurosurgery	1%
Cardiology	3%	OB/GYN	5%
Critical care	<1%	Ophthalmology	3%
Dermatology	4%	Oncology	<1%
Emergency medicine	1%	Orthopedic surgery	7%
Endocrinology	<1%	Otolaryngology	3%
Family practice	11%	Pain management	1%
Gastroenterology	4%	Pathology	<1%
General surgery	2%	Pediatric medicine	6%
Geriatrics	<1%	Psychiatry	<1%
Infectious disease	1%	Radiology	1%
Internal medicine	3%	Rheumatology	2%
Multispecialty w/ primary & specialty care	18%	Urology	1%
Multispecialty w/ specialty care only	3%	Other	11%
Nephrology	2%		

Which of the following best describes your organization?	
Independent medical practice	78%
Hospital or integrated delivery system (IDR), or medical practice owned by hospital or IDS	13%
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	5%

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