

HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

Making Things Simple (Or Simpler, At Any Rate)

November 10, 2011

The Centers for Medicare & Medicaid Services (“CMS”) recently issued certain regulatory rules and revisions in response to President Obama’s January 18, 2011 Executive Order 13563, which called for government agencies to reduce unnecessary regulatory burdens on businesses. Specifically, on October 18, 2011, CMS issued a final rule simplifying patient rights notification requirements for ambulatory surgical centers (“ASCs”) and also issued proposals for two additional sets of regulatory revisions dealing with (1) hospital and critical access hospital (“CAH”) Conditions of Participation (“CoPs”) and (2) other regulations affecting a wide range of healthcare settings. In the aggregate, CMS anticipates that these reforms will save more than \$5 billion over five years.

ASC Final Rule

The main reform in the final rule for ASCs is CMS’ announcement that ASCs will no longer be required to notify patients of their rights “in advance of the date of the procedure” but rather simply “prior to the start of the surgical procedure.” The previous wording effectively prohibited an ASC from performing a surgery on the same day as the patient referral, and ASCs argued that it resulted in unnecessary scheduling inconveniences and travel issues for some patients. Now ASCs have the ability to perform same-day surgeries and still meet the patient notification requirement. CMS has also made certain technical corrections to the wording of ASC regulations that are not anticipated to have a substantive impact on ASC operations.

Hospital and CAH CoPs Proposed Rule

In proposing reforms to existing CoPs for hospitals and CAHs, CMS acknowledges that it has not comprehensively reviewed the CoPs in several years. One of the most noteworthy proposed revisions, if adopted, would allow a single governing body to oversee multiple hospitals within a healthcare system, as opposed to requiring each hospital within the system to have its own governing body. This is anticipated to provide greater efficiencies and flexibility to hospital systems.¹ Among other proposals, CMS has also proposed the following reforms:

¹ But note that hospitals and CAHs accredited by The Joint Commission or other accrediting agencies may have to inquire into the manner in which these new liberalizations intersect with Joint Commission or other applicable accreditation requirements. While a full discussion of how the two sets of rules may intersect is beyond the scope of this article, note that The Joint Commission has addressed the governing body issue in a frequently asked questions document, stating that the same individuals can make up the governing body at more than one hospital as long as the responsibilities for each hospital's governing body are performed independently of carrying out responsibilities for another hospital. The FAQ document is available online at http://www.jointcommission.org/faqs_ccn/.

- Eliminating the requirement that outpatient services be overseen by a single director;
- Allowing CAHs to provide certain services, including radiology and laboratory services, under arrangement;
- Clarifying that physicians and non-physicians need not have medical staff membership at a hospital in order to be granted privileges at the hospital; and
- Permitting hospital patients or their caregivers to administer certain medications.

Other Medicare Proposed Rules

Another proposed rule, *Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction*, introduces a variety of regulatory reforms that affect several types of providers and suppliers, including ASCs, hospitals and end-stage renal disease (“ESRD”) facilities. One proposal that applies to physicians and non-physician practitioners is the elimination of the automatic deactivation of a supplier’s Medicare enrollment if the supplier has not submitted a claim for 12 consecutive months. In issuing the proposal, CMS indicates that it is more concerned with organizations that fail to submit a claim within a 12-month period than it is with individual practitioners who in some instances may not treat Medicare patients frequently. CMS has also proposed several other reforms, including the following:

- Easing the Life Safety Code standards that are applicable to ESRD facilities, given their non-residential nature;
- Eliminating the specific list of emergency equipment that ASCs are currently required to maintain on their premises;
- Removing the re-enrollment bar (which may vary from one to three years) when Medicare providers or suppliers have not responded timely to revalidation requests or other requests for additional information; and
- Updating certain obsolete regulations, such as removal of outdated personnel qualification language for physical therapists and occupational therapists and removal of certain vestigial provisions governing initial determinations, appeals, and reopenings of Medicare claims.

The provisions of the final rule affecting ASCs become effective on December 23, 2011. Any comments related to either of the two proposed rules discussed above are also due to CMS by December 23, 2011. If you have any questions regarding this *Health Law Update*, please contact any of the attorneys in our Healthcare Practice Group below.

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