DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3459–FN]

Medicare and Medicaid Programs; Approval of Application by the American Association for Accreditation of Ambulatory Surgery Facilities, dba QUAD A, for Continued CMS-Approval of Its Ambulatory Surgical Center (ASC) Accreditation Program

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

ACTION: Notice.

SUMMARY: This notice acknowledges the approval of an application by the American Association for Accreditation of Ambulatory Surgery Facilities, dba QUAD A, for continued recognition as a national accrediting organization for Ambulatory Surgical Centers that wish to participate in the Medicare or Medicaid programs.

DATES: The decision announced in this notice is applicable November 27, 2024, to November 27, 2029.

FOR FURTHER INFORMATION CONTACT:
Erin Imhoff, (410) 786–2337.
Joy Webb, (410) 786–1667.

SUPPLEMENTARY INFORMATION:

I. Background

Ambulatory Surgical Centers (ASCs) are distinct entities that operate exclusively for the purpose of furnishing outpatient surgical services to patients. Under the Medicare program, eligible beneficiaries may receive covered services from an ASC provided certain requirements are met. Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) establishes distinct criteria for a facility seeking designation as an ASC. 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 416 specify the conditions that an ASC must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for ASCs.

Generally, to enter into an agreement, an ASC must first be certified by a State survey agency (SA) as complying with the conditions or requirements set forth in part 416 of our Medicare regulations. Thereafter, the ASC is subject to regular surveys by an SA 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 that provider entity 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. The 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.

QUAD A's current term of approval for its ASC program expires November 27, 2024.

II. Application Approval Process

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 that were not in compliance with the conditions or requirements; and their ability to provide CMS with the necessary data for validation.

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

On June 13, 2024, we published a proposed notice in the **Federal Register** (89 FR 50330), announcing QUAD A's request for continued approval of its Medicare ASC accreditation program. In the June 13, 2024 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 QUAD A's Medicare ASC accreditation application in accordance with the criteria specified by our regulations, which include, but are not limited to the following:

- An administrative review of QUAD A's: (1) corporate policies; (2) financial and human resources available to accomplish the proposed surveys; (3) procedures for training, monitoring, and evaluation of its ASC surveyors; (4) ability to investigate and respond appropriately to complaints against accredited ASCs; and (5) survey review and decision-making process for accreditation.
- The equivalency of QUAD A's standards for ASCs as compared with Medicare's Conditions for Coverage (CfCs) for ASCs.
- QUAD A'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 QUAD A's processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

++ QUAD A's processes and procedures for monitoring an ASC found out of compliance with QUAD A's program requirements. These monitoring procedures are used only when QUAD A 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).

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

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

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

++ QUAD A's capacity to adequately fund required surveys.

++ QUAD A's policies with respect to whether surveys are announced or unannounced, to ensure that surveys are unannounced.

++ QUAD A'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.

++ QUAD A'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).

IV. Analysis of and Responses to Public Comments on the Proposed Notice

In accordance with section 1865(a)(3)(A) of the Act, the June 13, 2024 proposed notice also solicited public comments regarding whether QUAD A's requirements met or exceeded the Medicare CfCs for ASCs. No public comments were received in response to our proposed notice.

V. Provisions of the Final Notice

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

We compared QUAD A's ASC accreditation requirements and survey process with the Medicare CfCs of parts 416, and the survey and certification process requirements of parts 488 and 489. Our review and evaluation of QUAD A's ASC 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, QUAD A has completed revising its standards and certification processes in order to do all of the following:

- Meet the standard's requirements of all of the following regulations:

++ Section 416.40, to ensure that ASCs comply with state licensure requirements.

++ Section 416.44(b)(2), to clarify that an AO may recommend a waiver of specific provisions of the Life Safety Code (LSC), which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.

We also reviewed QUAD A's comparable survey processes, which were conducted as described in section III. of this final notice, and yielded the following areas where, as of the date of this notice, QUAD A has completed revising its survey processes in order to demonstrate that it uses survey processes that are comparable to state survey agency processes by:

++ Updating QUAD A's survey procedures to ensure all areas of the Health Care Facilities Code (HCFC) are surveyed and reflected in QUAD A's policies and surveyor guides.

++ Providing clarification to QUAD A's survey scheduling policies to explain the number of LSC surveyors required for survey teams at small, medium, and large ASCs.

++ Revising QUAD A policy to ensure surveyor qualifications include experience with the LSC and HCFC.

++ Providing additional surveyor training to ensure that LSC deficiency citations contain a sufficient level of detail and quantifiable information comparable to what is required by the CMS Principles of Documentation in Chapter 9 of the State Operations Manual.

++ Providing a process to ensure that any findings on the ASC surveyor infection control worksheet are cited appropriately in the final survey report.

++ Providing a process to ensure the appropriate sample of patient records, including open and closed records, is reviewed during surveys based on the ASC's case volume.

B. Term of Approval

Based on our review described in section III. and section V. of this final notice, we approve QUAD A as a national AO for ASCs that request participation in the Medicare program. The decision announced in this final notice is effective November 27, 2024 through November 27, 2029. In accordance with § 488.5(e)(2)(i) the term of the approval will not exceed 6 years.

VI. 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 Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Vanessa Garcia, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Vanessa Garcia,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3457–FN]

Medicare and Medicaid Programs; Approval of Application by Community Health Accreditation Partner (CHAP) Inc. for Continued CMS-Approval of Its Hospice Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services, HHS.

ACTION: Notice.

SUMMARY: This notice acknowledges the approval of an application by Community Health Accreditation Partner Inc., for continued CMS-approval as a national accrediting organization for its hospice programs that wish to participate in the Medicare or Medicaid programs.

DATES: The decision announced in this notice is applicable November 20, 2024 through November 20, 2029.

FOR FURTHER INFORMATION CONTACT: Lillian Williams, (410) 786–8636. Erin Imhoff, (410) 786–2337.

SUPPLEMENTARY INFORMATION:

I. Background

Under the Medicare program, eligible beneficiaries may receive covered services in a hospice provided certain requirements are met by the hospice. Section 1861(dd) of the Social Security Act (the Act) establishes distinct criteria for facilities seeking designation as a hospice. 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 418 specify the conditions that a hospice must meet in order to participate in the Medicare program, the scope of covered services, and the conditions for Medicare payment for hospices.

Generally, to enter into an agreement, a hospice must first be certified as complying with the conditions set forth in part 418 and recommended to the Centers for Medicare & Medicaid (CMS) for participation by a state survey agency. Thereafter, the hospice is