

## **An Open Letter to the Joint Commission Regarding MS.1.20.**

**August 22, 2007**

As attorneys who regularly advise hospitals and physician leaders regarding medical staff bylaws, governance and credentialing matters, we have serious concerns about the "final" revisions to Standard MS.1.20 published by the Joint Commission on July 10, 2007. This most recent promulgation, which is to be effective in two years on July 1, 2009, follows over three years of course reversals by the Joint Commission to "correct," "clarify," and withdraw various pronouncements regarding MS.1.20.

After efforts to obtain additional "input," the Joint Commission published a draft standard for field review in August, 2006. That draft was largely responsive to hospital industry criticisms, including medical staff leadership, that the previous draft was overly prescriptive and confusing as to which provisions needed to be placed in the bylaws versus the rules, regulations, policies, procedures or other documents.

Apparently responding to those concerns, the August, 2006 draft deferred to the judgment of the medical staff and hospital to make those placement decisions. Now the Joint Commission has adopted a standard that is materially different from the one released for field review, with no further opportunity for additional review and comment. The Joint Commission's action not only renders the field review process meaningless, but also results in the adoption of a final Standard that the public has never seen before.

MS.1.20 is significantly flawed, both substantively and procedurally. As detailed in this analysis, this yet again revised Joint Commission Standard will result in:

- Major confusion regarding the required content of governing medical staff documents;
- Needless and excessively time consuming and costly revision of most, if not all, hospital medical staff bylaws and related documents; and
- Confusing and disruptive restructuring of the roles and responsibilities of medical staff leadership and accountability

This latest version of MS.1.20 is a radical departure from the draft August, 2006 standard and injects back into the Standard the very elements that led to all the confusion and industry discontent stemming from the pre-August, 2006 proposals. A major concern is the imposition of what can only be termed unnecessary and confusing micromanagement by the Joint Commission regarding the manner in which hospitals and their medical staffs implement Joint Commission requirements related to medical staff organization, credentialing, privileging, membership, corrective action, and the myriad activities required of the medical staff. It also significantly reorders the governance relationship between the Medical Executive Committee ("MEC") and the "organized medical staff." This reversal of the Joint Commission's prior position operates to limit scrutiny and discussion of the provisions of the final standard, as has been the case for all previous proposals.

The final Standard has two significant changes which are very troublesome and are discussed in detail below.

**1. MS.1.20 Requirement That All Major Substantive Provisions Be Placed in Medical Staff Bylaws, and Vagueness Regarding What is Covered**

The draft August, 2006 standard deferred to individual medical staffs and hospitals about where and how medical staffs could define medical staff requirements, processes and procedures by simply saying that the "medical staff bylaws or rules and regulations and policies adopted by the organized medical staff and approved by the governing body" had to address all the requirements related to medical staff organization, membership, credentialing, and corrective action. It was up to individual medical staffs and hospital governing bodies to determine whether these provisions would be addressed in the medical staff bylaws or other documents, and whether and how policies, procedures, rules and regulations could be approved by the MEC on behalf of the full medical staff. That approach removed all the uncertainty concerning what had to be in which document, and what process had to be followed for approval.

The final Standard now mandates that certain specific matters must be in the medical staff bylaws and must be approved by the full medical staff. Other non-substantive "procedural details" may be placed in rules, regulations, policies or procedures and may be approved on behalf of the medical staff by the MEC. This alone is an unnecessary usurpation of the autonomy and integrity of medical staffs which are now prevented from acting in the manner they deem most efficient for their institution.

To make matters worse, the Joint Commission has returned to the use of confusing language which attempts to distinguish between "requirements," "processes," and "procedural details," which is precisely what caused much of the controversy and confusion before the draft August, 2006 standard. These vague distinctions are not only unnecessary but are also so ambiguous that medical staffs and medical staff professionals will find it extremely difficult to predict with any certainty what the Joint Commission and its surveyors will find to be acceptable. It is almost certain that these ambiguities will be result in different interpretations by different Joint Commission surveyors, thereby creating uneven, inconsistent enforcement and lack of predictability in the survey process. Following are some examples:

- All "requirements" for Elements of Performance ("EPs") 9-33 must now be in the bylaws. There is no exception. The "procedural details" for EPs 9-25 must also be in the bylaws, but the "procedural details" for EPs 26-33 can be in rules, regulations or policies approved on behalf of the medical staff by the MEC. It is unclear what is meant by the "requirements" that must be in the bylaws. For example, EP 10 refers to the "process for privileging licensed independent practitioners." Does that mean that all of the specific requirements to obtain privileges, like the need to have successfully performed "x" number of laparoscopic cholecystectomies, must now be in the bylaws? Exactly what "requirements" or criteria must be in the bylaws versus in separate credentialing standards which can be approved by MEC, if any?

- EP 17 provides that the "requirements" for performing H&Ps must be in the bylaws. Does that mean that the bylaws must now contain all the details regarding the required contents of an H&P, which are commonly found in medical staff rules or a medical records policy? And does that mean that if the "requirements" of what must be included in an H&P are to be changed the medical staff has to go through the entire bylaw amendment process?
- According to EP 10, the process for "privileging" licensed independent practitioners must be in the bylaws, but under to EP 26, the process for "credentialing" those practitioners can be in rules, regulations, or policies. What is the basis for that distinction between the processes for "privileging" versus "credentialing?" Apparently, as long as the "process" for "privileging" is in the bylaws, the "procedural details" related to credentialing can be elsewhere. Why? And why have separate requirements and separate processes for "credentialing" versus "privileging"?
- The ability to move procedural details to the rules and regulations for a limited number of EPs is somewhat meaningless and can hardly be viewed as a concession by the Joint Commission to an otherwise burdensome requirement. Not only are these details non-substantive, but many hospitals and medical staffs will prefer to keep process and procedural details together in one document rather than having to refer to two different documents, thereby forcing everything to be in the bylaws.
- EP 15 says that the composition of the hearing panel must be in the bylaws, which means that the associated "procedural details" related to the composition of the hearing panel also must be in the bylaws. Does that mean the entire process for selecting the hearing panel, including who appoints the panel, the process for notification to the practitioner of the proposed members of the panel, any right of the practitioner to object to panel members, the use of a hearing officer and the roles and responsibilities of the hearing officer are all "procedural details" related to the "composition of the hearing panel" which must be spelled out in the bylaws? Or, will EP 32, which permits the procedural details of "fair hearing and appeal processes" to be in policies, rules or regulations, control where the details regarding the selection of the hearing panel are spelled out? Will it be sufficient to simply say in the bylaws that the hearing panel shall consist of "x" number of members of the medical staff, and that all of the other processes for selecting the hearing committee are "procedural details" which can be placed in rules and regulations to be approved by the MEC unless overruled by the medical staff.
- The introduction to MS.1.20 states that one of the guiding principles behind the Standard is to allow for a more "efficient process" in creating and maintaining bylaws, rules, regulations, and policies. In fact, the Standard will have just the opposite result. The typical process for amending bylaws is methodical and sometimes cumbersome, frequently taking several months to complete. To allow for a more "efficient process," many medical staffs and

hospitals adopted separate fair hearing plans and credentialing manuals which can be implemented and amended on a more streamlined basis than if everything needs to be approved by both the full medical staff and board of directors. MS.1.20 now eliminates this more efficient option. If the medical staff and hospital are in agreement about placement and approval process for these provisions, why does the Joint Commission care?

The overwhelming hospital industry reaction to the standard proposed before August, 2006 was that there is simply no valid reason why a medical staff and board of directors should not be permitted to choose whether matters are addressed in the bylaws, which are subject to approval by the full medical staff, or whether the bylaws will delegate to the MEC the authority to act on certain substantive matters. If the end result is the adoption of requirements which meet the needs of the hospital, medical staff, and patients, (and Joint Commission, Medicare and other regulatory requirements) it should make no difference how they are adopted or where they are placed. Moreover, this overly prescriptive approach has no bearing whatsoever on the delivery of high quality health care services.

2. **MS.1.20 Reorders and Unnecessarily Disrupts the Existing Governance Relationship Between the Medical Executive Committee and the Medical Staff**

It has been reported that one of the principal concerns expressed by the American Medical Association and its representatives to the Joint Commission is that Medical Executive Committees across the country have been "co-opted" and are effectively controlled by hospitals through various means, including the fact that a number of MEC members are employed by or have contracts with the hospital. Even if one were to concede the possibility of there being a few medical staffs somewhere in the country that have experienced the "co-option" (query: is it co-option, or simply that the MEC and hospital administration work well together?), there is simply no data to support any contention that this is common, or in any way significant enough to merit this overarching change in the Standard.

MS.1.20 now seems to presume that hospital control of the MEC is the norm and consequently includes a requirement that the medical staff bylaws define a process for removing authority from the MEC which was previously delegated to it, and for bypassing or pre-empting an MEC decision if it is somehow not acceptable to the broader medical staff. This is truly an extraordinary development and ignores existing checks and balances which, to date, have worked to assure that the MEC represents the medical staff. These include the following:

- As a general rule, most MEC representatives are elected by eligible voting members of the medical staff, either by department or by election of at-large MEC members.
- Joint Commission Standards and bylaws require a process for the election and removal of department chairs and the medical staff officers. If they are not

carrying out their respective duties or if not adequately representing the interests of their constituency, they can be removed in accordance with the bylaw procedures.

Apparently in response to this perceived domination of Medical Executive Committees, the new Standard injects two new significant concepts as follows:

- A requirement that medical staff bylaws provide that the medical staff as a whole has the ability to adopt bylaws, rules, regulations and policies, and amendments, and propose them "directly" to the governing body.
- Medical staffs are "urged" to determine what steps they will take if they do not agree with "an action" taken by the Medical Executive Committee. "Such steps might include a process that would allow the organized medical staff, at its discretion, to extract and consider an action by the [MEC] prior to the action becoming effective."

These changes not only raise serious questions about the underlying premise to support this interference in medical staff governance, but also trigger significant interpretation issues such as the following:

- If a medical staff believes that its existing election/removal procedures adequately address this potential problem and does not succumb to the "urgings" of the Joint Commission, will it be cited by the Joint Commission surveyors as not being in compliance?
- What "actions" of the MEC are subject to "extraction and reconsideration" by the full medical staff? Although the encouragement to have a provision whereby the organized medical staff can override the actions of the MEC seems to be in the context of the MEC's approval of bylaws, rules, regulations or policies, the language in the Introduction to MS.1.20 is not limited to those actions and broadly refers to any action taken by MEC related to "patient safety and quality of care." Therefore, the medical staff's ability to override an MEC action would appear to be very broad. Does that mean that there should be a process for the organized medical staff to review, and potentially reverse, any action of the MEC, including a recommendation concerning approval or denial of a particular practitioner's application for appointment or reappointment, or a recommendation related to some disciplinary action in an individual case? Are the procedures designed to allow pre-emption of both MEC decisions and recommendations? This raises the prospect that an individual practitioner, who may be unhappy with a recommendation made by the MEC concerning a credentialing or disciplinary matter relating to the practitioner, could appeal to the full medical staff to override the action of the MEC. Such a process could wreck havoc on the credentialing and corrective action processes.

- The suggestion that the organized medical staff should be able to do something about an MEC action with which it does not agree before the action becomes effective is inconsistent with EP 23, which provides 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." If the organized medical staff can "extract" and reverse an MEC action before it becomes effective, then the authority of the MEC to act on behalf of the medical staff between meetings is effectively negated. Every action of the MEC would be subject to reconsideration and reversal by the full medical staff, and therefore could not be relied upon.
- How does one determine when the MEC is not representing the interests of the medical staff? The Standard seems to assume that the medical staff is some monolithic body in which there is complete consensus on all issues. This assumption could not be further from the truth. To avoid having a vocal minority of physicians implement the removal/extraction/pre-emption of the MEC, can the medical staff bylaws provide that the review of MEC actions by the full medical staff can only be initiated only by a majority or supermajority of the members of the organized medical staff?
- The August, 2006 draft Standard allowed the medical staff to approve medical staff bylaws and amendments and present them to the governing body for approval. Although most health care professionals viewed this as an over-reaction to the claimed MEC problem, it was viewed as a reasonable compromise given the Joint Commission's proposal to defer to the judgment of the medical staff and hospital on the bylaw placement standard. The final Standard goes even further by allowing the medical staff to not only develop bylaws but also rules, regulations, policies, and amendments thereto, in addition to bylaws, and to propose them directly to the governing body. It is also unclear whether this prerogative of going "directly" to the governing body would prohibit a bylaw provision that allowed matters proposed by the full medical staff to be considered and commented on by the MEC before they were acted on by the governing body.
- Whatever process is developed for the medical staff to review and potentially override the actions of the MEC, such a process will, at a minimum, delay the adoption of standards which may be critical to the maintenance of a hospital's accreditation, license, compliance with the Medicare COPs and numerous other requirements. It will also sow the seeds for undermining the required collegiality among peers that is critical to medical staff governance.

How does this Standard promote efficiencies and a smooth operating medical staff when its elected leaders can be second guessed, bypassed and pre-empted? The reality is that hospitals have an increasingly difficult time finding interested and dedicated physician leaders, whether to serve as department chairs, committee members, medical staff officers, board and board committee members or in other positions of

authority. If the individual decisions and recommendations of the MEC, and effectively the department chairs, can be constantly second guessed, challenged and overturned, and the MEC's authority removed, and if bylaws, rules and regulations can be proposed without its formal review and approval, many physicians will question what is the point of serving. The Joint Commission has truly done a disservice to medical staffs and hospitals, and apparently has deferred to the flawed judgment and representations of a vocal few at the expense of the overwhelming majority.

While not optimal, from the standpoint of efficient or quality "rule making," giving the organized medical staff the opportunity to propose bylaws, rules, regulations, policies and procedures for consideration by the governing body is an adequate response to any concerns that MEC actions are not consistent with the views of the organized medical staff, and a far better one than allowing individual actions of the MEC to be reviewed and reversed. If a majority of the members of the organized medical staff conclude that the MEC has abused the authority delegated to it, the problem can be remedied either by the organized medical staff proposing rules, regulations, or policies for consideration by the governing body, by amending the bylaws to revise the authority delegated to the MEC, or by electing new medical staff leaders. All of those approaches are far superior to providing for individual MEC actions to be reviewed, second guessed and reversed by the full medical staff.

### **Summary and Recommendation**

The new final Standard is a significant departure from the draft that was circulated for comment, and reverts back to the troublesome language that caused so much industry consternation for many years. For the Joint Commission to make such a radical change from a proposed Standard that was embraced by the health care industry, after numerous associations voiced their collective objections to the prior draft Standard (i.e., AHA, FAH, NAMSS) and without the opportunity for further comment, makes a mockery of the field review process.

This Standard is guaranteed to do three things. First, it will generate significant uncertainty regarding what must be in bylaws and what can be placed elsewhere - which will only drive confused medical staffs to put everything in their bylaws, creating a cumbersome, excessively detailed document that cannot be quickly or easily revised to adjust to new circumstances or take advantage of new and better processes.

Second, and most important, this standard will require a wholesale revision of many medical staff bylaws and related documents which is entirely unnecessary. Many hospitals now have privileging and credentialing procedures in "credentialing procedures manuals," and have matters such as the composition of hearing panels covered in "fair hearing and appellate review plans." There has been no problem with this arrangement in the past and to require that it be changed now is a colossal waste of time, money and effort with absolutely no resulting improvement in patient care or hospital operations.

Third, the Standard significantly interferes with the balance of medical authority and governance procedures by circumventing the decisions and recommendations of an

elected MEC. Rather than emphasize the use of existing removal and conflict of interest procedures, or encourage the development of dispute resolution mechanisms, the standard presumes that the MEC is not always acting in the medical staff's best interests and requires the development of a process to emasculate its authority and bypass its decisions. The standard potentially sets up two parallel medical staff governance bodies.

The time and costs associated with implementing and complying with Joint Commission Standards are both tangible and intangible. Workloads for medical staff professionals, including bylaw committees, will increase substantially and medical staff leaders who will serve without demanding payment will be ever more difficult to find. In addition, hospitals across the country will be forced to spend literally hundreds of thousands of dollars for legal fees and consultants in order to attempt to conform their bylaws and other documents to the uncertain requirements of the new standard. Finally, the standard will foster the loss of independent leaders who are vital to a medical staff. Ironically this supposedly was the problem that the AMA was seeking to avoid.

The Joint Commission should promptly withdraw the most recently promulgated Standard MS.1.20 and adopt the draft that was submitted for field review in August of 2006.

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