



PATIENTS OVER PAPERWORK

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

- Provide updates on how we are addressing Skilled Nursing Facilities/Nursing Homes burden.
- Describe how we are simplifying documentation requirements.
- Provide updates on where we are meeting with stakeholders to talk about burden.
- Remind stakeholders of current opportunities to provide feedback through Requests for Information and review proposed rules.

Pulse Check: Reducing Burden for Skilled Nursing Facilities/Nursing Homes

CMS has been working tirelessly to evaluate and streamline regulations and operations with the goal to reduce unnecessary burden, increase efficiencies, and improve the customer experience. This was no easy task.

We used several tactics to help us better understand burden related to nursing homes:

- Formal Requests for Information (RFI)
- Customer Centered Work Groups
- Human-Centered Design
- Engaging Stakeholders

We then identified vehicles to help reduce burden:

- Regulatory Actions
- Documentation Review
- Meaningful Measurement Framework
- Health IT
- Promoting Interoperability

Over the past year, we spent **hundreds of hours** combing through regulations, reviewing documentation requirements, reading stakeholder letters and recommendations, and going through notes and recordings from listening sessions, site visits, Subject Matter Expert interviews, and customer interviews. We listened, we learned and we acted. Today we are sharing with you how we are successfully reducing burden for one of our customer groups: Skilled Nursing Facilities/Nursing Homes.

What We Heard:

- Request for Information (RFIs)-As part of this commitment to engage our customers, CMS released nine RFIs in 2017 soliciting comments including an RFI in the Skilled Nursing Facility Prospective Payment System (CMS-1679-P). We **received 154 comments** on burden related to the nursing home experience.
- Customer Centered Workgroup-We leveraged tools such as human-centered design to capture customer perspectives as it relates to the Medicare Part A skilled nursing facility benefit. During the information-gathering stage, we spoke with **93 people** during visits to **3 nursing homes** and **hosted 22 listening sessions** around the country.

What We Learned:

- Comments from the RFIs related to the Skilled Nursing Facilities/Nursing Homes fell into 9 themes: Provider Participation Requirements, Alternative Payment Models (APMs), Documentation, Payment Policy & Coverage Determinations, Requirements for Participation, Workforce, Telehealth, and Miscellaneous. From there we grouped them and identified 15 actions CMS could take to address burden.
- During the site visits and customer interviews, we gained a better understanding that staff strive to create an environment that offers the safety, comfort, and dignity residents expect in their own home. To underscore this point, we designed our *Nursing Home Journey* map to depict residents, families, and staff interacting in a nursing home.
- Customers told us:
 - *"Unfortunately, health care has evolved into this: head in a bed, payer and a pulse—and that's it. I think everybody has lost sight of the actual... care of the patient. Nobody really looks at that anymore."*
 - *"There is more paperwork required if you decide not to care plan an issue than if you care plan an issue for which a care plan is not needed."*
 - *"Is it [admissions paperwork] really ever going to protect [the resident], or is it more to protect the facility?... Is the admissions person an advocate or an adversary?" -Family Member*

What We Did:

- 1) Skilled Nursing Facility Prospective Payment System (SNF PPS) (CMS-1696-P)

On April 27, 2018, the Centers for Medicare & Medicaid Services (CMS) [issued a proposed rule](#) [CMS-1696-P] outlining proposed Fiscal Year (FY) 2019 Medicare payment updates and proposed quality program changes for skilled nursing facilities (SNFs).

- Proposed a new case-mix model, Patient-Driven Payment Model (PDPM), to be effective October 1, 2019, which would move Medicare towards a more unified post-acute care payment system that better accounts for resident characteristics and unique care needs of the patient while also reducing significantly the administrative burden associated with the SNF PPS. PDPM would simplify complicated paperwork requirements for performing patient assessments by significantly reducing reporting burden (**approximately \$2.0 billion over 10 years**), helping to create greater contact between health care professionals and their patients.
- We reviewed the SNF Quality Reporting Program (SNF QRP) measure set in accordance with the [Meaningful Measures Initiative](#), and we are identifying how to move the SNF QRP forward in the least burdensome manner possible. In this proposed rule, we are proposing to adopt an additional factor to consider when evaluating measures for removal from the SNF QRP measure set. This factor takes into account costs that are associated with a measure and weighs them against the benefit of its continued use in the program.

2) Request for Information (RFIs)

We are actively addressing the 15 actions identified from the SNF comments, of which we have completed 2. Below is an example of how we listened to the RFI comment and were able to resolve it.

You said: “It makes us frustrated as leaders, because you think you've mastered the survey process, but we don't know how folks are interpreting it”

We listened: Nursing homes expect CMS and policy makers to understand their reality and be held accountable for conveying clear and specific expectations around rules. However, this is difficult due to updated rules and regulations that make them feel as if their "hands are tied."

We heard you: Facilities should refer to guidance in Appendix PP for information on the standards for compliance and how it will be used in the survey process.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf On September 7, 2017, we released a facility assessment tool that helps a nursing home determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.

3) Nursing Home Customer Centered Workgroup

- We're improving our webpages to better explain new initiatives aimed at reducing provider burden and to solicit further public feedback.

What Have We Already Done?

We continue to make progress in simplifying or clarifying existing documentation requirements. Today we'd like to highlight a change in procedures for therapeutic shoe inserts.

What needed updating? Allowing payment for therapeutic shoe inserts made with current technology.

Why was it updated? Suppliers, podiatrists, orthotists and prosthetists were not allowed to bill for therapeutic shoe inserts made using digital images, without an actual impression of the patient's foot.

What are we doing now? We changed the definitions in our Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Quality Standards to allow payment for these inserts. A new code for these inserts was effective April 2018.

For more information see the final [DMEPOS Quality Standards](#).

For more examples of newly simplified documentation requirements please review past newsletter issues.

How Can I Provide Feedback?

Please send suggestions about what documentation requirements we can improve to ReducingProviderBurden@cms.hhs.gov. Visit our webpage on [simplifying documentation requirements](#) for more information. You may also visit our Center for Program Integrity [events](#) webpage to connect with us in person, via webinar, or on one of our national calls.

What Are We Hearing?

Additionally, we have been conducting listening sessions across the country to understand burden as it relates to hospitals, nursing homes, beneficiaries, and clinicians. Over the past month, we met with the following stakeholders:

- From April 17-19, we conducted listening sessions and rural provider outreach in southern California. We discussed ways to reduce burden in multiple sectors of the health care industry in order to improve access to care and support innovation in care delivery.
- On April 20, CMS conducted a listening session with the American College of Physicians to hear firsthand about many burdens facing the physician community.

- On May 8, CMS conducted a listening session with the hospital stakeholders who shared burdens relevant to reporting including quality reporting, conditions of participation, certification and accreditation, billing and cost reporting, and clinician documentation and health records.
- On May 9, CMS conducted a listening session with the rural health providers to learn about burdens related to rural hospitals.
- On May 24, CMS conducted a listening session with senior counselors and providers to learn about burdens related to beneficiaries.
- On June 27, CMS conducted a listening session with leaders to learn about burdens related to beneficiaries receiving medical supplies.

Opportunity to Provide Feedback

Medicare Physician Fee Schedule and Quality Payment Program

The Centers for Medicare & Medicaid Services (CMS) proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation’s healthcare system and help restore the doctor-patient relationship by empowering clinicians to use their electronic health records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes.

If the proposals were finalized, clinicians would see a significant increase in productivity – leading to substantially more and better care provided to their patients. Removing unnecessary paperwork requirements through the PFS proposal would save individual clinicians an estimated 51 hours per year if 40 percent of their patients are in Medicare. Changes in the QPP proposal would collectively save clinicians an estimated 29,305 hours and approximately \$2.6 million in reduced administrative costs in CY 2019.

Public comments on the proposed rules are due by September 10, 2018.

For a fact sheet on the CY 2019 Physician Fee Schedule proposed rule, please visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html>

To view the CY 2019 Physician Fee Schedule proposed rule, please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf>

For a fact sheet on the CY 2019 Quality Payment Program proposed rule, please visit: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf>

To view the CY 2019 Quality Payment Program proposed rule, please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf>

For a fact sheet on the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration, please visit: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12.html>

CMS seeks public input on reducing the regulatory burdens of the Stark Law

One of the top areas of burden identified through the RFI process was compliance with the Stark Law and its accompanying regulations. CMS is now soliciting specific input on a range of issues identified with the Stark Law to help the agency better understand provider concerns and target its regulatory efforts to address those concerns.

CMS is particularly interested in the public's input on the structure of arrangements between parties that participate in alternative payment models or other novel financial arrangements, the need for revisions or additions to exceptions to the physician self-referral law, and terminology related to alternative payment models and the physician self-referral law. **Public comments on the Stark Law RFI are due by August 24, 2018.**

To view a blog by Administrator Verma, please visit: <https://blog.cms.gov/2018/06/20/working-together-for-value/>

The RFI can be downloaded from the *Federal Register* at: <https://www.federalregister.gov/public-inspection/current>

2019 Proposed Rules that aim at reducing burden

To view the Fiscal Year 2019 proposed rules posted at the *Federal Register* and a CMS fact sheet on each of the proposed rules, please visit the appropriate links:

- **Skilled Nursing Facility Prospective Payment System (SNF PPS) (CMS-1696-P)**, please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-09015.pdf> ; see the CMS SNF PPS Fact Sheet at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-4.html>
- **Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS), (CMS-1688-P)**, please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-08961.pdf>; see the CMS IRF PPS fact sheet at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27.html>

- **Hospice Wage Index and Payment Rate Update**, (CMS-1692-P), please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-08773.pdf>; see the CMS Hospice Wage Index & Payment fact sheet at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-3.html>
 - **Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)** (CMS-1690-P), please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-09069.pdf>; see the CMS IPF fact sheet at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-27-2.html>
 - **Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS)** (CMS-1694-P) please visit: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-08705.pdf>
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