



ANNUAL REGULATORY BURDEN REPORT

OCTOBER 2021

McMA

Medical Group Management Association®

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INTRODUCTION

The results of the Medical Group Management Association (MGMA)'s 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 impact of the ongoing public health emergency and the government response. The regulatory burden associated with the COVID-19 pandemic quickly emerged as a top issue group practices are facing in 2021.

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 400 group practices. 70% of respondents are in practices with less than 20 physicians and 10% are in practices with over 100 physicians. Over 80% of respondents are in independent practices.

About MGMA

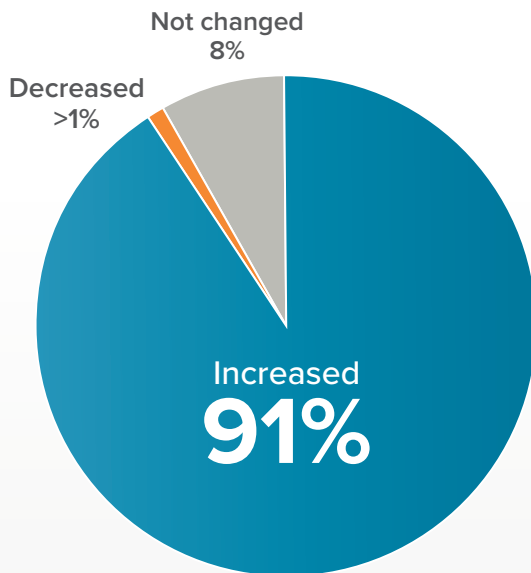
With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national 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

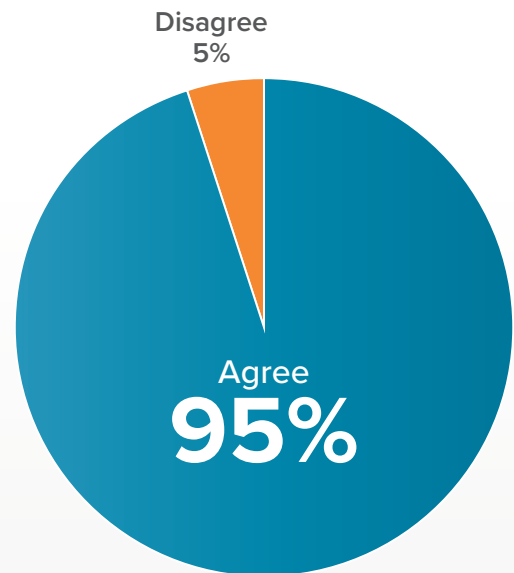
MGMA has long advocated that policymakers in Washington scale back regulatory burden for medical practices, arguing that these requirements divert time and resources away from delivering patient care. Yet, as indicated in this year's report, regulatory burden continues to rise.

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.

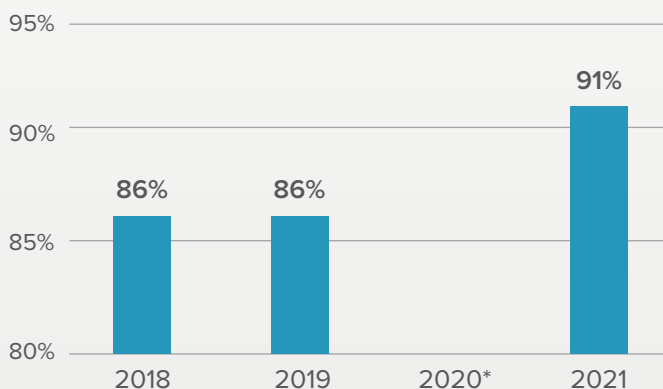
The overall regulatory burden on your medical practice over the past 12 months has:



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



Increase in Regulatory Burden on Medical Practices (2018-2021)



*Due to the impact of the COVID-19 pandemic, MGMA did not conduct the Annual Regulatory Burden survey in 2020.

What group practices are saying:

"[The Centers for Medicare and Medicaid Services] and [the Office of Management and Budget] grossly underestimate the cost in time and resources necessary to implement their regulations."

"We have had to employ additional admin staff and/or hire vendors to comply with [regulatory] requirements."

"Pretty much every decision from a physician is scrutinized..."

"Regulations continue to change, and the tools provided to meet the measures never put the burden on the vendors, the burden is always placed on the physician office."

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%	3%	7%	88%
COVID-19 workplace mandates	3%	8%	18%	71%
Medicare Quality Payment Program (MIPS/APMs)	6%	6%	16%	71%
COVID-19 Provider Relief Fund reporting requirements	3%	7%	23%	67%
Audits and appeals	3%	10%	22%	65%
Medicare Advantage chart audits	7%	10%	22%	60%
Lack of EHR interoperability	7%	12%	24%	56%
Translation and interpretation requirements	10%	16%	28%	47%
Medicare and Medicaid credentialing	6%	17%	35%	42%

What group practices are saying:

“Providers are spending too much on administrative time and personnel to fulfill these regulatory issues.”

“Some programs sound okay on paper but when implemented are burdensome and do not result in improved patient care.”

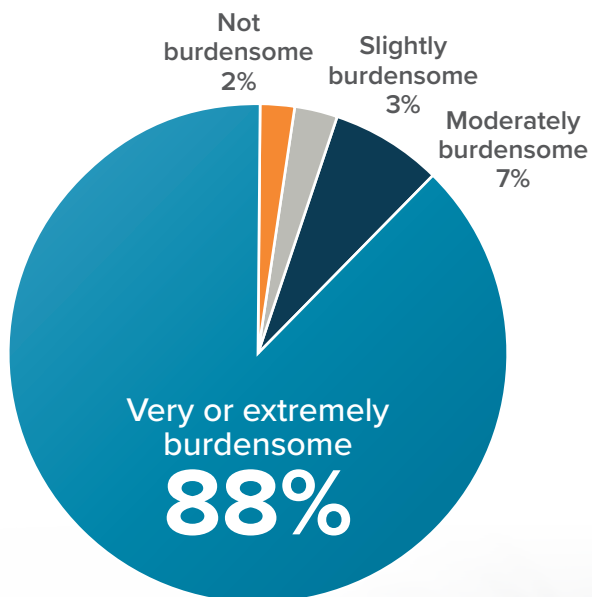
“Regulatory, audit, MIPS/APMS, and other requirements would not be so burdensome if government agencies would communicate openly and transparently about how to comply.”

PRIOR AUTHORIZATION

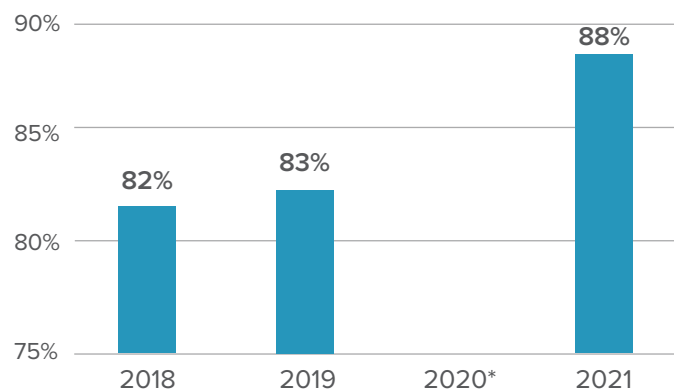
Administrative requirements, such as prior authorization, not only delay patient care but also increase provider costs and burden. For years, payers have required medical practices to obtain prior authorization before providing certain medical services and prescription drugs to patients. These health 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?



Increase in Regulatory Burden of Prior Authorization Requirements



*Due to the impact of the COVID-19 pandemic, MGMA did not conduct the Annual Regulatory Burden survey in 2020.

What group practices are saying:

"Prior authorizations have become extremely burdensome and delay patient care."

"The requirements and inconsistencies have repeatedly delayed care and have required us to hire additional staff simply to keep up with the ever-changing prior authorization environment."

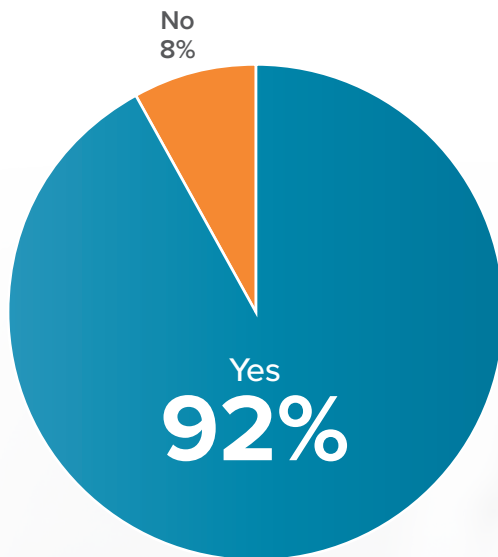
"Prior authorizations have increased tremendously and only delay treatment for the patients, while increasing overhead."

"Prior authorizations are incredibly time consuming and often lead to multiple attempts to try to get patients the care they need."

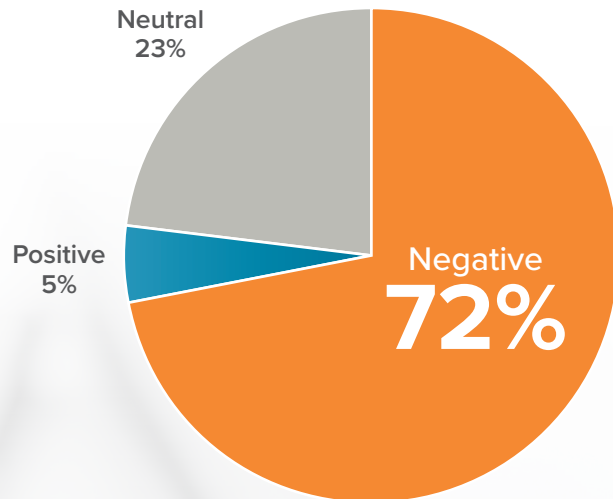
HEALTHCARE CONSOLIDATION

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. 75% of medical groups indicate that increasing regulatory burden has been a major contributor to the increasing rate of consolidation in healthcare.

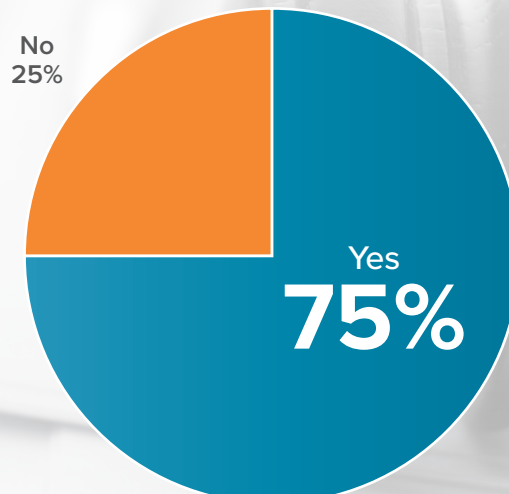
In your opinion, is healthcare consolidation increasing?



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?

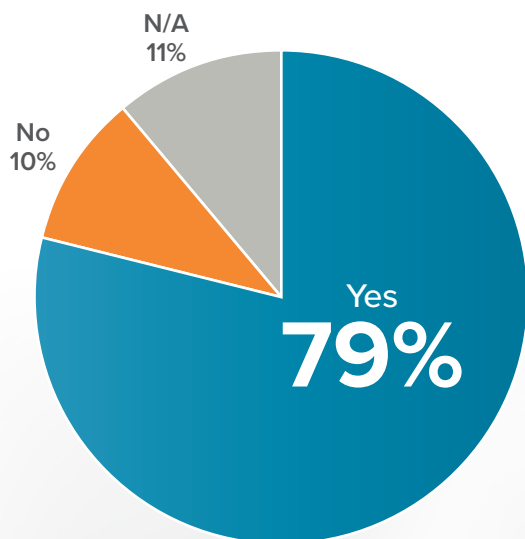


QUALITY PAYMENT PROGRAM

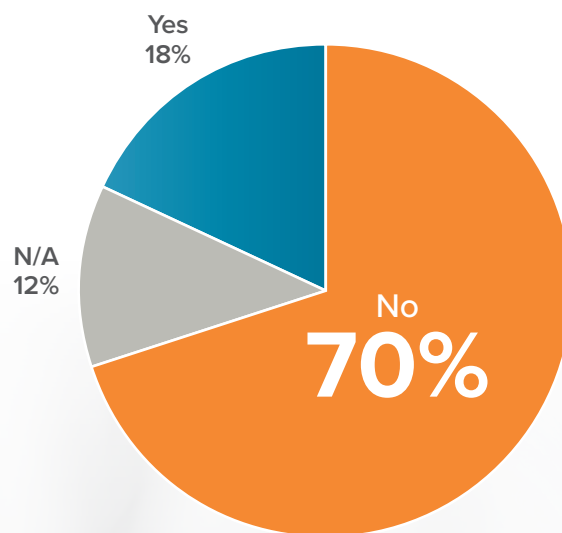
The Merit-based Incentive Payment System (MIPS), which 73% of respondents participate in, continues to present obstacles for those in the program. It is generally seen as a complex compliance program that focuses on reporting requirements rather than an initiative that furthers high-quality patient care. In fact, 79% 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.

Has the move toward value-based payment (in Medicare/Medicaid) ...

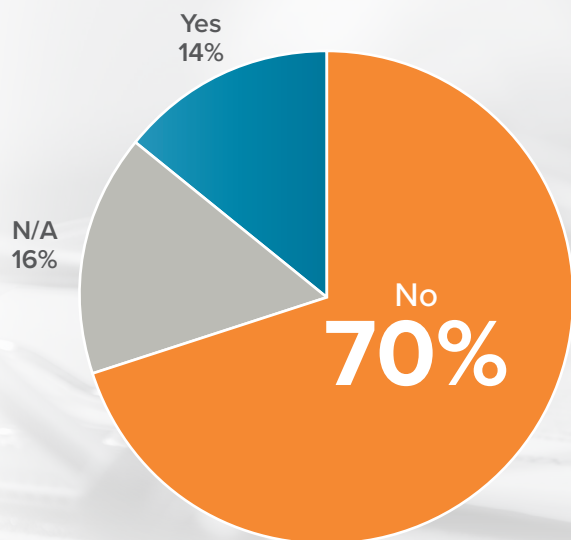
... Increased the regulatory burden on your practice?



... Improved the quality of care for your patients?



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



What group practices are saying:

"I find the pay for performance programs confusing, overly complicated and difficult to explain to others. If the goal is to increase quality while lowering costs, there must be a better way of accomplishing this goal."

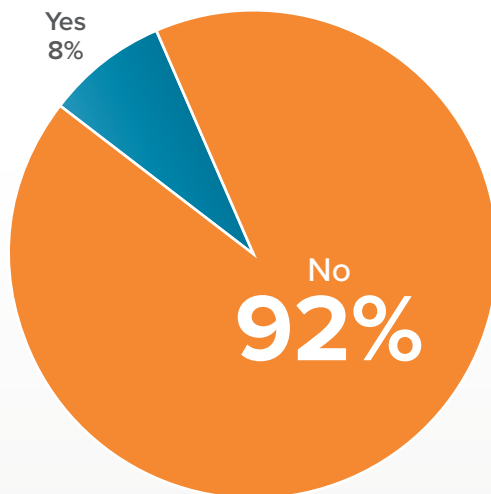
"The majority of our time is spent trying to understand and comply with the latest government requirements – none of which improves the quality of care or lowers the cost of care..."

QUALITY PAYMENT PROGRAM: MIPS

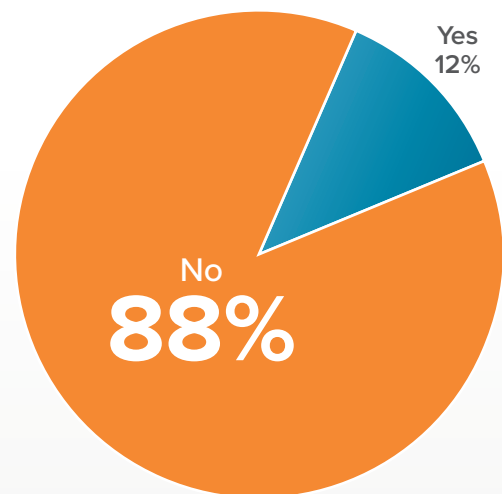
Current quality reporting programs require reporting a large number of measures, but they are often not drivers of meaningful improvements. MGMA has longstanding concerns that MIPS cost measures unfairly penalize clinicians and group practices for costs over which they have no control. MGMA regularly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

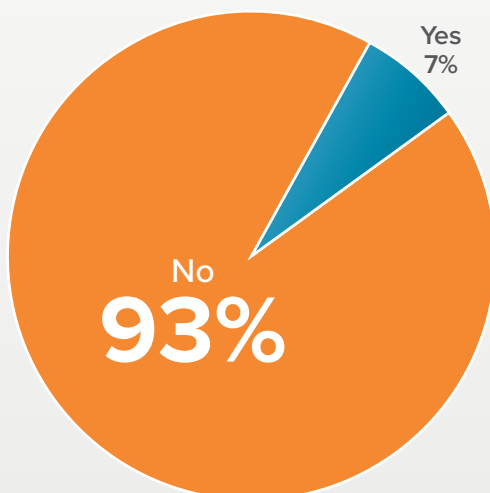
... Cost performance category?



... Quality performance category?



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



What group practices are saying:

“It would be nice to pay attention to our patients instead of a computer screen making sure we have their authorization and MIPS completed.”

“Being required to meet MIPS requirements during a pandemic is pretty much impossible. Our focus is on patient care and COVID questions and appts have taken up more than half the time.”

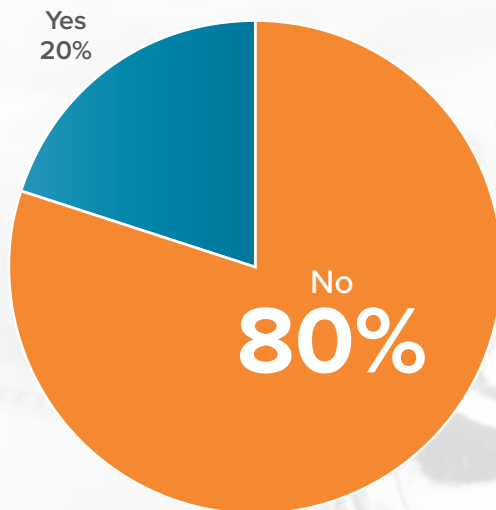
“MIPS program participation is extremely burdensome and doesn’t account for telemedicine which is a patient-centered option that is here to stay.”

QUALITY PAYMENT PROGRAM: APMS

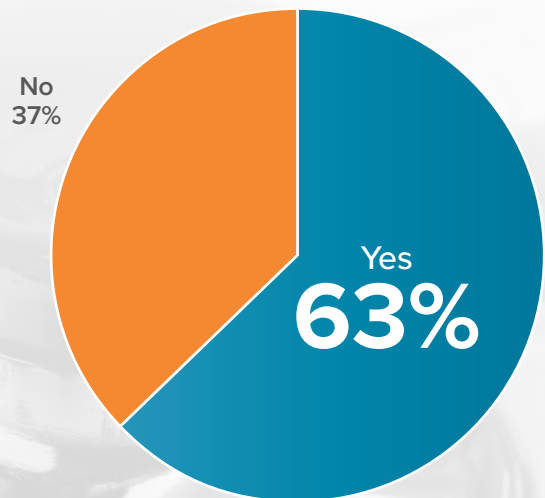
The goal of Advanced Alternative Payment Models (APMs) is to improve quality of care or patient outcomes without increasing spending. The Medicare Access and CHIP Reauthorization Act (MACRA) was passed to incentivize participation in APMs. This landmark legislation also created MIPS as an alternative 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 Alternative Payment Model (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		71%	
21-50		13%	
51-100		5%	
100+		11%	
Which of the following best describes your organization’s specialty focus of care?			
Allergy/immunology	>1%	Neurology	2%
Anesthesiology	2%	Neurosurgery	2%
Cardiac/thoracic surgery	>1%	OB/GYN	7%
Cardiology	3%	Oncology	1%
Critical care	1%	Ophthalmology	1%
Dermatology	4%	Orthopedic surgery	12%
Endocrinology	1%	Other (please specify)	6%
Family practice	13%	Otolaryngology	2%
Gastroenterology	4%	Pain management	1%
General surgery	2%	Pathology	>1%
Hematology	>1%	Pediatric medicine	3%
Infectious disease	1%	Psychiatry	>1%
Internal medicine	5%	Radiology	1%
Multispecialty with specialty care only	2%	Rheumatology	3%
Multispecialty with primary and specialty care	15%	Urology	3%
Nephrology	3%		
Which of the following best describes your organization?			
Independent medical practice		83%	
Hospital or integrated delivery system (IDS), or medical practice owned by hospital or IDS		9%	
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 (please specify)		4%	



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