Moderator: Jill Darling
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12:00 pm CT

(Amber): Welcome and thank you for standing by. At this time, all participants will be on listen only, until the question-and-answer session of today's conference. At that time, you may press Star 1 to ask a question. Today's conference is being recorded. If you have any objections, please disconnect at this time. I'd now like to hand the meeting over to your host, Ms. Jill Darling. You may begin.

Jill Darling: Great. Thank you (Amber). Good morning and good afternoon everyone and welcome to today's Rural Health Open Door Forum. We started an hour earlier than our normal 2 o'clock Eastern time, just to work around everybody's busy schedules here at CMS. We do have a pretty packed agenda today. So, we'll get started.

I'm sorry, one brief announcement from me and then we'll get started. This Open Door Forum is open to everyone, but if you are a member of the press, you may listen in. But please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov. And I will hand the call off to Cara James.

Cara James: Thank you so much Jill. And welcome to all of you to CMS's Rural Open-Door Forum. I'm Cara James, the Director of the CMS Office of Minority Health and Co-chair of the CMS Rural Health Council. You usually hear the voices of (John Hammarlund) and Carol Blackford on this call, but they are unable to join us today. So, I will be trying to aptly fill their shoes.

We have a packed agenda and lots of wonderful information that we're going to be sharing with you today to highlight several areas of interest in CMS's

recently issued Outpatient Prospective Payment System and Physician Fee Schedule Proposed Rules and our recently finalized Inpatient Prospective Payment Systems Rule.

We'll also provide an update on the agency's work to reduce burden throughout patient's over paperwork initiative. And, as always, we invite you to submit comments on our proposed rules via the process described on the federal register. And, as always, any remarks that you make today during our question and answer session do not count as formal comments.

If you have any questions about how to do that, or suggestions on future topics, please send a note to us at Ruralhealth@CMS.HHS.gov and we'll get back to you. Again, thank you for joining us and I'll turn the call back over to Jill.

Jill Darling: Great. Thank you, Cara. We'll dive right in and first we have Ryan Howe who will go over some of the Physician and Fee Schedule (NPRM) highlights.

Ryan Howe: Good afternoon, good morning everyone. We appreciate the opportunity to talk about the 2020 Proposed Physician Fee Schedule Rule. We think the rule continues our ongoing efforts to improve the health care system in ways that will result in better accessibility, quality, affordability, empowerment and innovation. And the Medicare Payment Policies have an important role to play in that work. And particularly for this audience.

So, I'll cover several highlights of the proposed payment rules and rates related to the Physician Fee Schedule and happily stay on to answer any specific questions that those calling in may have.

First, the proposed conversion factor reflects the physician update as required by law, as well as the budget neutrality adjustments that are also required by law, based on the changes in payment rates and policies that we propose. And under our proposed policies, the proposed conversion factor would be $36.09, which is a slight increase from the 2019 conversion factor of $36.04.

There are several policies that are proposed to be effective starting January 1, 2020, but I know of particular note is a continuing and ongoing policy matter related to the evaluation and management visits that we are making a proposal - a series of proposals that would be effective for January 1, 2021. Given the import, I wanted to start there.

As many of you are probably aware, we made proposals and finalized refined versions of those proposals to make significant changes to the E&M Visit Code Set and Payment Rates in last year's rule making. In finalizing that rule, we set the changes to become effective January 1, 2021 and we noted that we expected, based on comment, that Stakeholders, through the AMA Processes, like the CPT Editorial Panel and the RUC, with - again, based on their comments we anticipated that they would undertake significant changes of their own. And that we would take a look and consider those in future rule making.

Through the CPT process and the RUC Evaluation Process, the AMA has committed to making significant reform to the E&M Visit Codes for 2021. We took a look at those potential changes, as well as the recommended values. And in the 2020 (proposes) the fee schedule rule we are proposing to adopt, most of those coding changes and the recommended values through the RUC Process.

That would mean that for 2021, under the current proposal, both Medicare and CPT would follow the same set of rules. The one significant difference, which may be of note, we are proposing to incorporate an Add on Code that would be used to describe visits that are part of ongoing primary care, as well as care management related to particularly complicated and ongoing disease conditions.

And so, on all of those proposals, we are, as usual, seeking comment and we hope, as evidenced by the ongoing discussions with Stakeholders and how fruitful that has been in terms of continuing to refine what the policies are, we hope that we get extensive feedback for which we really rely.

We're making several other proposed changes that would take effect for 2020, including changing the Physician Supervision Requirements for Physician Assistants. We are proposing to modify the regulations so that Physician Assistants will have greater flexibility to practice more broadly in accordance to State Law and State Scope of Practice.

And in the absence of such State Law under our proposal, Medicare Physician Assistants or Physician Assistants would be required to demonstrate in the medical record that they worked with physicians in furnishing their services. We think that this provides maximum flexibility that we have under the current statute and will be helpful.

That's also, I should note, a significant amount of feedback that we got through the patients over (pay work) initiatives, which is ongoing. And we continue, not only to address changes in E&M visits, as well as supervision requirements, but we continue to refine the payment policies in those areas, as well as others based on the initial feedback we got and the feedback that we

continue to get from all of you regarding the need to reduce administrative work.

Similarly, we made proposals regarding the documentation requirements. So that Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives could review and verify, rather than redocument notes made in the medical record by others who are part of the medical team. We think that's a really important time saver and will help lift burden.

As part of our ongoing work to make sure that we're paying most effectively for care management services under the Physician Fee Schedule and to recognize the ever increasing needs of the Medicare patient population, as well as changes in medical practice, that are building on our team efforts and broad based care, we have heard a lot about the Care Management Codes. And where there are some challenges in billing the Care Management Codes for services like Chronic Care Management, we are proposing significant changes in the coding to chronic care management services that would be effective for 2020 that we believe based on public comment, again in the area of reducing administrative burden, these - in order to revise the coding, we're proposing to use G-codes instead of the CPT codes which have very specific billing instructions associated with them.

The G-codes we believe would be more likely to be able to be billed in more circumstances and what that will reflect in resource costs for serving patient's needs who have chronic medical conditions even in circumstances where some of the preexisting administrative requirements aren't quite met.

We think that the new G-codes recognize greater flexibilities and greater diversity in how those services are furnished, based on different care settings, but are paid under the PFS, and based on the needs of the individual patients.

That said, we also recognize that generally folks prefer to use CPT codes in - when billing Medicare and so we're also seeking comment on the relative merits of using the G-codes versus the CPT codes, given what we think are the greater flexibilities.

Along those same lines, we're proposing to create a new Care Management Code for Principal Care Management Services. This code would pay those clinicians who provide care management for patients with a single serious and high-risk condition. Again, lifting some of the requirements that would not allow for billing where we think Intensive Care Management work is ongoing.

We also wanted to mention, under the Physician Fee Schedule, but not formally a Physician Fee Schedule payment, though it's in the Physician Fee Schedule Rule, we're proposing payment, both for definition of services, the enrollment policies for outpatient opioid use disorder treatment services.

So, under the current benefit - under current Medicare benefits, there is no coverage for outpatient opioid use disorder treatment facilities. And based on provisions of law that were passed as part of the Support Act last Fall, under Part B, beneficiaries would have access to those services beginning as early as January 1, 2020.

So, we're going to propose the Physician Fee Schedule Rule includes service definitions and enrollment rules and rates as proposed for January 1, 2020 for those services under Medicare. And we're - in establishing, trying to establish a new benefit very quickly given the obvious and urgent needs of the patient

population, we are going to rely ever more on the feedback. And so, we look forward to the comments about how to ensure that Medicare beneficiaries have appropriate access to the much-needed services there.

The last thing I'll mention is the related comment solicitation and proposal on bundle payments to physicians and other practitioners who are treating substance use disorders and the patients who need that kind of care. And so, what we've heard a great deal is that there are some significant limitations for treatment of those services in terms of the modes of treatment. How patient check ins happen, et cetera.

And so, our proposal reflects an interest in paying in such a way that would allow maximum flexibility and promote maximum access to those care from professionals who would go under the fee schedule ordinarily. And so, we're seeking comment in the hopes to get that as right as possible. And with that, I'll turn it back to Jill.

Jill Darling: All right, thank you Ryan. We're going to go down to the Inpatient Prospective Payment System final rules and we have Joe Brooks, who will go over the CAH Ambulance Policy.

Joe Brooks: Thank you Jill. Hi, I'm Joe Brooks and I'll be speaking about the Critical Access Hospital, or CAH, Payment Policy for reasonable cost-based payment of CAH Ambulance Services. Prior to fiscal year 2020, regulations stated payment for ambulance services furnished by a CAH or by an entity that was owned and operated by a CAH, was 101% of the reasonable cost of the CAH or entity in furnishing those services, but only if the CAH or the entity was the only provider or supplier of ambulance services within a 35 mile drive of the CAH.

If there was another provider or supplier of ambulance services located within a 35-mile drive of the CAH, the CAH was paid for its ambulance services using the Ambulance Fee Schedule. By "provider" of ambulance services, we mean Medicare-participating providers that submit claims under Medicare for ambulance services (for example, hospitals, CAHs, skilled nursing facilities, and home health agencies). And by "supplier" of ambulance services we mean an entity that provides ambulance services and is independent of any Medicare-participating or non-Medicare-participating provider.

It was brought to our attention that there may be providers or suppliers of ambulance services that are located within a 35-mile drive of a CAH that are not owned or operated by the CAH and are not legally authorized to transport people either to or from the CAH.

For example, there could be a situation where an ambulance supplier is located within a 35-mile drive of a CAH, but in a different state, and the ambulance supplier does not have the appropriate state licensure to furnish ambulance services in the state where the CAH is located.

Under this scenario, the regulations required that the CAH be paid for its ambulance services using the Ambulance Fee Schedule, which in general provides lower payment rates than reasonable cost-based payments, even though the out-of-state ambulance supplier cannot actually furnish ambulance services to transport individuals either to or from the CAH. We believed this outcome was inconsistent with the intent of the Medicare Rule Hospital Flexibility Program which is to provide access to care for individuals living in remote and rural areas.

As such, we finalized our proposal to interpret the statutory requirement that the CAH or the CAH-owned and operated entity be the only provider or

supplier of ambulance services within a 35-mile drive of the CAH, to exclude consideration of ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals to or from the CAH.

This policy change is effective for cost reporting periods beginning on or after October 1, 2019. And with that, I will hand it over to my colleague, Renate Dombrowski to discuss CAH GME Policy.

Renate Dombrowski: Thanks Joe. Another policy included in the IPPS Final Rule relating to Critical Access Hospitals or CAHs involves residency training and CAHs. The policy included in the final rule considers CAHs to be non-provider settings for purposes of graduate medical education payments. I am going to review some additional background.

In general, hospitals can include residents training in non-provider settings in their resident count for graduate medical education payments if the hospitals pay the residents' salaries and fringe benefits while the residents are training in the non-provider settings.

Under the policy in effect prior to the final rule, CAHs that trained residents were not considered non-provider settings and instead were paid 101% of the reasonable cost associated with residency training. This policy was the result of the use of the term non-provider as part of the Affordable Care Act.

However, we heard concerns related to CMS's policy that CAHs were not considered non-provider settings for purposes of graduate medical education payments. In light of these concerns, we reexamined the statutory language associated with this policy, issues raised in prior rule making related to this policy, and the intent of the changes made by the Affordable Care Act.

As a result, and in order to support the training of residents in rural areas, we proposed and are finalizing a policy that effective with portions of cost reporting periods beginning on or after October 1, 2019, a hospital may include resident's training at a CAH in its count of residents, as long as the hospital meets the non-provider setting requirements, including paying the residents' salaries and fringe benefits while the residents are training at the CAH.

We are not changing our policy with respect to CAHs incurring the cost of training the residents. CAHs may continue to decide to instead incur the cost of training residents directly and receive payments based on 101% of the reasonable cost of these training costs. I'm going to turn it back to Jill.

Jill Darling: Great, thank you Renate. Now we'll go into the Outpatient Prospective Patient System, NPRM highlights. And first up, we have (Terri Postma).

(Terri Postma): Hi everyone. On June 24, the President signed an Executive Order that directs the Secretary of Health and Human Services to propose a regulation consistent with applicable law to require hospitals to publicly post standard charge information. The statutory basis for the proposals in the OPPS is the Public Health Service Act Section 2718(e), which requires each hospital operating within the United States to establish and update and annually make public a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis related groups.

Last year, in the fiscal year 2019, IPPS Rule, we issued guidance to hospitals reminding them of their obligation to comply with this law and requiring them to make public their charge master charges on the Internet in the machine-readable format.

Our proposals in the calendar year 2020 OPPS build on the prior guidance and our lessons learned since implementation on January 1 of this year, specifically, we're proposing a number of definitions, proposals regarding how the hospital should display their standard charges and penalties that would apply for noncompliance.

We're proposing the following definitions:

First, we're proposing to define a hospital as an institution in any state which is licensed as a hospital by the state. For purposes of this definition, a state would include each of the several states, the District of Columbia, Puerto Rico, Virgin Islands, Guam, American Samoa and Northern Mariana Island. This proposal also includes all Medicare enrolled institutions that are licensed as hospitals or approved as meeting licensing requirements, as well as any non-Medicare enrolled institutions that are licensed as a hospital.

We're also proposing that federally owned or operated institutions, such as Indian Health Service Program Institutions, U.S. Department of Veterans Affairs, or U.S. Defense Department Institutions that are not accessible to the general public, except in emergency situations, and already are making their charges publicly available, be deemed to have met the requirements of this section.

Second, we're proposing because no single standard hospital charge exists, we're proposing to define two types of standard charges, to include gross charges as represented in the hospital's charge master and payer specific negotiated charges. We believe that gross charges are important for self-pay individuals and negotiated charges are important for individuals with third party payer insurance.

Third, we're proposing a definition of hospital items and services that would include all individual items and services, as well as service packages that are provided by the hospital to a patient in connection with an inpatient admission or outpatient department visit. We also propose that hospital items and services includes facility fees and charges for employed professionals.

Regarding how the hospital should display their standard charges, we're proposing requirements for making all charges public, online, in a single machine-readable file for all items and services provided by the hospital. This file would contain the hospital's gross charges and payer specific negotiated charges for all individual items and services and service packages provided by the hospital.

In addition to the machine-readable file, and in response to feedback from last year's implementation, we're also proposing that hospitals make public their payer specific negotiated charges for up to 300 so-called “shoppable” services, that is, services that a patient can schedule in advance - and that the hospital display the charges for these shoppable services online in a consumer-friendly manner.

Last year, we received a number of inquiries regarding enforcement of hospital charge posting. As a result, we're proposing a mechanism for monitoring for non-compliance, for issuing warning notices, and requesting corrective action plans, and for imposing civil monetary penalties that amount to over $100,000 per year.

We're also seeking comment through request for information related to the role of quality measures in ensuring patients have all the information they need to shop for value care.

I just want to mention before I turn it over, that we are planning to hold an OPPS and ASC Proposed Rule Listening Session next week, Wednesday, August 14th, from 2:30 to 4:00 p.m. Eastern, where we'll be doing a deeper dive into these proposals. You can register for that via the Medicare Learning Network. And with that, I'll turn it over to Steven Johnson.

Steven Johnson: Thank you (Terri). In the course of statute, CMS is updating the OPPS payment rate by 2.7%. This update is based on the hospital market basket increase of 3.2%, minus a 0.5 percentage point adjustment for most effective productivity.

Overall OPPS payments are expected to increase in CY 2020 by 6.2-billion with aggregate payments including (unintelligible) cost sharing, expected to be around 79.2-billion for 2020, compared to an estimated 73-billion for 2019.

Section 340(b) of the Public Health Service Act allows participating hospitals and other providers to purchase certain covered outpatient drugs at discounted prices from manufacturers. Under CY 2018 OPPS/ACS Final Rule, CMS reexamined the appropriateness of the prior average sales price, plus 6% payment methodology for drugs acquired through the 340(b) Program, given that 340(b) hospitals acquired these drugs at deep discounts.

Beginning January 1, 2018, Medicare paid an adjusted amount of ASP, minus 22.5% for certain payable drugs or biologicals that are acquired through the 340(b) Program by a hospital paid under the OPPS that is not accepted from the Payment Adjustment Policy.

For CY 2020, CMS is proposing to continue to pay an adjusted amount of the ASP minus 22.5% for certain separately payable drugs and biologicals that are acquired through the 340(b) Program.

GMS, at this time, also acknowledges the ongoing litigation pertaining to the 340(e) Payment Adjustment and solicit comments on the alternative payment options for CY 2020 and potential remedies for CY 2018 and CY 2019 payments in the event of an adverse ruling on the 340(e) Payment Policy by the United States Court of Appeals. At this time, I'd like to turn it over to Elise Barringer who will talk about the Clinic Visit Payment Policy.

Elise Barringer: Thank you, Steven. As finalized in last year's rule, CMS is completing the two-year phase-in of the method to reduce unnecessary utilization in outpatient services by adjusting payments for clinic visits furnished in the off-campus hospital outpatient setting.

Clinic visits are the most common service billed under the OPPS. Currently CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting then in a physician office setting. This change would result in lower copayments for beneficiaries and savings for the Medicare Program and taxpayers, estimated to be a total of 810-million for 2020.

For example, for a clinic visit furnished in an accepted off-campus provider-based department, the average beneficiary cost-sharing is currently $16.00 in calendar year 2019, but will be $23.00 (unintelligible) policy. With the completion of the two-year phase-in, that cost sharing reduces to $9.00, saving beneficiaries an average of $14.00 each time they visit an off-campus department for a clinic visit in calendar year 2020. I'll turn it over to my colleague, (Scott Talaga).

(Scott Talaga): Thank you, Elise. And I'll go over the calendar year 2019 CSU Rate Update. In previous years, CMS has updated the annual payment rates for Ambulatory Surgical Centers or ASCs, by a percentage increase in consumer price index for all urban consumers, also known as the CPIU.

In the calendar year 2019, OPPS, ASCs final rule was (unintelligible). We finalized our proposal to apply the Hospital Market Basket update to the ASC payment system rates for an interim period of five years, calendar year 2019 through calendar year 2023. CMS is not proposing any changes to its policy to use the Hospital Market Basket update for ASC payment rates for calendar years 2020 through 2023.

Using the Hospital Market Basket, GMS proposes to update ASC rates for calendar year 2020 by 2.7% for ASCs leading relevant (calling) reporting requirement. This change is based on the projected Hospital Market Basket increase of 3.2% minus 0.5 percentage point adjustment for multi factor productivity.

Based on this proposed update, we estimate that total payments to ASCs, including beneficiary caution and estimated changes in enrollment, utilization encasement for calendar year 2020 would be approximately 5-billion, which is an increase of approximately $150-million compared to estimated calendar year 2019 Medicare payment.

Now we'll discuss changes to the ASC list of covered surgical procedures. The ASC covered procedures list or CPL is a list of covered surgical procedures that are payable by Medicare, when furnishing an ASC. Covered Surgical Procedures are those procedures that are separately paid under the OPPS, which would not be expected to pose a significant safety risk to a

beneficiary and would not typically be expected to require active medical monitoring and care at midnight following the procedure.

Under current policy, covered surgical procedures include those described by certain common procedural terminology, or CPT, codes that are within the surgical range and other codes that directly cross (unintelligible) or clinically similar to CPT codes within the surgical code range.

For calendar year 2020, CMS is proposing to add total knee arthroplasty, (unintelligible) and three additional coronary intervention procedures to the ASC CPL that may be paid in both the hospital and ASC setting. CMS is soliciting comment on if there should be any additional limitations on the provision of (GTA) or other procedures in the ASC setting.

Additionally, CMS is soliciting comments on how the agency could redesign the role of the ASC CPL to encourage physician's ability to determine setting of care as appropriate for a given beneficiary situation. Particularly in regard to ASCs. And now I'll turn it over to (AuSha Washington) to discuss changes to the Inpatient Only List.

(AuSha Washington): Hi there. This is (AuSha Washington) and I will be briefly discussing general changes to the Inpatient Only List. CMS is proposing to remove total hip arthroplasty from the Inpatient Only List, making it eligible to be paid in both the hospital inpatient and outpatient settings. We are also soliciting comments on several other procedures. Now I'll hand it to my colleague, (Lela), who will be discussing in more detail, changes to Two Midnight.

(Lela): Thanks, (AuSha). I'll be discussing a proposal for the review of procedures removed from the Inpatient Only List. CMS is proposing to establish a one-year exemption from certain medical review activities for procedures that are

removed from the Inpatient Only List beginning in calendar year 2020 and subsequent years.

Specifically, we are proposing that procedures that have been removed from the Inpatient Only List would not be eligible for referral to Recovery Audit Contractors, or RACs for noncompliance with the Two-Midnight Rule within the first calendar year of their removal from the Inpatient Only List.

This proposal is not an exception from the Two-Midnight Benchmark which states that generally services are considered appropriate for inpatient hospital admission and payment under Medicare Part A, when the physician expects the patient to require a stay that costs at least two-midnights and admits the patient to the hospital based upon that expectation.

During the one-year exemption period, procedures removed from the Inpatient Only List would not be considered by the Beneficiary Family-Centered Care Quality (Organizations), or (BFC) QIOs) in determining whether a provider exhibits persistent noncompliance with the Two-Midnight Rule for purposes of referral to the RAC.

Nor would these procedures be reviewed by RACs for patient status. BFCC QIOs, would have the opportunity to review such claims in order to provide education for practitioners and providers regarding compliance with the Two-Midnight Rule. But claims identified as noncompliant will not be denied with respect to site of service under Medicare Part A. So, now, I'm going to turn it over to my colleague (Josh McFeeters).

(Josh McFeeters): Thank you, (Lela). And I'm going to discuss changes in the level of supervision of Outpatient Therapeutic Hospital Services and Hospitals and Critical Access Hospitals, otherwise known as CAHs. For CY 2020, CMS is

proposing to change the required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and CAHs. General Supervision means that a procedure is furnished under the physician's (overall control), but that physician's presence is not required during the performance of the procedure.

This proposal would ensure a standard to minimum level of supervision for each hospital service furnished incident to a physician's service in accordance with the statute.

Next, I will talk about changes to the wage index. As in previous years, CMS is proposing to use the IPPS Wage Index. But the Wage Index for the OPPS, as in the FY 2020 IPPS Proposed Rule, CMS has proposed a number of policies to address Wage Index Disparities between high and low wage index value hospitals.

CMS has finalized those policies for the FY 2020 IPPS Final Rule. Those Wage Index policies will also be reflected in the final OPPS Wage Index starting in CY 2020. Now I'm going to turn the discussion over to Jill Darling.

Jill Darling: All right, thank you Josh. Our next and last topic is Patients over Paperwork Phase II with Mary Green.

Mary Green: Thanks Jill. Hi everybody. I'm going to do - talk about three things just to remind people what the Patients over Paperwork Project is. Talk a few minutes about some of the accomplishments from the first two years and then talk about what's coming next.

So, Patients over Paperwork is CMS' Press Agency Burden Reduction efforts. And it's all about working to reduce administrative burden for clinicians, providers, and beneficiaries so resources can be devoted to patient care. If we reduce burden - or we work on reducing burden primarily through reg changes, or reg guidance, and operational changes. And for the most part, during the first two years, regulatory changes have really been the focus.

Getting this right, to get this right, getting input from the medical community and the public generally, is absolutely critical. And a good part of the project is creating mechanisms to be able to do that. And we have gotten input through RFIs, through listening sessions, through interviews. We've done a survey and will likely be doing more surveys.

But probably most importantly, we've gotten input from actually visiting provider practices, clinician practices, and facilities. And even patient homes, to really see for ourselves and hear directly from frontline staff about how our policies or our regulations impact their day-to-day operations. That's how we can figure out what actually needs policy change, what needs clarification. And what some other underlying root cause of the burden like training issues or something like that, that can be addressed. And then we take that kind of information to our policy folks and others in CMS to address it.

We, use Human Centered Design approaches to gather that data and I mention that only because it's critical that when we hear things, we understand what we hear through the perspective of the customer and not just translate what we hear and interpret it in our own perspective. It's a critical way to take a look at the data to make sure we're representing the customer perspective.

So, we accomplished a lot in the first two years. Some were big things, some smaller things, but were still significant. For example, we eliminated 79

Quality Measures that had to be reported estimating that we're saving the medical community upwards of $128-million and 3.3-million hours. And that's to the medical community over a couple year time-span.

So far, some of the changes are more narrowly scoped. Like teaching physicians can now verify medical students' notes that they agree with just by saying that they verify it and not have to redocument the note itself. And that sounds like it's pretty narrow and pretty small, but that actually got a huge ovation at national meetings, because it's a significant change for the teaching physicians and it also helps medical students really become part of the chair team.

For the RFI that we led in 2017, we received input on 11-hundred burden topics. And sometimes that input was describing the burden itself and sometimes it was recommendations to address the burden. And of those 11-hundred, of the ones that CMS actually could potentially do something about, we addressed 80% of them.

We also did seven Human Centered Design Projects and they focus on nursing homes, home health, hospice, hospitals, clinicians, beneficiaries, and dialysis facilities. The focus of each one varied depending on the, you know, the topic of the project. For example, for beneficiaries, we focused on challenges in care transitions. And for hospitals we focused on the myriad of reporting requirements they have both for our programs and for the private sector programs.

Together, just looking at RAC changes alone, CMS estimates that we saved the medical community about $5.7-billion and 40-million hours through 2021 and that was since the spring - as of the spring of this year.

So, what's coming next? I want you to know that Patients over Paperwork is still going strong. The focus across the agency on burden reduction is still a tremendous focus even as you've been hearing about some of that in the other presentations.

We have put out another Burden Reduction RFI. The commentary closes on August 12th even though we still are asking people to send us whatever they want to send us. We ask them particularly to send us things that we didn't hear about the first time around in 2017.

We did ask more specific questions around documentation requirements and how they could be presented better. Around prior authorization. Around rural health, particular challenges in the rule setting. Or unintending consequences of our rules in the rural setting. And we also asked about dual eligible patients.

We launched a new (ECD) Project that just started. It's focused on Prior Authorization and it's focused on improving the process of Prior Authorization to make it more efficient, transparent, and standardized. This is looking at Prior Authorization in Fee for Service and Men's Care and it's looking across our programs Medicare and Medicaid and Marketplace. We're shaping a couple of other (ECD) Programs as well, so we're looking for at least three of them happening in this - it'll be starting up in the next year.

We continue to extend our reach to customers around the country. In the first two years, we reached about 2-thousand customers providing input to us through the onsite engagements, the listening sessions and that sort of thing. Now we're up to - we've touched every region. We are up to getting input from people in 40 states, two territories and we're over 4-thousand customers engaged somehow in providing input in this effort.

We are going to continue to get CMS staff to go out to these - visits to practice facilities to learn first-hand on the impact of the day-to-day operations. And the Administrator in particular, is asking us to get more and more CMS folk out there.

We are looking though, for other opportunities to get input from folks in between these, (kind of scheduled activities). So, we establish a Patients over Paperwork email address where you can send in your stories about the burdens that you experience either working in the health system or trying to navigate the health system.

And also, if there are things that we've done right and they've been reducing burden, we'd love to hear those stories as well. The email address is literally patientsoverpaperwork - as one word - @cms.hhs.gov. If you want to learn more about Patients Over Paperwork, you can go to our Web site on the CMS - or the Patients Over Paperwork portion of the CMS Web site and there's a Newsletter there you can sign up for if you want some ongoing input.

Jill Darling: Great, thank you Mary. And thank you to all of our speakers today. (Amber) can you please open the lines for Q&A please?

(Amber): Thank you. We'll now begin the question and answer session. If you would like to ask a question, please press Star 1. You will be prompted to record your name. Please be sure to unmute your phone. Once again, if you would like to ask a question, please press Star 1. And we will pause for just a moment so all those questions can start coming through.

Our first question comes from Dale Gibson. Your line is open.

Dale Gibson: Yes. I want to ask a quick question. It's not really about 2020, but the changeover from losing the Eligibility Lookup on the System to HETS. And I've contacted two MACS and neither one of them had any idea what I was talking about when I said HETS.

And I had been contacted a vendor - outside vendor - who does this type of thing and they didn't know anything about HETS, but they offered me Eligibility Lookup and it was quite expensive. I didn't know if someone there could tell me how I was supposed to get a hold of HETS? Or if they're aware of this cost?

I mean a normal cost would be close to $10-thousand a year for a hospital for this Eligibility Lookup for an outside vendor. And if that's passed onto Medicare, that could be a very high expense and loss of money to pay for health care.

Jill Darling: Hi, there. Unfortunately, we don't have anyone in the room right now to help answer your question, but if you please don't mind and send in your question to our Rural Health ODF email? It's ruralhealthodf - all one word - @cms.hhs.gov. Thank you.

(Amber): Okay, once again as a reminder, if you would like to ask a question, please press Star 1. Our next question comes from Ken Wolfgang. Your line is open.

Ken Wolfgang: Thank you. I recently had an opportunity to consult various Hospital Chargemasters that are posted online. And with the variable descriptions that are posted and no reference HCPCS or no reference CPT codes, it's very difficult to select and compare pricing between facilities.

I know there's been controversy regarding posting CPT codes, but has there been any solution or resolution to that so that there can be from institution to institution, comparison in prices? Thank you.

Terri Postma: Yes, thanks for your question. This is Terri. We agree with you, which is why in this year's OPPS Proposed Rule, we are proposing that when hospitals post their standard charges, they do so in such a manner that the charges can be compared in an apples-to-apples way across hospitals.

So, for example, by including certain data, like common billing codes, for example, in the data file. So, that's part of proposals and if there are any additional data points that you feel would be important for being able to compare those prices across hospital settings, we would appreciate your comments on that.

Ken Wolfgang: Thank you.

(Amber): And as a reminder, if you would like to ask a question, please press Star 1 and record your name. We have no other questions coming through at this time.

Jill Darling: All right. Well, thank you everyone for joining us today. We know there was a lot of information and we hope it all helps. So, thank you and have a wonderful day.

(Amber): Thank you. That concludes today's conference. Thank you for participating. You may now disconnect.

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