

REGULATORY BURDEN SURVEY

OCTOBER 2018

MGMA
Medical Group Management Association®

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INTRODUCTION

About the Survey

The federal government has focused on decreasing the regulatory burden on medical group practices. MGMA has long been a champion for decreased regulatory burden and increased administrative simplification and standardization in order to achieve a more efficient and effective care delivery process for patients and providers.

The findings presented here will be used in MGMA's advocacy efforts to inform Congress, the Administration, and the larger healthcare community about the impact of federal policies and regulations on medical groups. This study is the second in a series to assess the burden level of regulatory processes for physician practices participating in Medicare programs, following MGMA's 2017 Regulatory Burden survey.

About the Respondents

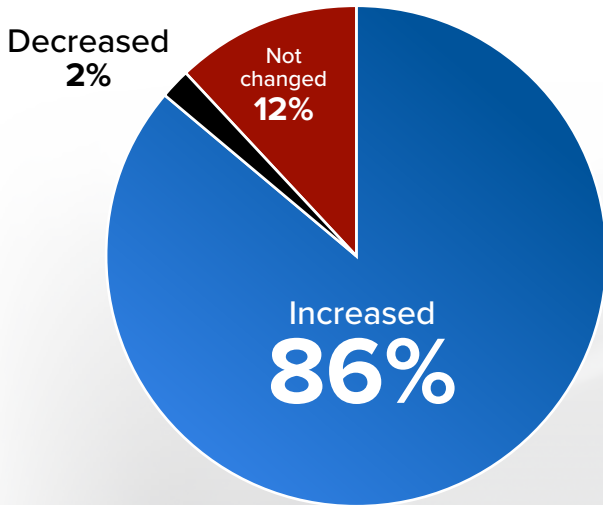
The survey includes responses from 426 individuals from group practices with the largest representation in independent medical practices and in groups with 6 to 20 physicians.

About MGMA

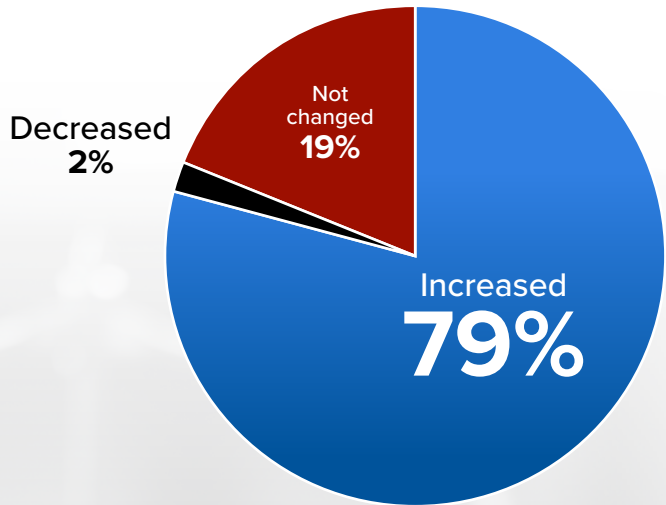
With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures and specialties that deliver almost half of the healthcare in the United States.

CURRENT STATE OF REGULATORY BURDEN

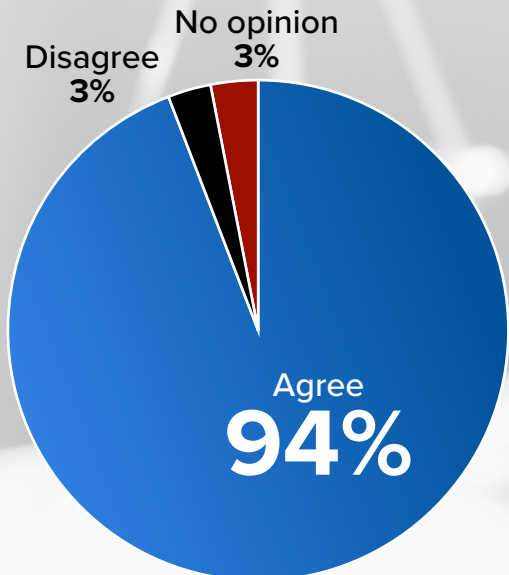
The overall regulatory burden on your medical practice over the past 12 months has:



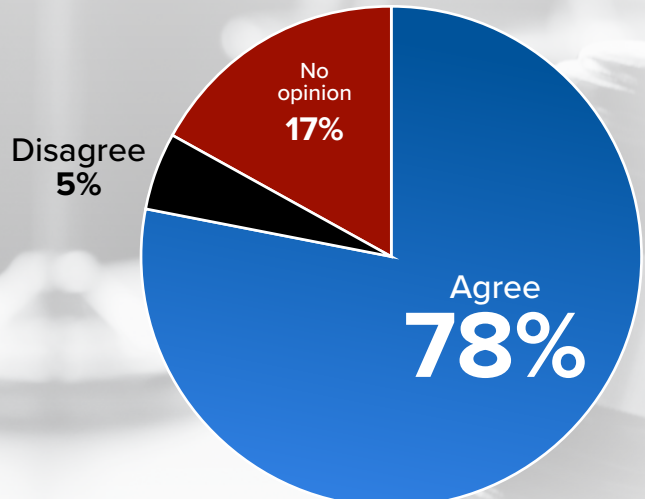
The overall regulatory burden on your medical practice associated with participation in the Medicare Program over the past 12 months has:



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



A reduction in regulatory burden would allow your practice to invest in new technology:



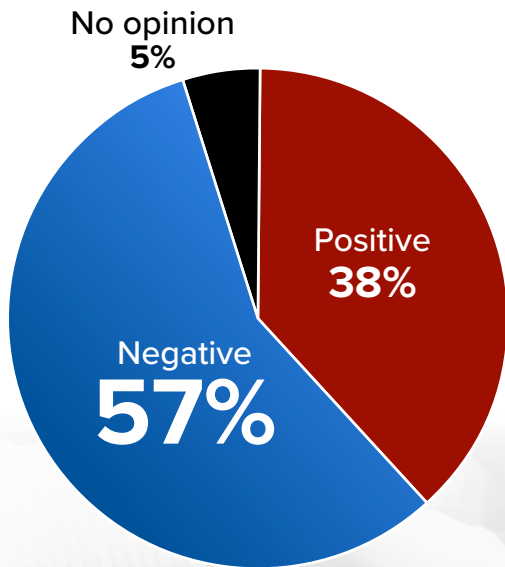
BURDEN LEVEL BY REGULATORY ISSUE

How burdensome would you rate each of the following applicable regulatory issues?

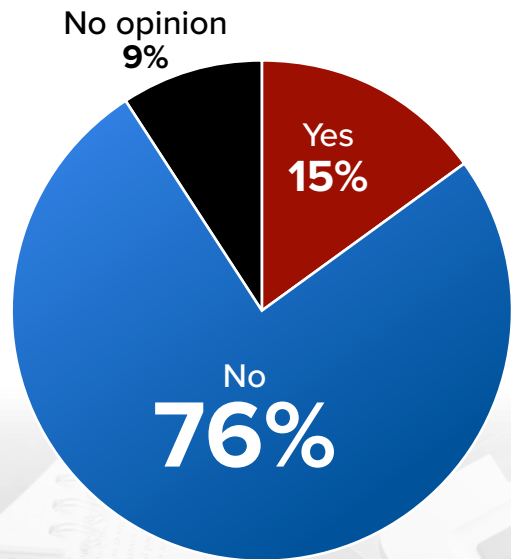
	Not burdensome	Slightly burdensome	Moderately burdensome	Very burdensome	Extremely burdensome	Very + Extremely
Medicare quality payment program (MIPS/APMs)	1%	2%	9%	22%	67%	88%
Prior authorization	1%	5%	12%	21%	61%	82%
Lack of EHR interoperability	2%	4%	15%	26%	54%	80%
Government EHR requirements	3%	4%	16%	30%	47%	77%
Audits and appeals	1%	7%	24%	36%	33%	68%
Medicare Advantage chart audits	2%	8%	23%	29%	37%	66%
Translation and interpretation requirements	6%	14%	21%	21%	38%	59%
Medicare and Medicaid credentialing	4%	10%	28%	28%	29%	57%
HIPAA privacy and security	7%	13%	30%	25%	24%	49%
Compliance with the Stark Law/Anti-Kickback statute	15%	22%	30%	17%	15%	32%

THE MOVE TOWARD VALUE

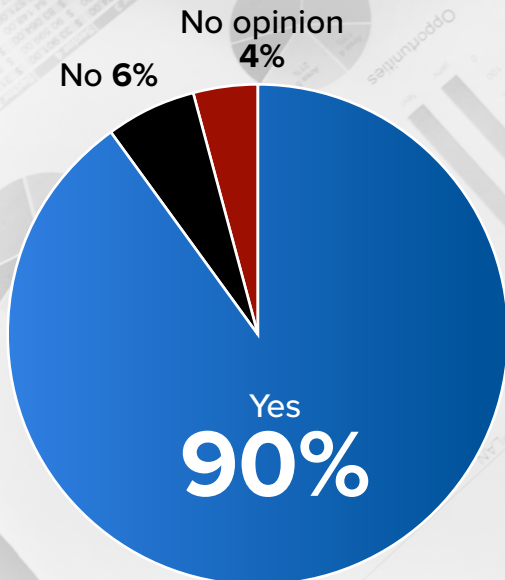
How do you view the move to paying physicians based on value of care delivered rather than volume of services provided?



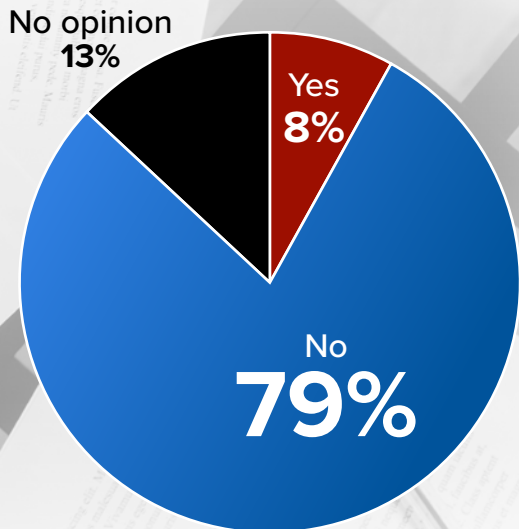
Has the move toward value-based payment (in Medicare/Medicaid) improved the quality of care for your patients?



Has the move toward value-base payment (in Medicare/Medicaid) increased the regulatory burden on your practice?



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



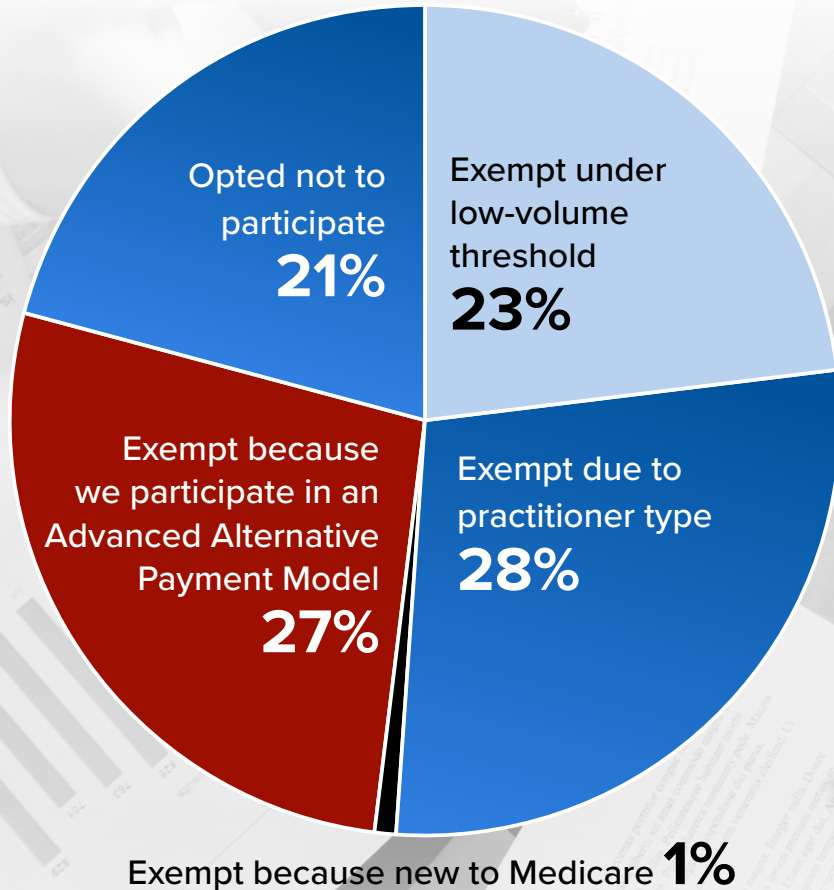
THE MEDICARE QUALITY PAYMENT PROGRAM

Does your practice participate in the Medicare Merit-based Incentive Payment System (MIPS)?



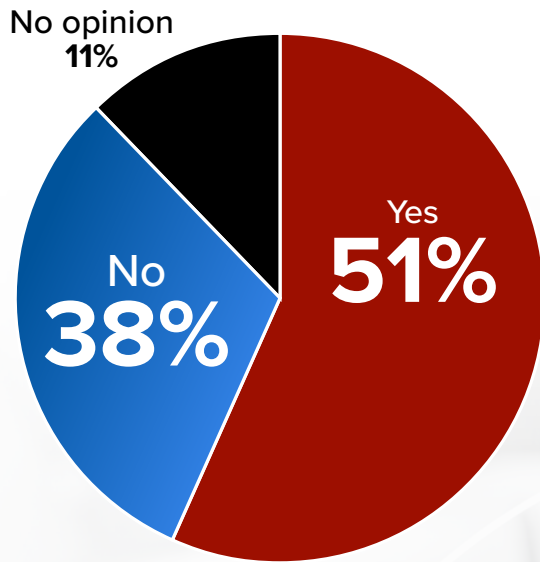
■ Yes ■ No

If not, which of the following best describes why your group practice is not participating in MIPS?

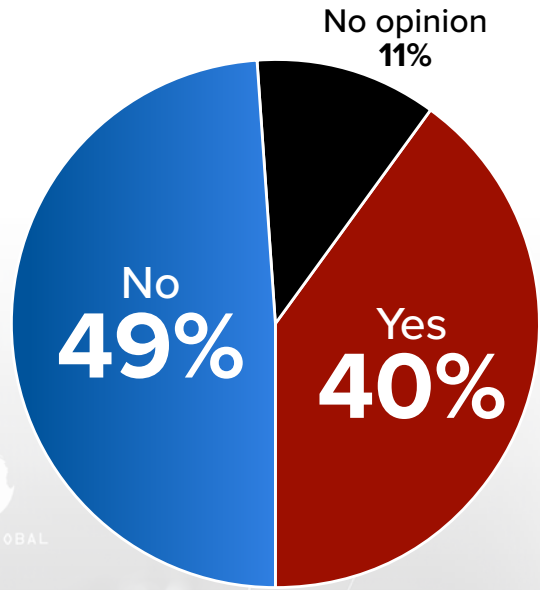


THE MEDICARE QUALITY PAYMENT PROGRAM

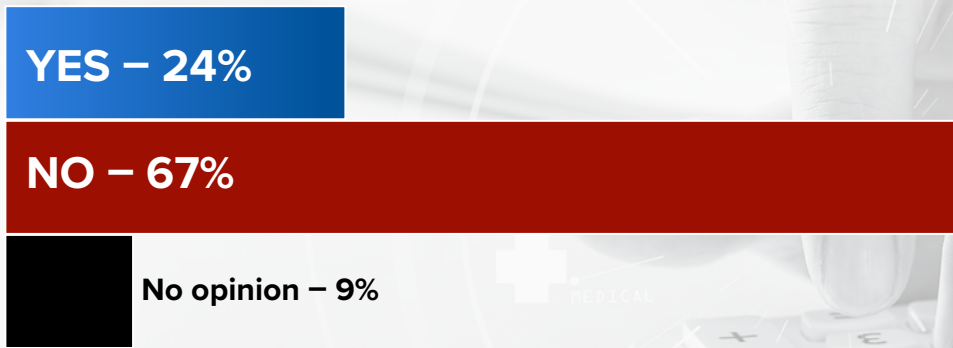
Do the clinicians in your practice understand how the Medicare MIPS program evaluates them on quality?



Do the clinicians in your practice understand how the Medicare MIPS program evaluates them on cost and utilization?



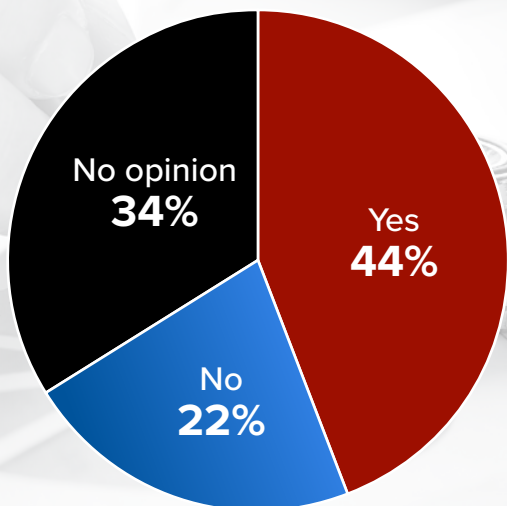
Does the Medicare MIPS program, as implemented by CMS, support your practice's clinical quality priorities?



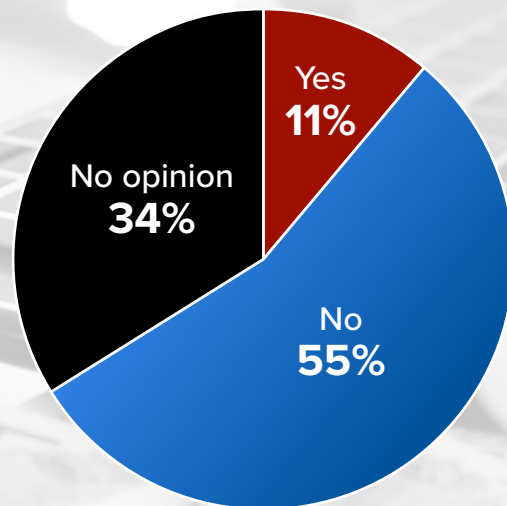
THE MEDICARE QUALITY PAYMENT PROGRAM

Please rate your satisfaction level with the following elements of the Medicare MIPS program?	Satisfaction Level					
	Very Dissatisfied	Dissatisfied	Neutral, Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied	Not Applicable
Availability of applicable measures	25%	30%	24%	18%	1%	2%
Full-year quality reporting period	32%	27%	22%	15%	1%	2%
Performance feedback	27%	37%	24%	8%	2%	3%
Reporting requirements and methods	33%	34%	21%	9%	1%	2%
Scoring methodology	34%	32%	27%	3%	1%	2%
Usability of the Quality Payment Program website	17%	26%	34%	17%	3%	4%

Would your practice be interested in participating in an Advanced Alternative Payment Model (AAPM) if it was clinically relevant and aligned with your quality goals?



Does Medicare offer an AAPM that is clinically relevant to your practice?



SURVEY PARTICIPANT DEMOGRAPHICS

How many full-time equivalent (FTE) physicians are in your organization?			
1-5		33%	
6-20		39%	
21-50		12%	
51-100		6%	
100+		10%	
Which of the following best describes your organization?			
Independent medical practice		76%	
Hospital or integrated delivery system (IDS), or medical practice owned by hospital or IDS		14%	
Medical school faculty practice plan or academic clinical science department		4%	
Managed services organization (MSO)		2%	
Physician practice management company (PPMC)		1%	
Independent practice association (IPA)		1%	
Other		4%	
Which of the following best describes your organization's specialty focus of care?			
Allergy/immunology	1%	Neurosurgery	1%
Anesthesiology	2%	OB/GYN	6%
Cardiology	4%	Ophthalmology	2%
Dermatology	3%	Oncology	1%
Endocrinology	1%	Orthopedic surgery	8%
Family practice	15%	Otolaryngology	3%
Gastroenterology	5%	Pain management	1%
General surgery	2%	Pediatric medicine	5%
Internal medicine	5%	Psychiatry	1%
Multispecialty with primary and specialty care	15%	Radiology	1%
Multispecialty with specialty care only	2%	Rheumatology	1%
Nephrology	2%	Urology	3%
Neurology	1%	Other	12%



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