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CMS Issues Final Rules To Cut Regulations For Hospitals and Healthcare Providers

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June 2012—On May 9, 2012, the Centers for Medicare and Medicaid Services (CMS) issued two final rules (Final Rules) aimed at reducing unnecessary, obsolete, or burdensome regulations on hospitals and healthcare providers. The Final Rules implement provisions from proposed rules issued on October 24, 2011. The Final Rules are aimed at achieving the key goal of President Obama's regulatory reform initiative by reducing unnecessary burdens on businesses and saving nearly $1.1 billion across the healthcare system in the first year and more than $5 billion over five years. The Final Rules become effective July 16, 2012.

Medicare Regulatory Reform Rule

The Medicare Regulatory Reform Rule (the "MRRR"), addresses Medicare regulatory requirements more broadly and eliminates duplicative, overlapping, and outdated requirements for healthcare providers. In addition to many other changes, the MRRR creates an exception, in certain circumstances, to the existing automatic mandatory re-enrollment bar provisions in current regulations. Specifically, under current regulation, a healthcare provider who has had their billing privileges revoked from participating in the Medicare program is automatically precluded from re-enrolling from the effective date of the revocation until the end of the re-enrollment bar (ie, a minimum of one year but not greater than three years). Under the MRRR, this automatic re-enrollment bar is eliminated in instances where providers have had their billing privileges revoked solely for failing to respond in a timely manner to a CMS revalidation request or other request for information.

Importantly, however, CMS made clear that this new exception will not prevent CMSs ability to combat fraudulent activity with respect to providers who fail to respond once or repeatedly to a revalidation or informational request. Notably, notwithstanding this new exception (a) CMS maintains the *discretion* to revoke billing privileges under certain circumstances; (b) CMS may deactivate (rather than revoke) the billing privileges of non-compliant providers; and (c) CMS will closely scrutinize any provider seeking to reactivate its billing privileges or re-enroll in Medicare after a revocation under higher screening standards.

This exception is important and timely as CMS is currently engaged in its massive enrollment revalidation effort through 2015 – sending out notices to all providers currently enrolled in Medicare requiring them to revalidate their enrollment information with CMS under new tougher screening controls designed to prevent fraud. Notably, however, this exception will not be applied retroactively. Moreover, as explained above, fitting within the exception will not eliminate all adverse consequences for non-compliant providers. As such, imaging providers and suppliers should continue to be diligent and respond in a timely manner to revalidation notices or other information requests from CMS.

Revisions to the Medicare Conditions of Participation (CoPs)

By way of background, CMS has established specific regulatory requirements (CoPs) that a hospital must meet in order to participate in Medicare. The recently issued Final Rule makes a significant revision to the Medical Staff CoP by broadening the concept of the "medical staff." Notably, the Final Rule differs significantly from the proposed rule, which would have added language to clarify that a hospital may grant privileges to both physicians and non-physicians to practice within their state's scope-of-practice law, ***regardless of whether they are also appointed to the hospital's medical staff***. There were over 1700 comments in response to the proposed rule, the vast majority of which were in opposition to the revisions.

Opposing commenters objected to allowing a hospital to grant privileges to a practitioner without requiring membership on the medical staff; objected to what they saw as "CMSs explicit endorsement of

the replacement of physicians with non-physician practitioners;" and to what they saw as CMSs explicit encouragement of the expansion of scope of practice laws by states.

Considering these comments, CMS revised this provision to allow a hospital's governing body the greatest flexibility in determining which categories of non-physician practitioners that it chooses to be eligible for appointment to the medical staff. In fact, CMS specifically states that the rule is "intended to encourage hospitals to be inclusive when they determine which categories of non-physician practitioners will be eligible for appointment to their medical staff." Once these eligible categories are determined by the governing body, the Final Rule directs the medical staff to examine the credentials of ***all eligible candidates*** and make its recommendations for medical staff appointments to the governing body in accordance with state law, including scope-of-practice laws and the medical staff bylaws, rules, and regulations. Finally, any candidates appointed to the medical staff must be granted all of the privileges, rights, and responsibilities accorded to the appointed medical staff members.

Thus, although the final version of the rule does encourage hospitals to include non-physicians as eligible members of their medical staffs, it preserved the autonomy of the medical staff and maintained the physician supervision standard over non-physician practitioners.

Watch for Future Changes

There were many comments submitted suggesting additional regulatory changes aimed at reducing unnecessary, obsolete, or burdensome regulations which CMS that were acknowledged but deferred for possible future rule making. Thus, imaging providers and suppliers should remain attentive for future revisions to existing regulations.

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