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ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

March 9, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce is conducting oversight to ensure that patient safety is being provided for, and that federal standards are being adhered to, in hospitals participating in the Medicare and Medicaid programs. Under the Social Security Act, as amended, hospitals participating in the Medicare program are required to meet certain minimum requirements specified in the statute as well as any supplemental requirements that are established by the Secretary of the Department of Health and Human Services (HHS) to protect the public health, otherwise known as the Conditions of Participation (CoPs).[1]

CoPs for hospitals, which were first published in 1966 and have since undergone subsequent revisions, are issued by HHS' Centers for Medicare and Medicaid Services (CMS).[2] State Survey Agencies, acting on behalf of CMS, may conduct the Medicare certification process and inspect hospitals to ensure compliance with the CoPs. Alternatively, hospitals may elect to seek accreditation from a private, CMS-approved, Accrediting Organization (AO), as permitted by Section 1865 of the Social Security Act.[3] According to CMS' most recent report to Congress, in Fiscal Year (FY) 2015, 89 percent of hospitals—3,500 hospitals in total—chose to demonstrate compliance with the CoPs through accreditation.[4]

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[1] 42 U.S.C. 1395x.
[2] *See,* 42 CFR pt. 482.
[3] 42 U.S.C. 1395bb.
[4] U.S. Dep't of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), *Review of Medicare's Program for Oversight of Accrediting Organizations and the Clinical Laboratory Improvement Validation Program – Fiscal Year 2016*, 16 (July 28, 2017), *available at* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-40.pdf.

Pursuant to Section 1875(b) of the Social Security Act, HHS is responsible for conducting oversight of AOs' activities and performance surveying healthcare facilities, including assessing the AOs' accreditation programs to ensure they comport with federal standards.[5] HHS, acting through CMS, undertakes this oversight in a variety of ways, including but not limited to, reviewing the equivalency of the accreditation requirements to the Medicare standards, survey processes and procedures, training, oversight of provider entities, and enforcement.[6] Although CMS has worked to strengthen its oversight of AOs, the Committee is concerned about the adequacy of CMS' oversight as well as the rigor of the AO survey process. For example, according to CMS' most recent annual report to Congress, in FY 2015, AOs conducting hospital surveys did not report 39 percent of 'condition level' deficiencies that were subsequently reported following validation surveys conducted by State Survey Agencies no later than 60 days following the AO survey.[7] CMS defines condition level deficiencies as being "the most serious type of deficiency cited, indicating a provider or supplier is not in compliance with an entire CoP."[8]

Given CMS' responsibility to ensure that hospitals participating in the Medicare and Medicaid programs are meeting the CoPs, as well as its oversight of AOs and State Survey Agencies that are acting on its behalf, we request that you please provide the following documents and information as soon as possible, but no later than March 23, 2018.

1. Copies of the most recent contracts between CMS and State Survey Agencies that encompass the State Survey Agency's responsibilities for the survey and certification process for health care providers, including but not limited to, hospital surveys and validation surveys;

2. Any correspondence or other documents that address disparity rates between validation surveys, performed by State Survey Agencies, and for hospital surveys performed by AOs;

3. Any correspondence or other documents between CMS and any State Survey Agency that addresses hospital surveys performed by the State Survey Agency;

4. Any correspondence or other documents that address adverse event and complaint reporting policies and procedures among CMS, AOs, and State Survey Agencies;

5. Copies of any complaints that CMS has received since FY 2012 that allege patient harm or misconduct in acute care hospitals, as well as any actions CMS took in response, including but not limited to, communications with State Survey Agencies and AOs.

An attachment to this letter provides additional information about complying with the Committee's request. If you have any questions about this letter, please contact Christopher

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[5] 42 U.S.C. 1395.
[6] CMS, *supra* note 4 at 3.
[7] CMS, *supra* note 4 at 41.
[8] *Id.* at 22.

Santini or Natalie Turner of the Majority Committee staff at 202-225-2927. Thank you for your prompt attention to this matter.

Sincerely,

Greg Walden
Chairman

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member

The Honorable Gene Green, Ranking Member
Subcommittee on Health

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

Attachment