



## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **Centers for Medicare & Medicaid Services**

**[CMS-3369-PN]**

### **Medicare and Medicaid Programs: Application from the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) for Continued CMS-Approval of its Outpatient Physical Therapy and Speech Language Pathology Services Accreditation Program**

**AGENCY:** Centers for Medicare and Medicaid Services (CMS), HHS.

**ACTION:** Notice with request for comment.

**SUMMARY:** This proposed notice acknowledges the receipt of an application from the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) for continued recognition as a national accrediting organization (AO) for clinics, rehabilitation agencies, or public health agencies that furnish outpatient physical therapy and speech language pathology services that wish to participate in the Medicare or Medicaid programs.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

**ADDRESSES:** In commenting, please refer to file code CMS-3369-PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-3369-PN,

P.O. Box 8010,

Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-3369-PN,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

**FOR FURTHER INFORMATION CONTACT:**

Erin McCoy, (410) 786-2337, Monda Shaver, (410) 786-3410, or Renee Henry, (410) 786-7828.

**SUPPLEMENTARY INFORMATION:**

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

## **I. Background**

Under section 1861(p) of the Medicare statute, eligible beneficiaries may receive outpatient physical therapy and speech language pathology (OPT) services from a provider of services, a clinic, rehabilitation agency, a public health agency, or others, provided certain requirements are met. Section 1832(a)(2)(C) of the Social Security Act (the Act) permits payment for OPT services. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities are at 42 CFR part 488. The regulations at 42 CFR part 485 subpart H specify the conditions that a clinic, rehabilitation agency or public health agency (“OPT providers”) must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for OPT providers.

Generally, to enter into an agreement, an OPT provider must first be certified by a State survey agency as complying with the conditions of participation set forth in part 485, subpart H of our Medicare regulations. Thereafter, the OPT provider is subject to regular surveys by a State survey agency to determine whether it continues to meet these requirements.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by a Centers for Medicare & Medicaid Services (CMS) approved national

accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we may deem those provider entities as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

If an AO is recognized by the Secretary of the Department of Health and Human Services as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program may be deemed to meet the Medicare conditions. An AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare conditions. Our regulations concerning the approval of AOs are set forth at § 488.5.

AAAASF's current term of approval for its OPT provider accreditation program expires April 4, 2019.

## **II. Approval of Deeming Organizations**

Section 1865(a)(2) of the Act and our regulations at § 488.5 require that our findings concerning review and approval of an AO's requirements consider, among other factors, the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that we publish, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day

public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of AAAASF's request for continued CMS approval of its OPT provider accreditation program. This proposed notice also solicits public comment on whether AAAASF's requirements meet or exceed the Medicare conditions of participation (CoPs) for OPT providers.

### **III. Evaluation of an AO's Accreditation Program**

AAAASF submitted all the necessary materials to enable us to make a determination concerning its request for continued CMS-approval of its OPT provider accreditation program. This application was determined to be complete on September 6, 2018. Under Section 1865(a)(2) of the Act and our regulations at § 488.5, our review and evaluation of AAAASF will be conducted in accordance with, but not necessarily limited to, the following factors:

- The equivalency of AAAASF's standards for OPT providers as compared with Medicare's CoPs for OPT providers.
- AAAASF's survey process to determine the following:
  - ++ The composition of the survey team, surveyor qualifications, and the ability of the organization to provide continuing surveyor training.
  - ++ The comparability of AAAASF's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.
  - ++ AAAASF's processes and procedures for monitoring an OPT provider found out of compliance with AAAASF's program requirements. These monitoring procedures are used only when AAAASF identifies noncompliance. If noncompliance is identified through validation

reviews or complaint surveys, the State survey agency monitors corrections as specified at § 488.9(c)(1).

++ AAAASF's capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

++ AAAASF's capacity to provide CMS with electronic data and reports necessary for effective validation and assessment of the organization's survey process.

++ The adequacy of AAAASF's staff and other resources, and its financial viability.

++ AAAASF's capacity to adequately fund required surveys.

++ AAAASF's policies with respect to whether surveys are announced or unannounced, to assure that surveys are unannounced.

++ AAAASF's agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS may require (including corrective action plans).

#### **IV. Collection of Information Requirements**

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

#### **V. Response to Public Comments**

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "**DATES**" section of this

preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Upon completion of our evaluation, including evaluation of comments received as a result of this proposed notice, we will publish a final notice in the **Federal Register** announcing the result of our evaluation.

Dated: October 19, 2018.

**Seema Verma,**

*Administrator,*

*Centers for Medicare & Medicaid Services.*