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CMS Proposes to Simplify Participation Requirements in the Cutting Administrative Requirements for Excellence in Patient Care ("CARE") Proposed Rule

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by Mara Sanders, Jamie McCarty, and Katelyn Tarrolly

Related People

- Mara Sanders
- Jamie McCarty
- Katelyn Tarrolly

On November 5, 2026, CMS issued the Cutting Administrative Requirements for Excellence in Patient *Care* ("CARE") proposed rule (CMS-3484-P). CMS has characterized the proposed rule as intended to reduce administrative burden on providers through deregulation. The rule would eliminate or streamline a range of existing participation requirements, including some that were only recently finalized, while also adding or revising several requirements. CMS estimates that, if enacted as proposed, the CARE rule would save providers approximately $320 million and 3.26 million staff hours.

Key changes under the proposed rule, by provider type, include:

Hospitals

- **Training and quality requirements:** The rule would eliminate certain hospital staff training requirements, including obstetrical-services training and annual emergency-services readiness training. The rule would also remove the recently finalized OB-specific Quality Assessment and Performance Improvement ("QAPI") requirements, which are otherwise set to take effect January 1, 2027.
- **Patient transfer protocols and policies:** The rule would eliminate the annual training requirement for hospital staff on patient transfer protocols, while retaining the underlying requirement that hospitals maintain written policies and procedures governing patient transfers.
- **Birth tissue:** In contrast to its broader deregulatory focus, the rule would establish new patient-rights requirements related to birth tissue collection, including informed-consent requirements and policies addressing requests to retain birth tissues for cultural, religious, or personal reasons.

Long-Term Care Facilities ("LTCs")

- **Infectious-disease reporting:** The rule would eliminate the existing weekly acute respiratory illness reporting requirement, which CMS estimates currently costs LTC facilities approximately $61 million and more than 600,000 staff hours annually. CMS

would retain authority to require specified infectious-disease reporting during a future Secretary-declared public health emergency ("PHE"), while eliminating resident vaccination status from the proposed PHE reporting elements. Importantly, the proposal would not eliminate facilities' underlying infection-prevention and control obligations.

- **COVID-19 vaccination:** The rule would eliminate requirements that LTCs educate staff about COVID-19 vaccination, offer vaccination to staff, and document those activities.
- **Resident transfers:** The rule would remove the requirement that LTC facilities notify the State Long-Term Care Ombudsman when a resident is temporarily transferred for emergency care.
- **Facility assessments:** The rule would remove the requirement for direct-care staff representatives to be actively involved in LTC facility assessments.
- **Physical environment:** The rule would exempt certain existing LTCs from current room-occupancy and bathroom standards following a change of ownership or a lapse in, and subsequent restoration of, certification.

Other Providers

- **Critical access hospitals ("CAHs")**
  - Like hospitals, CAHs would no longer be subject to certain training requirements relating to emergency-services readiness and obstetrical care or the recently finalized OB-specific QAPI requirements.
  - CAHs would also become subject to the same proposed birth-tissue informed-consent and policy requirements as hospitals.
  - The rule would codify CMS's existing interpretation that CAH distance requirements are measured against acute care hospitals and other CAHs, rather than psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, or rural emergency hospitals. The rule would retain the 35-mile distance standard, or 15 miles in mountainous terrain or areas where only secondary roads are available. It would also implement a statutory exemption enacted in the Consolidated Appropriations Act, 2026, for certain CAHs affected by recent distance-related enforcement actions.

- **Rural Emergency Hospitals ("REHs")**
  - The rule would remove expired COVID-19 requirements concerning ongoing data reporting and staff vaccination for REHs.
  - The rule would eliminate infectious-disease data reporting requirements for REHs during a PHE.

- **Intermediate Care Facilities for Individuals with Intellectual Disabilities ("ICFs/IID")**
  - The rule would eliminate requirements that ICFs/IID educate staff regarding the risks and benefits of COVID-19 vaccination and offer COVID-19 vaccination to *staff*. However, the proposal does not eliminate the corresponding requirements for clients: requirements concerning COVID-19 vaccine education and offers to *clients* and their representatives would remain in place, as would existing infection-control requirements.

Other Notable Proposed Changes

- **Medicaid Payment Transparency:** CMS would scale back Medicaid institutional payment transparency requirements adopted in 2024. Specifically, states would no longer be required to report annually, at the facility level, the percentage of Medicaid nursing facility payments spent on compensation for direct care workers and support staff or the percentage of Medicaid ICF/IID payments spent on support-staff compensation.
- **Updated Life-Safety and Physical-Environment Requirements:** The rule would also implement a series of changes to life-safety and physical-environment requirements, although the provider types affected vary by proposal. CMS would adopt the 2024 editions of the National Fire Protection Association Life Safety Code and Health Care Facilities Code for a broad range of Medicare- and Medicaid-participating providers, including hospitals, LTC facilities, CAHs, REHs, and ICFs/IID, among others. The rule would also permit hospitals, CAHs, REHs, and LTC facilities that are required to maintain emergency and standby power systems to use additional sources of emergency power and would adopt the 2022 Standard for Emergency and Standby Power Systems. Separately, CMS would provide greater flexibility regarding certain window and door requirements applicable to hospitals, CAHs, LTC facilities, and certain other facility types. CMS also proposes to codify its authority to waive certain Life Safety Code and Health Care Facilities Code provisions, permitting affected facilities, following CMS review, to comply with provisions of newer code editions when CMS determines that those provisions provide an equal or superior means of ensuring patient safety.

Takeaway for Providers, Effective Dates & Solicitation for Comments

- Providers should remember that these changes are proposals, not current requirements. Until CMS issues a final rule with applicable effective dates, existing participation requirements remain in place.
- Organizations should nevertheless review the proposal now to identify opportunities for comment, particularly where federal requirements overlap with state reporting, infection-control, staffing, or facility requirements.
- The proposed rule is scheduled for publication in the *Federal Register* on November 10, 2026, with comments due 60 days after publication.
- In addition to seeking comments on the specific proposals outlined above, CMS is soliciting comments on potential future reforms involving CRNA physician supervision, expanded PA and NP roles in LTCs, transplant program certification, infectious-disease reporting, and Medicaid institutional workforce shortages.