acofp | AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS

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Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

The burden of prior authorizations impedes efficient patient care. ACOFP supports streamlined administrative processes that reduce the time and complexity of obtaining necessary approvals. We support the broader adoption of electronic prior authorization (ePA) solutions, which, although not reducing the time providers spend preparing submissions, have significantly shortened decision times. We also promote a more standardized and automated process, which can be achieved by directly integrating a common record for all prior authorization-related information into the electronic health records. Standardization is critical given that physicians are required to fill out different forms from different Medicare Advantage (MA) plans for prior authorization, which is time consuming and inefficient. This is especially important given MA is more than 50 percent of Medicare now, and it is reflected in patient populations. MA has created new burdens not required by Medicare FFS, and we urge CMS to explore ways to streamline MA administrative and reporting requirements in alignment with those of Medicare FFS. Different requirements based on insurance type simply adds burden on physicians without benefitting patients. Streamlining this process will improve workflow, enhance transparency, and facilitate better communication between healthcare providers ultimately reducing administrative burdens.

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Administrative burden, including cumbersome electronic health record (EHR) systems, utilization management policies (e.g., prior authorization), and continuously changing regulatory rules, are forcing physicians to spend more time on administrative tasks rather than spending time with patients. Physicians spend even more time on these burdensome tasks and communications with patients after hours. These requirements are contributing to the physician shortages and are inhibiting appropriate patient care. Many physicians, burned out by paperwork requirements, retire early or leave medical practice for another profession, especially those in independent, solo, rural, and small practices where they do not have the resources to manage these paperwork requirements. As more of these practices are forced to close or relocate, healthcare shortages increase, and more communities lose access to care. ACOFP supports reducing burdensome paperwork requirements, including reporting requirements for quality measures, across federal programs to allow physicians to spend more time treating patients. We also urge the agency to consider requiring EHR interoperability and standardizing reporting requirements to reduce time spent on EHRs.

In addition, more needs to be done to support family physicians who have upgraded their EHR systems in compliance with federal programs, including Quality Payment Program (QPP), at great expense. Implementing EHR software is both incredibly time consuming and costly. A 2014 study found that small and rural hospitals were noticeably delayed compared to larger hospitals in terms of EHR implementation rates; further, only 5.8 percent of hospitals were able to meet all of the EHR stage two meaningful-use criteria. Many independent, solo, rural, and small practices are unable to change their EHR system as rules shift annually, so policymakers should consider whether any new EHR requirements will require additional information technology (IT) systems investments. It is essential that federal policymakers do not implement policies that require physicians to invest additional funds in EHR updates, management, and repairs without adequate financial and technical support.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers?

Artificial Intelligence (AI), including augmented intelligence, has the potential to decrease burnout rates given its ability to assist with providing care and reduce time and resources spent on administrative tasks. Specifically, studies illustrate that AI has the potential to deliver value to physicians by automating routine tasks, streamlining critical workflows, and relieving administrative burden. ACOFP supports AI as a tool to reduce administrative burden and address physician burnout. With the proper privacy and security precautions, AI could be utilized to search patient records to automate the reporting of clinical quality measures and outcomes in order to comply with reporting requirements. This could be helpful in lessening the burden of data input and reporting by physicians.

However, AI cannot replace the physician-patient relationship that is integral to patient care. While AI could be helpful in reviewing prior authorizations, physician input is critical when determining whether to allow or deny authorizations. Therefore, guardrails are necessary to ensure that physicians remain the ultimate clinical decisionmakers when it comes to patient care. Physicians must be required to provide input on the decision to deny care and the reason for denial.

Moreover, while AI can provide many benefits, we are concerned that what AI produces could misrepresent patient conditions and introduce AI bias. Physicians therefore must continue to play an active role in patient care to ensure AI products are accurate.

ACOFP also recognizes that AI can be expensive to deploy and that such costs could be a barrier to adoption for independent, solo, rural, and small practices. We support policies that promote access to AI for independent, solo, rural, and small practices so that physicians in practices of all sizes and in all geographic locations receive equal access and are not prevented from accessing tools that can reduce administrative burden.

Topic 2: Opportunities to Reduce Burden of Reporting and Documentation

2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?

It can be extremely burdensome and time consuming for physicians to determine the correct code for billing Medicare. This is especially difficult for basic screenings given the number of potential codes a physician can choose from. In addition, there may be multiple codes to address one issue and failing to include the correct code could limit or deny reimbursement for the service.

Specifically, while Advanced Primary Care Management (APCM) codes are well intended, they create another layer of confusion and physician decision making, with varying requirements, timing, details, etc. to appropriately utilize the codes. This creates challenges especially for independent, solo, rural, and small practices, who should focus their limited capacity on patient care, not identifying and billing the correct codes to reflect the work they are doing. For example, the utilization and understanding of "G" screening codes and the redundancy of reporting CPTs codes for data is particularly burdensome. The ability to navigate through the reporting regulatory details for these codes is cumbersome, especially given physicians have to determine how to use such codes directly. If there is going to be a standard of care (e.g., recommendations from the United States Preventive Services Task Force (USPSTF)), such standards should not make it more difficult for physicians to deliver the standard of care. Complying with additional administrative requirements in order to provide the standard of care is antithetical to advancing evidence-based medicine. Providers should be able to focus on providing the highest quality care without being burdened with cumbersome coding requirements.

In addition, we believe it is critical for CMS to ensure (to the extent the agency has the authority) consistent application of coding from the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) across different payor, both public and private.

Further, as previously referenced, the burden of prior authorizations impedes efficient patient care. ACOFP supports streamlined administrative processes that reduce the time and complexity of obtaining necessary approvals. We support the broader adoption of electronic prior authorization (ePA) solutions, which, although not reducing the time providers spend preparing submissions, have significantly shortened decision times. We also promote a more standardized and automated process, which can be achieved by directly integrating a common record for all prior authorization-related information into the electronic health records. Standardization is critical given that physicians are required to fill out different forms from different MA plans for prior authorization, which is time consuming and inefficient. This is especially important given MA is more than 50 percent of Medicare now, and it is reflected in patient populations. MA has created new burdens not required by Medicare fee-for-service (FFS), and we urge CMS to explore ways to streamline MA administrative and reporting requirements in alignment with those of Medicare FFS. Different requirements based on insurance type simply adds burden on physicians without benefitting patients. Streamlining this process will improve workflow, enhance transparency, and facilitate better communication between healthcare providers ultimately reducing administrative burdens.

<u>2B. Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?</u>

CMS should consider simplifying the current codes for basic screenings to limit the amount of time physicians spend sorting through codes rather than spending time with patients.

In addition, as previously noted, administrative burden, including cumbersome electronic health record (EHR) systems, utilization management policies (e.g., prior authorization), and continuously changing regulatory rules, are forcing physicians to spend more time on administrative tasks rather than spending time with patients. Physicians spend even more time on these burdensome tasks and communications with patients after hours. These requirements are contributing to the physician shortages and are inhibiting appropriate patient care. Many physicians, burned out by paperwork requirements, retire early or leave medical practice for another profession, especially those in independent, solo, rural, and small practices where they do not have the resources to manage these paperwork requirements. As more of these practices are forced to close or relocate, healthcare shortages increase, and more communities lose access to care. ACOFP supports reducing burdensome paperwork requirements, including reporting requirements for quality measures, across federal programs to allow physicians to spend more time treating patients. We also urge the agency to consider requiring EHR interoperability and standardizing reporting requirements to reduce time spent on EHRs.

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2C. Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number. (Note: The OMB Control Number consists of two groups of four digits joined by a hyphen and it generally appears on the top right of the first page of a Medicare form and the CMS form number generally appears on the bottom left of the page of a Medicare form.)

[ACOFP provided no comments on this.]

Topic 3: Identification of Duplicative Requirements

3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

[ACOFP provided no comments on this.]

3B. How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?

[ACOFP provided no comments on this.]

3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

Although telehealth utilization has leveled off as in-person visits have rebounded since the COVID-19 public health emergency (PHE), there has been a paradigm shift where the healthcare system now relies more on telehealth. Telehealth provided by a patient's established provider can be a powerful tool for care delivery due to its potential to improve access to care for countless Americans, especially for patients in rural and underserved areas. However, telehealth is particularly vulnerable to fraud and abuse and could lead to higher costs for patients. There are also limited data on the quality of telehealth. Additionally, there are concerns that telehealth could increase administrative burden, which should be avoided as much as possible. For example, based on a 2020 ACOFP member survey, 26 of respondents reported administrative burden associated with obtaining state licensures for using telehealth across state lines. ACOFP firmly believes that in-person care is the gold standard for care and that telehealth is a tool to improve care delivery when in-person care is not possible—not a silver bullet.

ACOFP is also concerned that the growth of telehealth could inadvertently disrupt existing physician-patient relationships and care coordination. Telehealth-only providers may have limited encounters with patients and may not appropriately coordinate with family physicians so that this could result in worsening medical conditions and poor health outcomes. ACOFP believes telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth.

Topic 4: Additional Recommendations

4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

Patient Choice and Patient Autonomy

ACOFP recognizes that patients have autonomy and can make their own choices related to their health care. ACOFP believes that physicians should not be penalized for not meeting quality metrics when patients do not want to receive a specific treatment. If a physician takes all steps

available to provide care to a patient, but a patient refuses such care, the patient's physician should not be penalized for unmet patient needs.