



CMS Issues Final Rules on Hospital Medical Staff Conditions of Participation

In early 2013, NAMSS provided comment to the Centers for Medicare & Medicaid Services' (CMS) proposals to the Medical Staff Conditions of Participation, *RIN 0938-AR49, Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II*. These proposals addressed several areas of interest to NAMSS members: dietitian privileging, hospital medical staff membership composition, hospital governing body representation, medical staff within multihospital systems, and outpatient hospital orders. CMS published its final rule on these measures on May 12, 2014.

To help you understand CMS's final rule, we have highlighted CMS's proposed rule to the above topics, NAMSS' 2013 comments on these proposals, CMS's final rules, and key takeaways below.

1. Hospital Registered Dietitian Privileges

CMS's Proposed Rule (2013): "We propose to include qualified dietitians as practitioners who may be privileged to order patient diets under the hospital conditions of participation (CoPs)."

NAMSS' Comment (2013): "NAMSS appreciates that CMS recognizes the role that allied healthcare providers play in delivering quality and competent patient care. The proposal recognizes changes that are occurring at the state level through scope of practice laws that allows dietitians to operate as independent practitioners and write patient orders. Enabling dietitians to sign off on patient orders without the physician's approval streamlines this process.

NAMSS requests clarification to affirm that the proposal only provides hospitals the *option* to credential and privilege dietitians. Many hospitals use contractors to supply dietitians. In these instances, there is not a consistent roster of dietitians on staff. If the proposal requires such hospitals to credential dietitians, MSPs in such settings would need to constantly credential new dietitians and the aforementioned high turnover rate would generate additional expenditures. NAMSS encourages CMS to consider these costs and to keep flexibility in the final rule by not *requiring* hospitals to credential and privilege dietitians."

CMS's Final Rule (2014): "We are permitting registered dietitians and other clinically qualified nutrition professionals to be privileged to order patient diets under the hospital conditions of participation (CoPs).

In order for patients to have access to the timely nutritional care that can be provided by RDs, a hospital must have the regulatory flexibility either to appoint RDs to the medical staff and grant them specific nutritional ordering privileges or to authorize the ordering privileges without appointment to the medical staff, all through the hospital's appropriate medical staff rules, regulations, and bylaws."

Key Takeaway: CMS permits, but does not require, hospitals to allow qualified dietitians to join their medical staff. The final rule acknowledges that granting dietitians privileges to order patient diets may not work for all facilities.

2. Hospital Medical Staff Composition

CMS's Proposed Rule (2013): "We propose to clarify the requirement that a hospital's medical staff must be generally composed of physicians but that it may also include, in accordance with state laws, including scope-of-practice laws, other categories of non-physician practitioners who are determined to be eligible for appointment by the governing body."

NAMSS' Comment (2013): "NAMSS appreciates this clarification to grant states and hospitals the flexibility to deem non-physician practitioners eligible for medical staff membership."

CMS's Final Rule (2014): "We are clarifying the requirement that a hospital's medical staff must be composed of doctors of medicine or osteopathy but that it may also include, in accordance with state laws, including scope-of-practice laws, other categories of physicians and non-physician practitioners who are determined to be eligible for appointment by the governing body."

Key Takeaway: Medical staff composition may include physicians and certain non-physician practitioners (such as advanced practice registered nurses, physician assistants, registered dietitians, and doctors of pharmacy), but facilities are not required to include these non-physician practitioners on their medical staff.

3. Hospital Governing Body

CMS's Proposed Rule (2013): "We are proposing to add a new provision to the 'medical staff' standard of the governing body CoP. This new provision would require a hospital's governing body to directly consult at least periodically throughout the calendar year or fiscal year with the individual responsible for the organized medical staff of the hospital, or his or her designee. For a multihospital system using a single governing body to oversee multiple hospitals within its system, this provision would require the single governing body to consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements proposed here. We are also proposing to remove the requirement for a medical staff member, or members, to be on a hospital's governing body."

NAMSS' Comment (2013): “Although the medical staff may have a stronger voice at the governing body level through regular consultation with the medical leadership than through individual physicians serving on the governing body, physician representation on the hospital governing body can be equally effective for many hospitals. Thus, while NAMSS commends CMS’s proposal to allow medical staff within a hospital direct consultation with the governing body, NAMSS recommends that CMS provides individual hospitals the option to incorporate direct physician involvement on the governing body while having the governing body seek direct input from the hospital’s medical staff leadership at least twice a year.

NAMSS also requests that CMS clarifies whether this requirement specifically pertains to the full governing body or encompasses subcommittees of the governing body. For instance, if a governing body has delegated decision-making authority to a medical staff oversight subcommittee, would the medical staff oversight subcommittee’s consultation with the medical leadership at least twice a year satisfy the new CoP requirement?”

CMS’s Final Rule (2014): “We are adding a new provision to the ‘medical staff’ standard of the governing body CoP. This new provision requires a hospital’s governing body to directly consult periodically throughout the calendar year or fiscal year with the individual responsible for the organized medical staff of the hospital, or his or her designee. For a multihospital system using a single governing body to oversee multiple hospitals within its system, this provision requires the single governing body to consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements finalized here. We are also removing the requirement for a medical staff member, or members, to be on a hospital’s governing body.”

Key Takeaway: Hospital governing bodies are no longer required to include medical staff members. They are instead required to directly consult with the individual responsible for the medical staff, or the designee, at least twice during a fiscal or calendar year. A single governing body overseeing a multihospital system will directly consult with the individual responsible for the medical staff, or the designee, of each hospital within its system at least twice during a fiscal or calendar year.

4. Hospital Medical Staff

CMS’s Proposed Rule (2013): “We propose to require that each hospital must have an organized and individual medical staff, distinct to that individual hospital, that operates under bylaws approved by the governing body and which is responsible for the quality of medical care provided to patients by that individual hospital.”

NAMSS’ Comment (2013): “NAMSS is concerned that CMS’s proposal to require each hospital to have its own distinct organized and individual medical staff reduces flexibility for multihospital systems to design and implement system-wide medical oversight structures that maximize efficiency and patient safety. CMS has taken contradictory positions with regard to the ‘single medical staff’ requirement in October 2011, May 2012, and in the current proposed regulation and should clarify these contradictions.

NAMSS also seeks clarification on the extent of the ‘single medical staff’ requirement. CMS refers to ‘each hospital.’ Does this mean each entity operating under a single state hospital license – even if it has multiple sites of operation? Does this mean each entity operating under a single hospital Medicare provider number – even if it has multiple sites of operation? A multisite hospital operating under either a single state license or a single Medicare provider number should be deemed a single ‘hospital’ for purposes of the single medical staff requirement. NAMSS requests that CMS confirms this interpretation.

NAMSS is particularly concerned that the current proposed single-medical-staff requirement contradicts and undermines CMS’s expressed intent to provide greater flexibility to hospitals in designing effective governance structures. For instance, the current CoPs expressly permit multihospital systems to have a unified governing body. CMS has explained that this will promote ‘efficient and effective’ governance and can help hospitals ‘achieve significant progress in quality programs’ (77 Fed. Reg. 29034, 29037-38 [May 16, 2012]). However, despite recognizing the benefits of a unified governing body in promoting efficient and effective governance and quality, CMS is denying multi-hospital systems the flexibility to maintain a unified medical staff, which could help hospital systems achieve the same goals.

CMS expresses a concern that a large system with a single medical staff ‘may not appropriately be able to address the needs of each individual hospital in each local area’ (78 Fed. Reg. 9216, 9221 [February 7, 2013]). NAMSS agrees that any medical staff structure should provide for local medical leadership of local issues, but disagrees that such a structure is inconsistent with having a unified, system-wide medical staff. NAMSS is aware of multihospital systems that have developed a medical staff structure that combines an overarching unified body with local medical staff leadership. Such a structure can achieve the benefits of coordination and efficiency across a system, with local medical oversight of local issues and concerns.

Multihospital systems should have the flexibility to design medical oversight structures that enable them to maximize efficiency, quality, and patient safety at the system and individual hospital level, consistent with applicable state law and accreditation requirements. NAMSS urges CMS to reconsider and clarify its position regarding the ‘single medical staff’ requirement to permit such flexibility.

NAMSS requests that CMS’s final rule better reflect its intent to eliminate ineffective and inefficient policies by consistently granting individual hospitals more flexibility to enable hands-on medical leadership at the local level while still maintaining the benefits of a unified, system-wide medical staff.”

CMS’s Final Rule (2014): “We are retaining the current regulatory provision but reinterpreting it to allow for either a unique medical staff for each hospital or for a unified and integrated medical staff shared by multiple hospitals within a hospital system. We are adding four new provisions to hold a hospital responsible for showing that it actively addresses its use of a system unified and integrated medical staff model.

(1) We are requiring that the medical staff members holding privileges at each separately certified hospital in the system have voted either to participate in a unified and integrated medical staff structure or to opt out of such a structure, and to maintain a hospital-specific separate and distinct medical staff for their respective hospital.

(2) We are requiring that the unified and integrated medical staff has bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight – as well as its peer review policies and due process rights guarantees – which include a process for the members of the medical staff of each separately certified hospital (that is, all medical staff members who hold specific privileges to practice at that hospital) to be advised of their rights 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 hospital.

(3) We are requiring that the unified and integrated medical staff is established in a manner that takes into account each hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.

(4) We are also requiring that the unified and integrated medical staff gives due consideration to the needs and concerns of members of the medical staff, regardless of practice or location, and the hospital has mechanisms in place to assure that issues localized to particular hospitals are duly considered and addressed.”

Key Takeaway: Medical staff in multihospital systems may integrate into a larger medical staff or operate individually within the system. The final rule revises the proposed mandate that each hospital within a multihospital system have its own medical staff and reverts to the original and current requirement that “the hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.” The final rule adds the above four stipulations to the original/current requirement to ensure that each hospital “actively addresses its use of a unified and integrated staff model.”

5. Practitioners Permitted to Order Hospital Outpatient Services

CMS’s Proposed Rule (2013): “We propose to revise the outpatient services CoP to allow for practitioners who are not on the hospital’s medical staff to order hospital outpatient services for their patients when authorized by the medical staff and allowed by state law.”

NAMSS’ Comment (2013): “NAMSS appreciates CMS’s clarification regarding outpatient orders for practitioners who are not members of a hospital’s medical staff and the resulting efficiencies that it affords hospitals and MSPs. In realizing these efficiencies, NAMSS recommends that CMS specify the timeframe and the duration of the verification process for such orders, as they vary in frequency and urgency.”

CMS’s Final Rule: “We are revising the outpatient services CoP to allow for practitioners who are not on the hospital’s medical staff to order hospital outpatient services for their patients when authorized by the medical staff and allowed by state law.”

Key Takeaway: Any practitioner who is responsible for the care of the patient, licensed in the state in which he/she cares for the patient, acts within his/her scope of practice under state law, and is authorized in accordance with medical staff policy and approved by its governing body may order outpatient services. This applies to hospital medical staff members who are privileged

to order applicable outpatient services, as well as practitioners who are not medical staff members, but meet the above criteria for “authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients.” These requirements also apply to all hospital outpatient services.

Looking Ahead

Reducing waste and increasing effective and efficient hospital management is a constant task that requires careful deliberation. NAMSS appreciates CMS’s consideration of public feedback and will continue to monitor proposed CoPs changes to ensure that NAMSS’ member interests are represented.

These rules takes effect on July, 12, 2014 – 60 days from CMS’s May 12, 2014, publication of its final rule in the Federal Register: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf>.

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