



Charles N. Kahn III
President and CEO

April 15, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

SUBJECT: CMS-3367-P, Medicare Program; Strengthening Oversight of Accrediting Organizations (AOs) and Preventing AO Conflict of Interest, and Related Provisions; 89 Fed. Reg. 11,996 (Feb. 15, 2024)

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the above notice of proposed rulemaking regarding *Strengthening Oversight of Accrediting Organizations (AOs) and Preventing AO Conflict of Interest, and Related Provisions*. The FAH is the national representative of more than 1,000 leading tax-paying community hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. These tax-paying hospitals account for nearly 20% of U.S. hospitals and serve their communities proudly while providing high-quality health care to their patients.

Our members are Medicare participants that must comply with specified statutory requirements of the Social Security Act (the Act) and other regulatory requirements designed to protect the health and safety of patients, generally known as Conditions of Participation (CoPs). Some of our members demonstrate compliance with the applicable CoPs by achieving accreditation through a CMS-approved national AO that is authorized to "deem" compliance, rather than through a State Survey Agency certification, in accordance with Section 1865(a) of the Act. The service provided by the AOs is of vital importance to our members because the "deemed" status for accreditation earned by the hospitals satisfies the CMS requirement that a

provider qualifies, or continues to qualify, for participation in the Medicare program. Our members have established effective working relationships with the AOs, which ensures that Medicare's health and safety requirements for beneficiaries are met or exceeded.

The FAH provides the comments below in an effort to facilitate the work of both the AOs and CMS in ensuring that neither actual nor perceived conflicts of interest damage public trust in the accreditation system or hospitals' quality of care.

The Definition of "Fee-Based Consulting Services" Should Not Include Subscription-Based Generic Consultative Tools

CMS proposes restricting AOs with deeming authority and a fee-based consulting practice from providing "fee-based consulting services" prior to a provider's initial survey and providing such services to their accredited providers during the 12-month period prior to each provider's reaccreditation survey. **The FAH urges CMS to clarify that the definition of "fee-based consulting services" does not include use of AOs' subscription-based generic consultative tools.** If "fee-based consulting services" is defined too broadly, this could prove detrimental and undermine hospital efforts to ensure they meet the CoPs and appropriately advance quality and safety initiatives.

Our members often utilize annual subscription web-based, generic tools and seminars offered by an AO or its consulting arm, including during the 12 months prior to a survey, to generate self-assessment reports that help hospitals meet the CoPs and prepare for a survey. These commonly used AO tools and seminars would not represent a conflict of interest because they do not result in the: (i) AO or its consulting arm facilitating or advising on hospital-specific situations or complaints being evaluated by an AO; or (ii) development of a material personal relationship with a representative of the AO or its consulting arm. Hospitals may contact technical or tool navigation support at the AO consulting arm, including within 12 months prior to an initial or reaccreditation survey, but these interactions are on a sporadic, as needed basis, and are not tailored to a hospital's individual survey needs or a specific complaint being assessed about a hospital.

Hospitals would be adversely impacted if these types of resources could no longer be used during the 12-month period prior to a survey. Such a restriction would leave hospitals without a source of guidance to self-assess and ensure appropriate compliance with the quality and safety requirements of the Medicare CoPs. Lack of access to these much relied upon preparatory tools would undermine hospitals' ability to promote quality and safety standards for patients and could lead to unnecessary and preventable citations and detrimental accreditation survey results that are not reflective of the hospital's overall performance and intent in meeting the CoPs. Accordingly, the FAH urges CMS to clarify that the definition of "fee-based consulting services" does not include hospital use of subscription-based tools and seminars.

Finally, regarding the provision of "consultation services," under the proposed rule, AOs would be required to biannually report to CMS the names and CMS Certification Number (CCN) for all health care providers to which the AO or its associated consulting arm recently provided consultation services. We urge CMS to clarify that limitations on the "fee-based consultation

services” would apply specifically to individual hospitals with which the AO contracts to provide the consultation services – and not to all hospitals across an entire hospital system, many of which may not contract with the AO for these services.

CMS Should Reconsider the Parameters of an “Unannounced Survey”

The proposed rule sets forth a definition of “unannounced survey” that makes several scheduling and notification requirements of the AOs. Under the proposal, the AO would be required to cease any advance notification to the hospital and its staff so that the facility would be unaware of the survey until the time that the survey team arrives. AOs also would be required to schedule surveys so that their timing or occurrence would not be predictable to the facility being surveyed. Further, in June 2023, CMS released [guidance](#) that parallels the intentions of the proposed rule, with similar requirements for “unannounced surveys.”

The proposed rule’s new definition of “unannounced survey” reinforces an inefficient policy that overestimates the value of providing a facility a brief advance notice of a survey. Both the June 2023 guidance and the proposed rule give too much credence to what a facility could do to improve the results of an impending survey in the short amount of advance notice that an AO may provide, often inadvertently.

The FAH recommends that CMS encourage AOs to provide hospitals 24 hours’ advance notice of a survey which would allow time for hospitals to ensure appropriate staff are available for the survey. While there may be instances in which a hospital’s staff members may not be available for the survey, for example, due to travel or illness, providing the hospital with a brief advance notice would allow the hospital to resolve simple scheduling issues that could ensure maximum access to hospital leadership and other staff who could better facilitate a smooth survey process and answer surveyors’ questions more robustly. This would allow surveyors to garner the needed feedback in a more efficient manner, making the survey results more useful and reflective of the care the hospital provides for the facility, public, and CMS’ consideration.

CMS discusses in the proposed rule its concern that unannounced surveys are required “to prevent the provider or supplier from making unusual preparations for the survey that would not represent the ongoing typical condition of the provider and true nature and quality of care provided.” 89 *Fed. Reg.* 12,004. Yet, a 24-hour window of time would represent an appropriate balance to these concerns – this window would not allow enough time to make unusual preparations while at the same time it would allow hospitals an opportunity to ensure a more efficient, robust, and smoother survey process.

The Proposed Rule Does Not Provide Sufficient Information Regarding an AO’s Plan of Correction and Subsequent Public Release

CMS further proposes expanding the types of AO survey validation activities that would yield an AO’s performance measures. AOs with performance measures below a CMS-determined threshold would submit a plan of correction that documents specific actions being

taken by the AO to improve performance and the timeframe for implementation of the actions. The AO also would be required to submit plans for ongoing monitoring of the plan of correction toward achieving an acceptable level of performance. Once the plan of correction is approved by CMS, the AO would be required to identify the individual responsible for implementation and monitoring of the plan, which would be made publicly available.

It is unclear from the proposed rule the extent of the data that would be included in the AO's public plan of correction and related CMS analysis. We are concerned that public release of this information could potentially adversely impact hospitals being surveyed by the AO and undermine public confidence in hospitals that may have been surveyed by the AO, yet that performed well on the survey and met the Medicare CoPs. With these unintended consequences in mind, **the FAH urges CMS to provide more specific information regarding the public nature of an AO's plan of correction and related analysis, as referenced in the proposed rule, and ensure that this information could not potentially identify an individual hospital or hospital system. Alternatively, at a minimum, if hospitals were potentially identified in such an AO analysis or public report, hospitals should be permitted the opportunity to provide comment before public release of an AO plan of correction.**

Surveys Need Greater Transparency

Lastly, we note that AOs often combine the triennial deemed status surveys with a complaint survey during a survey visit. Each of these surveys has very different rules and requirements. Combining them into one evaluation, especially when each type of survey is not identified by the surveyor, is confusing for hospital staff and risks conflating results against varying standards, increasing the possibility that a hospital will receive inaccurate results. **Thus, we urge CMS to ensure that surveyors clearly identify the purpose of each survey being conducted, along with providing appropriate instruction for each such survey, with outreach to hospital staff to assess any issues that arise and develop a plan to address them.**

The FAH appreciates the time and effort CMS has dedicated to seeking to remove even the appearance of AO conflicts of interest in their relationships with the hospitals that the AOs accredit. The AOs are performing a function that facilitates the government's enforcement programs. As such, CMS oversight must carefully and diligently proceed in a manner that will ensure that the AOs are held to the highest standards of ethical conduct. It is important that CMS continues to invest in the review of AOs as the organizations provide both accreditation and fee-based consulting services to ensure continued public trust in the accreditation standards and in the hospitals' compliance with the CoPs and provision of high-quality care. The FAH remains available and willing to work with CMS and the AOs to ensure that actual or perceived conflicts of interest are identified, prevented, and addressed as needed.

Thank you for the opportunity to comment on the proposed rule. The FAH looks forward to its continued partnership with CMS as we strive to continuously improve the health care system. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Shirley M. [unclear]". The signature is fluid and cursive, with a large initial "S" and a long horizontal stroke at the end.