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CLIENT ADVISORY

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Proposed Regulatory Changes Impact Hospital Medical Staff Structure and Other Provider Requirements

On February 4, 2013, the Centers for Medicare & Medicaid Services ("CMS") published a proposed rule entitled "Medicare and Medicaid Programs; Part II—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction" (the "Proposed Rule").[i] The Proposed Rule continues CMS' efforts to uphold President Obama's Executive Order 13563 by removing or revising obsolete, duplicative or unnecessary regulatory requirements and Conditions of Participation ("CoPs") to reduce procedural burdens on healthcare providers and reduce system costs. The Proposed Rule also responds to stakeholder concerns with certain provisions of CMS' May 16, 2012 final rule. Comments may be submitted on the Proposed Rule through April 8, 2013.

I. Clarification on Governing Body Requirements

In May 2012, CMS released a final rule which required that each hospital governing body, or a multi-hospital governing body, include at least one medical staff member.[ii] In response to objections from the American Hospital Association, the American Medical Association, and others, CMS undertook additional review of this new requirement. State laws and other practical barriers made compliance challenging and/or impossible for some healthcare providers.

The Proposed Rule rescinds the requirement that each hospital governing body or multi-hospital governing body include a medical staff member. In the alternative, CMS proposes to require that a hospital's governing body periodically consult with a designated member of the medical staff. For multi-hospital systems with a single governing body, the Proposed Rule requires that the governing body consult with a designated member of each hospital's medical staff.

II. Clarification Requiring a Distinct Medical Staff for Each Hospital

CMS also proposes to revise the hospital CoPs to require that each hospital have an organized and individual medical staff, distinct to that individual hospital, that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided to patients by that individual hospital. Such revision further clarifies CMS' recent comments regarding medical staff structure. In its comments to the proposed rule issued October 24, 2011,[iii] CMS noted that the Medical Staff CoP (42 CFR §482.22) does not require each hospital in a multi-hospital system to have a "single and separate medical staff" for each hospital. This was interpreted by some to mean the multi-hospital systems with separate national provider identifier numbers for each hospital could have an integrated medical staff including practitioners at more than one hospital. However, when CMS released its final rule in May 2012, it seemed to reverse course and stated that its comment simply pointed out potential ambiguity in the CoPs.[iv] CMS interprets the CoPs require "each hospital, regardless of whether it is a part of a multi-hospital system, have a single and separate medical staff, as a matter of CMS policy." The changes in the Proposed Rule clarify any ambiguity created by CMS' commentary, and, if implemented, would clearly require each hospital to have an individual medical staff.

III. Other Proposed Changes

Other notable provisions of the Proposed Rule include:

- Reducing requirements ambulatory surgery centers must meet to provide radiological services;
- Including qualified dieticians as practitioners who may be

[i] 78 Fed. Reg. 9216. Feb. 4, 2013.
[ii] 77 Fed. Reg. 29034. May 16, 2012.
[iii] 76 Fed. Reg. 65891, Oct. 24, 2011.
[iv] 77 Fed. Reg. 29034. May 16, 2012.

privileged to order patient diets under the hospital CoPs;

- Removing "direct" from the in-house radiopharmaceutical preparation requirement, which would allow trained nuclear medicine technicians in hospitals to prepare radiopharmaceuticals for nuclear medicine without the presence of a supervising physician or pharmacist;
- Reclassifying swing bed requirements to allow a hospital's compliance with "swing bed' requirements to be evaluated during accreditation surveys;
- Eliminating redundant transplant center data submission requirements and automatic, three-year review and survey processes;
- Allowing long term care facilities to apply for a deadline extension on the requirement for installed automatic sprinkler systems;
- Eliminating the critical access hospital CoP requirement that the critical access hospital develop its patient care policies with at least one member who is not a member of the critical access hospital staff;
- Eliminating the requirement that physicians be onsite once every two weeks at small critical access hospitals, rural health clinics and federally qualified health centers; and
- Revising the outpatient services CoP to allow practitioners who are not on a hospital's medical staff to order hospital outpatient services for their patients when authorized by the medical staff and allowed by state law.

IV. Comment Period

CMS seeks feedback on the Proposed Rule and has encouraged stakeholders to comment by April 8, 2013.

V. Conclusion

If you would like more information on the Proposed Rule, or if you have questions concerning governance or CoPs, 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.