National Association of Public Hospitals and Health Systems

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April 8, 2013

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

Ref: Medicare and Medicaid Programs; Part II—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Proposed Rule (CMS-3267-P), 78 *Federal Register* 9216 (Feb. 7, 2013)

Dear Ms. Tavenner,

The National Association of Public Hospitals and Health Systems (NAPH) appreciates the opportunity to submit comments on the above-mentioned rule and the agency's continued effort to reduce regulatory burdens that limit flexibility or divert resources from the efficient and effective delivery of patient care.

NAPH represents about 200 safety net hospitals and health systems across the country. These organizations constitute just 2 percent of acute care hospitals nationwide but provide 20 percent of all hospital uncompensated care. Our members predominantly serve patients covered by public programs and the uninsured—25 percent of the inpatient services provided by NAPH members are to Medicare beneficiaries, another 36 percent are to Medicaid recipients, and 18 percent are to uninsured patients. Many NAPH members also provide specialized inpatient and emergency services not available elsewhere in their community. The high cost of providing so much complex care to low-income and uninsured patients leaves NAPH members with limited resources, propelling them to find increasingly efficient strategies for serving their patients. However, simultaneously implementing new models of care to improve coordination and quality and maintaining a mission to serve the most vulnerable patients is a delicate balance. Therefore, NAPH and our members particularly appreciate the Centers for Medicare & Medicaid Services' (CMS') ongoing effort to reduce regulatory burden and improve flexibility, and we offer the following recommendations to this end.

1. **NAPH supports CMS' proposal to rescind the requirement to include a member of the medical staff in the governing board as a condition of participation.**

NAPH strongly supports CMS' proposal to rescind the requirement included in its May 2012 final rule that a hospital's governing body include a member of the medical staff. NAPH particularly appreciates CMS' acknowledgment of the substantial legal issues this provision would have posed for public hospitals, as raised by NAPH in its response of June 8, 2012.

As explained in that response, the requirement that a medical staff member be included on the hospital's governing body would have been in direct conflict with state and local laws that specify membership requirements for public hospital governing boards. In many states or their political subdivisions, governance rules for public institutions (which many NAPH members are) are specifically set forth under statute. Often, these rules define who is permitted or required to be appointed to the governing board. Or, the rules may stipulate the governing board be directly elected by constituents. CMS' proposal to rescind the medical staff member requirement would relieve NAPH members from the untenable position of being either out of compliance with the conditions of participation or in direct violation of state or local law.

Specifically, this new requirement would have posed a significant challenge to many public hospitals that have governing bodies that are directly elected by constituents, appointed by governing officials, overseen by a state university board of regents or supervisors, or held to other requirements by law. For example, In California, all 15 county-operated hospitals have directly elected boards of supervisors that govern these hospitals and this new requirement would conflicts with otherwise applicable legal requirements for public hospitals in these circumstances. In Iowa, not only are county hospital board members also directly elected, but Iowa law explicitly prohibits any person with medical staff privileges at the county hospital, and his or her spouse, from serving on the hospital's board. Likewise, Ohio law specifically precludes county hospitals—many of which employ all of their physicians—from placing any physician who is employed by the hospital on their board. Hospitals that operate under these state and local laws would not be able to comply with the conditions of participation if CMS does not rescind this new requirement.

NAPH understands the importance of ensuring a hospital's governing body hears the medical staff perspective on quality of care. CMS' alternative proposal—requiring the governing body to consult directly with the individual responsible for the hospital's medical staff or that person's designee on a periodic basis regarding quality of care—will provide this assurance while leaving appropriate flexibility in the composition of the hospital's governing body. For these reasons, we urge CMS to finalize its rescission of the requirement to include a member of the medical staff on a hospital's governing body.

2. **CMS should allow for flexibility in the medical staff structure in multihospital systems.**

CMS should reconsider its position that each hospital, including those in multihospital systems, must have a separate and distinct medical staff to avoid unnecessarily restricting hospital staffing decisions. Allowing flexibility in medical staff structure would be consistent with CMS' proposal to allow medical staffs to include nonphysician practitioners so long as it is appropriate

under state law and determined by the hospital's governing body. NAPH shares CMS' belief that hospital operating structure decisions should focus on the quality and efficiency of patient care. If multihospital systems determine that a single, integrated medical staff structure is the best structure to deliver more coordinated, patient-centered care to their patients, these systems should have the flexibility to implement those structures. CMS should reconsider the premise that the individual medical staff model is the best model in every situation for overseeing care delivery and for moving forward with quality improvements. A reasonable alternative, for example, could be to permit hospital systems to have a single medical staff for facilities in the same region or state. Such systems might be better able to address CMS' stated concern about ability to tailor to local needs, as opposed to a hospital system that is nationwide. CMS should provide hospitals with flexibility to shape their medical staff in the way that best and most efficiently serves the needs of their patients, particularly as hospitals are considering new and innovative ways to deliver care to their communities during this time of reform.

3. **CMS should finalize other provisions that eliminate barriers to care and unnecessary burdens that divert scarce resources.**

NAPH appreciates CMS' willingness to revise a range of regulations based on stakeholder comments indicating certain proposals would create barriers to care or otherwise unnecessarily burden providers of essential services, such as NAPH members.

- NAPH supports expanding categories of practitioners who are permitted to order outpatient referrals for rehabilitation and respiratory care services. CMS' proposal clarifies previous guidance, which would have unintentionally restricted the ability of appropriately licensed practitioners to provide such referrals, and therefore, restricted the delivery of necessary patient care. NAPH supports CMS in issuing new guidance to rectify the problem and further proposing regulatory clarification to assure the hospital community.

- NAPH supports CMS' proposals to remove regulatory burdens related to organ transplants, particularly the proposals to add flexibility to the onsite review and re-approval processes. NAPH also supports CMS' proposals to remove obsolete or redundant reporting requirements (e.g., the requirement to separately notify CMS of change in transplant volume and survival rate data, given CMS routinely receives these data from other sources, and the now-obsolete exception for separate outcome review for adult and pediatric lung transplants). NAPH members are a critical source of access to organ transplant services, and CMS' proposals will ensure scarce hospital resources are not diverted from providing care to cover administrative costs that do not improve compliance or patient care.

- NAPH supports CMS' proposal to eliminate the requirement for federally qualified health center (and rural health center) conditions of participation that a physician be onsite at least once in every 2-week period. We agree CMS should provide flexibility regarding the method and time frames for physician supervision of care, particularly in rural and physician shortage areas, and in light of improvements in telemedicine capabilities and innovations in care delivery involving nonphysician practitioners.

For these reasons, CMS should finalize these proposals and further support hospitals by eliminating barriers to care and reducing unnecessary burdens on providers.

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NAPH appreciates CMS' consideration of these comments. We look forward to continuing to work with CMS to identify and reduce regulatory barriers that interfere with the efficient delivery of quality patient care and the effective operation of the Medicaid and Medicare programs. If you have questions, please contact Xiaoyi Huang, assistant vice president for policy, at (202) 585-0127.

Sincerely,

Bruce Siegel, MD, MPH
President and Chief Executive Officer