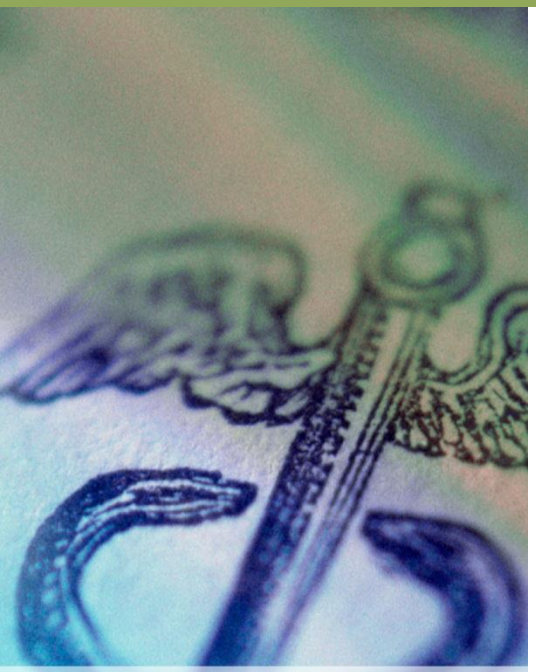

2015 GAMSS EDUCATION CONFERENCE

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Final Medicare Medical Staff Conditions of Participation: What Should be in your Bylaws

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Areas To Be Covered

- Hospital Governing Board
  - Do physicians have to serve on boards?
  - How must board consult with the organized medical staff if physicians are not on the board?
- Hospital Medical Staff – Membership
  - What practitioners can be appointed as members of the medical staff?
  - Must membership be expanded if permitted under state law?
- Hospital Medical Staff – Separate or Unified?
  - Overview of options to create a single, unified and integrated medical staff in a multi-hospital system.

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Areas To Be Covered (cont'd)

- How must the Board interact with staff at each hospital?
- What is the medical staff voting process and who can vote?
- Must members in a unified medical staff have the option to create a separate medical staff?
- What impact on bylaws?
- What if the staffs serve different patient populations and have other unique circumstances?

- Ordering Hospital Outpatient Services
  - Who can order?

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Hospital Governing Board

- Background
  - On May 16, 2012, CMS published a final rule that allowed one governing board to oversee multiple hospitals in a multi-hospital system.
  - If there is one board but there are separately certified hospitals, each must demonstrate compliance with the Medicare CoPs.
  - Rule also required that a medical staff member or members from at least one of the hospitals be included on the board.
  - Many hospitals responded that the rule created complications, especially for public hospitals where local rules or state statutes required board members to be publicly elected or appointed by a government official.

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Hospital Governing Board (cont'd)

- Final Rule and CMS September Guidance
  - Hospitals are not required to have physician board members.
  - If hospital chooses this option, it must:
    - Consult directly with the individual who is assigned the responsibility for the organization and conduct of the medical staff – probably the medical staff president.
    - "Direct consultation" means that the board or a subcommittee meets either face-to-face or via a live telecommunications system.

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Hospital Governing Board (cont'd)

- Consultations must occur periodically, but at least twice a year.
- Must include discussions related to quality of patient care provided at the hospital, such as specific population needs, scope and complexity of hospital services and development of performance improvement standards.
- In a multi-hospital system, consultations must be with the responsible physician of each hospital medical staff.
- Hospital must evidence and document that it has been appropriately responsive to requests from medical staff representative regarding quality of care issues.

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Hospital Governing Board (cont'd)

- In a multi-hospital system, the requirement can be met by means other than a separate meeting with the representative from each hospital medical staff, such as through a committee structure and teleconferencing BUT issues for each hospital must be addressed.
- If medical staff members have opted for a unified staff, the board can meet with leader of the medical staff to fulfill this requirement, but the leader needs to be aware of the concerns or views of members practicing at each separately certified member hospital.
- Requirement can be met if there is a medical staff representative on the board if
  - the representative or his/her designee is responsible for the organization and conduct of the hospital's medical staff
  - there are periodic meetings to discuss matters of the quality of medical care delivered at the hospital.
- Boards clearly can have more than one physician member.

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Hospital Governing Board (cont'd)

- Impact and Recommendations
  - If the entity is not a public hospital or other hospital which requires election or appointment to board by a government official, then best practice is to have medical staff representation.
  - Based on the description of the responsible physician, appointment of the president of the medical staff will meet this requirement.
  - "Direct consultation" is still required whether or not there is medical staff representation on the board.
  - Hospital must document that these consultations occurred—such as minutes, agenda, parties present—and that matters related to the quality of patient care were discussed.

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Hospital Governing Board (cont'd)

- Must decide whether to utilize full board or a board committee.
- In a multi-hospital system, depending on the number of hospitals, a committee approach could be utilized, whether by region or state or as a whole, but could be difficult to manage given divergent issues, different patient population and other unique factors.
- Board or board committee could be split up to meet with medical staff representatives.

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Hospital Governing Board (cont'd)

- Decide which committee best suits this requirement.
- Will likely need to modify both the corporate and medical staff bylaws depending on course of action.
- Can adopt uniform bylaws or policies across multi-hospital system, but must specifically reference each participating hospital.
- Minutes of governing body must be written so that its actions apply to a specific certified hospital.

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Hospital Governing Board (cont'd)

- Departments of separately certified hospitals with a single board cannot be operated in an integrated manner. For example, each must have its own nursing service.
- Policies can be identical but services have to be separate.
- There must be a specific QAPI program for each program but can use same quality indicators or method to track adverse events – need specific hospital results.

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Hospital Medical Staff - Membership

- Background
  - The May 16, 2012 final rule on the permitted composition of the medical staff was confusing with regard to the use of “non-physician practitioners” because it inadvertently excluded other practitioners from medical staff membership.
  - The requirement that the medical staff must include DOs and MDs also suggested that other practitioners were excluded even if they met the state’s definition of “physician.”

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Hospital Medical Staff – Membership (cont'd)

- Final Rule
  - The medical staff must be composed of MDs and DOs.
  - In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, i.e., dentists, podiatrists, and non-physician practitioners, who also are determined to be eligible by the board, i.e., APNs, PAs.
- Impact and Recommendations
  - Hospitals are not required to put anyone other than MDs and DOs on the medical staff, even if permitted to do so under state law.
  - Consider expanding membership if permitted under state law.

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Hospital Medical Staff – Membership (cont'd)

- Board has final say on which categories of physician and non-physician practitioners are entitled to medical staff membership.
- Even if not allowed to be a member of the medical staff, practitioners can be given clinical privileges as long as they are credentialed and privileged in accordance with the applicable bylaws and policies and the privileges granted are within the scope of permitted practice under state law and as approved by the board.

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Hospital Medical Staff – Unified Integrated Staff

- Background
  - Previous rule required that each hospital must have a separate medical staff for each separately certified hospital in a multi-hospital system.
  - Because the rule was somewhat ambiguous, a number of multi-hospital systems created a unified and integrated staff.
  - Many of the comments received by CMS from individual physicians as well as state and national physician organizations strongly supported the separate medical staff rule and urged CMS to reinforce the standard and clarify the ambiguity.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- The concern expressed was that the concept of "self governance" under TJC standards would be destroyed and that individual autonomy and local concerns and issues at the hospital would be ignored or not adequately addressed in a unified medical staff.
- On the other hand, most hospitals and health systems supported the option of creating a unified and integrated staff. One unidentified Commentator reported that the model "substantially contributed to our success as an integrated delivery system and has accelerated our quality, safety, and efficiency performance."
- As additional support for this claim, it identified significant improvements in lowering in-hospital mortality rates and readmission rates and it had the second lowest congestive heart failure readmission rates in the nation based on published CMS data.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Final Rule
  - Medical staff members of each separately certified hospital in a multi-hospital system must have voted in the majority, in accordance with the bylaws, either to accept or opt out of a unified and integrated staff structure for their hospital.
    - Board must also agree to a unified and integrated staff.
    - Unless otherwise stated in bylaws, this means a majority of those physician members eligible to vote.
    - Telemedicine physicians are not eligible to vote.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- A unified staff has one set of bylaws, rules and requirements that describe its processes for self-governance, appointment, credentialing, privileging, oversight, peer review, and hearing rights as applied to all members of the unified staff; and a process for advising them in writing of their right to opt out.
- The unified staff must be established in a manner which takes into consideration each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- The unified staff:
  - Establishes and implements policies and procedures to ensure that the needs and concerns expressed by medical staff members at each hospital are given due consideration.
  - Mechanisms must be in place to ensure that issues localized to particular hospitals are considered and addressed.
- Separately certified hospitals that share a single integrated staff must also share one governing body.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- A multi-campus hospital is not a multi-hospital system and therefore can only have one medical staff and not separate staffs at each hospital.
- The option to use a single unified staff has to be permitted under state law.
- The choice of whether to opt in or opt out of a single unified staff in a multi-hospital system is not an all-in or all-out option. The system can have staffs which have made different choices.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- A system which had a unified medical staff prior to July 11, 2014, when the standard became effective, will serve as evidence of its election to approve this structure – no new vote is required (the standard assumes a prior vote took place).
- For a system that had a unified staff prior to July 22, 2014, bylaws need to be amended within six months to reflect requirements of §482.22(b)(4)(i-iv). Nothing precludes the ability to conduct a vote prior to completion of bylaw amendments.
- All system governing bodies which select this option, whether before or after July 11, 2014, must still review and document that this election was made and that the decision does not conflict with state or local laws or regulations.
  - CMS surveyors will request this documentation.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Must also inform medical staff members of their right to opt out.
- Privileges given to practitioners need to be specific to each practitioner and to each hospital where he or she exercises privileges and the services offered there.
- Process for medical staff to opt in or opt out must be in the bylaws of all system hospitals, even hospitals where the medical staff is not participating in a unified staff.
- Depending on state law, the unified medical staff bylaws, rules and regulations can be in addition to or a substitute for hospital-specific ones, but cannot conflict.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Medical staff and board has the flexibility of determining the details of the voting process.
  - How the opt-in or opt-out vote can be requested.
  - What categories of membership holding privileges to practice onsite can vote.
  - Whether voting will be in writing and by open or secret ballot.
  - Method cannot be more restrictive than currently afforded under bylaws when considering and voting on amendments—i.e., it cannot require approval by two-thirds of voting members if only a majority is required.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Cannot require as a condition of opting out a petition signed by the same number of voting members as would be required for a successful opt-out vote.

- When a hospital system has a unified medical staff and a medical staff has exercised its right to hold a vote on opting out, the decision cannot be delegated solely to the unified medical executive committee, even if the MEC is otherwise given this authority for other matters pursuant to the bylaws. Eligible members must still be able to vote.
  - But if the system has a separate medical staff and is voting on whether to opt in to a unified staff, the vote can be made by the MEC if bylaws give it this right.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Minimal intervals between consideration of an opt-in or opt-out vote can be established but cannot be longer than two years.
- Guidance does not say whether Board has the right to veto or not accept opt-out vote.

- Policies and Procedures
  - Given the likely differences between system hospitals, the expectation is that these differences and the varying needs will be reflected in the policies and procedures of each hospital.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- There can be systemwide standards, but they must reflect uniqueness of each facility where appropriate.
- Data collected and results (for example, for the QAPI program) must be hospital-specific.
- Must have written policies and procedures in place that address how the unified staff addresses needs and concerns of its practicing members relating to patient needs and healthcare quality.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Written policy must cover:
  - A process for raising local concerns and needs
  - How members are informed about the process
  - A process for referring concerns and needs to an appropriate committee
  - Must document outcome

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Impact and recommendations
  - All hospitals and medical staffs in a multi-hospital system with separately certified hospitals must amend bylaws to include opt-in and opt-out procedures even if they are not considering a unified medical staff.
  - Should convene bylaws committee to develop process and amendments as soon as possible.
  - Must also develop policies as per CoP requirements, but need to follow internal development and approval procedures.

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Hospital Medical Staff – Unified Integrated Staff (cont'd)

- Documentation of compliance with requirements are extremely important. Written notice of opt-in or opt-out rights should be placed in physician's credentials file.
- Questions as to whether to create a unified staff or to participate in one should take place between leaders of the medical staff and hospital using an existing committee with joint membership, or an ad hoc committee to determine level of interest/disinterest.
- Need to determine impact on Medicare reimbursement if moving toward single governing body and single CCN member.

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Ordering Outpatient Services

- Background
  - The goal of the November 18, 2011 final version of the Interpretive Guideline was to expand the categories of practitioners who could order rehab, respiratory and other outpatient services, but the requirement that they also had to have medical staff privileges at the hospital had the opposite effect.
  - Many practitioners who place these orders are not on the hospital's medical staff and sometimes are located in different geographic markets and states.

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Ordering Outpatient Services (cont'd)

- Final Rule
  - Outpatient services must be ordered by a practitioner who meets the following conditions:
    - Is responsible for the care of the patient
    - Is licensed in the state where he or she provides care to the patient
    - Is acting within his or her scope of practice under state law
    - Is authorized in accordance with state law and policies adopted by the medical staff and approved by the board to order the applicable outpatient services.

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Ordering Outpatient Services (cont'd)

- Standard applies to:
  - All practitioners on the medical staff who have been given privileges to order the applicable services
  - All practitioners not on the medical staff but who satisfy the eligibility criteria.
- Impact and recommendations
  - Need to decide what categories of practitioners and what outpatient services each category can order consistent with that state's scope of practice statutes.
  - Would need to check statutes first if allowing out of state practitioners to order services.

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Resource List

- Revised CMS final rule: www.federalregister.gov/articles/2014/05/12/2014-10687/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and#h-19

- CMS Interpretive Guidelines: www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R122SOMA.pdf

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