April 8, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

***RE: Proposed rule for Medicare and Medicaid Programs; Part II-Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, CMS 3267-P***

Dear Ms. Tavenner:

The Centers for Medicare & Medicaid Services (CMS) in its proposed rule, *Part II: Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction*, seeks to revise the hospital Conditions of Participation (CoPs) to require every hospital, including those within multi-hospital systems, to have its own distinct medical staff. On behalf of the undersigned organizations, representing more than 5,000 hospitals across the nation, including not-for-profit, for-profit, academic, children's, and safety net hospitals, we urge CMS to withdraw this proposal. This provision would remove the ability of hospital systems and their medical staffs to make their own determinations about the optimal medical staff framework and would prohibit medical staffs in some multi-hospital systems from having an integrated, unified organization across two or more hospitals. CMS has not offered a compelling reason as to why such a policy is necessary.

CMS should enable hospital systems and their affiliated medical staffs to decide, together, what medical staff structure works best for their patients. The medical staff proposal by CMS fails to recognize the patient safety benefits that integrated medical staffs can offer, disregards the sizeable burden that would be placed on some medical staffs that currently utilize a single, integrated structure, and perpetuates inconsistencies in how CMS regulates hospitals. For these reasons, CMS should withdraw its proposal. It would be more valuable for CMS to support

efforts of medical staffs and governing boards to develop effective leadership and communication.

**Patient safety and quality of care can be enhanced through single, integrated medical staffs.** Either an integrated or a separate medical staff structure could work best depending on the circumstances of each hospital system. Some medical staffs have adopted an integrated model to better ensure that standards for care are consistently high across all of the hospitals in the organization. A unified structure also enhances peer review and ongoing professional practice evaluation and can achieve comprehensive training and education with respect to best practices. Further, quality improvement projects, such as those adopted by thousands of hospitals through the Partnership for Patients campaign, have an added advantage when implemented by an integrated medical staff because project leaders can more easily achieve standardization of evidence-based protocols across settings.

The Department of Health and Human Services (HHS) has embraced the notion that patients benefit from integrated models of care delivery. For example, in implementing the *Patient Protection and Affordable Care Act*, HHS has promoted the establishment of hundreds of accountable care organizations, supported the development of medical homes, and encouraged hospitals to coordinate care more effectively across providers through the readmissions penalty program. In addition, last year CMS adopted a policy allowing multi-hospital systems to operate with a single, unified governing body. CMS should not impose a requirement that would prevent medical staffs from also taking advantage of the benefits of a coordinated approach, if that is how they choose to operate.

**CMS's proposal creates significant and unnecessary burden for some hospitals.** Some of the medical staffs of our system-members have been operating in an integrated way for 15 years or more. If the proposal for separate medical staffs is finalized, the medical staffs of these hospital systems would be required to break down their structures and devote significant time and effort to recreate separate structures at each hospital. For example, each new medical staff would be required to develop its own bylaws, rules, procedures and policies, which could take months. Further, these medical staffs would spend additional resources, on an ongoing basis, to try to recreate the communication and efficiencies lost in disbanding a unified structure. CMS has supplied no data demonstrating that one medical staff structure is better than another or substantiating the need to dismantle medical staffs that are already functioning well.

**The proposal is inconsistent in its treatment of hospital system structures.** CMS defines hospitals in terms of their provider agreements. Therefore, while the proposal would preclude health care systems with separately certified hospitals from utilizing unified medical staffs, it also would require multi-hospital systems with a single CMS certification number to have unified medical staffs. Instead of establishing one consistent policy for all hospital systems, the CMS proposal would codify regulations that in practice apply inconsistently across hospital systems. In addition, the ability to have a unified medical staff would depend on the mechanics of a system's provider agreement, rather than on an evaluation of what structure would work best for each individual system. We believe this is unsound policy.

If CMS's goal is to ensure that the unique needs of each hospital in a multi-hospital system are met, we ask you to recognize integrated medical staffs that already provide for meaningful input from medical staff members of all hospitals in the system. Instead of requiring a particular structure for all hospitals, CMS should support efforts by hospitals to ensure the leadership of the medical staff and the governing board can facilitate communication and participation, especially with regard to quality and patient safety.

We urge CMS to withdraw its proposal to require separate medical staffs at each hospital because it fails to achieve a policy that is reasoned, consistent and reflective of the benefits of an integrated approach. Further, CMS should not substitute its own judgment for that of medical staffs or implement policies that create burden for some systems by requiring them to abandon efficiencies that have positively impacted patient care. We believe the standard for the medical staff structure should be flexible, so that systems and medical staffs desiring to take advantage of the benefits of integration have that option. A standard that allows a coordinated approach is consistent with other CMS policies and regulations and with a modern approach to health care delivery.

We appreciate the opportunity to comment on this proposal.

Sincerely,

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