Testimony

of Jeffrey Smith

to the

Special Committee on Aging

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Chairman Scott, Ranking Member Gillibrand, and Members of the Committee:

Thank you for the opportunity to testify on the important subject of how administrative and regulatory red-tape fuels physician burnout and impacts patient access to care. I am Jeffrey Smith and I am honored to speak on behalf of the Medical Group Management Association, MGMA, as its incoming board chair. MGMA has over 70,000 members across the United States representing 15,000 medical group practices and more than 350,000 physicians. Our members include small independent practices, large integrated systems, and everything in between. I am also the Chief Executive Officer of Piedmont HealthCare, PA, a physician owned and led multi-specialty medical group with over 230 physicians and providers and 1,180 employees headquartered in Statesville, NC. I have over 40 years of healthcare experience and have also worked in the hospital setting as the Vice President of Finance, audited hospitals for Medicare, and worked in public accounting focusing on healthcare.

I feel deeply passionate about this issue in part because I have seen its impact firsthand while working alongside my wife earlier in my career, who is a nurse, and currently through my daughter, who now serves as a primary care physician in my practice. Having navigated years of escalating regulatory burdens and increasingly complex Medicare payment structures, I am intimately familiar with how these pressures lead to physician burnout and in turn, threaten the ability of physician groups to operate effectively.

MGMA has long advocated for reducing regulatory burden and advancing common-sense policy reforms, as our members consistently cite administrative requirements and documentation as primary challenges to practice sustainability. MGMA has conducted a long-standing regulatory burden survey with our members, receiving feedback on their top regulatory hurdles and how they impact practice operations and patient access. In our 2026 survey of over 230 medical group practices, there is a clear connection between regulatory burden, a broken payment system, and physician burnout.[1] Regulatory burden and

[1]Findings referenced reflect preliminary insights from MGMA's forthcoming 2026 Regulatory Burden and Administrative Feedback Report, scheduled for release in the near term. For additional context, MGMA's 2023 Regulatory Burden Report is available at: https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf.

financial stress are the top two factors in physician burnout, which makes the increase in regulatory hurdles and the failure for Medicare payment to keep up with inflation especially dangerous in today's healthcare system. Over 90 percent of practices have seen an increase in administrative burden in the past three years, while the 2026 Medicare Part B conversion factor is barely above the 2024 level after years of continuous cuts.

Burnout is driving physicians out of practice, and regulatory burden is a major contributor with significant downstream effects. In my own practice, I have increasingly seen more physicians being driven towards early retirement who would have ordinarily stayed in the profession longer. For older physicians for whom retirement is not feasible or desirable, many are significantly reducing their availability as increasingly long work hours become detrimental to their health. The loss of these doctors and the reduction of their hours have a significant impact on patient access.

Extensive documentation requirements and full schedules leave physicians with limited time during patient visits and strain practice resources. Administrative burden related to regulations impacts work–life balance, something I've seen firsthand in my daughter, who often must complete these tasks at home after her children fall asleep. These pressures are driving physicians to leave their communities entirely, relocating to areas with higher reimbursement and predictable schedules to secure the practice infrastructure, and ultimately, the family support they need.

More than half of the practices in MGMA's 2026 survey report losing a physician to burnout in the past three years, and among those, over 75 percent say regulatory burden played a substantial role. Regulatory burden affects recruitment, as over half of practices indicate it makes attracting new physicians more difficult. Ultimately, burnout reduces patient access, leading to longer waiting times, shorter visits, and practices becoming unable to accept new patients. Staffing shortages intensify physician burnout, as remaining clinicians are forced to absorb the extra workload. One medical group relayed being unable to hire an interventional radiologist for over two years and for many, physician recruitment has become a persistent and ongoing challenge. Practices rely increasingly more on advanced practice providers (APP) to backfill physician shortages. While APPs play an important role in our healthcare system, there are limitations across specialties and scope of practice regulations, which can create administrative and patient access challenges.

Given the increasing physician burnout and ongoing workforce shortage, MGMA supports federal legislative efforts to strengthen and expand physician training programs including increasing the number of graduate medical education (GME) positions supported by federal funding. We appreciate the members of the committee who have cosponsored the bipartisan Resident Physician Shortage Reduction Act of 2025 (S. 2439), which aims to increase federal support for physicians' GME program. As I have seen firsthand with my daughter and son-in-law who are both physicians, medical school debt is substantial and can be a barrier to entry for many aspiring medical students. Student debt can shape where physicians may choose to practice as they may gravitate towards specialties and geographic markets that pay more in an effort to repay their loans sooner. MGMA also supports removing barriers in federal student loan programs and pathways for foreign doctors to train and work in the U.S., like H-1B and J-1 visa programs, to help ensure a more reliable supply of physicians, particularly in rural and underserved areas where shortages and recruitment challenges are most acute.

While we support these efforts to increase the physician workforce, addressing administrative and regulatory policies that are leading to physician burnout would help stem the tide of workforce shortages on the front end and support doctors already in practice. I would like to highlight the following burdens that I and other MGMA members are facing that significantly contribute to physician burnout and impede patient access to care, while also reviewing potential congressional solutions to mitigate these concerns and bolster the ability of this nation's medical groups to continue serving their communities.

Medicare Advantage Challenges Increasing

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.[2] 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 is also a significant lack of standardization across Medicare Advantage plans. Blue Cross requirements differ from Cigna, which differ again from Aetna. In my practice, we have had to hire whole teams dedicated to value-based care just to interpret what "quality" means for each payer, yet often with no clear understanding of the true impact on quality or cost savings from these programs. Exacerbating these concerns are the frequent and lengthy delays of up to 18 months to receive final feedback from payers, which undermines the value of this information and leads to additional cost expenditures. Without standardization, administrative costs become unmanageable. Larger practices like mine can absorb more of the cost but for many practices, the cost is unsurmountable.

There are ample opportunities to ensure that the Medicare Advantage program does not add to unnecessary administrative and payment concerns. 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. Further, legislation to address unwarranted downcoding trends in Medicare Advantage would alleviate a substantial pain point for physician practices.

Prior Authorization

One of the top cited regulatory burdens for medical groups is prior authorization, a process that requires physicians, practices, and hospitals to obtain advance approval from health plans before patients can receive certain tests, treatments, or medications. Practices now rank Medicare Advantage plans as the most burdensome payer for obtaining prior authorization. Only roughly 12 percent of prior authorization denials for Medicare Advantage are appealed, of which, approximately 80 percent are ultimately

[2]Centers for Medicare & Medicaid Services. "Medicare Monthly Enrollment." CMS Data. https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment.

overturned upon appeal.[3] 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 unnecessary denials lead to delays in critical patient care and worsening health conditions, but they also create costly, burdensome, inefficiencies in our healthcare system.

We have seen federal efforts to reform prior authorization and increase transparency through recent rulemaking[4] and an Administration-led pledge from some of the nation's largest insurers to simplify the process in June 2025.[5] Although MGMA appreciates the pledged commitment from health insurance companies, prior experience has demonstrated the importance of pairing industry commitments with congressional oversight and statutory action to ensure meaningful, enforceable accountability. A similar pledge from the insurance industry in 2018[6] failed to produce meaningful change, and prior authorization remains a top regulatory burden for medical group practices. In fact, in our recent survey, 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 different employees per physician to assist physicians with regulatory and administrative tasks like prior authorization. I oversee 75 offices in the Charlotte metro area and each practice has at least one staff member doing prior authorizations alone. While hiring support staff is helpful for reducing physician burnout, it is still a poor use of resources that could otherwise go toward patient care, such as hiring nurses or expanding service hours.

Members continue to cite staffing demands, added costs, and negative effects on patient care from 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

[3]KFF, "Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024." Kaiser Family Foundation, https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024.

[4]Centers for Medicare & Medicaid Services, "CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)," https://www.cms.gov/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f. Requires Medicare Advantage plans, Medicaid and CHIP fee-for-service programs, Medicaid and CHIP managed care plans, and Qualified Health Plan issuers on the Federally-Facilitated Exchanges to adopt standardized electronic data-exchange and prior authorization APIs to streamline approvals, reduce burden, and improve timely access to patient information.

[5]Medical Group Management Association, "MGMA Statement on Health Plans' Commitment to Simplify Prior Authorization," June 23, 2025, https://www.mgma.com/press-statements/june-23-2025-mgma-statement-on-health-plans-commitment-to-simplify-prior-authorization. The pledge requires insurers to reduce the services needing prior authorization, provide 90-day continuity for existing authorizations during coverage transitions, improve denial and appeal explanations, expand real-time electronic prior authorization decisions, and implement standardized electronic systems that apply interoperability to prior authorization by 2027—extending key elements of the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) to commercial and employer plans and ultimately affecting most Americans.

[6]Medical Group Management Association, "Consensus statement on improving the prior authorization process, 2018", https://www.mgma.com/getkaiasset/87f683d9-401c-4137-946b-761abe36c2f7/01.01.2018_PA-consensus-statement.pdf.

patients, and divert physician time away from clinical work, contributing directly to burnout. From a cost perspective, prior authorization has driven meaningful increases in practice overhead at a time when expenses across healthcare continue to rise. We have been required to add and reallocate staff to manage authorizations, appeals, and follow-up, absorb productivity losses when physicians and clinical teams intervene, and carry unreimbursed administrative labor that is not reflected in payer rates. These costs are compounded by rising wages, technology expenses, and compliance requirements, collectively placing downward pressure on margins and limiting our ability to reinvest in patient access and care delivery."

- "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."
- "Patients often become upset while waiting for a prior authorization, and they frequently blame the provider. If a prior authorization is denied, the provider may have to complete a peer-to-peer review with the insurance company… The downtime spent on peer-to-peer calls—being placed on hold, rescheduling, and completing endless paperwork that may be sent to us three or four times—ties up my staff, only for us to receive a final letter saying the request is denied. It's beyond frustrating."

While the Administration has pledged to streamline prior authorization and reduce overall regulatory burden across the government, the launch of the Medicare Wasteful and Inappropriate Service Reduction (WISeR) Model expands the use of prior authorization in traditional Medicare for 17 outpatient services in six states, and introduces a new, non-standardized approach that is inconsistent with federal regulations for prior authorization and the industry pledge. We harbor concerns that the WISeR model may increase administrative and patient burdens in traditional Medicare and urged for the model to be delayed a year to avoid repeating well-documented problems with prior authorization.[7]

The Improving Seniors' Timely Access to Care Act (H.R. 3514; S. 1816), which is sponsored by both the Chairman, Ranking Member, and many members of the committee, 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 well as insurers in the Better Medicare Alliance, as it would implement common sense reforms to improve the transparency surrounding prior authorization utilization and expediate an often-laborious process. MGMA considers this important legislation a must-pass in this Congress and has worked diligently with the Regulatory Relief Coalition to support this legislation.[8]

[7]Medical Group Management Association, "National Medical Organizations Applaud WISeR Amendment and Seek Reforms," https://www.mgma.com/getkaiasset/ce980cc9-d7d7-4bd6-818be59ba2f2a06c/NatMedicalOrgsApplaud%20WISeRamdtandSeekReforms.pdf.

[8]The Regulatory Relief Coalition (RRC) is a group of national physician specialty organizations advocating for regulatory burden reduction in Medicare so that physicians can spend more time treating patients. https://regrelief.org/.

Regulatory Burdens Associated with 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 beset with issues as it requires clinicians to report on quality measures that are not clinically relevant to them. The cost reporting measure holds clinicians accountable for costs outside of their control. Complying with these requirements is a time-consuming and laborious process, as studies have shown the significant amount of staff time and money dedicated to MIPS reporting.[9] Compounding these issues is the lack of adequate and timely feedback by CMS on measuring performance. Without receiving appropriate feedback about which patients are assigned to them and what costs outside of their practice they must account for, physicians are unable to correct issues.

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

- **Reduce reporting burden and better align performance measures with clinical care**. CMS should remove the silos between the different performance categories; providing multi-category credit for MIPS measures that fulfill multiple categorical functions would avoid the duplicative steps of documenting and reporting on the same activities. The MIPS cost performance category has numerous issues related to measuring costs outside of a provider's control and opaque scoring procedures; it is essential to revise this category significantly. Additional changes are needed to improve reporting on quality measures and allow providers reporting through clinical data registries to automatically satisfy Promoting Interoperability and Improvement Activities requirements.
- **Improve the performance threshold**. The current MIPS threshold of 75 points results in many providers being unnecessarily penalized. Congress should freeze the threshold at 60 points. Further, the Government Accountability Office (GAO) should submit a report to Congress and the Department of Health and Human Services (HHS) in consultation with physician organizations that details recommendations for a replacement performance threshold.
- **Reform how payment adjustments are calculated.** The current tournament-style model of

[9]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.

MIPS needs to be eliminated to stop undermining the financial viability of practices participating in MIPS that receive a negative payment adjustment. A new model with payment adjustments tied to the annual payment update would be more equitable while continuing to incentivize groups to improve their performance. Groups who score below the performance threshold would receive a reduced payment update compared to those at or above the threshold. The penalties would fund bonuses for the high performers and go towards an improvement fund.

- **Ensure timely and actionable feedback from CMS**. Providers do not receive the timely and accurate feedback from CMS needed to understand their performance and be able to make changes to reduce costs or improve scores. A redesigned MIPS program must include this vital feedback in a digestible format, and if quarterly reports are not provided, then medical groups should be held harmless from any penalties.

The APM incentive payment has been essential to medical groups attempting to transition 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 freezing the 2026 QP thresholds at the 2024 level. We look forward to working with Congress to ensure that APMs offer a viable and stable pathway for medical groups to transition to value-based care while reducing reporting burden.

Administrative Simplification Opportunities under HHS

Numerous processes under HHS's purview could be standardized and simplified to reduce duplicative and unnecessarily time-consuming tasks that impact physician burnout. There are myriad opportunities to reduce the complexity of reporting for Medicare providers. Simplifying and streamlining healthcare transactions, documentation requirements, claims reviews, and audits would reduce administrative burdens and costs and allow medical groups to dedicate more time to patient care.

Provider enrollment and credentialing in Medicare is often a laborious, complex, and cumbersome process. Improving credentialing systems that CMS oversees, such as the Provider Enrollment, Chain and Ownership System (PECOS), should be a priority to offer needed relief. MGMA members have consistently ranked credentialing processes as adding regulatory burden to their practices; standardizing and aligning requirements across payers while reducing paperwork would help address this longstanding concern. Credentialing is important for medical groups – for payment, network participation, compliance, and improvements to the credentialing process would have added benefits beyond just administrative burden like potentially helping with delays to patient access and disruptions in revenue. Adding to this strain are the various websites and portals specific to CMS that practices have to use for enrollment, revalidation, changes of addresses, adding providers, etc. Navigating these various portals – NPPES, PECOS, HARP for example – all lead to increased staff time and increase the potential for administrative mistakes. One member with providers in reports having to complete the same application five times to enroll a provider in each of the five states. Streamlining Medicare systems would better facilitate the capture of this data, while simplifying these administrative processes and lower practice costs.

Inadequate Medicare Payment Amplifies Regulatory Burden and Physician Burnout

All of these administrative barriers and regulatory red tape are exacerbated by the continued under-reimbursement of the Medicare Part B payment system. Financial stressors, such as declining reimbursements and rising costs, were the second largest contributing factor to physician burnout in our 2026 survey. An essential factor to these financial stressors is the downward trajectory of Medicare Part B reimbursement for the past few decades.

Medical groups dealt with a 2.83 percent 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 Congress thankfully enacted a 2.5 percent increase to 2026 Medicare reimbursement, CMS's recently finalized payment rates for 2026, that incorporated the 2.5 percent increase, are barely above 2024 reimbursement levels. This small increase is undercut by budget-neutrality policies that decrease reimbursement for certain specialties, while at the same time failing to keep up with inflation. In addition to failing to keep up with the costs of treatment for Medicare beneficiaries, given the centrality of Medicare rates to benchmarks for commercial payers and Medicaid, inadequate Medicare reimbursement has cascading effects across payers.

Members continue to express frustration and illuminate the negative effects of declining reimbursement to both physician well-being and patient access:

- "Physicians are exhausted trying to treat cancer patients in the office setting because Medicaid and Medicare reimbursement do not cover the cost of the chemotherapy. We are always looking for alternative treatments or specialty pharmacies to support our local patients and keep cancer care in our area."
- "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."
- "Discussions about how a private practice can survive when inflation is going up, but our reimbursements are dropping. Evaluating lower-level providers (PAs/NPs) to see patients and cut costs. Constant scramble to cut costs and see more patients. VERY STRESSFUL to physicians who have dedicated their lives to medicine. "

Given the current path of Medicare reimbursement, with its frequent reductions due to outdated budget neutrality requirements and lack of an inflationary update, it is necessary to enact lasting reform. The Strengthening Medicare for Patients and Providers Act of 2025 (H.R. 6160) would make structural changes to the Medicare payment system that is needed to sustainably support medical groups and avoid these yearly 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) made 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 and stopping a major factor of physician burnout. Comprehensive reform is needed to avoid the detrimental effects of increased physician burnout due to inadequate reimbursement.

Increasing Consolidation

The challenges discussed throughout this testimony coalesce to undermine 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 trend in independent practices selling their practices is stark – according to the Physicians Advocacy Institute, 77.6 percent of physicians are employed by hospitals/health systems and other corporate entities.[10] The GAO reported that 47 percent of physicians were affiliated or employed with a hospital system in 2024.[11]

Of practices that have experienced an ownership change in the last three years that was affected by physician burnout and regulatory burden, many MGMA members report distressing stories of how burnout contributes to increased consolidation: "After being physician-owned for over 100 years, the practice sold to a hospital at the close of 2025." The 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. Everyday our practice receives calls offering to buy us and take the burden off our hands. We are cannibalizing ourselves due to these pressures and making it extremely difficult for physician practices to stay independent, especially in rural areas.

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 from 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 long-term reforms, like those discussed in this testimony, would help lead to a more robust and dynamic practice environment.

Conclusion

[10]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/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023.
[11] Government Accountability Office, "Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation," Sept. 22, 2025, https://www.gao.gov/products/gao-25-107450.

I sincerely appreciate the opportunity to testify today and share both my personal experience and other MGMA members' experiences on how regulatory burden contributes to physician burnout. A confluence of administrative and financial pressures is driving physicians out of practice, increasing consolidation, and undermining patient access in communities across the nation. Thankfully, Congress has numerous opportunities to address these issues and help bolster medical groups' ability to provide high-quality, cost-effective care, and create a more satisfying experience for physicians and patients alike. I look forward to answering any questions you may have.