ACP Responds to CMS Request for Information on Putting Patients Over Paperwork

Recommendations include ways to reduce burden of prior authorization requests and refining quality measures

Sept. 20, 2019 (ACP) – Solidifying a long-standing initiative to reduce administrative burdens for physicians, the American College of Physicians has submitted recommendations to the U.S. Centers for Medicare and Medicaid Services (CMS) in response to a request for feedback from the agency.

"ACP has been proactive in addressing these issues, and our efforts started before the CMS requested information from stakeholders," said Dr. Ryan D. Mire, chair of ACP's Medical Practice and Quality Committee. ACP launched its "Patients Before Paperwork" initiative in 2015, and since then, the College has been gathering testimonials from physicians regarding their experiences with administrative obstacles to care.

In a letter to CMS Administrator Seema Verma, signed by Mire, ACP lauded CMS for focusing on reducing administrative burdens and for the "Patients Over Paperwork" and "Meaningful Measures" initiatives that CMS launched in 2017. In its letter to CMS, the College offered ideas for areas of improvement including the burdensome prior authorization and beneficiary enrollment process.

As it stands, physicians spend more than 20 hours a week on administrative tasks, which can negatively affect patient care and the health care system. These tasks are also a main driver of physician burnout. ACP's recommendations aim to restore the patient-physician relationship, improve practice efficiency, and reduce burnout.

When it comes to reducing administrative tasks, "prior authorization is a hot topic" and one of the top complaints of physicians, Mire said. To reduce the burden of prior authorization requests, ACP is calling for a tighter timeframe for insurers to make decisions on therapy. "It can take two to three days for an initial response to a prior authorization request, and this leaves patients without medication during that time," he said. "If a request is denied, we must start the appeal process, which can add weeks to the

amount of time that patients are without their life-saving medication." On average, 90 percent of appeals are approved, which suggests that this process could be simplified and streamlined, he added.

In addition, ACP is requesting that renewals for the same drug or device for the same patient be automatically approved. "If a drug or device was approved last year, we should not have to re-enter the same request every year," Mire said. Standardized forms across payers will also help the process flow more smoothly. Moreover, formularies should be updated in real-time to eliminate guesswork about what will or won't be approved.

Doctors also spend a significant amount of time confirming beneficiary enrollment, coverage and patient history. Mire said this information should all be available at the point of care so that labs and services are not duplicated or missed.

Another way to reduce administrative burdens is to refine some of the quality measures for Merit-Based Incentive Payment System (MIPS) reporting. The Medicare Access and CHIP Reauthorization Act (MACRA) is designed to shift physician payment so that it rewards value and quality over volume via the creation of the Quality Payment Program (QPP). The QPP offers two pathways for reimbursement: MIPS and Alternative Payment Models (APMs).

In terms of MIPS, ACP's Performance Measurement Committee reviewed the measures applicable to internal medicine and rated just 37 percent of these measures as "valid." "The goal should be to choose meaningful measures that matter and get rid of measures that have no positive benefit for patient outcomes," Mire said. Reducing the overall number of required measures will also reduce administrative burden.

APMs have been underutilized, and the College urges CMS to expand participation by approving new models, particularly for Advanced APMs. In its letter to CMS, ACP suggests that working more closely with the Physician Focused Payment Model Technical Advisory Committee (PTAC) on evaluation and approval of new models will increase the speed of this process. PTAC was created as part of MACRA to evaluate proposals for physician-focused payment models and make recommendations about whether they should be included as APMs.

"When physicians are working in the trenches, they feel like they are alone dealing with these issues, but ACP is working hard to reduce administrative burdens and improve patient care and physician well-being," Mire said.

Members can do their part to advocate for reduced administrative burdens. "Legislators need to hear from their own constituents," Mire said. "Sharing stories at national and local leadership days is the best way to let your legislators know what is happening, and this information can be very impactful."

More Information

Information on ACP's Patients Before Paperwork Initiative is available on the ACP website.

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