PATIENTS OVER PAPERWORK

In our 10th 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 beneficiaries. In this edition we include:

- A Highlight Article: Applying a Rural Lens to Burden Reduction
- Patients over Paperwork: A Journey Forward 2 Year Anniversary Event Summary
- Description of how we're simplifying documentation for:
  - Immunosuppressive drugs
  - Home health recertification
- Recovery Audit Contractor (RAC) Updates
- Proposed and final policy updates that reduce burden:
  1. Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting updates
  2. Physician Fee Schedule and Quality Payment Program updates
  3. Simplifying DMEPOS payment requirements
  4. Home Health Protective Payment System reduces provider burden
  5. Modernizing and clarifying the Stark Law
  6. Omnibus Burden Reduction (Conditions of Participation) Final Rule
  7. Policies to Advance Rural Health and Medical Innovation
  8. Updated Requirements for Arbitration Agreements and New Regulations

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Applying a Rural Lens to Burden Reduction

On the heels of National Rural Health Day we want to celebrate Patients over Paperwork's efforts to reduce burden for rural communities. Over the past few years, CMS has taken meaningful steps towards understanding the challenges and seeking solutions associated with providing high quality health care in rural communities. In 2018, as part of the Rethinking Rural Health Initiative, we released our Rural Health Strategy to help improve health care in rural America.

The strategy addresses many concerns of rural America and aims to support CMS' overall effort to reduce provider burden and align with other CMS priorities. "Patients living in rural America face unique challenges and burdens when accessing reliable, affordable healthcare," said CMS Administrator Seema Verma. "We are committed to addressing provider burnout and administrative burden across America, including rural areas. We have updated policies to reduce burden for rural providers and clinicians and given them more time and the ability to use more innovative tools so that they can spend more time with patients."

A top agency objective has been to apply a rural lens to CMS programs and policies. Since the beginning of Patients over Paperwork, we have done just that and have been seeking to reduce burden by improving access to care through provider engagement and support and advancing telehealth and telemedicine.

We understand that the incredible relationships rural clinicians build with their patients is a core strength of rural medicine. We have seen this first hand as we have made our way around the country through Patients over Paperwork onsite engagement sessions and through our Rural Road Trips. Collectively we have visited 46 states, the District, and 2 territories, visited numerous rural facilities, and listened to hundreds of clinicians, beneficiaries, and health care staff.

We know from our Patients over Paperwork customer engagement and Human-Centered Design work how important it is to meet our customers where they work or receive care. Rural Road Trips have been particularly important to help CMS staff learn more about challenges providing or receiving health care services in rural settings, including administrative burdens, and share what we hear with CMS policymakers to inform policy. In 2019 alone, we have already conducted or plan to conduct visits to Eastern Texas, Alabama, Arizona, Missouri, Utah, Southwest Oregon, Pennsylvania, and West Virginia.

Using input from our listening sessions, visits to clinical practices and facilities, and responses to our 2017 Request for Information (RFI), we have made substantial improvements to reduce burden for rural communities. As of May 2019, through final and proposed rules, we estimate burden savings to rural facilities, including Federally Qualified Health Centers, at around $100 million and 950,000 hours between 2018 and 2021.

We didn't just stop there. We have taken what you said, harnessed innovation, and applied our rural lens to reduce burden across the spectrum.

You said: Rural providers often find it difficult to determine the most updated information on the Quality Payment Program (QPP), which makes it hard to actively participate in the program.

We listened: Reducing burden and tailoring support to rural and small practices helped 94% of eligible rural clinicians participate in the QPP. Out of those, 93% received a positive payment adjustment.

You said: Rural clinicians face challenges with access to care for their patients especially in finding a specialist physician nearby a beneficiary with multiple complex care needs.

We listened: We are advancing new policies to pay for more services delivered using innovative communication technology, such as:

- For CY 2020, we finalized our proposal to increasing payment for transitional care management (TCM) services which are care management services provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays. We are creating a Medicare-specific code for additional time spent beyond the initial 20 minutes allowed in the current coding for chronic care management (CCM) services, which are services provided to beneficiaries with multiple chronic conditions over a calendar month. We are also creating new coding for principal care management (PCM) services, for patients with only a single serious and high-risk chronic condition.

- For CY 2020, we are adding the following codes to the list of telehealth services: HCPCS codes G2086, G2087, G2088, which describe a bundled episode of care for treatment of opioid use disorders.
- Implementing the requirements of the Bipartisan Budget Act of 2018 to allow Medicare beneficiaries receiving home dialysis to receive certain services in additional locations via telehealth technology and covering telehealth services provided by mobile stroke units and removing originating site type and geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- Supporting the remote sharing of information by paying clinicians for virtual check-ins and remote physiologic monitoring services.
- CMS finalized policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019. CMS finalized the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments. CMS also finalized policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

You said: Rural health providers were concerned that the current wage index system perpetuates disparities in reimbursement across the country. Providers stated that hospitals that pay higher wages receive a higher Medicare reimbursement, and therefore, can afford to pay their staff more. Conversely, they stated that low wage index hospitals often cannot afford to pay wages that would allow them to climb to a higher wage index.

We listened: In August, CMS issued a final rule to increase the wage index for certain low wage hospitals, many of them rural, to allow those hospitals to better retain and recruit a skilled workforce.

Improving rural health while reducing burden doesn't stop there. Other examples include:

- Changes to Low-volume Hospital (LVH) policies related to proximity to Indian Health Service facilities
- Decrease regulatory burden coming from Medicare Advantage, Medicaid, and Marketplace Plans' variations in training requirements for Hospital Star Rating corrections for low-volume facilities.
- De-prioritization of monitoring and enforcement related to the critical access hospital (CAH) 96-hour certification requirement and 2 year moratorium on direct physician supervision requirements of hospital outpatient services for 2018 and 2019. For Calendar Year (CY) 2020 CMS is finalizing a change to the generally applicable minimum required level of supervision for hospital outpatient therapeutic services furnished by all hospitals and CAHs from direct supervision to general supervision.

We are committed to keeping the momentum going as we continue to implement the Rural Health Strategy. We are creating more ways for rural areas to transform care delivery by offering new innovative payment models that provide the flexibility needed to tailor integrated care systems to the unique needs of rural Americans.

Patients over Paperwork: A Journey Forward 2-Year Anniversary Event

On October 29, 2019 CMS celebrated the second anniversary of Patients over Paperwork, which began with an RFI that yielded more than 3,000 data points on more than 1,100 different issues. To date, Patients over Paperwork has yielded estimated savings of $6.6 billion to the medical community with a reduction of approximately 42 million hours of burden through 2021.

As a part of the celebration, we hosted members of Congress, clinicians and industry stakeholders in Washington, DC to share insights on the impact of regulatory burden and how Patients over Paperwork is already making a positive impact. Attendees also participated in listening sessions on: Conditions of Participation (CoP) and Enforcement, Rural Health, Value-Based Arrangements, Meaningful Measures, Prior Authorization, Innovation, and Program Integrity.

More information can be found here:

Recording of the event

Administrator Seema Verma's Remarks

CMS Staff Testimonial Video

Documentation Simplification

As part of our Patients over Paperwork Initiative, Medicare is simplifying documentation requirements allowing you to focus more on your patients and less on paperwork including confusing and time-consuming claims documentation. Two updates are:

Shipping immunosuppressive drugs

BEFORE: Suppliers could only ship immunosuppressive drugs to the patient's home following an inpatient stay.

AFTER: Suppliers may deliver the initial prescriptions of a beneficiary's immunosuppressive drugs to an alternate address, such as the transplant facility or other location where the beneficiary is temporarily staying.

Documentation for home health recertification

BEFORE: Physicians needed to include a separate statement about how much longer home health services would be needed as part of the home health recertification.

AFTER: A separate statement is not needed.

Recovery Audits: Improvements to Protect Taxpayer Dollars and put Patients over Paperwork

CMS uses several types of contractors to verify that Medicare Fee for Service (FFS) claims are paid based on Medicare requirements. One type of contractor is a Recovery Audit Contractor (RAC). The Medicare FFS RAC Program is one of many tools we use to prevent and reduce improper payments. RACs identify and correct overpayments made on claims for health care services provided to beneficiaries, identify underpayments to providers, and provide information that allows us to prevent future improper payments.

You said: Audits are time-consuming, necessitating high administrative expenses, and often result in lengthy appeals.

We listened: We made meaningful changes as we re-examined all aspects of our RAC processes. We identified areas where we could reduce provider burden and appeals, and increase program transparency, while enhancing program oversight and effectiveness.

- We are making RAC audits fairer to providers. Previously, RACs could select a certain type of claim to audit. Now, they must audit proportionately to the types of claims a provider submits.
- We changed how we identify whom to audit. Instead of treating all providers the same, we conduct fewer audits for providers with low claims denial rates.
- We gave providers more time to submit additional documentation to support their claim. This build-in 30-day discussion period, after an improper payment is identified, means that providers do not have to choose between initiating a discussion with the RAC and filing an appeal. CMS expects this will continue to reduce the number of appeals.

More information on the Medicare FFS Recovery Audit Program can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/

New CMS Policies to Reduce Burden

1) **CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)**

   CMS is finalizing changes to the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs to further meaningful measurement and reporting for quality of care in the outpatient surgical setting while limiting burden.

   - Hospital Outpatient Quality Reporting (OQR) Program

- The Hospital OQR Program requires hospitals to meet quality reporting requirements, or receive a reduction of 2.0 percentage points in their annual payment update if these requirements are not met.
- CMS is finalizing the removal of one web-based measure for the CY 2022 Program Year from the Hospital OQR Program, External Beam Radiotherapy (EBRT) for Bone Metastases (OP-33).

For more information visit: https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

2) Physician Fee Schedule and Quality Payment Program Final Rule Allows Clinicians to Spend More Time Delivering High Quality Care for Patients

Earlier this month, CMS finalized major policy changes that will reduce clinical burden, ensure appropriate payment for clinicians, and enable them to provide their patients with high quality care. It is **projected that starting in 2023 clinicians will save 2.3 million hours per year in burden reduction.**

We are taking additional steps to address the longstanding criticism from clinicians that billing and coding requirements for Evaluation and Management (E/M) services from the mid-1990s are burdensome and overly complicated. As a result of these updates, starting January 1, 2021, clinicians will be able to make better use of their time and restore the doctor-patient relationship by spending less time on documenting visits and more time on treating their patients. In this final rule, we are also increasing payment for office and outpatient E/M visits as well as providing enhanced payments for certain types of visits, recognizing the value of clinicians' time spent treating the growing number of patients with greater needs and multiple medical conditions. These changes will also take effect January 1, 2021.

Physician Supervision Requirements for Physician Assistants (PAs)
We are updating our regulation on physician supervision of PAs to give PAs greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice. In the absence of any state rules, CMS is finalizing a revision to the current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting the PA's scope of practice and indicating the working relationship(s) the PA has with the supervising physician(s) when furnishing professional services.

In addition, the final rule improves the Quality Payment Program (QPP) by streamlining requirements with the goal of reducing clinician burden by including a new, simple way for clinicians to participate in CMS's pay-for-performance program, the Merit-based Incentive Payment System (MIPS). This new framework, the MIPS Value Pathways (MVPs), will be developed in collaboration with stakeholders such as medical professional societies, and will begin in the 2021 performance period.

For more information:

Fact sheet on the CY 2020 Physician Fee Schedule final rule

Fact sheet on the CY 2020 Quality Payment Program final rule

CY 2020 Physician Fee Schedule and Quality Payment Program final rule (CMS-1715-F)

3) Finalized changes to the Medicare rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS), the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS), and the ESRD Quality Incentive Program (QIP)

On October 31, 2019, CMS issued a final rule that updated and revised Medicare rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS), the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS), and the ESRD Quality Incentive Program (QIP).

Aligned with the goals of the Patients over Paperwork initiative, CMS is committed to reducing burden while eliminating potential fraud and abuse. In the final rule, CMS is simplifying its DMEPOS payment requirements so that practitioners can focus their attention on caring for Medicare beneficiaries. To help with this effort, CMS is streamlining the requirements for ordering DMEPOS items and developing a single list of DMEPOS items potentially subject to certain payment requirements. The final rule increases CMS flexibilities, allowing for quicker action for potential fraud and abuse without increasing provider burden.

For more information:

Fact sheet on the CY 2020 final rule (CMS-1713-F) Final Rule

4) New Home Health Prospective Payment System responds to unique needs of patients and reduces burden on providers

On October 31, 2019, CMS finalized changes to the Home Health Prospective Payment System (HH PPS) CMS-1711-FC. The final rule with comment period eliminates burdensome requirements of the Medicare program that are more stringent than applicable Federal or State laws for maintenance therapy.

In response to public feedback received under our Patients over Paperwork initiative and as part of the Executive Order and the Trump Administration's efforts to cut the red tape, CMS is modifying its regulations to allow therapist assistants—rather than only therapists—to perform maintenance therapy under the Medicare home health benefit, in accordance with individual state practice requirements. This change allows therapist assistants to utilize all of the skills under their license and gives home health agencies the opportunity to use both therapists and therapist assistants to perform maintenance therapy.

CMS is also implementing the Patient-Driven Groupings Model (PDGM), a new case-mix payment methodology for home health services, which more accurately pays for home health services and focuses on patient needs by relying heavily on patient characteristics rather than volume of care.

For more information visit: https://www.cms.gov/newsroom/press-releases/trump-administration-delivers-promise-strengthen-medicare-new-home-infusion-therapy-benefit-and-home

5) Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule

On October 9, 2019, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the "Stark Law"). The proposed rule supports the CMS "Patients over Paperwork" initiative by reducing unnecessary regulatory burden on physicians and other healthcare providers while reinforcing the Stark Law's goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest. Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other healthcare providers to coordinate the care of the patients they serve – allowing providers across different healthcare settings to work together to ensure patients receive the highest quality of care.

In order to be considered, comments must be submitted by December 31, 2019.

The proposed rule (CMS-1720-P) can be downloaded from the *Federal Register* at: https://www.federalregister.gov/documents/2019/10/17/2019-22028/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

6) The Omnibus Burden Reduction (Conditions of Participation) Final Rule

On September 26th, 2019, CMS took action at President Trump's direction to "cut the red tape," bringing relief to America's healthcare providers through the reduction of unnecessary burden, allowing them to focus on their top priority: patients. The Omnibus Burden Reduction (Conditions of Participation) Final Rule strengthens patient safety by removing unnecessary, obsolete, or excessively burdensome Medicare regulations on hospitals and other healthcare providers. This rule advances CMS's Patients over Paperwork initiative by saving providers an estimated 4.4 million hours previously spent on paperwork with an overall total savings projected of $800 million annually and giving doctors more time to spend with their patients.

For more information visit: https://www.cms.gov/newsroom/fact-sheets/omnibus-burden-reduction-conditions-participation-final-rule-cms-3346-f

7) CMS Finalizes Policies to Advance Rural Health and Medical Innovation

In August 2019, CMS issued a final rule that updated and revised policy changes to spur competition and innovation that will help deliver improved care and outcomes at a better value to patients. The final rule updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for FY 2020 and advances two key CMS priorities—"Rethinking Rural Health" and "Unleashing Innovation"—by making historic changes to how Medicare pays hospitals. This final rule:

- Increases Medicare add-on payments for high cost eligible new technologies from 50 to 65%.
- Clarifies policies on "substantial clinical improvement" to qualify for new technology add on payments.
- Provides an alternative pathway where Breakthrough Devices are no longer required to meet the "substantial clinical improvement" criterion to qualify for new technology add-on payments
- Provides an alternative pathway where Qualified Infectious Disease Products are no longer required to meet the "substantial clinical improvement" criterion to qualify for new technology add-on payments, which are increased from 50 to 75%

The final rule also reduces burdens in several ways:

- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program: collects and publishes data on an announced set of quality measures. CMS finalized the removal of one measure because the burden associated with the measure outweighs the value of its inclusion in the program, the External Beam Radiotherapy for Bone Metastases measure, beginning with the FY 2022 program year;
- Medicare Promoting Interoperability Program- CMS continues to make changes to the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals, including changes intended to reduce the burden on providers of complying with program requirements.
    - We finalized our proposal to continue for the CY 2020 EHR reporting period the Query of PDMP measure as optional and available for bonus points instead of being required as was finalized last year. To minimize burden, we also finalized our proposal to convert this measure from a numerator/denominator to a yes/no attestation beginning with the EHR reporting period in CY 2019.
    - We finalized our proposal to remove the Verify Opioid Treatment Agreement measure beginning in CY 2020 from the Promoting Interoperability Program based on received feedback from stakeholders that this measure presents significant implementation challenges, leads to an increase in burden, and does not further interoperability.

For More Information:
Final Rule
Fact Sheet

8) CMS Rules Update Requirements for Nursing Homes that put Patients over Paperwork

July 2019, CMS announced a proposed rule – that emphasize CMS' commitment to ensuring safety and quality in nursing homes. These rules are components of the agency's five-part approach to ensuring high-quality long term care (LTC) facility system. The approach includes strengthening requirements for LTC facilities, also known as nursing homes, working with states to enforce statutory and regulatory requirements, increasing transparency of nursing home performance, improving quality, and putting patient safety first by removing unnecessary burdens on providers. In addition to protecting patients and reducing burdens, the rule helps nursing homes focus their resources on their residents by ***saving them $616 million in administrative costs*** annually that can be reinvested in patient care.

More information can be found here:
Final and Proposed Rules
The fact sheet is available here: LTC Regulatory Provisions.

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.

We want to hear from you. Email your feedback or share your burden story: PatientsoverPaperwork@cms.hhs.gov

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

To learn more about what CMS is doing for rural health, visit our website at go.cms.gov/ruralhealth and read our CMS Rural Health Strategy. Follow #ReThinkingRuralHealth on Twitter to see the latest from CMS on rural health.