

Centers for Medicare and Medicaid Services
First Friday Call-Clinician Outreach Meeting
Moderator: Eugene Freund
Friday, April 6th, 2018
1:30 p.m. ET

OPERATOR: Good afternoon. My name is (Heidi) and I will be your conference operator today. At this time, I would like to welcome everyone to the First Friday Call-Clinician Outreach Meeting.

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 your question, press the pound key. Thank you.

Dr. Eugene Freund, you may begin your conference.

Eugene Freund: Hi. Welcome, all, and welcome to the first spring meeting of this conference even though we are looking at a wintery, potentially a wintery weekend next in the Baltimore DC area.

I do want to mention that this is an informational meeting only and is not for the press. Press are happy or welcome to listen in but if they have any questions, refer to those the press.cms.gov mailbox.

Without any further ado, I am going to turn it over to our first presenter who is Stefanie Costello here in our Office of Communication who will be talking about the Patients Over Paperwork Initiative.

Stefanie Costello: Great. Thanks, Gene. Today, we thought we'd go over the Patients Over Paperwork Initiative with you all. Hopefully, you've heard about it, and we've kicked it off now last year in late 2017 but we've had a lot of updates in progress, and we really wanted to make sure you all understood the initiative

and everything that's going on. It's pretty big. It touches a lot of parts of the agency, and we're pretty excited about it.

So, our goal at CMS is to put patients first. We have established an internal process to evaluate and streamline our regulations, and we have several goals:

- We want to reduce unnecessary burden.
- We want to increase efficiencies,
- Make things more efficient of reporting,
- And then improve the beneficiary experience.

We want high quality, and of course, we want patient safety.

We are moving the needle to remove these regulatory obstacles that get in the way of providers spending time with patients and other healthcare consumers.

So, again, our top priority here is putting patients first. And this goes in line with President Trump's Cut the Red Tape Initiative. And CMS has established a different internal process to help go along with that.

If you follow along with the slide deck, I'm now on slide three. CMS is one of the top agencies for regulations every year. And over the past five years, we have published annually an average of 58 rules per year annually nearing 11,000 published manuscripts pages.

And while some of these regulations are essential to ensuring patient and provider safety and program integrity, we realized that some of them might be more of a burden than helpful. And so, we really want to make sure that our providers are spending more time with their patients and not on the paperwork. So, that's really what we're trying to fix.

We are applying an interesting approach to this. We're going out and we're listening to folks. We're listening to providers. We read a lot of the letters that your associations have sent to us. Some of your reports that we're seeing to understand the climate out there around burden and you all are talking about it. We want to let you know that we're hearing it.

So, an example of some of the things we heard as we were setting this up was claims being denied for a chemotherapy agent because the nurse's administration record was initialed rather than signed for a whole signature.

Requiring providers to report on several meetings for use measures that they may have been anything but meaningful to them. And so, these are some antidotes we were hearing that kind of set the stage with the type of things we've been looking at with the submission.

On the next page, this is slide five. We have set some goals for the initiative based on all of the things we've been hearing and just some of our own thoughts for putting this initiative forward.

We are aiming to increase the number of customers, clinicians, institutional providers, health plan that are engaged through direct and indirect outreach. We want to decrease the hours and dollars of clinicians and providers spent on CMS mandated compliance. And we want to increase the proportion of tasks that CMS customers can do in a completely digital way.

Now, this is a lot. These things again touched multiple parts of the agency, and what we're trying to do is see what different programs we have out there that we currently run, which ones are creating burden, and how do we simplify those.

So, we have a pretty robust approach, and that's here on page six. So, we set up an agency wide process to evaluate and streamline our regulations and operations with a goal to reduce unnecessary burden, increase efficiencies, and improve the customer experience. You'll hear those three pieces a lot.

So, one of the things we did in 2017 was we had our Request for Information, and we sought feedback related to Final Rules published in 2017 including a Request for Information on burden.

For Medicare fee-for-service, we did receive a lot of comments from that. And what we're doing now is we are going through those. We're reviewing

them, covering the nine rules that we asked for feedback on. And we're looking at all of the stakeholders that are impacted in the different programs.

So, we're really going through right now and taking a look at those RFIs. And, hopefully, you'll get a little bit more information, we're going to do a write-up on that soon, and we'll be publishing that as part of the Patient Over Paperwork newsletter, so keep your eyes up for that.

We've created customer-centered workgroups, and these are pretty great because we have identified several customer segments, its customer population that CMS touches and that we work with.

So, we've created these workgroups to focus on these certain population. So far, we have set up our Skilled Nursing Facility customers-centered workgroup. We have one on Clinicians which was set up already.

We also set up our beneficiary customer-centered workgroup, and we have a number of workgroups that we're getting ready to stand up over in the next couple of months including hospital and hospice, state, and suppliers. And they're going to be launching listening sessions, interviews, and site visits.

Because the skilled nursing facilities was launched first, we were able to conduct, just with that workgroup alone, eight listening sessions, three site visits, and 86 subject matter expert interviews.

And it helped us to get information for us to develop a journey map, and I'll show you an example of that later. The customer-centered workgroups are made up of CMS staff.

And so, you will hear more about those as process continues. We'll get updates, but note that that is going on. There is Journey Mapping on here, but I'm going to wait to talk about that as an example in one of the slides later in the deck.

And then we have our Meaningful Measures framework. So, by putting patients at the center of our work, we're determining the highest quality

measurement and improvement priorities that are the most important to improve patient outcome.

Specifically, we have Meaningful Measures which will lower provider's reporting burden, focus on quality improvement, and only the most critical areas that we adopt the most meaningful quality measures, and that we get better patient outcomes at lower cost.

We had some information about Meaningful Measures in one of our newsletters, and I'll send some things out. We'll have Gene send some things out after this call that you can read some of that and we'll have some more information about Meaningful Measures coming soon.

And Health IT is another big topic. And as you remember some of the goals earlier today that was doing things in a digital way. So, we need Health IT to do that.

You might have seen the press release or actually clicked on the video of Administrator Seema Verma giving her speech at the HIMSS conference this last March. This is where she revealed the Health IT plan, also our last Patient Over Paperwork newsletter focused on the Health IT.

So what we're doing is CMS is moving towards a healthcare system in which patients have control of their data and can easily take it with them as they move in and out of the healthcare system.

With the CMS initiative, My HealthE Data, patients will be empowered to make informed choices about their care, lead a greater, leading to greater competition and reducing cost.

CMS launched the Blue Button 2.0 which is a developer-friendly, standards-based API that enables Medicare beneficiaries to connect their claims data to the application services and research programs.

Patients will be empowered through data as CMS refocuses our Electronic Health Record incentive programs and help the healthcare providers to

streamline their data. CMS is working across the government to achieve interoperability in this health information section. So, again, Health IT is part of this.

Also promoting interoperability, you heard me touch on that. We've been working with the Office of the National Health Coordinator. We've been working with the VA. We've been working with the White House, other parts of HHS to make sure that we are all working together to get the best outcome for our patient.

And, lastly, is engaging stakeholders, and we're doing that through a number of ways. You heard me talk about the listening sessions that we're doing. We're planning on going out over this next year and doing listening sessions at the state level, at national conferences, meetings like this where we can let you know about Patients over Paperwork.

And there might be opportunities over the next several months where we might need some of your input. We really want to make sure that you're all engaged and that you're – that we're really hearing what your pain points are or what works through you, and that we are making those improvements.

And with that ,we also want to make sure that you all heard about the improvements we're doing, and that you all are seeing that we are moving the needle forward. So, this is kind of our big approach. And like I said earlier, these initiatives are really big so it touches a lot of different programs.

So, here is a little write-up about our customer workgroup that I talked about earlier. These customer-centered workgroup goal is to learn and understand the customer experience and internalize it. Remember those perspectives as we did work overtime or establish similar workgroups for health plans, states and suppliers.

So, the customer-centered workgroups are comprised of CMS staff but we have, we are using these workgroups to be able to go out and listen and to do the site visits and gather those customer experiences. And from there, we created a journey map which I'll get to in a little bit.

We have been, on slide eight we have a customer defined burden. We had decided to use tools to capture these customers' perspective. We are using human-centered design; that's the approach that we're using but the tech industry, businesses have been using this for years.

The academic settings have been using this for a while, and we're utilizing these now for the work of really understanding burden and putting the customer at the center of everything, thus, creating these journey maps.

And we're also going to establish mechanisms across CMS to share and learn for the work and from the input that our customers have given.

So the next slide here is our clinician journey map, a Medicare fee-for-service, and you all can take a look at this. And this is an example of one of the journey maps.

And as we get our customer-centered workgroups that have the more of the site visits, we'll be releasing additional journey maps for every customer segment. When we release those, we'll be putting them out through our Patient Over Paperwork newsletter that goes out monthly as well as posting them online.

And so, we'll make sure that Gene gets that information as well once it's up and running. But this is just an example of a journey from the clinician and their talks about their pinpoint. And we'll also take some time to look at that later but this is just an example to one of the journey maps that we've created.

So, that's a lot I've share with you all in the last 10 minutes, but I wanted to give you all some resources to be able to look at your, look at on your own.

The first is we have our Patients Over Paperwork initiative. You can get to it from the URL. If you go to cms.gov, it's the headlining story, so you can also click on the right from cms.gov.

And these are our newsletter. They come out monthly, and you can sign up for it here. It's with the regular HHS CMS sign up process, so if you already

sign up to receive quality payment programs information, and now you want to get this, you can go in there and just click Patients Over Paperwork and it will take you there. And then all about the past newsletters are posted on this URL here. So, these are some of our resources and we definitely encourage you to take a look at this.

So, that's all I have today but I wanted to be able to have some time to, for you all to ask some questions. So, we can open it up for questions at this time.

Operator: As a reminder, if you would like to ask a question, please press star then one on your telephone keypad. And we'll pause for a moment to see if we have any questions.

Again, that's star then one to ask a question. And you have a question from the line of Robert Tennant with Medical Group Management. Please go ahead. Your line is open. Robert Tennant, please unmute your line and go ahead.

Robert Tennant: Thanks so much for that update. What we're interested in the MEPS program. Can you give us a sense of (A) when the regulation for the 2019 program will be released and if it would be a significant change from the 2018 program? In particular, we're looking at the length of time to report quality measures. Thank you.

Stefanie Costello: Eugene, do you want to take that one?

Eugene Freund: I don't have a clear answer to that one at this point other than as we do the work and that those kind of fit into the clinician workgroup.

One of the things, a couple of the things we have heard is that we can mess things up by changing things too much to be, in the interest of improving things. I don't know where current regulations are as far as MEPS goes.

Stephanie, do you know?

Stefanie Costello: Yes. I'm not, I'm not sure. We can get back to you. I know I'm just trying to go back. I know a couple of things came out this week. I know we released our 2018 eligibility tools today, and that came out.

So, if you're signed up for the Quality Payment Program newsletter, and I can also forward this to Gene, we have that. And then I know, I think something else came out. If you just give me just a minute, let me look through and pull that up.

Eugene Freund: But you were asking about 2019, correct?

Stefanie Costello: Yes. And that information has not been released yet. And I don't know what the timing on that is.

Robert Tennant: OK. Yes. Thank you. And thanks for putting out the eligibility tool. We saw that this morning. Thank you.

Eugene Freund: Yes.

Stefanie Costello: Yes.

Operator: And your next question comes from the line of Jan Towers with AANP. Please, go ahead.

Jan Towers: We were having a discussion related to the requirements through 2018.

Where are those published? Are they the same as 2017 or some of the broader things that we see announced like the, being able to come in partially or totally depending on how many entries reports you sent in on the Quality Measures? Is that the same for 2017? We can't find it anywhere where it's written. What you did that for 2018? Am I making sense?

Stefanie Costello: I don't know off the top of my head. You can always email the Quality Payment Program, QPP@cms.hhs.gov. We have a service center that gets back to people pretty quickly. So, you can email them and they should be able to get back to you and point you to the exact place.

And I think that's the best I can give you right now. I don't know exactly where all the information is housed, or if we might have a resource on QPP.gov. I can take a minute and try to find it. Have you been through that website or looked at our resources?

Jan Towers: There's a section that's a year two, but it doesn't tell you anything about it so you can't tell whether it's 2017. If we didn't send anything in, you got a minus four and you could at least break even if you send at least one thing in. And if you did (96), you got more and then four year (that are still) but we can't find anything about that on 2018. Is it the same?

Stefanie Costello: I can't confirm without looking at it if it changed or not. So, if you just give me a little bit of – let me see if I can...

Jan Towers: OK.

Stefanie Costello: ...find something and then I will let you know.

Eugene Freund: Yes, Jan. It is the case that this for 2018, it is still, you know, the resources we have are still developing. I do think that that would be a – and it would have probably been a little premature to put it on today's agenda but I think in the next month or two, that would actually be a good topic for this particular forum. So, thanks for...

Jan Towers: You're into it 2018 now.

Eugene Freund: I know. I know.

Operator: And there are no further questions in the queue.

Eugene Freund: Thank you for all of that. Just as a little late breaker, we have (Amy Hammonds) online who will be providing a reminder about the Open Payments Program.

Amy Hammonds: Hi, everyone. This is Amy. We just wanted to give a quick update on Open Payments, some activities that started now.

So, just so everyone knows, this part Saturday, March 31st, the submission window closed for the reporting entities to submit any program, your data, or other new records that they had to submit to the Open Payment System. So, that period has ended for them which mean that review and dispute has started. So, review and dispute opened on Sunday, April 1st.

And for those of you that might not be super familiar with the program, the review and dispute period is for the cover recipient for the physicians in teaching hospitals. It's a 45-day window where they can come in and review the data that's been attributed to them so they have a chance to look at it and review it before it's published.

During this period, the cover recipient, or if they have an authorized representative in the Open Payment System, they can affirm that the data is accurate. And again, if they think that something is reported incompletely or inaccurately, they have the option to submit a dispute.

But just as a reminder, CMS does not mediate the disputes. The cover recipients should work directly with the reporting entities to reach those resolution for those disputes. And also, the cover recipient reveals the data as voluntary. But again, we do strongly encourage the reviews and such how to make sure that the data is accurate.

If you've been following along on the First Friday calls, you probably heard me mention it in the past couple of months that in order to participate in the review and dispute, you do have to be registered in the Open Payment System.

So, first, you have to register in the Enterprise Identity Management System, and then you request access to the Open Payment System through that.

If you have previously registered in the Open Payment System but you haven't accessed your account in 180 days or more, you'll actually have to reactivate your account. So you can do that reactivation through the helpdesk.

I'll give you their phone number in case if anybody needs to go through that process. The helpdesk phone number is 1855-326-8366. And right now, our

helpdesk is operating beginning at 8:30 AM through 7:30 PM, and that's Monday through Friday.

The final thing for the review and dispute periods that's important to note is that it does close on May 15th. So, in order for disputes and potential updates to the dispute of records to be included in the June 2018 publication, the dispute needs to be initiated by that May 15th date.

So, we do encourage early review of the data that make sure that there is a decent amount of time for the resolutions to be reached.

And then, if there is a dispute submitted on that May 15th date, the reporting entities do have an extended period to resolve any disputes that they have until May 30th to do any of the correction about disputes in order to be included in that June publication have to be in by that May 15th date.

So, I think that's everything all of our updates right now from Open Payments. And as always, we have our resources available on our website at cms.gov/openpayments.

And also, another resource that might be helpful for you guys is we hosted the National Provider Call last month, so the presentation and the transcript of that call is available. That gives a really good overview of the program and also the review and dispute action that can be taken right now.

So that's everything I have. I'm happy to entertain any questions if there are any. But if not, I'll hand it back over to Eugene.

Eugene Freund: Thank you very much, Amy. Any questions?

Operator: Again, as a reminder, if you would like to ask a question, just press star then one on your telephone keypad. And we have a question from the line of (Robert Ferno) with CMS.

(Robert Ferno): Hey, Gene. This is (Dr. Ferno) from CMS. I don't know if it helps (at all) but for that previous question about 2018 QPP, there is a slide deck available about year two for 2018.

And to (switch) via your question, there is not an official Pick Your Pace Program similar to 2017; however, the minimum established points needed to avoid a negative adjustment is 15 points where it was three for 2017.

So, it is higher than 2017 but it is still very attainable without doing the full 70 points needed for exceptional performers. So, I just want to chime in if that's any help.

Eugene Freund: Thanks for that, (Rob). And a lot of that can be found right at that QPP.cms.gov website. There is a link to resources on that page.

And another piece of good news is that if you are submitting and using the EIDM account for that, you won't let locked out for your checking your Open Payments. So, that's another benefit.

Other questions? Thank you, (Rob).

Operator: Again, that's star then one to ask a question. And there are no further questions in the queue.

Eugene Freund: OK. I just wanted to spend the last little bit of time. Kind of pointing you to our CMS.gov/newcard – that's one word "newcard."

If you just Google or otherwise search for CMS and new card, we've got some updated resources there. The mailing plan has been updated. It's been modified a little bit. And the information on that gets regularly updated.

And I wanted to mainly give people an opportunity to fill us in if they're hearing about any issues. At this point in time, it's possible that clinicians out there will have had brand-new Medicare patients come to their offices with the new Medicare beneficiary identifiers.

And that's pretty much what they should be seeing at this point if you're a provider of any type. So, I'll open up for questions on that.

Operator: Again, to ask a question, please press star then one on your telephone keypad. And there are currently no questions.

Eugene Freund: OK. Well, our mailbox is open for questions about that also. So, I'll take no news as good news, at least for this, albeit a relatively sophisticated crowd. So, thank you very much.

That is the end of this call. Our next meeting is May 4th. We already have a couple of items on the agenda. We'll try to get the QPP Program on that agenda. We'll also be having some of our colleagues who deal with beneficiary complaints and with Medicare Advantage talking about the answers to a question that came out a couple of weeks ago about what is the practitioner to do if they think that maybe a covered service by Medicare is not being provided by a Medicare Advantage plan?

So, we'll be talking about our, the various dispute options that are there for patients and practitioners. And that's coming up next month. And that's basically it for right now. Thank you very much for attending, and thanks for your attention.

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

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