TABLE 1 TO § 488.2—Continued

Section	Subject
1832(a)(2)(F)	Requirements for ambulatory surgical centers (ASCs).
1832(a)(2)(J)	Requirements for partial hospitalization services provided by community mental health centers (CMHCs).
1861(e)	Requirements for hospitals.
1861(f)	Requirements for psychiatric hospitals.
1861(m)	Requirements for Home Health Services.
1861(o)	Requirements for Home Health Agencies.
1861(p)(4)	Requirements for rehabilitation agencies.
1861(z)	Institutional planning standards that hospitals and SNFs must meet.
1861(aa)	Requirements for rural health clinics (RHCs) and federally qualified health centers (FQHCs).
1861(cc)(2)	Requirements for comprehensive outpatient rehabilitation facilities (CORFs).
1861(dd)	Requirements for hospices.
1861(ee)	Discharge planning guidelines for hospitals.
1861(ff)(3)(A)	Requirements for CMHCs.
1861(ss)(2)	Accreditation of religious nonmedical health care institutions.
1861(kkk)	Requirements for rural emergency hospitals (REHs).
1863	Consultation with state agencies, accrediting bodies, and other organizations to develop conditions of participation, conditions for coverage, conditions for certification, and requirements for providers or suppliers.
1864	Use of State survey agencies.
1865	Effect of accreditation.
1875(b)	Requirements for performance review of CMS-approved accreditation programs.
1880	Requirements for hospitals and SNFs of the Indian Health Service.
1881	Requirements for end stage renal disease (ESRD) facilities.
1883	Requirements for hospitals that furnish extended care services.
1891	Conditions of participation for home health agencies; home health quality.
1902	Requirements for participation in the Medicaid program.
1913	Medicaid requirements for hospitals that provide nursing facility (NF) care.
1919	Medicaid requirements for NFs.

[88 FR 59335, Aug. 28, 2023]

§ 488.3 Conditions of participation, conditions for coverage, conditions for certification and long term care requirements.

(a) *Basic rules.* To be approved for participation in, or coverage under, the Medicare program, a prospective provider or supplier must meet the following:

(1) Meet the applicable statutory definitions in section 1138(b), 1819, 1820, 1832(a)(2)(C), 1832(a)(2)(F), 1832(a)(2)(J), 1834(e), 1861, 1881, 1883, 1891, 1913 or 1919 of the Act.

(2) Be in compliance with the applicable conditions, certification requirements, or long term care requirements prescribed in part 405 subparts U or X, part 410 subpart E, part 416, part 418 subpart C, parts 482 through 486, part 491 subpart A, or part 494 of this chapter.

(b) *Special conditions.* The Secretary shall consult with state agencies and national AOs, as applicable, to develop CoP, CfC, conditions for certification and long term care requirements.

(1) The Secretary may, at a state's request, approve health and safety requirements for providers or suppliers in the state that exceed Medicare program requirements.

(2) If a state or political subdivision imposes requirements on institutions (that exceed the Medicare program requirements) as a condition for the purchase of health services under a state Medicaid plan approved under title XIX of the Act, (or if Guam, Puerto Rico, or the Virgin Islands does so under a state plan for Old Age Assistance under title I of the Act, or for Aid to the Aged, Blind, and Disabled under the original title XVI of the Act), the Secretary imposes similar requirements as a condition for payment under Medicare in that state or political subdivision.

[80 FR 29835, May 22, 2015]

§ 488.4 General rules for a CMS-approved accreditation program for providers and suppliers.

(a) The following requirements apply when a national accrediting organization has applied for CMS approval of a provider or supplier accreditation program and CMS has found that the program provides reasonable assurance for

providers or suppliers accredited under the program:

(1) When a provider or supplier demonstrates full compliance with all of the accreditation program requirements of the accrediting organization's CMS-approved accreditation program, the accrediting organization may recommend that CMS grant deemed status to the provider or supplier.

(2) CMS may deem the provider or supplier, excluding kidney transplant centers within a hospital and ESRD facilities, to be in compliance with the applicable Medicare conditions or requirements. The deemed status provider or supplier is subject to validation surveys as provided at § 488.9.

(b) [Reserved]

[80 FR 29835, May 22, 2015]

§ 488.5 Application and re-application procedures for national accrediting organizations.

(a) *Information submitted with application.* A national accrediting organization applying to CMS for approval or re-approval of an accreditation program under § 488.4 must furnish CMS with all of the following information and materials to demonstrate that the program provides reasonable assurance that the entities accredited under the program meet or exceed the applicable Medicare conditions or requirements. This information must include the following:

(1) Documentation that demonstrates the organization meets the definition of a ''national accrediting organization'' under § 488.1 as it relates to the accreditation program.

(2) The type of provider or supplier accreditation program for which the organization is requesting approval or re-approval.

(3) A detailed crosswalk (in table format) that identifies, for each of the applicable Medicare conditions or requirements, the exact language of the organization's comparable accreditation requirements and standards.

(4) A detailed description of the organization's survey process to confirm that a provider or supplier meets or exceeds the Medicare program requirements. This description must include all of the following information:

(i) Frequency of surveys performed and an agreement by the organization to re-survey every accredited provider or supplier, through unannounced surveys, no later than 36 months after the prior accreditation effective date, including an explanation of how the accrediting organization will maintain the schedule it proposes. If there is a statutorily-mandated survey interval of less than 36 months, the organization must indicate how it will adhere to the statutory schedule.

(ii) Documentation demonstrating the comparability of the organization's survey process and surveyor guidance to those required for state survey agencies conducting federal Medicare surveys for the same provider or supplier type, in accordance with the applicable requirements or conditions of participation or conditions for coverage or certification.

(iii) Copies of the organization's survey forms, guidelines, and instructions to surveyors.

(iv) Documentation demonstrating that the organization's survey reports identify, for each finding of non-compliance with accreditation standards, the comparable Medicare CoP, CfC, conditions for certification, or requirements.

(v) Description of the organization's accreditation survey review process.

(vi) Description of the organization's procedures and timelines for notifying surveyed facilities of non-compliance with the accreditation program's standards.

(vii) Description of the organization's procedures and timelines for monitoring the provider's or supplier's correction of identified non-compliance with the accreditation program's standards.

(viii) A statement acknowledging that, as a condition for CMS approval of a national accrediting organization's accreditation program, the organization agrees to provide CMS with information extracted from each accreditation survey for a specified provider or supplier as part of its data submissions required under paragraph (a)(11)(ii) of this section, a copy of all survey reports and related information for applicants seeking initial participation in Medicare, and, upon request from CMS,