This is the second issue of our recurring newsletter about Patients over Paperwork, our effort to reduce administrative burden and improve the customer experience while putting patients first. In this edition, we reflect on 2017 and update you on how we have been working to reduce burdensome regulations, streamline requirements and improve the clarity of our programmatic guidance. This work is in accordance with our agency's strategic goals:

1. Empower patients and clinicians to make decisions about their health care.
2. Usher in a new era of state flexibility and local leadership.
3. Support innovative approaches to improve quality, accessibility, and affordability.
4. Improve the CMS customer experience.

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Quality Measures

You Said: CMS quality programs have too many quality measures that are not meaningful to patients or providers. Reporting on these measures takes valuable time away from patient care.

We Heard You: Across our rules, CMS is adopting policies that balance the meaningfulness of quality measurement data with efforts to limit provider burden and improve the doctor-patient relationship. In 2017, CMS took initial steps to reduce the number of quality measures in our programs, and will continue to make progress on this initiative in 2018.

- **Hospital Outpatient Quality Reporting Program**
  CMS finalized the removal of six measures, resulting in an estimated burden reduction of 457,490 hours and $16.7 million reduction in associated stakeholder costs for the 2020 payment determination.

- **Ambulatory Surgical Center (ASC) Quality Reporting Program**
  CMS finalized the removal of three measures. Removing these measures will alleviate maintenance costs and administrative burdens to the ASCs, resulting in reducing burden by an estimated 1,314 hours and $48,066 for the 2019 payment determination.

CMS also delayed implementation of the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) under the ASCQR Program beginning with the 2018 data collection.

- **End Stage Renal Disease Quality Incentive Program**

  In 2017, CMS finalized that beginning with the 2021 program year, it would replace two current vascular access measures with two vascular access measures that are more meaningful to providers and patients and are strongly associated with desired patient outcomes. CMS also updated the current transfusion measure to reflect the specifications that the National Quality Forum endorsed for that measure which was based on input from physicians, patients and other stakeholders.

- **Removal of OASIS Items**

  In 2017, CMS finalized that effective January 1, 2019, it would remove 235 data elements from 33 items on the Outcome and Assessment Information Set (OASIS) assessment instrument.

  CMS estimates an annual net burden reduction of $145,986,343 associated with the changes to the Home Health Quality Reporting Program (HH QRP) made in 2017, which includes the removal of these OASIS items. This corresponds to an estimated net reduction in HH clinician burden of 2,016,386 hours annually.

Quality Payment Program (QPP) (5522-FC)

You Said: CMS quality and payment programs are too hard to understand and data submission is very complicated with uncertainty.

We Heard You: CMS consolidated the data submission experience under QPP so that clinicians no longer need to submit data in multiple systems under the various legacy programs (for example Physician Quality Reporting System (PQRS, the Meaningful Use program and the Physician Value Modifier). Since January 2nd, 2018 providers can go to QPP.CMS.gov to log into an authenticated account and submit data to satisfy all Merit-based Incentive Payment System (MIPS) reporting requirements. There is a new sign in tab on QPP.CMS.gov and remember-data submission should be started early.

For providers submitting data under the legacy programs, those user accounts will be the same in QPP. Starting now, new or updated user accounts can be accessed within the secure portal on the QPP website.

We continue to use stakeholder feedback to improve the QPP.CMS.gov website. CMS uses direct input from clinicians and practice managers to improve the user experience submitting data. User testing enables us to build a website that incorporates clinicians and practice managers' perspectives and

preferences.

Finally, to further simplify and streamline data submission under QPP, clinicians using registries or Qualified Clinical Data Registries can use an Application Programming Interface (API) to submit data for MIPS.

- **Merit-based Incentive Payment System (MIPS)**

Slow transition towards full implementation of MIPS

>**You Said:** Clinicians want to participate but may not be fully ready in year two.

>**We Heard You:** We raised the low-volume threshold for MIPS in order to exclude more clinicians, such as solo practitioners and small groups, who may not have the resources needed to be successful in quality reporting.

Virtual Groups:

>We implemented a mechanism for solo practitioners and small groups with 10 or fewer clinicians to form virtual groups to report under the MIPS program. We believe this option will reduce the collective reporting burden.

Advancing Care Information:

>**You Said:** Not all Electronic Health Record (EHR) vendors upgraded to the 2015 Edition Certified EHR Technology (CEHRT) in time for the 2018 performance period of MIPS. In addition, not all clinicians are able to report under the Advancing Care Information performance category of MIPS for a variety of reasons beyond their control.

>**We Heard You:** We recognize that some practices may find adopting new certified health information technology (IT) challenging. To allow more time for the migration, clinicians participating in MIPS may continue to use 2014 Edition CEHRT in year two. Clinicians that exclusively use 2015 Edition CEHRT will receive a bonus in their advancing care information category score. The advantages of 2015 Edition CEHRT include improved functionalities, better care coordination, and enhanced technical advancement.

>We have added new hardship exceptions for the advancing care information performance category: for small practices, for those who work in ambulatory surgical centers, and for those whose CEHRT has become decertified. We have also expanded the definition of a hospital-based clinician.

To Learn More, Visit: https://qpp.cms.gov

Appropriate Use Criteria for Advanced Diagnostic Imaging

You Said: Clinicians have too many changes coming at once with the Appropriate Use Criteria (AUC) requirements coming at the same time as the start of the QPP.

We Heard You: In order to ensure practitioners and stakeholders have adequate time to prepare for the requirements under the AUC program, we have established the following:

- We finalized a delayed effective date of January 1, 2020 for the AUC consultation and reporting requirements for advanced diagnostic imaging services.
- This delay allows practitioners to work through implementation of MIPS before having to implement a new AUC program.
- The AUC program will begin in 2020 with an educational and operations testing year during which Medicare claims will continue to be paid even if they do not correctly include required AUC consultation information.
- Early AUC adopters will have available an 18-month voluntary participation period starting in July 2018 and extending through December 2019.
- This timing will allow us to use feedback from our stakeholders and from Medicare claims data to assess and adjust the AUC program before Medicare payment to practitioners is impacted.

Documentation Review

- **Clarified Proof of Delivery Requirements**

  Before: The Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) help CMS to administer the DME benefit. Some DME MACs were routinely asking suppliers for proof of delivery for every DME claim reviewed. Suppliers often find it hard to respond to requests for this paperwork.

  After: New guidance in the CMS Program Integrity Manual advise MACs to request proof of delivery documentation for only those DME items that require a written order prior to delivery, such as Power Mobility Devices. While suppliers are still required to keep proof of delivery for every item they bill, this should reduce the amount of paperwork suppliers submit to MACs during medical review.

  To Learn More, Visit: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R750PI.pdf

- **Clarified Signature Requirements**

  Before: CMS contractors occasionally denied claims when a nurse initialed a medication administration log instead of including a full signature.

  After: CMS clarified guidance in the Program Integrity Manual, such that providers ultimately responsible for the beneficiary's care must sign the medical record; however, claims won't be denied if a support care provider (such as a nurse documenting chemotherapy) doesn't sign part of the record.

  To Learn More, Visit: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R751PI.pdf

- **Clarified Medical Review of Inpatient Rehabilitation Facility (IRF) Claims**

  You Said: IRF claims are denied even though patients need and could benefit from an inpatient rehabilitation program.

  We Heard You: CMS clarified guidance to its contractors, requiring them to use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not based on any threshold of therapy time.

  To Learn More, Visit: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17036.pdf

Quality and Safety Oversight

You Said: Some Long Term Care (LTC) Facilities were not prepared for the start of Phase 2 of the Long Term Care Requirements of Participation beginning in November of 2017.

We Heard You: CMS directed LTC Facility surveyors to focus on education rather than discretionary penalties related to the implementation of specific new Requirements of Participation for 18 months. This gives facilities more time and support to comply while still supporting resident safety.

You Said: Civil Monetary Penalties (CMPs) are not applied consistently or fairly to nursing homes found out of compliance with certain Requirements of Participation.

We Heard You: To increase national consistency in imposing CMPs, CMS revised the CMS Analytic Tool that is used to determine the appropriate CMP amount based on the citation. Specifically, CMS reduced

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the penalty amounts for non-compliance with Requirements of Participation by moving to a per-instance CMP instead of per-day CMPs for past noncompliance that existed before the current survey and does not continue. CMS provided its regional offices with clearer guidance around using CMPs to ensure consistency and predictability.

Promote Affordability for Consumers

- CMS responded to the President's Executive Order (E.O.) on Reducing Regulation and Controlling Regulatory Costs and examined Title 1 of the Patient Protection and Affordable Care Act (PPACA), the associated regulations, and sub-regulatory guidance documents, to identify areas for reducing burden and providing flexibility to issuers, states, and patients to support patient-centered healthcare.
- In response to the President's E.O. on Promoting Healthcare Choice, CMS is working with the Departments of Treasury and Labor to consider regulatory changes to expand access to short-term, limited-duration plans, which are plans that are exempt from many of the onerous provisions of the PPACA.
- CMS also issued a Request for Information (RFI) in early June seeking recommendations and input from the public on how to create a more flexible, streamlined approach to the regulatory structure of the individual and small group markets.
- Most recently, CMS issued a proposed rule, the "2019 Payment Notice," intended to increase flexibility in the individual market, improve program integrity, and reduce regulatory burdens associated with the PPACA in the individual and small group markets.

States

- **Section 1115 Demonstration Project Process Improvements**
  CMS approved the first 10-year Medicaid demonstration renewal. With this approval, CMS demonstrated that the new Medicaid policy is reducing the administrative burden for section 1115 demonstration approval and monitoring processes for states while also assuring adequate federal oversight and evaluation. These updates allow Mississippi -- and other states with -- to help beneficiaries and keep a successful Medicaid program going without delays, interruptions, or routine approvals.

- **Guidance and clarification to states on implementing the Medicaid access to care regulations for fee-for-service issued November 2015, specifically the requirements found at CFR 447.203(b)**
  > **You Said:** States officials have expressed confusion over the scope of the access to care regulation and concerns over burden associated with regulatory requirements. States requested clarification regarding circumstances in which provider payment reductions would likely not result in diminished access to care, including states: that pay at or

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above the Medicare rate under fee-for-service, are proposing relatively minor reductions to provider payment rates, or have high managed care penetration rates.

We Heard You: The letter clarified the application of the rule and provided specific guidance to help states determine whether provider payment changes are likely to diminish access or are nominal in nature.

- **State Medicaid Director (SMD) Letter on New Section 1115 Policy for Demonstrations to Improve Substance Use Disorder Treatment**

    CMS announced a new direction on working with states on section 1115 demonstrations to improve access to and quality of treatment for Medicaid beneficiaries with opioid use disorder and other substance use disorders. With this policy, which will take the place of the initiative announced in the State Medicaid Directors' letter issued on July 27, 2015, we are shifting away from up-front requirements for states and instead offering new flexibilities while increasing states' responsibilities to monitor and report the impact of changes implemented through these demonstrations.

Burden Reduction Highlights

- **Making Connections**

    On October 26, 2017, Administrator Seema Verma launched the Patients over Paperwork Initiative with a national partner listening session hosted by CMS. Administrator Verma invited stakeholders to listen and understand their viewpoints on how CMS regulations practically affect the everyday life of providers and their beneficiaries across our programs and across all settings of care.

    On October 30, 2017, Administrator Verma discussed CMS' efforts to reduce regulatory burden at the Health Care Payment Learning and Action Network Fall Summit in Arlington, VA. This is where she also announced a new approach to streamlining quality measures to reduce the burden of reporting on all providers, called "Meaningful Measures."

    On November 12, 2017, during a keynote address at the American Academy of Ophthalmology (AAO) 2017 121st Annual Meeting in New Orleans, LA, Administrator Verma discussed the agency's efforts to reduce regulatory burden and acknowledged the AAO for its work to reduce burden, aligned with CMS's work

    On December 1, 2017, Administrator Verma sat down with Dr. Don Rucker, National Coordinator for Health Information Technology, to discuss Patients over Paperwork, Meaningful Measures, and how CMS and The Office of the National Coordinator for Health Information Technology (ONC) will continue working together – and partner with policies that support one another – to always put patients first. In an effort to help guide

federal policy, Administrator Verma emphasized CMS' aim to listen to the needs of frontline healthcare workers.

- **What we are hearing**

  A provider in Hartford, CT told Administrator Verma that she was going to close her practice after decades in medicine because she simply could not keep up with all of the regulations.

  Another provider in Cleveland, OH told the Administrator that he was overwhelmed by having to personally fax patient records – in 2017. Many of us have personal phones with the power of a supercomputer, but providers are still faxing documents. Administrator Verma noted that these examples tell us that our system needs to be changed.

  Following the October 2017 Patients over Paperwork Kick-off event, CMS received letters with feedback and suggestions for reducing burden. We heard from the American Society for Radiation Oncology, The National Association for the Support of Long Term Care, Federation of American Hospitals, The American Health Care Association and National Center for Assisted Living, National Rural Health Association, the American College of Radiology, American Academy of Ophthalmology, American Academy of Orthopedic Surgeons, American Hospital Association, Leading Age, and American Academy of Family Physicians.