

2026 Issue Brief

Reduce Administrative Waste, Promote Innovation, and Ensure Long-Term Stability

Issue

Administrative complexity, regulatory instability, and excessive paperwork continue to strain the U.S. healthcare system and accelerate clinician burnout. Physicians and care teams are increasingly overwhelmed by shifting regulations, duplicative reporting requirements, and complicated reimbursement processes that divert time and resources away from patient care and increase costs. These burdens contribute to workforce exhaustion, increase healthcare inefficiencies, and create unnecessary barriers for patients seeking timely, coordinated care. Policymakers must address the significant administrative waste that currently exists in our nation’s healthcare system so that providers can focus on what matters most, improving patient care.

Reduce Administrative Complexity and Waste

- **Prior Authorization:** Excessive prior authorization (PA) requirements delay access to medically necessary care and impose significant administrative waste. AMGA commends recent steps to improve PA processes and believes these are important steps in the right direction. However, continued progress is essential. There were approximately 53 million prior PA requests in MA in 2024. Over four million, or 7.7%, of those requests were denied, and of the denied requests, 11.5% were appealed and 80.7% were fully or partially overturned.ⁱ The appeals process highlights inefficiencies, as the high approval rates suggest that many initial denials may be unwarranted. For example, an AMGA member reports instituting a 14-day delay in scheduling magnetic resonance imaging (MRI) simply to manage the denials from payers. While ultimately scheduled, approved, and reimbursed, the system effectively penalizes the patient.

AMGA strongly supports further efforts to reduce or eliminate unnecessary PA requirements by accelerating decision timeframes, establishing transparent approval standards, implementing “gold carding” for high-performing providers who consistently meet evidence-based care standards, and enhancing enforcement of PA standards.

- **Information Blocking and “Immediate Resulting”:** AMGA strongly supports patient access to health information. However, AMGA urges the Department of Health and Human Services (HHS) to revise the regulatory requirementsⁱⁱ to broaden the definition of patient harm to include mental or emotional harm. AMGA members have consistently reported troubling instances where patients

learned of serious diagnoses—such as cancer diagnoses, miscarriages, or infectious diseases—through automated portal notifications before physicians could provide context or counseling.

Promote Innovation in Care Delivery Models, Digital Health, and Team-Based Care

- **Skilled Nursing Facility (SNF) 3-Day Rule:** Currently, Medicare requires beneficiaries to stay in an inpatient hospital for three days before Medicare will cover care provided by a SNF. The three-day inpatient stay rule for skilled nursing facility (SNF) coverage under Medicare is outdated and restricts timely access to appropriate post-acute care. Eliminating this requirement would align coverage with clinical need, reduce unnecessary hospitalizations, and facilitate efficient, patient-centered transitions of care.

Ensure Long-Term Regulatory Stability

- In recent years, Congress and Centers for Medicare and Medicaid Services (CMS) have worked to remove the barriers and obstacles that prevent medical group practices and integrated systems of care from delivering the highest quality care in the most efficient and cost-effective way. AMGA recommends building on these efforts by continuing to modernize Medicare laws and regulations to support care delivery patterns which have evolved since Medicare’s inception. AMGA and the Medicare and CHIP Reauthorization Act (MACRA) and Value-based Care Task Force identified specific policies that warrant reform or repeal.ⁱⁱⁱ Revising or eliminating these regulations would enhance provider efficiency, support chronic disease prevention and management, and accelerate systemwide progress toward improved health outcomes and cost containment. An itemized table of legislative and regulatory barriers that contribute toward waste in the U.S. healthcare system and delay access to care is included at the end of this document.

AMGA asks Congress to:

- **Ensure that prior authorization processes are analyzed and then reduced or removed to ensure access to timely quality care**
 - **Approve S. 3762, the Prior Authorization Relief Act, which would require the HHS Secretary to complete an audit and standardize PA requirements in MA**
- **Work with HHS to protect patients from harm caused by “immediate resulting” by broadening the definition of patient harm to include mental or emotional harm**
- **Ensure patients receive the right care at the right time, by approving H.R. 3954, the Improving Access to Medicare Coverage Act, which would remove the 3-day inpatient hospital stay Medicare requirement for SNF care**
- **Explore opportunities to work with HHS and CMS to remove legislative and regulatory barriers detailed by the AMGA MACRA and Value-based Care Task Force**



| Barrier | Issue | Citations/Reference Points |
|---|---|---|
| Prior Authorization | The prior authorization process leads to delay in patient care and payment reductions due to cumbersome requirements and errors, resulting in payers forgoing payment for appropriate medical services. | 42 CFR Chapter IV, Subchapter B: §422.122, §422.568, §422.570, §422.572 |
| Merit-Based Incentive Payment System (MIPS) Low Volume Threshold | Exempting too many providers from the Merit-Based Incentive Payment System (MIPS) undermines the program and minimizes rewards available due to budget neutrality requirements. | 42 CFR Chapter IV, Subchapter B §414.1310 |
| Patient-Threshold Requirements for CMS High-Value Care Models | Arbitrary minimum patient numbers eliminate smaller, non-urban practices from participation in CMS high-value care programs. | CMMI models: Request for Application |
| Telehealth Prescription of Controlled Medication | Expiring flexibilities for telehealth prescriptions of controlled medications will burden patients and providers. | 42 CFR Part 12 Chapter II § 1307.41 |
| Excessive Penalties for Information Blocking | ONC's final rule implementing penalties under the 21st Century Cures Act could impose significant fines on providers found to engage in information blocking. | 45 CFR Part 171; RIN 0955-AA05; 21st Century Cures Act |
| Face-to-Face Requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) | Unclear Medicare rules for durable medical equipment cause administrative burdens and care delays. | 42 CFR 410.38(d)(2) |
| DMEPOS Written Order/Prescription | Documentation requirements for durable medical equipment orders add unnecessary burdens. | 42 CFR 410.38(d)(1) |
| Home Health Services Timeframe Requirements | Rescheduling visits requires physician permission, creating administrative burdens. | 42 CFR 424.22(b)(1) |

| Barrier | Issue | Citations/Reference Points |
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| Skilled Nursing Facility 3-Day Rule | Requirement for a 3-consecutive-day inpatient hospital stay prevents transitions to appropriate care settings. | Section 1861(i) of the Social Security Act and 42 CFR 409.30 |
| Medicare Advantage Surveys | Patients need help understanding surveys, potentially leading to negative penalties for providers. | 42 CFR 422.162(a) "CAHPS" |
| Dual-Special Needs Plans (D-SNP) Education for Providers | Redundant education requirements for providers increase administrative burdens. | 42 CFR 422.107(c) |
| Documenting Suspect Conditions from Home Assessments | Inaccurate "suspect" conditions must be documented, potentially leading to care denials. | 42 CFR 424.22(c)(1) |
| Preferred Provider List | Providing a list of preferred post-acute care facilities can improve patient outcomes and care coordination. This policy should be extended beyond the Next Generation ACO demonstration and apply to all providers in Medicare high-value care arrangements. | Next Generation ACO Demonstration |

ⁱ Fuglesten Biniek, J., Sroczynski, N., Freed, M., & Neuman, T. (2026, January 28). *Medicare Advantage insurers made nearly 53 million prior authorization determinations in 2024*. KFF. <https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/>

ⁱⁱ 45 CFR § 171.201

ⁱⁱⁱ American Medical Group Association. (n.d.). *AMGA MACRA and value-based care task force recommendations: AMGA's six pillars to improve care delivery and continue the transition to high-value care*. https://www.amga.org/getmedia/2861c46e-b965-4c4b-b8df-f43b40d054aa/amga_macra_recommendations.pdf