The Joint Commission

August 12, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

[Docket: CMS-6082-NC, RIN: 0938-ZB54. Submitted electronically via http://www.regulations.gov]

Dear Administrator Verma:

The Joint Commission appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) request for information on *Reducing Administrative Burden to Put Patients Over Paperwork*.

Founded in 1951, The Joint Commission seeks to continuously improve health care for the public in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. An independent, not-for-profit organization, The Joint Commission accredits and/or certifies more than 22,000 health care organizations and programs in the United States. The Joint Commission evaluates health care organizations across the continuum of care, including most of the nation's hospitals. In addition, Joint Commission programs encompass clinical laboratories, ambulatory care and office-based surgery facilities, behavioral health care, home care, hospice, and long-term care organizations. Joint Commission accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting state-of-the-art performance standards. Although accreditation is voluntary, a variety of federal and state government regulatory bodies, including CMS, recognize and rely upon The Joint Commission's decisions and findings for Medicare or licensure purposes.

The Joint Commission supports CMS' continued efforts to reduce administrative and regulatory requirements that consume providers' time and resources while contributing little to quality of care or patient health. The Joint Commission continues to be concerned that CMS is not considering the costs to the delivery system that emanate from unnecessary processes and other types of administrative requirements placed on accrediting organizations (AOs) working on behalf of CMS. The burden of this part of the regulatory framework ends up on the backs of providers and practitioners because not-for-profit AOs must pass on these costs. For several years, The Joint Commission has pointed out regulatory practices around the "deeming rule"[1] that have resulted in unnecessary system costs and impeded quality improvement. The Joint Commission urges CMS to make changes to this rule a priority. The deeming rule provides the basis for surveying to the Conditions of Participation (CoPs)s, and it is important that this framework be examined before

[1] Revisions to Deeming Authority Survey, Certification, and Enforcement Procedures, 80 Fed. Reg. 29796 (May 22, 2015).

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turning to individual CoPs.

When examining the impact of requirements and the overall goal of promoting high-quality, safe care for patients. The Joint Commission also urges CMS to move forward with the validation redesign, which would require regulatory changes for the oversight of AOs. Additionally, The Joint Commission urges a review of acute care hospitals, psychiatric hospital, and critical access hospital (CAH) CoPs in their entirety to help modernize the Medicare program and ultimately reduce regulatory burden for health care. The American Hospital Association estimates that complying with federal regulations accounts for $1,200 of the cost of every hospital admission, with the hospital CoPs being one of the most burdensome domains.[2] This estimation of cost is in isolation of the costs that accrediting bodies pass on to hospitals via higher accreditation fees when the process for applying these CoPs is out of date or ineffective. Furthermore, this cost estimation does not take into account the lost opportunity cost of improving quality when time is taken up with less beneficial processes or requirements.

Below are The Joint Commission's specific comments.

Administrative Burden on Accrediting Organizations

While appreciative of CMS' ongoing initiative to reduce administrative burden in the health care delivery system, The Joint Commission maintains that the focus on providers and patients is too narrow and ignores the role of AOs in promoting high-quality care. In prior regulatory changes to reduce administrative burden, costs placed on AOs are never acknowledged or estimated. For example, a newly proposed CoP for patient event notifications would place burden on AOs to assess compliance – either by extending the length of a survey by a day or adding another surveyor with the appropriate technical expertise to the survey team. Accrediting bodies would also incur costs around training surveyors to assess a new CoP. These costs were not acknowledged in the cost analysis and would be passed on to hospitals via accreditation fees, regardless of whether using accrediting bodies to apply the CoP is an effective mechanism.

CMS relies on AOs to survey facilities for compliance with Medicare's health and safety standards. Section 1865(a)(1) and (a)(2) of the Social Security Act (the Act) conveys requirements by which a national accreditation body can obtain deemed status for assessing that providers and suppliers have met or exceeded the CoPs for Medicare. Requirements pertaining to deemed status are found at *§§ 488.1* through *488.9*. These requirements are complex and add to the overall cost of AO operations. The Joint Commission recommends that CMS review the deeming provisions to remove any burdensome requirements that do not add to the quality or safety of care.

Each year, CMS releases information on priority and workload for State Survey Agencies. Surveys of facilities for which there is an option to achieve deemed Medicare status by demonstrating compliance through an AO survey are assigned lower priority, Tier 4. Given that AOs play a chief role in assessing quality and safety of facilities throughout the nation, it is critical that administrative burden on AOs be considered in any comprehensive examination of administrative burden.

[2] American Hospital Association, *Regulatory Overload Report*, Nov. 3, 2017, *available at* https://www.aha.org/guidesreports/2017-11-03-regulatory-overload-report.

Revisions to Deeming Authority Survey, Certification, and Enforcement Procedures Final Rule[3]

For a number of years, The Joint Commission has pointed out regulatory practices around the "deeming rule" that have added unnecessary system costs and hindered health care organizations from improving quality. These processes have been in place since the 1960s and are often in contradiction to both modern quality improvement science and today's technology-intensive delivery of care. For example, the 60-day timeframe for a plan of correction is not feasible to address structural issues of ligature risks. Similarly, the requirements around medical record review do not work well in the current environment of electronic health records. Facilities should look for certain issues, but not exhaustively review the medical record as was practical in an era of simpler, paper records. Further, the overall regulatory process for certifying health care organizations to participate in Medicare has created lost opportunity for quality improvement as time is spent on less effective processes.

The Joint Commission urges that this rule become a regulatory change priority. An improved deeming rule would benefit to quality of care for all beneficiaries, irrespective of whether they are served in facilities surveyed directly by CMS or by AOs. Addressing the "deeming rule" would also reduce administrative costs in the Medicare program without sacrificing any of oversight responsibilities.

Medicare's Program for Oversight of Accrediting Organizations

Section 1864(c) of the Social Security Act (the Act) authorizes the Secretary to enter into agreements with State Survey Agencies for the purpose of conducting validation surveys in accredited facilities to ensure that AOs are holding provider entities accountable for compliance with Medicare requirements. Section 1875(b) of the Act further requires CMS to submit an annual report to Congress on its oversight of national AOs and their CMS-approved accreditation programs. CMS has codified this authority at *§ 488.8 ongoing review of accrediting organizations* and *§ 488.9 validation surveys* as well as in guidance to State Survey Agencies. The annual report to Congress includes a performance evaluation of each CMS-approved AO to verify that accredited provider entities demonstrate compliance with the Medicare CoPs, with the most known measure being the disparity rate of validation surveys.

The Joint Commission has been collaborating with CMS since June 2018 to develop and pilot a redesigned validation process for CMS to use as part of their oversight activities of accreditation organizations. The redesigned process intends to eliminate the need for a separate state survey event within 60 days of an accreditation survey and shift the focus of validation events to CMS oversight of accrediting organizations' survey processes and ability to evaluate Medicare requirements. The Joint Commission has conducted state agency-observed pilot surveys for the Joint Commission's Hospital, Ambulatory Surgery Center, and Psychiatric Hospital programs, and the Joint Commission's first Home Health validation observation survey occurred in July. Thus far, The Joint Commission and state agency survey teams have arrived at similar conclusions regarding survey

[3] 80 Fed. Reg. 29796 (May 22, 2015).

findings and outcomes, and surveyed organizations have appreciated the elimination of separate state surveys.

While the pilot is underway, the requirements at *§ 488.9* are still in place, so The Joint Commission is tasked with managing two separate processes for survey and validation. The Joint Commission urges CMS to move towards full implementation of the validation redesign, making the necessary regulatory revisions to allow full transition.

Conditions of Participation for Hospitals (42 CFR Part 482)

The Joint Commission maintains that some of the requirements in the CoPs for hospitals are outdated and do not add value to care delivery. Although pieces of the CoPs and associated interpretive guidance have been revised in recent years, it is time for a wholesale reexamination of the hospital CoPs to ensure that they reflect how care is delivered today. The current CoPs were developed in an era of hospital departments and need to be recast to reflect today's service-line approach and integrated delivery systems. The existing framework impedes the smooth application of CoPs for delivery systems with multiple hospitals. The CoPs currently prohibit the integration of services across a system. For systems with campuses in close proximity, allowing integration could improve efficiency and allow facilities to share resources when necessary. Each organization could maintain their supervisory structure over the service at the individual hospital.

It is also critical to review the CoPs to identify areas where requirements are not contributing to quality but are placing unnecessary burden on hospitals for compliance. For example, CMS should consider removing *§ 482.12(d)* from the CoPs. This condition requires a hospital to have an institutional plan and budget, and there is a level of specificity in this requirement that is not necessary. This requirement does not contribute to quality and safety and appears to be included in the CoPs because of the Social Security Act *§ 1122(g)*.

Similarly, *§ 482.12(e)(2)* requires the hospital to maintain a list of all contracted services, including the scope and nature of services provided. Simply maintaining a list is not valuable to ensuring quality of contracted services. The more important aspect is that contracted services are provided in a manner that maintains regulatory compliance and meets the quality expectations of the organization. The Joint Commission recommends that CMS should review all conditions across programs related to maintaining "lists" and remove or revise any requirements that do not contribute to improved quality and safety.

Conditions of Participation for Psychiatric Hospitals (§§ 482.60, 482.61, 482.62)

The CoPs for psychiatric hospitals are well past due for revisions to modernize and reduce administrative burden. As noted in prior comment letter, when these provisions originated in the 1960s, psychiatric care was delivered very differently. The length of stay in a psychiatric facility was often measured in months or years, as opposed to days in current practice. There have been no substantive revisions to the requirements for psychiatric hospitals since the initial provisions were implemented. The regulations and interpretive guidance are no longer relevant to the clinical practice of psychiatry. Psychiatric providers waste valuable time meeting antiquated standards when there is a critical need to improve access to mental health services in the nation and psychiatry is the second greatest physician shortage area in the United States.

Since 2016, The Joint Commission has been requesting modernization of the psychiatric hospital CoPs, yet CMS has indicated that revisions are unlikely to occur in the near future. It is critical that CMS bring these provisions in line with modern treatment practices for psychiatric care.

The Joint Commission suggests that the three CoPs for psychiatric hospitals could be streamlined and reduced to the following:

- Psychiatric hospitals must be engaged in providing, by or under the supervision of a psychiatric physician, psychiatric (including mental health and addiction) services. Hospital clinical leadership must minimally include a psychiatric medical director, psychiatric nursing director, and a clinical services director.

- All patients admitted to a psychiatric unit must receive a multidisciplinary assessment focused on the reasons the patient was admitted, an assessment of history and behaviors, and the development of a multidisciplinary treatment plan to address the primary reason(s) for hospitalization, as well as an aftercare plan/strategy. The multidisciplinary team performing the assessments and developing and carrying out the treatment plan must include at least one representative from 1) psychiatric medicine; 2) psychiatric nursing; 3) physical medicine (history and physical and medical follow ups); and 4) clinical therapies (e.g., social work, psychology, professional counselors, marriage and family therapists, etc.).

- A formal documented multidisciplinary treatment plan must be developed for each patient focusing on the reasons the patient was admitted to the hospital, and it must include plans related to aftercare treatment(s). Mental health, addiction, and physical medical illnesses/disorders must all be addressed.

- The hospital must have an adequate number of qualified professionals and supportive staff to carry out the requirements outlined above.

Conditions of Participation for Critical Access Hospitals (42 CFR 485 Subpart F)

CMS should consider evaluating and revising the CAH and CAH Distinct Part Units (DPUs) for psychiatric and rehabilitation services requirements. Currently, the DPUs are required to comply with the Hospital CoPs. As DPUs are either rehabilitation or psychiatric units/beds, a majority of the Hospital CoPs would not make sense to apply within these areas. The Joint Commission recommends that CMS streamline requirements to create a single set of CoPs that are reasonable to apply throughout the entire CAH.

The Joint Commission is pleased to answer any questions you may have regarding our comments. If you have any questions, please do not hesitate to contact me or my staff: Kathryn Spates at 202-783-6655 or kspates@jointcommission.org or Brigid Russell at 202-783-6655 or brussell@jointcommission.org.

Sincerely,

Margaret VanAmringe, MHS
Executive Vice President for Public Policy and Government Relations