October 2, 2023

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House Committee on Ways and Means
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Hon. Richard Neal
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The Healthcare Business Management Association (HBMA) is pleased to submit this letter expressing our views on the Lower Cost More Transparency (LCMT) Act.

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 supports the provisions in the bill that will increase funding for physician residency training. 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, unreasonable network restrictions 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.

We are concerned that the price transparency provisions of this bill will contribute to the administrative burdens that providers face. For example, requiring certain healthcare facilities to disclose minimum and maximum insurer-negotiated rates in addition to cash prices places the price transparency burden on the facilities. This reporting requirement is redundant since the same information will be published under the hospital price transparency regulations and the Transparency in Coverage final rule.

Additionally, this information will not be helpful to patients unless it is specific to their coverage. The No Surprises Act (NSA) Advanced Explanation of Benefit (AEOB) provision will provide such information to patients. Once implemented, the AEOB will be a significant administrative burden for healthcare providers and facilities. The LCMT Act's new price transparency requirements for facilities will create new and redundant administrative burdens for these facilities with no additive value to patients.

While many of the LCMT Act's price transparency provisions do not apply to physician practices, we believe these policies could be expanded to this setting in the future. These and future price transparency policies should not place added administrative burdens on physician practices. It is more appropriate and realistic to place price transparency responsibilities on health plans. The patient's in-network rate is the price that matters. Health plans are in the best position to share this information, and as mentioned above, are already required to disclose this information to the public and to their members through existing regulations. Adding a redundant requirement to physician practices will exacerbate burnout and drive more healthcare professionals to early exits from the clinical workforce.

We strongly support Section 110 which requires a Report on the Impact of Medicare Regulations on Provider and Payer Consolidation. Regulatory burdens are unfunded mandates that require additional investments of administrative resources without increasing reimbursements to compensate providers for the expenses associated with complying with these regulatory requirements. This creates an incentive for independent practices to join large systems which take on those administrative burdens. These burdens also incentivize large practices and systems to consolidate with each other to gain the leverage necessary to negotiate reimbursement rates from commercial payers to compensate for these administrative burdens.

According to the American Medical Association (AMA), less than half of physicians work for a physician-owned independent practice. Many physicians prefer independent practice because it gives them greater autonomy over how they practice medicine, more control over their schedules, and the ability to make decisions about participating in value-based payment programs that are right for them. Additionally, independent practices often provide care at lower cost compared to large systems. Burdensome regulations and financial pressures are taking away clinicians' ability to make the right decision for them regarding independent practice.

The LCMT Act's provision requiring hospital off-campus outpatient departments (OPD)s to include a unique identifier for each location on claims for services provided at these facilities is an example of this burden. Requiring a unique identifier for off-campus PBDs is redundant with existing place of service (POS) codes that are already required on healthcare claims. 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. 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 only.

In conclusion, we encourage the Committees to utilize 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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