HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

October 2, 2023

Hon. Bernie Sanders
Chair, Senate HELP Committee
428 Dirksen Senate Office Building
Washington, DC 20510

Hon. Bill Cassidy
Ranking Member, Senate HELP Committee
428 Dirksen Senate Office Building
Washington, DC 20510

The Healthcare Business Management Association (HBMA) is pleased to submit this letter expressing our views on the Bipartisan Primary Care and Health Workforce (BPCHW) Act that was introduced on September 14th.

HBMA is a non-profit professional trade association for the healthcare revenue cycle management (RCM) industry in the United States. HBMA members play an essential role in the operational and financial aspects of the healthcare system. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care - where it should be directed - instead of on the many administrative burdens they currently face. The RCM process involves everything from the lifecycle of a claim to credentialing, compliance, coding and managing participation in value-based payment programs.

HBMA members typically serve physicians that are independent practices (not employed by a healthcare system). In many cases, these independent practices will be contracted to provide healthcare services at hospital outpatient and inpatient departments. Hospitals and healthcare systems usually conduct their RCM functions "in-house."

HBMA supports the provisions of the bill that would fund training programs for physicians and other non-physician practitioners (NPP). These investments in training new healthcare professionals will help address shortages across the clinical workforce which will improve access to care for patients. However, the bill does not address the root cause of the clinical workforce issues that contribute to the shortage.

This clinical workforce shortage is largely caused by clinicians retiring and leaving the workforce before the typical retirement age due to financial pressures and administrative burdens. Congress has a responsibility to address these issues that are caused by federal reimbursement policies that do not adequately reimburse clinicians and other policies that add new burdensome regulatory requirements. These unfunded regulatory mandates further detract from low reimbursement rates. Commercial payers also contribute to these administrative burdens through prior authorization and non-compliance with laws such as the No Surprises Act. To fully address clinical workforce issues Congress must also take action to reduce burdens caused by commercial payers. A recent survey from the Physicians Foundation (part 2 and part 3) further highlight the burdens physicians and practices face in greater detail.

HBMA reiterates our appreciation for the opportunity to meet with HELP Committee staff to discuss our concerns with certain sections of the first version of the bill that was released earlier

this summer. We were specifically concerned about 1) the operational challenges associated with the bill's provision to prohibit hospitals from charging facility fees and from sending patients more than one bill for certain services, 2) paying for certain hospital outpatient services at the Qualifying Payment Amount (QPA) rate for the physician office setting, and 3) the provision that would require hospital provider-based departments (PBD) to include a unique identifier on claims.

The new version of the bill scales back the facility fee prohibition by limiting this policy to Evaluation and Management (E/M) and telehealth services. However, the new version of the policy broadens the policy from the original version of the bill by not differentiating between on- and off-campus PBDs and by applying this policy to all commercial health plans and uninsured patients. The new version maintains the unique identifier requirement for hospital PBDs. Lastly, the new version no longer includes a provision to reimburse services subject to the facility fee prohibition at the QPA amount.

We are pleased to see the new version of the bill no longer include the QPA provision. However, we reiterate our concern with Sections 302 and 303 in the bill that prohibit facility fees for certain services and require unique identifiers for off-campus PBDs.

Requiring a unique identifier for off-campus PBDs is redundant with existing place of service (POS) codes that are already required on healthcare claims. Including a unique identifier for each facility provides no additive value to the RCM process.

Prohibiting hospitals from charging facility fees will create major confusion for both hospital and physician billing. Facility fees are billed separately from professional fees for hospital services because in some cases the physician is not employed by the hospital. Patient consent forms and hospital signage already communicates to patients that they may receive separate bills for a facility fee and professional services. We acknowledge that more can be done to educate patients about what bills to expect for their service.

However, it is a misconception that the facility fee is an unfair additional charge. Facility fees are intended to provide hospitals with reimbursement for the overhead necessary for providing the service while the physician charges separately for their professional fee.

Under the policy banning facility fees for certain services, physicians will be the only entity that can receive reimbursement for applicable PBD services. This means that hospitals will likely insert themselves into the reimbursement negotiations independent practices have with payers to add a facility payment to this rate. Further, hospitals could then require physician practices to share some of their revenue with the hospital to compensate for the lost facility fee.

We understand the Committee's desire to simplify the medical billing process for patients. However, it is important to recognize that the current medical billing system is set up in a way for physicians and hospitals to bill for both overhead costs and professional services - whether these services are billed together or separate. We believe a more realistic solution should focus on what the patient pays. The Committee should consider replacing the facility fee billing ban with a policy that limits patients to receiving a single cost-sharing bill when a facility fee is

billed separately from a professional service. This will maintain the ability for hospitals and physicians to bill for their part of the service while also simplifying the billing process for the patient.

We understand that this policy is intended to help offset the cost of the workforce training and community health center reauthorization provisions. We strongly urge the Committee to replace this policy with a different spending offset that will not create new operational challenges for hospitals and healthcare providers. These burdensome policies are a direct contrast to the healthcare workforce issues the Committee hopes to address.

In conclusion, we encourage the Committee to continue utilizing HBMA as a resource for this and other policies that impact the healthcare claim submission process. We are happy to provide additional information to help the Committee develop and refine policies to avoid adding operational and financial burdens on physician practices.

Thank you for considering our recommendations. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) or Brad Lund (brad@hbma.org) if you wish to discuss our recommendations further.

Sincerely,

Landon Tooke

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President
Healthcare Business Management Association