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 American College of Allergy Asthma and Immunology's (ACAAI) Advocacy Council appreciates the Committee's decision to prioritize healthcare workforce challenges with a hearing on this topic and 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 address these important issues that our members are experiencing firsthand.

ACAAI represents more than 6,000 board certified allergists and healthcare professionals. Allergists specialize in treating adult and pediatric patients with chronic conditions such as asthma, food allergies, hives or urticaria, stinging insect hypersensitivity, sinus problems, allergic rhinitis, anaphylaxis, immune deficiencies, and atopic dermatitis or eczema, among other conditions.

Our members are on the frontline of many of the workforce challenges your committee hopes to address. Our recommendations will focus on how to help the existing workforce as well as how we can ensure the next generation of healthcare professionals meets the needs of our patients.

The healthcare workforce is overburdened by clinical, financial, and administrative challenges. Failure to address these issues will exacerbate the existing problem of clinician burnout which can negatively impact both quality and access to care. Part of the solution is strengthening the clinical workforce which has not yet recovered to pre-pandemic staffing levels. As we consider solutions to the workforce challenges, we must dedicate our resources to the right trainees as well as to the right patient communities.

❖ Reduce Administrative Burden

One of the most important ways Congress can help the healthcare workforce is by reducing administrative burdens on physicians. 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's statement - Advisory on Addressing Healthcare Worker Burnout - acknowledges that administrative burdens contribute to burnout, "Several factors likely

contributed to the immense challenges and demands that health workers faced even before the COVID-19 pandemic: a rapidly changing healthcare 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 especially difficult for small practices, who do not have the resources to understand and manage these responsibilities as well as older clinicians who would rather leave the clinical workforce than deal with these challenges.

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

Value-based Payments

Value-based payment programs such as MIPS and Alternative Payment Models (APM) are a major source of administrative burdens. The cost and quality goals of these programs are laudable but require a substantial resource investment to succeed, with limited opportunities for significant payment increases. Congress must simplify these programs and recalibrate the payment incentives to ensure that they provide meaningful financial rewards.

Prior Authorization

Prior authorization is among the top administrative pain points for medical practices. It is common knowledge that health plans are overutilizing prior authorization and making the process more difficult than it needs to be. Upwards of 90% of prior authorizations are approved either by the health plan or upon appeal. The low rate of appropriately denied prior authorization requests shows that prior authorization does not need to be used as widely as it is. 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*, considered in the last Congress, had broad bipartisan support, and would help streamline the prior authorization process. We encourage Congress to pass this legislation with an addition 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. We urge CMS to adopt necessary guidelines to ensure that payers do not circumvent this concept by preventing clinicians who prescribe higher-cost biologics from reaching the threshold needed to achieve the gold card status. CMS should conduct appropriate oversight over gold carding programs.

Health care professionals' time should be spent caring for patients – not bogged down in the administrative busy work.

No Surprises Act

The No Surprises Act, while incredibly beneficial for patients, creates significant administrative burdens on medical practices through its Good Faith Estimate (GFE) and Advanced EOB (AEOB) provisions.

The GFE, as currently enforced, requires a convening provider or facility to furnish an uninsured or self-pay patient with a "good faith estimate" of the cost for the care they reasonably expect to provide to the patient. Many practices already provide this information to patients upon request, but the GFE standardizes the format and timeliness of these notifications.

While this requirement makes our scheduling processes more difficult, our main concern is with the sections of these provisions that are not currently being enforced. Those unenforced provisions require the GFE to also include all care "reasonably expected" to be furnished "in connection" to the primary item or service on the GFE. Examples of connected care include lab tests or images. Under this requirement, the convening provider is responsible for gathering the connected care cost information to include in the patient's GFE. However, it is almost impossible for the convening provider to obtain this information. The convening provider has to figure out what specific co-facility/co-provider the patient will use and contact them to complete this portion of the GFE - in the limited timeframe of only a few business days. There is no existing operational workflow for this communication. Practices will need to engage in manual communications by phone or email – all of which require financial and staff resources.

Congress can easily fix this issue by updating the NSA statute to omit the connected care requirement. 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 described.

❖ **Increase Medicare Reimbursement to Physicians**

Another factor contributing to physician burnout is declining reimbursement rates from both government and commercial payers. These reimbursement challenges - combined with the many administrative burdens - are key contributors to physician burnout and workforce challenges that the Committee hopes to address.

MedPAC acknowledges the full scope of this issue by showing how Medicare reimbursement has significantly lagged behind the Medicare Economic Index (MEI) since 2010. Clinicians can only earn meaningful positive Medicare reimbursement increases through programs like MIPS and APMs. However, it is increasingly difficult to earn a meaningful positive payment adjustment; MIPS and APMs are not viable options for many specialists. Congress must pass legislation that provides regular and meaningful positive updates to the Medicare Physician Fee Schedule (PFS) Conversion Factor (CF) to account for rising inflation and the fact that practices are not reimbursed for the financial costs of administrative burdens described above.

Each year physicians spend the last two months of the year advocating Congress to prevent various Medicare reimbursement reductions from taking effect at the start of the forthcoming calendar year. While we appreciate Congress preventing most of these reductions from taking effect, legislative solutions are temporary and do not always address all of the reductions. Congress must permanently address payment cuts like the 4% PAYGO reduction.

Congress should also stop extending the 2% Medicare sequestration reduction. That policy, which first took effect in 2011, was intended to only last for ten years. However, these reductions have not only been extended every year since then, but they also appear to now be a permanent fixture in Medicare's reimbursement policy. These reductions, combined with other policies such as the expiration of the MIPS exceptional performance bonus, make it increasingly difficult for practices to earn any meaningful positive Medicare reimbursement adjustment. During this time, our operating costs have dramatically increased. Providing greater financial certainty for practices will ease a major burden on the healthcare workforce.

❖ **Training the Next Generation of our Healthcare Workforce**

One of the most direct ways Congress can help address our country's healthcare workforce challenges is to increase the number of physicians in the workforce. While there are many ways to achieve this, increasing the size of the pipeline of new residents is the most important strategy. This means the federal government should increase Graduate Medical Education (GME) funding to create a consistent growth in our medical workforce. New GME funding would only be a fraction of the cost compared to the $900 billion the Medicare program spent in 2021.

While the Committee has discussed making it easier for physicians from other countries to practice in the U.S., we believe that increasing GME slots must be tied to increases in medical school enrollments. We want to continue to attract the best and brightest from the entire world. However, we do not want to do this at the expense of our domestic workforce. New GME slots must prioritize our growing number of medical school graduates instead of international graduates.

We support the Committee's desire to dedicate new workforce resources to underserved populations. Congress should assure that resources are dedicated to chronic conditions like asthma, allergies and immunodeficiencies. Specialists are better positioned to treat severe and uncontrolled versions of these conditions than primary care physicians or non-physician practitioners (NPP). We agree it is important to invest in our primary care workforce, but Congress must also proportionally invest in specialists.

Increasing the number of physicians in the workforce must be balanced with equal investments in nurses and other NPPs. These clinicians are integral parts of our clinical practice. The nurse and NPP shortages – especially since the COVID-19 pandemic – are well documented. Congress must also prioritize strengthening this portion of the healthcare workforce.

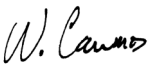
❖ **Conclusion**

Thank you for reviewing our recommendations for how to address workforce challenges. Clinicians are facing a wide array of clinical, administrative and financial burdens that exacerbate burnout and early exits from the clinical workforce. There is much that Congress can and should do to help relieve these pressures. Additionally, there is a clear need to increase the size of the medical workforce to compensate for current shortages.

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

Sincerely,

Kathleen R. May, MD, FACAAI
President
American College of Allergy, Asthma and Immunology



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