Centers for Medicare and Medicaid Services
Rural Health Open Door Forum
Moderator: Jill Darling
Thursday, April 5, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Jack) and I will be your conference facilitator today. At this time, I would like to welcome everyone to Centers for Medicare and Medicaid Services Rural Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw the question, press the pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Jack). Good morning and good afternoon everyone. I am Jill Darling in the CMS Office of Communications. And welcome to today's Rural Health Open Door Forum.

Before we get into – before I hand the call off to John Hammarlund, I have one brief announcement. This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen and please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact CMS at press@cms.hhs.gov.

So now I'll hand the call off to our co-chair, John Hammarlund.

John Hammarlund: Thanks so much, Jill. Well, hello everybody thank you so much for joining the call and welcome. I also want to thank our colleagues, my

colleagues in CMS headquarters for being on today's call. And also to thank the regional rural health coordinators, one of them is in each of the 10 regional offices for CMS for joining the call as well. You will note that we have only one agenda item, but as my mom used to say it's a doozy.

And we are absolutely delighted and honored to have Jean Moody-Williams with us today. Jean is the deputy director of the Center for Clinical Standards and Quality at CMS and he's really the leader and mover behind our Patients over Paperwork initiative. So you are getting it from the proverbial horse's mouth today. We are delighted to have Jean on this call to talk to you about this very important initiative and we hope to answer your questions.

So with that, I will hand it back over to Jill and again welcome everybody to today's call.

Jill Darling: Thank you, John. And I will now hand the call off to Jean Moody-Williams.

Jean Moody-Williams: Thank you, Jill and John, and hopefully I can live up to being a doozy. We do have really a quite a bit to talk about today. A number of things that are happening within CMS and hopefully much of this is a review; I hope that you have heard about the number of activities as we've been trying to get the word out in a number of ways to speaking or newsletters all of which of course are available on our website. But I will give you some highlights and then refer you to few resources, if you would like to get a little bit more information.

Last year at CMS we established an internal process to evaluate and streamline regulations. We really had a goal to reduce – we had three things we wanted to reduce unnecessary burden. We wanted to increase efficiency and also to improve the beneficiary experience. And with this – with these aims, we really were looking to have a number of satisfied customers and I mentioned the beneficiaries as we look at always putting our patients first. But that also included the experience that the clinicians, institutional providers, health plans, those that are engaged all across the country whether that be in the urban area, a rural area, communities all across to really look at how we can engage as we try to reduce burden and improve experience.

When we look at this, we want to decrease the number of hours and the number of dollars, healthcare dollars that providers spend on CMS mandated compliance and increased the proportion of tax that customers can do digitally. So and get away from the paper. And that's where we came up with the term Patients over Paperwork and that's the name of this initiative of Patients over Paperwork.

And I've mentioned the word reduce and streamline quite a bit already. But I do have to mention that I am and have been most of my professional career probably improvement professional. So as we do this work, first and foremost, we want to ensure the best possible care for patients and families. And so we've been listening patients regarding improvements needed and reducing obstacles for clinician, but balancing those things that we do because of safety with those things that really we don't necessarily need to do.

And I would like to state that because when I started talking about some of the things that we are reducing there is a concern well are you really fulfilling your oversight responsibilities. And I guarantee you we keep all of that in mind.

But we publish a lot of paper and I know this audience knows that because you get the benefit of reading all of that, nearly an 11,000 pages of regulations each year. Now that doesn't happen just because we like to write a lot. Often times we race to adjust the next year's requirement. There is little time in between or we have a new piece of legislation to adjust. And we have not always taken the time to pause and go back to see what kinds of things we can eliminate.

What are the advancements and technology or science in evidence that have been made that maybe able to help us change the way that we've thought about things. What kinds of improvements have been made that have been accomplished and we no longer need to have that particular regulation that we had. So that's exactly what we are doing.

And an example of what I am talking about, we had a claims that were being denied for chemotherapy agents because the nurse's administration record was initialed rather than signed. And regulation said well it had to be signed. So when you went back to the medical record, it was clear that the chemotherapy was provided, the nurse had initial providing it, but the service was denied. And those are the kinds of things we are going through to say what does that – is that really accomplishing the goal of getting the patients what they need and paying for those things that we should be paying for.

We also of course as we've got about doing listening sessions; several things have kind of risen to the top in the area of burden including some of our measurement activity, quality measurement activity that I am going to talk about in just a bit. Some of the activity related to electronic health records and documentation among other things.

So we sought out as I said over a year ago to begin to work through this to our Patients over Paperwork initiative. And exact – so what exactly are we trying to do as we engage our customers and our stakeholders and to helping us identify these areas of burden and wait. And how exactly are we doing it?

So I want to spend a few minutes on that because if you don't really have an implementation plan, sometimes this just becomes slogans or phrases that are hollow and we certainly don't want that.

So what are we doing? We have established as with any initiative of this type, there has to be leadership at the top that's committed to making change. And so we have established an executive level burden reduction steering committee that really helps to coordinate a reduction activities across the agency.

And this becomes important as we might be changing something on one side of the house that has an unintentional consequence on another side of the house. Or that has the consequence to a clinician practice or a beneficiary's health. So we have to look across the entire agency to see what a change will mean when we make one.

We also having had that leadership which of course our Administrator Seema Verma is an active leader of that and all of us at the executive level sit on that steering committee. In addition, we established customer centered workgroups.

And so through these customer centered workgroups we are looking at burden through a stakeholder's lens by establishing these workgroups with beneficiaries, skill nursing facility, hospitals, hospice, a number of different areas where we are looking at institutions, clinicians, beneficiaries using a human centered design approach, which many of you on the line are undoubtedly familiar with which really is I guess a big term for going out and observing what's going on in the field. How people, what pain points are they realizing as they implement the policies that we have created; sitting at a computer with someone in a dialysis facility that's trying to enter information into CROWNWeb; looking at a clinician, practice manager who is putting information into the system for Quality Payment program; and or going and following nurse's assistant, a medical assistant around a skilled nursing facility to see what they have to do to gather information.

I mean I can go on and on about the different kinds of things that we are observing. And then holding listening sessions with the billing office and the housekeeping and marketing just to see how these policies impact what's going on in the field.

For the skilled nursing facility, which is one of the first that we started and we are still working on that, but have made a lot of progress. So today, we have conducted more than eight listening sessions across the country. We have more planned in regional offices. We've done at least three or more site visits to nursing facilities. And we've had interviews with more than 86 subject matter experts in a wide variety of areas using this human centered design tools to collect information. So that's kind of the people side of it, the customer side of it, hearing directly in probably a more natural environment.

But we are also doing more formal processes through request for information. So CMS feedback related to final rules published in 2017 by including a request for information on burden and I am sure that you saw that and hopefully you responded to that. In fact, I know that many of you did because we've received over 2,600 comments. And we've reviewed each and every one of them. And we had to present them to the administrator. And through those discussions, we talked about an action for each one of the comments that we received.

For example some could be just a rulemaking. And you will see that in our upcoming releases of our rules, soon our fiscal year rules and then after that the calendar year rules. I think you'll be able to identify where we took comments that we received from the RFI and apply them. And but not everything requires addressing through rulemaking. We could address some of these things through sub-reg. And so we are looking at some of our practices, our guidances, our state letters, all of those kinds of things to see what we can change there.

And then interestingly some things we found was really just requiring clarification. Perhaps a misunderstanding has surfaced of what the intent of a particular policy was and how it has been interpreted. So that in and of itself was really very useful.

Now you'll recall I also mentioned documentation rose to the top when we had our initial listening sessions. And so we are working to simplify documentation requirements so that healthcare providers can spend less time on paper works and more time on partnered with patients.

And we are doing this with our Center for Program Integrity because this again we are working across the agency and many of these things that we have are to ensure program integrity so they are actively involved. Generally, I'll get a question yes, you are doing this on one end, but if somebody is going to come behind on the backend and ding me for something because it wasn't there. So that's why we are working closely together with CPI.

We have – they have actually updated six requirements and there are dozen more in the queue. And this could be found on our website under there is a link on the Patients over Paperwork part of the website they can take you. But let me give you an example of one that we recently did.

We revised the manual instructions to allow teaching physicians to verify in the medical record the student documentation of billable services of an exam or a medical decision of the history and physical that they may have conducted for patient. So prior to this if the student went in and get the physical exam the – and then signed off on it, the teaching physician would have to come back in, verify the exam and then rewrite the entire thing.

So now the teaching physician still has to verify it because it is a medical student to make sure age is correct, but then if it is correct rather than having to rewrite the entire thing, they can simply sign off on that particular work.

We also have implemented the policies surrounding the use of scribes as it relates to electronic health records. I have had the opportunity to go out and do a number of speaking engagements over the last couple of months and hearing how certain practices are using this ability to help make the practice of documentation and the EHR more efficient and given them more time with their patients.

And we've clarified guidance to contractors requiring some of the requirements that they have to complete to build for intensive rehab therapy for example. We are in the process of making many of the submission of documentation electronic trying to get rid of the – you probably wouldn't be surprised that the number of things that has to be faxed would in fact many people would rather submit it electronically. So those are just a few examples of what we are doing when it relates to documentation.

So I've covered kind of the regulations. I've covered now some of the things that we are doing in the area of documentation. But quality measurement, which of course something I am very familiar with sits in our center, also rose to the top. So we are getting to do a lot of work as well.

And what we of course heard was the need to add – make the measures meaningful that they really add value to the patient's experience and provide useful information to the clinician. And this too is an area where we have to balance because the patients and their families and their caregivers are requesting more and more information to be able to help them make decisions particularly as our healthcare system converts or transition transforms to value-based care, where we are asking them to make more decisions and participate in the process, at the same time, not having checkbox measures that are really not doing anything to help the process for clinicians. So we had some objectives.

We wanted to make sure that – and hopefully you have had the opportunity to see the Meaningful Measures framework, which we do have some webinars that we have taped on our, we have a Meaningful Measures website on at cms.gov that can also provide additional information on this. But we were looking to see what are those areas that; are high impact? What areas are patient centered and meaningful to patients? And move into outcomes-based wherever possible.

You will note for example in a Hospital Value-Based Purchasing Program that we have moved many of the process measures out that were either topped out or didn't necessarily correlate topped out being little room for improvement left. Or didn't necessarily correlate to outcomes or those kinds of things we have taken out of the program.

And again rulemaking coming out soon, you'll be able to see some other things that we'll be proposing. And we are going to look forward to your comments to see, are we getting it right? Are there other things we should be considering? What else should we be doing?

We looked to see as we move to more alternative payment models do we have the right measures for that? Many of our measures were based on a pure fee for service model and don't work well in some of the advanced alternative payment model. So how do we bridge that gap?

And then one of the top things that I am sure you can identify with is how do we align across payers, so that we don't always have and sometimes it's necessary because states want to do different things and look at different areas but that not everything is different across Medicare and Medicaid and commercial payers.

And I can say where we announced the Meaningful Measures framework, we immediately had many partners that joined in – that wanted to join in with us to align their work with this activity. As a matter of fact, we didn't come up with this framework all by ourselves; it's drawn from work done by the National Quality Forum, The National Academies of Medicine or the IOM at the time and the Health Care Payment Learning and Action Network, which is primarily composed of commercial payers. And so we are working closely with them on this measurement framework.

And one of the six key priorities of the framework is to improve access for rural communities. Another is eliminating healthcare disparities. And there are four other high priority areas and then what we do is we take and we look at the measure that we have where are the gaps, what are those that are not fulfilling this and what additional things that we move?

Now moving slightly away from measurement, I want to talk about something that's been in the news quite a bit. Administrator Verma announced at a recent HIMSS conference is really looking at how we move the healthcare system when it comes to health information technology. And we are moving toward a healthcare system and which patients have control of their data and can easily take it with them as they move in and out of the healthcare system. That is a priority that she has clearly stated for us at the agency and for those that work with us and they partner with us.

With the CMS initiative, one of which is (My Healthy Data), patients will be empowered to make inform choices about their care leading to greater competition and reduced costs.

We launched the Medicare Blue Button 2.0, which will allow Medicare beneficiaries to receive their claims information electronically. And this will significantly improve their experience as the data will be in a universal and secure format that they can share. So we had Blue Button before, so this is not new. But if you have ever been on there, you went on and you got your claims in a PDF format.

But we are working now to allow patients to have access to their prescription records allow them to share their medical record information with the new clinician or if they are participating, for example, in a clinical trial, they'll be able to – they could give permission to the researcher and pre-populate their medication list for example.

We have our – since this announcement which happened probably back in February I think it was, in (early) February, we have attracted more than a thousand organizations, I'm sorry a hundred organizations. We hope to get to a thousand including some of the most notable names in technology innovation. And they are joining to develop programs using the data using open API access. We are expecting to see great innovation in this area.

We are also overhauling – looking at how we can encourage interoperability and save time and cost. So we are streamlining our EHR incentive program for hospitals for and that includes those and all over that participate in the Meaningful Use program as well as the Quality Payment program. And you'll see these things in the rules to come out. We want to increase the focus on interoperability and reduce the amount of effort to comply with the requirements.

And I know you are probably saying, well, it's not all on the provider. We use the tools that we have and we certainly heard that from you. So we are working with our partners at the Office of the National Coordinator, who has more of the oversight of vendors. We really don't have that kind of authority over vendors. But they are working and doing a number of things to look at how to as well promote interoperability.

We are taking steps against information blocking and looking to see how to prevent burden as we get patients the data that they need to move from one phase to the next.

Lastly, I just want to address some burden in a program that I am sure you are familiar with, the Quality Payment program. And we just closed the submission for this program on Tuesday. And while we don't have the data to share today I just can't help but stop right now and thank you all for all of the work that you did to ensure that your clinicians could participate in this program. We had a great deal of participation. We had a lot of good questions that came in and we know that it could not have been done without your help and your support, so thank you for that.

And hopefully I can come back and tell you what the submission rates were and where we can improve for year two because we still have lots of work to do. But for year two, we did try to recognize some of the challenges that clinicians in small practices in rural areas face in participating in the Quality Payment program. And our contract – our technical assistance partners have been very active in working with you all. We also finalized several policies in year two looking at the low volume threshold virtual groups avoiding points to small practices, (three) points for small practices for measures in the quality performance category that don't meet the data completeness requirements. We added a new hardship exception for advancing care information for small practices and providing side bonus points to the final score for small practices.

Now that talked about year one, we just finished submission; year two, we are in the midst of the performance period and we've implemented policies there. But year three, we have started the policy making for year three. And we will be releasing a notice of proposed rulemaking in the physician fee schedule. So we are asking you to look for that in the physician fee schedule this year. I know in the prior years, we've done it as a standalone. So but please look out for that and give us your feedback as year three policies come out.

And we have the benefit of some changes that came through a Bipartisan Budget Act of 2018. On February 9 of 2018, Congress passed the Bipartisan

Budget Act of 2018, which did contain provisions that made several changes to the merit-based incentive payment check of the Quality Payment program. And these changes were a direct result of the feedback that you all provided, that your associations provided to the Hill. And as a result we have new flexibilities. And we are going to use these flexibilities as we look – one of the big ones that we heard from everybody about was the inclusion of Medicare Part B drugs and other items and services.

It was required that we included that, which meant more people were required to participate in the program. But that concern was heard and beginning in year two of 2018 of the program, we will calculate the low volume threshold based on a lot of charges for covered professional service under the Medicare physician fee schedule. And the number of Part B patients who are also covered under the fee schedule. This means that eligibility determination will no longer include charges for Medicare Part B drugs.

Now this doesn't impact eligibility for 2017, which of course is over – the submission period is over, but it will for year two. But we will look at that for the payment adjustment.

So I am going to stop there because I think I have covered a lot of information, but you can see that we are trying to look at things holistically. And there are still a lot of opportunity through these proposed rules that come out or guidance's or just through listening sessions to give us additional feedback on things that you see we could do to uphold our oversight responsibility, but at the same time make it easier for providers to do what they need to do to take care – to provide the kind of care that they want to for their patients.

So let me see if there are any questions on that that I can answer.

Operator: As a reminder, ladies and gentlemen, if you'd like to ask a question, please press star then the number one on your telephone keypad. If you'd like to withdraw your question, press the pound key. Please limit your questions to one question and one follow up question to allow other participants time for

question. If you require any further follow up, you may press star one again to rejoin the queue. Again that's star one to ask a question by phone.

Your first question comes from the line of (Gina Goodman) with (Blanco) Medical. Your line is open.

(Gina Goodman):   My question was answered, I'm sorry.

Operator: Your next question comes from the line of (Danny Wade) with (Ascension). Your line is open.

(Danny Wade):   Hi, thank you so much for the presentation today. This was all a lot of really great information, incredibly helpful and we really appreciate everything CMS has done and is doing. My question might be just a little off topic, but I don't know if John might know this. But in line with the changes made under the BBA, we are keeping a close eye out for guidance on requirements around the low volume hospital adjuster and MDH. And I wanted to just make sure that nothing come out from CMS yet, we haven't seen it. And if we've missed it, let us know or if you all know timing on when that might happen. Thank you.

Jean Moody-Williams: John, do you want to take that. I don't – I can say I don't believe that we have released anything on that as of yet unless you are aware of anything, John.

John Hammarlund: Yes, this is John Hammarlund. I don't – I am not aware of anything yet about that. Thanks for the question.

(Danny Wade):   Thanks.

Operator: Again if you'd like to ask a question, please press star one on your telephone keypad.

There are no further questions at this time. I would now like to turn the call back over to the presenter.

John Hammarlund: And actually …

Jean Moody-Williams: I'd like to thank you before I turn it back and let you know that we are still listening. We are still here to work with you as you work through issues on anything and please feel free to reach out to me.

John Hammarlund: And this is John Hammarlund, I just want to say Jean, don't worry we most certainly will invite you back to one of the future calls. We are delighted to have you today and appreciate you providing all this information. And I just will amplify one point you made Jean mentioned that there are many ways that we are getting information from the provider community about so called pain points with their engagements to CMS in terms of reducing burden et cetera.

And she mentioned one of the sources of information are listening sessions, some of which are being sponsored by the CMS regional offices. And she also mentioned that we are being especially attuned to the needs of rural providers. And so I can't give you any definitive schedule yet, but I can let you know that definitely some of the regional offices are planning on doing special listening sessions relevant for rural communities and rural providers.

So sort of stay tuned and who knows some of you may be invited to a listening session in the future and we certainly appreciate you are giving us the input that we see. So stay tuned for that. Again, Jean, thanks so much for coming today.

Jean Moody-Williams: Sure, thank you.

Jill Darling: And now this is Jill Darling. As a reminder, I know usually (Carol) mentions on every call. If you do have any topics you would like for us to talk about, you know, we can get the proper folks in the room to talk about that. So the e-mail it is on the agenda, it's always on the agenda, its ruralhealthodf@cms.hhs.gov. So thanks, everyone. Have a great day.

Operator: Thank you for participating in today's Rural Health Open Door Forum conference call. This call will be available for replay beginning on April 5th at 5:00 p.m. Eastern Standard Time till April 9th at 11:59 p.m. Eastern Standard Time. The conference ID for the replay is 32618232. That number

again was 32618232. The number to dial for the replay is 855-859-2056.
Again that number is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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