James L. Madara, MD
Executive Vice President, CEO

American Medical Association
515 N. State Street
Chicago, Illinois 60654

ama-assn.org

(p) 312.464.5000
(f) 312.464.4184

June 13, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Interpretive Guidelines regarding *Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation* (CMS-3244-F)

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to you in regard to the final rule entitled, *Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation* (CMS-3244-F). It has come to our attention that some hospital groups are attempting to force changes to the governing body and medical staff provisions of the final rule. **We strongly urge the Centers for Medicare and Medicaid Services (CMS) to retain the provisions of the final rule that require a medical staff at each individual hospital and the inclusion of a member of the medical staff on the governing body.**

The AMA also is concerned that those groups that are pressing CMS to change the Conditions of Participation (CoPs) will seek to accomplish the same purpose through revisions in the interpretive guidelines that accompany the CoPs. It is imperative, therefore, that CMS engage with all stakeholders, including the AMA and medical specialty societies, as the interpretive guidelines are revised. **We strongly urge CMS to ensure that this process is transparent and does not contravene the provisions of the final rule.**

Medical Staff at Each Individual Hospital

We strongly support CMS' decision to require a medical staff at each individual hospital. In this era of payment and delivery reform, the medical staff is increasingly leading and developing innovative care coordination and patient-centered efforts. The medical staff also informs these care improvement efforts as they progress, and serves as a vital resource for real-time clinical feedback regarding what does and does not work. For these efforts to be successful, it is essential that a locally organized medical staff oversee care delivery and provide a primary perspective regarding how *that* hospital's care coordination efforts are working for *that* local patient population.

We strongly disagree with the recent assertion by some hospital groups that CMS did not provide adequate notice that this provision was under consideration. In the proposed rule, CMS stated that it was "considering changes to the Medical staff CoPs at § 482.22 that would allow a multi-hospital system the option of having a single organized medical staff," and explicitly invited comment on the issue. (*See* 76 Fed. Reg. 65899) In fact, many stakeholders discussed the issue of a single medical staff in their comments on the proposal. These comments clearly reflect an awareness that the question of whether a multi-system hospital should be permitted to have a single medical staff, or should be required to have a medical staff at each individual hospital, was under consideration.

For example, the American Hospital Association (AHA) proposed regulatory language in its comment letter to support its view that a multi-system hospital should be allowed a single medical staff, and not be required to have a medical staff at each individual hospital. (*See* AHA Letter to Marilyn Tavenner *RE: Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation* [CMS-3244-P] at page 2. Dec. 16, 2011) Conversely, the AMA submitted comments in strong support of the requirement of a medical staff at each individual hospital. (*See* AMA Letter to Marilyn Tavenner *RE: Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation* [CMS-3244-P] at pages 2 – 4. Dec. 23, 2011)

We strongly urge CMS to retain its final language that requires a medical staff at each individual hospital. The proposed rule clearly articulated that the issue was under consideration, and CMS' final decision to require a medical staff at each individual hospital will enable the important work of the medical staff to lead payment and delivery reform efforts.

Medical Staff Representation on the Governing Body

We are extremely disappointed that CMS finalized its proposal to allow a single governing body for a multi-hospital system. This provision will cause serious harm to patients by extracting the governing body from the local hospital setting and seriously inhibiting its ability to assess and address the acute clinical needs of each individual hospital's patient population. CMS should instead require a governing body at each individual hospital, and encourage governing bodies to work together on issues of care delivery.

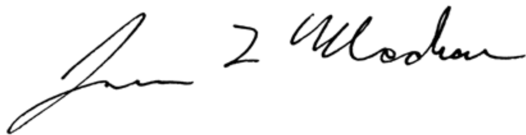
However, we strongly support CMS' decision to require a member of the medical staff to be included on the governing body. CMS' decision to include a medical staff member on the governing body is absolutely essential to the delivery of quality care. The governing body and the medical staff share a mutual responsibility for the provision of quality care and a safe environment for patients. While the corporate executives, attorneys, civic leaders, and other non-clinicians who sit on the governing body often bring relevant expertise to the overall management of the hospital, as non-clinicians, they are not equipped to evaluate and guide patient care at the facility. CMS' requirement of a common member who sits on both the medical staff and the governing body will promote greater coordination between the two entities, and further inform patient health and safety initiatives within the hospital.

We strongly oppose arguments recently made by hospital groups that this provision should be omitted from the final rule. As we understand it, hospital groups now assert that some states and hospitals have rules that prohibit the nomination of a medical staff member to the governing body. We find this logic very troubling. If, in some cases, the medical staff is so removed from the governing body as to be precluded from participation, CMS' explicit authorization of the inclusion of a medical staff member on the governing body is especially needed. Given the extraordinary power that the governing body has over hospital operations and patient care, we think that many patients would be astonished and appalled to learn that there are rules that seek to exclude medical staff members from service on the governing body. While we understand that CMS may need to make exceptions for instances where state law may be contradicted by this provision of the final rule, for the reasons herein, we strongly urge CMS to retain the regulatory language in its current form.

Conclusion

We strongly urge CMS to retain the provisions of the final rule that require a medical staff at each individual hospital and a medical staff member on the governing body, and to engage with the AMA and medical specialty societies as CMS revises the CoPs interpretive guidelines for hospitals. We welcome the opportunity to support and work with CMS on this issue, and will contact you to follow up on our request. Should you wish to follow-up or have any questions, please contact Margaret Garikes, Director, Division of Federal Affairs, at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,



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