May 16, 2024

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
215 Dirksen Senate Office Building
Washington, DC 20510

Re: MGMA Statement for the Record — Senate Committee on Finance Hearing, "Rural Health Care: Supporting Lives and Improving Communities"

Dear Chairman Wyden and Ranking Member Crapo:

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 supporting and improving rural healthcare. We appreciate the Committee examining the multifaceted issues facing medical groups in these regions; patient access to care is paramount, and we hope our response today will assist the Committee in enacting legislation to address the current challenges facing practices in rural areas.

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 policy recommendations.

Rural practices face a multitude of challenges in maintaining their ability to operate and provide high-quality care. More than 15% of all Americans live in rural areas, and patients in these areas generally tend to be older and sicker than patients in urban centers.[1] The reality of operating a rural practice, coupled with inflation, staffing shortages, and Medicare physician payment cuts, coalesce to make it difficult for these practices to thrive. Federal policy should support and promote the success of these vital medical groups.

Key Recommendations

- **Provide an annual inflation-based physician payment update based on the Medicare Economic Index (MEI) and modernize the budget neutrality aspect of Medicare payment.** Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023*, which would provide a long-needed annual Medicare physician payment update tied to inflation, as measured by the MEI. Congress needs to also mitigate the negative impact of the antiquated budget neutrality requirements of the Medicare Physician Fee Schedule (PFS) by enacting the *Provider Reimbursement Stability Act of 2023*.

[1] Centers for Disease Control and Prevention, About Rural Health, Nov. 28, 2023.

- **Make commonsense changes to the Merit-based Incentive Payment System (MIPS)** such as alleviating the reporting burden, and extending the Small, Underserved, and Rural Support (SURS) program that expired in 2022.
- **Work to address the physician shortage** by properly funding Graduate Medical Education (GME) programs and increasing Medicare-supported medical residency positions.
- **Implement prior authorization reform.** Prior authorization burden is particularly felt by rural practices and contributes to staff burnout. Congress should enact an updated version of the *Improving Seniors' Timely Access to Care Act* to alleviate what has historically been the number one regulatory burden facing medical groups. The *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* would make additional needed reforms to the prior authorization process if passed into law.
- **Permanently institute many of the telehealth flexibilities currently in place.**
- **Provide positive financial incentives to support rural practices transitioning into value-based care.** Congress should extend the Alternative Payment Model (APM) incentive bonus at 5%, provide resources to assist practices with the transition into APMs, and allow the Centers for Medicare & Medicaid Services (CMS) the ability to set the qualifying participant threshold at an appropriate level that does not discourage APM participation. Numerous provisions in the *Value in Health Care Act of 2023* would help address these concerns.
- **Support the development of physician-led, value-based care models designed to succeed in rural and underserved communities.**

Medicare Reimbursement

While rural practices face unique challenges compared to their urban counterparts, these issues are exacerbated by the dire Medicare physician reimbursement outlook medical groups face throughout the nation. Under the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), Congress repealed the flawed Sustainable Growth Rate (SGR) and reformed Medicare's approach to physician payment. While well intentioned, physician payments have not kept up with inflation or the cost of running a medical practice under MACRA's revised methodology for updating the Medicare PFS.

In addition to no annual positive payment update, medical groups also experience annual reimbursement cuts stemming from 2021 PFS changes and correlating budget neutrality requirements. CMS finalized a 3.37% cut to the Medicare conversion factor in its 2024 Medicare PFS; from Jan. 1 to March 8 of this year, medical groups absorbed a 3.37% reduction to reimbursement. Following congressional action to partially mitigate 1.68% of the cut in the *Consolidated Appropriations Act of 2024* (CAA, 2024), physician practices are left with a 1.69% reduction for the rest of the year. These ongoing cuts are untenable for practices and must be averted to ensure the financial viability of medical groups.

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."[2] This echoes what medical groups are saying, with 87% of groups

[2] 2024 Medicare Board of Trustees Annual Report, May 6, 2024.

reporting reimbursement not keeping up with inflation impacts current and future Medicare patient access.[3]

In the face of ongoing Medicare cuts, the cost of running a medical practice continue to rise — 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. Eighty-nine percent of medical groups reported an increase in operating costs in 2023.[4]

An annual inflation-based physician payment update based on the MEI is needed to prevent further damage to rural medical groups' ability to continue operating. Congress should pass the *Strengthening Medicare for Patients and Providers Act of 2023,* which would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI.

Further, MGMA recommends the Committee work to mitigate the harmful impact of Medicare's budget neutrality requirements. The *Provider Reimbursement Stability Act of 2023* would modernize many aspects of Medicare budget neutrality and would make significant changes to alleviate the adverse effects practices are experiencing. The legislation would increase the triggering threshold from $20 million to $53 million (while adding an update to keep pace with inflation), institute new utilization review requirements to better reflect the reality of providers using certain services compared to CMS' estimates, and more.

MGMA urges Congress to make changes to budget neutrality in unison with the long-needed annual inflationary update. The current policies work in concert to undermine the financial viability of medical practices, as medical groups will be facing another cut in 2025 absent congressional intervention.

Merit-based Incentive Payment System (MIPS) Reform

MACRA instituted the Quality Payment Program (QPP) that includes MIPS which was intended to be an on-ramp in the transition to value-based care for medical groups to join APMs. Unfortunately, the program has been beset with issues. A study found that in 2019, physicians spent more than 53 hours per year on MIPS-related activities and MIPS cost practices $12,811 per physician to participate.[5] Aside from onerous reporting requirements that do not drive meaningful clinical improvements and unfairly penalize clinicians, the $500 million funding for the MIPS exceptional performance bonus expired at the end of 2022. MGMA urges Congress to extend the exceptional performance bonus, which will support physician practices as they work to comply with MIPS requirements.

Rural, small, and medically underserved practices can be disproportionally disadvantaged under MIPS. The SURS program provided direct support for these practices, but funding appropriated under MACRA expired in February 2022. MGMA encourages Congress to extend this critical program by passing the *SURS Extension Act*, as it is needed to assist practices in rural and underserved areas understand the continuously changing policies in MIPS and succeed in the program.

Healthcare Workforce

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[3] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023.
[4] MGMA Stat Poll, July 12, 2023.
[5] Dhruv Khullar, Amelia Bond, Eloise May O'Donnell, *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System*, Jama Network, May 14, 2021.

MGMA has been a longtime champion of increased funding and reasonable improvements to the GME program, as the U.S. healthcare system will face a shortage of up to 86,000 physicians by 2036.[6] We appreciate the progress Congress has made over the past few years adding Medicare-funded GME slots through the *Consolidated Appropriations Acts of 2021 and 2023,* but there is still a critical need for more doctors to treat our nation's aging population.

The *Resident Physician Shortage Reduction Act of 2023* is an important bipartisan piece of legislation that would help address the physician shortage facing the nation which is especially pronounced in rural communities. This bill would increase Medicare-supported medical residency positions by 14,000 over the course of seven years. These slots are a lifeline to ensuring patients have access to care and we urge the Committee to support its passage.

Similarly, the Teaching Health Center Graduate Medical Education (THCGME) program provides essential training for doctors in certain outpatient settings. The THCGME program represents a great opportunity to address healthcare disparities since most of the teaching health centers are in rural and high-need areas, with over 60% of the training sites being in medically underserved communities according to Health Resources and Services Administration. MGMA recommends the Committee provide sustainable funding to this program to promote physicians treating rural and underserved communities.

There are additional critical workforce challenges as staffing shortages across clinical and nonclinical positions remain a concern for medical group practices. Fifty-six percent of medical groups reported staffing as their biggest productivity roadblock in an April 18, 2023, MGMA *Stat* poll.[7] As Congress continues to examine ways to bolster the healthcare workforce, MGMA hopes the Committee takes a comprehensive view of the staffing concerns facing medical groups to better strengthen the workforce programs under its purview.

Prior Authorization Burden Contributing to Staff Burnout

A major contributor to the healthcare workforce shortage is the worsening problem of physician and staff burnout, with 65% of physicians having reported experiencing burnout in 2022.[8] Many of the issues discussed in this letter compound to increase burnout — when you add prior authorization requirements that MGMA members consistently rank as their number one regulatory burden on top of these issues, it only hastens staff resignations and employee turnover. 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.[9] Ninety-two percent of physician practices reported having to hire or redistribute staff to work on prior authorizations due to the increase in requests.[10] Practices are already facing significant workforce shortage issues — this situation is simply unsustainable.

The *Improving Seniors' Timely Access to Care Act*, which we anticipate will soon be reintroduced, would make welcomed changes to ease this burden. Previous iterations of this legislation had widespread

[6] Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2021 to 2036, Mar. 2024.
[7] MGMA *Stat* poll, Apr. 20, 2023.
[8] Jackson Physician Search and MGMA, Back from Burnout: Confronting the Post-Pandemic Physician Turnover Crisis, Oct. 7, 2022.
[9] *Supra* note 4.
[10] *Id.*

bipartisan, bicameral support with over 53 Senators and 327 Representatives cosponsoring the bill in 2022. We strongly urge Congress to pass this long-needed legislation, as well as the *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* as these bills would make additional important changes to prior authorization.

Innovative Models and Technology

Telehealth

Over the past several years, telehealth technology has proven critical in maintaining access to care throughout the COVID-19 Public Health Emergency (PHE). Telehealth services are even more important for patients in rural areas where the closest practice may be hours away and patients may not have access to transportation. It is critical to enact policies building off the demonstrable success of telehealth services during the COVID-19 PHE to enable medical groups to best serve patients where they are and not unnecessarily restrict care.

MGMA appreciates Congress' extension of many important telehealth flexibilities through 2024 in the *Consolidated Appropriations Act of 2023.* Many of these policies, such as eliminating geographic and originating site restrictions, should be permanently implemented as telehealth should not be constrained to Medicare beneficiaries in facilities located in rural areas, as required prior to the flexibilities granted under the COVID-19 PHE waivers. Legislation like the *CONNECT for Health Act of 2023* would permanently institute many of these policies, facilitating sustainable telehealth treatment for patients.

APM Development

Value-based care (VBC) models must be designed to address the challenges facing rural practices if CMS wants to meet its goal of having every Medicare beneficiary in an accountable care arrangement by 2030. Rural practices face numerous barriers to both joining and successfully participating in VBC arrangements as the application requirements and parameters around many of the CMS Innovation Center (CMMI) models often do not allow rural groups to participate. Seventy-eight percent of medical groups reported that Medicare does not offer an Advanced APM that is clinically relevant to their practice, with 56% of members being interested in participating in a clinically relevant model if one were to exist.[11]

CMMI has yet to test any of the models PTAC has recommended and is missing an important opportunity to expand methods of participation. MGMA supports leveraging the expertise of PTAC to develop new, voluntary, physician-led APMs that meet the needs of rural practices.

APM Incentive Payment and Qualifying Participant Threshold

Shifting program requirements and financial incentives instituted under MACRA do not align with enabling rural practices to successfully participate in APMs. Congress recently extended the APM incentive payment at 1.88% for 2024 — a decrease from 3.5% in 2023, and 5% in 2022. MGMA strongly urges Congress to reinstate the full 5% as this payment is necessary to cover costs, support investments, and safeguard the financial viability of medical groups in the program.

Further, the qualifying participation (QP) threshold to participate in an APM is unreasonably high. Participants need to meet this threshold to qualify for the APM incentive bonus and to avoid reporting under MIPS; it was set to increase this year, but Congress intervened by freezing the threshold in the

[11] *Id.*

Consolidated Appropriations Act of 2023. Practices should not be subject to an excessively high threshold that fosters uncertainty and hinders their ability to participate — MGMA supports giving CMS the flexibility to adjust the QP threshold so that it is not set arbitrarily high. The *Value in Health Care Act of 2023* would work to address the APM incentive payment and QP threshold problems facing practices and we support its passage.

Conclusion

MGMA thanks the Committee for its leadership in examining the multitude of issues facing rural medical groups. We look forward to working with you to craft commonsense policies that will allow medical groups in rural areas to continue providing high-quality patient care. 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