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CLIENT ADVISORY

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CMS Issues Final Rule Making Significant Changes to Hospital CoP Requirements for Medical Staffs, additional changes to Hospital CoPs

On May 12, 2014, the Centers for Medicare & Medicaid Services (CMS) issued its final rule: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Part II (the "2014 Final Rule"). The 2014 Final Rule makes significant changes to the Medicare Conditions of Participation for Hospitals ("CoPs") related to medical staffs and their structures, most notably allowing a multi-hospital system to implement a single unified and integrated medical staff. Additional changes to the CoPs permit dieticians to be privileged, reclassify swing beds to allow for accreditation by a CMS-approved accreditation agency, and allow non-privileged practitioners to provide orders for outpatient services. The final rule also amends the CoPs for critical access hospitals ("CAHs") to no longer require the input of at least one person who is not part of the staff of the CAH to provide advice on the CAH's policies and procedures and to remove the requirement that a physician be onsite at least once in every two week period. The following changes are effective July 11, 2014:

I. Unified and Integrated Medical Staff Permissible

The 2014 Final Rule reverses CMS' longstanding prohibition on multi-hospital systems developing a single unified and integrated medical staff. CMS previously required that each Medicare-certified hospital have its own distinct medical staff. Now hospitals with separate provider numbers that are part of a multi-hospital system can integrate their medical staffs if they are able to satisfy four provisions:

1. The medical staff members of each separately certified hospital in the system (that is, all medical staff members who hold specific privileges to practice at that hospital) must vote by majority, to accept a unified and integrated medical staff structure, or to opt-out.

2. The unified and integrated medical staff must have bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight. These governing documents must include a process for the members of the medical staff of each separately certified hospital to be advised of the medical staff's right to opt-out of the unified and integrated medical staff structure after a majority vote by the members.

3. The unified 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.

4. The unified medical staff has policies to ensure that the needs of the separately certified hospitals are given due consideration and that address localized issues.

The 2014 Final Rule recognizes the benefits of a unified medical staff and at the same time seeks to protect the opportunity for self-governance by member hospitals in a health system. For multi-hospital systems that already have an integrated medical staff, or for those in the planning stage, it is important to incorporate the required opt-out procedure into the governing documents. It is also important to note that state law also may limit a health system's ability to have a unified and integrated medical staff structure.

II. Hospital Governing Body Must Consult Medical Staff Representative

The 2014 Final Rule also altered requirements imposed on hospital governing bodies. The new rule eliminates a 2012 requirement that the composition of hospital governing bodies must include one member of the hospital's medical staff. A governing body may still choose to appoint a member of the medical staff, but this is no longer required. In addition, the 2014 Final Rule requires a hospital's governing body to consult with the individual assigned responsibility for the organization and conduct of the hospital's Medical Staff or their designee periodically throughout the year. The rule does not specifically address how many consultations must occur, only that they are periodically throughout the calendar or fiscal year. As for the format of the consultations, they must occur "either face-to-face or via a telecommunications system permitting immediate, synchronous communication" and include discussion of matters related to the quality of medical care provided to patients of each hospital. For a multi-hospital system with a single governing body, the governing body must consult with the individual responsible for the organized Medical Staff (or his or her designee) of each hospital within the system. According to CMS, these changes are intended to increase communication between Medical Staffs and governing bodies while eliminating potential conflicts with state and local law that arose from the requirement that a medical staff member be appointed to the hospital governing body.

III. Clarification on the Composition of Hospital Medical Staffs

The 2014 Final Rule modifies Section 482.22(a) to clarify that the medical staff *must* be composed of doctors of medicine or osteopathy, and that it *may* also include other categories physicians (e.g., dental surgeons, dentists, podiatrists, optometrists, and chiropractors) and non-physician practitioners (e.g., Advanced Practice Registered Nurses, Physician Assistants, Registered Dietitians, and Doctors of Pharmacy). These practitioners must still be deemed eligible for appointment by the hospital's governing body, in accordance with state law, including scope-of-practice laws. The revisions to this section are not intended to change the regulation; rather they are to address confusion created by the non-physician category. When the 2012 final rule added this category it led to speculation that other physicians (not doctors of medicine or osteopathy) were purposely excluded. However, with this change CMS clarified that the omission was unintentional.

In a comment on this section CMS reiterated that if state law limits the composition of the medical staff to certain categories of practitioners (such as only doctors of medicine or osteopathy), there is nothing in the CoPs that prohibits hospitals and their medical staffs from establishing certain practice privileges for practitioners excluded from medical staff membership under state law. Additionally, privileges can be granted to individual excluded practitioners as long as such privileges are recommended by the Medical Staff, approved by the hospital's governing body, and in accordance with state law.

IV. Non-Medical Staff Practitioner Outpatient Orders, Dieticians, and Swing Bed Classifications

The 2014 Final Rule codifies into regulation recent changes to CMS' Interpretive Guidelines regarding the ordering of outpatient services. Revisions to 42 CFR 482.54 specify that orders for outpatient services may be made by any practitioner who is responsible for the patient's care, licensed in the state where the practitioner provides care to the patient, acting within the practitioner's scope of practice under state law, and authorized in accordance with policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services.

CMS also amends the former requirement that a therapeutic diet be prescribed only by the practitioner or practitioners responsible for the patient's care. CMS' Interpretive Guidelines addressing this prior requirement had stated that a dietician may assess a patient's nutritional needs and provide recommendations, but that only the practitioner responsible for the patient's care may actually prescribe the patient's diet. This resulted in hospitals not granting dieticians ordering privileges. To allow hospitals flexibility regarding the granting of ordering privileges to dieticians, CMS amends the CoPs to provide that therapeutic diets must be ordered by the practitioner responsible for the patient's care, by a qualified dietician, or by other clinically qualified nutrition professionals as authorized by the medical staff and in accordance with state law.

Because current requirements for hospital providers of long-term care services are located in Subpart E of 482, they fall outside of those requirements that can be surveyed by an accreditation organization. To allow for surveys by such accreditation organizations, CMS reassigns all requirements for swing-bed services from Section 482.66, Subpart E, to Section 482. 58, Subpart D.

V. CAH Onsite Physician Requirements and Policies and Procedures

The 2014 Final Rule eliminates the current requirement that a physician must be onsite at a CAH at least once in every two week period. CMS found that rural CAHs in particular faced a heavy burden meeting this requirement. The 2014 Final Rule requires that a physician be present for sufficient periods of time to provide medical direction and supervision and be available through telemedicine services for consultation, assistance with emergencies, or patient referrals.

Additionally, CMS eliminates the former requirement that at least one member of the professional group providing advice on the development of the CAH's policies and procedures

VI. Conclusion

If you would like more information on the 2014 Final Rule, or if you have questions concerning Medical Staff governance, bylaws or operations issues, or the Medicare CoPs in general, please contact Jim Daniel (jdaniel@hdjn.com), Kim Daniel (kdaniel@hdjn.com) or Matt Connors (mconnors@hdjn.com), available by phone at (866) 967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at www.hdjn.com.