Comments for the Record

Comments on Reducing Administrative Burden To Put Patients Over Paperwork

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Thank you for the opportunity to comment on the "Patients Over Paperwork" initiative. Determining ways to further streamline administrative burdens is an admirable goal for any governmental agency. As of this submittal, the Centers for Medicare & Medicaid Services (CMS) inventory of "information collection requirements" (ICRs) accounts for roughly 199 million hours of paperwork annually – the equivalent of 97,628 full-time employees – at a stated cost of $8.2 billion. Examining this pool of paperwork requirements further, there are a series of ICRs that CMS should reassess in order to avoid duplicative and unnecessary requirements.

MOST TIME-INTENSIVE PAPERWORK REQUIREMENTS

Like many agencies whose decisions impact a significant portion of the population, CMS has a host of ICRs that impose significant burdens in the aggregate but are relatively small on a per-respondent basis. It can be difficult to find even marginal per-respondent time savings on items such as forms that only take minutes to complete. As such, focusing on ICRs with a higher per-respondent burden may prove more fruitful in finding potential savings. The following table contains 30 ICR entries (active as of this submittal) in CMS's portfolio with a per-respondent burden exceeding 100 hours.

ICR Number	Title	Respondents	Hours	Hours per Respondent
0938-1251	Healthcare Fraud Prevention Partnership (HFPP): Data Sharing and Information Exchange (CMS-10501)	55	176,800	3,214.5
0938-0974	Payment Error Rate Measurement in Medicaid and the State Children Health Insurance Program (CMS-10166)	34	56,100	1,650.0
0938-1353	Marketplace Operations (CMS-10637)	2,930	2,339,000	798.3
0938-0050	Hospitals and Health Care Complex Cost Report	6,088	4,097,224	673.0
0938-1249	Marketplace Quality Standards (CMS-10520)	1,770	1,085,095	613.0
0938-0686	(CMS-R-185) Granting and Withdrawal of Deeming Authority to Private Nonprofit Accreditation Organizations and of State Exemption Under State Laboratory Programs and Supporting Regs)	9	5,464	607.1

0938-1012	Payment Error Rate Measurement – State Medicaid and CHIP Eligibility (CMS-10184)	1,583	946,164	597.7
0938-1144	Application to Be a Qualified Entity to Receive Medicare Data for Performance Measurement (CMS-10394)	10	5,000	500.0
0938-0907	Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR, Section 412.64	3,400	1,632,000	480.0
0938-0790	Medicare and Medicaid; Programs For All-Inclusive Care For The Elderly (PACE) Contained in 42 CFR Part 460 (CMS-R-244)	165	71,455	433.1
0938-0338	(CMS-R-43) Medicare and Medicaid Programs: Conditions of Participation for Portable X-ray Suppliers	1,527	532,959	349.0
0938-1188	Medicaid and CHIP Program (MACPro) (CMS-10434)	280	96,844	345.9
0938-1028	HEDIS Data Collection for Medicare Advantage (CMS-10219)	515	164,800	320.0
0938-0578	Medicaid Drug Rebate Program – Manufacturers and Supporting Regulation at 42 CFR 447.534 (CMS-367)	12,810	3,618,703	282.5
0938-0444	(CMS-R-65) Final Peer Review Organizations Sanction and Supporting Regulations	18	4,716	262.0
0938-1327	The PACE Organization (PO) Monitoring and Audit Process in 42 CFR Part 460 (CMS-10630)	72	17,280	240.0
0938-1264	Program of all-Inclusive Care for the Elderly PACE Quality Data Entry in the CMS Health Plan Monitoring System (HPMS) (CMS-10525)	1,440	330,600	229.6
0938-1000	Medicare Parts C and D Program Audit Protocols and Data Requests (CMS-10191)	241	52,261	216.9
0938-0463	Skilled Nursing Facility and Skilled Nursing Facility Cost Report and Supporting Regulations in 42 CFR 413.20, 413.24, and 413.106	14,486	2,926,172	202.0
0938-0758	Hospice Facility Cost Report	3,545	666,460	188.0
0938-1153	Hospice Quality Reporting Program (CMS-10390)	4,259	686,631	161.2

0938-0977	Retiree Drug Subsidy Payment Request Instructions (CMS-10170)	2,482	374,782	151.0
0938-1286	Quality Improvement Strategy Implementation Plan and Progress Report (CMS-10540)	250	36,000	144.0
0938-1022	Hospital Reporting Initiative–Hospital Quality Measures (CMS-10210)	17,600	2,520,100	143.2
0938-1114	Medical Loss Ratio (IFR) Information Collection Requirements and Supporting Regulations (CMS-10361)	22	3,080	140.0
0938-1312	Establishment of an Exchange by a State and Qualified Health Plans (CMS-10593)	409	56,457	138.0
0938-0701	Medicare Health Outcomes Survey (HOS) (CMS-10203)	1,485	183,115	123.3
0938-1317	Reapplication Submission Requirement for Qualified Entities under ACA Section 10332 (CMS-10596)	10	1,200	120.0
0938-1134	Methods for Assuring Access to Covered Medicaid Services Under 42 CFR 447.203 and 447.204 (CMS-10391)	202	23,898	118.3
0938-0688	(CMS-R-13) Conditions of Coverage for Organ Procurement Organizations (OPOs) and Supporting Regulations	128	13,234	103.4

Altogether, these 30 ICRs represent roughly 22.7 million hours of paperwork. Even a mere 10 percent reduction in this pool would yield nearly 2.3 million hours in savings. While there may be more granular savings possible in ascertaining how certain requirements interact with specific parts of the patient and provider experience, there are items that seem clearly ripe for review on a more general administrative level. The following are two such examples worth highlighting in particular.

DUPLICATE HOSPITAL WAGE COST ACCOUNTING

The “Hospitals and Health Care Complex Cost Report” (ICR # 0938-0050) provides a vast amount of health care cost data that is likely critical in CMS’s ability to manage relevant programs. One of the main cost centers of any hospital is, of course, its employees’ pay. “Part II” of the overall worksheet covers the collection of such wage data. The worksheet is fairly comprehensive in this regard, which in turn calls into question the purpose of another ICR on the above list.

The “Hospital Wage Index Occupational Mix Survey” (ICR # 0938-0907) provides data periodically in order to help calculate a wage index. It is unclear why this collection is necessary in light of the information provided under ICR # 0938-0050. The survey worksheet appears to include similar fields as the overall cost report. In fact, the survey’s instructions explicitly refer back to the methodology utilized in the relevant portion of the cost report.

This seems to make the survey largely superfluous as CMS should already have the necessary data from a given hospital's overall cost report. Requiring hospitals to then spend time recording that same data again is unduly extraneous. If there are aspects of it that supplement gaps in the cost report, then it should be pared back to simply those items. Otherwise, the overall requirement – and its roughly 1.6 million hours of paperwork – would make an excellent candidate for general reconsideration.

PAYMENT ERROR RATE MEASUREMENT OVERALL

Minimizing the amount of erroneous payments to Medicaid and the Children's Health Insurance Program (CHIP) is an important goal. It is, however, unclear why there are two separate information collections devoted towards that end. The ICRs are 0938-0974 and 0938-1012; the abstracts are below.

0938-0974

Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and SCHIP. To comply with the IPIA, CMS needs the information to be collected from States and providers in order to sample and review adjudicated claims in a randomly selected number of States. Based on the reviews, State-specific error rates will be calculated which will be calculated which will serve as the basis for calculating national error rates for Medicaid and SCHIP.

0938-1012

The Improper Payments Information Act (IPIA) of 2002 requires CMS to produce national error rates for Medicaid and SCHIP. To comply with the IPIA, CMS needs the information to be collected in order to provide some Federal overview of state eligibility determinations to ensure correctness and consistency among states and to use the State-specific error rates as the basis for calculating national eligibility error rates for Medicaid and SCHIP.

Both ICRs originate from the same legislation, the IPIA, and largely contain the same language. Digging deeper, the primary component of 0938-0974 is a single report summarizing a state's corrective actions. On the other hand, 0938-1012 includes a series of more granular reports regarding erroneous payments. Yet, upon examining the 0938-0974 report more closely, it seems that all the data included in it could be found in the data provided under 0938-1012; it simply puts the onus on the respondent to summarize said data. While that report's overall burden of 56,100 hours is relatively modest in the overall picture, it does represent one of the highest per-respondent burdens (1,650 hours annually) while providing no real original data.

CONCLUSION

The above examples are only two issues pulled from a pool of 30 paperwork requirements with notably high per-respondent burdens. They are included here because they represent relatively clear instances of unnecessarily duplicative paperwork requirements. Nevertheless, it would likely be useful for CMS, in ongoing consultation with stakeholders and perhaps informed by other comments in this docket, to further examine the other entries on the list included. While some are relatively modest in the aggregate, their high per-respondent burdens provide the widest margins for even partial reconsideration, if not rescission.