



Centers for Medicare & Medicaid Services

[CMS-3400-FN]

Medicare and Medicaid Programs; Application from the Accreditation Commission for Health Care (ACHC) for Continued Approval of its Home Health Agency Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final notice.

SUMMARY: This final notice announces our decision to approve The Accreditation Commission for Health Care (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 of participation (CoPs).

DATES: This decision announced in this final notice is effective February 24, 2021 through February 24, 2025.

FOR FURTHER INFORMATION CONTACT: Tara Lemons (410) 786-3030.

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SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA), provided certain requirements are met. Sections 1861(m) and (o), 1891 and 1895 of the Social Security Act (the Act) establish distinct criteria for an entity seeking designation as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of facilities and other entities are at 42 CFR part 488. The regulations at 42 CFR parts 409 and 484 specify the

conditions that an HHA must meet to participate in the Medicare program, the scope of covered services and the conditions for Medicare payment for home health care.

Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a state survey agency as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by a state survey agency to determine whether it continues to meet these requirements. However, there is an alternative to certification surveys by state agencies. Accreditation by a nationally recognized Medicare accreditation program approved by CMS may substitute for both initial and ongoing state review.

Section 1865(a)(1) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization that all applicable Medicare conditions are met or exceeded, we will deem those provider entities as having met our requirements. Accreditation by an accrediting organization is voluntary and is not required for Medicare participation.

If an accrediting organization is recognized by the Secretary of Health and Human Services (the Secretary) as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accrediting organization applying for CMS approval of their accreditation program under 42 CFR part 488, subpart A, must provide CMS with reasonable assurance that the accrediting organization requires the 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 §488.5. Section 488.5(e)(2)(i) requires accrediting organizations to reapply for continued approval of its Medicare accreditation program every 6 years or sooner as determined by CMS.

The Accreditation Commission for Health Care (ACHC's) term of approval for their HHA accreditation program expires February 24, 2021.

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 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 September 28, 2020 **Federal Register** (85 FR 60796), we published a proposed notice announcing ACHC's request for continued approval of its Medicare HHA accreditation program. In the September 28, 2020 proposed notice, we detailed our evaluation criteria. Under section 1865(a)(2) of the Act and in our regulations at §488.5, 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 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 HHA accreditation program standards to our current Medicare conditions of participation (CoPs) for HHAs.
- A documentation review of ACHC's survey process to do the following:

++ 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 §488.9(c)).

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

++ Establish ACHC's ability to provide CMS 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.

++ Confirm ACHC's policies and procedures to avoid conflicts of interest, including the appearance of conflicts of interest, involving individuals who conduct surveys or participate in accreditation decisions.

++ Obtain ACHC's agreement to provide CMS 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 September 28, 2020 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 parts 409 and 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 in order to meet the following requirements:

- Section 484.102(b) to include the requirement to review and update emergency preparedness policies and procedures at least every 2 years.
- Section 484.105(b)(1)(i) to ensure that the administrator is appointed by and reports to the governing body.
- Section 488.26(b) to ensure surveyor documentation relating to non-compliance with particular Medicare conditions reflects the manner and degree of non-compliance, cited at the appropriate level (that is, condition versus standard level).
- Section 488.5(a)(4)(vii) to describe ACHC's procedures and timelines for monitoring provider's or supplier's correction of identified non-compliance with relevant standards, including the criteria ACHC uses to determine when a desk review versus an on-site review would be acceptable for monitoring the correction of non-compliance.

B. Term of Approval

Based on our review and observations described in section III. of this final notice, we approve ACHC as a national accreditation organization for HHAs that request participation in the Medicare program, effective February 24, 2021 through February 24, 2025.

V. 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.).

The Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), Elizabeth Richter, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: February 24, 2021.

Lynette Wilson,

Federal Register Liaison,

Centers for Medicare & Medicaid Services.

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