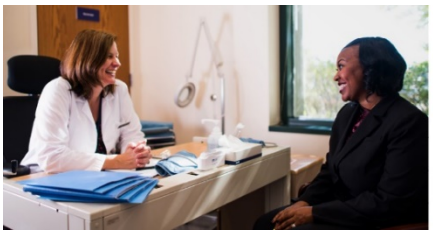


PATIENTS OVER PAPERWORK

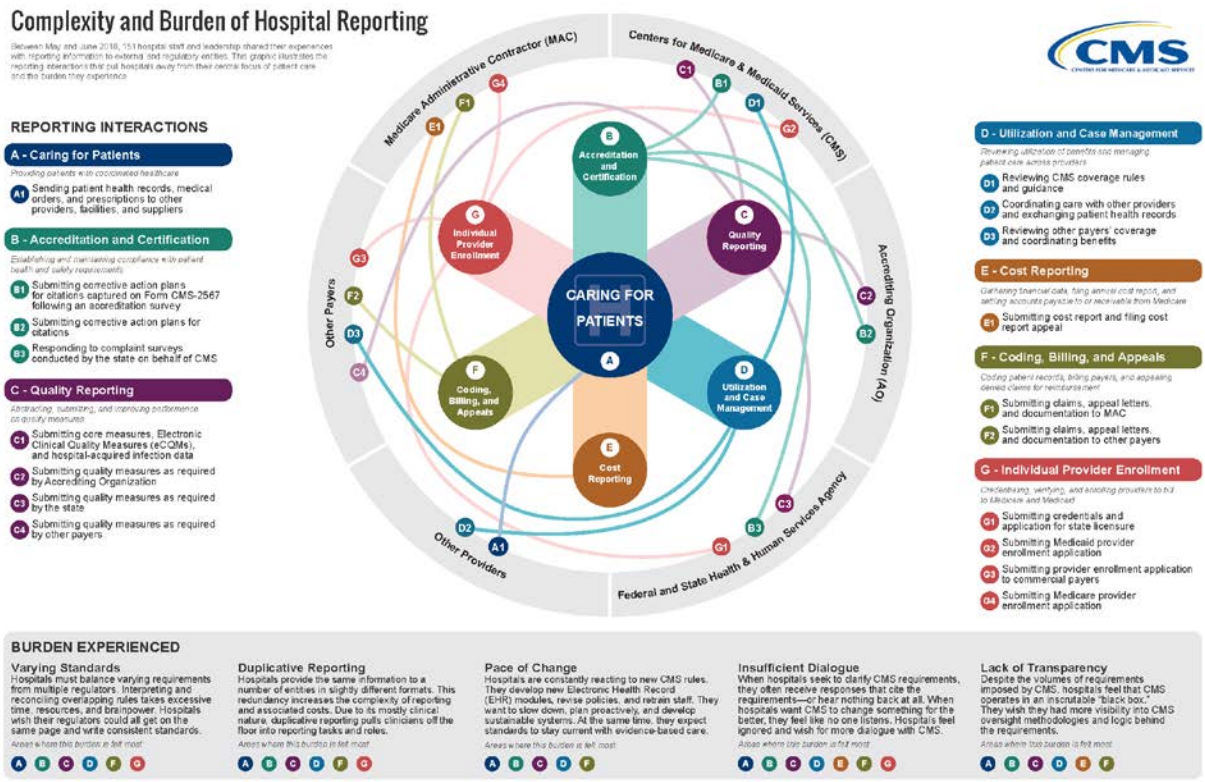
In CMS's ninth issue of the Patients over Paperwork newsletter, we're updating you on our ongoing work to reduce administrative burden and improve the customer experience for hospitals.

This latest edition covers three topics:

I. **Status Update: Reducing Hospital Provider Burden with Human Centered Design**
II. **Modernization Update: Local Coverage Determination (LCD)**
III. **Snapshot: Recent Policies and Proposed Rules Aimed at Reducing Burden**

Status Update: Reducing Hospital Provider Burden with Human Centered Design

CMS is ensuring that patients are at the center of the agency's work, and is unveiling a new tool to illustrate the hospital provider burden: The Complexity and Burden of Hospital Reporting Ecosystem Map. The map was developed by our Patients over Paperwork Hospital On-Site Engagement team, who learned firsthand about the burdens hospitals face related to reporting. The map provides a visual depiction of key reporting interactions between hospital staff and external regulatory bodies and payers, as well as accrediting organizations. It will be an educational reference tool for CMS staff as they work to develop policies, programs and services.



Changing the way CMS does business

CMS leveraged Human Centered Design (HCD) to involve our customer's perspective in learning more about burden. Last summer we hit the road and visited seven locations in seven states. We logged hundreds of hours meeting with over 200 hospital leadership, management, and clinical staff; subject matter experts; and hospital associations to hear their perspectives on reporting information to external and regulatory bodies. Hearing from the customers in their hospital setting was key in showing us their challenges. One quality director told us:

> "I don't get it. Some of the core measures are very, very heavy on psych. My psych dashboard is about seven pages. If a patient is quitting and going through active withdrawal from opioids. Do you really think that's the time to hit them with smoking cessation?"

While in the field, we made almost 2000 observations and often heard the same thing repeatedly. We were able to pinpoint examples of burden and narrow down 130 themes into 16 insights some of which include:

- Hospitals want to partner with us to improve healthcare.
- Each hospital serves a unique population, so broad policies don't always fit. Hospitals think we make it harder to succeed by judging them on an uneven playing field.

- Hospitals think some regulations get in the way of improving patient outcomes. As a result, clinicians often feel forced to choose between providing evidence-based care and checking a regulatory box.
- Hospital staff feel they spend too much time resolving misaligned requirements and interpreting conflicting guidance.
- Hospitals are required to send the same information to different places in slightly different formats. This means hospitals have to hire staff and consultants to manage this complexity.

How customers inform our work

These insights and in-person observations were valuable. In every hospital we visited, we were hearing that hospital staff were very appreciative that we were joining them in their environment to understand how they do business. We wanted to continue to explore other customers that work with or in the hospital setting. So, our team and CMS Regional Office staff held more than twenty listening sessions with hospital staff, vendors, and associations. These sessions enabled us to identify trends and patterns of experiences across providers, and generated insights that are more detailed.

At the center of our Human Centered Design process is participatory design, where we worked directly with hospitals and CMS employees to collaboratively understand the context of their work and engagement with CMS, as well as the solutions we are creating to support them. Having staff visit facilities aids in their understanding and affects policies in ways that cannot be accomplished by sitting at a desk. Upon returning from a facility, one CMS staff member said:

> "Thank you for asking me to participate in a Hospital site visit. After reviewing the work from the Nursing Home team, I wasn't sure what this was about, but now I get it. This is very important work, and I want to be involved in more going forward. Now, each time I look at our policies and rules, I see things differently."

Reducing burden with customers in mind

Hospitals told us they wanted a more streamlined and less duplicative audit process; so, CMS developed provider compliance processes that are the same among Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Unified Program Integrity Contractors (UPICs). Now, these contractors are consistent when they decide to educate instead of auditing providers. We are also reducing burden by easing documentation requirements and giving flexibility, while keeping important patient and program integrity protections.

We also heard many stories about increasing electronic health record (EHR) efficiency. The FY 2019 Inpatient Prospective Payment System (IPPS) Final Rule improves the use of EHRs and makes it easier for providers to spend more time with patients. For example, the rule finalizes a

new performance-based scoring methodology for the Medicare Promoting Interoperability Program that has a smaller set of objectives that gives a more flexible, less burdensome structure.

The IPPS Final rule also allowed us to take out measures that don't emphasize interoperability and the electronic exchange of health information or improve patient outcomes. Through Meaningful Measures, we removed quality measures that were:

- Duplicative.
- Showed no meaningful distinction in provider or patient performance.
- Were overly costly to maintain and report when compared to the benefits of keeping them.

Specifically, the IPPS final rule removes 18 measures from our quality programs that met the criteria above and takes the duplication out of 25 other measures. In addition, the IPPS final rule further reduces burden by:

- Removing the requirement that certification statements detail where to find the required information in the medical record.
- Removing the requirement that a written inpatient admission order be in the medical record as a specific condition of Medicare Part A payment.

Moving forward

Our goal is to have patients and customers at the center of our work using the *Complexity and Burden of Hospital Reporting Ecosystem* as an education tool. When staff understand the customers' perspective, they are able to write better policies, programs, and services. We are also excited to share it with our partners and stakeholders, letting them know we value and strive to understand our relationship with them. With tools like this, we are better equipped to reduce burden in a meaningful way.

Local Coverage Determination (LCD) Modernization Updates

We've been working hard to reduce burden by modernizing LCDs. Most stakeholders acknowledged that the local coverage process is an important means to provide decisions on items and services that benefit Medicare's beneficiaries. However, there is concern about the lack of transparency of the local coverage process, including notifying stakeholders of proposed revisions to, and drafting of, new LCDs. We heard additional concerns from stakeholders regarding feedback on information provided during open public meetings, a lack of non-physician representation on Contractor Advisory Committees (CACs), and concerns that CAC meetings are not open to the public. Here are 11 updates:

1) **You said:** Remove the exclusion of practitioners who are not physicians from serving on

the Contractor Advisory Committee (CAC) from sub-regulatory guidance.

We heard you: We revised CAC requirements and now all health care professionals, beneficiary representatives, and medical organizations can participate in the CAC process.

2) **You said:** Require Medicare Administrative Contractor (MAC) CAC meetings to be open, public, and on the record, with minutes taken and posted to the MAC's website.

   We heard you: We revised CAC meeting requirements and all future CAC meetings will be open to the public. We also improved the CAC meeting process by:

   - Allowing a substitute. If the CAC member or alternate can't attend the CAC meeting, a substitute can attend if the MAC is notified and approval is given at least 1 week prior to the meeting.
   - Requiring MACs to work with CAC members to pick a meeting location that maximizes participation.
   - Allowing MACs the option to host in-person and/or telephonic/video/on-line conference/etc. meetings.
   - Letting MACs record (video, audio or both) meetings instead of taking meeting minutes. If MACs record CAC meetings, they are required to keep the recordings on their website.
   - Revising the role of CAC members to review the quality of the evidence used to develop LCDs instead of only representing their constituency as an advisor. We believe that CAC advice is most useful when it comes from a process of full scientific inquiry and thoughtful discussion with careful recommendation framing and clearly identifying the recommendations' basis.
   - Including the CAC's summary of recommendations regarding the policy in the final LCD when a MAC finds that it should ask for CAC consultation for a proposed LCD.

3) **You said:** Require MACs to develop LCDs in a more open and transparent way. You also said, require MACs to include from the beginning a reason for a proposed LCD and any evidence they're using to limit or deny coverage.

   We heard you: MACs now have to implement all requirements outlined in 21st Century Cures Act. They also have to summarize the opinions they've gotten from health care professional expert(s), professional societies, etc. before they draft a proposed LCD and include this information in the proposed LCD.

4) **You said:** Don't allow MACs to replicate LCDs on a nationwide basis without completely

following the process for LCD development, assessment, and implementation.

We heard you: We've revised MAC instructions to clearly identify all the steps in the LCD process to make sure the MACs are transparent and that they follow consistent processes in each MAC jurisdiction.

5) **You said:** Look for ways to reduce LCD variability caused by ICD-10 coding instead of local input or local practice patterns.

   We heard you: We encourage MACs to collaborate on LCDs and have revised the MAC award fee metric to encourage them to collaborate across jurisdictions.

6) **You said:** Develop systems to make sure stakeholders are notified that LCDs have been posted publicly.

   We heard you: We've revised MAC instructions to make sure they notify the public that LCD decisions have been published and give the web link to the final decision. MACs may use several 508 compliant and accessible ways to inform stakeholders to educate providers, including the "What's New Report" on the Medicare Coverage Database, email listservs, etc.

7) **You said:** The way to ask for and get feedback to stakeholders about information from public meetings aren't working effectively. Too many times, MACs host public meetings but there are long lags in LCD publication and feedback on public comments. Then, the final LCD's published but doesn't reflect what was discussed during public meetings because the evidence changed.

   We heard you: We have revised MAC instructions to make sure MACs finalize or retire all proposed LCDs within a rolling year of the proposed LCD's publication date on the MCD (365 days). We've also required MACs to respond to all the written comments they get during the proposed LCD comment period. Now, the LCD process makes sure the MAC response to public comments article (RTC) is published on the start date of the notice period. The RTC Article will stay publicly available indefinitely on the MCD or the MCD Archive.

8) **You said:** It's hard to find meeting information on the various MAC websites.

   We heard you: We've revised MAC instructions to make sure MACs let the public know about the dates, times, and locations for open meetings. We're giving MACs the option to use email listservs or other education methods to inform the public. We're now requiring that the listserv or other method clearly identify the locations, times, dates, and telephone/video/on-line conference information for open meetings and that it's clearly distinguished from the CAC meeting information. We've also instructed MACs to post on their websites planned agendas for open meetings at least 2 weeks before the meetings. MACs also have to let the public know the agenda's been posted.

9) **You said:** Providers don't understand how to ask for a LCD to be developed.

   We heard you: We've set up a new process for providers to use to request a LCD and are requiring MACs to implement the new process.

10) **You said:** Providers don't understand how to set up an informal meeting to talk about potential LCD requests.

    We heard you: We've developed a new informal meeting process that the MACs are required to implement.

11) **You said:** There isn't transparency in the LCD Reconsideration process.

    We heard you: We've revised the LCD Reconsideration process to make sure there's public feedback on coverage changes and blended the LCD process so it's consistent with National Coverage Determination reconsideration processes.

Snapshot: Recent Policies and Proposed Rules Aimed at Reducing Burden

New Innovations in Technology Promote Patient Access and Could Make Health Data Exchange a Reality for Millions

On Monday, February 11, 2019, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) released proposed rules to support seamless and secure access, exchange, and use of electronic health information. The rules would increase choice and competition while fostering innovation that promotes patient access to and control over their health information.

CMS' proposed changes to the healthcare system support the goals of the MyHealthEData initiative, and would increase the seamless flow of health information, reduce burden on patients and providers, and foster innovation by unleashing data for researchers and innovators.

These proposed changes, in part, came from comments received from 5 of the 9 RFIs CMS issued in 2017 on burden reduction, flexibilities, and efficiency. We reviewed 419 comments from interoperability RFIs. We received 78 comments related to burden and interoperability or health IT.

To view the CMS proposed rule (CMS-9115-P), please visit:
https://www.cms.gov/Center/Special-Topic/Interoperability-Center.html

For a fact sheet on the CMS proposed rule (CMS-9115-P), please visit: https://www.cms.gov/newsroom/fact-sheets/cms-advances-interoperability-patient-access-health-data-through-new-proposals

For a fact sheet on the ONC proposed rule, please visit: https://www.healthit.gov/topic/laws-regulation-and-policy/notice-proposed-rulemaking-improve-interoperability-health

CMS Finalizes "Pathways to Success," an Overhaul of Medicare's National ACO Program

On December 21, 2018, CMS issued a final rule that redesigns and sets a new direction for the Medicare Accountable Care Organizations or "ACOs." ACOs are groups of healthcare providers that take responsibility for the total cost and quality of care for their patients, and in exchange they can receive a portion of the savings they achieve if they meet quality standards or may owe a portion of losses incurred To ensure the ACO program delivers the most value, Pathways to Success is designed to advance five goals: Accountability, Competition, Engagement, Integrity, and Quality.

Updates to Repayment Mechanism Requirements for Two-sided Model ACOs: The final rule includes modifications to the proposed repayment mechanism arrangement requirements for ACOs in performance-based risk tracks to reduce burden. In response to commenters' suggestions, both BASIC and ENHANCED track ACOs may have a lower repayment mechanism amount that is based on a percentage of ACO participants' Medicare Part A and B revenue. Under the final rule, an ACO will not have to increase the amount of its repayment mechanism unless the difference between the recalculated repayment mechanism amounts exceeds the existing repayment mechanism amount by at least 50% or $1,000,000. We are reducing the period of time after the end of the agreement period that the repayment mechanism must be in effect from 24 months to 12 months, and we are permitting all ACOs to establish repayment mechanisms for a shorter duration as long as the arrangement provides for automatic annual renewal.

Beneficiary Notification: To further empower beneficiary choice, we are finalizing requirements to strengthen beneficiary notifications. An ACO must ensure that Medicare FFS beneficiaries are notified about all of the following: (1) its ACO providers/suppliers are participating in the Shared Savings Program; (2) the beneficiary's opportunity to decline claims data sharing; and (3) the beneficiary's ability to, and the process by which, he or she may identify or change identification of the individual he or she designated as their primary clinician for purposes of voluntary alignment. To mitigate the burden of these additional notifications, we are developing template notices for ACOs and ACO participants to use.

To learn more visit: https://www.cms.gov/newsroom/press-releases/cms-finalizes-pathways-success-overhaul-medicares-national-aco-program

CMS achieved improper payment rate reductions in Medicare Fee-For-Service (FFS), Medicare Part C, Medicare Part D, Medicaid, and Children's Health Insurance Program

CMS is pleased to have achieved decreases in the Medicare, Medicaid, and Children's Health Insurance Program improper payment rate and continues to explore additional opportunities to reduce the improper payment rate across all programs. We remain committed to collaborating across CMS and with stakeholders to address potential vulnerabilities, strengthen our program integrity efforts, and minimize unnecessary administrative burden for our partners.

To learn more visit: https://www.cms.gov/newsroom/fact-sheets/cms-achieved-improper-payment-rate-reductions-medicare-fee-service-ffs-medicare-part-c-medicare-part

CMS Launches New podcast "CMS: Beyond the Policy" offers regular episodes that discuss agency updates and policies in a user-friendly medium

CMS launched "CMS: Beyond the Policy," a new podcast highlighting updates and changes to policies and programs in an easily accessible and conversational format. We created this new resource as a direct response to requests from doctors and other providers who wanted updates that they could listen to on the way to the office, as it is often difficult to participate in webinars during practice hours.

CMS: Beyond the Policy's inaugural episode focuses on Evaluation and Management Coding (E/M Codes). Last November, CMS finalized changes in the Calendar Year 2019 Physician Fee Schedule (PFS) as part of efforts to help create a more accessible, affordable and innovative healthcare system that delivers quality for patients and empowers them to make the best decisions about their healthcare. The Calendar Year 2019 PFS included significant changes to how doctors and other clinicians document office and outpatient visits billed to Medicare. These changes are part of CMS's "Patients over Paperwork" initiative and one of many steps CMS is taking to reduce the amount of burdensome regulations on physicians allowing them to focus on delivering the best quality care to their patients.

New episodes of the podcast will be released periodically and will welcome a range of subject matter experts, stakeholders, and Administrator Verma herself.

The first episode of CMS: Beyond the Policy are available for download on iTunes and Google.

We would love to hear your ideas on future topics. If you have an idea, please email: Partnership@cms.hhs.gov

Physicians and Non-Physician Practitioners: New Medicare Enrollment Application

CMS received approval for a new Medicare Enrollment Application for physicians and non-physician practitioners (CMS-855I dated 12/2018). Many changes are minor; the major ones reduce provider burden:

- Eliminated reporting for advanced diagnostic imaging, Clinical Laboratory Improvement Amendments number, and the Food and Drug Administration radiology certification number
- Expanded instructions for individual and group affiliations to simplify reporting
- Made it optional to list a contact person
- Added electronic storage information for those who no longer keep paper records
- Created a more logical data flow

You may begin using the new application immediately. Through April 30, Medicare Administrative Contractors will accept applications dated 7/2011, but after that, you have to use the new version.

How can I learn more?

Learn more about Patients over Paperwork.

Join our listserv to get this newsletter and any other Patients over Paperwork updates. You can also find our past newsletters.

Tweet about Patients over Paperwork using the hashtag #patientsoverpaperwork and #RegReform.

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