Medical Staff Bylaws: Meeting New Medicare Conditions of Participation and Joint Commission Requirements

Complying With CMS Changes and Updating Hospital Governance Documents

THURSDAY, SEPTEMBER 11, 2014

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today’s faculty features:

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The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical *The Joint Commission Perspectives®*. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

### Revisions to Deemed Program Requirements for Hospitals

**Applicable to Hospitals**

**Effective September 29, 2014**

**Human Resources (HR)**

*Standard HR.01.02.01*

The hospital defines staff qualifications.

**Elements of Performance for HR.01.02.01**

**A 12.** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The activities program is directed by a professional who meets one of the following criteria:

- Is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which he or she practices and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990
- Has two years of experience in a social or recreational program within the last five years, one year of which was full time in a patient activities program in a health care setting
- Is a qualified occupational therapist or occupational therapy assistant
- Has completed a training course approved by the state

**A 13.** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, or mistreatment of residents or of misappropriation of their property.

**Standard HR.01.02.05**

The hospital verifies staff qualifications.

**Element of Performance for HR.01.02.05**

**A 17.** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: A qualified social worker is an individual who has a bachelor’s degree in social work or a bachelor’s degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, or psychology and has one year of supervised social work experience in a health care setting working directly with individuals.

**Leadership (LD)**

*Standard LD.04.02.03*

Ethical principles guide the hospital’s business practices.

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Key:
- **A** indicates scoring category A;
- **C** indicates scoring category C;
- **🗂** indicates that documentation is required;
- **ستحق** indicates Measure of Success is needed;
- **⚠️** indicates an Immediate Threat to Health or Safety;
- ** практичес** indicates situational decision rules apply;
- **✔️** indicates direct impact requirements apply;
- **risk area** indicates an identified risk area
Elements of Performance for LD.04.02.03

C. 13. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following:

- The items and services included in the state plan for which the resident may not be charged
- Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services

A. 14. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13.

C. 15. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: When a resident becomes eligible for Medicaid after admission to the hospital, the hospital charges the resident only the Medicaid-allowable charge.

A. 16. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Residents are informed before or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services not covered under Medicare or by the facility’s per diem rate.

Medical Staff (MS)

Standard MS.01.01.01
Medical staff bylaws address self-governance and accountability to the governing body.

Element of Performance for MS.01.01.01

A. 37. For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the bylaws describe the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.

Standard MS.01.01.05
For hospitals that use Joint Commission accreditation for deemed status purposes: Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.

Elements of Performance for MS.01.01.05

A. 1. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.

A. 2. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.

A. 3. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.

A. 4. For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff...
medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.

**Provision of Care, Treatment, and Services (PC)**

**Standard PC.01.02.09**
The hospital assesses the patient who may be a victim of possible abuse and neglect.

**Elements of Performance for PC.01.02.09**

A8. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care:** The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. (See also RI.01.06.03, EP 3)

**Standard PC.02.01.03**
The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

**Element of Performance for PC.02.01.03**

A1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. *

*Note: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:

- Responsible for the care of the patient
- Licensed in the state where he or she provides care to the patient
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

*: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

**Standard PC.02.02.01**
The hospital coordinates the patient’s care, treatment, and services based on the patient’s needs.

**Elements of Performance for PC.02.02.01**

C8. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care:** The hospital provides activity services directly or through referral for ambulatory and nonambulatory residents at various functional levels.

C9. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care:** The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge.

A12. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care:** The hospital provides 24-hour emergency dental services directly or through arrangement with an external provider.

**Standard PC.02.02.09**
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care; Residents participate in social and recreational activities according to their abilities and interests.

**Elements of Performance for PC.02.02.09**

C1. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care:** The hospital offers residents a variety of social and recreational activities according to their abilities and interests.

C3. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care:** The hospital helps residents to participate in social and recreational activities according to their abilities and interests.

**Standard PC.04.01.03**
The hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged.

**Note:** Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident’s health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident’s urgent medical needs; or a resident has not resided in the facility for 30 days.

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following:

- The reason for transfer or discharge
- The effective date of transfer or discharge
- The location to which the resident is transferred or discharged
- A statement that the resident has the right to appeal the action to the state
- The name, address, and telephone number of the state’s long term care ombudsman
- For a resident who is developmentally disabled, the mailing address and telephone number of the agency responsible for the protection and advocacy, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act
- For a resident who is mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy, established under the Protection and Advocacy for Mentally Ill Individuals Act

The hospital documents the patient’s discharge information.

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization.

For a resident who is developmentally disabled, the mailing address and telephone number of the agency responsible for the protection and advocacy, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act.

For a resident who is mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy, established under the Protection and Advocacy for Mentally Ill Individuals Act.

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Residents are not transferred or discharged from the hospital unless they meet specific criteria, in accordance with law and regulation.

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital transfers or discharges residents only when at least one of the following conditions is met:

- The resident’s health has improved to the point where he or she no longer needs the hospital’s services.
- The transfer or discharge is necessary for the resident’s benefit or if the hospital cannot meet the resident’s needs.
- The health or safety of the resident is endangered by remaining in the hospital.
- The hospital has provided the resident, who has not paid for his or her stay, with reasonable notice of transfer or discharge, as defined by the hospital and in accordance with law and regulation.
- The hospital ceases operation.
- The resident leaves against medical advice and signs a form stating that his or her action runs contrary to medical advice.
- Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals
- Information about the resident’s behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
- Nursing information that is useful in the resident’s care
- Any advance directives
- Instructions given to the resident before discharge

Rights and Responsibilities of the Individual (RI)

**Standard RI.01.06.05**
The patient has the right to an environment that preserves dignity and contributes to a positive self-image.

**Elements of Performance for RI.01.06.05**

| C 8. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital provides accommodations for residents with significant others living in the same facility when both individuals consent to the arrangement. |


| C 14. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The resident has the right to have access to stationery, postage, and writing implements at the resident’s own expense. |


**Standard RI.01.06.09**
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The resident has the right to choose his or her medical, dental, and other licensed independent practitioner care providers.

**Elements of Performance for RI.01.06.09**

| C 1. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital supports the resident’s right to choose an attending physician, dentist, and other licensed independent practitioner. |


| C 2. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital supports the resident’s right to request a different licensed independent practitioner upon admission and throughout the course of care. |


| C 3. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital makes reasonable attempts to respond to requests from residents to choose a different licensed independent practitioner upon admission and throughout the course of care. |


**Standard RI.01.06.11**
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The resident has the right to communicate with his or her medical, dental, and other licensed independent practitioner care providers.

**Element of Performance for RI.01.06.11**

| C 3. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital supports the resident’s right to request a different licensed independent practitioner upon admission and throughout the course of care. |


**Standard RI.01.07.05**
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The resident has the right to receive and restrict visitors.

**Elements of Performance for RI.01.07.05**

| A 1. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital establishes liberal visiting hours that are limited only by the resident’s personal preferences. |


| C 3. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital provides space for the resident to receive visitors in comfort and privacy. |


| A 5. | For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital supports the resident’s right to choose with whom he or she communicates. |
A 6. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.

Standard RI.01.07.07
For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital protects the rights of patients and residents who work for or on behalf of the hospital.

Elements of Performance for RI.01.07.07
A 1. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital has a written policy that addresses situations in which patients and residents work for or on behalf of the hospital.

C 2. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital implements its policy regarding patients and residents who work for or on behalf of the hospital.

A 3. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Wages paid to patients and residents who work for or on behalf of the hospital are in accordance with law and regulation.

C 4. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital incorporates work performed by the patient or resident for or on behalf of the hospital into the plan of care.

A 5. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: Patients and residents have the right to refuse to work for or on behalf of the hospital.

Standard RI.01.07.13
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The resident has the right to transportation services, as appropriate to his or her care or service plan.

Element of Performance for RI.01.07.13
C 1. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds used for long term care: The hospital arranges transportation for the resident to and from physician or dentist appointments and other activities identified in the resident’s care or service plan.
July 1, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC  20201

Re: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II [CMS-3267-F]

Dear Administrator Tavenner:

The undersigned organizations write to express our extreme disappointment with the Centers for Medicare & Medicaid Services (CMS) final rule entitled Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II [CMS-3267-F]. This rule makes unprecedented changes to the Medicare hospital Conditions of Participation (CoPs) that will dramatically alter the make-up and efficacy of hospital medical staffs nationwide.

As we evaluate the lawfulness of CMS’ significant new regulatory actions, revisions, and interpretations in this final rule, we strongly urge CMS to delay the effective date of July 11, 2014. We understand that in a recent letter to the American Medical Association (AMA), CMS declined to delay the effective date of its revisions to the medical staff CoP. We strongly disagree with this decision and urge CMS to reconsider. This date does not allow adequate time for CMS to clarify its ruling nor for medical staffs to be educated about the major ramifications of the rule and duly amend their bylaws.

According to CMS’ discussion and the final regulations in CMS-3267-F, CMS has adopted what amounts to a sea change in the manner by which medical staffs nationwide are allowed to operate under the hospital CoPs, compared with longstanding rules in force since the inception of the hospital CoPs. Specifically, multi-hospital systems may now have a single, integrated medical staff for the hospital system at large, and are no longer required to have a medical staff structure at each individual hospital.

As physicians have repeatedly emphasized in past communications to CMS on this issue, we think that this is an ill-conceived policy that will disenfranchise physicians and hinder their input into hospital programs, especially for those physicians in rural or geographically distant hospitals.¹ We have also expressed serious concerns about the negative effects that this structure may have on patient care as well as the negative repercussions for system-wide care coordination activities.

We are deeply concerned that CMS’ timeline to implement these changes is woefully inadequate. In addition, a number of issues remain unclear and require further interpretation. As CMS mulls these

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issues, we strongly request that CMS delay enforcement of this rule until at least May 12, 2015, one year after publication of the final rule:

(1) **Initiation.** CMS provides that medical staffs may opt-in or opt-out of the single integrated medical staff structure at the behest of the multi-hospital system. The question of whether a medical staff may self-initiate the formation of a single integrated medical staff remains unclear. While we strongly disagree with CMS’ new policy to allow a single integrated medical staff structure for a multi-hospital system, we think it is unconscionable to permit the medical staff to opt-in or opt-out solely at the behest of the multi-hospital system. We wonder why, if CMS thinks there are many good reasons for a medical staff to integrate upon the initiation of the multi-hospital system, medical staffs may not also be positioned to self-initiate an integrated structure. Clarity on this point is needed.

(2) **Licensure.** Some medical staffs require that each member of the medical staff be licensed in the state in which the hospital provides services. In large, multi-state hospitals, will physicians who become a part of a single integrated medical staff be required to be licensed in each state in which the hospital provides services? As state licensure conveys rules, responsibilities, and legal standards unique to each state, this could create significant logistical issues and add to physicians’ administrative burden and is an issue that requires clarification.

(3) **Peer review.** CMS’ new policy permitting a system-wide medical staff for a multi-hospital system creates the possibility that a physician could be subject to peer review by a system-wide medical staff that has little familiarity with the standard of care or needs in the physician’s community. In addition, states differ as to protections they provide governing peer review. Has CMS considered the question of which state’s peer review laws will prevail in cases where there is such a disparity? Could an integrated system pick and choose peer review laws it will comply with from among all the states where it has hospitals?

(4) **Opt-in/opt-out.** We appreciate that CMS sought to create a middle-ground approach by requiring that multi-hospital systems have medical staffs at each individual hospital either opt-in or opt-out to a single integrated medical staff model. We wonder how this will work in practical terms. Must the hospital seek the participation of each medical staff within the system? Or can they pick and choose which medical staffs they want to work with, and leave the others out? Can a medical staff opt-in, in January 2016, and then opt-out in July 2016? What is the process for opting in and opting out? What manner of majority is needed? Opting in would require substantial revisions to the medical staff bylaws, which generally require a two-thirds vote. So will it actually take more than a majority to opt-in in these cases? Or does CMS propose to invalidate or allow governing bodies to override medical staff bylaws (which in many states are considered a legally binding contract between the hospital and the medical staff)?

CMS’ current timeline for implementation gives a significant advantage to the multi-hospital systems. It does not allow for adequate time to educate medical staffs around the country of the new changes. While we recognize that the rule allows, but does not require, implementation on July 11, 2014, it is certain that many multi-hospital systems will aggressively pursue the implementation of a single integrated medical

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2 42 CFR § 482.22(b)(4).
staff model at the earliest hour. Most medical staffs are unaware of or unprepared for the impending decision to either integrate into a single model or opt-out, and will undoubtedly be ill served by the expediency of these requests. CMS should give medical staffs both clarifying guidance as well as more time to understand and explore these issues.

It is of the utmost urgency, therefore, that CMS act immediately to delay the implementation of this final rule until May 12, 2015 to give medical staffs adequate time to ascertain the legal and practical ramifications of this rule.

Sincerely,

American Medical Association
American Academy of Dermatology Association
American Academy of Emergency Medicine
American Academy of Hospice and Palliative Medicine
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology—Head and Neck Surgery
American Association for Hand Surgery
American Association of Neurological Surgeons
American Clinical Neurophysiology Society (ACNS)
American College of Cardiology
American College of Emergency Physicians
American College of Mohs Surgery
American College of Radiology
American College of Surgeons
American Orthopaedic Foot and Ankle Society
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Shoulder and Elbow Surgeons
American Society for Surgery of the Hand
American Society of Dermatopathology
American Society of Echocardiography
American Society of Interventional Pain Physicians
American Spinal Injury Association
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
J. Robert Gladden Orthopaedic Society
Musculoskeletal Tumor Society
National Association of Medical Examiners
Orthopaedic Trauma Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society of Critical Care Medicine
Society of Interventional Radiology
Medical Association of the State of Alabama
    Arizona Medical Association
    Arkansas Medical Society
    California Medical Association
    Colorado Medical Society
    Connecticut State Medical Society
    Medical Society of Delaware
Medical Society of the District of Columbia
    Florida Medical Association Inc
    Medical Association of Georgia
    Hawaii Medical Association
    Idaho Medical Association
    Illinois State Medical Society
    Indiana State Medical Association
    Kansas Medical Society
    Kentucky Medical Association
    Louisiana State Medical Society
    Maine Medical Association
    MedChi, The Maryland State Medical Society
    Massachusetts Medical Society
    Michigan State Medical Society
    Minnesota Medical Association
    Mississippi State Medical Association
    Missouri State Medical Association
    Montana Medical Association
    Nebraska Medical Association
    Nevada State Medical Association
    Medical Society of New Jersey
    New Mexico Medical Society
    Medical Society of the State of New York
    North Carolina Medical Society
    North Dakota Medical Association
    Ohio State Medical Association
    Oklahoma State Medical Association
    Oregon Medical Association
    Pennsylvania Medical Society
    Rhode Island Medical Society
    South Carolina Medical Association
    South Dakota State Medical Association
    Tennessee Medical Association
    Texas Medical Association
    Utah Medical Association
    Vermont Medical Society
    Medical Society of Virginia
    Washington State Medical Association
    West Virginia State Medical Association
    Wyoming Medical Society
DATE: May 20, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Final Rule - Promoting Program Efficiency, Transparency, and Burden Reduction; Part II - Informational Only

Memorandum Summary

- **Publication of Final Rule:** CMS-3267-F was published on May 12, 2014. In this final rule we implement reforms in Medicare regulations that the Centers for Medicare & Medicaid Services (CMS) has identified as unnecessary, obsolete, or excessively burdensome on health care providers and beneficiaries, as well as certain regulations under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

- **Effective Date:** These regulations are effective on July 11, 2014, with the exception of amendments to:
  - 42 CFR Part 483, related to nursing home sprinklers, which are effective May 12, 2014;
  - 42 CFR Part 485, Subpart F, related to inpatient services in critical access hospitals (CAHs), which were effective October 1, 2013; and
  - 42 CFR Part 491, related to rural health clinic non-physician practitioners, which are effective July 1, 2014.

A. Background
In Executive Order 13563, “Improving Regulations and Regulatory Review”, the President directed each executive agency to establish a plan for ongoing retrospective review of existing significant regulations to identify those rules that can be eliminated as obsolete, unnecessary, burdensome, or counterproductive, or that can be modified to be more effective, efficient, flexible, and streamlined.

The final rule “Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II” was published on May 12, 2014 and responds directly to the President’s instructions. The publication may be viewed at: http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf. Listed below are some highlights.
B. Long Term Care Facilities (Automatic Sprinkler Systems): The rule permits a temporary extension of the automatic sprinkler system installation due date under limited circumstances: the facility is constructing a replacement facility, or undergoing major modifications to unsprinklered living areas, or the facility has been unable comply with the original deadline due to a disaster or emergency as indicated by a declaration under section 319 of the Public Health Service Act. CMS may grant an extension of the sprinkler due date for up to two years from the original August 13, 2013 due date. For those facilities granted a temporary extension but that later encounter last minute construction or other unusual circumstances outside the facility’s control, the rule provides authority for CMS to consider a final extension up to an additional one year extension of the deadline. As a condition for granting any extension, the rule provides authority for CMS to require additional, interim fire protection safeguards. Additional information concerning the process for requesting an extension may be found in S&C Memorandum 14-29-LSC, accessible at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

C. Clinical Laboratory Improvement Amendments of 1988: The rule makes adjustments to CMS regulations governing actions we take when we find certain violations of proficiency testing requirements under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The changes may prevent confusion on the part of laboratories, reduce the risk of noncompliance, and establish policies under which certain PT referrals by laboratories will not generally be subject to revocation of a CLIA certificate, or a two-year prohibition on laboratory ownership or operation that may be applied to an owner and an operator when a CLIA certificate is revoked.

- **Treatment of proficiency testing samples:** We are adding a clarifying statement that explicitly notes that the requirement to treat proficiency testing (PT) samples in the same manner as patient specimens does not mean that it is acceptable to refer PT samples to another laboratory for testing even if that is the protocol for patient specimens.

- **Intentional referral carve-out:** We are carving out a narrow exception in our long-standing interpretation of what constitutes an “intentional” referral of PT samples. In these instances, the laboratory will be subject to alternate sanctions.

- **New definitions:** To clarify the stipulations of the intentional referral carve-out, we are also adding the following terms, with their definitions, to the regulation: Reflex testing, Confirmatory testing, and repeat PT referral.


C. Acute Care Services: Unless specifically noted otherwise, changes below are found in the final rule: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II, adopted May 12, 2014 and effective July 11, 2014.
Sources of other changes are the following rules:

Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation;

Payment Policies Related to Patient Status, adopted August 19, 2013 and effective October 1, 2013; this rule included CAH changes; and

Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral, adopted May 2, 2014 and effective July 1, 2014; this rule included RHC changes.

C.1. ASC Conditions for Coverage, 42 CFR Part 416

- Surgical Services, §416.42

§416.42(b)(2) corrects a technical error by correctly cross-referencing to §416.42(c) when referencing the regulation that permits exemption from physician supervision of non-physician practitioners who administer anesthesia.

- Laboratory and Radiologic Services, §416.49

§416.49(b) was revised to:
- Make explicit that radiologic services may only be provided in an ASC when integral to procedures offered by the ASC.
- Require an ASC providing radiologic services to comply with only the following provisions of the hospital Condition of Participation for radiologic services: §482.26(b) (Safety for patients and personnel), (c)(2) (Personnel who may use radiologic equipment) and (d)(2) (Maintenance of records of radiologic services). Certain hospital requirements (related to mandatory provision of radiologic services, supervision of such services by a radiologist, and practitioner signing of radiologic reports) no longer apply to ASCs.
- Require the ASC’s governing body to appoint an individual qualified in accordance with State law and ASC policies who is responsible for assuring that all radiologic services are provided in accordance with the cross-referenced Hospital requirements.

C.2. Hospital Conditions of Participation, 42 CFR Part 482

- Governing Body, §482.12

- §482.12 was revised to remove the requirement that the hospital’s governing body must include a member or members of the medical staff, in favor of required consultation (described below).
o §482.12(a) was revised to add a new requirement at §482.12(a)(10) for the governing body to consult directly with the individual responsible for the organization and conduct of the hospital’s medical staff, or his/her designee. The consultation is required to be periodic throughout the year and to include discussion of matters related to the quality of medical care provided to the hospital’s patients. For a multi-hospital system using a single governing body, there must be consultation directly with the individual (or designee) responsible for the medical staff in each hospital within its system.

• Medical Staff, §482.22
  o §482.22(a) was revised to indicate that the medical staff must include MDs or DOs, but may also include other categories of physicians listed at §482.12(c)(1), as well non-physician practitioners. A prior rule change inadvertently omitted the reference to other categories of physicians.
  o §482.22(b) was revised to add new §482.22(b)(4), which permits a hospital which is part of a hospital system consisting of multiple separately certified hospitals to have a unified, integrated medical staff for its member hospitals, in accordance with State law. Each separately certified hospital in a system using a unified, integrated medical staff must demonstrate that:
    • The medical staff members holding privileges at each separately certified hospital have voted by majority, in accordance with medical staff bylaws, to accept a unified, integrated medical staff, or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital;
    • The unified, integrated medical staff has bylaws, rules and requirements describing its processes for self-governance, appointment, credentialing, privileging, oversight, peer review policies and due process rights guarantees. Members of the medical staff at each separately certified hospital must be advised of their right to opt out after a majority vote to maintain a separate and distinct medical staff for their hospitals;
    • The unified, integrated medical staff is established in a manner that takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital; and
    • The unified, integrated medical staff establishes and implements policies and procedures to ensure the needs and concerns expressed by members at each separately certified hospital are given due consideration, and that there are mechanisms to ensure that issues localized to particular hospitals are duly considered and addressed.

• Food and dietetic services, §482.28
  §482.28 (b)(1) and (2) were revised to permit a qualified dietitian or qualified nutrition professional to order diets if authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals. This includes therapeutic diet ordering. This means that ordering of diets is no longer restricted to practitioners responsible for the care of the patient.
• **Nuclear Medicine Services, §482.53**

§482.53(b)(1) was revised to remove the requirement for “direct” supervision of in-house preparation of radiopharmaceuticals is by an appropriately trained registered pharmacist or MD/DO. This means it is no longer required that a supervising physician or pharmacist must always be present when radiopharmaceuticals are being prepared.

• **Outpatient Services, §482.54**

A new standard at §482.54(c) was added to the hospital Outpatient Services CoP which codifies current SOM Interpretive Guidelines regarding the ordering of outpatient services. Outpatient services can be ordered by any practitioner responsible for the care of the patient, who is licensed and acting within his or her scope of practice in the State where he or she provides care to the patient, and who has been authorized by the medical staff and approved by the governing body to order specific outpatient services. This new standard applies to members of the medical staff who have been granted privileges to order outpatient services as well as practitioners not on the medical staff but who are authorized to order outpatient services and refer patients for outpatient services by meeting the criteria listed.

• **Swing-Bed Services, §482.58**

The regulation governing swing bed services was moved from Subpart E, concerning Specialty Hospitals, to Subpart D, concerning Optional Hospital Services. This means that CMS-approved Medicare hospital accreditation programs will now have to develop and implement standards for swing-bed services, and that separate State surveys of swing-bed services will not be required in deemed status hospitals, once CMS has approved the revised accrediting organization standards.

### C3. Critical Access Hospitals (CAHs), 42 CFR Part 485, Subpart F

• **Designation and Certification of CAHs, §485.606**

The cross-reference to hospital swing bed services found in this CAH regulation was revised to reflect the renumbering of the hospital regulation. This CAH regulation prohibits a State from denying CAH designation to an otherwise eligible hospital solely because the hospital provides swing bed services. The revision has no substantive effect on the current CAH requirement.

• **Number of Beds and Length of Stay, §485.620**

The provision at §485.620(a) was revised to remove an outdated reference to a January 1, 2004 effective date, after which a CAH may not maintain more than 25 inpatient beds that may be used to provide either inpatient or swing-bed services. *This change was effective October 1, 2013.* The revision has no substantive effect on the current CAH requirement.
• Staffing and Staff Responsibilities, §485.631

  §485.631(b)(1)(v) & (vi) were revised to:

  • Address confusion about the prior rule’s requirements concerning physician review of outpatient records by deleting §485.631(b)(1)(vi) and incorporating its provisions into §485.631(b)(1)(v). The revised requirement calls for a CAH MD or DO to periodically review a sample of outpatient records of patients cared for by non-physician practitioners, but only to the extent required under State law where State law requires such record reviews and/or co-signatures. The requirement is not substantively different from the current CAH requirement, but is stated more clearly.

  • Remove the requirement for those reviews which are required under State law to take place at least every two weeks.

  §485.631(b)(2) was revised to remove the requirement that an MD or DO must be present in the CAH at least once every two weeks. CAH MDs/DOs are now required to be present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH. This revision recognizes that many of the MD/DO required functions may be performed remotely via electronic means, and that the time required to be on-site will vary from CAH to CAH, depending on the volume and type of services they offer.

• Provision of Services, §485.635

  §485.635(a)(2) was revised to remove the requirement for the CAH’s patient care policies to be developed with the advice of at least one individual who is not a member of the CAH’s professional healthcare staff.

  §485.635(a)(3)(vii) was revised to remove language that could have been misunderstood as making it appear optional for a CAH to provide acute inpatient services. This change was effective October 1, 2013.

  §485.635(b)(1) was revised to add a new, explicit requirement at §485.635(b)(1)(ii) for CAHs to furnish acute care inpatient services. After regulation changes adopted in 2012 removed language referring to “direct” services a CAH must provide, as opposed to services a CAH may provide under arrangement, the language remaining could have been misinterpreted to suggest that a CAH must only provide outpatient services. This change was effective October 1, 2013.

  §485.635(c) was revised to remove inpatient hospital care as a service that may be provided under arrangement, to avoid creating the misperception that CAHs are not required to furnish inpatient services. This change was effective October 1, 2013.

C.4. Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs), 42 CFR Part 491

• Definitions, §491.2

  The definition of a “physician” has been revised to include a doctor of dental surgery or dental medicine, a doctor of podiatry or surgical chiropody, or a chiropractor, within the
limitations of services these types of physicians are permitted to offer under Section 1861(r) of the Social Security Act. However, it continues to be the case that only MDs or DOs may fulfill the requirements for supervision, collaboration and oversight of non-physician practitioners in an RHC or FQHC.

- **Staffing and Staff Responsibilities, §491.8**
  - §491.8(a)(3) was revised to permit an RHC to have a nurse practitioner or physician assistant provide services under contract to the RHC, so long as the RHC has at least one employee who is a nurse practitioner or physician assistant. *This change is effective July 1, 2014.*
  - §491.8(a)(6) was revised to require for RHCs that a nurse practitioner, physician assistant, or certified nurse-midwife is available to furnish patient care services at least 50% of the time the RHC operates. This aligns the regulatory language with the current statutory requirement. Note that since the statutory provision was self-implementing, CMS has enforced the 50% standard even prior to this regulation change. (See S&C 09-14)
  - §491.8(b) has been revised to delete the requirement formerly at §491.8(b)(2) for a physician to be present in the RHC or FQHC at least once every two weeks. This recognizes that many of the physician’s required functions may be performed remotely via electronic means, but does not remove the requirement that a practitioner, whether a physician or non-physician practitioner, must be present at all times the RHC or FQHC operates. Provisions formerly at §491.8(b)(1)(i) – (iii) have been renumbered to be §491.8(b)(1) – (3), but are otherwise the same.


**Effective Date:** These regulations are effective on July 11, 2014, with the exception of amendments to:

- 42 CFR Part 483, related to nursing home sprinklers, which are effective May 12, 2014;
- 42 CFR Part 485, Subpart F, related to inpatient services in critical access hospitals (CAHs), which were effective October 1, 2013; and
- 42 CFR Part 491, related to rural health clinic non-physician practitioners, which are effective July 1, 2014.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management
The Single Shared Governing Body in Multi-Hospital Systems – CMS Revisions to 42 CFR 482.12 in a Climate of Change

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On May 16, 2012, the Centers for Medicare and Medicaid Services (CMS) released its final rule CMS 3244-P reforming hospital and critical access hospital (CAH) Conditions of Participation. The final rule was released following a commentary period which began with issuance of the proposed rule on October 24, 2011. The revisions followed a retrospective review of regulatory provisions by CMS in response to President Obama’s Executive Order 13563 entitled “Improving Regulations and Regulatory Review”. The President’s order directed that executive agencies undertake a review to modify, streamline and reduce regulatory frameworks to create greater efficiencies, flexibility and effectiveness for regulated industries. The CMS announced that its final rule “responds directly to the President’s instructions… by reducing outmoded or unnecessarily burdensome rules and thereby increasing the ability of hospitals and CAHs to devote resources to providing high quality patient care.”

The final rule contained multiple provisions addressing areas of medical staff governance, including expansion of access to the medical staff for non-physicians, specifically APRN’s and PA’s, and the ability of podiatrists to participate in medical staff leadership. One of the most controversial was the revision of CMS’ interpretation of 42 CFR 482.12 which mandates that hospitals have a governing body legally responsible for the conduct of the hospital. The CMS had previously interpreted this provision as requiring that “each hospital facility” have a separate governing body. The revised rule clarified the governing body requirement to allow for a single governing body to oversee all hospitals within multi-hospital systems. The CMS declared that the revision and clarification was meant “to reflect current hospital organizational structure whereby multi-hospital systems have integrated their governing body functions to oversee care in a more efficient and effective manner.”

The proposed rule announced in October 2011 elicited strong, and very different, reactions from advocates for physicians and hospitals. One of the most significant issues was whether the CMS was considering allowing a single medical staff to oversee all hospitals within multi-hospital systems. In the proposed rule, CMS stated that it had considered changes to the Medical Staff Conditions of Payment (“CoP”) at 42 CFR 482.22 that would allow a multi-hospital system the option of a single medical staff. In the May 16, 2012 final rule, the CMS emphasized that it continued to interpret 482.22 to require that each hospital have a separate medical staff. As will be discussed below, the final rule announced in May 2012 raised additional questions and reaction. As recently as February 7, 2013, the CMS announced new language to address some of those concerns. The ongoing discussion of this rule reflects the profound structural issues confronting hospitals and physicians in today’s complex system of care delivery.

Reaction and Comments to the Proposed Rule for a Single Governing Body for Multi-Hospital Systems

On December 23, 2011, a letter on behalf of the American Medical Association, medical specialty boards and state medical associations expressed strong opposition to the CMS proposed revisions stating: “These revisions would cause serious harm to patients by diluting the authority of the medical staff to set professional and clinical standards for patient care, and by extracting
the governing body from the local setting, rendering it incapable of assessing the acute clinical needs of the hospital’s patient population.\(^3\)

The AMA’s letter stressed that medical staff self governance is a basic requirement for joint commission accreditation, and is mandated by states. The signatories expressed their fear that the CMS proposal would undermine the self governance requirement by allowing a multi-hospital system to engage a single governing body for multiple hospitals “regardless of physical proximity, and without meaningful input by physicians at the respective member hospitals.”\(^4\)

The American Hospital Association and other hospital organizations applauded the proposed rule and the revised interpretation regarding a single shared medical staff governing body. In its December 16, 2011 letter, the AHA echoed the CMS observation that there “exists today a more integrated organizational model adopted by many hospitals” and expressed its concern that the wording of the proposed rule did not go far enough.\(^5\) It urged the CMS to amend the language of the proposed rule to clearly state that the final rule will allow multi-hospital systems to operate with a single integrated medical staff. The AHA also stressed its belief that the changes would promote higher quality care by removing “antiquated regulatory burdens.”\(^6\)

While the letters cited above framed the opposing viewpoints of organizations representing the major stakeholders, there were many comments which reflected both the larger implications and more nuanced issues involved in the change in policy. Overall, CMS received 1,729 comments in response to the proposed rule and the issuance of the final rule did not in any fashion end the discussion.

**Supporters Comments**

The comments in favor of the proposed rule for a single governing body focused on the belief that the requirement of a separate governing body for each hospital is now obsolete and redundant. Commenters in favor of the rule viewed simplification, flexibility and consistency of policies across a system as essential in advancing the more integrated organizational models adopted by many hospitals. Many comments stressed the efficiencies, cost savings, enhancement of mutual accountability, interdependence and more effective oversight.

Other comments in support focused on the advantages of shared learning, promulgation of best practices and standardized performance metrics and elimination of variances. Supporters asked that the CMS go further by expressly stating its belief that multi-hospital systems can effectively be lead by a single governing body.

**Comments in Opposition**

Those opposing or hoping to reduce the scope of the rule advocated for CMS to take the position that multi-hospital systems cannot be effectively governed by a single governing body. While the CMS would not do so, opponents asked for and received the CMS’ endorsement of sub-boards as a valuable resource in hospital governance. In doing so, the CMS stated “we believe there is an important and essential and symbiotic relationship that should exist between a hospital’s governing body and its medical staff.”\(^7\)

The issues of communication and coordination between governing bodies and medical staffs was at the center of many of the comments opposing the changes. Commenters expressed concerns that creating a more remote governing body would adversely impact a governing body’s “informed understanding of the care coordination challenges at each member hospital.” The CMS embraced this concern and created a new controversy by including within the final rule the requirement that a hospital’s governing body include at least one member of the medical staff. This resulted in a swift and vocal reaction from many who pointed out that this requirement may conflict with state law for many hospitals and that CMS had not included this as an issue in its proposed rule in October 2011. On February 7, 2013 the CMS reversed its position on this issue by removing the requirement...
of medical staff representation on a governing body. Instead, the CMS imposed the requirement the governing bodies consult with medical staff leadership to ensure close cooperation and collaboration seen as vital to the delivery of quality care.

Other commenters expressed concerns regarding the impact of “remote management” on diverse institutions within a system. Some suggested that the CMS limit application of the rule to large hospital systems with similar hospital members, or to limit the rule by geography or specialty. In response, the CMS emphasized that it was not endorsing or seeking to impose a requirement of a single governing body for multi-hospital systems. It was instead seeking to provide flexibility for systems that viewed this as appropriate for its needs. The CMS reminded commenters “…that the proposed revision to this requirement is an option that each multi-hospital system is free to choose or not choose for itself.”

Another concern addressed in the final rule was the question of how the CMS viewed compliance by individual hospitals within a system. The CMS responded by noting that it offers flexibility regarding “how and whether [hospitals] choose to participate in the Medicare program.” It noted that it is not uncommon to find multiple hospital campuses with one owner enrolled in Medicare as one hospital. Other systems enroll their hospitals separately to, among other concerns, avoid a situation in which one hospital’s problems jeopardize the Medicare participation of sister hospitals. Ultimately, the CMS stated that it defers to governing bodies to determine its own interests when applying for participation. However, it stressed “each separately certified hospital is accountable for implementing applicable policies, including securing policy approvals by its separate medical staffs” even when promulgated as system wide initiatives.

The Growth of Multi-Hospital Systems and its Impact on Medical Staff Governance

The response to the proposed and final rules highlights the systemic issues both physicians and hospitals now face in adapting to and implementing the reforms that all stakeholders agree are necessary. Not surprisingly, the commenters who supported and opposed the proposed rule each viewed their positions as essential to promoting and maintaining the highest quality of care. Physicians see the independence of medical staff self governance within their respective hospitals as essential to their autonomy and the maintenance of the highest quality of care. They maintain that stance, however, in an environment in which “systemness,” “integration” and “alignment” are promoted as essential strategies to accommodate the monumental changes which have occurred in the delivery of health care.

Since the 1960’s, scholars and members of the healthcare industry have examined the growth of multi-hospital systems in the United States and its impact on the delivery of care. In an article in 1982, Joseph S. Coyne undertook an extensive review of the published data and offered a comparative study of hospital economic and operational performance between system and independent hospitals. A similar review was undertaken by Ermann and Grabel in 1985. Both articles noted that the growth of multi-hospital systems had increased significantly and was an inevitable feature of the healthcare system.

In 1982, one of every three hospitals and 36% of hospital beds belonged to a multi-hospital system. Today, the data reflects that more than half of all hospital admissions take place in the 200 largest hospital systems. That growth has been attributed to a host of factors and estimates are that 60% of all admissions are in hospitals that are part of a system. No one sees that trend changing. On the contrary, the ability to deal with the challenges in reimbursement, particularly the bundled payment initiatives; the drive toward consolidation and coordination of quality initiatives; and the encouragement of integrated care models, point toward a reliance on “systemness” to advance what are seen as essential reforms in care delivery.

In March of 2010, the Health Education and Research Trust (“HRET”) published “A Guide to Achieving Higher Performance in Multi-Hospital Systems.” The guide set forth findings of an extensive review of best practices associated with high performing health systems. The recommendation of creating alignment across the health system to promote quality and safety goals was an essential part of the findings by the HRET. The use of EMR is seen as a catalyst for these changes, as are the creation of standardized treatment protocols and the creation of system wide metrics for managing clinical performance. Systems we
represent are focusing tremendous resources on enhancing quality through an integrated model which demands greater coordination, communication and acquiescence by physicians to the needs of the system.

The push for integration has raised fundamental questions as to whether the traditional medical staff model and its attachment to physician autonomy is itself an impediment to accomplishing higher quality. In a 2008 editorial, Mark Shields, M.D., M.B.A made the argument that the current organizational structures in place within hospitals are indeed a significant impediment to promoting quality.12 Quoting an article by Baker and Smithson, the editorial stated that hospital medical staff organizations “are just not cut out for effective accountability. Their only real authority is the power to restrict or revoke privileges. They work within an arcane political structure… heavily stacked in favor of physician autonomy versus their accountability…” 13

It is naïve to think that quality is the only driver of physician insistence on confining medical staff governance within individual hospitals. There are very strong financial forces at work resulting in intense resistance on the part of medical staffs operating within systems to hand over control to outside groups. In its December 23, 2011 letter, the AMA and other groups used the example of a small rural hospital operating in large urban based hospital systems to illustrate the potential threat to medical staff and hospital autonomy. The reality is that rivalries and resistance to consolidating medical staff governance exist between hospitals of equal size within systems precisely because physicians’ insistence on medical staff independence is driven by multiple factors, not the least of which is their perceived financial interests. We have seen hospitals of both different and similar sizes within systems compete fiercely for resources and physician recruitment.

While the forces of autonomy are evident in all systems, it would be inaccurate to portray multi-hospital systems as consisting of individual hospital medical staffs and governing bodies as exclusively operating within their own silos resistant to any cooperation and consolidation. The fact is that administrators, boards and physician leaders operating within systems have long acknowledged the value in working with their sister hospitals in numerous areas. They have also expressed frustration with the barriers that the traditional model has placed in the way of coordination with other hospitals within their systems in the areas of promoting quality and medical staff management. This is particularly so with sharing of confidential peer review information and consolidation of fair hearings for physicians subjected to corrective action by multiple hospitals within a system. It took an initiative by providers in California to enact a peer review sharing statute in 2012 precisely because of extreme variation in the interpretation of the evidentiary privilege mandating confidentiality of peer review information.14

On a practical level, the issue of consolidation of fair hearings is an area in which hospitals operating within systems can take advantage of efficiencies not available to independent hospitals. Physicians often have medical staff membership in multiple hospitals within a particular system and the problems that lead to focused review or corrective action are not usually confined to a single facility. We have seen many cases in which multiple hospitals within a system have taken action based on similar issues. There are also events which take place at one hospital which are of such concern that other hospitals may wish to use that event as a basis to suspend or remove a physician. As with the sharing of information, we have seen variation in how systems approach this type of problem. The unfortunate reality is that fair hearings result in tremendous expense and consumption of time and resources. To the extent that the desire for autonomy translates into one medical staff bearing the burden of providing a hearing even with knowledge of similar actions at other hospitals, there is significant potential for waste, inefficiency and duplication.

The Drive for Alignment and Systemness as Essential for Achieving Quality

Beyond the practical considerations outlined above, there are much deeper and more fundamental issues raised by the current forces which are driving reform. In many ways, the CMS final rule represents a very small part of the reality that is taking place. The creation of system-wide oversight, policies and CPOE’s, performance metrics, and other quality initiatives are taking place on a daily basis and beg the question of how the initiatives will be implemented and enforced within the current model. Practically
speaking, getting a medical staff to take meaningful action even on what would seem to be clear cut quality issues sometimes presents challenges. Asking the current medical staff model to bear the burden of ensuring compliance with the initiatives that are an essential part of system reform is an altogether different and very complicated proposition.

What seems clear is that all stakeholders will need to confront the drive for alignment and whether the current model can be effectively engaged to support the changes necessary for physicians, hospitals and systems to thrive. An obvious response is to balance these interests by ensuring that individual hospitals maintain their voice and are appropriately represented on governing bodies, and by allowing for sub-boards and affording independence and strength to the existing committee structure within the individual hospitals. In one of our systems, we recently helped a specialty hospital whose license was merged with the main hospital create a structure that assured its medical staff oversight of critical issues notwithstanding the loss of its medical executive committee and board. The situation was complicated by the fact that the smaller hospital responded to the changes by forming a leadership counsel which duplicated the role of the supervisory committee. This created the potential for inconsistent findings and action vis physicians. Because the latter posed significant liability risk, an alternative solution was created to ameliorate those risks.

**Conclusion**

The reaction to the CMS revisions demonstrates how deeply entrenched physician autonomy and the current structure are in the delivery of care. Permitting a single shared governing body within multi-hospital systems is but one piece of a much larger puzzle. While the current system has been built around, and quality enhanced by, the independent medical staff structure, no one should underestimate the forces driving systems toward greater integration and the extent to which those changes will inevitably force all those involved with medical staff governance to confront and appropriately manage this new reality.

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1 77 Fed.Reg. 29034
2 77 Fed.Reg. 29037
4 Id.
6 Id.
7 77 Fed. Reg. 29038
8 Id.
9 77 Fed. Reg. 29039
Clinical Integration Provides the Key to Quality Improvement, American Journal of Medical Quality, 2008, Mark Shields, M.D., M.B.A

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