HALL RENDER'S TIMELY TRIAGE – FEBRUARY 17, 2014

2-MIDNIGHT RULE ENFORCEMENT DELAYED UNTIL OCTOBER 1, 2014

On January 31, 2014, the Centers for Medicare and Medicaid Services ("CMS") announced another delay in enforcement of the 2-Midnight Rule, now pushed back to **October 1, 2014**. The delay provides additional time for CMS to educate hospitals on how to implement the 2-Midnight Rule, which has raised a host of questions and requests for clarification.

The 2-Midnight Rule was introduced as part of the FY 2014 hospital inpatient prospective payment system and long-term care hospital ("LTCH") prospective payment system final rule published in the Federal Register on August 19, 2013 ("Final Rule"). The Final Rule sought to clarify and modify how CMS and its contractors review hospital and critical access hospital ("CAH") inpatient admissions for payment purposes. The 2-Midnight Rule sets forth a presumption that an inpatient admission for surgery, diagnostic tests and other treatment is generally appropriate when (i) the physician expects a Medicare beneficiary to require a stay that crosses at least 2 midnights; and (ii) the physician admits the beneficiary based upon that reasonable expectation. Admission orders, certification of the medical necessity of the inpatient stay and excellent documentation in the medical record are required to establish that Part A payment is justified. While observation services and emergency room treatment provided before the entry of a formal admission order are outpatient services by definition, a Medicare contractor may consider this outpatient time when determining if it was reasonable for the physician to have expected a beneficiary to require a greater than or equal to 2-midnight stay as part of an admission decision.

In view of the delayed effective date, here's what hospitals need to know during the ongoing "Probe and Educate" period:

1. Medicare Administrative Contractors ("MACs") will conduct **pre-payment** patient status reviews for claims with dates of admission on or after October 1, 2013 and before September 30, 2014. These reviews pertain to claims submitted by acute care inpatient hospitals, LTCHs and inpatient psychiatric facilities. Based on the reviews, MACs will perform additional educational outreach. When conducting a "Probe and Educate" patient status review, CMS will instruct MACs to assess the hospital's compliance with three things: i) the admission order requirements; ii) the certification requirements; and iii) the 2-midnight benchmark.

2. Generally, CMS will **not** conduct **post-payment** patient status reviews for claims with dates of admission October 1, 2013 through October 1, 2014.

3. Recovery auditors will **not** conduct **pre-payment** patient status reviews for claims with dates of admission October 1, 2013 through October 1, 2014. However, they may conduct claim reviews unrelated to patient status (i.e., unrelated to the appropriateness of the inpatient admission). For example, recovery auditors as well as MACs and Supplemental Medical Review Contractors will continue to perform other types of inpatient hospital reviews, such as coding reviews and reviews for the medical necessity of surgical procedures provided to hospitalized beneficiaries. Patient status reviews for dates of admission **prior to** October 1, 2013 will continue based on applicable policy at the time of the admission.

4. Recovery auditors may conduct **post-payment** inpatient hospital status and medical necessity reviews but are limited to claims **for inpatient stays less than 2 midnights** for dates of admission prior to October 1, 2013 and for currently approved complex issues.

CMS will host an **MLN Connection National Provider Call on February 27, 2014 from 2:30 to 4:00 PM EST** to review the 2-Midnight Rule, address FAQs and answer questions from the public.

Additional information may be found here, including further clarification on the requirements for physician orders and physician certification of hospital inpatient services.

NEW EMERGENCY PREPAREDNESS REQUIREMENTS FOR 17 TYPES OF MEDICARE/MEDICAID PROVIDERS AND SUPPLIERS-PROPOSED RULE

On December 27, 2013, CMS published a proposed rule ("Proposed Rule") that would establish new national emergency preparedness requirements that 17 different types of providers and suppliers ("Providers") would need to meet to participate in the Medicare and Medicaid programs. Upon reviewing multiple emergency preparedness resources, CMS concluded that the current regulatory emergency

preparedness framework contains gaps with respect to personnel training and communication and coordination of care within communities during emergencies and disasters. **The Proposed Rule can be found here.**

The purpose of the new requirements would be to ensure that Providers have effective plans to deal with both natural and man-made disasters, including the ability to coordinate with governmental emergency preparedness systems and the ability to meet the needs of patients, residents and clients during disasters and emergencies. For purposes of the Proposed Rule, CMS defines "emergency'' or "disaster'' as "*an event affecting the overall target population or the community at large that precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official such as a governor, the Secretary of the Department of Health and Human Services (HHS), or the President of the United States*."

The proposed requirements vary somewhat from one type of Provider to another. For example, inpatient facilities such as hospitals, CAHs or skilled nursing facilities would have greater responsibility than outpatient facilities for ensuring the safety of patients and others during an emergency since inpatient facilities provide continuous care. ASCs, rural health clinics and ESRD facilities, in many cases, can simply close and send patients and staff home or to another shelter during a disaster.

A series of natural and man-made disasters starting with 9/11 and continuing with anthrax attacks, hurricanes, floods and the H1N1 pandemic put emergency preparedness on the national agenda. These recent events made it clear that disasters can disrupt health care delivery and alter the demand for health care services. CMS believes emergency management must be integrated into the consciousness and daily routines of Providers. CMS reviewed guidance prepared by governmental agencies such as the CDC, HRSA and the Office of the Assistant Secretary for Preparedness and Response, as well as best practices in the health care industry as set forth by The Joint Commission, the National Fire Protection Association and other organizations. It also reviewed existing Medicare emergency preparedness requirements for Providers and determined the existing regulatory infrastructure was inconsistent and inadequate.

CMS has identified four key elements it has incorporated into the Proposed Rule that it believes would enable Providers to more effectively respond to disaster situations and protect the safety of patients and others. The Proposed Rule would require:

1. Risk assessment and planning: Providers perform a risk assessment utilizing an "all-hazards" approach prior to establishing an emergency plan. An all-hazards approach is defined as "*an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. This approach is specific to the location of the provider and supplier considering the particular types of hazards which may most likely occur in their area*."
2. Policies and procedures: Facilities develop and implement policies and procedures based on the outcome of the risk assessment and the emergency plan.
3. Communication plan: Facilities develop and maintain emergency preparedness communication plans such that patient care would be "well-coordinated" both within the affected facilities as well as across public health departments and emergency systems.
4. Training and testing: Facilities develop and maintain emergency preparedness training and testing programs. This means facilities would train their workforces on their emergency response policies and procedures, including conducting annual drills and exercises to test facility emergency plans.

CMS is soliciting comments on the Proposed Rule. **Comments are due by 5 PM EST on February 25, 2014** and should be filed as set forth in the Federal Register.

NOTICES

1. CMS announced an in-person and by telephone **Town Hall Meeting to be held on February 24, 2014 at 1:00 PM to 5:00 PM EST** to solicit input on the future of the Physician Compare website.

Registration is due by February 17, 2014.

The Affordable Care Act required CMS to make publicly available through Physician Compare, comparable information on quality and patient experience measures addressing physician performance. The purpose of the requirement is to provide consumers meaningful information with which to make informed health care decisions and to incentivize physicians to maximize their performance. CMS intends to post the first set of measure data in early 2014, reflecting data collected in program year 2012. CMS would like input regarding additional

information that can be used on Physician Compare in the future to make the website as beneficial as possible. For example, CMS is interested in hearing opinions on what measures would most accurately identify quality care and what measures would most accurately represent various medical specialties. Click here for further details.

2. On February 10, 2014, the Office of the National Coordinator for Health Information Technology of HHS announced a "Digital Privacy Notice Challenge." The competition invites designers, developers and patient privacy experts to create a HIPAA-compliant online model notice of privacy practices that is accessible and easily understandable by patients as well as easily integrated into existing entity websites. The competition offers a creative response to research finding that HIPAA-required notices of privacy practices often are poorly understood by patients who have a fundamental right to be informed of their privacy rights concerning their personal health information as well as a right to information addressing their health plan and health care provider privacy practices. Certain rules apply to the competition. More information is available here.

Entries for the Digital Privacy Notice Challenge will be accepted from February 7 through April 7, 2014. $25,000 in cash prizes will be awarded. Winners will be announced May through June of 2014.

If you have any questions or would like additional information on these topics, please contact Adele Merenstein at 317-752-4427 or amerenst@hallrender.com or your regular Hall Render attorney.

Please visit the Hall Render Blog at http://blogs.hallrender.com/ for more information on topics related to health care law.