HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

March 20, 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

Re: Senate HELP Committee Request for Information on Healthcare Workforce Challenges

The Healthcare Business Management Association (HBMA) thanks you for prioritizing healthcare workforce challenges with both a hearing on this important topic and now a request for information (RFI) that will hopefully inform bipartisan legislation to address these important problems. We welcome this opportunity to provide our recommendations on how to relieve pressures on an already strained healthcare workforce.

The Healthcare Business Management Association (HBMA), a non-profit professional trade association, is a major voice in the revenue cycle management industry in the United States. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

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 revenue cycle management (RCM) process involves everything from the lifecycle of a claim to credentialing, coding and managing participation in value-based payment programs.

The growing administrative burdens on practices due to policies from Congress, CMS and commercial health plans are a major contributor to physician burnout. The U.S. Surgeon General acknowledges that administrative burdens are a contributor to burnout in its Advisory on Addressing Healthcare Worker Burnout, “Several factors likely contributed to the immense challenges and demands that health workers faced even before the COVID-19 pandemic: a rapidly changing health care environment, where advances in health information and biomedical technology are accompanied by burdensome administrative tasks, requirements, and a complex array of information to synthesize.”

These administrative burdens are disproportionately more harmful for small practices that do not have the resources to understand and manage these responsibilities as well as older clinicians who would rather retire than deal with these challenges.

Administrative burdens also impose financial costs on practices. Research suggests administrative spending accounts for between 15 and 30 percent of total healthcare spending which translates to upwards of $1 trillion.

Another factor contributing to physician burnout is declining reimbursement rates from both government and commercial payers. MedPAC recognizes that Medicare reimbursement has significantly lagged MEI since 2010. Clinicians can only earn meaningful positive Medicare

reimbursement increases through programs like MIPS and APMs. However, MIPS is increasingly difficult to earn a meaningful positive payment adjustment and APMs are not viable options for many specialists. Similarly, the No Surprises Act (NSA), while helpful for patients, has incentivized commercial health plans to force more providers out of their networks.

These reimbursement challenges combined with the many administrative burdens are key contributors to physician burnout and workforce challenges that the Committee hopes to address.

We are glad the Committee's hearing on healthcare workforce challenges spoke about these important issues. The hearing also discussed how to improve the pipeline of new clinicians and how our workforce is meeting the needs of underserved communities. Addressing financial and administrative burdens must be part of the solution. Otherwise, we will fail to maximize our investment in the new generation of our clinical workforce.

Below is a series of recommendations for how to alleviate financial and administrative burdens to improve the health of our healthcare workforce:

- **Pass legislation that provides regular positive updates to the Medicare Physician Fee Schedule Conversion Factor.**
  Every year, provider organizations lobby Congress to avert pending cuts to Medicare reimbursements. While we appreciate Congressional action to prevent Medicare reimbursement cuts, Congress generally does not fully address these cuts and only passes temporary fixes for the cuts it does address. Congress must immediately stabilize Medicare reimbursement rates by ending this annual cycle of averting reimbursement reductions at the last minute.

  This includes permanently ending the 2% sequestration reduction, permanently waiving the 4% PAYGO reduction that was temporarily prevented until 2025, and restoring appropriations for the MIPS exceptional performance bonus.

  Congress must also provide regular, positive updates to the Medicare Physician Fee Schedule Conversion Factor to account for the effects of inflation and the fact that clinicians currently are not compensated for the administrative burdens they face.

  Providing financial stability and certainty will alleviate much of the pressures on physician practices that contribute to burnout and early exits from the clinical workforce.

- **Enforce existing electronic transaction standards.**
  Despite being passed in 1996, we have yet to fully realize the benefits promised by HIPAA's Administrative Simplification provisions. HIPAA, and the Affordable Care Act (ACA), both advance electronic transaction standards that medical practices and RCM companies rely on for administrative functions ranging from eligibility checks to claim submission and payment.

  The purpose of these standards is to reduce administrative burdens by creating simple, electronic processes for conducting business functions that all parties must support. However, there is a significant opportunity to increase utilization of these transactions which could save the healthcare system billions of dollars.

  In addition to adopting new standards, CMS must do more to improve the effectiveness of standards that have already been adopted. Too often, a payer will meet the letter of

the standard but not its spirit. For example, the standards for remittance advice includes operating rules for how to use Remittance Advice Remark Codes (RARC) and Claims Adjustment Reason Codes (CARC) that provide information about how a claim was adjudicated. In many cases, the RARC and CARC combinations we receive on a claim do not align with the actual issue they are trying to describe. In these scenarios, the health plan complied with the standard and its operating rules for how to use these codes but increased administrative burdens by not providing accurate information. The frequency of this and similar administrative issues is a main cause of administrative burdens that could easily by prevented by better enforcement and oversight from CMS.

We also know that commercial health plans deliberately try to circumvent these standards. The most egregious example is EFT payments to providers using the 835 standard transaction. EFT is one of the most common formats for electronic payments. HIPAA requires health plans to pay providers using the standard EFT transaction standard if the provider requests that method and prohibits payers from charging anything beyond a nominal telecommunication fee for this transaction.

Health plans increasingly attempt to pay providers using other electronic methods such as virtual credit cards (VCC) which carry a transaction fee. Providers can opt out of VCCs but this is an administratively burdensome process. Some payers contract with a vendor to facilitate the standard EFT payment. Those vendors exploit a regulatory loophole to charge a fee for the EFT transaction.

Providers do not want to pay a fee to get paid. It's akin to an employer charging a transaction fee to direct deposit an employee's paycheck in their bank account. Congress should work with CMS to guarantee that providers always have the ability to get paid without being charged a transaction fee.

- **Improve the quality of quality programs such as MIPS and APMs.**
  Value-based payment programs have laudable goals to reduce spending while increasing quality. However, they are one of the top sources of administrative burdens that contribute to burnout and early exits from the clinical workforce. We worry that the added administrative resources necessary to succeed in these programs are greater than the potential financial rewards and cost savings they promise. The potential reward is insufficient compared to the level of financial risk practices must accept to participate in these programs. Congress should carefully review the existing value-based payment programs and reassess if their potential benefits outweigh the administrative and financial burdens they create.

- **Continue to address the burdens of prior authorization.**
  Prior authorization is one of the top administrative pain points for practices. Health plans are overutilizing prior authorization and make the process more difficult than it needs to be. Upwards of 90% of prior authorizations are either approved or improperly denied. The administrative burdens of prior authorization far outweigh the potential benefit of preventing wasteful services. This ultimately creates barriers to patients accessing care.

  The *Improving Seniors Timely Access to Care Act*, which has broad bipartisan support, would help streamline the prior authorization process. We encourage Congress to pass this legislation. However, this bill does not do enough to limit how health plans use prior authorization. We believe additional legislation is needed to place more restrictions on how health plans can use prior authorization. This bill should penalize health plans for

high rates of improperly denied requests and incentivize “gold card” programs that let providers with high approval rates avoid some of these requirements.

Prior authorization creates administrative waste for both health plans and providers. We need to ask ourselves if we would rather have healthcare professionals caring for patients in clinical settings or working for health plans performing administrative reviews of prior authorization requests.

- **No Surprises Act**
  The No Surprises Act (NSA) includes many beneficial protections for patients. However, it has become one of the top sources of administrative and financial burdens for clinicians. Congress must improve the NSA statute to address important operational and policy challenges.
  - **Clarify congressional intent that the QPA has no added weight compared to other factors in the IDR process.**
    HBMA opposed CMS’ attempt to give the QPA added weight compared to other factors in the IDR process in the original version of the NSA implementing regulations. Making the QPA, generally defined as the median in-network rate for that service, the most likely outcome in an IDR dispute creates an incentive for health plans to remove physicians from their networks who have contracts above the median. By definition, this means half of the physicians in a plan’s network are subject to this new pressure.

    Our concern is a reality. We have many examples of physicians receiving significant in-network rate reductions and health plans outright terminating practices from their networks. These letters vaguely cite “the No Surprises Act” to justify these actions. We can provide copies of these letters upon request.

    The IDR process is intended to resolve these reimbursement disputes in a neutral manner. CMS instead chose to implement these requirements in a way that favors health plans which has resulted in unfair contracting tactics from health plans. We are glad that legal challenges have clarified that CMS cannot give the QPA added weight in IDR disputes.

  - **Conduct vigorous oversight of how health plans calculate the QPA.**
    We are concerned that health plans are not accurately calculating the QPA amount. The NSA does not include any requirement for health plans to be transparent about how they calculate this amount. It only says that CMS will conduct audits to verify they are accurate. We have not heard any updates from CMS about these audits. Our members have internal data that suggests the QPA amount is not accurate.

    Congress should request information from health plans about their QPA calculations and should encourage CMS to audit every health plan’s QPA calculation.

  - **Make the Good Faith Estimate and Advanced EOB requirements easier for practices to operationalize.**
    While not fully implemented yet, the NSA’s Good Faith Estimate (GFE) and Advanced EOB (AEOB) requirements will be an immensely complicated administrative burden on practices. The challenges these requirements will pose cannot be overstated.

Congress should change the NSA statute to remove the requirement that GFEs include care "reasonably expected" to be furnished "in connection to" a primary item or service. This requirement means the convening provider must coordinate with other practices and facilities to get their cost estimate information for the completed GFE. The convening provider or facility has no realistic way of knowing what co-provider or co-facility the patient will utilize. If they do learn this information, the convening provider or facility must utilize manual processes to get this information.

As an example, if a convening provider believes a patient needs a lab test when the patient schedules their care, they GFE must include a cost estimate from the lab. However, the convening provider has no way of knowing what lab the patient will utilize and only has a few days to provide this information. Additionally, there is no standard transaction to facilitate this information exchange.

The easiest solution is to not require the convening provider to include connected care. Patients can still get the same price information by requesting individual GFEs from each individual provider or facility. This solution reduces burdens on practices while ensuring that patients can still access the same information – which will likely be more accurate than what is currently required.

Thank you for reviewing our recommendations for how to address workforce challenges. Clinicians are facing a wide array of administrative and financial burdens that exacerbate burnout and early exits from the clinical workforce. While it is important to ensure we have a strong pipeline of new clinicians that meet the healthcare needs of our population, we must also improve the situation for the existing clinical workforce. Removing financial and administrative burdens allows clinicians to better focus their time and resources on patient care.

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