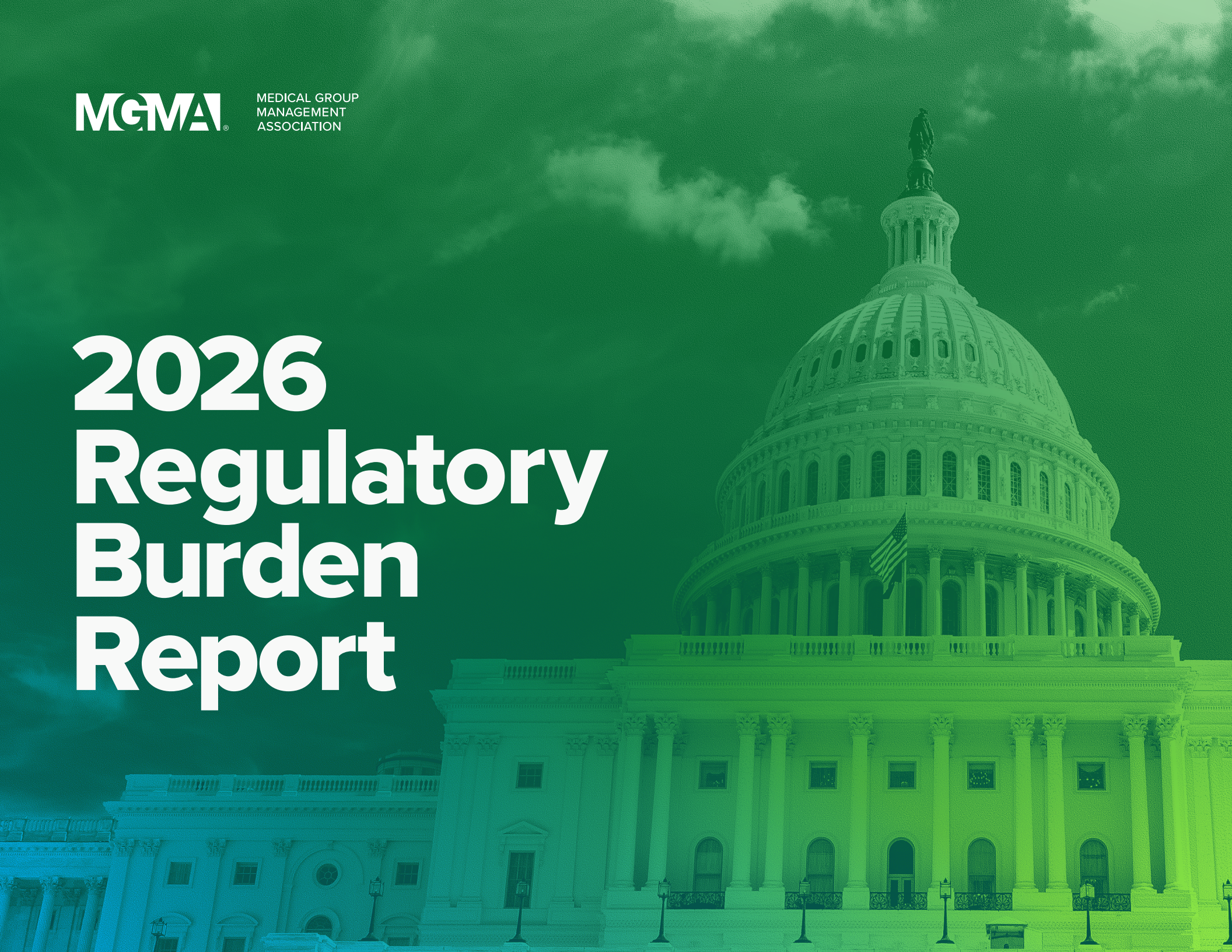




MEDICAL GROUP  
MANAGEMENT  
ASSOCIATION

# 2026 Regulatory Burden Report



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## Executive Summary

The Medical Group Management Association's (MGMA) 2026 Regulatory Burden Report highlights the negative impacts that increased regulatory burden and decreased reimbursement has on the healthcare system. These factors contribute to increased physician burnout, consolidation, and ultimately, make it more difficult for patients to access the care they need.

Prior authorization, Medicare Advantage requirements, and quality reporting are the most critical issues requiring practices to divert time and resources away from patient care and into administrative tasks. With over 25% of healthcare spending going towards administrative overhead, Congress and the Administration must enact comprehensive policy reforms to promote reliable payment systems, while reining in regulatory burdens to ensure continued patient access and the sustainability of medical practices.

## About the Respondents

The Report includes survey responses from executives representing over 230 group practices. Fifty-two percent of respondents are in practices with 20 or fewer physicians, and twenty-six percent are in practices with 100 or more physicians. Sixty percent of respondents are in independent practices.

## KEY FINDINGS

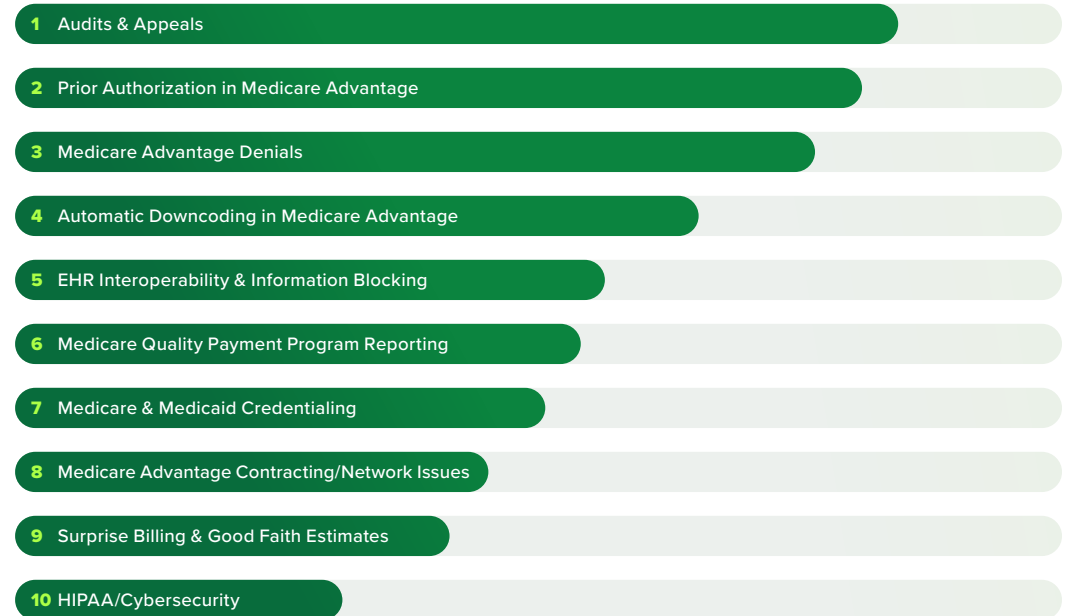
# Overview: Regulatory Burden

Regulatory and administrative requirements continue to plague medical groups, and coupled with reimbursement that fails to cover the cost of providing care, leads to physician burnout.

The top-ranked administrative burdens reflect the range of issues impacting all aspects of practice operations, from audits and appeals to electronic health record (EHR) interoperability and credentialing. Regulatory hurdles are time-consuming and costly, as they take physicians' time away from providing care and require practices to hire staff to handle administrative tasks. Medical groups report almost unanimously that administrative burden has increased in the past three years.

It's becoming more difficult for practices to serve patients in their communities, as an ever-growing list of administrative requirements divert resources from providing care. Without policy intervention, administrative burdens will expand leading to more financial challenges and physician burnout, threatening patients' access to care.

## Top regulatory burdens according to MGMA members



*Days are spent delivering emotionally demanding care to patients with complex disorders. That work is meaningful. What is exhausting is the layer of documentation, coding, quality reporting, payer rules, downcoding, denials, appeals, and enrollment systems that must be managed after the clinic closes. We have experienced periods where patients were seen and cared for, but payments were delayed or frozen because of PECOS errors, address mismatches, or reporting conflicts ...” – MEMBER TESTIMONIAL*

KEY FINDINGS

# Overview: Regulatory Burden

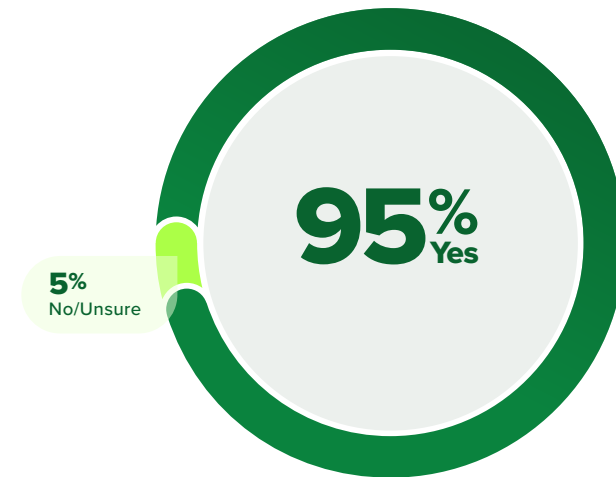
“

Administrative burden and payer requirements increasingly rely on manual tasks—completing forms, making calls, and navigating duplicative processes. Combined with ongoing Medicare, Medicaid, and commercial payer reimbursement reductions, these pressures have led not only to physician burnout but also to physicians and staff seeking opportunities outside of direct patient care.” – MEMBER TESTIMONIAL

“

We have had to hire or take on more administrative burden in terms of prior authorizations, good faith estimates, new regulations from HIPAA or cyber security to adhere to, etc. We’ve also experienced automatic denials, reimbursements not keeping pace with costs and more recently have been made aware of a payer that now requires referral authorizations.” – MEMBER TESTIMONIAL

MGMA members saw an increase in regulatory burden in their practice over the past 3 years



of practices have three or more full-time administrative staff per physician to assist physicians with administrative and regulatory-related tasks such as prior authorization, denials, and quality reporting

## KEY FINDINGS

# Medicare Advantage

Medicare Advantage has quickly become the leading source of administrative burden for medical groups.

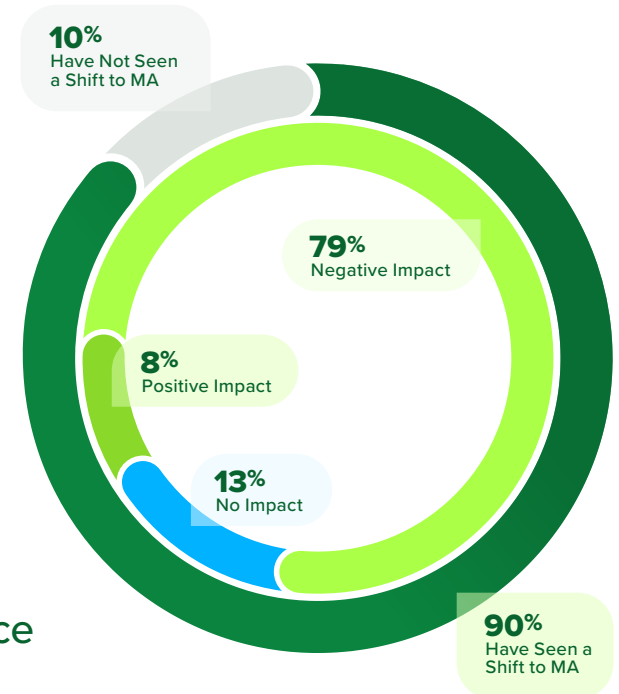
Three of the top five regulatory burdens are exclusively related to Medicare Advantage (MA) (downcoding, prior authorization, and denials). The top regulatory burden, audits and appeals, also is commonly associated with MA as practices must comply with mandatory Risk Adjustment Data Validation (RADV) audits and appeal denied claims.

In recent years, MA has grown to the point where over half of Medicare-eligible individuals are enrolled in an MA plan. For enrollees, MA plans often cost less than Traditional Medicare and provide supplemental benefits not covered by Traditional Medicare. While MA has benefited certain patients and helped jump-start value-based care arrangements in practices, it's also placed a significant burden on practices.

With the growth of MA and the administrative burdens that come with the program, practices are forced to invest more time and money in administrative processes just to receive their negotiated MA payments. If providers are not promptly paid their negotiated rates and are subject to overly burdensome utilization tactics, participating in MA will become increasingly unsustainable and practices may decide to end MA contracts.

**90%**  
of practices have  
seen a shift to  
Medical Advantage

**79%**  
of those practices say  
it's had a negative  
impact on their practice



KEY FINDINGS

# Prior Authorization

**Frustration grows as payers increase burdensome prior authorization requirements.**

Prior authorization remains a top regulatory burden for medical groups and results in a significant and uncompensated administrative workload for both physicians and administrative staff. Requiring health plan approval before patients receive treatment can delay necessary care. Private payers continue to have the most burdensome prior authorization tactics in commercial and Medicare Advantage plans. Now, the expansion of prior authorization in Traditional Medicare through the Wasteful and Inappropriate Service Reduction (WISeR) Model poses a new threat to practices providing certain services.

While new regulations require faster prior authorization response times from Medicare Advantage payers, improved turnaround times alone will not alleviate the immense burden of prior authorization on practices. Meaningful reform to rein in the volume of services requiring prior authorization is needed to ensure practices can focus resources on providing actual patient care rather than explaining the necessity of treatments to health plans.

## MGMA members cited Medicare Advantage and commercial plans as the most burdensome payers for obtaining prior authorization



“Prior authorization remains one of the most significant administrative and financial challenges in our practice. Clinical staff and physicians spend substantial time navigating inconsistent payer requirements, duplicative documentation requests, and unclear approval criteria — often for services that are evidence-based and routinely provided. These processes delay care, frustrate patients, and divert physician time away from clinical work, contributing directly to burnout.” – MEMBER TESTIMONIAL

“In the last year, I have had to add two new staff dedicated to handle the growing volume of prior authorizations, bringing the team to a total of four working on them full-time. This was the only way to ensure prior authorizations were completed on time and to avoid rescheduling patients, since nearly all of our visits require authorization. As a result, our payroll and overall clinic costs have increased significantly.” – MEMBER TESTIMONIAL

90% 

of practices report an increase prior authorization burden in the past 12 months

KEY FINDINGS

# Quality Payment Program

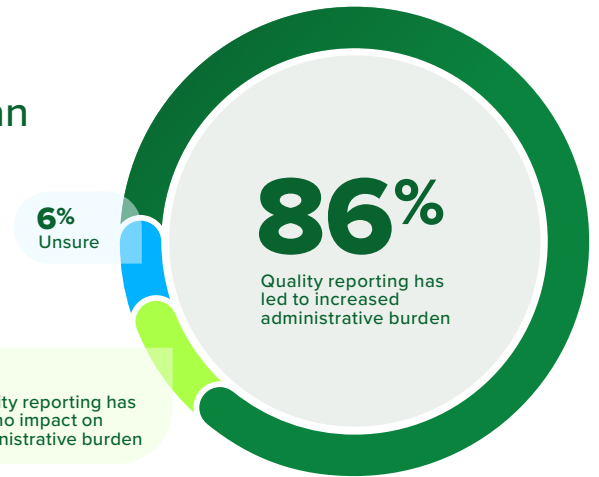
As development of clinically-relevant APMs has stalled, medical groups remain stuck in MIPS, which rewards reporting over quality.

Over half of practices remain in the Merit-based Incentive Payment System (MIPS) and continue to suffer from the laborious and time-consuming reporting burden which force clinicians to report on quality measures that are not clinically relevant to them and even holds them responsible for costs outside their control. Ultimately, MIPS does not provide value to practices or reflect the quality of care provided.

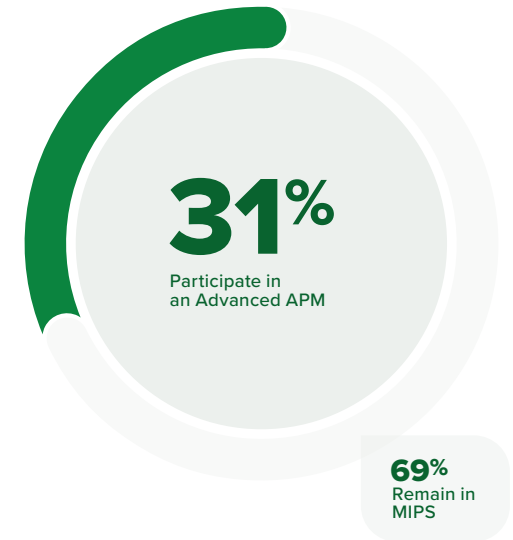
A reduction in reporting burden, alignment of performance measures with clinical care, and additional reforms are necessary to ensure MIPS is a sustainable program for providers until participation in Advanced Alternative Payment Models (APMs) is achievable. In the meantime, increased development of Advanced APMs that expand participation opportunities to a wider variety of specialties is needed to successfully transition away from MIPS.

MGMA members cited MIPS quality reporting greatly impacts physician administrative burden

“MIPS has created an environment of fear and excess workflows that add little to no value for staff and patients. Licensed providers are under the foot of regulatory burden, preventing patients from accessing appropriate treatments in a timely fashion.”  
- MEMBER TESTIMONIAL



Less than half of practices are participating in an Advanced APM and many practices report being unable to participate due to a lack of clinically relevant models



## KEY FINDINGS

# Physician Burnout

**Growing regulatory and administrative burdens are the leading cause of physician burnout.**

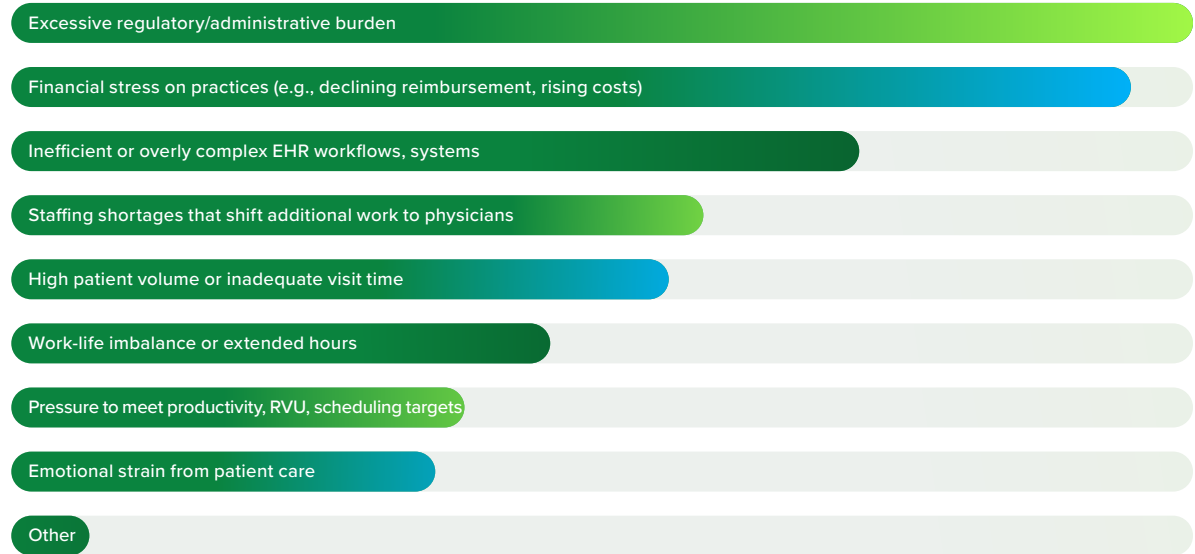
Physician burnout is an escalating threat to the stability of the medical workforce, driven largely by financial pressures and growing regulatory demands. When physicians retire early or leave clinical practice altogether, medical groups must devote substantial time and resources to recruitment — a process that can take months or even years.

In the meantime, staffing shortages place additional strain on remaining clinicians, increasing workloads and contributing to even higher burnout rates. Patients also feel the impact through longer wait times and reduced access to care. The financial consequences are significant: prolonged vacancies limit a practice's ability to operate at full capacity and optimize revenue.

Regulatory burden not only fuels burnout but also complicates recruitment efforts. As these requirements continue to expand, they risk intensifying the cycle of workforce shortages and physician fatigue.

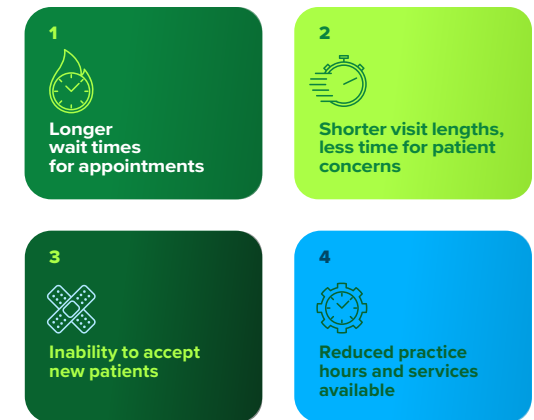
To help reverse this trend, MGMA supports policies that reduce unnecessary regulatory burden while strengthening and expanding physician training programs to ensure a sustainable pipeline of future clinicians.

## Top factors contributing to physician burnout



“*More time spent on regulatory and administrative matters led to decreased time with patients, resulting in provider frustration. Couple that with declining reimbursement, no salary increases, and at times, decreased paychecks.*”  
— MEMBER TESTIMONIAL

## Top 4 impacts of physician burnout on patient access



KEY FINDINGS

# Physician Burnout

“

*Administrative burden has caused physicians to be wary of participating in certain programs or insurance types. The additional work required to comply with these programs, which have not shown to increase quality outcomes, eats into clinic time, reducing the amount of patients that can be seen each day which increases access burdens.”*

– MEMBER TESTIMONIAL

“

*Physician burnout has manifested through increased after-hours documentation, reduced clinical availability, transitions to part-time status, and delayed retirement decisions. Providers frequently cite regulatory documentation, prior authorization workload, and EHR inefficiencies as primary drivers, with downstream impacts on recruitment, retention, and patient access.”*

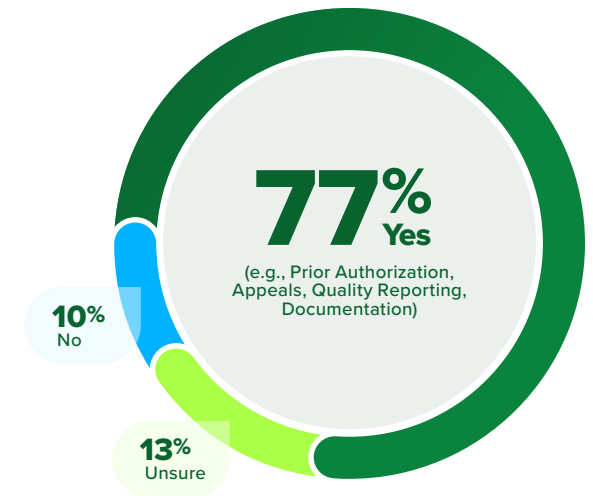
– MEMBER TESTIMONIAL

“

*Part of the burnout stems from declining reimbursement. It's difficult for providers to watch the value of their work consistently decrease over time while still being expected to deliver the same high level of care. Physicians are doing more work for less pay, which also makes it harder to recruit new physicians, all while contributing to the physician shortage.”*

– MEMBER TESTIMONIAL

MGMA members cited regulatory burden as a significant factor in physician burnout



# Policy Recommendations

Administrative burdens, inadequate reimbursement, and physician burnout have created an environment that threatens medical groups' ability to provide patient care. The complexity of these issues will require systemic change that includes reduction in regulatory burdens, sustainable reimbursement, and a reliable workforce.

## MGMA believes the following reforms are necessary

### Quality Payment Program:

- Comprehensive overhaul of the MIPS program to reduce reporting burden and end tournament-style model of scoring
- Long-term extension of the Advanced APM incentive payment and QP threshold freeze

### Medicare Advantage:

- Increased oversight of MA plans to ensure prompt payment of accurately coded claims

### Workforce Development:

- Increased investment in federally funded graduate medical education slots

### Prior Authorization:

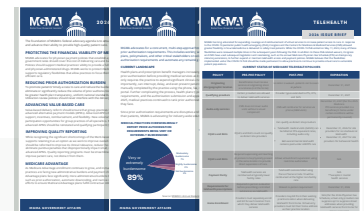
- Standardization in electronic prior authorization transactions and increased transparency for prior authorization in MA and commercial plans
- Reduction of the overall volume of prior authorization across federal and private payers

### Fee-for-Service Reimbursement:

- Annual Medicare conversion factor updates tied to inflation
- Modernize antiquated Medicare budget neutrality requirements



For more information on MGMA's recommendations on these issues, please [see our position papers](#).



# Survey Participant Demographics

## Number of Full-Time Equivalent (FTE) at Participant Organization

<b>1 - 5</b>	<b>23%</b>
<b>6 - 20</b>	<b>29%</b>
<b>21 - 50</b>	<b>13%</b>
<b>51 - 100</b>	<b>9%</b>
<b>100+</b>	<b>26%</b>

## Participant Organization Type

Independent Medical Practice	<b>61%</b>
Hospital, integrated delivery system (IDS), or medical practice owned by a hospital or IDS	<b>29%</b>
Medical school faculty practice plan or academic clinical science department	<b>4%</b>
Management services organization (MSO)	<b>1%</b>
Physician practice management company (PPMC)	<b>1%</b>
Independent practice association (IPA)	<b>0%</b>
Other	<b>4%</b>

## 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 DC, please contact us at

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