March 18, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S House of Representatives
2123 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record for the House Committee on Energy and Commerce Subcommittee on Health Hearing, "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape"

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for holding this important hearing on "Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape." There are numerous policies working in concert that impact patient affordability and add unnecessary costs and strain to medical groups. Congress has an ample opportunity to pass legislation to address longstanding challenges facing physician practices and support their ability to provide high-quality, cost-effective care.

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 legislative recommendations.

MGMA members consistently cite administrative requirements and documentation as primary challenges to practice sustainability. We have long advocated for reducing regulatory burden and reforming the inadequate Medicare payment system that exacerbates costly administrative tasks and ultimately undermines the financial viability of medical groups. Patient access to affordable care is vital, and allowing these administrative and financial challenges to persist will only lead to longer waiting times, shorter visits, and practices becoming unable to accept new patients. We offer the following recommendations for legislative action that would help address policies that impact affordability and ensure patients can continue accessing care in their communities.

Increasing Healthcare Consolidation

Myriad administrative, regulatory, and financial concerns weaken the ability of independent medical groups to stay in operation and ultimately lead many physicians to sell their practices and either become employed or retire. The data is clear and disconcerting — according to the Physicians Advocacy Institute, 77.6 percent

of physicians are employed by hospitals/health systems and other corporate entities.[1] MGMA members report how this confluence of issues undercuts their ability to stay independent: "After being physician-owned for over 100 years, the practice sold to a hospital at the close of 2025."[2] Mounting regulatory burden and administrative work coupled with increasing costs and decreasing reimbursement has pushed physicians to leave independent practice and seek employment in health systems.

Even when independent groups sell to systems, these practices are still often operating at a loss. MGMA has collected data for years that indicates health systems often operate medical groups at an annual loss of over $200,000 per FTE physician. These practices are subsidized by hospital inpatient revenue, insurance plan revenue, and more. This demonstrates that payment and cost issues do not fully alleviate once a practice is acquired. Medical groups provide substantial additional benefits to systems, such as ancillaries like imaging and labs, referrals, and value-based care benefits such as controlling volumes and performance in capitated contracts. But unlike large systems, independent groups don't have large cash reserves and other revenue sources to weather the costs associated with increasing burden.

Enacting lasting reforms discussed below in more detail would facilitate a more robust ambulatory practice environment for both independent and system-based group practices.

Medicare Part B Payment Reform

A significant factor contributing to increased consolidation is the ongoing under-reimbursement by the Medicare Part B payment system. Medical groups dealt with a 2.83% cut to the Medicare conversion factor for all of 2025 that has compounded other financial pressures such as staffing shortages and rising operating costs. While we appreciate Congress for passing a 2.5% increase to 2026 Medicare reimbursement, the Centers for Medicare & Medicaid Services (CMS) finalized payment rates for 2026 are barely above 2024 reimbursement levels. This minor increase is undercut by other CMS policies that decrease reimbursement for certain specialties. Given the downward trajectory of Medicare reimbursement, with its frequent reductions and lack of an inflationary update, it is time to enact structural reform to stop the cascading negative effects of inadequate reimbursement that does not cover the cost of providing care.

The Strengthening Medicare for Patients and Providers Act of 2025 (H.R. 6160) would make structural changes to the Medicare payment system that are needed to support medical groups and avoid annual threats to their financial viability. This legislation would provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI). This inflationary update is necessary to not only align with other CMS payment systems, but also adequately account for the cost of operating a medical group.

Antiquated budget neutrality policies in the PFS must be modernized; we urge Congress to institute changes to budget neutrality in unison with an annual inflationary update. The Provider Reimbursement Stability Act of 2023 (introduced last Congress as H.R. 6371) would make common sense changes to Medicare budget neutrality requirements such as increasing the low threshold for triggering cuts and allowing CMS flexibility to correct issues with erroneous budget projections. Similar legislation would help make much needed modernizing changes. A holistic approach would go a long way toward establishing an appropriate reimbursement system that supports the financial viability of medical groups.

[1] Physician Advocacy Institute, "PAI-Avalere Report on Physician Employment Trends and Acquisitions on Medical Practices: 2019-2023," April 2024, https://www.physiciansadvocacyinstitute.org/PAI-Research/PAIAvalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023.
[2] Taken from MGMA's upcoming 2026 Regulatory Burden Survey, scheduled for release soon.

Prior Authorization Burden

Onerous prior authorization requirements continuously rank as a top regulatory burden facing medical groups. Medical group practices face a significant and uncompensated administrative workload for these unnecessary denials, and the greater harm is that many patients abandon efforts to obtain necessary care rather than navigate the appeal process after the initial denial. Not only do these denials lead to delays in critical patient care and worsening health conditions, but they also create costly and burdensome inefficiencies in our healthcare system. In our recent regulatory burden survey of over 230 medical group practices, 95 percent of practices said that prior authorization is a significant burden for their practice and 85 percent report that the burden of prior authorization has increased in just the last 12 months. Over 35 percent of practices surveyed report employing at least three administrative employees per physician to assist physicians with regulatory and administrative tasks like prior authorization.

The widely supported Improving Seniors' Timely Access to Care Act (H.R. 3514; S. 1816) — which has 66 cosponsors in the Senate and 260 in the House of Representatives — would make long-needed changes to prior authorization and allow practices to focus resources on clinical care instead of dealing with these administrative processes. A prior iteration of the bill passed the House unanimously, and the current version has a preliminary Congressional Budget Office score of $0. This legislation has the support of hundreds of healthcare organizations as it would implement common sense changes to improve the transparency surrounding prior authorization utilization and expediate an often-laborious process. Passing this important legislation would help reduce excessive costs and allow physician practices to better allocate resources to clinical care.

Reform the Quality Payment Program (QPP)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) replaced the sustainable growth rate formula with the 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).

Unfortunately, MIPS has been plagued with issues as it requires clinicians to report on quality measures that are not clinically relevant to them. Complying with MIPS is a time-consuming and laborious process. Studies have shown the significant amount of staff time and money dedicated to MIPS reporting with an average cost of $12 811 per physician, and clinicians and administrators spent more than 200 hours per physician on MIPS reporting activities.[3]

Medical groups report that MIPS requirements detract from patient care efforts due to significant program compliance costs that could be more efficiently allocated to clinical priorities. The QPP reporting burden is substantial — 86 percent of MGMA members surveyed who participate in MIPS found reporting to lead to increased administrative burden with little clinical benefit. "MIPS is especially unworkable," as one MGMA member succinctly put it in our 2026 survey. This aligns with what MGMA members have unfortunately said for years. To address these significant concerns, we recommend Congress reform the MIPS program to improve its clinical relevance and reduce the cost and administrative burden of

[3] Dhruv Kullar, MD, MPP; Amelia M. Bond, PhD; Eloise May O'Donnell, MPH, "Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System," JAMA Network, May 14, 2021, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

reporting. Specifically, Congress could pass legislation that aligns with policies developed in conjunction with physician specialty societies, the American Medical Association, and MGMA [4]

Additionally, the APM incentive payment has been essential to medical groups attempting to transition from MIPS to value-based care models, allowing them to make the necessary infrastructure investments to succeed in these arrangements. The lapse of the incentive payment and increases to the qualifying APM participant (QP) thresholds in 2025 contributed to additional financial instability for practices and prevented them from making critical investments in value-based care operations and technologies. We thank Congress for passing the Continuing Appropriations Act, 2026, that reinstated the Advanced APM incentive payment at 3.1 percent for the 2026 performance year and reverted the 2026 QP thresholds at the 2024 level. Congress should work to further extend these policies to ensure that APMs offer a viable and stable pathway for medical groups to transition to value-based care.

Administrative and Payment Challenges within Medicare Advantage

Medicare Advantage has allowed beneficiaries to access new benefits and can serve as an opportunity for innovation and value-based care. Many large medical groups find value for themselves and their patients in administering their own Medicare Advantage plans. However, as over half of Medicare-enrollees have opted for Medicare Advantage plans administered by commercial insurers, it has created daunting new challenges for many practices. Audits and appeals, denials, prior authorization, and downcoding in Medicare Advantage all rank within the top 5 burdens reported by medical groups. Over 90 percent of practices have seen an increase in Medicare Advantage vs. traditional Medicare and of those, over 75 percent report this shift having a negative impact.

There are abundant opportunities to ensure that the Medicare Advantage program does not contribute to unnecessary administrative and payment challenges. Legislation like the bipartisan, bicameral Medicare Advantage Prompt Pay Act (H.R. 5454, S. 2879), which would require Medicare Advantage plans to pay 95 percent of clean claims in 14 days for in-network providers and 30 days for out-of-network providers, would help ease issues with delayed payments and associated administrative headaches. Moreover, legislation to address unwarranted downcoding trends in Medicare Advantage would alleviate a substantial pain point for physician practices.

The Stark Law and Physician-Owned Hospitals

MGMA has worked with Congress for over 30 years to reduce burden associated with the Physician Self-Referral (Stark) Law. Unfortunately, those efforts have been highly frustrating as with each successive CMS rulemaking, the complexity of the Stark Law has grown to the point where it is incomprehensible to the average group practice administrator or physician. The Stark Law is a strict liability statute (proof of specific intent is not required to violate the law) with severe penalty provisions that exacerbate these concerns.

Congress should promote greater competition and innovation by working to standardize compliance and eliminate the numerous conflicting requirements placed on healthcare providers while maintaining flexibility for the group practice model. Though existing exceptions to the Stark Law's prohibitions are numerous, they contain complex criteria and obscure terminology subject to regulatory interpretation and

[4] See Testimony of Incoming MGMA Board Chair Jeffrey Smith to the Senate Special Committee on Aging, Feb. 11, 2026, Pgs. 6-7, https://www.mgma.com/getkaiasset/6a56d712-bf14-4a95-850f-82a35b87f181/MGMA%20Testimony%20Senate%20Special%20Committee%20on%20Aging.pdf.

factual determinations that open the door to inadvertent noncompliance. Congress should enact legislation to make the following long-needed changes:

- Significantly reform the compensation arrangement provision (42 USC 1395nn(a)(2)(B)), as it is not needed under a value-based payment system where overutilization is no longer a problem.
- Enhance the group practice model by significantly simplifying the statutory definition of a group practice.
- Revise penalty provisions to limit fines to situations where the prohibited referrals result in some demonstrable harm to the government or the patients served.

Further, Congress should pass the Patient Access to Higher Quality Health Care Act of 2025 (H.R. 4002), that would repeal the statutory restrictions on the whole hospital exception to the Stark Law, which would eliminate statutory and regulatory barriers that prevent the formation or expansion of physician-owned hospitals. This would restore the ability for physicians to open and expand hospitals to deliver care through integrated models, thereby spurring innovation and improving patient choice.

Conclusion

MGMA sincerely appreciates your attention to provider incentives and healthcare trends impacting patient affordability. We urge you to pass the above-referenced legislation to reinforce group practices' ability to provide high-quality, cost-effective 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