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PULSE

Share Your Opinion on Medical Debt Credit Reporting Changes

As the CFPB considers a rulemaking under the FCRA, there are options to share your feedback on the proposals.

The Consumer Financial Protection Bureau is considering a rulemaking on consumer reporting under the Fair Credit Reporting Act, which also focuses on medical debt and data brokers. ACA International is encouraging all members and their health care provider clients to get involved as the process continues.

In October, the CFPB released an outline of the proposals required under the Small Business Regulatory Enforcement Fairness Act (SBREFA) and convened a panel of small-entity representatives, which included ACA members, to provide feedback on the impacts of the potential rulemaking.

The CFPB has concluded meetings with the SBREFA panel, which will now complete a report on panel participants' feedback. The CFPB will consider that feedback as it drafts a proposed rule. Once the proposed rule is issued, the CFPB will open public comment and issue a final rule and an implementation period for regulated entities.

ACA submitted a comprehensive response (PDF) to the bureau's proposed changes, as did small-entity representatives (SERs) Jennifer Whipple, ACA Board Treasurer, and Jack Brown III, chair of ACA's Federal Affairs Committee.

"This proposal makes sweeping changes that will have a significant impact on our entire American economy," Whipple said in her comments (PDF). "It is my personal and professional belief that this proposal was presented prematurely and the CFPB must withdraw it."

Brown shared similar points in his comments (PDF).

"My colleagues and I are concerned that the proposal as it is now articulated will cause more harm to consumers and not help them with the costs of medical care," Brown said. "First, the proposal missed several steps in engaging all stakeholders to address the affordability problem. Further, the proposal may exacerbate America's problem of underinsured families by making it less attractive to have health insurance."

The sweeping, complex and comprehensive outline related to the FCRA could fundamentally alter the

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U.S. credit-based economy as it is today in terms of consequences for not paying your bills. It is critical that the CFPB and lawmakers in Congress hear directly from stakeholders that will be impacted, both immediately and continually throughout the rulemaking process.

Without including medical providers, the SBREFA panel does not cover all impacted small businesses. These proposals are more than a financial regulation—they have massive implications for health care providers, which will lead to reduced access to care for poor and rural communities.

ACA encourages members and their health care provider clients to prepare to contact the CFPB, the U.S. Small Business Administration, health care trade associations, and members of Congress about their work with consumers and the potential impact of these proposals.

There are options to engage with the CFPB until it announces the next step in its rulemaking, or at least consider your messaging and the impacts these proposals could have on your business to prepare for public comments.

ACA created some sample letters on the proposed credit reporting rule that health care providers can send or use as a guide to send to the CFPB, Congress, trade associations and more going forward.

Sample Letter One (PDF)
Sample Letter Two (PDF)
Instructions to Send Your Message on FCRA Proposals (PDF)

These resources can be used for the next stages in the process, for example public comments when the formal rule comes out, letters to Congress and letters to health care trade associations, or comments on an Advanced Notice of Proposed Rulemaking, should the CFPB provide that.

ACA also has letter templates to use to send to congressional representatives to share the impact of medical debt credit reporting changes available on the Advocacy Resource Center under the Medical Debt Credit Reporting Overview drop down menu.

This will not be the only time ACA members and their medical creditor clients will have the opportunity to provide meaningful input, but it is an important opportunity to start demonstrating the complexity of this issue.

In the future, ACA will provide additional resources and talking points to aid in the public comment process and engage with stakeholders once the proposed rule is released.

As noted in the instructions linked earlier, we are asking you to consider copying ACA and any health care trade associations you and your clients belong to, as well as members of Congress, when you send your comments to the CFPB. Copying ACA and your trade associations is important to help build a record that can be shared during our advocacy meetings in Washington, D.C., and to encourage other trade associations to make this a priority.

The CFPB's comprehensive outline of proposals (PDF) is available here to review, and the CFPB has provided a summary of topics discussed as well.

Regulatory Oversight in Health Care Hinders Patient Care

Overwhelming regulatory burdens, particularly in the form of prior authorizations, are diverting critical resources away from patient care, according to recent MGMA findings.

In the complex landscape of health care, the struggle to balance regulatory compliance with providing optimal patient care is an ongoing challenge. According to the Medical Group Management Association's (MGMA) latest "Annual Regulatory Burden Survey," executives from over 350 group practices, including independent practices, are sounding the alarm on the increasing burden of regulations, with an emphasis on the negative impact of prior authorizations.

The survey, which polled a diverse range of health care leaders, brought to light the pervasive sentiment that regulatory requirements are impinging on the ability of health care providers to focus on what matters most: the well-being of their patients. According to the study, 90% of respondents stated that the overall regulatory burden on their medical practice has escalated over the past year.

At the forefront of these regulatory challenges is the notorious prior authorization process, cited by 89% of respondents as very or extremely burdensome. This process, aimed at ensuring the necessity of certain medical procedures or treatments, has become a significant roadblock for practices, diverting attention and resources away

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NEWS & NOTES

AHA Endorses Assistance for Rural Community Hospitals Act

The American Hospital Association (AHA) has voiced its support for the Assistance for Rural Community Hospitals Act (ARCH Act), a legislative initiative aimed at extending the Medicare-dependent hospital program and enhanced low-volume Medicare adjustment for an additional five years.

In a letter dated Nov. 27 to Representatives Carol Miller (R-W.Va.) and Terri Sewell (D-Ala.), AHA's Senior Vice President of Advocacy and Political Affairs Lisa Kidder Hrobsky emphasized the critical role played by rural hospitals in providing economic stability and access to care within their communities.

The letter commends the proposed legislation for its potential to sustain rural hospitals, enabling them to navigate financial challenges and adapt to significant shifts in care delivery. The ARCH Act, introduced on Nov. 16 by Miller and Sewell, not only aims to bolster the financial resilience of rural hospitals but also calls for a Government Accountability Office report to assess the impact of Medicare rural hospital designations on strengthening rural healthcare.

Read more here.

Unauthorized Access at LA Hospital Exposes Patient Data

Mission Community Hospital in Los Angeles recently confirmed a security breach in its IT network, where an unauthorized party gained access to patient information. The breach was discovered on May 1, prompting an immediate investigation with the assistance of a third-party cybersecurity firm.

The investigation revealed that the unauthorized party successfully infiltrated the network and accessed files containing sensitive information, including names, addresses, dates of birth, Social Security numbers, driver's license numbers, financial account details, medical record numbers, health insurance information, and diagnosis details.

Mission Community Hospital is in the process of notifying affected patients and is finalizing its examination of the compromised data. Individuals whose Social Security or driver's license numbers were compromised will be offered complimentary credit monitoring and identity theft protection services.

Read more here.

Regulatory Oversight in Health Care cont. from page 3

from patient care. The consequences are clear, with 97% of respondents noting that their patients have experienced delays or denials for medically necessary care due to these authorization requirements.

The impact of prior authorizations extends beyond delays and denials. The survey found that 92% of practices have had to hire or redistribute staff to manage the surge in authorization requests. This allocation of resources is a direct result of the challenges associated with inconsistent payer payment policies, routine approval requests, and decision delays—all contributing to the strain on health care providers.

Additionally, audits and appeals, Medicare's Quality Payment Program, surprise billing and good faith estimate requirements, Medicare Advantage chart audits, and the lack of Electronic Health Record (EHR) interoperability all contribute to the growing regulatory landscape.

Despite these challenges, the survey illuminated a unanimous desire for change among health care leaders. Ninety-seven percent of respondents agreed that a reduction in regulatory burdens would enable their practices to redirect resources toward patient care.

Notably, the survey highlighted skepticism regarding the effectiveness of Medicare's Quality Payment Program, specifically the Merit-Based Incentive Program (MIPS) and Advanced Alternative Payment Models (APMs). According to their findings, 72% of respondents expressed dissatisfaction, asserting that the move toward value-based payment initiatives in Medicare and Medicaid has not improved the quality of care for patients. Additionally, 94% stated that this shift has not lessened the regulatory burden on their practices.

MIPS, a track within the Quality Payment Program, was particularly criticized for being viewed as a "complex compliance program that focuses on reporting requirements rather than an initiative that furthers high-quality patient care," as reported by MGMA.

Download MGMA's report here.

DATAWATCH

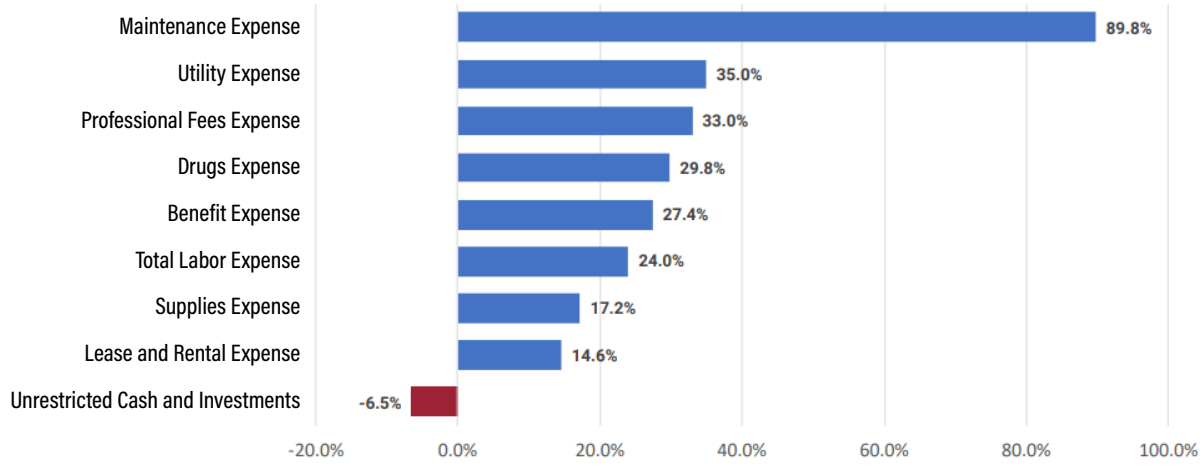
Surge in Insurance Claim Denials Hits Hospitals' Finances

A recent analysis by Syntellis Performance Solutions and the American Hospital Association reveals hospitals and health systems are grappling with a substantial surge in claim denials from the past year.

From January 2022 to July 2023, Medicare Advantage denials skyrocketed by nearly 56%, while commercial denials increased by around 20%, contributing to a 63% and 20% growth, respectively, in denials as a percentage of net patient service revenue for the median hospital. This reduction in reimbursement exacerbates financial challenges at a time when health systems are already witnessing a decline in cash reserves, dropping by 28% since January 2022.

Operating expenses have also surged across various categories, including a 90% increase in maintenance costs and a 35% rise in utility costs, putting further strain on hospitals already grappling with workforce challenges.

Operating Expenses Increasing



Source: *Hospital Vitals: Financial and Operational Trends, Q1-Q2 2023.* https://tinyurl.com/528mh4vp

PULSE

is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

Communications Department
ACA International
3200 Courthouse Lane
Eagan, MN 55121
comm@acainternational.org

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