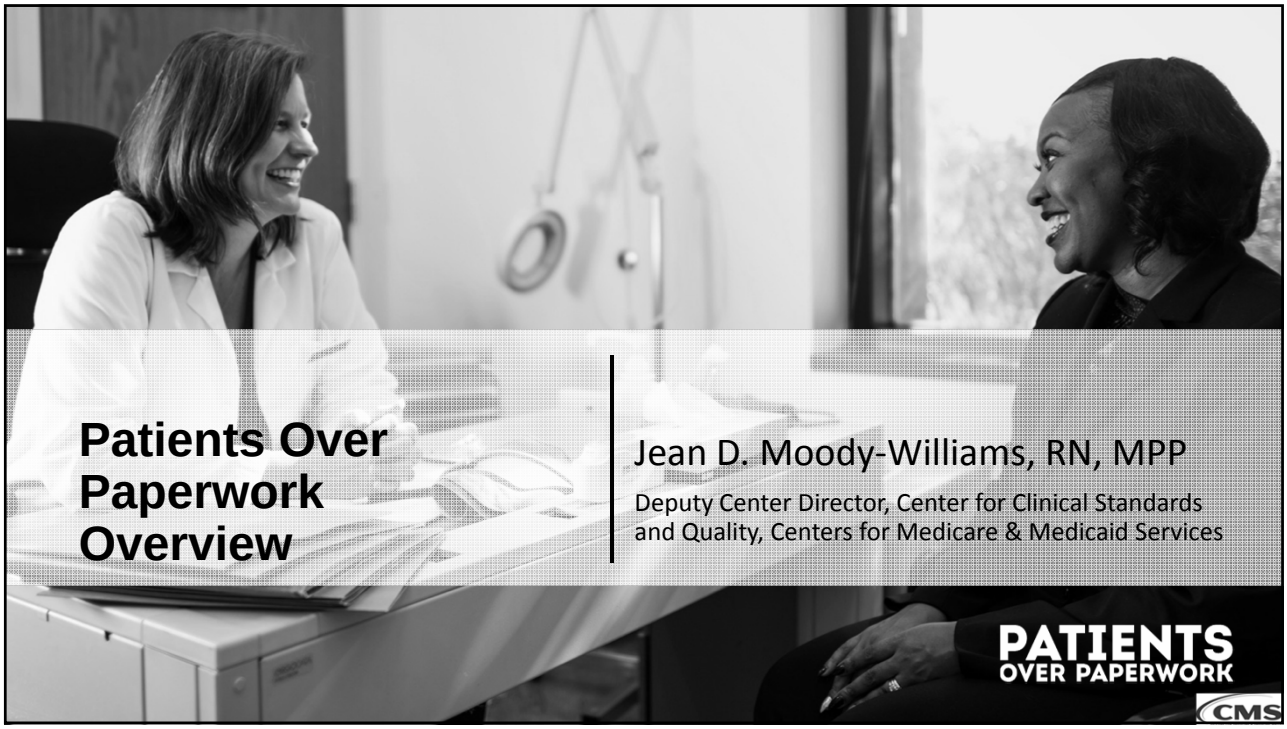


Understand the different perspectives that others bring

Tomorrow's Healthcare

- **We all view value from a different perspective and all have an important contribution to make**
- **Patients and Families can change our viewpoint when allowed to shape healthcare decisions and policy**
- **The moving process provides a great reminder of how people approach and view things differently and how important it is to include the voice of patients and families.**

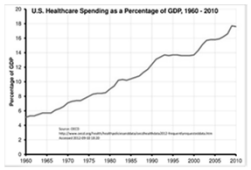
My View of My House

The Realtors View of the House

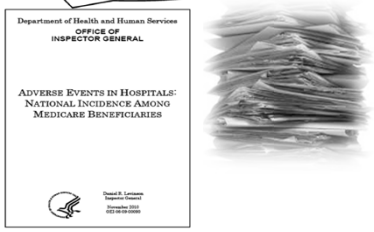
The Lender's View of the House

Appraiser's View of the House

Not too long ago - 1 in 7



about 1 in 7 experienced an adverse event



7

The Need for Solutions

PATIENTS OVER PAPERWORK

Putting Patients First

- CMS has established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience.
- CMS is moving the needle to remove regulatory obstacles that get in the way of providers spending time with patients and healthcare consumers.

CMS 9

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What are we trying to fix?

CMS publishes nearly 11,000 pages of regulations every year. Some of these regulations are necessary to ensure patient safety and program integrity, but many are overly burdensome forcing providers to spend more time on paperwork than they do with their patients.

CMS 3

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What we are hearing:

Example: Claims being denied for a chemotherapy agent because the nurse's administration record was initialed rather than signed with a full signature…

Example: Requiring providers to report on several Meaningful Use measures that may have been anything but meaningful to them….

CMS 4

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Goals

- Patient over Paperwork aims to:
  - Increase the number of customers – clinicians, institutional providers, health plans, etc. engaged through direct and indirect outreach;
  - Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance; and
  - Increase the proportion of tasks that CMS customers can do in a completely digital way.

CMS 12

PATIENTS OVER PAPERWORK

Approach

CMS has set up an agency-wide process to evaluate and streamline our regulations and our operations with the goal to reduce unnecessary burden, increase efficiencies and improve the customer experience.

- Formal Requests for Information
- Customer Centered Work groups
- Journey Mapping
- Meaningful Measurement Framework
- Promoting Interoperability
- Engaging Stakeholders

CMS 13

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Customer Work Groups

We are establishing customer-centered workgroups focusing first on clinicians, beneficiaries, and institutional providers. The job of these workgroups is to learn from and understand the customer experience, internalize it, and remember these perspectives as we do this work. Over time, we'll establish similar workgroups for health plans, states and suppliers.

CMS 14

PATIENTS OVER PAPERWORK

Customer Defined Burden

We will use tools to capture customer perspectives, like human-centered design and journey maps of the customer experience. We will establish mechanisms to share across CMS what we learn from our customers so we all benefit from that input.

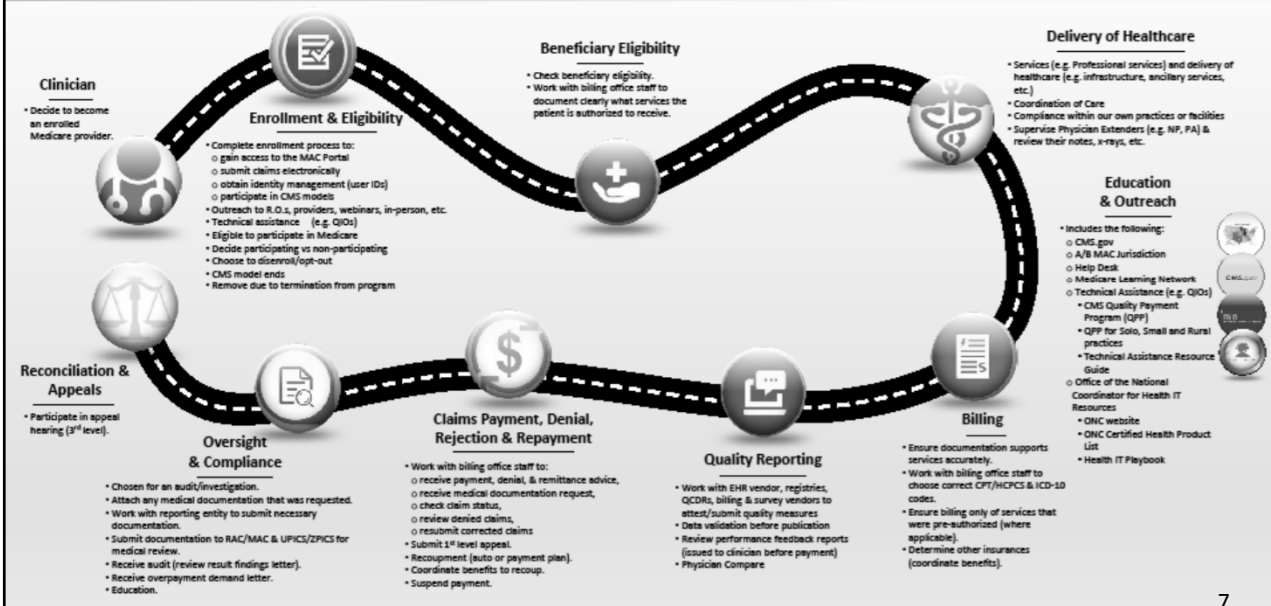
CMS 15

Medicare FFS Clinician Journey

Reduce administrative burden so that providers can focus on delivering high quality healthcare to their patients.

Version 9.5

CMS OFFICE OF INFORMATION TECHNOLOGY



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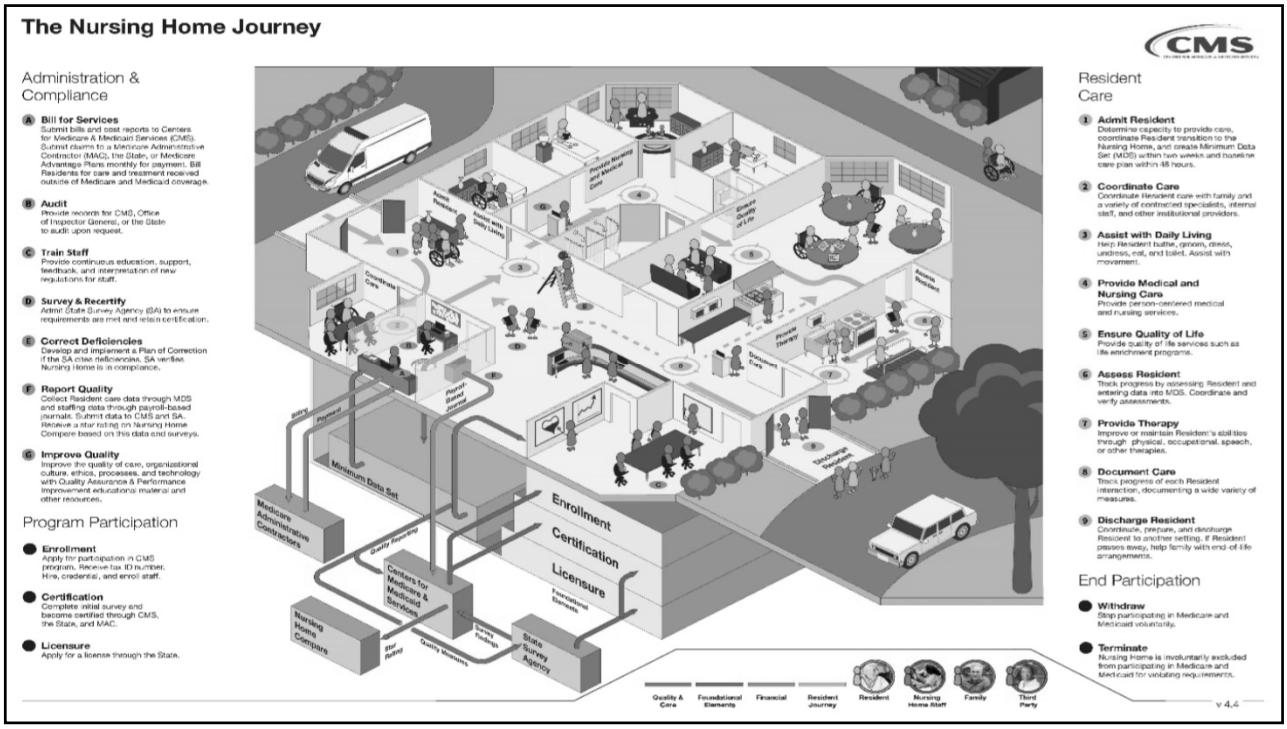

PATIENTS OVER PAPERWORK

Burden Reduction Activities

- We've met with providers, beneficiaries, family members, caregivers, and health care professionals to inform our actions.
- In total, we conducted 21 site visits, nearly 300 customer interviews, 97 subject matter expert interviews, and held 73 listening sessions around the country.
- We also asked stakeholders, through RFIs, to send us their ideas on how we can reduce burden, and we received over 2,800 comments that we have been going through with a fine tooth comb to find any way we can reduce regulations and improve patient care.

CMS 18

PATIENTS OVER PAPERWORK

Burden Reduction Activities

- Between 2018 and 2021, CMS now projects the Patients Over Paperwork initiative will eliminate more than 53 million hours of burden for providers and save our healthcare system close to $5.2 billion in rules finalized last year and this year and other current proposals.
- On September 17, 2017 we published a proposed rule that would save thousands or hours and produce an additional $1.12 billion in savings every year.

CMS 19

PATIENTS OVER PAPERWORK

- As we developed proposals, we considered,
  - Proposals that simplify and streamline processes;
  - Proposals that reduce the frequency of activities and revise timelines
  - Proposals that are obsolete, duplicative, or that contain unnecessary requirements.

Always keeping the health and safety of patients at the forefront

PATIENTS OVER PAPERWORK

The Omnibus Rule included proposals for nearly every healthcare setting:

- Emergency Preparedness flexibilities
- Integrated QAPI and Infection Control Plans
- Flexibility in pre-surgery/pre procedure assessment for outpatient surgeries and procedures
- Reducing requirements for CAHs to review policies and procedures
- Transplant Center flexibilities
- Modernization of Hospice Rule
- Considerations for portable x-ray orders

The Da Vinci Project Goals

1. Improve "Provider to Payer" information exchange
   - At the time of service
   - Integrated into the provider's workflow
   - Examples:
     - Is **prior authorization** required by my patient's insurance company for the item I'm about to order?
     - Does my patient's insurance company have a **documentation template** for the service for which I'm about to refer my patient?
2. Improve "Provider to Provider" interoperability
   - Kill the fax machine!
   - Allow electronic sending of orders, plans of care and other types of medical records

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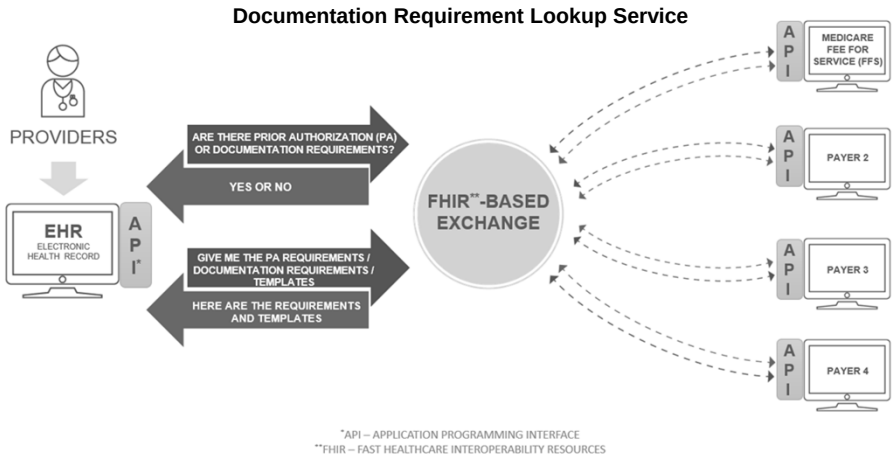
Providers will have access to the "RIGHT" documentation requirements at the time of service



go.cms.gov/MedicareRequirementsLookup

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Interoperability – My HealthE Data

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Interoperability as a Priority

- **MyHealthEData - Using all CMS levers and authority to reward a move towards interoperability and the sharing of healthcare data with patients. Many of the levers are in programs houses in CCSQ:**
- **Overhauling CMS programs to encourage interoperability and save time and costs.** CMS is streamlining the EHR Incentive Program ("Meaningful Use") program for hospitals and the Quality Payment Program for clinicians (part of MACRA) to increase the programs' focus on interoperability and reduce the amount of effort required to comply with them.
- **CMS will prioritize the use of quality measures and improvement activities in value-based care and quality programs that lead to interoperability.**
- **CMS is also taking steps against information blocking** – a practice in which providers prevent patients from getting their data, by requiring under some CMS programs hospitals and clinicians to show they have not engaged in data blocking activities.
- **Requiring providers to update their health IT systems to ensure data sharing.** CMS will not be delaying the requirement that hospitals and clinicians use the updated 2015 Edition of Certified EHR Technology (or "CEHRT") under some of its programs, which may require providers to update their systems to the 2015 Edition to allow for better sharing of healthcare data with care teams and patients. CMS will also be implementing use of 2015 Edition CEHRT as a requirement for participants in Center for Medicare and Medicaid Innovation (CMMI) models and ACOs.
- **CMS will ensure that a patient's data follows them after they are discharged from the hospital.** CMS will be specifying what types of information- ideally in an electronic format- must be shared by a hospital with a patient's receiving facility or provider.
- **Partnership with ONC on EHR Burden Reduction**
- **Launching Medicare's Blue Button 2.0 which will allow Medicare beneficiaries to receive their claims information electronically.** This will significantly improve the beneficiaries' experience as the data will be in a universal and secure format that they can share.

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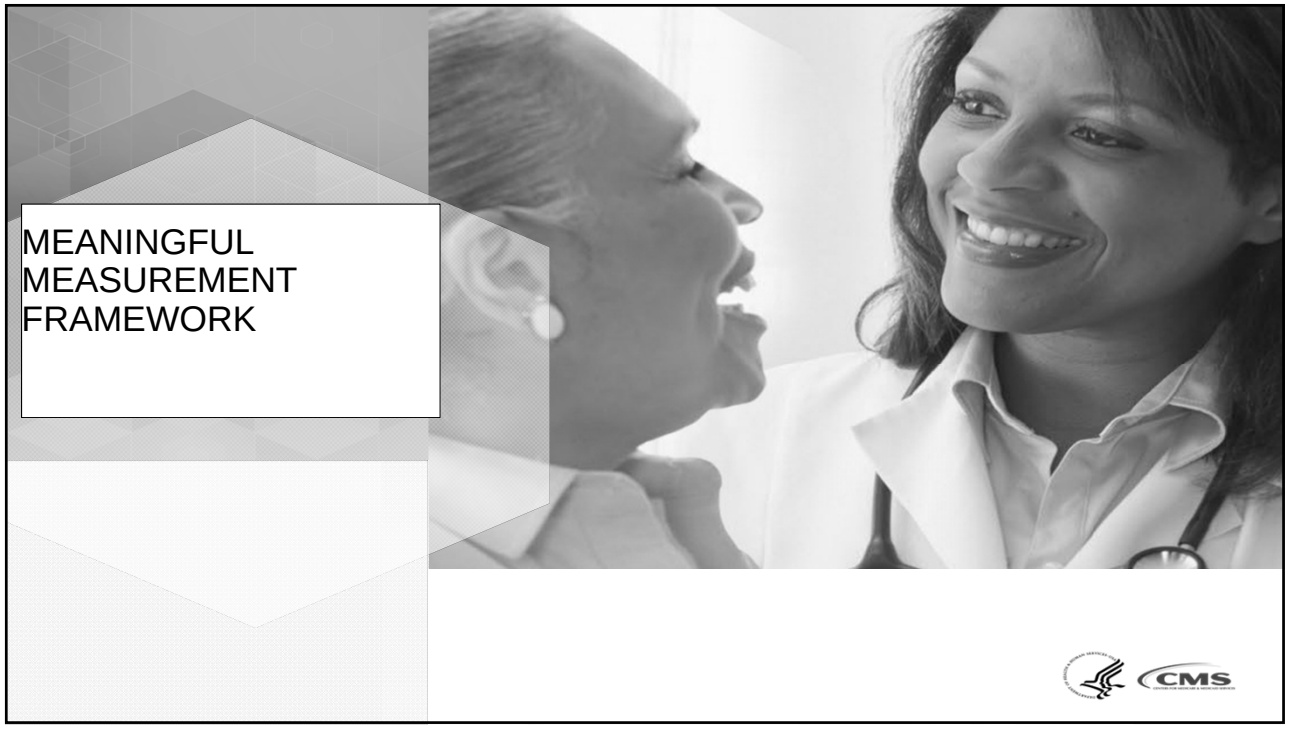

Meaningful Measures Initiative

- Launched in 2017, the purpose of the Meaningful Measures initiative is to:
- Improve outcomes for patients
- Reduce data reporting burden and costs on clinicians and other health care providers
- Focus CMS's quality measurement and improvement efforts to better align with what is most meaningful to patients

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Meaningful Measures Objectives

- **Meaningful Measures focus everyone's efforts on the same quality areas and lend specificity to help identify measures that:**

Address high-impact measure areas that safeguard public health

Are patient-centered and meaningful to patients, clinicians and providers

Are outcome-based where possible

Fulfill requirements in programs' statutes

Minimize level of burden for providers

Identify significant opportunity for improvement

Address measure needs for population based payment through alternative payment models

Align across programs and/or with other payers

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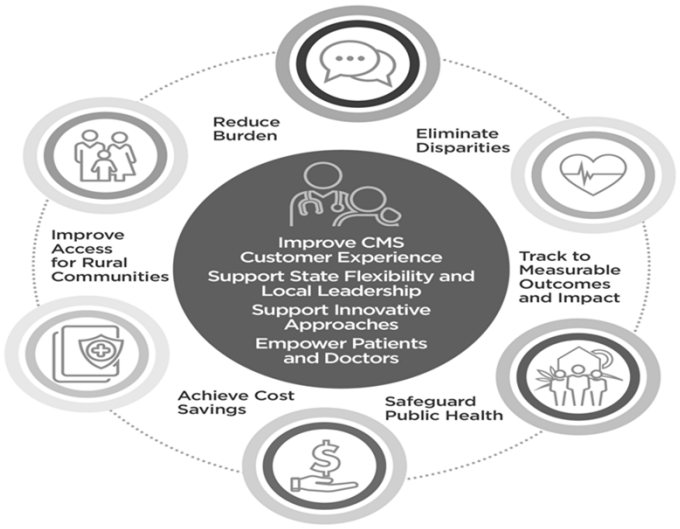
Meaningful Measures



- **Promote Effective Communication & Coordination of Care**
  - Meaningful Measure Areas:
    - Medication Management
    - Admissions and Readmissions to Hospitals
    - Transfer of Health Information and Interoperability
- **Promote Effective Prevention & Treatment of Chronic Disease**
  - Meaningful Measure Areas:
    - Preventive Care
    - Management of Chronic Conditions
    - Prevention, Treatment, and Management of Mental Health
    - Prevention and Treatment of Opioid and Substance Use Disorders
    - Risk Adjusted Mortality
- **Work with Communities to Promote Best Practices of Healthy Living**
  - Meaningful Measure Areas:
    - Equity of Care
    - Community Engagement
- **Make Care Affordable**
  - Meaningful Measure Areas:
    - Appropriate Use of Healthcare
    - Patient-focused Episode of Care
    - Risk Adjusted Total Cost of Care
- **Make Care Safer by Reducing Harm Caused in the Delivery of Care**
  - Meaningful Measure Areas:
    - Healthcare-associated Infections
    - Preventable Healthcare Harm
- **Strengthen Person & Family Engagement as Partners in their Care**
  - Meaningful Measure Areas:
    - Care is Personalized and Aligned with Patient's Goals
    - End of Life Care according to Preferences
    - Patient's Experience of Care
    - Patient Reported Functional Outcomes

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Patient Safety

Healthcare-Associated Infections

Preventable Healthcare Harm

Meaningful Measure Areas

Programs Using Illustrative Measures

Hospital-Acquired Condition Reduction Program (HACRP)
Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
Medicaid and CHIP (Medicaid & CHIP)
Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
Skilled Nursing Facility Quality Reporting Program (SNF QRP)
Hospital Inpatient Quality Reporting (IQR) Program
Home Health Quality Reporting Program (HH QRP)
Quality Improvement Organization (QIO)

Measures

Central Line-Associated Bloodstream Infection (CLABSI)
HACRP, LTCH QRP, Medicaid & CHIP, QIO

Surgical Site Infections (SSI)
IQR

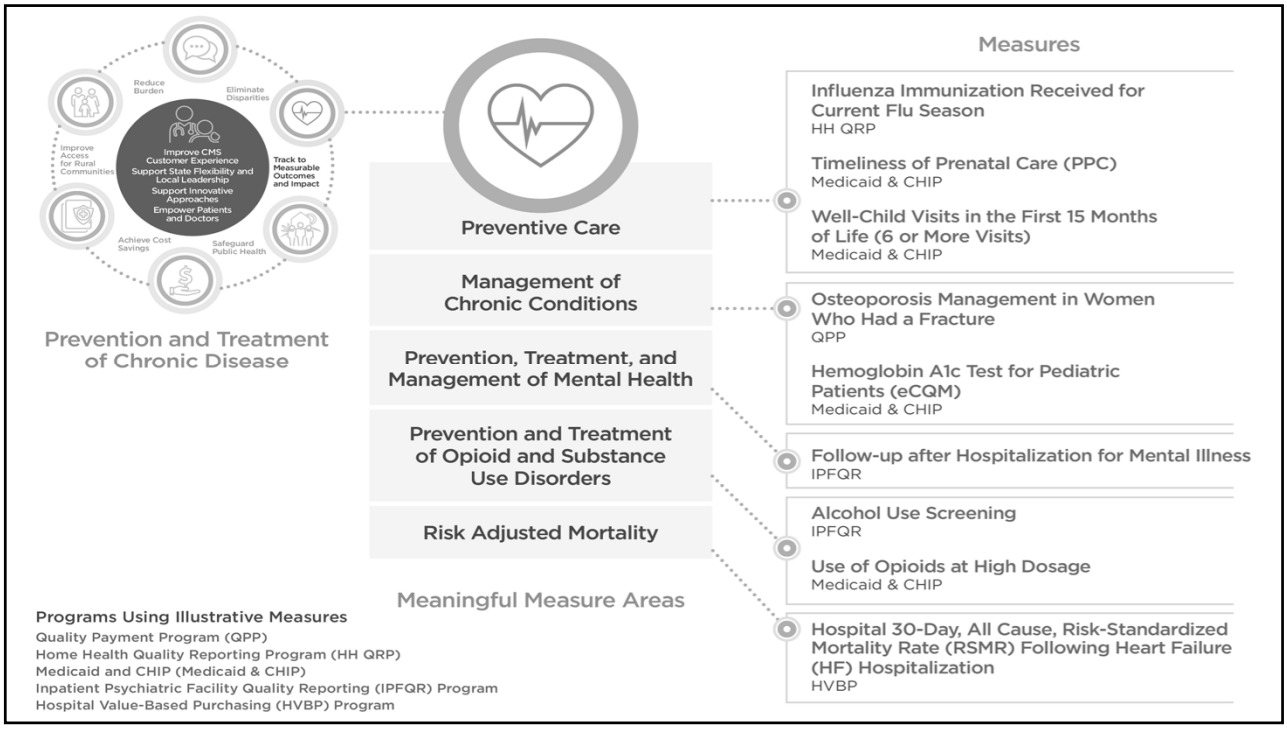
Pediatric Central Line-Associated Bloodstream Infections Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
Medicaid & CHIP

Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Outcome Measure
LTCH QRP, IRF QRP

Catheter-Associated Urinary Tract Infection (CAUTI)
IRF QRP, LTCH QRP, QIO

Early Elective Delivery
Medicaid & CHIP

Percent of Patients or Residents with Pressure Ulcers that are New or Worsened
IRF QRP, LTCH QRP, SNF QRP, HH QRP



Meaningful Measures

Meaningful Measures Area: Interoperability

- Lack of interoperability has posed significant challenges to the use of health IT for data exchange and care coordination
- HHS has explicit authority to advance interoperability as described in the *21st Century Cures Act*.
- CMS is committed to advancing health information technology to:
  - Mature technology
  - Mature standards governed by HHS, and
  - Less regulatory obstacles to interoperability.

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Taking a Critical Look at Measures

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

- Remove six measures,
- Estimated burden reduction of 457,490 hours and $16.7 million

Ambulatory Surgical Center (ASC) Quality Reporting Program

- Finalized the removal of three measures.
- Estimated Burden Reduction of 1,314 hours and $48,066 for the 2019 payment determination.
- 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.

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Taking a Critical Look at Measures

- **End Stage Renal Disease Quality Incentive Program**
  - Replaced 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.
  - 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.
  - Net burden reduction of $145,986,343 and HH clinician burden of 2,016,386 hours annually.

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Currently Acknowledged Categories of Value Based Care

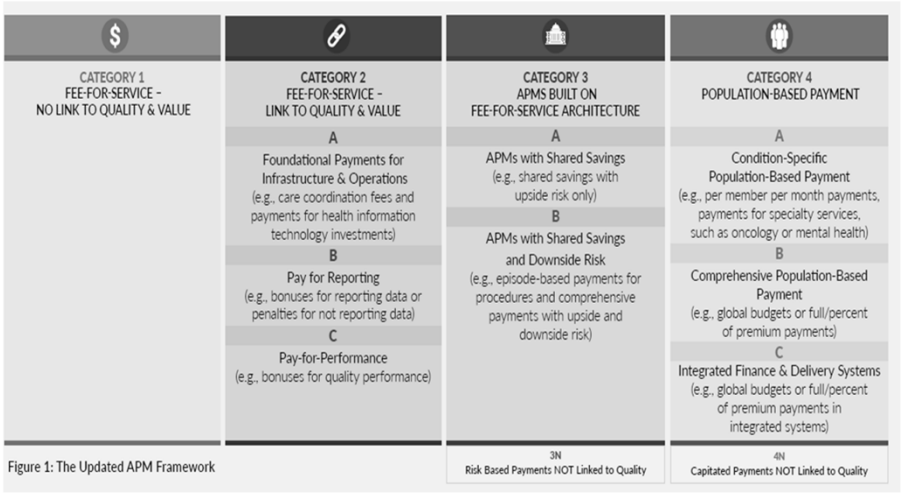

Figure 1: The Updated APM Framework

The Health Care Payment Learning & Action Network (LAN) , Alternative Payment Model (APM) Framework, Updated July 2017

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Quality Payment Program

MIPS and Advanced APMs

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in MIPS, you will earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternative Payment Models (Advanced APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

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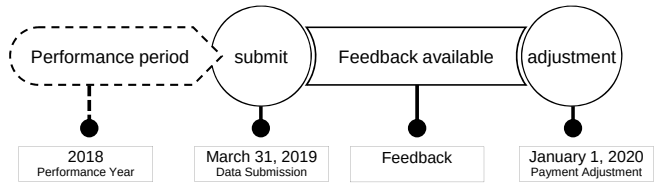
MIPS Year 2 (2018)

Timeline for Year 2



- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

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CMS Program Impacts

30	quality measures improved on by 430 CMS Accountable Care Organizations (Medicare Shared Savings Program)
2.1	million fewer incidents of harm and $28 billion saved (Hospital-Acquired Conditions Reduction Program)
22%	improvement in dialysis adequacy and 17% decrease in readmissions for dialysis patients (ESRD Quality Incentive Program)
$319	million net savings to Medicare total cost of care through avoidance of preventable readmissions and ER visits (Maryland All-Payer Model)
150,000	fewer all-cause readmissions with rate decline to 17.5% (Hospital Readmissions Reduction Program)

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A-5

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Resources

For more information visit:
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