KENT MOORE, AMY MULLINS, MD, SANDY POGONES, ERIN SOLIS, AND BRENNAN CANTRELL

The Quest for Administrative Simplification: What's Being Done

Progress has been made on several fronts, including prior authorization reform and reducing documentation burdens. But there's more work to do.

Administrative burdens have long been one of the most frustrating aspects of practicing medicine in the U.S. Physicians report spending an inordinate amount of time doing paperwork for things like prior authorizations, medical record documentation, and, especially lately, data reporting for a variety of quality measurement programs.

A 2019 survey by CompHealth and the American Academy of Family Physicians (AAFP) found that 71% of physicians cited clerical burdens as one of the top causes of unhappiness on the job.[1] The AAFP and other groups have heard the calls for administrative simplification and are working toward it on several fronts. The quest can be summarized in this statement from Leo Babauta's

ABOUT THE AUTHORS

Kent Moore is senior strategist for physician payment, Dr. Mullins is medical director of quality and science, Sandy Pogones is senior strategist for healthcare quality, Erin Solis is manager of practice and payment, and Brennan Cantrell is commercial health insurance strategist for the American Academy of Family Physicians. Author disclosures: no relevant financial affiliations.

book *The Power of Less*: "Simplicity boils down to two steps: 1. Identify the essential. 2. Eliminate the rest."

Here's a brief summary of the principles that are guiding the AAFP and a rundown of what's being done to tame the beast of administrative burden.

PRINCIPLES FOR ADMINISTRATIVE SIMPLIFICATION

The quest for administrative simplicity is inspired by primary care's daunting and often demoralizing regulatory framework. Every payer seems to have its own rules and ways of doing things — a major problem given that many physicians have 10 or more payers. Physicians and their practice teams must learn and navigate the rules and forms of each payer, spending countless hours reviewing documents and checking boxes to meet the plans' requirements.

This reduces time with patients and drives up operating costs for practices. It is one of the reasons independent practices close and a leading cause of physician burnout.[2,3] Like the road to hell, the administrative framework in which primary care practices operate is paved with good intentions, but it has expanded to an untenable level and become a significant barrier to achieving the Quadruple Aim.

Spurred by this problem, the AAFP adopted a set of "Principles for Administrative Simplification" in 2018 to focus the organization's advocacy (see https://www.aafp.org/about/policies/all/principles-administrative-simplification.html). The principles are meant to ensure patients have timely access to treatment while reducing administrative burdens for physicians. They cover four key areas: prior authorizations, certification and documentation of medical necessity for supplies and services, harmonization of quality measures, and medical record documentation.

PRIOR AUTHORIZATIONS

Physicians strive to deliver efficient, high-quality care. But the frequent phone calls, faxes, and forms that physicians and their teams must manage to obtain prior authorizations from prescription drug plans, home health companies, durable medical equipment (DME) suppliers, and others impede this goal.

The AAFP's principles include advocating that prior authorizations should be eliminated for DME, medical supplies, and generic drugs. Before being used for other items, prior authorizations should be justified in terms of their financial recovery, and the rules should be transparent and easy to follow.

The AAFP also advocates that physicians who participate in financial risk-sharing agreements with health plans should be exempt from prior authorizations within those plans.

The AAFP is participating in an American Medical Association (AMA)-sponsored workgroup on prior authorization reform and has advocated for reform with the Centers for Medicare & Medicaid Services (CMS) as well as the country's largest private payers during annual meetings.

The AAFP adopted a set of "Principles for Administrative Simplification" in 2018 to focus the organization's advocacy.

There has been some recent progress on the legislative and regulatory fronts. Congress has introduced the "Improving Seniors' Access to Care Act" and the "Safe Step Act," two AAFP-endorsed bills that would reform prior authorization within Medicare Advantage plans and streamline step-therapy requirements for prescription drugs within employer-based health plans. Late last year, CMS proposed a new rule to automate prior authorization requirements

KEY POINTS

- Administrative burdens are one of the top reasons that independent physician practices close and physicians burn out.
- The American Academy of Family Physicians' "Principles for Administrative Simplification" focus on four areas: prior authorizations, certifications, quality measures, and documentation.
- Advocacy efforts have led to rule changes and legislative proposals that provide some relief from administrative burdens. But more needs to be done.

in state Medicaid plans and private plans sold on the Affordable Care Act exchange.[4] Implementation of the rule has been delayed as the Biden Administration reviews it, but the new administration is expected to adopt it eventually.

CERTIFICATION AND DOCUMENTATION OF MEDICAL NECESSITY

The constant task of certifying and documenting medical necessity so that patients can receive medical supplies and services has become an impediment to patient care as well. Many times physicians are required to repeatedly submit this information for patients with chronic conditions, even if their condition hasn't changed. This needlessly piles on more administrative burden.

The AAFP's principles state that a physician's attestation of clinical diagnosis should be sufficient documentation of medical necessity for DME or medical supplies. Physicians should not have to explain why patients who are amputees need prosthetics, for example, or why patients with diabetes need glucose testing items.

> Physicians who participate in financial risk-sharing agreements with health plans should be exempt from prior authorizations within those plans.

The AAFP's principles also push for more standardization of forms so that physicians are not required to fill out a new form every time a patient switches brands.

QUALITY MEASURE ALIGNMENT

Another area in which family physicians long for administrative simplification is performance measurement. Every payer seems to have its own set of quality or performance measures. Even when it seems on the surface like they're using the same measure, they often define it differently. Worse, some of the measures payers choose are not clinically meaningful or relevant to family medicine.

The AAFP is participating in national efforts to harmonize these measures, aiming for less redundancy and more consistency. That means supporting measures that are meaningful to family physicians and opposing those that are not integral to primary care. The AAFP is working closely with the National Quality Forum, which houses both the Measure Applications Partnership (MAP) and the Core Quality Measure Collaborative (CQMC). The MAP and CQMC work to identify and align measures across federal and private payers. When measures are aligned, measuring performance becomes simpler.

The AAFP gives feedback that reflects clinical guidelines on specific measures while they are under development, so the finalized measures make sense clinically. The AAFP's principles also state that performance measures should be equitable for all family physicians regardless of where they practice or what populations they serve, so family physicians are only held accountable for things they can reasonably control.

Nationally, the AAFP has also been advocating for measures that reflect the true value of family medicine through measure development, public comments, and representation on panels of technical experts. This advocacy is also beginning to show results. The Patient-Centered Primary Care Measure,[5] recently developed through a collaborative effort of leading primary care authorities, is a patient-reported measure that focuses on the elements of primary care that are known to add value to the health care system: access, comprehensiveness, coordination, continuity, care management, and patient engagement.

MEDICAL RECORD DOCUMENTATION

The age of electronic health records has failed to curb the documentation demands placed on physicians. In fact, documentation requirements have, in many cases, increased. But there has been progress recently on a critical area for family physicians: coding and documentation requirements for most evaluation and management (E/M) visits.

In 2018, the AMA's CPT Editorial Panel established a workgroup to review and

revise the guidelines for office visit/outpatient E/M services. Two AAFP members were included in the group. The workgroup's goals of decreasing the administrative burden of documentation and coding and decreasing documentation that is not needed for patient care were in line with AAFP principles. The group's recommendations were approved at the February 2019 CPT Editorial Panel meeting and went into effect Jan. 1, 2021.

The new guidelines simplify documentation of office/outpatient E/M services in multiple ways. First, they eliminate the need to check any boxes for history or exam to get credit for a certain level of service. Physicians now only need to concern themselves with medical decision making or time when they're coding those visits. Second, the new guidelines allow physicians to code office/outpatient E/M services based on time whenever they wish to do so, eliminating the previous need to determine whether counseling or coordination of care dominated the encounter. The changes also allow physicians to count all time associated with a visit on the date of service, not just the face-to-face portion. This simplifies the process of determining what time counts toward the visit level.

Throughout 2020, the AAFP developed a variety of resources (see https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management.html) to help members prepare and implement the new E/M coding and documentation guidelines. The AAFP also advocated with private payers to ensure they adopt the new guidelines uniformly.

Another ongoing effort to decrease the documentation burden has been the AAFP Innovation Lab, which pilots promising technological solutions that leverage artificial intelligence (AI) and automation to handle routine tasks for clinicians. Early pilots of an AI-powered virtual digital assistant have found substantial decreases in after-hours documentation, with reductions of up to three hours per day in some cases. (For more information, see the AAFP Innovation Lab white paper https://www.aafp.org/dam/AAFP/documents/media_center/charts-graphs/digitalassistant-innovationlab--phase-1-whitepaper.pdf.)

THE QUEST CONTINUES

Regrettably, the quest for administrative simplicity is not over. Prior authorization has been addressed, but not resolved. The same is true for certification and documentation and harmonization of quality measures. The E/M changes are now in effect, but the AAFP continues to weigh in on other aspects of medical record documentation, including changes to HIPAA requirements.

> Every payer seems to have its own set of quality or performance measures.

Progress has been made in some areas, and persistence will yield even more. As writer Elbert Hubbard once put it, "Know what you want to do, hold the thought firmly, and do every day what should be done, and every sunset will see you that much nearer your goal."[6] FPM

1. Saley C. 2019 AAFP/CompHealth physician happiness survey. CompHealth Blog. March 19, 2019. Accessed June 10, 2021. https://comphealth.com/resources/physician-happiness-survey/

2. Li D, Tutty M. How to sustain independent physician practices. MedCity News. Nov. 12, 2020. Accessed June 10, 2021. https://medcitynews.com/2020/11/how-to-sustain-independent-physician-practices/

3. Patel RS, Bachu R, Adikey A, Malik M, Shah M. Factors related to physician burnout and its consequences: a review. *Behav Sci (Basel).* 2018;8(11):98.

4. Centers for Medicare & Medicaid Services. Reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges. *Federal Register.* Dec. 18, 2020. Accessed June 10, 2021. https://www.federalregister.gov/documents/2020/12/18/2020-27593/medicaid-program-patient-protection-and-affordable-care-act-reducing-provider-and-patient-burden-by

5. Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC. A new comprehensive measure of high-value aspects of primary care. *Ann Fam Med.* 2019;17(3):221-230.

6. Hubbard E. *Selected Writings of Elbert Hubbard: His Mintage of Wisdom, Coined from a Life of Love, Laughter and Work, Volume 10.* W.H. Wise & Company. 1922.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.