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NAMSS: 31st Annual Conference
Marriott Marquis, New York, New York

Final Rule MS.1.20: Back To the Past

October 3, 2007

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An Evolving Standard

- Standards governing medical staff bylaws were found at MS.2.2 - 2.4 prior to 2004.
- In 2004, M.S.1.20 was created in order to identify what provisions needed to be included in the bylaws as opposed to rules and regulations.
  - September 29, 2004 – “Correction” issued to identify difference between “process” provisions, which needed to be in bylaws, and “procedural” matters, which did not.

An Evolving Standard (cont'd)

- October 21, 2004 – "Clarification" issued to further define differences between "process" and "procedural."

- MS.1.20 was universally criticized by many hospitals and trade associations including NAMSS, AHA, FAH and other state associations based on the following:
  - Elements of Performance (EPs) were extremely confusing and overly prescriptive as to what needed to be in bylaws versus rules, regs and policies.

An Evolving Standard (cont'd)

- Requirement that most, if not all, substantive provisions be placed in bylaws would lead to a significant increase in time and a drain on resources necessary to move sections in rules, regs and policies back into the bylaws.
- Traditional bylaw amendment process is extremely cumbersome and can take 6 to 12 months to pass amendments.
- MS.1.20 does nothing to address or further patient interests and the delivery of quality health care.

An Evolving Standard (cont'd)

- Interferes with role of MEC and raises questions about the ultimate authority of the governing body.

- In response to these field review comments and criticisms, the Joint Commission prepared revisions to MS.1.20 which were issued in August, 2006.
  - Deferred to the judgment of the medical staff and hospital as to what was to be included in bylaws, rules, regs and policies as long as EPs were met, and were adopted by the organized medical staff and governing body – major break through.

An Evolving Standard (cont'd)

- Introduced a requirement that there be a method for selecting and removing medical staff officers and MEC members.
- Proposed for the first time that the organized medical staff be able to adopt medical staff bylaws and amendments and present them directly to the governing body for approval.
- Restriction that medical staff bylaws and rules, regs and policies and the corporate bylaws could not confict was removed.

An Evolving Standard (cont'd)

- As a whole, the hospital industry accepted the August, 2006 proposed standard as a balanced and reasonable approach to the issues of bylaws, medical staff governance and the inter-relationship between the organized medical staff and the governing body.
- This past July, a “final” version of MS.1.20 was adopted. Although the stated goal was to support and reinforce “a productive working relationship between the organized medical staff and the governing body” while “minimizing disruptions to the hospital, including its medical staff”, MS.1.20 is very similar to the criticized 2004 Standard. (See Attachment A)

MS.1.20 – The Standard, It's Impact and Proposed Solutions

- MS.1.20 already has generated industry opposition from NAMSS (See Attachment B) and several prominent health care attorneys (See Attachments C and D).
- All requirements appearing in EPS 9-33 must be in the medical staff bylaws.
  - Any "procedural details" associated with requirements EP 9-25 also must be in bylaws.
    - "A 'process' is a series of steps taken to accomplish a goal."
      - Credentialing process of collecting information, evaluating information and making a decision.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- " A 'procedural detail' describes in detail how each step in the process is carried out."
  - Who collects info, how files are kept, what organizations need to be contacted to collect the info.
- Procedural details, if any, for EPS 26-33 must appear either in the bylaws or rules, regs or policies.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- EPs 9 - 33
  - EP 9: The structure of the organized medical staff.
  - EP 10: The process for privileging licensed independent practitioners.
  - EP 11:Qualifications for appointment to the organized medical staff.
  - EP 12: Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- EP 13: Indications for summary suspension of a practitioner's medical staff membership or clinical privileges.
- EP 14: Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.
- * EP 15: The composition of the fair hearing committee. (See also EP 32.)

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- *EP 16: The roles and responsibilities of each category of practitioner on the medical staff (active, courtesy, etc.).
- *EP 17: Requirements for performing medical histories and physical examinations.
- EP 18: Those practitioners who are eligible to vote on the medical staff bylaws and their amendments.
- *EP 19: A list of all the officer positions for the organized medical staff.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- *EP 20: The medical staff executive committee's function, size, and composition; the authority delegated to the medical staff executive committee by the organized medical staff to act on its behalf; and how such authority is delegated or removed.
- EP21: The process for selecting and removing the medical staff executive committee members.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- EP 22: That the medical staff executive committee includes physicians and may include other practitioners as determined by the organized medical staff.
- *EP23: That the medical staff executive committee acts on the behalf of the organized medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- EP 25: The process for adopting and amending medical staff rules and regulations, and policies. The medical staff bylaws must include the requirements in Elements of Performance 26-33. The procedural details, if any, associated with Elements of Performance 26-33 must appear either in the medical staff bylaws, or in rules and regulations or policies (See Elements of Performance 1 - 4).

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- EP 26: The process for credentialing licensed independent practitioners.
- EP 27: The process for appointment to membership on the organized medical staff.
- *EP 28: The process for selecting and removing the organized medical staff officers.
- *EP29: The process for automatic suspension of a practitioner's medical staff membership or clinical privileges.

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- *EP30: The process for summary suspension of a practitioner's medical staff membership or clinical privileges.
- *EP31: The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.
- *EP32: The fair hearing and appeal process (see also EP 15), which at a minimum shall include:

MS.1.20 – The Standard, It's Impact and Proposed Solutions (Cont'd)

- The process for scheduling hearings
- The process for conducting hearings
- The appeal process

– EP 33: If departments of the organized medical staff exist, the qualifications and roles and responsibilities of the department chair, which shall include the following: (See Attachment A)

Notes Regarding Elements of Performance 9-33

- "All requirements and procedural details addressed in the medical staff bylaws must be adopted and amended by the whole of the organized medical staff and approved by the governing body."
  - Questions and Comments:
    - What is meant by the "whole of the organized medical staff."
    - Under most bylaws, only medical staff members who are eligible to vote can participate in a medical staff bylaw amendment process.

Notes Regarding Elements of Performance 9-33 (cont'd)

- Are hospitals and medical staffs now required to let everyone vote?
- This requirement supposedly is based on a CMS Conditions of Participation standard which states only that the "medical staff must adopt and enforce bylaws . . . ."
- CMS also does not obligate hospitals to include all of the sections referenced in EPs 9-33 in the medical staff bylaws.
- In fact, only EPs 9, 10, 11, 17, 26 and 27 arguably are required to be in the bylaws.

Notes Regarding Elements of Performance 9-33 (cont'd)

- Discussions with CMS elicited a concession that the "medical staff" can be limited to eligible voting members although there is no written clarification on this point.
- An open question is whether CMS and/or the Joint Commission is requiring that all bylaw amendments must be approved by eligible voting members or if streamlined measures approved by the medical staff and governing body are acceptable which do not always require a medical staff vote.

Notes Regarding Elements of Performance 9-33 (cont'd)

– Proposed Solutions

- Neither the Joint Commission nor CMS define or require a specific process for amending bylaws.
- Although the traditional approach (i.e., Bylaws Committee – MEC – Medical Staff – Governing Body) better protects the rank and file members by giving them a more active role in the process, medical staff should be allowed to determine if a more streamlined process makes sense for certain bylaw sections.

Notes Regarding Elements of Performance 9-33 (cont'd)

- For those medical staffs which have developed, for example, fair hearing plans and credentialing manuals which can be amended by the MEC without a formal vote by the medical staff, this procedure can be maintained when these plans and manuals are integrated into the bylaws.
- Traditional approach can apply to the "core" bylaws and the streamlined approach can apply to designated sections as approved by the medical staff and hospital.

Notes Regarding Elements of Performance 9-33 (cont'd)

- Proposed Solutions
  - Depending on how the Joint Commission/CMS resolve these questions, if at all, hospitals and medical staffs should reevaluate their existing quorum and voting procedures.
  - Although quorum and approval standards typically require a high percentage of affirmative votes in order for an amendment to pass, the shear volume of required bylaw amendments will likely require votes at every quarterly and annual meeting of the medical staffs, as well as special sessions.

Notes Regarding Elements of Performance 9-33 (cont'd)

- The difficulty in achieving a quorum and required approvals is already a problem. Therefore, hospitals and medical staffs will need to consider the possible reduction of quorum requirements.
- In addition, voting procedures will have to be reconsidered so as to possibly allow for proxies, electronic votes, voting by mail and other means as a way of meeting the specified approval requirements.

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EP 3

- The organized medical staff, or the medical staff executive committee as delegated by the organized medical staff, adopts and amends and the governing body approves, any rules and regulations and policies that address procedural details of the requirements in Elements of Performance 26-33.

EP 3 (cont'd)

– Questions and Comments:
  - The combined effect of the Note and EP 3 is that the MEC is not empowered to independently adopt any medical staff bylaw or any procedural detail regarding the "requirements," "process" or "indications" in EPs 9-33.
  - The MEC, if approved by the organized medical staff and governing body, can address and adopt "procedural details" associated with the requirements in EPs 26-33.

EP 3 (cont'd)

- Questions and Comments
  - For all practical purposes, the "procedural details" previous discussed as examples have absolutely no substantive value. It makes little sense to develop a separate document of non-substantive procedures to supplement the credentialing, corrective actions and fair hearing and appeal provisions referenced in EPs 26-33. It makes more sense to combine both processes and procedural details in a single document for ease of review.

EP 3 (cont'd)

- Proposed Solutions
  - Hospital must decide if the MEC will be given authority to adopt procedural details or instead require a vote of the medical staff.
  - Unless Joint Commission clarifies this standard so as to imbue "procedural details" with more substance, it is not worth the effort to develop separate rules, regulations or policies concerning these details.

EP 4

- Regardless of whether the medical staff executive committee is empowered to act on behalf of the organized medical staff, the organized medical staff as a whole has the ability to adopt medical staff bylaws, rules and regulations, and policies and amendments thereto, and propose them directly to the governing body.

EP 4 (cont'd)

- Questions and Comments
  - This is truly an extraordinary and unprecedented requirement. The August, 2006 proposed standard would have limited this authority to proposing only medical staff bylaws directly to the governing body.
  - This raises the question of whether any and all medical staff documents are included under this standard.

EP 4 (cont'd)

- Is any document or policy excluded?
- Many policies do not even make it to the board. Does this mean that a policy, which otherwise would need MEC approval, can instead be approved by the organized medical staff without Board review?
- Can the medical staff and hospital decide that only bylaws and rules and regs can be adopted and sent directly to the Board but not policies?

EP 4 (cont'd)

- Neither the Introduction nor any other language in the Revisions indicate what standard, if any, is to be applied so as to trigger the organized medical staff's authority to bypass the MEC and go directly to the governing body regarding these documents.
- Arguably, based on language in the Revisions, efforts to propose directly to the governing body as well as to bypass or remove MEC authority, (see discussion below) is limited to "issues of patient safety and quality of care." It would not be difficult to argue, however, that almost any action, decision, standard, bylaw, rule, regulation or policy is not somehow linked into patient safety and quality of care.

EP 4 (cont'd)

- The Joint Commission should identify the kinds of decisions that are not related to patient safety and quality of care.
- If not, it should be left to the discretion of the medical staff and hospital to define what is meant by "issues of patients safety and quality of care as well as the basis or standard that must be met before the medical staff can propose directly to the governing body.

EP 4 (cont'd)

- Proposed Solutions
  - Need to determine whether ability of organized medical staff to propose directly to governing body is tied to the same or a different standard for removing MEC authority or bypassing the MEC altogether. For example, if current medical staff bylaws require two-thirds of the voting medical staff to approve any bylaw amendment, then perhaps two-thirds approval should be required before the organized medical staff can submit proposed documents directly to the governing body or to remove authority from the MEC, or to bypass the MEC.

EP 4 (cont'd)

- If quorum and approval percentages are reduced as discussed above, the direct proposal, bypass or removal procedures could be similarly reduced.

EP 7

- Medical Staff Bylaws, Rules and Regulations, and Policies and the Governing Body Bylaws do not conflict.
  - Questions and Comments
    - This EP had been deleted in the August, 2006 proposed standards. The decision to delete this Standard was reversed.

EP 15

- The composition of the fair hearing committee
  - Questions and Comments
    - Most medical staff bylaws/fair hearing plans described the required number of fair hearing Committee Members. Some go further to require that there be at least one non-competing physician in the specialty practice on the committee.

EP 15

- Proposed Solution
  - Assuming the Joint Commission does not change its position on what provisions must be included in medical staff bylaws, one option is to convert fair hearing plans, credentialing manuals and other provisions, which now must be included in the bylaws, into separate bylaw articles.

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EP 15 (cont'd)

- These new articles need to be updated to comply with the new Joint Commission Medical Staff and Leadership standards.
- If these documents include a streamlined amendment process which did not require approval by eligible voting medical staff members, you should consider keeping this option.

EP 16

- The roles and responsibilities of each category or practitioner on the medical staff, (active, courtesy, etc.)
  - Questions and Comments
    - Most medical staff bylaws already set forth the roles and responsibilities of physicians in each of the applicable staff categories.
  - Proposed Solutions
    - To the extent that the respective roles and responsibilities are not very clear, you can use MS.1.20 as a way to clarify same.

EP 16 (cont'd)

- Many medical staffs and hospitals are considering the adoption of a separate staff category that allows practitioners to remain members of the medical staff with certain voting rights and responsibilities but without the ability to exercise clinical privileges. There are many medical staff members with little or no activity thereby making it difficult to reappoint them every two years. Establishment of such a category, which has been approved by the Joint Commission and CMS, allows the physicians to stay involved while eliminating the need to go through reappointment process.

EP 17

- Requirements for performing medical histories and physical examinations.
  - Questions and Comment
    - This was added because CMS now requires that the medical staff bylaws set forth "a requirement that a physical examination and medical history be done no more than 7 days before or 48 hours after an admission. . . ."

EP 17 (cont'd)

- All hospitals typically include detailed requirements for conducting histories and physicals in a policy or a regulation. This detail is not typically found in medical staff bylaws.

- Proposed Solution
  - Include the general requirement in the bylaws but consider placing the specific details of an H&P in a separate rule, reg or policy which is binding on physicians.

EP 17 (cont'd)

- Could also consider attaching policy to the bylaws.
- Raises the question of whether the Joint Commission will allow "attachments" to the bylaws as long as it is clear these attachments are part and parcel of the medical staff bylaws rather than a separate rule, regulation or policy.

EP 18

- Those practitioners who are eligible to vote on the medical staff bylaws and their amendments.
  - Questions and Comments
    - This is not a new requirement. The fact that it makes reference to those who are "eligible to vote" on medical staff bylaws and amendments would suggest that the "whole medical staff" is not required to pass on amendments unless otherwise set forth in the medical staff bylaws.
    - The Joint Commission needs to clarify this question.

EP 19

- A list of all the officer positions with the organized medical staff.
  - Questions and Comments
    - Most medical staff bylaws already include the list of officers and their respective responsibilities (See also EP 28 which addresses the selection and removal of officers).

EP 20

- The medical staff executive's committee's function, size and composition; the authority delegated to the medical staff executive committee body by the organized medical staff to act on his behalf; and how such authority is delegated or removed.
  - Questions and Comments
    - This is the first time the Joint Commission has introduced a requirement that the medical staff identify a policy or standard in advance as to how any authority granted to the MEC is both given and taken away.

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EP 20 (cont'd)

- This is truly is a potentially unsettling provision and may significantly alter the government structure between the MEC and the organized medical staff.
- Part of the driving force behind this change was a general concern expressed by the AMA Hospital Medical Staff Section members and representatives on the Joint Commission that many MEC reps are either paid or have a contractual relationship with the hospital and therefore, cannot object to represent the interest of the organized medical staff.

EP 20 (cont'd)

- The Joint Commission does not identify or suggest what the manner or method should be for delegating and removing such authority.
- In an extraordinary comment, the Revisions provide:

> "While the revised Standard does not state what a medical staff should do if it does not agree with an action taken by its medical staff executive committee, the introduction urges the medical staff to consider in advance what action it would take if such a situation occurred (emphasis added).

EP 20 (cont'd)

- Later on, the Introduction provides:

  "Such steps might include a process that would allow the organized medical staff, at its discretion, to extract and consider an action by the Medical Staff Executive Committee prior to the action becoming effective."

EP 20 (cont'd)

- This language is unprecedented and raises numerous questions.
- Will a hospital and medical staff be cited if it affirmatively decides not to develop a process for removing MEC authority?
- What if a medical staff decides that its existing procedures, which address conflicts of interest and the manner in which medical staff officers, department chairs, and MEC members can be removed, is sufficient? Must it go further by also defining how MEC authority, not just individuals, is to be removed?

EP 20 (cont'd)

- Does the medical staff and hospital have the complete discretion to devise whatever methodology is acceptable to both?

– Proposed Solution

- As was discussed above, with respect to the organized medical staff's right to propose bylaws and policies directly to the governing body, the medical staff and hospital also should be permitted to create a similar standard, i.e., two-thirds of the voting organized medical staff must approve any recommendation to remove the MEC's authority or to extract an MEC recommendation before it becomes effective.

EP 20 (cont'd)

- Language should require that such efforts must be clearly and directly tied to "issues of patient safety and quality of care."
- Consider a provision that mandates some type of dispute resolution process/mandatory meeting requirement as a pre-condition to a decision to bypass or remove the MEC's authority.

EP 20 (cont'd)

- Possible language could include:
  - The Medical Executive Committee and the medical staff members should strive at all times to work cooperatively and professionally on all matters affecting the medical staff and the hospital.
  - In the event that good faith disagreements arise as to whether the Medical Executive Committee is exercising its stated authority and responsibilities, as set forth under Article ___, Section __ of these bylaws, in a manner which

EP 20 (cont'd)

represents the majority views of the eligible voting members of the Medical Staff on issues which directly affect patient safety and quality of care, a representative group of the medical staff shall be entitled and shall be required to request a meeting with the Medical Executive Committee.

- The request shall set forth in detail the basis of the medical staff's position as to why the Medical Executive Committee, as a whole, or any of its members, has not represented the views of the medical staff on issues of patient safety and quality of care. The Medical Executive Committee shall schedule a meeting to address these issues as soon as practicable but no later than 30 days after receipt of this request.

EP 20 (cont'd)

- The purpose of this meeting is to enter into a good faith dialogue to address and resolve the identified issues. Such resolution could include, but not be limited to, the withdrawal or passage of a MEC action or recommendation, the removal of an MEC representative, or the removal of one or more of the stated responsibilities ("remedial action") under Article __, Section __ of the Bylaws.

EP 20 (cont'd)

- If the basis for the requested meeting is resolved in an manner acceptable to both the medical staff representatives and the MEC, appropriate and timely steps shall be taken to implement the agreed to solution, subject to review and approval by the Board of Directors.
- If both sides have not been able to reach agreement, the medical staff representatives may then pursue steps to take remedial action as set forth in Article ___ of these Bylaws.

EP 20 (cont'd)

- Article ___: Procedures for Taking Remedial Action.

– If the medical staff and the Medical Executive Committee are not able to resolve identified differences pursuant to Article __, Section __ of these Bylaws, the Medical Staff may recommend that eligible voting members support one or more forms of remedial action. The method of obtaining any approval for this remedial action initiative shall be the same procedures as required for amending the Medical Staff Bylaws under Article __.

EP 23

- That the medical staff executive committee acts on the behalf of the organized medical staff between meetings of the organized medical staff, within the scope of its responsibilities as determined by the organized medical staff
  - Questions and Comments
    - ➢ This EP reaffirms the standard that the medical staff decides what authority to delegate to the MEC, the scope of its responsibilities and that such authority and responsibilities can be removed.

EP 23

- Proposed solutions
  - As stated, both medical staff and hospital should be able to create a standard which it deems reasonable.
  - **Please note**: The Introduction provides that if conflicts arise between the governing body and the medical staff concerning bylaws, rules and regulations or policies, the conflict management process referenced in Standard LD.2.40 must be followed. This is a type of conflict resolution procedure which require the parties to try and work out their differences. Interestingly, the Joint Commission does not propose a similar process in lieu of bypassing or removing MEC authority when there is a difference of opinion or dispute between the organized medical staff and the MEC.

Pre-Published Leadership Standards

- The Joint Commission's intent behind the Medical Staff Standards and MS.1.20 can be more clearly understood in the context of the Pre-Published Leadership Standards.
- The Leadership Standards represent a significant shift because it views the governing body, hospital management AND leaders of the organized staff as the three equal and responsible parties.

Pre-Published Leadership Standards (cont'd)

- What is the "organized medical staff" and who are the real leaders if the MEC can be pre-empted?

- These leaders are expected to "work together to create the hospital's mission, vision and goals" (LD. 2.10, EPI) which are linked to "the safety and quality of care, treatment and services" (See Rationale for LD. 2.10)
- The governing body is expected to "involve senior managers and leaders of the organized medical staff in governance and management functions" (See Leadership Relationships – Introduction)

Pre-Published Leadership Standards (cont'd)

- Recognizes that conflicts of interest among the leaders will arise and requires that these conflicts be addressed through an established policy (see LD 2.20)
- Standard presumes that the medical staff has a sufficient and adequate number of leaders who are willing to become actively involved in "governance and management functions"

Pre-Published Leadership Standards (cont'd)

- Most hospitals have trouble, as do medical staffs, in finding qualified physician leaders willing to serve in the positions of medical staff officer, department and division heads, committee chairs and committee members, medical directors, board members and board committee members
- There often times is little turn over in leadership positions

Pre-Published Leadership Standards (cont'd)

- Physicians typically serve on multiple medical staffs, with multiple ED call obligations, and cannot afford the time or lost income to serve in these capacities
- Physicians are often times seeking some form of payment or reimbursement for these services
  - Most medical staffs cannot afford to pay
  - If paid by the hospital, are these "leaders" now being co-opted? Is their objectivity now tainted?

Next Steps

- On October 24th, the Joint Commission is holding an audio conference for accredited hospitals to specifically discuss and clarify MS.1.20 – You need to participate.
- Joint Commission is likely to address and answer some of the questions and concerns voiced by NAMSS and other organizations – Will it be enough?
- If hospitals are supportive, concerned or opposed to the Standard, they need to discuss with senior management and have them contact their state hospital association, state associations for medical staff services, and the AHA or FAH to express their views.

Next Steps (cont'd)

- AHA is not likely to request any changes unless its members complain loud enough
- Until all of this settles down, it is best to sit tight before making any bylaw changes – but be ready to move quickly.
- Hospitals have until July, 2009 to come into compliance.