



July 31, 2018

The Honorable Lamar Alexander
Chair, Committee on
Health, Education, Labor, and Pensions
U.S. Senate
Washington, DC 20510

The Honorable Patty Murray
Ranking Member, Committee on
Health, Education, Labor, and Pensions
U.S. Senate
Washington, DC 20515

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the American Academy of Family Physicians (AAFP) and the 131,400 family physicians and medical student members we represent, I write to share our support for efforts to identify and address administrative costs associated with health care delivery. The regulatory framework with which primary care physicians must comply is daunting and often demoralizing. Standardization is not required among public or private payers, and many physicians participate with 10 or more payers. Physicians are forced to learn and navigate the rules and forms of each payer. Thus, physicians spend countless hours reviewing documents and checking boxes to meet the requirements of health insurance plans. This is time that physicians could better spend caring for patients.

As then-AAFP President, Dr. Robert Wergin, FFAFP, testified during the Senate HELP Committee's 2015 electronic health record hearing, administrative burdens are interfering with the practice of medicine and the doctor-patient relationship. The regulatory framework for physician practices has driven operating costs up and caused reduced face time with patients. The administrative and regulatory burden is one of the top reasons independent practices close and is a leading cause of physician burnout. Since that time, the AAFP shared feedback on the health information technology provisions enacted within the *21st Century Cures Act* and guidance on the law's implementation process. We continue to engage the Centers for Medicare and Medicaid Services in efforts to implement these laws. The AAFP has also led the way in quality measure harmonization through our work with CMS on the Core Quality Measures Collaborative and ongoing work with family physicians. We recognize the administration's efforts to address this issue through proposals for 2019 and look forward to providing substantive feedback on those proposals and the new physician fee schedule's documentation guidelines.

Despite the good intent of underlying health care policies, administrative burden has expanded to an untenable level and is a significant barrier to achieving the Quadruple Aim. The American Academy of Family Physicians has developed the following prioritized list of principles on administrative simplification. Adherence to these principles will ensure that patients have timely access to treatment while reducing administrative burden on physicians.

1. Prior Authorization

Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior

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authorizations (PAs) from prescription drug plans and durable medical equipment suppliers, and others impede this goal.

Principles:

- Activities requiring prior authorization (PA) must be justified in terms of financial recovery, cost of administration, workflow burden, and lack of another feasible method of utilization control.
- Rules and criteria for PA determination must be transparent and available to the prescribing physician, at the point of care. If a service or medication is denied, the reviewing entity should provide the physician with the criteria for denial. For medications, it should provide alternative choices to eliminate a guessing game.
- PA for imaging services should be eliminated for physicians with aligned financial incentives (e.g. shared savings, etc.) and proven successful stewardship.
- There should be a goal of eliminating PA for durable medical equipment (DME), supplies, and generic drugs.

Transitional steps include:

- Limiting and reducing the number of products and services requiring PA.
- Adopting a standardized form and process for PA among all payers.
- Requiring payers and pharmacy benefit managers (PBMs) that design PA specifically to save the payer or PBM money rather than benefit the patient to pay physicians for their time, as decided by the 2008 *Merck-Medco v. Gibson* court case.
- Requiring payers to pay physicians for PAs that exceed a specified number of prescriptions or are not resolved within a set time period.
- Prohibiting payers from requiring repeated PAs for effective medication management for patients with chronic disease and PA for standard and inexpensive drugs.

2. Quality Measures and the Need for Measure Harmonization

Quality measures have proliferated in the past 15 years, leading to a significant compliance burden for physicians. Most of the measures are disease-specific process measures, rather than more meaningful evidence-based outcomes measures. With many family physicians submitting claims to more than 10 payers, the adoption of a single set of quality measures across all public and private payers is critical.

Principles:

- Quality measures should be focused on improving processes and outcomes of care in terms that matter to patients.
- Quality measures should be based on best evidence and reflect variations in care consistent with appropriate professional judgment.
- Quality measures should be practical given variations of systems and resources available across practice settings.
- Quality measures should not separately evaluate cost of care from quality and appropriateness.
- Payers should take into account the burden of data collection, particularly in the aggregation of multiple measures.
- Payers should provide transparency for methodology used to rate or rank physicians.

- All payers (Medicare, Medicaid, Veterans Administration, commercial insurers, ERISA plans, and any third-party administrator plan) should implement the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure parsimony, alignment, harmonization, and the avoidance of competing quality measures.
- Quality measure feedback reports should be simplified and standardized across all payers to make them more actionable.
- Quality measures should be updated regularly or when new evidence is developed.
- As new quality measures are adopted, sponsoring entities should sunset other quality measures.
- Physicians should not be accountable for quality measures that they do not have neither control over nor authority to improve.

3. Certification and Documentation

Physicians want to efficiently order what their patients need to manage their disease conditions in a way that maintains their health. The current procedures surrounding coverage of medical supplies and services impede this goal and add no discernible value to the care of patients.

Principles:

- The physician's order should be sufficient. Physicians should not have to sign multiple forms from various outside entities for patients to receive needed physical therapy, home health, hospice, or Durable Medical Equipment (DME), including diabetic supplies.
- Physicians should not be required to recertify DME supplies annually for patients with chronic conditions.
- Authorization for supplies should be generic so that physicians are not required to fill out a new form every time a patient switches brands, including but not limited to diabetic supplies.
- Authorization forms should be universal across payers. Data within the forms should be standardized to allow for automated EHR extraction and population of forms.
- Physicians should not be required to attest to the patient's status when the service is provided by another licensed health professional as is the case with diabetic footwear.

4. Medical Record Documentation

Documentation burdens have increased dramatically, despite adoption of Electronic Health Records (EHRs). Documentation requirements for public and private payer programs and initiatives have escalated. Further, the Centers for Medicare and Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management (E/M) Services, established 20 years ago, do little to support patient care, and serve more as a framework to help physicians justify their level of billing (e.g. level 3, 4, or 5) than to help physicians diagnose, manage, and treat patients. Adherence to the guidelines consumes a significant amount of physician time and does not reflect the workflow of primary care physicians. The guidelines were drafted for use with paper-based medical records, and do not reflect the current use and further potential use of electronic health records and team-based care. The guidelines negatively impact the usability of EHR software programs.

Principles:

- Changes must be made to the outdated E/M documentation guidelines and the Medicare Program Integrity Manual. The changes should include the acceptability of medical information entered by any care team member related to a patient's visit. This standard should be applied by all Medicare contractors, Medicaid, marketplace policies, and private payers.
- The primary purpose of medical record documentation should be to record essential elements of the patient encounter and communicate that information to other providers. The use of templated data and box-checking should be viewed as administrative work that does not contribute to the care and wellbeing of the patient.
- EHR vendors, physicians, and workflow engineers must collaborate to redesign and optimize EHR systems.

Again, we appreciate the opportunity to offer our thoughts on this important issue and help set a specific, measurable, achievable, relevant, and time-bound goal to reduce administrative burden and focus on patients over paperwork. The AAFP stands ready to assist you in addressing this important issue. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Meigs, Jr.', with a stylized flourish at the end and the initials 'MD' written below it.

John Meigs, Jr., MD, FAAFP
Board Chair