HEALTH CARE PROVIDER ALERT

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CMS Announces Proposed Rules Reducing the Regulatory Burden on Ambulatory Surgery Centers, Hospitals and Other Participating Providers and Suppliers

By John Waters, Counsel

On September 17, 2018 the Centers for Medicare & Medicaid Services (CMS) announced proposed rules to revise the applicable conditions of participation (CoPs) for providers and conditions for coverage (CfCs) in connection with its efforts to reduce the regulatory burden in accordance with the January 30, 2017 Executive Order "Reducing Regulation and Controlling Regulatory Costs" (Executive Order 13771).

The proposed rule would reduce the regulatory burden on participating providers and suppliers as follows:

Emergency Preparedness

- *Emergency program:* Providing facilities with the flexibility to review their emergency program every two years, or more often at their own discretion.
- *Emergency plan:* Eliminating the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, State and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts.
- *Training:* Providing facilities discretion to allow training to occur annually or more often at their own discretion.
- *Testing (for inpatient providers/suppliers):* Increasing testing flexibility by allowing one of the two annually-required testing exercises to be an exercise of the facility's choice.
- *Testing (for outpatient providers/suppliers):* Reducing the annual testing requirement for facilities from two testing exercises to one testing exercise.

Hospitals

- Allowing multi-hospital systems to have unified and integrated Quality Assessment and Performance Improvement and infection control programs for all of its member hospitals.
- Allowing discretion on when an autopsy is indicated in certain instances.
- Allowing hospitals the flexibility to establish a medical staff policy describing the circumstances under which a pre surgery/pre procedure assessment for an outpatient could be utilized, instead of a comprehensive medical history and physical examination.
- Clarifying for psychiatric hospitals the requirement that allows for the use of non-physician practitioners or doctors of medicine/doctors of osteopathy to document progress notes of patients receiving services in psychiatric hospitals.

Critical Access Hospital (CAHs), Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)

Hospital and CAH swing-bed providers:

- Removing cross-references to requirements for long term care facilities that do not apply to patients in swing-beds.

CAHs:

- Reducing the frequency of CAHs' review of their policies and procedures from an annual review to biennial review.
- Removing the requirement for CAHs to disclose the names of people with a financial interest in the CAH, as this information is already collected outside of the conditions of participation.

RHCs and FQHCs..

- Reducing the frequency of the review of their patient care policies from an annual review to biennial review.

Ambulatory Surgical Centers (ASCs)

- Removing the requirements that ASCs have a written transfer agreement with a hospital that meets certain Medicare requirements or ensuring that all physician performing surgery in the ASC have admitting privileges in a hospital that meets certain Medicare requirements.
- Removing the requirements that a physician or other qualified practitioner conduct a complete comprehensive medical history and physical assessment (H&P) on each patient not more than 30 days before the date of the scheduled surgery. Additionally, CMS proposes to require that each ASC establish and implement a policy that identifies patients who require an H&P assessment prior to surgery.

Transplant Centers

- Updating the terminology used in the regulations to conform to the terminology used and understood within the transplant community.
- Removing requirements for transplant centers to re-submit clinical experience, outcomes, and other data in order to obtain Medicare approval.

Hospices

- Allowing hospices to defer to State licensure requirements for their aides regardless of the State content or format, and allowing states to set forth training and competency requirements that meet the needs of their populations.
- Encouraging more seamless integration of information provided by the hospice's drug management expert into routine interdisciplinary group meetings rather than the "check box" approach that hospices currently implement.
- Replacing a requirement that hospices provide a physical paper copy of policies and procedures with a requirement that hospices provide information regarding the use, storage and disposal of controlled drugs

to the patient or patient representative, and family, which can be developed in a manner that speaks to the perspectives and information needs of patients and families.

- Assuring requirements for hospices that provide hospice care to residents of a skilled nursing facility/nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities to move the requirement for facility staff orientation to the standard related to the written agreement established between hospices and facilities.

Comprehensive Outpatient Rehabilitation Facilities

- Decreasing the frequency and implementation of a utilization review plan from four times per year to annually.

Community Mental Health Centers (CMHCs)

- Removing a requirement for CMHCs to update the client comprehensive assessment every 30 days for all CMHC clients and only retain the minimum 30-day assessment update for those clients who receive partial hospitalization program services.

Portable X-Ray Services

- Replacing the four training and education requirements of a technologist that focus on accreditation of the school where a technologist received training with a single, streamlined qualification that focuses on the skills and abilities of the technologist.

- Allowing for portable x-ray services to be ordered in writing, by telephone, or by electronic methods.

Religious Nonmedical Health Care Institutions (RNHCIs)

- Simplifying discharge planning for RNHCIs by requiring them only to provide discharge instructions to the patient and/or the patient's caregiver when the patient is discharged home.

- Removing the requirement that RNHCIs discharge planning include medical care once a patient leaves the RNHCI facility. However, if an RNHCI determines that a patient either does or does not require discharge instructions, this decision must be made based on the RNHCI's existing policies.

If you have any questions about this topic, please contact one of the following Roetzel attorneys for more information and guidance.

Ericka Adler, Manager
eadler@ralaw.com

Avery Delott
adelott@ralaw.com

David Hochman
dhochman@ralaw.com

Christina Kuta
ckuta@ralaw.com

Lee Levin
llevin@ralaw.com

John Waters
jwaters@ralaw.com