American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

September 4, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: Proposed Rule: Medicare Program, Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements and Survey and Enforcement Requirements for Home Health Agencies (CMS-1358-P).

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations – including approximately 1,200 hospital-based home health agencies (HHAs) – and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) home health prospective payment system (PPS) proposed rule for calendar year 2013.

In this letter, we offer brief comments related to several provisions of the proposed survey, certification and enforcement processes for HHAs. We appreciate that CMS is promulgating regulations for these processes, which will provide HHAs with more guidance and information on CMS's expectations. Our comments are based on our members' experiences with the hospital survey and enforcement process, and we believe they provide important insights about establishing effective and fair evaluations of regulatory compliance.

MINIMUM QUALIFICATIONS FOR SURVEYORS

Under section 1891(c)(2)(C)(iii) of the *Social Security Act*, the Department of Health and Human Services secretary is responsible for setting minimum qualifications for surveyors. CMS would establish these minimum qualifications for surveyors in proposed § 488.735. Specifically, CMS states: "We are proposing that he or she successfully complete the relevant CMS-Sponsored Basic HHA Surveyor Training Course and any associated course prerequisites prior to conducting an HH survey." The qualifications also preclude an individual from conducting a survey of a HHA if he or she has a financial interest in or a recent employment relationship with that HHA.

While we applaud the idea of training for surveyors, we are disappointed that the proposed minimum qualifications do not describe a basic set of required knowledge, such as clinical experience, a familiarity with the home health care delivery system, and/or an understanding of federal regulations including the Conditions of Participation (CoP). It is unclear what levels of education and experience CMS expects surveyors to possess. In the final rule, CMS should explain what skills and experience it believes are needed for surveyors to be able to accurately evaluate compliance with the CoPs. In addition, CMS should publish a description of the required course for surveyors, and define and describe the prerequisite courses or requirements.

In the hospital survey process, we have perceived a noticeable variability in the knowledge, experience and training levels of the surveyors. This variability leads to inconsistency in the survey process across states and the U.S. Given that surveyors often make judgment calls as to what level of citation to issue, and taking into account that the proposed penalties can be severe enough to diminish a HHA's ability to provide high-quality care to patients, it is imperative that CMS ensure that surveyors are adequately trained and devote sufficient resources for that purpose. CMS should explain (1) how it ensures that surveyors possess consistent levels of competence, knowledge and skill; and (2) the initial and ongoing training requirements and opportunities for surveyors, which includes a description of training courses.

INFORMAL DISPUTE RESOLUTION (IDR)

At proposed § 488.745, an agency is provided the informal opportunity to dispute condition-level findings. We support the idea of IDR and would like to further understand how CMS intends to ensure the process is unbiased. Ideally, a third party would oversee this process, but it appears that IDR would be provided by CMS or the state. Additionally, we understand that upon request of IDR, CMS would *not* delay the onset of any penalties. Should a condition-level finding be accompanied by civil money penalties (CMPs) on a per-day basis or suspension of payments, a HHA might be discouraged from requesting the IDR process. It also concerns us that the language of the proposed regulation does not require a timetable for CMS or the state to provide IDR. In the final rule, CMS should outline what it means by its goal to use the IDR process to "settle disagreements at the earliest stage." The language of the final regulation should outline not only the opportunity of the HHA to request an IDR but also the responsibility for CMS or the state to provide IDR within 15 days to any HHA that makes the request.

CIVIL MONEY PENALTIES AND SUSPENSION OF PAYMENT

Proposed § 488.845 sets out the policies for using CMPs and includes provisions for both per-day and per-instance monetary penalties. We recognize the value in creating incentives for HHAs to comply with quality and safety standards. At the same time, we encourage CMS to proceed cautiously in how it applies CMPs, especially with regard to per-day penalties. As noted above, the process of making a citation can be subjective, and what may be intended as a fine for HHAs could put some small HHAs in financial

jeopardy. It is unclear how quickly a per-day CMP would be removed and whether a survey agency would be required to revisit the HHA in a timely manner to determine that it had achieved compliance. As hospitals work with HHAs and other providers to deliver continuing care after discharge and prevent unnecessary readmissions, we would hope that a penalty would be assessed in a way that does not undercut the stability of a HHA that typically provides high quality care. These same concerns arise for suspensions of payment for new admissions and new payment episodes. We urge CMS to give HHAs time to correct deficiencies before the implementation of CMPs or suspensions of payment. Further, we urge CMS to reconsider the wisdom of using per diem penalties. These would seemingly give the surveying agency and CMS a financial incentive to drag their feet in certifying that a defect had been corrected by the HHA.

IMMEDIATE JEOPARDY (IJ) CITATIONS

Proposed § 488.825 describes the procedures CMS will take after a HHA is cited at the IJ level. To avoid confusion in this section, we suggest that CMS amend slightly the proposed wording of § 488.825 (a)(1) to read, "CMS immediately terminates the HHA provider agreement in accordance with § 489.53*(a)(17) and § 489.53(d)(2)(iii)*." This change will make it clear which sections of § 489.53 apply.

We also believe that CMS needs to revise the way IJ citations are handled. The decision of whether a citation should be issued at the condition-level or the IJ-level is subjective. Our member hospitals have experienced inconsistency in the way IJ citations are processed. For example, some state survey agencies appear to cite IJs more frequently than others. Our experience leads us to believe that a handful of states may account for a large proportion of IJ citations. In addition, disagreement may exist between the state survey agency and the regional office as to what constitutes an IJ situation, putting hospitals in the middle. In the coming months, we will be making recommendations for improvements in the IJ process. In the meantime, CMS should explain in further detail how it intends to ensure that IJ criteria are applied consistently and fairly for HHAs. A fair process is especially important for smaller organizations, given that CMS publicizes IJ citations. Negative publicity can impact the stability of small HHAs.

Thank you for the opportunity to comment. If you have any questions, please contact me or Nancy Foster, vice president for quality and patient safety, at nfoster@aha.org or Evelyn Knolle, senior associate director for policy, at eknolle@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President