Press Release

CMS Proposes to Lift Unnecessary Regulations and Ease Burden on Providers

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Proposed rule driven by agency's Patients Over Paperwork initiative, expected to save U.S. healthcare facilities $1.12 billion per year

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Today, the Centers for Medicare and Medicaid Services (CMS) announced a proposed rule to relieve burden on healthcare providers by removing unnecessary, obsolete or excessively burdensome Medicare compliance requirements for healthcare facilities. Collectively, these updates would save healthcare providers an estimated $1.12 billion annually. Taking into account policies across rules finalized in 2017 and 2018 as well as this and other proposed rules, savings are estimated at $5.2 billion.

CMS developed the proposed rule in response to President Trump's charge to federal agencies to "cut the red tape" and reduce burdensome regulations. In addition, feedback from Requests for Information (RFIs) the agency issued seeking stakeholder input on regulatory burdens helped inform this proposed rule, with particular attention to comments and anecdotal insights from clinicians serving Medicare beneficiaries.

"We are committed to putting patients over paperwork, while at the same time increasing the quality of care and ensuring patient safety and bolstering program integrity," said CMS Administrator Seema Verma. "With this proposed rule, CMS takes a major step forward in its efforts to modernize the Medicare program by removing regulations that are outdated and burdensome. The changes we're proposing will dramatically reduce the amount of time and resources that healthcare facilities have to spend on CMS-mandated compliance activities that do not improve the quality of care, so that hospitals and healthcare professionals can focus on their primary mission: treating patients."

Many of the proposals simplify and streamline Medicare's conditions of participation, conditions for coverage, and other requirements for participation for facilities, so they can meet health and safety standards more efficiently. This proposal ensures continued protection for patient health and safety.

A key provision would reduce burden and promote efficiency to support patients who need organ transplants. The rule would eliminate a duplicative requirement on transplant programs to submit data and other information more than once for "re-approval" by Medicare. Re-approval has led to transplant programs avoiding performing transplants for certain patients, causing some organs to go unused. CMS will maintain other requirements in order to continue to monitor outcomes and quality of care in transplant programs after initial Medicare approval.

Additional provisions in the proposed rule would, for example:

- Streamline hospital outpatient and ambulatory surgical center requirements for conducting comprehensive medical histories and physical assessments.
- Allow multi-hospital systems to have unified and integrated Quality Assessment and Performance Improvement programs for all of their member hospitals.
- Simplify the ordering process for portable x-rays and modernize the personnel requirements for portable x-ray technologists.
- Remove duplicative ownership disclosure requirements for Critical Access Hospitals.

Patients Over Paperwork

Following President Trump's leadership in his "Cut the Red Tape Initiative," today's proposed rule is the latest in a series of steps that are reducing unnecessary burden on facilities, generating efficiencies and giving healthcare providers more time to spend with their patients.

Since CMS's Patients Over Paperwork initiative began in 2017, the agency has led a robust RFI process, held interviews with diverse stakeholder groups, visited healthcare facilities across the country and organized work groups. Stakeholders that participated include: beneficiaries/consumers, clinicians/individual providers, institutional providers, government entities, health plans and members of the supply chain. These efforts to better engage with stakeholders yielded 3,040 mentions of burden, which CMS categorized as related to 1,146 different issues.

To date, CMS has taken action to address 55 percent (624) of the burden topics raised, while approaches to 16 percent (185) of the topics remain under consideration and 29 percent (337) were either referred to another agency or did not require further action.

Across rules finalized in 2017 and 2018 and current proposed rules to address these topics, CMS projects savings of nearly $5.2 billion and a reduction of 53 million hours through 2021. That results in saving 6,000 years of burden hours over the next three years.

	Burden Reduction ($)	Burden Reduction (Hours)
2018	$ 183 million	10.8 million
2019	$ 1.6 billion	12.6 million
2020	$ 1.7 billion	15.3 million
2021	$ 1.7 billion	14.3 million
Total:	$ 5.2 billion	53 million

Moreover, many of the policies produce ongoing annual savings not captured in this total. CMS also remains focused on ways to reduce burden through reforms to the Stark Law and Evaluation and Management Codes. Even beyond the burden reduction captured in these rules, we have been working at all levels to streamline and modernize our programs, such as by reducing the administrative burden providers associated with provider audits. This Administration has awarded new Recovery Audit Contracts (RAC) with checks and balances in place to ensure providers are not adversely impacted from reviews; modified its traditional medical review process to move to a targeted review and education process; and streamlined and clarified documentation requirements in payment manuals.

Experts agree that reducing unnecessary burden is critical to improving patient care. Burden hours represent the amount of time healthcare providers spend complying with federal regulations. A study published in the Annals of Internal Medicine found that for every hour providers spend seeing patients, nearly two additional hours are spent on paperwork.

Meaningful Measures

CMS has heard from providers that overly burdensome and redundant measures have taken time away from patients, which is why CMS launched the Meaningful Measures initiative. Under this initiative CMS is closely examining all measures, and proposing to eliminate ones that are outdated, are duplicative, are overly burdensome, or are not strongly linked to patient outcomes.

A recent Health Affairs study reported that U.S. physicians and their staff in four common specialties spend, on average, 15.1 hours per week and more than $40,000 per year reporting quality measures. This equates to 785 hours per physician and more than $15.4 billion annually. The vast majority - 81 percent - of practices reported that they now spend more effort dealing with quality measures than three years ago, and only 27 percent said current measures are representative of the quality of care.

A Family Practice Management review notes that the proliferation of quality measures and the pay-for-performance (P4P) systems that use them have led to significant administrative burdens and unintended consequences, often devaluing the patient-physician relationship and contributing to clinician burnout.

Through several proposed rules, including this one, CMS seeks to eliminate reporting requirements for 105 out of 416 measures across the agency's programs, saving healthcare providers $178 million over the next two years.

Feedback Welcome

CMS looks forward to feedback on the proposal and will accept comments until November 19, 2018. Comments may be submitted electronically through our e-Regulation website https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking.

To learn more about the proposed rule, please visit the Federal Register: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-19599.pdf

Read the CMS fact sheet on the proposed rule; an "at a glance" overview of Medicare Burden Reduction can be found here: https://downloads.cms.gov/files/MedicareBurdenReductionfinal.pdf

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