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CMS Medical Staffing Rule Leaves Questions Unanswered

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Health Law Alert

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On May 12, 2014, the Centers for Medicare & Medicaid Services published in the Federal Register the final rule to the Medicare Conditions of Participation ("CoPs"), including CoPs for Medical Staffs and the Governing Board. The Medical Staff revisions were to clarify the May 16, 2012, final rule (77 FR 29061) which revised 42 CFR Section 482.22. Two of the three subjects covered by the final rule, medical staff composition and governing body, are fairly straightforward. Therefore, this article will concentrate on the ambiguity relating to how medical staffs in a multihospital system may either opt in or opt out of the unified and integrated medical staff.

Medical Staff Composition CoPs

Final Rule

The second medical staff revision adopted by CMS concerns members of the medical staff. Under the May 16, 2012, final rule, CMS defined a medical staff as one composed of doctors of medicine or osteopathy and also allowed for other categories of nonphysician practitioners, in accordance with state law and including scope-of-practice state laws.

Subsequently, CMS received many comments concerning ambiguous language of the 2012 final rule. As a result, CMS revised Section 482.22(a) to state that medical staffs must be composed of doctors of medicine or osteopathy, but in accordance with state law and the scope-of-practice laws, the medical staff may also include other categories of independent practitioners (e.g., doctors of podiatry, optometry, dental surgery and dental medicine), chiropractors and clinical psychologists, and also dependent practitioners determined to be eligible by the governing body for appointment to the medical staff, such as advanced practice nurses, physician assistants, registered dieticians and doctors of pharmacy. As a result of the breadth of this definition, state law must be examined carefully in order to determine which of the enumerated categories of professionals may be included on a medical staff in a particular state.

Attorneys

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Comment

As the final rule states, any changes to the composition of a medical staff must be in compliance with state law. However, the fact that CMS specifically discuses allowing other types of practitioners on the medical staff, such as optometrists, chiropractors, clinical psychologists and other dependent practitioners, especially with the increasing importance and reliance on dependent practitioners, not only in rural hospitals but in all hospitals, medical staffs will now be able to look to increasing the type of practitioners on the medical staff. In many cases, dependent practitioners may be added to the medical staff in a separate category, often called "allied health professionals." This increases the trend to provide greater access to health providers in areas that may have been traditionally underserved. It also is consistent with the Affordable Care Act's design to emphasize and make more available preventative care.

Governing Body CoPs

Final Rule

With respect to the governing body CoPs, in the May 12, 2014, final rule, CMS removed the requirement that a medical staff member must serve on the governing board, replacing it with a requirement that the governing body directly consult with the individual responsible for the medical staff of a hospital (i.e., the medical staff president) or a designee periodically throughout the fiscal or calendar year (42 CFR 482.12 (a)(10)). CMS contemplates that the consultation would include, at a minimum, issues related to the quality of medical care. The extent of the consultation should relate to the scope and complexity of services, the patient population and issues of patient safety identified by the hospital's quality assessment and performance improvement programs.

Comment

In most cases, this final rule will not affect the composition of hospital governing boards. Hospitals have long seen the value of having physicians on the governing board, not only for the physician perspective in quality of care, strategic and operating decisions, but to get the "buy in" from the medical staff through its representative on the board. This has always been a delicate balance, particularly when physician interests do not align with those concerns of the board or the board's objectives. There are instances where a medical staff and hospital administration are at such odds, or where a smaller hospital's medical staff is mostly composed of physicians also on the medical staff of a larger, competing hospital, where the smaller hospital may wish to remove physician representation on the board because of its concern for strategic decisions being leaked to the competing hospital.

Unified and Integrated Medical Staff CoPs

Final Rule

The 2012 final rule required that each hospital must have its own independent medical staff. After publication of the final rule, CMS received enough complaints that it issued the 2014 CoPs, which would allow for a unified and integrated medical staff among multiple hospitals in a health care system. CMS stated in the preamble that "it is in the best interest of hospitals, medical staff members and patients to modify our proposed prohibition on the use of a unified and integrated medical staff for a multihospital system and its member hospitals so as to enable the medical staff of each hospital to voluntarily integrate itself into a larger system medical staff." Notwithstanding the revisions in the 2014 final rule, in providing for a unified and integrated medical staff of a multihospital system, CMS emphasized that each separately participating hospital within the system is still required to comply with all other hospital CoPs.

As such, CMS listed the following requirements for a unified and integrated medical staff:

- A majority vote of the medical staff of each separate hospital in a multihospital system is required to either participate in or opt out of a unified and integrated structure.
- If a unified and integrated medical staff is adopted, it must have bylaws, rules and requirements that describe self-governance, appointment, credentialing, privileges and oversight processes for the integrated staff. In addition, a process must be developed for each hospital's medical staff to opt out of the unified and integrated staff through a majority vote.

- The unified and integrated medical staff is established in a manner that takes into account each member hospital's unique circumstances, patient population and patient population differences.
- The unified and integrated medical staff must develop policies and procedures addressing the needs and concerns of members of the medical staff of each separate hospital.

Discussion

The first requirement set forth above for a unified and integrated medical staff is a majority vote of a medical staff of each separate hospital in a multihospital system. Specifically, 42 C.F.R. 482.22(b)(1) states that "[A]ll medical staff members who hold specific privileges to practice at a hospital" have voted "by majority, in accordance with medical staff bylaws," to opt in or opt out of a unified and integrated medical staff. However, what constitutes a majority?

The final rule can be read two ways. One, the final rule states that a majority of all members of the medical staff with privileges have voted to either opt in or opt out of the unified and integrated medical staff. Two, the final rule also states that in accordance with the medical staff bylaws, a majority of a medical staff has voted to either opt in or opt out. Under the first interpretation, a larger number of medical staff members would be required to approve the integrated approach. In such a situation, those who rarely utilize the hospital would have the same voice and vote as those in the active categories. The second approach interprets the operative sentence as a whole. That is, it does not disregard the phrase, "in accordance with the medical staff bylaws." Most bylaws have limitations on who may vote. For instance, courtesy and consulting staff categories, as well as allied health practitioners categories, often do not have a right to vote.

The two different readings of the operative sentence could lead to three possible alternatives. Assume a large hospital with 500 medical staff members who have clinical privileges. In this example, a quorum is 50 percent of the medical staff members with privileges, and the manner of action at a meeting is 51 percent of the quorum. Under the "all" members interpretation, a majority vote would require 251 members to either opt in or opt out of a unified and integrated medical staff.

On the other hand, under the "in accordance with medical staff bylaws" interpretation, these could be two results. First, it could be read so that the 51 percent of the quorum, or 126 members, would be needed to make the opt-in or opt-out decision. Alternatively, it could be read that only a majority of those members entitled to vote (i.e., active, associate staff) would be counted for a quorum and voting purposes. Thus, these would be less than 126 needed under this reading.

While we believe the interpretation only allowing the vote of those who are permitted to vote under the medical staff bylaws may be the stronger approach, there is no doubt that *clarification from CMS would be helpful.*

Comment

The first step in determining whether or not a multihospital system would want to develop a unified and integrated medical staff must come from the System's Governing Board.

Determining factors include:

- geographic distance among hospitals: a system with five hospitals within 200 miles of each other versus a system with hospitals in five different states;
- the type of services and acuity of medical problems: an inner city trauma hospital versus a critical access hospital;
- historical independence: a system with 10 hospitals with independent medical staffs versus two systems merging and the need to integrate the services and cultures of those two systems; and
- the ability to obtain physician acceptance, particularly when the acuity of services provided are not similar, or there is an academic component to one or more sites, and the remaining sites are community-based, without an educational program.