



Advising the Congress on Medicare issues

Mandated report:
Physician supervision requirements in Critical
Access Hospitals and small rural hospitals

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Overview

- The Commission's mandate
- Define levels of physician supervision
- History of physician supervision requirements and their enforcement
- Analysis of supervision requirement effects
 - Access
 - Quality
 - Economic impact
- Discussion

The Commission's mandate

- 21st Century Cures Act (Section 16004 Continuing Access to Hospitals Act of 2016)
 - (a) Extension of enforcement instruction on supervision requirements for outpatient therapeutic services in critical access hospitals (CAHs) and small rural hospitals through 2016
 - (b) Report – MedPAC shall submit to the Congress a report analyzing the effect of the extension of the enforcement instruction on the access to health care by Medicare beneficiaries, on the economic impact and the impact upon hospital staffing needs, and on the quality of health care furnished to such beneficiaries
- Report due to the Congress by December 13, 2017

Levels of physician supervision

1. *General supervision*: Physician or non-physician providers' (NPP) overall direction and control, but their presence is not required during the performance of the procedure (e.g., blood transfusion service)
2. *Direct supervision*: Physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure, but they do not have to be present in the room (e.g., chemotherapy intravenous infusion)
 - Hospitalists or emergency department (ED) physicians can provide direct supervision if they are “interruptible,” licensed, and have hospital privileges to furnish the services
 - Medicare defaults to direct supervision for outpatient therapeutic services

Levels of physician supervision (con't.)

3. *Non-surgical extended duration therapeutic services (NSEDTS) supervision:* Hybrid of direct and general supervision, which requires direct supervision initially with potential transition to general supervision (e.g., therapeutic/ prophylactic injections and infusions)
4. *Personal supervision:* Physician or NPP must be in attendance in the room during the performance of the procedure (e.g., ultrasonic guidance for administration of radiation therapy)

Regulatory history of physician supervision requirements

- In CY 2009 rulemaking, CMS clarified and restated their policy that outpatient therapeutic services must be *directly supervised* by an appropriate physician or NPP
- In 2012, CMS implemented an independent review process, using the Hospital Outpatient Payment Panel (HOPP), to provide advice on the appropriate supervision level for each outpatient therapeutic service
 - CMS has reduced the level of supervision for about 50 services from direct to general supervision

Enforcement of supervision levels in CAHs and small rural hospitals

- Concern from hospitals that CAHs and small rural hospitals have insufficient staff to furnish direct supervision, and they have difficulty recruiting clinicians
- CY 2010 – 2013: CMS did not enforce the direct supervision requirements in CAHs and small rural hospitals
- CY 2014 – 2016: Congress extended the nonenforcement
- CY 2018 – 2019: CMS proposed to continue to not enforce the requirement

Methods

- Spoke with several CAHs and CMS about direct supervision requirements
- Organized findings into access, quality and economic impact
- CAHs most frequently discussed direct supervision requirements for chemotherapy and cardiac rehabilitation (CR) services

Findings: Access

- The direct supervision requirements do not appear to be limiting the types of services they provide
- CAHs have implemented various processes that they believe address direct supervision requirements, as well as offer appropriate access to care
 - CAHs are using ED or family physicians in the same building or nearby to address physician supervision requirements
 - One CAH schedules their few chemotherapy appointments on the one to two days of the week the oncologist is present at the CAH

Findings: Quality

- CMS notes that there have been no patient safety concerns raised to them about hospitals using inappropriate physician supervision
 - No way to monitor this requirement through administrative data, so a “whistle-blower” would likely be how CMS would learn of any concerns
- All CAHs we spoke with reported having a physician available to respond to adverse reaction during therapeutic services
- One CAH explained that their oncologist will refer high-acuity patients to begin chemotherapy in a larger hospital, and if no initial complications then treatment can continue at the CAH

Findings: Economic impact

- CAHs described processes they have put in place in an attempt to comply with supervision requirements, but they are unsure whether they meet the requirements
- CAHs are using current staff to offer what they believe to be the appropriate supervision, so the economic impact of the supervision requirement appears to be limited
 - CAHs are using ED or family physicians in the same building or nearby to address physician supervision requirements
 - Specialist personally present for some aspects, for others a nurse with ED physician (in a short amount of time)

Summation

- *June 2012 report to the Congress:* Expectations for quality of care in rural and urban areas should be equal for nonemergency services rural providers chose to deliver
- Determining the supervision needed for these discretionary services is a clinical decision about the appropriate level of patient safety
- Guidance to CMS:
 - CMS should continue to use clinical judgement regarding the patient's safety when deciding the most appropriate supervision level, and that judgement should apply to both urban and rural hospitals
 - CMS should offer more clarity on the definition of “immediately available” and “interruptable” in the direct supervision requirement by providing a minimum time requirement for a physician to be with the patient, if needed during the therapeutic service

Discussion

- Clarifying questions
- Findings
- Finalize and submit to the Congress