DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality

Admin Info: 23-02-ALL-AOs

DATE: November 7, 2022

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Guidance for Accrediting Organizations related to Survey Activities for Existing Medicare-Certified Providers and Suppliers

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) has been transitioning certain certification enrollment administrative functions performed by the CMS SOG Locations (formerly CMS Regional Offices) to CMS's Center for Program Integrity (CPI) and its Provider Enrollment Oversight Group (PEOG) and to the Medicare Administrative Contractors (MACs).
- As a result of these transition activities, we have determined that some existing processes, which only apply to those AO programs that have been granted deeming authority by CMS, would also benefit from being aligned with the transition and streamlining.
- CMS is providing updated guidance and procedures related to:
  - Initial AO Surveys for existing Medicare-certified providers and suppliers
  - Removal or Withdrawal of Deeming Status
  - Copying the State Agency (SA) on reaccreditation surveys
- The guidance within this memorandum supersedes any previous instructions provided to the AOs in the AO Resource Manual.

Background and General Overview

Section 1865(a)(1) of the Social Security Act provides that if a provider entity demonstrates through accreditation by a national accrediting organization (AO), CMS will deem the provider entity as having met such requirements, if the AO is recognized as having accreditation standards that meet or exceed the Medicare requirements. Accreditation by an AO with a CMS-approved program is voluntary and is not required for Medicare participation, and facilities may seek deemed status through a CMS-approved AO at any time.

Currently, nine AOs offer CMS-approved accreditation programs for purposes of certifying compliance with Medicare health and safety standards for the following provider/supplier types:

- Ambulatory Surgical Centers (ASCs)
- Critical Access Hospitals (CAHs)
- Hospitals (including Psychiatric hospitals)
- Home Health Agencies (HHAs)
- Hospices

- End-Stage Renal Disease (ESRD) Facilities
- Rural Health Clinics (RHCs); and
- Outpatient Physical Therapy/Speech Pathology (OPT/SP)

To improve the efficiency of the certification and enrollment process for Medicare-participating providers and suppliers, CMS is transitioning certain certification-enrollment functions historically performed by the CMS SOG Locations to CPI/PEOG and the MACs.

The transition started in January 2022 and has included processing instructions for Voluntary Terminations; Changes of Ownership (CHOW); Administrative Changes, also known as Changes of Information (such as address changes, name changes, additional service locations, relocations, etc.), and Initial Certification. The transition includes all the above programs eligible for deeming, except the CAH and RHC programs.

While CAHs and RHCs have not been included in the transition work discussed here, we are providing the guidance below, which applies to all deeming programs, including CAHs and RHCs.

Initial Accreditation/Deemed Status of Programs with a CMS Certification Number (CCN)

For a provider/supplier that is a Medicare-certified facility with a CCN that is seeking deemed status with an AO for the first time or is seeking to change their deemed status from one AO to another AO, the following processes will apply:

1) The Medicare-certified provider/supplier will contact the AO to request deemed status.

2) The AO will notify the appropriate SA that the request was received.

3) The AO will conduct an initial survey of the Medicare-participating provider/supplier and approve or deny accreditation based on their existing processes.

4) If approved, the AO sends its approval letter directly to the SA.

NOTE: An AO may not recommend deemed status for the provider/supplier should the provider/supplier fails to meet the AOs standards of the CMS-approved program. If the existing Medicare-certified facility is not approved by the AO, the AO will communicate their recommendation of denial to the SA and the applicable CMS Location. In these circumstances, the jurisdiction of the existing provider/supplier will remain with the SA. If an existing Medicare-certified facility fails to be recommended for deemed status by another AO (in situations where the provider/supplier is changing from one AO to another AO), the SA must take jurisdiction of that provider/supplier.

5) The SA will update the national database (e.g., ASPEN or iQIES) to reflect the current deemed status if approved by the AO. Facilities with CCNs are immediately matched to facilities already in the national database. AOs will remain responsible for updating ASSURE.

A Medicare-certified provider/supplier with a CCN that is seeking deemed status with an AO for the first time or changing from one AO to another AO, does not require any action from the MAC or CPI/PEOG. Since they are an existing provider/supplier, if approved by the AO, there would be no change in its existing CCN.

Additionally, for these existing providers/suppliers, a plan of correction (PoC) process is applicable since they are participating Medicare providers designated under an initial with CCN.

Facilities withdrawing Deeming Status; Voluntary or Involuntary

The AO will notify the SA about an existing Medicare-certified provider/supplier that is selecting to voluntarily withdraw their accreditation/deemed status from the AO. The SA will update the national database, and the AO will remain responsible for updating the ASSURE database.

For an existing Medicare-certified provider/supplier that has been involuntarily dropped from accreditation/deemed status by the AO (e.g., based on failure to meet the requirements or failure to pay), the AO will notify the SA and the CMS Location. The SA will update the national database (e.g., ASPEN or iQIES), and the AO will remain responsible for updating the ASSURE database.

The SA will take jurisdiction over the existing Medicare-certified provider/supplier in both circumstances.

Reaccreditation Surveys

For an AO conducting reaccreditation surveys, the AO must copy the SA on their notification letters or email notices to CMS for accreditation renewals. The AO must provide the accreditation status (full accreditation or denial of accreditation) of deemed facilities to the SA. The SA will ensure the national database is updated to reflect the correct AO and effective date of the AO action.

Training

CMS will provide an overview of this process to all AOs. The CMS Locations will provide guidance and assistance to SAs unfamiliar with updating processes in the national database.

Contacts

Contact information for SAs and AOs is available on the Quality, Safety & Oversight Group (QSOG) website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc

For questions or concerns about this memorandum, please contact the following mailbox: QSOG_Certification@cms.hhs.gov.

Effective Date: The effective date of this process will commence on November 7, 2022. This information should be communicated to all survey and certification staff, their managers, and the State/CMS Location training coordinators within 30 days of this memorandum.

/s/

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