October 5, 2023

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
1129 Longworth House Office Building
Washington, DC 20515

**Re: Request for Information – Improving Access to Health Care in Rural and Underserved Areas**

Dear Chairman Smith and Ranking Member Neal:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) would like to thank the Committee for the opportunity to provide feedback on improving access to healthcare in rural and underserved areas. 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 addressing the current challenges facing practices in rural and underserved areas.

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's diverse membership uniquely situates us to offer the following policy recommendations.

Rural practices face myriad challenges in maintaining their ability to operate and provide high-quality care. Approximately 60% of the 7,200 federal designated health professional shortage areas occur in rural areas.[1] Fifteen percent of all Americans live in rural areas, and patients in these areas generally tend to be older and sicker than patients in urban centers.[2] 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**

- **Avert the proposed 3.36% cut to physician reimbursement under the Medicare Physician Fee Schedule (PFS) and provide an annual inflation-based physician payment update based on the Medicare Economic Index (MEI).** Congress should prevent the proposed cuts to physician

[1] Association of American Medical Colleges, Attracting the next generation of physicians to rural medicine, https://www.aamc.org/news/attracting-next-generation-physicians-rural-medicine.
[2] See Centers for Disease Control and Prevention, About Rural Health, May 9, 2023, https://www.cdc.gov/ruralhealth/about.html#:~:text=Rural%20Americans%20are%20more%20likely,stroke%20than%20their%20urban%20counterparts.

payment and pass the *Strengthening Medicare for Patients and Providers Act*, which would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI. Congress should also work to mitigate the negative impact of budget neutrality requirements of the PFS and make changes to the Merit-based Incentive Payment System (MIPS), such as extending the Small, Underserved, and Rural Support (SURS) program that expired last year.

- **Work to address the physician shortage by properly funding Graduate Medical Education 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.
- **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.**

**Sustainable Provider and Facility Financing**

A fundamental bedrock needed to support medical groups' ability to provide high-quality care to Medicare beneficiaries is a functioning and appropriate reimbursement system. The cost of running a medical practice increased 47% from 2001 to 2023 while Medicare physician payments increased just 9% according to the American Medical Association.[3] Medicare physician payment effectively decreased by 26% from 2001 to 2023 when adjusted for inflation in practice costs. Costs continue to grow as 89% of medical groups reported an increase in operating costs in a July 13, 2023, MGMA *Stat* poll.[4]

Rural practices are particularly susceptible to rising costs combined with the negative effects of Medicare payment cuts. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) recently met in September to discuss rural value-based care models and reviewed the myriad negative effects the current payment system has on practices. More than 600 rural hospitals are at risk of closure due to financial instability, and as Dr. Elizabeth Fowler discussed in her remarks to PTAC, rural Accountable Care Organizations (ACOS) are less likely to participate in two-sided risk models due to problems keeping their doors open under the current system.

[3] AMA, Medicare updates compared to inflation (2001 – 2023), https://www.ama-assn.org/system/files/ama-medicare-gaps-chart-grassroots-insert.pdf.
[4] MGMA *stat* poll, July 13, 2023, https://www.mgma.com/mgma-stat/higher-costs-persist-for-medical-groups-even-as-inflations-growth-slows.

*Physician Reimbursement under Medicare*

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 recently proposed in its 2024 Medicare PFS a 3.36% cut to physician reimbursement. This cut is untenable for practices and must be averted to ensure the financial viability of medical groups. MGMA conducted a survey last year of 517 medical group practices, ranging from small practices to large 2,500 physician health systems, assessing the impact of potential Medicare payment cuts, and evaluating how physician practices would respond.[5] Practices reported they would consider limiting the number of new Medicare patients, reducing charity care, reducing number of clinical staff, and closing satellite locations. Ninety percent of medical groups responded that Medicare reimbursement in 2022 did not adequately cover the cost of care provided.

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,* which would provide an annual Medicare physician payment update tied to inflation, as measured by the MEI. MGMA joined approximately 100 physician organizations to create the "Characteristics of a Rational Medicare Payment System" which focused on ensuring financial stability and predictability, promoting value-based care, and safeguarding access to high-quality care.[6] These principles, which would ensure alignment and predictability for physician practices, should be considered as well.

Further, MGMA recommends the Committee work to mitigate the harmful impact of budget neutrality requirements under the Medicare PFS. Congress needs to reexamine the current PFS budget neutrality requirements and explore alternatives such as increasing the $20 million budget neutrality trigger and exempting certain services from budget neutrality.

*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

[5] MGMA, Impact of Payment Reductions to Medicare Rates in 2023, Sept. 21, 2022, https://www.mgma.com/getmedia/b0716bbf-d21f-4ead-b1cb-9371485e62ff/09-21-2022-Impact-of-Payment-Reductions-to-Medicare-Rates-in-2023-Full-Report.pdf.aspx.

[6] Characteristics of a Rational Medicare Payment System, https://www.ama-assn.org/system/files/characteristics-rational-medicare-payment-principles-signatories.pdf.

per year on MIPS-related activities and MIPS cost practices $12,811 per physician to participate.[7] 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 that is needed to assist practices in rural and underserved areas understand the continuously changing policies in MIPS and succeed in the program.

**Healthcare Workforce**

MGMA has been a longtime champion of increased funding and reasonable improvements to the GME Program, as there will be a projected shortage of between 37,800 and 124,000 doctors by 2034.[8] 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. Funding for the THCGME Program is set to expire this year, 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.[9] As Congress continues to examine ways to bolster the healthcare workforce, MGMA hopes the Committee takes a

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[7] 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, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

[8] Association of American Medical Colleges, The Complexities of Physician Supply and Demand: Projections from 2019-2034, June 2021, https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mountingphysician-shortage.

[9] MGMA *stat* poll, Apr. 20, 2023, https://www.mgma.com/mgma-stats/as-healthcare-staffing-woes-linger-reduced-capacity-remains-the-biggest-roadblock-to-productivity.

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 worker shortage is the worsening problem of physician and staff burnout, with 65% of physicians reporting having experienced burnout in 2022.[10] Many of the issues discussed in this letter compound to increase burnout —adding prior authorization requirements that MGMA members consistently rank as their number one regulatory burden to these issues only hastens staff resignations and employee turnover. In MGMA's 2022 regulatory burden survey, 89% of members reported hiring additional staff or redistributing their current staffing resources to process prior authorizations due to the increased number of requests, with 82% saying prior authorization requirements were very or extremely burdensome.[11] Requiring practices to divert critical resources away from clinical care to comply with these unnecessarily burdensome administrative processes is antithetical to an efficient healthcare system.

MGMA thanks this Committee for introducing and passing an updated version of the *Improving Seniors' Timely Access to Care Act* earlier this summer. Previous iterations of this commonsense legislation to alleviate prior authorization burden had widespread bipartisan, bicameral support with over 53 Senators and 327 Representatives cosponsoring the bill last year. We strongly urge Congress to pass this long-needed legislation to help address this unnecessary burden. We further support enacting the *GOLD CARD Act* and the *Reducing Medically Unnecessary Delays in Care Act* as these bills would make 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. Building off the demonstrable success of telehealth services during the COVID-19 PHE is needed 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*

[10]Jackson Physician Search and MGMA, Back from Burnout: Confronting the Post-Pandemic Physician Turnover Crisis, Oct. 7, 2022, https://www.mgma.com/deep-dives/back-from-burnout-confronting-the-post-pandemic-physician-turnover-crisis?utm_source=referral&utm_medium=pressrelease&utm_campaign=bde-gen-oct-2022-jpsreport.

[11] MGMA, Annual Regulatory Burden Report, Oct. 2022, https://www.mgma.com/getkaiasset/b7e88b99-8e93-44a9-8144-725ca956089e/10.11.2022-MGMA-Regulatory-Burden-Report-FINAL.pdf.

*2023* would permanently institute many of these policies and we support its enactment to facilitate 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 Medicare does not offer an Advanced APM that is clinically relevant to their practice, with 61% of members being interested in participating in a clinically relevant model if one were to exist.[12]

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 practice to successfully participate in APMs. MGMA appreciates Congress acting at the end of last year to extend the APM incentive bonus at 3.5% for an additional year. This bonus had previously been set at 5%, and is vital to covering costs, supporting investments, and safeguarding the financial viability of medical groups in the program. MGMA recommends Congress reinstate the 5% payment bonus for APM participation for at least six years.

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 *Consolidated Appropriations Act of 2023.* CMS recently proposed to increase the already high threshold again in 2024. 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.

*Medicare Shared Savings Program (MSSP) and Rural ACO Policies*

To further assist the voluntary transition to VBC in rural communities, medical groups need appropriate support to build the necessary infrastructure. Rural practices have limited available capital and finite resources to participate in ACOs and other VBC models. Groups need access to upfront investments and tools to succeed. We appreciate CMS recently introducing the Advanced Incentive Payments to help enable new ACOs to participate in underserved areas. MGMA recommends implementing additional policies that aid and provide technical support to groups participating in rural ACOs, such as those

[12] *Id.*

outlined in the *Value in Health Care Act*. This would build the expertise and infrastructure needed for practices to succeed in these accountable care arrangements.

The "rural glitch" remains an impediment to long-term sustainability of ACOs participating in rural areas due to a flaw in the MSSP benchmarking methodology. This disadvantages rural ACOs for reducing costs as the methodology removes the benefit of a regional adjustment. Congress should work to alleviate this disincentive for MSSP participation.

We suggest the Committee continue to work with VBC stakeholders to examine how to properly incentivize and promote accountable care in rural settings. Leveraging the expertise of rural practices participating in these arrangements is essential to crafting effective policy that does not undermine access to care.

**Conclusion**

MGMA thanks the Committee for its leadership in examining the multitude of issues facing rural practices. We look forward to working with you and your congressional colleagues to craft commonsense policies that will allow medical groups in rural and underserved 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