CMS medical staff and governing body conditions of participation: third time's a charm

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This bulletin focuses solely on the revised Hospital Conditions of Participation (CoPs) related to the relationship between a hospital and its medical staff (482.12 and 482.22).

As we are all aware, the revisions to the Centers for Medicare & Medicaid Services (CMS) CoPs covering requirements of the hospital governing body and medical staff have had a tortured history. The good news is that in the 2014 final rule published May 12, 2014, it appears that CMS did, in fact, take into consideration concerns that were raised with respect to the prior proposed revisions in several areas. The bad news is that some of the new rules will continue to raise challenges.

Hospital medical staff: composition (482.22). The 2014 final rule seeks to accomplish what we believe CMS has been trying to accomplish since 2012. Although the debate was robust, the final rule is relatively straightforward. It provides that the medical staff: (a) must consist of either doctors of medicine or osteopathy; (b) may include other categories of physicians (e.g., dentists, podiatrists, clinical psychologists, optometrists and chiropractors); and (c) may include non-physicians (e.g., advanced practice providers, physician assistants, registered dietitians, doctors of pharmacy, etc.). Such appointments must be within state regulatory boundaries and approved by the governing body.

Hospital governing body (482.12). The second revision, although more complex, is also much improved over the original 2012 final rule. In the 2014 final rule, CMS reaffirmed its 2013 proposed rule providing that the hospital's governing body must consult with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff or his/her designee (e.g., the medical staff president) periodically throughout the calendar/fiscal year. The 2014 final rule does not include the 2012 provision that a member of the medical staff must be a member of the governing body (but it permits a hospital to allow such an appointment/election).

The comments also make clear that if a member of the medical staff is on the governing body, that person cannot be a substitute for the "responsible" individual unless that person is, in fact, the "responsible" person. The rule does not clarify what it means by "periodically" but does state that the meetings (a) must be meaningful; (b) may consist of a number of medical staff leaders to the extent the governing body has authority over more than one hospital (provided that the unique needs of each hospital and its patients are recognized); and (c) must include a discussion of matters related to the quality of medical care provided to patients of the/each hospital.

Hospital medical staff: structure (482.22). The third revision is the most challenging — not in what it now authorizes, but in how hospital systems will be able to implement it (should they wish to do so). In 2012 and 2013, CMS stood firm on its position that each Medicare-certified hospital must have a distinct medical staff (i.e., distinct hospitals could not combine their medical staffs into a single entity). CMS notes in its comments that it has now changed its position because the prior "apparently ambiguous language might have led some stakeholders to interpret §482.22 as allowing for separately certified hospitals, as members of a multi-hospital system, to share a unified and integrated medical staff." Perhaps more importantly, the comments appear to recognize that CMS' prior position created a barrier to CMS' clinical integration agenda (e.g., modern care delivery systems, more efficient sharing of knowledge and innovation, etc.).

But the final rule is tricky in that, although it permits medical staffs to be combined, it also requires that medical staffs be capable of opposing and/or opting out of such combinations. The basic provisions are:

1. The hospitals must be part of a hospital system.
2. The voting members of the medical staff vote, by a majority and consistent with the bylaws, to either (a) accept a unified and integrated medical staff structure; or (b) to opt out of such structure and to maintain a separate and distinct medical staff for their hospital.
3. The unified medical staff has appropriate bylaws that include a process whereby the voting members of each separately certified hospital are advised of their right to opt out and to return to a separate and distinct medical staff.
4. The unified medical staff is established such that it takes into account each member hospital's unique circumstances and significant differences in patient populations and services offered (e.g., this would appear to permit the combination of the medical staffs of a hospital and a critical access hospital).
5. The unified medical staff has policies to ensure that the needs of the separately certified hospitals are given due consideration and that localized issues are addressed.

The ability to unite medical staffs is a welcomed clarification. However, if you have already united your medical staffs or if you are interested in doing so now, the 'elephant in the room' is the requirement of language permitting an "opt out" at any time by majority vote. Addressing this provision will require careful consideration of how it can best be implemented while recognizing the importance of maintaining consistency in an integrated model.

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