



PATIENTS OVER PAPERWORK

This is the fifth issue of our recurring Patients over Paperwork newsletter, our ongoing effort to reduce administrative burden and improve the customer experience while putting patients first. In this edition, we:

- Discuss our Patients over Paperwork Rulemaking efforts and regulatory review process—including the efforts to request and address feedback through nine public comment solicitations on regulatory burden.
- Describe the clarification we made regarding billing for immunosuppressive drugs.
- Highlight how the [final rule](#) that updates Medicare Advantage (MA) and the prescription drug benefit program (Part D) reduces burden.

Medicare Fee-for-Service (FFS) Request For Information (RFI) Comments Analysis

What information did CMS Solicit?

Increasing the number of CMS' customers who are engaged through outreach by hearing directly from you on improving your experience has been, and continues to be, an important goal for CMS. As part of this commitment to engage our customers, CMS released nine Requests for Information (RFIs) in 2017 soliciting comments on:

- burdensome regulations,
- recommendations to reduce provider burdens, and
- suggestions for how to better achieve transparency, flexibility, program simplification and innovation through regulatory, sub-regulatory, policy, practice, and procedural changes.

Where did CMS Solicit Comments?

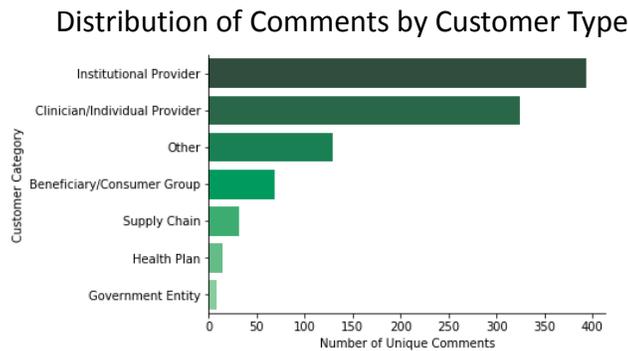
These RFIs were included in the Notice of Proposed Rulemaking (NPRM) for 9 of the Medicare FFS payment rules:

1. Hospital Inpatient Prospective Payment System (CMS-1677-P)
2. Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center

- Payment System (CMS-1678-P)
- 3. Physician Fee Schedule (CMS-1676-P)
- 4. End-Stage Renal Disease Prospective Payment System (CMS-1674-P)
- 5. Home Health Prospective Payment System (CMS-1672-P)
- 6. Skilled Nursing Facility Prospective Payment System (CMS-1679-P)
- 7. Hospice Prospective Payment System (CMS-1675-P)
- 8. Inpatient Rehabilitation Facility Prospective Payment System (CMS-1671-P)
- 9. Inpatient Psychiatric Facility Prospective Payment System (CMS-1673-NC)

What did CMS hear?

CMS received and reviewed over 2,600 comments in response to these RFIs, including submissions from over 2,194 unique institutional providers, clinicians, beneficiaries, health plans, small/rural entities, and more.



In these comments, CMS identified over 3,000 mentions of burden, which were organized into 14 categories: Each category includes burdens and recommendations related to:

- 1. Alternative Payment Models (APMs):** The regulatory requirements of the Innovation Center’s Alternative Payment Models, such as Accountable Care Organizations (ACOs) and other shared savings models, as well as episode-based payment models.
- 2. Auditing & Claims Denials:** The auditing and appeals process, including issues related to contractors and claims denials.
- 3. Documentation:** The documentation requirements, such as beneficiary notices, eligibility documentation, and the registration process.
- 4. Health Information Technology (IT):** The software requirements, interoperability policies, implementation timelines, and regulations governing data sharing.
- 5. Telehealth:** The regulations governing the delivery of telehealth services.
- 6. Workforce:** The regulations governing staffing and training, supervision requirements, and policies impacting scope of practice.

- 7. Provider Participation Requirements:** The participation requirements, including Conditions of Participation (CoPs), Requirements of Participation (RoPs), and Conditions for Coverage (CfCs).
- 8. Interagency Collaboration:** The policies or guidance requiring the involvement of multiple agencies, such as collaboration between CMS and the Center for Disease Control and Prevention (CDC).
- 9. Opioid/Substance Use Issues:** The opioid epidemic, such as the confidentiality restrictions for substance use disorder data, the Prescription Drug Monitoring Program, and prescribing practices.
- 10. Quality Measures & Reporting:** The quality measures and reporting requirements, including quality reporting programs, cost reporting, public reporting of quality data, and measure coordination across programs.
- 11. Physician self-referral law (Stark Law) and other fraud and abuse:** The burdens related to compliance with the physician self-referral law and other fraud and abuse laws.
- 12. Payment Policy & Coverage Determinations:** The Payment Policy and coverage determinations, such as billing, coding, observation status requirements, the Merit-based Incentive Payment System (MIPS), and site neutral payment policies.
- 13. Medicare-Adjacent Payment Systems:** Comments that fall outside the scope of the Medicare Fee-for-Service (FFS) payment rules, such as comments related to Medicare Advantage or Medicaid.
- 14. Miscellaneous:** Comments includes an assortment falling outside of the above burden themes, including comments related to delivery and coordination of care, translation requirements, and the regulatory process in general.

We are actively reviewing all of the burdens and recommendations received to identify opportunities to implement regulatory or sub-regulatory changes to reduce burden in our policies and programs, and have already made progress in a number of areas—including those mentioned in the [January newsletter](#). Moreover, from this feedback, CMS has continued collaborating with partners across government to address customer concerns that require the involvement of multiple agencies.

As these efforts evolve, we will continue to solicit ideas for ways to reduce regulatory burden on an ongoing basis, and look forward to working with our stakeholders to better understand their experiences with CMS regulations.

We heard you, now what?

CMS has used feedback from RFIs to drive policies that aim at reducing burden.

You told us:	Action taken to reduce burden
<p>Medicare and Medicaid EHR Incentive Programs: Providers find the EHR Incentive Program (also known as “Meaningful Use”) to be too burdensome with too many requirements that are not meaningful to providers. It is also very difficult for providers to be able to exchange health information about their patients with other providers and with patients electronically, and often don’t have the information they need at the point of care in order to be able to take the best care of their patients.</p>	<p>CMS is proposing to focus the Meaningful Use program on interoperability while reducing burden. We are placing emphasis on exchange of health information between patients and providers. CMS is proposing a new scoring methodology, new, more relevant measures, and the removal of certain measures that do not emphasize interoperability or that have been particularly difficult for providers to report.</p> <p>To learn more click here.</p>
<p>Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Conditions (HAC) Reduction Program, Hospital Value-Based Purchasing (VBP) Program, Hospital Inpatient Quality Reporting (IQR) Program: Institutional Providers and Health plans call for CMS to: Complement and refine quality measure sets for VBP, HRRP, the HACRP, and the IQR Program to focus on improvement and attainment of established goals and remove the overlapping measures from the VBP score calculation for hospitals that are penalized under the HAC program to avoid penalizing these providers twice or merge VBP and HAC into one program.</p>	<p>In response to feedback from commenters regarding Meaningful Measures (particularly those of the IQR, VBP, HAC, and HRRP), CMS has proposed to de-duplicate, review, and streamline quality measures across hospital quality and value-based purchasing programs to reduce paperwork and reporting burden on providers. These proposals will remove a total of 19 measures from the quality programs and will de-duplicate another 21 measures, while adopting 1 claims-based readmissions measure.</p> <p>To learn more click here.</p>
<p>1) Remove the requirement that Part A certification statements detail where in the medical record the required information can be found</p> <p>2) Reduce the number of denied claims for clerical errors in documenting physician admission orders by removing the requirement that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment.</p>	<p>CMS is proposing to reduce administrative burden and claim denials for minor technicalities, while still retaining important patient and program integrity standards. CMS is proposing to remove the requirement that Part A certification statements detail where in the medical record the required information can be found and the requirement that a written admission order be present in the medical record as a specific condition of Part A payment.</p> <p>To learn more click here.</p>

<p>We heard about a variety of burdens related to documentation requirements, including a lack of flexibility and an increasing amount of time spent on paperwork versus patient care. Institutional providers also discussed burdens related to the number of claims denied due to technical documentation errors.</p>	
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Documentation review:

Clarified billing for Immunosuppressive Drugs

Before: If a supplier mailed an immunosuppressive drug shortly before the end of a beneficiary’s inpatient stay and used the mailing date as the date of service, the claim could be rejected. This happened because the claim’s date of service preceded the beneficiary’s date of discharge.

After: We clarified that a supplier can use the discharge date as the date of service if mailing immunosuppressive drugs one or two days before discharge.

[Read more about the clarification in this Medicare Learning Network article.](#)

Reducing burden through Medicare Advantage and the Prescription Drug Benefit Program

On April 2, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a [final rule](#) that updates Medicare Advantage (MA) and the prescription drug benefit program (Part D) by promoting innovation and empowering MA and Part D sponsors with new tools to improve quality of care and provide more plan choices for MA and Part D enrollees. In addition to creating opportunities for innovation and additional plan choices in MA and Part D, the final changes will result in an estimated \$295 million in savings a year for the Medicare program over 5 years (2019 through 2023) – resulting in lower premiums or additional benefits.

The final rule furthers the work of Patients over Paperwork and would empower patients and doctors in making decisions about patient healthcare. Specifically, the final rule reduces regulatory burdens by:

- Authorizing CMS to permit plans to use notice of electronic posting (and provision of copies upon request) to satisfy disclosure requirements for certain bulky documents to

Medicare beneficiaries, thereby empowering patients with the information to make their own healthcare decisions;

- Eliminating requirements that plans submit, in addition to their bids, similar and overlapping accounting information;
- Making it easier for plans to communicate with beneficiaries by streamlining government review and approval of marketing materials used by plans; and
- Eliminating enrollment requirements for healthcare providers and prescribers that bring value to Medicare Advantage and Part D beneficiaries.

How can I learn more?

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