Regulatory burdens impede lower-cost, higher-quality care

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The 2018 Medicare Physician Fee Schedule proposed rule contained items on expanding telehealth services, reducing documentation requirements and other elements physicians support, but several more steps are recommended to achieve regulatory relief that could result in noticeable benefits for patients.

The proposed rule also expressed a desire by the Centers for Medicare and Medicaid Services (CMS) to start a “national conversation” about improving the health care system by reducing unnecessary burdens and ensuring “that patients and their providers and physicians are making the best health care choices possible.”

To that end, the AMA provided a detailed list of issues for CMS to consider in its quest to simplify the health care system. The AMA has been working on reducing physician burden with the states and specialties. The list was developed by the AMA Federation of Medicine regulatory relief workgroup.

“The regulatory burden placed on physicians is a major component of physician burnout,” wrote AMA CEO and Executive Vice President James L. Madara, MD, in a recent comment letter on the proposed 2018 fee schedule. “Physicians can spend too much of their time on administrative tasks rather than providing care to patients.”

Do away with “redundant requirements”

The AMA’s comment letter includes suggestions for reducing prior authorization,, backing for delaying implementation of the appropriate-use criteria (AUC) requirements for advanced diagnostic images, and support for lowering documentation submissions for physicians participating in Medicare Shared Savings Program accountable care organizations.

While seeking lower regulatory burdens connected to administrative requirements, the AMA also acknowledged the need to improve Medicare program integrity, fight fraud and identify waste—but added that there are better ways to do this than what is in place.

“Broad-brush requirements that impose burdens on physicians, rather than focusing on those providers who have demonstrated a propensity to commit fraud or abuse, inequitably affect physicians and providers who are good actors and result in unnecessary costs to the health care system,” Dr. Madara wrote.

The AMA suggests creating a stakeholder workgroup to address certification concerns. The AMA continues to have a dialogue with CMS about reducing regulatory burden. As a result of those discussions, the Association is collecting examples from states and specialty societies about forms and requirements that are contributing to unnecessary paperwork. The AMA also recommends that CMS work with public and private stakeholders to discuss how to “develop a framework that properly balances eliminating fraud and abuse while not negatively impacting honest providers with burdensome and unnecessary requirements.”

“Eliminating and streamlining reporting, monitoring and documentation requirements will improve the health care delivery system by reducing unnecessary burdens for physicians and making the health care system more effective, simple and accessible,” Dr. Madara wrote. He added that Medicare certification requirements “are a major imposition that delay care with redundant requirements for verifying physician orders and voluminous medical records, where the salient patient information is buried in reams of purposeless, formulaic language.”

According to a recent AMA survey, a medical practice completes an average of 37 prior-authorization requirements weekly, per physician, taking a physician and the doctor’s staff an average of 16 hours—or about two working days—to process. In response, the AMA and more than 100 other organizations representing physicians, hospitals, pharmacists, medical groups and patients have endorsed 21 principles aimed at fixing prior authorization and utilization-management practices. In the comment letter, the AMA urged CMS to adopt these principles.

The comment letter also contains several suggestions regarding implementation of a mandate included in the Protecting Access to Medicare Act of 2014, which requires physicians to consult appropriate-use criteria before ordering advanced imaging services.

“CMS should focus its outlier identification on areas where there is an underutilization of services that are always appropriate and overutilization of services that are almost always never appropriate,” the letter states. “It will also be important to select only those conditions where there is significant variation in utilization among physicians and where there are generally agreed upon treatment guidelines.”

Addressing EHR problems

The AMA continues to urge the administration to tackle physicians' frustrations with electronic health records (EHRs) through several different mechanisms, including: increasing transparency on the costs of using EHRs; prohibiting vendor data blocking; increasing meaningful interoperability for physicians and patients; and allowing for flexibility in the design of EHRs.

The letter also notes how E&M guidelines create an unnecessary administrative burden and a "major obstacle" to the usefulness of EHRs by requiring documentation to justify a physician's code selection instead of "prioritizing documentation relevant to the patient's current and future treatment."

"Consequently, EHR vendors use very prescriptive methods to capture 'structured' information to align physician services with coding levels, adding unnecessary and extraneous work that blurs the focus of clinical care and detracts from the physician-patient narrative," the letter states. CMS, the AMA said, should evaluate the balance of compliance needs with the burden of reporting.

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