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Reducing Unnecessary Administrative Tasks on Physicians and Patients

Congress should take action to help reduce excessive administrative tasks that negatively impact physicians and their patients, including: streamlining the "prior authorization" process, starting with Medicare's Part D program, better integrating clinical data into clinicians' electronic health records (EHRs), overseeing CMS' effort to overhaul clinical documentation guidelines, and ensuring that patients needing follow-up care in skilled nursing facilities aren't saddled with financial burdens and endless red tape as a result of the three-midnight rule, as described below in the "What is ACP Asking of Congress" section.

What's it all about?

The complexity of the U.S. healthcare system has resulted in an excessive amount of unnecessary administrative tasks imposed on both physicians and patients. These administrative tasks divert physicians' time and focus away from providing high-value care. In fact, the literature has consistently found that clinicians and their staff spend 3-5 hours per week on billing and insurance-related activities and up to 15 hours per week on quality measurement and reporting activities. Moreover, administrative burdens are costly, can prevent patients from receiving timely and appropriate treatment, and significantly contribute to the burnout epidemic among physicians. Under ACP's Patients Before Paperwork initiative, the College developed a cohesive framework for analyzing administrative tasks to better understand the source, intent, and impact of any given administrative task – providing the foundation for detailed policy recommendations for revising, streamlining, or removing entirely burdensome administrative tasks. The framework and recommendations call attention to the untapped potential of electronic health records (EHRs) to improve care as well as provide a better understanding of the daily issues physicians face including prior authorization obstacles and irrelevant clinical documentation guidelines – all of which take away from high-value patient care and can even result in administrative hassles and coverage issues for patients.

What progress has been made in addressing administrative burdens?

Over the past year, both the Administration and Congress have shown a strong commitment to reducing administrative burden and have been actively collecting information from key stakeholders, including front-line physicians, on the unnecessary administrative burdens they face on a regular basis. CMS launched their Patients over Paperwork and Meaningful Measures initiatives – both focused on reducing unnecessary administrative tasks and largely reflective of ACP's own policy. CMS and ONC have held numerous listening sessions to discuss and better understand clinician burden, updated documentation guidelines to allow teaching physicians to use their students' clinical note instead of having to re-document the entire encounter, and issued Requests for Information throughout all of their payment regulations to gather stakeholder feedback on how to further simplify clinical documentation guidelines and reduce administrative burden. In Congress, the House Ways & Means Subcommittee on Health is in the 2nd phase of its Medicare Red Tape Relief Project in which they are gathering information on specific Medicare regulations that interfere with providing high-value care to Medicare beneficiaries and we anticipate a report on their findings to provide support for some type of future legislation.

What more can Congress do to address this issue?

Improve EHR Operability: Electronic Health Records (EHRs) are meant to house critical data about a patient's health and should facilitate the ability of clinicians to access the data they need to make the best medical decisions for their patients. While much discussion has focused on the need for EHRs to be able to effectively communicate with one another (i.e. interoperability), equal attention should be paid to EHRs operating effectively in their own right (i.e. operability). Congress should focus on improving operability in the following areas, all of which currently add unneeded administrative burden on physicians:

Prior Authorization: On a daily basis, clinicians are often required to seek approval from a patient's health insurer in order to prescribe a certain medication, known as "prior authorization." This process involves varying forms, data elements, and submission mechanisms and forces the clinician to enter unnecessary data in the EHR or perform duplicative tasks outside of the clinical workflow. This often inhibits clinical decision-making at the point of care and creates unnecessary burden. Bipartisan legislation has been introduced in Congress to streamline this burdensome process within Medicare's Part D program through the *Standardizing Electronic Prior Authorization for Safe Prescribing Act* (H.R. 4841). ACP supports this legislation and believes it is a good first step toward reducing process-related burden.

Integration of Clinical Data: Clinicians need access to appropriate, timely, and accurate patient information in order to make the best clinical decisions at the point of care. Unfortunately, the ability to access key information, such as the patient's prescribing history with the state, and integrating that data into a clinician's EHR is woefully lacking. Legislation has been introduced, the CONNECTIONS Act, which would improve such data collection and integrate into physicians' clinical workflow that information housed in prescription drug monitoring programs (PDMPs).

Clinical Documentation Guidelines: The ability of EHRs to collect, display, and share usable information among clinicians and with patients and families is directly impacted by coding and other regulatory requirements. Template driven documentation originated as a consequence of the 1995 and 1997 Evaluation and Management (E/M) Documentation Guidelines—which redefined the cognitive office visit by what was *documented*, rather than what service is actually provided. EHRs then digitized these templates and created software to make sure that what was required for a particular E/M CPT code (e.g. how physicians report their services) was addressed within the patient record, losing the patient's story along the way. The purpose of clinical documentation should return to supporting excellence in patient care, and to preserving the patient narrative.

Reduce Patient Hassles: Current law requires that a patient spend at least THREE consecutive days in a hospital as an inpatient in order to qualify for Medicare coverage of a subsequent stay in a skilled nursing facility (SNF). This is known as the three midnight rule. However, unbeknownst to patients, they are often put under "observational" status in the hospital for several days and these observation days are not counted toward the 3-day stay requirement because they are considered outpatient days. This can and often does result in a huge bill for the patient, if he/she needs skilled nursing care after a hospital stay. What follows is often an arduous appeals process that creates red tape for both the patient and his/her physician who often must intervene. To clinicians, care provided to patients in observation status is indistinguishable from the care provided to inpatients. Legislation has been introduced that would ensure observational status counts toward the 3-day requirement, as contained in *the Improving Access to Medicare Coverage Act*.

What is ACP asking of Congress?
Congress should accelerate its efforts to reduce administrative burdens on clinicians and patients, including:

House members should cosponsor the Standardizing Electronic Prior Authorization for Safe Prescribing Act (H.R. 4841), introduced by Rep. David Schweikert (R-AZ), which standardizes electronic prior authorization for prescription drugs under Medicare Part D. ACP urges lawmakers to adopt even greater harmonization of standards and automation of prior authorization across the health care industry. Senators should introduce companion legislation.

House members should cosponsor the CONNECTIONS Act (H.R. 5812), by Reps. Griffith (R-VA) and Pallone (D-NJ) that would authorize CDC grants to state-run PDMPs to improve data collection and integration into physician clinical workflow specifically of controlled substances overdose prevention and surveillance activities. This draft is a good first step toward greater integration of clinical data into clinicians' EHRs, for use at the point of care. Senators should introduce companion legislation.

Lawmakers should urge congressional health care committees with jurisdiction over Medicare to exercise their oversight authority of CMS' effort to overhaul clinical documentation guidelines with input from practicing clinicians. The guidelines should ensure that the narrative of the patient's history, which is invaluable from the clinical perspective, can be easily documented, preserved, and accessible within the record.

Senators and House members should cosponsor the Improving Access to Medicare Coverage Act of 2017 (S. 568/H.R. 1421), which deems patients under observation as inpatients for the purposes of satisfying the Medicare 3-day inpatient stay requirement. This legislation would help ensure that patients are not saddled with unexpected medical bills while in observation status, and reduce hassles for patients and clinicians alike.

Who can I contact to learn more?
advocacy@acponline.org; Digital version of this issue brief can be found at: https://www.acpservices.org/leadership-day/policy-priority-issues