American College of Physicians
Leading Internal Medicine, Improving Lives

March 19, 2018

Honorable Kevin Brady
U.S. House of Representatives
Washington, DC 20515

Honorable Peter Roskam
U.S. House of Representatives
Washington, DC 20515

Re: The American College of Physician's (ACP) Participation in the Ways and Means Subcommittee on Health Medicare Red Tape Relief Project Roundtable

Dear Committee Chairman Kevin Brady and Health Subcommittee Chairman Peter Roskam:

On behalf of the American College of Physicians (ACP), I want to express my thanks for convening the roundtable on Medicare Red Tape Relief. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 internal medicine physicians (internists), related subspecialists, and medical students.

ACP greatly appreciates the Subcommittee's efforts on reducing red tape in the Medicare program as well as the opportunity to provide the physician perspective on administrative burden. The College has long advocated for reducing administrative tasks and putting patients first through our ongoing Patients Before Paperwork initiative and the development of significant policy recommendations for reducing administrative burden throughout the health care industry, including a recent policy paper focused on transparency and alignment within Medicare Advantage. We have also expressed strong support for CMS Administrator Seema Verma's similar effort to reduce unnecessary Medicare red tape and to require meaningful measures. Congress can help support this effort by encouraging changes to reduce duplicate forms and unnecessary follow-up visits, to revamp clinical documentation requirements for office visits, and to better capture performance measure data, and address the lack of practical interoperability.

We look forward to participating in ongoing future dialogue on these critical issues. Administrative burdens lead to inefficient delivery of care to our patients and are a major contributing factor to the burn-out epidemic among physicians.

Sincerely,

Robert McLean, MD, FACP, FACR
Incoming President-Elect, American College of Physicians

[Enclosure: Statement before the Ways and Means Subcommittee on Health Medicare Red Tape Relief Project Roundtable]

American College of Physicians

Statement before the Ways and Means Subcommittee on Health

Medicare Red Tape Relief Project Roundtable

March 15, 2018

Good afternoon. I want to thank all the Committee members for convening today's roundtable on Red Tape Relief. My name is Robert McLean, and I am here representing the American College of Physicians (ACP). I have been practicing primary care internal medicine and rheumatology for over 20 years in New Haven, CT and currently see upwards of 50 Medicare patients per week.

Through ACP's Patients Before Paperwork initiative, we have laid out a cohesive framework to evaluate administrative tasks with an eye toward removing barriers that unnecessarily interfere with meaningful interaction between clinicians and their patients. Let me lead you through a recent office visit to help you understand why physicians feel like they are being tied in knots as they try to take care of patients.

I saw a man a few days ago, say his name was Mr. Roskam. He has a few chronic medical conditions including diabetes, sleep apnea, and arthritic problems causing episodic back muscle pains. He was in a Medicare Advantage Plan last year and then heard from some friends that a different plan was better and so he switched at the start of this year. As we started the visit and I logged onto my electronic health record (EHR), he indicated there was a delay in a refill on his diabetic testing supplies. I recalled some paperwork I had seen just the day before. He had called my office about this last week, and I then had provided a printed prescription with all of the necessary information to his pharmacy. Then yesterday, I had received a request from the pharmacy to complete their specific Medicare form for diabetic testing supplies. They had included my original prescription with all of the information so it could be transcribed onto their form and I could physically sign their form. Needless Duplication!

My First "low-hanging fruit" Recommendation: Remove the requirement for a duplicative form to be signed by the physician in order to submit a request for diabetic testing supplies.

And speaking of refills, the patient asked me to refill a muscle relaxer medication he used occasionally for his back pain. We reviewed how different ones tried previously, made him too sleepy, and that one particular inexpensive generic worked well. It was last filled six months ago, and so I then sent the prescription electronically.

I then asked questions and entered information into my chart note in ways to ensure I completed several different sections to satisfy coding criteria. In addition to documenting presence and absence of symptoms and historical elements, then I re-document the status of each of the problems in the Assessment/Plan portion of the chart. I am putting the same information in more than one part of the chart, and I am putting in information that is irrelevant to the issues of the current office visit. For a certain level of visit, I have to ask questions about upwards of nine organ systems and examine and document seven body parts, even if they are not relevant to today's visit! What craziness! And why? Our clinical notes have turned into random assortments of medical words & phrases to meet documentation requirements established back in mid-1990s. We have lost the clinical narrative.

My Second Recommendation: We need to update documentation guidelines. Haven't we updated most other aspects of healthcare in 20 years? The history and physical exam requirements are ridiculous and without clinical relevance and need to be re-written with a specialty-specific framework.

As I look in the "Health Maintenance" part of the chart, I see the patient is overdue for his yearly diabetic eye exam. He tells me he saw his eye specialist a month ago, yet I have not received documentation of that. It is a key quality metric being followed by my group and being tracked by his Medicare Advantage Plan. Yet, if I cannot track down documentation from his eye doctor and have my staff scan it into my EHR in just the right way, then I will not receive "credit" that I have taken adequate

care of his diabetes. The lack of adequate interoperability between different EHR systems makes this an ongoing challenge that is very frustrating to physicians.

We are wrapping up, and I get a knock on the door. My medical assistant hands me a fax from the pharmacy about that generic muscle relaxer. It has been denied because it is not on the Medicare Advantage Plan's formulary. So now I need to fill out a different form – another administrative burden for me, and delay in the patient getting the prescription.

My Third Recommendation: Variations among Medicare Advantage Plans around formularies, processes, and performance measures drive physicians and patients crazy. Alignment is critical.