July 18, 2023

The Honorable Beth Van Duyne
Chairwoman
House Committee on Small Business
Oversight, Investigations & Regulations Subcommittee
2361 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kweisi Mfume
Ranking Member
House Committee on Small Business
Oversight, Investigations & Regulations Subcommittee
2069 Rayburn House Office Building
Washington, D.C. 20515

Re: MGMA Testimony — "Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses"

Dear Chairwoman Van Duyne and Ranking Member Mfume:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Subcommittee for holding this hearing on "Burdensome Red Tape: Overregulation in Health Care and the Impact on Small Businesses." We appreciate the opportunity to provide feedback on this important topic.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems representing more than 350,000 physicians. 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 onerous requirements imposed on medical groups continue to rise, further impeding a practice's ability to ensure high-quality, timely patient care. MGMA's diverse membership uniquely situates us to offer the following feedback regarding the impact of regulatory burden on small medical group practices.

Background

Research published by *Health Affairs* found that administrative spending accounts for between 15 and 30% of medical spending. Separately, *Health Affairs* also noted that not all administrative spending adds value, citing the redundancy of quality and pay-for-performance systems. Medical groups constantly face a barrage of administrative and regulatory burdens that divert resources away from patient care. Eighty-nine percent of medical groups report that the overall regulatory burden on their practices has increased over the past 12 months and 97% of medical groups report that a reduction in regulatory burden would allow for reallocation of resources toward patient care. MGMA is encouraged by the Subcommittee's willingness to examine the impact of burdensome red tape on small businesses. We support policies that promote innovative, high-quality, and cost-effective care delivery untethered from excessive, one-size-fits-all regulations.

Ongoing challenges

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 program is substantial — 64.56% of MGMA members surveyed for the 2022 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 reporting program requires that clinicians 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.

In the 2024 proposed Medicare Physician Fee Schedule (PFS), CMS proposes to increase the MIPS performance threshold from 75 points in 2023 to 82 points for 2024. This increase from an already high 2023 threshold will result in penalties for many small practices as the mean MIPS score for small groups was 73.71 points in 2021, according to the most recent QPP Experience Report. CMS estimates that 46% of MIPS eligible clinicians would receive a negative payment adjustment for the CY 2024 performance period/2026 MIPS payment year if the proposed PFS policies are finalized.

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 61% of members being 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. Small practices especially find it hard to join APMs and need support through investments, resources, and tools to transition to value-based care.

In conjunction with a shortage of APMs, 76% of MGMA members reported that the CMS implementation of value-based payment reforms has increased the regulatory burden on their practice. The qualifying participation (QP) threshold to participate in an APM is unreasonably high, and CMS has recently proposed in the 2024 PFS to increase the threshold. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS. Shifting requirements and ambiguous incentives work in concert to add confusion and instability to APM participation.

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. Moreover, the American Medical Association's analysis of Medicare Trustees report data found that Medicare physician payment has ultimately been reduced by 26% when adjusted for inflation over the past 20 years. A congressional solution, such as the bipartisan *Strengthening Medicare for Patients and Providers Act*, is needed to better support physician practices while policymakers examine commonsense ways to reform physician payment and address pervasive administrative burden.

Reducing prior authorization requirements and burdens

Prior authorization requirements are routinely identified by medical groups as the most challenging and burdensome obstacle to running their practices 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 report little progress in any of these areas.

MGMA is increasingly alarmed by reports of rising prior authorization requirements — 98% of medical groups recently reported that prior authorization requirements had stayed the same or increased over the previous 12 months. Seventy-seven percent of groups reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests. Sixty percent of groups surveyed reported that there were at least three different employees involved in completing a single prior authorization request. Group practices are already facing significant workforce shortage issues — this situation is simply unsustainable.

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, little has been done to adequately address these concerns. These requirements disproportionally impact small businesses and medical groups who do not have the resources, infrastructure, and personnel to process these prior authorization requests. Especially, if the requests are ultimately approved. It is critical that Congress step in and provide much-needed relief from these arbitrary and burdensome requirements.

Conclusion

We thank the Subcommittee for its leadership on this critical issue. We look forward to working with you and your congressional colleagues to craft commonsense 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 Claire Ernst, Director of Government Affairs, at cernst@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs