



**Center for Clinical Standards and Quality/Survey & Certification Group**

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**Policy and Requirements for an Application for Approval of an Accreditation Program**

**Laws and Regulations**

Section 1865(a)(1) of the Social Security Act (the Act) permits providers and suppliers "accredited" by an approved national accreditation organization (AO) to be exempt from routine surveys by State survey agencies to determine compliance with Medicare conditions. Accreditation by an AO is voluntary and is not required for Medicare certification. Section 1865(a)(1) of the Act provides that if the Secretary finds that accreditation of a provider entity by a national accreditation body demonstrates that all applicable conditions are met or exceeded, the Secretary deems those requirements to be met by the provider or supplier. Before permitting deemed status for an AO's accredited provider/supplier entities, Section 1865(a)(2) of the Act further requires that CMS consider the AO's:

- requirements for accreditation;
- survey procedures and processes;
- ability to provide adequate resources for conducting required surveys;
- ability to supply information for use in enforcement activities;
- monitoring procedures for provider/supplier entities found out of compliance with the conditions or requirements; and
- ability to provide CMS with the necessary data for validation and verification of survey and oversight activities.

In order to be granted deeming authority for Medicare, an AO must apply and demonstrate its ability to meet or exceed the Medicare conditions of participation/coverage as cited in the Code of Federal Regulations:

Hospices in accordance with 42 CFR 418

Hospitals in accordance with 42 CFR 482

Psychiatric Hospitals in accordance with 42 CFR 482

End Stage Renal Disease (ESRDs) in accordance with 42 CFR 494 and 42 CFR 405 Subpart U

Ambulatory Surgical Centers (ASCs) in accordance with 42 CFR 416

Home Health Agencies (HHAs) in accordance with 42 CFR 484

Critical Access Hospitals (CAHs) in accordance with 42 CFR 485 Subpart F

Rural Health Clinics (RHCs) in accordance with 42 CFR 491

Organizations that provide Outpatient Physical Therapy and Speech Language Pathology Services (OPTs) in accordance with 42 CFR 485, subpart H

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42 CFR 488.4 sets forth the procedures for reviewing and approving national accreditation organizations that request recognition as providing reasonable assurance that their standards meet or exceed Medicare conditions. The regulation at 42 CFR 488.5(e)(2) ("Final Notice") sets six years as a maximum term of approval.

CMS is required to specify the materials it requires for all applications and will specify the deadline for reapplication by a currently approved AO. In addition, AOs are subject to ongoing Federal oversight. CMS has elected to improve the efficiency of its oversight by clarifying its informational requests and by focusing on items under 42 CFR 488.5 and 42 CFR 488.8.

CMS' application requirements are attached. As part of the application or reapplication review process, CMS will conduct an onsite inspection at the AO's corporate/operational headquarters to validate the accreditation organization's operations, as well as perform a survey observation to verify implementation of the AO's survey processes, as permitted under 42 CFR 488.8(h).

If you have any questions regarding this document or the application requirements, you may contact Monda Shaver, Technical Director of Accreditation, Division of Acute Care Services, at [monda.shaver@cms.hhs.gov](mailto:monda.shaver@cms.hhs.gov).

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