DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Dear Clinician,

CMS has been hard at work to address the burden placed on clinicians by federal health care regulations. Through our "Patients over Paperwork" initiative we are collecting feedback and updating policies in Medicare and Medicaid that are outdated, duplicative, or overly burdensome. Over the past year I have traveled the nation and met with clinicians, and the feedback I have heard has guided my efforts at the agency.

One key initiative that we have launched involves streamlining the measures that clinicians report; a recent Health Affairs study found that U.S. medical practices in four common specialties on average spend, per physician, a striking 15.1 hours per week and over $40,000 per year reporting quality metrics. The litany of regulations in healthcare contributes to the consolidation we're seeing in the system. According to a survey by the American Medical Association, the percent of clinicians with ownership status in their practice declined from 53 percent in 2012 to 47 percent in 2016, with younger physicians more than three times as likely as older physicians to be employed by hospitals.

As one example of a common sense regulatory change that we have made this year, we changed our policy on medical student documentation, so patient notes written by a medical student can now be used for billing purposes after the attending physician signs off. Through our implementation of MACRA, we have worked to ensure a gradual transition for clinicians to the new payment system. And more recently, we addressed payment differentials between sites of service that reduce competition in the system.

In the 2019 proposed rule for the Physician Fee Schedule, CMS recognized another opportunity to act on the feedback that we have been receiving regarding clinician burden and the burnout that can come as a result. We have heard repeatedly that a major source of burnout is the documentation burden associated with evaluation and management (E/M) coding, and that a change is long overdue.

The current 1995/1997 E/M framework was built upon a model of clinical care involving complaint or symptom-based face-to-face encounters between a patient and a clinician. Since the 1990s, the nature of clinical work has evolved, including greater emphasis on patient-centered, collaborative models of care with clinical teams working together to manage chronic conditions. The intensity of this work, which often requires complex medical decision-making and care coordination, is not well represented in the current E/M framework. As a result, clinicians find themselves having to perform and document clinical activity that may be of only marginal relevance to the visit, but is required in order to receive the level of payment that their effort deserves.

CMS sought to update documentation requirements and propose a new model of payment for E/M services. In response to our proposals, the agency received more than 15,000 comments, which reaffirmed the need to reduce burden on clinicians and provided us with specific feedback on how to improve our proposal. We appreciate the input and have responded. Effective January 1, 2019, we will:

- Simplify the documentation of history and exam for established patients such that when relevant information is already contained in the medical record, clinicians can focus their documentation on what has changed since the last visit rather than having to re-document information.
- Clarify that for both new and established E/M office visits, a Chief Complaint or other historical information already entered into the record by ancillary staff or by patients themselves may simply be reviewed and verified rather than re-entered.
- Eliminate the requirement for documenting the medical necessity of furnishing visits in the patient's home versus in an office.
- Remove potentially duplicative requirements for certain notations in medical records that may have previously been documented by residents or other members of the medical team.

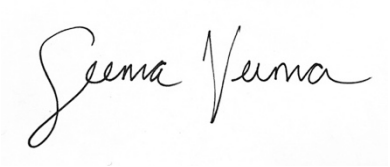
Beginning in 2021, we will implement payment and coding changes to achieve additional burden reduction. Billing for visits will be simplified and payment will vary primarily based on attributes that do not require separate, complex documentation. For 2021, we intend to:

- Implement a single payment rate for visits currently reported as levels two, three, and four. These represent a majority of office/outpatient visits with clinicians. This means that for the majority of visits, the required documentation related to payment will be limited to what is required for a level two visit.
- Retain a separate payment rate for the most complex patients – those currently reported through use of the level five codes. Also we will retain the current separate code for level one visits, which are predominantly used for visits with clinical support staff.
- Introduce coding that adjusts rates upward to account for additional resource costs inherent and routine in furnishing certain types of non-procedural care. These codes would only be reportable with level two through four visits, and their use generally would not impose new per-visit documentation requirements.
- Introduce coding that adjusts rates upward for use with level two through four visits to account for the additional resource requirements when practitioners need to spend extended time with a patient.
- Allow for flexibility in how level two through five visits are documented – specifically introducing a choice to use the current framework, medical decision-making, or time.

We acknowledge that there is a great deal of work to do to further modernize the payment structure for office/outpatient visits and associated documentation requirements. We are

committed to getting this right in order to reflect the evolving nature of clinical practice, respect the work of physicians and other clinicians, and support the best experience of care for every patient. A two-year delay for the payment and coding changes will give clinicians more time to integrate changes in workflow that may be required. In addition, the extra time will allow CMS to continue working with the clinician community on this effort.

CMS is committed to reducing administrative burden. We need clinicians to be able to leverage their full skill set and provide high-quality patient care, instead of being consumed by paperwork. We welcome your feedback and look forward to continuing engagement with clinicians to improve the framework through which we understand and value the care that they provide.



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