CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Burden Reduction

Problem: We met with thousands of clinicians and stakeholders over the past year and learned one of their top concerns is the amount of paperwork and burden they are required to do which takes time away from the patient.

Solution: The Centers for Medicare & Medicaid Services (CMS) issued Requests for Information (RFIs) to solicit comments on burden reduction, flexibilities, and efficiencies through the annual rulemaking process for nine Medicare Fee-for-Service payment rules. Over 2,800 comments were received.

Resulting in:

- **55%:** burden topics resolved or actively being addressed
- **16%:** burden topics under consideration
- **29%:** burden topics referred to another agency for consideration or no further CMS action required

We went across the country to hear directly from the field through:

- **21:** site visits
- **Nearly 300:** customer interviews
- **97:** subject matter expert interviews
- **73:** listening sessions and other engagement opportunities focusing on four customer segments — Beneficiary, Nursing Home, Clinician and Hospitals

PATIENTS OVER PAPERWORK—AT A GLANCE

Medicare Burden Reduction Proposal for CY/FY 2018 and 2019

- **105:** measures removed
- **4 out of 5:** measures remaining
- **$178 million:** net dollars saved — meaningful measures only
- **$5.2 billion:** total savings between 2018 and 2021
- **53 million:** total burden hours reduced between 2018–2021

BURDEN REDUCTION (BY YEAR)

Total projected savings from rules finalized in 2017 and 2018 and current proposed rules:

Close to $5.2 billion

More than 53 million hours (6,000 years of time)

	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**

BURDEN REDUCTION (BY PROVIDER TYPE)

Savings 2018–2021

Provider Types	Dollars	Hours
Accountable Care Organizations (ACOs)	$3.9 million	45,000
Ambulatory Surgical Centers (ASCs)	$1.4 billion	915,000
Clinicians	$15 million	17.5 million
End Stage Renal Disease (ESRD)	$56 million	633,000
Home Health	$496 million	8.4 million
Hospice	$269 million	1 million
Hospital	$1.2 billion	14 million
Long Term Care	$497 million	6.6 million
Rural/Federally Qualified Health Center (FQHC)	$100 million	950,000

Note: Provider breakdown is a subset of the overall projected savings and does not include all provider type categories.

MEANINGFUL MEASURES

CMS's Meaningful Measures initiative is centered on patient safety, quality of care, transparency, and ensuring that the measure sets providers are asked to report make the most sense. The modernizing proposals to advance CMS's Meaningful Measures Initiative released in **eliminated 105 measures of 416 resulting in projected savings of $178 million and an anticipated reduction of 4.6 million burden hours!**