



Summary of the Regulatory Burden Reduction Proposed Rule

On Monday, September 17, the Centers for Medicare & Medicaid Services (CMS) released a [proposed rule](#) that reforms Medicare regulations that the agency identified as unnecessary, obsolete, or excessively burdensome on health care providers. Overall, CMS estimates that these proposals would save healthcare providers \$1.1 billion annually. In this 285-page rule, CMS includes a number of proposals that impact emergency physicians and the patients we serve. These include:

- **Emergency Preparedness Requirements**
 - ***Requirements for Emergency Plans:*** CMS is proposing to eliminate the requirement that hospitals document efforts to contact local, tribal, regional, State, and Federal emergency preparedness officials, and that they document their participation in collaborative and cooperative planning efforts. Hospitals would still be required to include a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Only the documentation requirements would be eliminated.
 - ***Requirements for Annual Review of Emergency Program:*** Facilities participating in Medicare and/or Medicaid are now required to review their emergency preparedness programs annually. This includes a review of their emergency plans, policies and procedures, communication plans, and training and testing programs. CMS is proposing to revise these requirements, so that facilities only have to update these programs every 2 years. Facilities should update their emergency preparedness program more frequently than every 2 years as needed (for example, if staff changes occur or lessons-learned are acquired from a real-life event or exercise).
 - ***Requirements for Training:*** CMS is proposing to revise the requirement that facilities develop and maintain a training program based on the facility's emergency plan annually. Instead, CMS would require that facilities provide training every two years after facilities conduct initial training for their emergency program. In addition, CMS proposes to require additional training when the emergency plan is significantly updated.

- ***Requirements for Testing:*** For providers of inpatient services, CMS proposes to expand the testing requirement options such that one of the two annually required testing exercises may be an exercise of their choice (which may include one community-based full-scale exercise, an individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.) For outpatient providers, CMS believes that conducting two testing exercises per year is overly burdensome as these providers do not provide the same level of acuity or inpatient services for their patients. Therefore, CMS proposes to require that providers of outpatient services conduct only one testing exercise per year. Furthermore, these providers would only have to participate in either a community-based full-scale exercise or conduct an individual facility-based functional exercise every other year. In the opposite years, these providers would be allowed to conduct the testing exercise of their choice.
 - The proposed rule also clarifies that clarify that if inpatient or outpatient providers experience an actual natural or man-made emergency that requires activation of their emergency plan, they will be exempt from their next required exercise following the onset of the actual event.

- **Ambulatory Surgical Center (ASC)**
 - ***Transfer Agreements with Hospitals:*** CMS is proposing to remove current requirements that an ASC must have a written transfer agreement and the physicians performing surgery in the ASC must have admitting privileges with a hospital that is a local, Medicare-participating hospital or a local, nonparticipating hospital that is eligible for payment for emergency services. CMS believes that this policy change would address the competition barriers that currently exist in some situations where hospitals providing outpatient surgical services refuse to sign written transfer agreements or grant admitting privileges to physicians performing surgery in an ASC. CMS believes that in the absence of a transfer agreement or admitting privileges, ASCs would continue to have access to local emergency services to transfer patients to the nearest appropriate hospital for continued care. The Emergency Medical Treatment and Labor Act (EMTALA) emergency response regulations would continue to address the emergency transfer of a patient from an ASC to a nearby hospital.

 - ***Documentation Requirements:*** CMS is proposing to replace ASC current admission and pre-surgical assessment policies with new requirements that defer to the facility's established policies for pre-surgical medical histories and physical examinations.

- **Hospitals**

- ***Quality Assurance and Performance Improvement (QAPI) and Infection Programs:*** CMS is proposing to allow each hospital that is part of a hospital system consisting of multiple separately certified hospitals to have a unified and integrated QAPI and infection control program as long as these decisions are in accordance with all applicable State and local laws.
- **Medical History and Physical Examination Requirements:** Similar to the ASC changes described above, CMS is modifying current history and physical (H&P) requirements for hospitals. A hospital and its medical staff would be free to exercise their clinical judgment in determining whether a policy for identifying specific patients as not requiring a comprehensive H&P (or any update to it) prior to specific outpatient surgical or procedural services, and instead requiring only a pre-surgical assessment for these patients, would be their best course.

- **Other Proposals**

- ***Hospital and CAH Swing-Bed Providers:*** CMS is proposing to eliminate unnecessary requirements for long term care facilities that do not apply because of the short amount of time patients are in swing-beds.
- ***Community Mental Health Centers (CMHCs):*** CMS is proposing to remove 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.
- ***Psychiatric Hospitals:*** CMS is proposing to clarify current regulations that allow non-physician practitioners or MDs and DOs to document progress notes of patients receiving services in psychiatric hospitals.