Submitted Electronically

April 8, 2013

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3267-P
P.O. Box 8010
Baltimore, MD 21244-8010

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 Florida Hospital Association (FHA), on behalf of its more than 200 hospital and health system members, appreciates the opportunity to respond to the request for comments on the proposed rule for regulatory burden reduction issued February 7. In this proposed rule, the Centers for Medicare & Medicaid Services (CMS) conveyed its intent to change the language of the hospital Conditions of Participation (CoPs) to state that each hospital must have an individual and distinct medical staff. This modification would preclude multi-hospital systems from having integrated medical staffs among hospitals that are separately certified.

Hospital leaders and medical staffs, working together, should be able to determine what medical staff structure best enables them to provide high-quality care to patients. Unified medical staffs offer opportunities to enhance quality and patient safety. Therefore, we urge CMS to reject the proposal to require a separate medical staff at each independently certified hospital. Instead, CMS should focus on what the medical staff and hospital leadership must accomplish to achieve high-quality, safe care.

The FHA and many of our hospitals are involved in the Partnership for Patients (PfP) campaign, which helps hospitals implement quality improvement processes that have been proven to reduce adverse events such as central line-associated bloodstream infections (CLABSI), falls and preventable readmissions. In this work, the concept of standardization is a central component of process improvement. Unified medical staffs can play an important role in helping PfP projects succeed because they can share knowledge and implement standardized, consistent patient care protocols across sites in a more streamlined manner.

In addition to quality improvement benefits, hospitals and their medical staffs may choose a unified medical staff because:

- There is an increased opportunity to improve peer review processes. For example, physicians are less likely to be in the same practice or competing practices with those whom they evaluate.

- Patient safety can be enhanced through shared privileging and Ongoing Professional Practice Evaluation (OPPE). For example, when practitioner skill deficits are found, they can be addressed more comprehensively through a single medical staff structure.
- Integrated medical staffs can achieve more efficient sharing of knowledge and innovations among physicians.
- Hospitals can achieve better physician on-call coverage in short-supply specialties.
- An integrated model better supports the move toward accountable care organizations and modern care delivery systems.
- Unified medical staffs can better coordinate community health and service planning.

Unified medical staffs are self-governing entities that can and do recognize the diversity of their hospitals, as well as the viewpoints and concerns of medical staff members across the system. Under the CoPs, medical staffs adopt the bylaws that are approved by the governing body, requiring both the support of the medical staff and the governing body when a system moves to adopt an integrated medical staff model. Requirements of The Joint Commission also require a collaborative relationship and prevent unilateral action with regard to medical staff bylaws.

Under CMS's current proposal, some health systems would be faced with the heavy burden of breaking down their medical staff structures to comply with a requirement that conflicts with the multiple efforts the agency and the Department of Health and Human Services have made to promote integrated care and coordinated delivery models. Medical staffs that voted to embrace a unified structure would have to dismantle the framework under which they have functioned for many years and recreate new organizations at each hospital. For example, they would need to develop and adopt bylaws at each hospital, which could take many months. They would have to establish policies, procedures and committee structures at each hospital. And they would need to create ways to regain the benefits they would lose in being required to dismantle an integrated model.

We reiterate that CMS should let hospital leaders and medical staffs decide what structure makes the most sense for their organization and their patients**.** Given that unified and separate medical staff structures offer different benefits, CMS cannot know what makes the most sense in every situation. CMS should defer to medical staffs and hospital leaders to carefully consider the advantages of each model and to make a decision based upon what structure is best for the patients, communities and hospitals involved.

Again, the FHA appreciates the opportunity to submit these comments. If there are any questions or need further information, please do not hesitate to contact me at kathyr@fha.org.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services