



This document is scheduled to be published in the Federal Register on 01/20/2015 and available online at <http://federalregister.gov/a/2015-00699>, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-3303-FN]

Medicare and Medicaid Programs; Continued Approval of the Accreditation Commission for Health Care, Inc.; Home Health Agency Accreditation Program

AGENCY: Centers for Medicare and Medicaid Services, HHS.

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve the Accreditation Commission for Health Care, Inc., (ACHC) for continued recognition as a national accrediting organization for home health agencies (HHAs) that wish to participate in the Medicare or Medicaid programs. An HHA that participates in Medicaid must also meet the Medicare conditions for participation (CoPs) as required under 42 CFR 488.6(b).

DATES: This final notice is effective February 24, 2015 through February 24, 2021.

FOR FURTHER INFORMATION CONTACT:

Cindy Melanson, (410) 786-0310, or Patricia Chmielewski, (410) 786-6899.

SUPPLEMENTARY INFORMATION:

I. Background

A healthcare provider may enter into an agreement with Medicare to participate in the program as a HHA provided certain requirements are met. Sections 1861(o) and 1891 of the Social Security Act (the Act), establish distinct criteria for facilities seeking designation as a HHA. Regulations concerning Medicare provider agreements in general are at 42 CFR part 489 and those pertaining to the survey and certification for Medicare participation of providers and certain types of suppliers are at part 488. The regulations at part 484 specify the specific conditions that a provider must meet to participate in the Medicare program as an HHA.

Generally, to enter into a Medicare provider agreement, a facility must first be certified as complying with the conditions set forth in part 484 and recommended to us for participation by a state survey agency. Thereafter, the HHA is subject to periodic surveys by a state survey agency to determine whether it continues to meet these conditions. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by us may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that, if the Secretary of the Department of Health and Human Services, (the Secretary) finds that accreditation of a provider entity by an approved national accrediting organization meets or exceeds all applicable Medicare conditions, we may treat the provider entity as having met those conditions, that is, we may “deem” the provider entity to be in compliance. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

Part 488, subpart A, implements the provisions of section 1865 and requires that a national accrediting organization applying for approval of its Medicare accreditation program must provide us with reasonable assurance that the accrediting organization requires its accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of accrediting organizations are set forth at §488.4 and §488.8(d)(3). The regulations at §488.8(d)(3) require an accrediting organization to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by us. ACHC’s current term of approval as a recognized Medicare accreditation program for HHAs expires February 24, 2015.

II. Application Approval Process

Section 1865(a)(3)(A) of the Act provides a statutory timetable to ensure that our review of applications for CMS-approval of an accreditation program is conducted in a timely manner. The Act provides us with 210 days after the date of receipt of a complete application, with any documentation necessary to make the determination, to complete our survey activities and application process. Within

60 days after receiving a complete application, we must publish a notice in the **Federal Register** that identifies the national accrediting body making the request, describes the request, and provides no less than a 30-day public comment period. At the end of the 210-day period, we must publish a notice in the **Federal Register** approving or denying the application.

III. Provisions of the Proposed Notice

In the August 22, 2014 **Federal Register** (79 FR 49777), we published a proposed notice announcing ACHC's request for continued approval of its Medicare HHA accreditation program. In that notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at §488.4 and §488.8, we conducted a review of ACHC's Medicare HHA accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An onsite administrative review of ACHC's: (1) Corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its HHA surveyors; (4) ability to investigate and respond appropriately to complaints against accredited HHAs; and, (5) survey review and decision-making process for accreditation.
 - The comparison of ACHC's Medicare accreditation program standards to our current Medicare HHA CoPs.
 - A documentation review of ACHC's survey process to:
 - ++ Determine the composition of the survey team, surveyor qualifications, and ACHC's ability to provide continuing surveyor training.
 - ++ Compare ACHC's processes to those we require of state survey agencies, including periodic resurvey and the ability to investigate and respond appropriately to complaints against accredited HHAs.
 - ++ Evaluate ACHC's procedures for monitoring HHAs it has found to be out of compliance with ACHC's program requirements. (This pertains only to monitoring procedures when ACHC

identifies non-compliance. If noncompliance is identified by a state survey agency through a validation survey, the state survey agency monitors corrections as specified at §488.7(d.)

++ Assess ACHC's ability to report deficiencies to the surveyed HHA and respond to the HHA's plan of correction in a timely manner.

++ Establish ACHC's ability to provide us with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ Determine the adequacy of ACHC's staff and other resources.

++ Confirm ACHC's ability to provide adequate funding for performing required surveys.

++ Confirm ACHC's policies with respect to surveys being unannounced.

++ Obtain ACHC's agreement to provide us with a copy of the most current accreditation survey together with any other information related to the survey as we may require, including corrective action plans.

In accordance with section 1865(a)(3)(A) of the Act, the August 22, 2014 proposed notice also solicited public comments regarding whether ACHC's requirements met or exceeded the Medicare CoPs for HHAs. No comments were received in response to our proposed notice.

IV. Provisions of the Final Notice

A. Differences Between ACHC's Standards and Requirements for Accreditation and Medicare Conditions and Survey Requirements

We compared ACHC's HHA accreditation requirements and survey process with the Medicare CoPs of 42 CFR part 484, and the survey and certification process requirements of parts 488 and 489. Our review and evaluation of ACHC's HHA application, which were conducted as described in section III of this final notice, yielded the following areas where, as of the date of this notice, ACHC has completed revising its standards and certification processes to meet the requirements at:

- Section 1891(c)(2)(A) of the Act, to ensure all renewal surveys are conducted within 36

months of the last survey end date.

- §484.10(c)(2), to address the patient's right to participate in the planning of care.
- §484.14(e), to ensure personnel records include qualifications and current licensure.
- §488.8(a)(2)(v), to ensure data submitted in CMS' Accrediting Organization System for Storing User Recorded Experiences (ASSURE) database is complete and accurate.
- §489.3, to ensure situations that rise to the level of immediate jeopardy (IJ) are cited at the condition level.

B. Term of Approval

Based on our review and observations described in section IV of this final notice, we have determined that the ACHC accreditation program requirements meet or exceed our requirements. Therefore, we approve the ACHC as a national accreditation organization for HHAs that request participation in the Medicare program, effective February 24, 2015 through February 24, 2021.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

CMS-33303-FN

Dated: January 9, 2015.

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

BILLING CODE: 4120-01-P

[FR Doc. 2015-00699 Filed 01/16/2015 at 8:45 am; Publication Date: 01/20/2015]