The Single Shared Governing Body in Multi-Hospital Systems – CMS Revisions to 42 CFR 482.12 in a Climate of Change

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On May 16, 2012, the Centers for Medicare and Medicaid Services (CMS) released its final rule CMS 3244-P reforming hospital and critical access hospital (CAH) Conditions of Participation. The final rule was released following a commentary period which began with issuance of the proposed rule on October 24, 2011. The revisions followed a retrospective review of regulatory provisions by CMS in response to President Obama's Executive Order 13563 entitled “Improving Regulations and Regulatory Review”. The President's order directed that executive agencies undertake a review to modify, streamline and reduce regulatory frameworks to create greater efficiencies, flexibility and effectiveness for regulated industries. The CMS announced that its final rule “responds directly to the President's instructions… by reducing outmoded or unnecessarily burdensome rules and thereby increasing the ability of hospitals and CAHs to devote resources to providing high quality patient care.”

The final rule contained multiple provisions addressing areas of medical staff governance, including expansion of access to the medical staff for non-physicians, specifically APRN's and PA's, and the ability of podiatrists to participate in medical staff leadership. One of the most controversial was the revision of CMS' interpretation of 42 CFR 482.12 which mandates that hospitals have a governing body legally responsible for the conduct of the hospital. The CMS had previously interpreted this provision as requiring that “each hospital facility” have a separate governing body. The revised rule clarified the governing body requirement to allow for a single governing body to oversee all hospitals within multi-hospital systems. The CMS declared that the revision and clarification was meant “to reflect current hospital organizational structure whereby multi-hospital systems have integrated their governing body functions to oversee care in a more efficient and effective manner.”

The proposed rule announced in October 2011 elicited strong, and very different, reactions from advocates for physicians and hospitals. One of the most significant issues was whether the CMS was considering allowing a single medical staff to oversee all hospitals within multi-hospital systems. In the proposed rule, CMS stated that it had considered changes to the Medical Staff Conditions of Payment (“CoP”) at 42 CFR 482.22 that would allow a multi-hospital system the option of a single medical staff. In the May 16, 2012 final rule, the CMS emphasized that it continued to interpret 482.22 to require that each hospital have a separate medical staff. As will be discussed below, the final rule announced in May 2012 raised additional questions and reaction. As recently as February 7, 2013, the CMS announced new language to address some of those concerns. The ongoing discussion of this rule reflects the profound structural issues confronting hospitals and physicians in today's complex system of care delivery.

Reaction and Comments to the Proposed Rule for a Single Governing Body for Multi-Hospital Systems

On December 23, 2011, a letter on behalf of the American Medical Association, medical specialty boards and state medical associations expressed strong opposition to the CMS proposed revisions stating: “These revisions would cause serious harm to patients by diluting the authority of the medical staff to set professional and clinical standards for patient care, and by extracting..."
the governing body from the local setting, rendering it incapable of assessing the acute clinical needs of the hospital's patient population.\(^3\)

The AMA’s letter stressed that medical staff self governance is a basic requirement for joint commission accreditation, and is mandated by states. The signatories expressed their fear that the CMS proposal would undermine the self governance requirement by allowing a multi-hospital system to engage a single governing body for multiple hospitals “regardless of physical proximity, and without meaningful input by physicians at the respective member hospitals.”\(^4\)

The American Hospital Association and other hospital organizations applauded the proposed rule and the revised interpretation regarding a single shared medical staff governing body. In its December 16, 2011 letter, the AHA echoed the CMS observation that there “exists today a more integrated organizational model adopted by many hospitals” and expressed its concern that the wording of the proposed rule did not go far enough.\(^5\) It urged the CMS to amend the language of the proposed rule to clearly state that the final rule will allow multi-hospital systems to operate with a single integrated medical staff. The AHA also stressed its belief that the changes would promote higher quality care by removing “antiquated regulatory burdens.”\(^6\)

While the letters cited above framed the opposing viewpoints of organizations representing the major stakeholders, there were many comments which reflected both the larger implications and more nuanced issues involved in the change in policy. Overall, CMS received 1,729 comments in response to the proposed rule and the issuance of the final rule did not in any fashion end the discussion.

**Supporters Comments**

The comments in favor of the proposed rule for a single governing body focused on the belief that the requirement of a separate governing body for each hospital is now obsolete and redundant. Commenters in favor of the rule viewed simplification, flexibility and consistency of policies across a system as essential in advancing the more integrated organizational models adopted by many hospitals. Many comments stressed the efficiencies, cost savings, enhancement of mutual accountability, interdependence and more effective oversight.

Other comments in support focused on the advantages of shared learning, promulgation of best practices and standardized performance metrics and elimination of variances. Supporters asked that that the CMS go further by expressly stating its belief that multi-hospital systems can effectively be lead by a single governing body.

**Comments in Opposition**

Those opposing or hoping to reduce the scope of the rule advocated for CMS to take the position that multi-hospital systems cannot be effectively governed by a single governing body. While the CMS would not do so, opponents asked for and received the CMS’ endorsement of sub-boards as a valuable resource in hospital governance. In doing so, the CMS stated “we believe there is an important and essential and symbiotic relationship that should exist between a hospital’s governing body and its medical staff.”\(^7\)

The issues of communication and coordination between governing bodies and medical staffs was at the center of many of the comments opposing the changes. Commenters expressed concerns that creating a more remote governing body would adversely impact a governing body’s “informed understanding of the care coordination challenges at each member hospital.” The CMS embraced this concern and created a new controversy by including within the final rule the requirement that a hospital’s governing body include at least one member of the medical staff. This resulted in a swift and vocal reaction from many who pointed out that this requirement may conflict with state law for many hospitals and that CMS had not included this as an issue in its proposed rule in October 2011. On February 7, 2013 the CMS reversed its position on this issue by removing the requirement.
of medical staff representation on a governing body. Instead, the CMS imposed the requirement the governing bodies consult with medical staff leadership to ensure close cooperation and collaboration seen as vital to the delivery of quality care.

Other commenters expressed concerns regarding the impact of “remote management” on diverse institutions within a system. Some suggested that the CMS limit application of the rule to large hospital systems with similar hospital members, or to limit the rule by geography or specialty. In response, the CMS emphasized that it was not endorsing or seeking to impose a requirement of a single governing body for multi-hospital systems. It was instead seeking to provide flexibility for systems that viewed this as appropriate for its needs. The CMS reminded commenters “...that the proposed revision to this requirement is an option that each multi-hospital system is free to choose or not choose for itself.”

Another concern addressed in the final rule was the question of how the CMS viewed compliance by individual hospitals within a system. The CMS responded by noting that it offers flexibility regarding “how and whether [hospitals] choose to participate in the Medicare program.” It noted that it is not uncommon to find multiple hospital campuses with one owner enrolled in Medicare as one hospital. Other systems enroll their hospitals separately to, among other concerns, avoid a situation in which one hospital’s problems jeopardize the Medicare participation of sister hospitals. Ultimately, the CMS stated that it defers to governing bodies to determine its own interests when applying for participation. However, it stressed “each separately certified hospital is accountable for implementing applicable policies, including securing policy approvals by its separate medical staffs” even when promulgated as system wide initiatives.

The Growth of Multi-Hospital Systems and its Impact on Medical Staff Governance

The response to the proposed and final rules highlights the systemic issues both physicians and hospitals now face in adapting to and implementing the reforms that all stakeholders agree are necessary. Not surprisingly, the commenters who supported and opposed the proposed rule each viewed their positions as essential to promoting and maintaining the highest quality of care. Physicians see the independence of medical staff self governance within their respective hospitals as essential to their autonomy and the maintenance of the highest quality of care. They maintain that stance, however, in an environment in which “systemness,” “integration” and “alignment” are promoted as essential strategies to accommodate the monumental changes which have occurred in the delivery of health care.

Since the 1960’s, scholars and members of the healthcare industry have examined the growth of multi-hospital systems in the United States and its impact on the delivery of care. In an article in 1982, Joseph S. Coyne undertook an extensive review of the published data and offered a comparative study of hospital economic and operational performance between system and independent hospitals. A similar review was undertaken by Ermann and Grabel in 1985. Both articles noted that the growth of multi-hospital systems had increased significantly and was an inevitable feature of the healthcare system.

In 1982, one of every three hospitals and 36% of hospital beds belonged to a multi-hospital system. Today, the data reflects that more than half of all hospital admissions take place in the 200 largest hospital systems. That growth has been attributed to a host of factors and estimates are that 60% of all admissions are in hospitals that are part of a system. No one sees that trend changing. On the contrary, the ability to deal with the challenges in reimbursement, particularly the bundled payment initiatives; the drive toward consolidation and coordination of quality initiatives; and the encouragement of integrated care models, point toward a reliance on “systemness” to advance what are seen as essential reforms in care delivery.

In March of 2010, the Health Education and Research Trust (“HRET”) published “A Guide to Achieving Higher Performance in Multi-Hospital Systems.” The guide set forth findings of an extensive review of best practices associated with high performing health systems. The recommendation of creating alignment across the health system to promote quality and safety goals was an essential part of the findings by the HRET. The use of EMR is seen as a catalyst for these changes, as are the creation of standardized treatment protocols and the creation of system wide metrics for managing clinical performance. Systems we
represent are focusing tremendous resources on enhancing quality through an integrated model which demands greater coordination, communication and acquiescence by physicians to the needs of the system.

The push for integration has raised fundamental questions as to whether the traditional medical staff model and its attachment to physician autonomy is itself an impediment to accomplishing higher quality. In a 2008 editorial, Mark Shields, M.D., M.B.A made the argument that the current organizational structures in place within hospitals are indeed a significant impediment to promoting quality. 12 Quoting an article by Baker and Smithson, the editorial stated that hospital medical staff organizations “are just not cut out for effective accountability. Their only real authority is the power to restrict or revoke privileges. They work within an arcane political structure… heavily stacked in favor of physician autonomy versus their accountability…”

It is naïve to think that quality is the only driver of physician insistence on confining medical staff governance within individual hospitals. There are very strong financial forces at work resulting in intense resistance on the part of medical staffs operating within systems to hand over control to outside groups. In its December 23, 2011 letter, the AMA and other groups used the example of a small rural hospital operating in large urban based hospital systems to illustrate the potential threat to medical staff and hospital autonomy. The reality is that rivalries and resistance to consolidating medical staff governance exist between hospitals of equal size within systems precisely because physicians’ insistence on medical staff independence is driven by multiple factors, not the least of which is their perceived financial interests. We have seen hospitals of both different and similar sizes within systems compete fiercely for resources and physician recruitment.

While the forces of autonomy are evident in all systems, it would be inaccurate to portray multi-hospital systems as consisting of individual hospital medical staffs and governing bodies as exclusively operating within their own silos resistant to any cooperation and consolidation. The fact is that administrators, boards and physician leaders operating within systems have long acknowledged the value in working with their sister hospitals in numerous areas. They have also expressed frustration with the barriers that the traditional model has placed in the way of coordination with other hospitals within their systems in the areas of promoting quality and medical staff management. This is particularly so with sharing of confidential peer review information and consolidation of fair hearings for physicians subjected to corrective action by multiple hospitals within a system. It took an initiative by providers in California to enact a peer review sharing statute in 2012 precisely because of extreme variation in the interpretation of the evidentiary privilege mandating confidentiality of peer review information. 14

On a practical level, the issue of consolidation of fair hearings is an area in which hospitals operating within systems can take advantage of efficiencies not available to independent hospitals. Physicians often have medical staff membership in multiple hospitals within a particular system and the problems that lead to focused review or corrective action are not usually confined to a single facility. We have seen many cases in which multiple hospitals within a system have taken action based on similar issues. There are also events which take place at one hospital which are of such concern that other hospitals may wish to use that event as a basis to suspend or remove a physician. As with the sharing of information, we have seen variation in how systems approach this type of problem. The unfortunate reality is that fair hearings result in tremendous expense and consumption of time and resources. To the extent that the desire for autonomy translates into one medical staff bearing the burden of providing a hearing even with knowledge of similar actions at other hospitals, there is significant potential for waste, inefficiency and duplication.

The Drive for Alignment and Systemness as Essential for Achieving Quality

Beyond the practical considerations outlined above, there are much deeper and more fundamental issues raised by the current forces which are driving reform. In many ways, the CMS final rule represents a very small part of the reality that is taking place. The creation of system-wide oversight, policies and CPOE’s, performance metrics, and other quality initiatives are taking place on a daily basis and beg the question of how the initiatives will be implemented and enforced within the current model.
speaking, getting a medical staff to take meaningful action even on what would seem to be clear cut quality issues sometimes presents challenges. Asking the current medical staff model to bear the burden of ensuring compliance with the initiatives that are an essential part of system reform is an altogether different and very complicated proposition.

What seems clear is that all stakeholders will need to confront the drive for alignment and whether the current model can be effectively engaged to support the changes necessary for physicians, hospitals and systems to thrive. An obvious response is to balance these interests by ensuring that individual hospitals maintain their voice and are appropriately represented on governing bodies, and by allowing for sub-boards and affording independence and strength to the existing committee structure within the individual hospitals. In one of our systems, we recently helped a specialty hospital whose license was merged with the main hospital create a structure that assured its medical staff oversight of critical issues notwithstanding the loss of its medical executive committee and board. The situation was complicated by the fact that the smaller hospital responded to the changes by forming a leadership counsel which duplicated the role of the supervisory committee. This created the potential for inconsistent findings and action vis physicians. Because the latter posed significant liability risk, an alternative solution was created to ameliorate those risks.

Conclusion

The reaction to the CMS revisions demonstrates how deeply entrenched physician autonomy and the current structure are in the delivery of care. Permitting a single shared governing body within multi-hospital systems is but one piece of a much larger puzzle. While the current system has been built around, and quality enhanced by, the independent medical staff structure, no one should underestimate the forces driving systems toward greater integration and the extent to which those changes will inevitably force all those involved with medical staff governance to confront and appropriately manage this new reality.

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1 77 Fed.Reg. 29034
2 77 Fed.Reg. 29037
4 Id.
6 Id.
7 77 Fed. Reg. 29038
8 Id.
9 77 Fed. Reg. 29039
10 Joseph S. Coyne, Hospital Performance in Multihospital Systems: A Comparative Study of System and Independent Hospitals, Health Services Research, 17:4 (Winter 1982)
Clinical Integration Provides the Key to Quality Improvement, American Journal of Medical Quality, 2008, Mark Shields, M.D., M.B.A

Baker, Stuart and Smithson, Ken, Medical Staff Organizations: A Persistent Anomaly, Health Affairs, 2007

Business and Professions Code Section 809.08