PUBLICATION

CMS Issues Cost Savings Reforms to Medicare Regulatory Requirements [Ober|Kaler]

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On May 12, 2014, CMS issued a final rule [PDF], reforming certain Medicare regulatory requirements and eliminating those identified as unnecessary, obsolete, or excessively burdensome. Many of the streamlined provisions relate to health and safety standards tied to Conditions of Participation (CoPs). The rulemaking is in keeping with President Obama's "regulatory lookback" initiative, through which federal agencies strive to streamline and eliminate excessively burdensome and unnecessary regulations. This article outlines some of the major final revisions:

Ambulatory Surgical Centers

Revises Conditions for Coverage (CfC) requirements relating to provision of radiological services that are integral to ASC surgical procedures, by allowing ASCs to appoint a qualified individual, who need not be an MD or DO, to supervise radiologic services.

Hospitals

- *Governing Body:* Adds to governing body CoP to require the governing body to directly consult with the individual responsible for the organized medical staff periodically throughout the year regarding the quality of care provided; for multi-hospital systems using a single governing body, the governing body must meet with the responsible individual at each facility; eliminates the requirement for governing bodies to include a medical staff member.
- *Medical Staff:* Clarifies that medical staffs *must* be composed of physicians, and *may* include non-MD or DO physicians as well as non-physician practitioners, in accordance with State laws, determined to be eligible for appointment by the governing body; re-interprets existing provisions relating to multi-hospital systems to allow for a unique medical staff for each hospital *or* for a shared unified and integrated medical staff; adds provisions to the CoP to require hospitals to demonstrate that they actively address their use of a unified and integrated medical staff.
- *Food and Dietetic Services:* Permits qualified dieticians or qualified nutrition professionals (as authorized be medical staffs and in accordance with State law) to order therapeutic diets without physician preapproval; clarifies position that all patient diets are therapeutic in nature.
- *Nuclear Medicine Services:* Permits hospital-based trained nuclear medicine technicians to prepare radiopharmaceuticals without the "direct" supervision of a physician or pharmacist; presence of a pharmacist or physician will no longer be necessary during delivery of off-hour nuclear medicine tests.
- *Outpatient Services:* Revises CoP to allow non-medical staff practitioners who are responsible for the care of the patient and authorized by State law and by medical staff policies to order hospital outpatient services for their patients.
- *Swing Bed Services:* Relocates the swing bed services CoP to Subpart D so as to classify swing beds as an optional service; eliminates need for separate State Survey Agency survey by permitting CMS approved accrediting organizations to approve compliance with swing bed requirements.

Transplant Centers and Organ Procurement Organizations

- *Reports to CMS:* Eliminates unnecessary, confusing, and burdensome required reporting of decreases in number of transplants.
- *Transplant Outcome Review:* Eliminates unnecessary requirement for separate CMS review of lung transplant outcomes.
- *Volume and Clinical Experience Requirements:* Eliminates confusing language relating to provision of certain numbers of transplants during Scientific Registry for Transplant Recipients (SRTR) reporting periods; clarifies that "there is no requirement for a transplant center to perform a certain number of transplants 'during the time frame reported in the most recent SRTR center-specific report.'"
- *Transplant Center Re-Approval Process:* Eliminates unnecessary automatic three year re-approval cycle; adopts more flexible re-approval cycle and survey schedule; clarifies that the review of mitigating factors process could occur at any time following non-compliance with CoPs; provides new sample set of mitigating factors that CMS would consider.

Long-Term Care Facilities

Provides opportunity for long-term care facilities meeting certain conditions to apply for extensions of up to two years to the automatic sprinkler system requirement; allows for one year renewals of the extensions; recognizes major disaster events as potential bases for extensions.

Rural Health and Primary Care

- *Critical Access Hospital (CAH) Provision of Services:* Eliminates CoP requiring that a non-CAH staff member be included in development of patient care policies.
- *CAH and RHC/FQHC Physician Responsibilities:* After acknowledging the remote nature and geographic barriers for facilities, and the advancements in telemedicine, CMS eliminates the requirement that physicians be onsite once in every 2-week period for CAHs and RHC/FQHCs (except in extraordinary circumstances); revises language to require MDs or DOs to periodically review and sign a sample of outpatient records cared for by mid-level practitioners only where required by State law.
- *RHC/FQHC Definitions – Physician:* Revises RHC/FQHC definition of physician to conform to Medicare payment regulations' definition; clarifies that other non- MDs and DOs may practice at RHCs and FQHCs to the extent allowed by the Social Security Act and by State law.

Intermediate Care Facilities for Individuals who are Intellectually Disabled

Eliminates requirement for time-limited agreements, replaced with agreements that would remain in effect until the Secretary or State determined that the facility no longer met the requirements; increased survey timing flexibility; revised regulatory provision relating to certification of facilities with standard level deficiencies.

Ober|Kaler's Comments

The final rule has a broad scope, touching on various industry entities and practices, with the goal of increasing efficiency to improve patient care. CMS expects that these hospitals and health care providers may save up to $660 million annually through the revisions in this final rule, and up to $8 billion over the next five years in combination with the May 2012 final rulemaking. The final rule takes effect on July 11, 2014 (except the revisions to 42 CFR Part 483 that became effective May 12, 2014).