PATIENTS OVER PAPERWORK

In this seventh issue of our Patients over Paperwork newsletter, we are giving you an update on our ongoing work to reduce administrative burden and improve the customer experience while putting patients first. In this edition, we highlight our progress on burden reduction efforts:

- Give you an overview of how we are reducing burden in 2018.
- Update you on our Requests for Information (RFI) process, including our progress in addressing comments.
- Describe how we are engaging with customers through our customer centered workgroups.
- Update you on our proposed and final rules that aim to save money and reduce burden hours.
- Update you about our documentation simplification efforts.
- Highlight our other initiatives that reduce burden.

How are we reducing burden?

Over the past few years, stakeholders have been telling us about regulatory burden and that paperwork is increasing. We have listened and made a thoughtful plan, the Patients over Paperwork initiative, to address burden across our programs. Patients over Paperwork's goals are to:

- Reduce unnecessary burden.
- Increase efficiencies.
- Improve the patient experience.

First, we tried to fully understand providers' concerns about burden, especially where they were feeling burden the most. We did this in 2 parts through Requests for Information (RFIs) and customer engagement. Last year, we issued 9 RFIs to solicit comments on burden. We received 2,800 comments and have been working over the past 6 months to address them.

We also realized that RFIs alone were not enough to understand the burden providers feel when they are delivering care. We established 4 customer centered workgroups and traveled across the country to visit health care facilities and speak directly with care providers, beneficiaries, and patients.

Second, we addressed burden through the Federal Rulemaking process. As of September 2018, we have proposed and finalized a number of rules that directly reduce burden and give

providers more time with patients. We estimate that across rules finalized in 2017 and 2018 and current proposed rules CMS **projects savings of nearly $5.2 billion and a reduction of 53 million hours through 2021**. That means **saving 6,000 years of burden hours** over the next 4 years!

Recently, we released a proposed rule to lift unnecessary regulations and ease burden on providers. The updates collectively would **save health care providers an estimated $1.12 billion annually**. Many of the proposed provisions simplify and streamline the Medicare Conditions of Participation and Requirements for Participation for facilities so that health and safety standards can be met more efficiently. You can get more information in our fact sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-proposed-regulatory-provisions-promote-program-efficiency-0
You can also electronically submit comments through our e-Regulation website here: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking

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What did we learn from our RFIs?

To reduce burden, we had to understand:

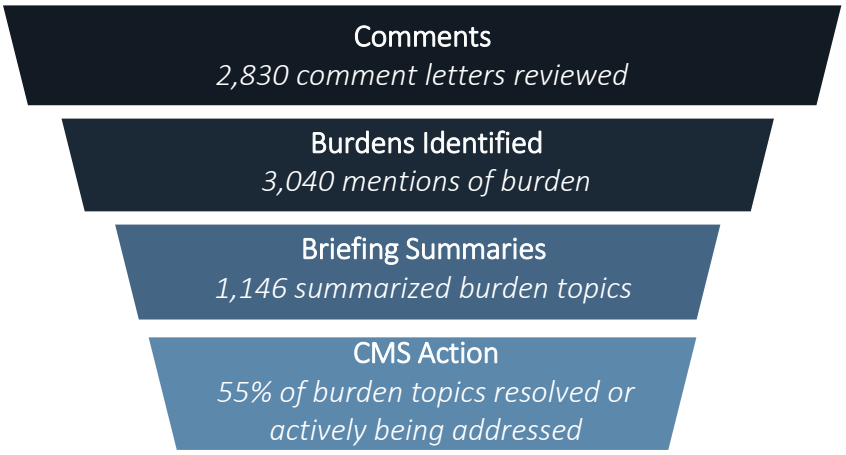
- Where providers felt the most burden.
- What their big pain points were.
- How we could solve them.

Last year, we issued RFIs to solicit comments on burden reduction, flexibilities, and efficiencies through the annual rulemaking process for 9 Medicare Fee-for-Service payment rules. We **received over 2,800 RFI responses** from 7 stakeholder groups: Beneficiary/Consumer, Clinician/Individual Provider, Institutional Provider, Government Entity, Health Plan, Supply Chain, and Others.

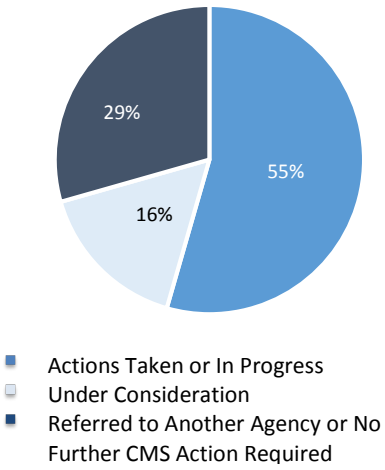
Our policy analysts spent hundreds of hours reviewing comments and identified 3,040 mentions of burden. We synthesized and consolidated the 3,040 comments into **1,146 burden topics.** Examples of burden topics include: time intensive auditing/compliance practices across provider settings, time-consuming prior authorization requirements, lack of uniformity in home health eligibility documentation requirements, and Repetitive Medicare Secondary Payer Questionnaire (MSPQ) process.

As of July 2018, we identified 284 actions we have taken or are taking in response to the RFI burdens, **addressing 624 (55%)** of the 1,146 burden topics. An additional 185 burden topics (16%) remain under consideration, and 337 (29%) were either referred to another agency or decided they didn't require further action.

RFI Data Analysis Work stream



Burden Topic Action Status



For example:

Burden identified in RFI comment: Program compliance costs, such as those associated with beneficiary notices and requirements to deliver, explain, log, and continually support related provider-patient interactions, sometimes outweigh the clinical value of the policy or program.

Recommendation: Consider revisiting notice requirements and condensing them into fewer, more concise notices that redirect beneficiaries to other resources. Maintain most information in the beneficiary manual (Medicare and You), provided to all beneficiaries.

Action taken: In January 2018, we released a newly revised Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN), which eliminated the need for the 5 SNF Denial Letters and the Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF).

What did we learn from our customer centered workgroups?

While we were reviewing RFI comments about burden, we were also busy looking for ways to reduce burden for consumers. To start, we focused on 4 customer segments:

1. Nursing homes
2. Beneficiaries
3. Clinicians
4. Hospitals.

To understand the customer experience, we left Washington and went into the field. Over the past year, we have traveled the United States engaging customers in various health care delivery settings.

We met with providers, beneficiaries, family members, caretakers, and health care clinical and support staff. **We conducted 21 site visits, nearly 300 customer interviews and 97 Subject Matter Expert interviews, and held 73 listening sessions and other engagement activities**. From this, we were able to learn from our customers in a fuller way how our policies impact care delivery and innovations they are trying to advance.

Workgroup	Site Visits	Customers Interviewed / Observed	SME Interviews	Additional Activities (Listening Sessions, Road Shows, Bus Tours)
Nursing Home	3	64	41	22
Beneficiary	2	46	22	2
Clinician	9	32	8	28
Hospital	7	151	26	21

What we heard:

- "Clinicians have become data entry staff. We spend twice the amount of time entering data in the electronic medical record than the time we actually spend seeing and treating our patients. We hire people to deal with paperwork. DEATH BY A THOUSAND CLICKS!" (Clinician)
- "Continue this open dialogue from staff allowing us to identify issues. Involve many different job titles, including [physicians]. Know that we appreciate what you [are] doing [with Patients over Paperwork] and we want to work together to make healthcare better." (Hospital Executive)
- "Streamline it. Streamline the measures. Streamline the consistency. Streamline the process. Consistency. Why do all the measures have to be different ways, different times, different periods? Have some consistency in time frames, reporting methodology. Streamline the methodology. And realize that this electronic reporting is not all necessarily labor-free." (Hospital Executive)

Some ways we addressed concerns:

You said: Requiring teaching physicians to re-document most updates made by medical students in the patient record as part of a billable Evaluation and Management (E/M) service created burden.

We listened and acted: As of January 1, 2018, a teaching physician may rely on the medical student documentation and verify it rather than re-documenting the (E/M) service. In those cases, Medicare Administrative Contractors shall consider the documentation requirement met if the teaching physician signs and dates the medical student's entry in the medical record.

You said: Facilities spend countless hours requiring duplicative questionnaires be answered at the time of admission and reviewing and documenting where in the medical record required information can be found.

We listened and acted: We are reducing burden by removing the admission order documentation requirement in an effort to reduce duplicative documentation requirements. We believe this requirement will continue to be appropriately addressed through the enforcement of the hospital conditions of participation, as well as the hospital admission order payment requirements.

How has regulatory action helped?

We have issued a number of proposed and final rules that, in part, aim to reduce burden and have made a lot of progress. We estimate that across rules finalized in 2017 and 2018 and current proposed rules CMS **projects savings of nearly $5.2 billion and a reduction of 53 million hours through 2021**. That means **saving 6,000 years of burden hours** over the next 4 years!

Burden Reduction Impact:

Total projected savings from rules finalized in 2017 and 2018

Savings reflected from 2018-2021 equals $5.2 billion and 53 million hours

Provider Types	Dollars	Hours
Accountable Care Organizations (ACOs)	$3.9 million	45,000
Ambulatory Surgical Centers (ASCs)	$1.4 billion	915,000
Clinicians	$15 million	17.5 million
End Stage Renal Disease (ESRD)	$56 million	633,000
Home Health	$496 million	8.4 million
Hospice	$269 million	1 million
Hospital	$1.2 billion	14 million
Long Term Care	$497 million	6.6 million
Rural/Federally Qualified Health Center (FQHC)	$100 million	950,000

Note: Provider breakdown is a subset of the overall projected savings and does not include all provider type categories

Regulatory action taken to reduce burden:

- **Physician Fee Schedule (PFS) including Evaluation and Management (E/M)**
  You said: Stakeholders maintain that CMS evaluation and management documentation guidelines are outdated, complex, ambiguous, and that they fail to distinguish meaningful differences among code levels.

We listened: CMS acknowledged that the current guidelines create an administrative burden and increased audit risk for some providers. We proposed a number of recommendations for E/M visits to begin the discussion. Currently, we are in the process of reviewing each and every comment and suggestion we received. We thank the clinician and provider community for engaging with us in this process.

- **Medicare Hospital Inpatient Prospective Payment System (IPPS) & Long-Term Care Hospital (LTCH) Prospective Payment System**
  This rule incorporates a variety of changes in response to stakeholders' suggestions about ways to reduce burden for hospitals. **Overall, the rule will reduce the number of hours hospitals spend on paperwork by about 2 million hours.** For example: Removing the requirement that certification statements detail where in the medical record the required information can be found.

- **Nursing Homes**
  The Skilled Nursing Facility PPS final rule reduces unnecessary burden on providers by easing documentation requirements and offering more flexibility. As part of our actions to modernize Medicare, the SNF PPS rule makes an innovative new classification system, the Patient Driven Payment Model (PDPM). The PDPM ties skilled nursing facility payments to patients' conditions and care needs rather than volume of services provided. PDPM simplifies 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.

- **Inpatient Rehabilitation Facilities**
  The rule finalizes a variety of changes in response to suggestions from the public on ways to reduce burden for IRFs. In addition to policies that reduce the number of measures IRFs are required to report, we are reducing burden by easing documentation requirements and providing flexibility in several areas. The final rule will ***reduce regulatory burden for IRF providers by well over 300,000 hours***.

- **Hospices**
  This rule enables more efficient use of Hospice Compare data in the Hospice Quality Reporting Program by no longer directly displaying the 7 component measures from which a composite measure is calculated on Hospice Compare. We would still provide the public the ability to view these component measures in a manner that avoids confusion on Hospice Compare.

- **Home Health Agencies**
  In an effort to reduce unnecessary burdens for physicians, we are proposing to eliminate the requirement that the certifying physicians estimate how much longer skilled services are required when recertifying the need for continued home health care. This proposal is responsive to industry concerns about regulatory burden reduction and

could reduce claims denials that solely result from an estimation missing from the recertification statement. **We estimate that this proposal would result in annualized savings to certifying physicians of $14 million beginning in calendar year 2019.**

- **End-Stage Renal Disease (ESRD)**
  This proposed rule takes significant steps forward by strengthening quality incentives and reducing administrative burden. Based on stakeholder feedback, we plan to reduce ESRD facility-related documentation burdens for certain payment adjustments so that requirements are more consistent with other payment systems. We are also proposing to update the measure set for the ESRD Quality Incentive Program so that it's more closely aligned with the quality priorities the agency has adopted as part of the Meaningful Measures Initiative.

What is the Documentation Requirement Simplification Initiative?

We are simplifying Medicare documentation requirements so clinicians spend less time on paperwork, including confusing and time-consuming claims documentation, allowing for more time with patients. We have made some important changes already: In the past year, **we completed 9 sub-regulatory documentation requirements simplifications**.

Here are some of our most recent simplifications:

1. Simplified the requirements for preliminary/verbal Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) orders.
Before: Our instructions were not clear about whether preliminary (verbal) orders for DMEPOS items were conditions of payment.
After: Suppliers may dispense most items of DMEPOS based on a verbal order or preliminary written order from the treating physician. However, Medicare medical review contractors will look to the signed, written order to see if the item meets our payment requirements.
View the change request for more information.

2. Clarified DMEPOS written order prior to delivery date requirements.
Before: There was confusion about whether contractors needed to verify that a written order was received by checking for a fax transmittal date or a date
stamp.
After: If the written order is dated the day of or prior to delivery there is no need for affirmative documentation of its being "received."
View the change request for more information.

What are our cross-cutting initiatives?

We are committed to reducing burden across our whole agency. We have launched several initiatives that make up Patients over Paperwork and they all have the same goal: making patients our top priority.

Meaningful Measures

Our Meaningful Measures initiative is centered on: patient safety, quality of care, transparency, and making sure the measure sets providers are asked to report make the most sense. The modernizing proposals to advance our Meaningful Measures Initiative have or will **eliminate 105 measures resulting in projected savings of $178 million and an *anticipated reduction of 4.6 million burden* hours!**

- In the Inpatient Prospective Payment System and Long-Term Care Hospital (IPPS/LTCH) PPS final rule, we are removing unnecessary, redundant, and process-driven measures from several pay-for-reporting and pay-for-performance quality programs. The final rule eliminates a number of measures acute care hospitals are currently required to report across the four hospital pay-for-reporting and value-based purchasing quality programs. It also "de-duplicates" certain measures that are in multiple programs, keeping them in the program where they can best incentivize improvement and maintaining transparency through public reporting. **In all, these changes will remove 18 measures from the programs and de-duplicate another 25 measures.**

- We are making a variety of other changes to reduce the hours providers spend on paperwork through hospital quality and value measures. This new flexibility will allow hospitals to spend more time providing care to their patients, thereby improving the quality of care their patients receive. Overall, changes in the hospital quality and value measures across the four programs will **eliminate more than 2 million burden hours for hospitals impacted by the IPPS/LTCH PPS rule, saving them about $75 million annually** after these changes take effect.

My HealthEdata & Interoperability

MyHealthEdata aims to empower patients by ensuring that they control their health care data and can decide how their data is going to be used, all the while keeping the information safe and secure.

- To further spur innovation in this era of digital health, CMS has recently released Medicare Advantage data sets and next year we expect to make Medicaid and Children's' Health Insurance Program (CHIP) data available. These data sets will provide researchers and innovators with data on a new population of 74 million beneficiaries.
- We believe the future of interoperability centers on digital health and the implementation of APIs. We are committed to requiring that providers begin using 2015

Edition certified electronic health record (EHR) technology starting in 2019 because this version opens APIs.

- Recently, we overhauled the Meaningful Use programs changing the name to the "Promoting Interoperability" programs. This is more than a name change, it is a change in direction for the programs – from programs that support the adoption of health IT, to programs that promote interoperability and patient access to data.
- When we announced MyHealthEData, we also unveiled Blue Button 2.0. -- a developer-friendly, standards based API, which will allow a majority of Medicare beneficiaries to connect their claims data to third party applications, services, and research programs. There are **now 600 developers signed up to experiment with this API**, more than doubling participation since March of this year.

How can I learn more?

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