STATEMENT

on behalf of

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on the topic of

Reducing Paperwork, Cutting Costs: Alleviating Administrative Burdens in Health Care

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Chairman Whitehouse, Ranking Member Grassley, and members of the committee, I am Anthony DiGiorgio, assistant professor of neurological surgery and affiliated faculty at the Institute for Health Policy Studies at the University of California, San Francisco. I am honored to testify before the committee today on administrative burdens in health care, a topic on which I am very passionate. I applaud the committee for addressing this important issue. Today, I am here in my personal capacity and the views expressed are my own and do not necessarily reflect those of UCSF, it's department of neurological surgery or Institute for Health Policy Studies, or the Mercatus Center.

In my testimony today, I will focus on:

1. The increasing administrative burdens on clinicians
2. The role of CMS billing regulations and electronic health record mandates
3. How more competition in healthcare can mitigate these problems

Administrative Burdens

As a frontline physician in a safety-net hospital, I feel the crushing weight of administrative burdens. I also see that these burdens are largely driven by federal regulation. In the past two decades, there have been no gains in efficiency for US healthcare, demonstrated by a lack of labor productivity growth according to the US Bureau of Labor and Statistics.[1] The growth in the healthcare sector has been entirely due to an enlarging workforce, not to increased efficiency of that workfoce.[1,2] More importantly, that growth in jobs has been almost exclusively administrative, where employment growth has outpaced physicians by over 20 to 1.[3] These administrators haven't improved healthcare delivery, rather they are employed to navigate increasingly complex government regulations which create unnecessary complexity in care delivery. The bureaucratic burdens from these poorly designed systems and

ineffective regulatory policies are inevitably placed on frontline clinicians like me, eroding the time I and my colleagues can devote to clinical care and ultimately leading to exit from the practice of medicine. Time motion studies have shown that physicians now spend less than a third of their day in direct patient contact,[4,5] and the average physician spends 15.5 hours per week solely on administrative tasks.[6]

These administrative burdens drive physician burnout, an existential threat to the healthcare workforce.[7] While every industry faces burnout, nearly two-thirds of doctors show symptoms,[8] a substantially higher rate than their peers in non-healthcare industries.[7] As these burned-out physicians leave practice, replacing them costs the healthcare system billions of dollars per year[9] while those who continue to practice while burned out have worse quality of care, further adding to costs.[10] Even medical students see that the regulatory burdens devalue patient care, as a recent survey shows that 61% of US medical students favor non-clinical careers.[11]

These administrative burdens overwhelmingly come from government regulations. Medicare's rules regulating quality metrics and billing create this outsized documentation burden. This, coupled with inefficient electronic medical records, explain why healthcare labor productivity has been stagnant since the dawn of the information age. While there are also burdens associated with the commercial market, such as prior authorization, my focus today is on those which come from federal regulations and the Centers for Medicare and Medicaid Services (CMS)

Improving healthcare delivery would save billions over the next decade.[2] Optimizing service delivery requires a dynamic system that is responsive to market forces, driven by patient preferences and a locus of control centered on the patient-physician interaction. This can be achieved by deregulation and cultivating a competitive market that fosters innovation in healthcare financing and delivery.

Administrative Pricing & Billing Regulations

For 80 years, centralized planning has failed in healthcare, dating back to the Hill-Burton act. Be it administrative pricing or quality metrics, top-down control has largely contributed to the inefficiencies we see in frontline clinical practice.

A transition to value-based care has the potential to control costs. However, the current strategy of attaching quality metrics to fee-for-service payments has added to the administrative burden and worsened physician burnout. CMS has 2,266 quality metrics in its inventory, [12] at the cost of over $1 billion on quality metric development alone. [13] Independent physician practices commonly face substantial costs in metric reporting, estimated at around $15.4 billion annually, with actual costs likely exceeding this figure.[14] On average, outpatient physicians dedicate 2.6 hours weekly on metric reporting while non-physician staff contribute an additional 12.5 hours each week.[14] The impact is also pronounced for hospitals. For instance, an average community hospital with 161 beds needs 4.6 full-time employees just to meet the demands of quality metric reporting.[15] Larger hospitals face even greater demands. The Johns Hopkins Hospital allocates 108,000 person-hours a year to manage 162 distinct metrics.[16] These intensive requirements often drive smaller community practices towards consolidation due to the lack of sufficient infrastructure to manage the load.

Quality metrics don't just increase costs, they harm patients. A 2019 report by the Government Accountability Office raised concerns about whether the existing quality metric scheme aligns with strategic goals.[17] Others note that few of the approved metrics have been validated clinically.[18] MIPS

(Merit-Based Incentive Payment System) was introduced to transition fee-for-serve to a risk corridor. This is a great concept with terrible execution. Physicians' scores and outcomes do not consistently correlate.[19] The incentives have punished physicians who treat poor patients, driving them to treat fewer.[20] It has far too many quality metrics and budget neutrality neutered the bonus and penalty system, making it financially meaningless. The Hospital Readmission Reduction Program is associated with decreased readmissions, as expected, but also with increased 30-day post-discharge mortality after hospitalization for heart failure.[21] A clear example of Goodhart's law: when a measure becomes a target, it ceases to be a good measure. Additionally, although patient satisfaction metrics are generally recognized as important, higher scores in this area have been associated with increased costs and worse mortality rates.[22] Quality metrics also disproportionately penalize safety net hospitals[23] and hospitals which care for minority patients.[24,25]

Institutions follow incentives. Having a sicker baseline population increases hospital revenues by capturing more complexity for increased DRG payment and by improving quality metrics. The burden of documenting this baseline risk falls on frontline clinicians, who are hounded by administrators to make patients seem as sick as possible according to the specific documentation criteria set by CMS. There's a greater return on investment in simply gaming the numbers than in improving quality. One study shows a greater than 40% increase in revenue margin by simply having billing staff round with the physicians.[26]

Meanwhile, clinicians are beholden to documentation requirements that satisfy Medicare billing regulations. There are over 11,000 billing codes,[27] and the 2023 Medicare fee for service hospital payment rule was 1525 pages long.[28] CMS is currently responsible for regulatory minutia on these codes, including rate setting and billing requirements. These arbitrary documentation requirements add to the administrative burden. Collectively, US physicians spend 125 million hours on documentation outside of normal office hours, much of that for billing purposes alone.[29] One study showed that trauma surgeons spend 73 full 24-hour days to complete the documentation required to satisfy Medicare's billing requirements for a year of work.[30] This is where all that administrative hiring comes in. After all this documentation, administrative staff are needed to manage those data into the highest bill possible.

Along with regulatory burdens that come with administrative pricing, the overly regulated electronic medical records, or EMRs, make matters worse. [31] While EMRs have some modest improvements in some areas over paper charts, they are horrendously inefficient. Coupled with increasing tasks handed down by administrators, these inefficient systems have physicians tethered to their computers instead of interacting with patients. This is largely due to regulatory policy, as US physicians spend significantly more time on the EMR than physicians in other countries.[32] There are many other studies demonstrating the burden of EMRs on frontline clinicians. For example, physicians spend 2 hours on the computer for every hour of patient time.[5] Surgery residents spend nearly 8 contiguous months on the EMRs during 5 years of training,[33] while internal medicine residents spend 40% of their time on a computer.[34] The burden goes outside office hours, where significantly more physicians who use EMR end up documenting outside of office hours than physicians who do not.[29] We did a study of our own at UCSF and found that neurosurgery residents spend 20 hours of their overnight call shift logged in to the computer.[35] These systems are so inefficient that hospital IT departments are often needed to assist physicians in ordering life-saving medications. [36] A recent paper from JAMA describes "the day the EMR went down" with the author stating "our patient care on that day was the most patient-centered and most collaborative than ever in my 2½ years of residency."[37] What does it say about a technology that its failure improves service delivery?

The advent of the EMR may allow a clinician to access medical records remotely, but that has transformed into an environment where it is expected that physicians be constantly attached to a computer. Much of this is due to CMS's mandate of "meaningful use core measures."[38] These regulations mandated computerized physician order entry (CPOE), which relegates the physician to an order entry clerk, completing cumbersome tasks in the EMR which could be completed by a medical assistant or clerk. Additionally, the "meaningful use" rules require a reconciliation of all orders after transferring level of care, another needless burden.[38] More rules, such as the "appropriate use criteria" add additional busywork just to order routine imaging studies. Our study found that residents spent around 21% of their EMR time simply on order entry.[35] Chat messages integrated into the EMR have added to the distraction burden, where physicians are often contacted via pager or EMR chat hundreds of times each shift. The constant interruptions and superfluous warning messages generated by the EMR also lead to distracted clinicians, alarm fatigue and more "near miss" events. [36,39]

Again, I feel this strain personally. Doctors are asked to put orders into the EMR day and night, taking us away from our families to perform order entry. Our relationships with nurses have also suffered, as they must hound physicians for trivial orders that they, as licensed healthcare professionals, are more than qualified to enter. The nurses suffer the EMR burden beyond that, also being glued to the computer to document seemingly endless minutia. That is why the author of the "Day the EMR System Went Down" article felt a renewed collaboration with nursing staff when the inefficient computers were removed from their relationship.

Increasing Competition to Drive Improvements in Administrative Burdens

Knowledge is widely distributed in healthcare, making it inappropriate for central planning.[40] Competition, resulting in a highly dynamic marketplace, will reward efficiency and quality better than centrally planned administrative pricing or quality metrics. In a highly competitive market, one needn't regulate efficiency; it occurs naturally.

Increased penetration of Medicare Advantage and Medicaid Managed Care Organizations will transition CMS from a plan operator to a plan regulator.[28] Instead of focusing vast resources on fee-for-service payment schedules, CMS can focus on the right risk-adjustment and payment approach, letting the plans figure out how to deliver the best care at the lowest cost. This will allow it to target quality regulation and administrative burdens in those markets and move population health. Regulations should foster a competitive insurance market, such as eliminating the cap on administrative costs introduced by the ACA. This competitive market, including managed care plans, will give greater freedom to patients to select the coverage that suit their needs. These reforms would give patients more control over selecting their healthcare providers. This patient-driven competition will promote market responses of increased efficiency and quality.

While prior CMS initiatives such as the "physicians over paperwork" rules[41] or the pause in the "appropriate use criteria" have shown promise in reducing the documentation burden for physicians,[42] it highlights the fact that these burdens are subject to the whims of executive branch bureaucrats. In a CMS which no longer regulates fee-for-service payment schedules, physician specialty societies would ideally work with payers to determine optimal billing practices. The commercial market has its own set of administrative burdens, but by eliminating CMS's role in payment schedule management, it would force plans to optimize on their own.

Hospital consolidation must be addressed as well. Over 90% of metropolitan statistical areas are consolidated hospital markets.[43] These consolidated markets lead to increase costs and lower quality,[44] along with giving large corporations monopsony purchasing power for physician labor. Competition can be improved by leveling the playing field for new entrants, such as addressing site neutral payments, the ban on physician owned hospitals and the 340B drug pricing program. Additionally, congress should empower the FTC and DOJ to challenge consolidation in the industry. The resulting dynamic marketplace, with increased competition in both the hospital and insurance space, will drive innovation in processes, promoting the emergence of more efficient EMR[45], billing infrastructure and prior authorization procedures. Regulators should prioritize EMR interoperability[45] and end-user experience over meaningful use and billing requirements,[46] allowing a highly competitive marketplace to drive hospitals to purchase clinician friendly systems. By centering the patient-physician relationship as the locus of control for resource allocation, the market will reward efficient, high-quality care.

Along with these market-based reforms, CMS should go on a quality diet, capping the total number of metrics and creating a living system of metrics which retires or modifies metrics as health goals are fulfilled or if they are found to be ineffective or harmful. Additionally, metrics should attend to the clinician experience, fostering improvement in high-friction processes. These could be aimed at large hospital systems rather than individual clinicians, with simple metrics which cannot be gamed, utilizing the latest technologies to automate data collection. Third parties should be encouraged to create quality metrics, again letting metrics which promote quality and efficiency emerge from a dynamic system.[47]

Lastly, we must acknowledge the need for utilization controls in curbing fraud, waste, and abuse. Physician specialty groups are well positioned to play a pivotal role in this reform effort by developing guidelines and actively engaging with payers to streamline prior authorization, a process in need of improvement.[48] CMS has already taken steps to improve prior authorization, and there is still some room for improvement. However, both physicians and payers share a vested interest in minimizing wasteful practices and ensuring the judicious use of resources. By fostering collaboration and encouraging bottom-up reform initiatives, these stakeholders can work synergistically to curb inefficiencies and safeguard against fraudulent activities. Competition has a disciplining effect, and this would curb misconduct from both payers and clinicians. This approach not only promotes greater accountability and transparency but also aligns with the overarching goal of optimizing healthcare delivery for the benefit of patients and physicians alike.

This testimony underscores the role of federal regulations in administrative burdens. These reform proposals emphasize the need for a dynamic healthcare system driven by patient preferences and market forces. By promoting competition, we can create a healthcare environment that naturally rewards efficiency and quality. Ultimately, it is time to give the market a chance to drive meaningful change in healthcare delivery, allowing frontline physicians to focus on what matters most: providing quality care to patients without the suffocating weight of unnecessary administrative burdens.

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