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What is CMS Doing to Reduce Administrative Burden for Physicians?

Are you familiar with the CMS initiative, Patients over Paperwork, introduced in 2017? If not, you'll want to get up-to-speed. Many providers are watching the program's development with a close eye due to its intent to eliminate "overly burdensome and unnecessary regulations and sub-regulatory guidance in order to allow clinicians and providers to spend less time on paperwork and more time on their primary mission – improving their patients' health." Sounds like the relief providers have been waiting for.

In its second Request for Information (RFI) for this initiative in June, 2019, CMS solicited public comment and new ideas that weren't proposed during its first RFI. As of the Comments Close date of August 12, 2019, nearly 570 responses had been received.

Responses were encouraging, many hitting on common areas of clinician complaint directly related to challenges in the provision of timely patient care, billing and reimbursement, and participation in value-based payment programs such as the Merit-Based Incentive Payment System (MIPS).

Let's look at some of those comments and recommendations as they impact your pathology practice.

The **COLLEGE OF AMERICAN PATHOLOGISTS (CAP)**, the world's leading organization of board-certified pathologists, contributed to the RFI with insightful new proposals, expanding upon its previous list of recommendations for regulatory relief drafted after meeting with the Department of Health and Human Services in 2017. For example:

> Prior Authorization
>
> In agreement with the American Medical Association, the CAP considers prior authorization overused, inefficient, costly and often responsible for delays in patients receiving care. Honing-in further on the specialty of pathology, the CAP raises the issue of laboratory benefits management programs which, it deems, limits clinical decision making in the use of clinical laboratory and pathology services. Its position is that laboratory benefits management programs and other prior authorization protocols should be:
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> - Based on peer-reviewed published evidence
> - Subject to routine and timely updates based on accepted standards of clinical practice
> - Able to be overridden by the physician in accordance with his/her medical judgment
> - Prohibited from facilitating business practices that would adversely impact billing/claims adjudication for a pathology/laboratory provider rendering services based on appropriately ordered testing
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> The CAP recommends limiting prior authorization requirements to testing where it is needed most (e.g. highly esoteric molecular/genomic testing) and streamlining prior authorization processes including those in Medicare Advantage plans.

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Physician Burden in Obtaining Hospital-Owned Data for Registry Reporting of MIPS Measures

The CAP deems CMS' elimination of the claims-based reporting option for MIPS to have put pathologists at a disadvantage because of the difficulty in accessing data from hospitals' EHRs and LISs for the quality category of the program. Relative to its own clinical data registry, The Pathologists Quality Registry, the organization further states that a large number of physicians using it are not able to obtain that data from their hospitals that cite privacy and security concerns as the reason. Although CMS has indicated there aren't any formal regulations prohibiting a hospital from releasing the information, the issue has remained deadlocked because hospitals set their own legal requirements for accessing data.

The CAP recommends that CMS work together with the Office of the National Coordinator (ONC) to create solutions facilitating the flow of information between EHRs, LISs and registries and to incorporate a "hold harmless" provision for hospitals, physicians and laboratories in the event of a data breach.

Clinical Laboratory Fee Schedule

Maintaining that the data collection process for Protecting Access to Medicare Act (PAMA) was flawed, the CAP specifically cites CMS' definition of "applicable laboratory" as a major contributor because it excludes most hospital laboratories. Accordingly, carving-out this significant portion of the laboratory market skews the PAMA payment rates to "reflect disproportionately large commercial clinical laboratories."

The CAP proposes that a more thorough data collection process is required to ensure that the final rates are accurate, and recommends CMS continue working toward a broader and more appropriate scope of the laboratory market for the next reporting period.

The **HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION** (HBMA) is a revenue cycle management authority with a membership representing nearly 350 revenue cycle management firms and professional billing entities. In its response to the RFI, the HBMA offered multiple recommendations for reducing administrative burdens that directly and continually bog-down the revenue cycles of physician practices. For example:

Local Coverage Determinations (LCD)

LCDs are coverage policies developed by the individual Medicare Administrative Contractors (MACs) and, as such, are inconsistent across MAC jurisdictions with regards to content and/or timing. The HBMA maintains that MACs "routinely fail to update their internal systems to properly accept and adjudicate their own LCDs" and since CMS updates its systems only quarterly, clinicians can wait months for the needed corrections and subsequent payments.

The HBMA recommends eliminating existing LCDs and ending the authority of MACs to develop new LCDs moving forward.

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Provider Enrollment

The process of enrolling clinicians onto an insurance company's provider panel is frequently handled by a practice's billing or revenue cycle management organization. CMS uses the information obtained during this process to administer several programs and policies.

HBMA suggests a number of improvements that can be made to reduce the administrative burden and delay associated with the enrollment procedure overall:

- Allow practices to list their billing agent or revenue cycle management company on the enrollment form for documentation requests so those entities can directly receive and respond to the requests and eliminate the practice as a "middle-man"
- Expand PECOS to function as a centralized enrollment system for all payers, eliminating the delay associated with enrolling and maintaining the same information in multiple systems
- Allow medical records requests for providers to be sent electronically and stored in PECOS, reducing the manual process of mailing hard copies

Merit-based Incentive Payment System (MIPS) and Value-based Payment Programs

The HBMA describes MIPS and other value-based payment programs as continuing to place "significant administrative burden" on practices. Citing annual changes to these programs that require resource-intensive monitoring and development of ongoing workflow processes for reporting data, the HBMA recommends that CMS simplify the reporting requirements for MIPS and other such programs. Further, the HBMA contends there are specialties that want to participate in MIPS but do not have enough quality measures for their specialty. This is a valid concern for anatomic pathology that lost 3 quality measures for the 2019 performance year, leaving just 5 in that specialty set to report for the quality category of the program.

The HBMA's recommendation here is for CMS to expedite the measure development process and replace topped-out measures. A topped-out measure is one with consistently high performance rates by the MIPS participants. In most cases these measures will be phased-out of the program over a four year period during which they will be capped at a lower maximum score before being eliminated completely. All 5 of the quality measures in the pathology specialty set for 2019 have been designated as topped-out.

The Patients over Paperwork initiative is gaining ground. APS will continue to follow progress and keep you apprised of key points along the way. We encourage you to review additional comments submitted to the RFI at the following link:

https://www.federalregister.gov/documents/2019/06/11/2019-12215/request-for-information-reducing-administrative-burden-to-put-patients-over-paperwork

Please contact Karen Harmon at APS with any questions: kmharmon@apsmedbill.com.