

## Hospital Oversight in Medicare: Accreditation and Deeming Authority

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**OVERVIEW** — *To be eligible to receive payment from Medicare, hospitals must be certified to meet certain conditions. Hospitals may gain such credentials by choosing to be reviewed by a state certification agency under contract to the Centers for Medicare & Medicaid Services or to be accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. This issue brief looks at how accreditation of hospitals developed and how it continues to change. It considers the legal and practical reasons that a majority of hospitals choose accreditation and why some hospitals do not, along with broader consideration of the extent to which accreditation may be judged of value to Medicare beneficiaries. The intersection of state and federal oversight responsibilities and the role of accrediting organizations in hospital quality improvement also are examined.*

# Hospital Oversight in Medicare: Accreditation and Deeming Authority

Accreditation is a recognized stamp of approval for many institutions in the United States, including colleges and universities, social service agencies, and health care plans and providers. Achieving such recognition adds luster to an institution's image and may be a point of professional pride for employees. Accreditation may bring distinction in the form of dollars as well as favorable opinion. It may make a health plan more attractive to potential purchasers; large employers in particular may insist that the plans with which they do business be accredited. Accrediting organizations maintain that because the review process encourages institutions to improve quality, accreditation can be used as a means to maintain high standards in health care delivery.

In some instances, accreditation status may be seen as a prerequisite to, or an advantage in, doing business with key customers. Hospitals, for example, use accreditation to become providers in the Medicare program.

To receive payment from Medicare, health care providers must meet certain statutory requirements and comply with regulations established by the secretary of the Department of Health and Human Services (DHHS). Hospitals can qualify for reimbursement in three ways: they may seek accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), they may seek accreditation from the American Osteopathic Association (AOA), or they may apply to the Centers for Medicare and Medicaid Services (CMS) for a review to determine whether they satisfy Medicare's Conditions of Participation (CoP) for hospitals. (These reviews are actually carried out by state agencies under contract with CMS.) Those hospitals accredited by JCAHO or AOA are deemed to fulfill the Medicare CoPs.<sup>1</sup>

JCAHO's hospital deeming authority was written into law when Medicare was created in 1965. Several other approved accrediting organizations, including AOA, were subsequently granted deeming authority for specified Medicare facilities or services by CMS. For example, the Community Health Accreditation Program (CHAP) accredits home health agencies and hospices. The areas covered by the Accreditation Association for Ambulatory Health Care and the Commission on Accreditation of Rehabilitation Facilities are implicit in their names. Other accreditors have deeming authorities that are more specialized, such as those of the American Society for Histocompatibility and Immunogenics

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or the American Association of Blood Banks. Several organizations have deeming authority for clinical laboratories. With the partial exception of JCAHO, all of these organizations must be re-approved at regular intervals by CMS in order to maintain deeming authority. (JCAHO's non-hospital deeming authorities—for clinical laboratories, ambulatory care, home health care, critical access hospitals, health care networks, Medicare Advantage plans, and ambulatory surgical centers—are also subject to CMS review.)

The concept of deeming authority is not universally endorsed. Critics periodically call on both federal and state governments to exert more direct control over patient safety and quality of care, rather than delegating responsibility to accrediting organizations. Nelson Sabatini, Maryland's then-secretary of health and mental hygiene, expostulated in 2004 that the federal government and many state governments have turned over their authority to private-sector organizations, which he believes to have "uncomfortably close ties to the industry they survey."<sup>2</sup> (His comment was prompted by state surveyors' findings of significant errors on the part of a lab accredited by the College of American Pathologists.) In the latest of a series of reports, the Government Accountability Office (GAO) reaffirmed that CMS needs additional authority for adequate oversight of patient safety in hospitals.<sup>3</sup>

This issue brief reviews the development of hospital accreditation, policy issues in the current process, and proposals for change. It looks at the factors that influence a hospital's decision to pursue or bypass accreditation. It also examines possible conflicts of interest that accrediting organizations may encounter.

## THE DEVELOPMENT OF STANDARDS FOR HOSPITALS

Private, voluntary efforts to improve the quality of care in hospitals by setting minimum, and later more ambitious, standards began with the American College of Surgeons (ACS) in the early 20th century (Figure 1, next page). The organization's founders made hospital standardization one of their founding principles, and in 1918 established five requirements that comprised a Minimum Standard for acceptable hospital operation. The requirements were structural in nature; for example, a hospital had to have an organized medical staff of licensed medical school graduates, who together would develop policies and rules to govern the hospital's work. Although such standards may not seem groundbreaking, the ACS estimated that between 1918 and 1935, the percentage of hospitals that met the requirements increased from 20 to 90.<sup>4</sup>

The ACS accredited hospitals for several decades, supplementing the Minimum Standard with additional requirements as time went on. Eventually, ACS leaders decided the accrediting burden should be shared more broadly, and they joined with the American Medical Association (AMA), the American Hospital Association (AHA), and the American College of Physicians to

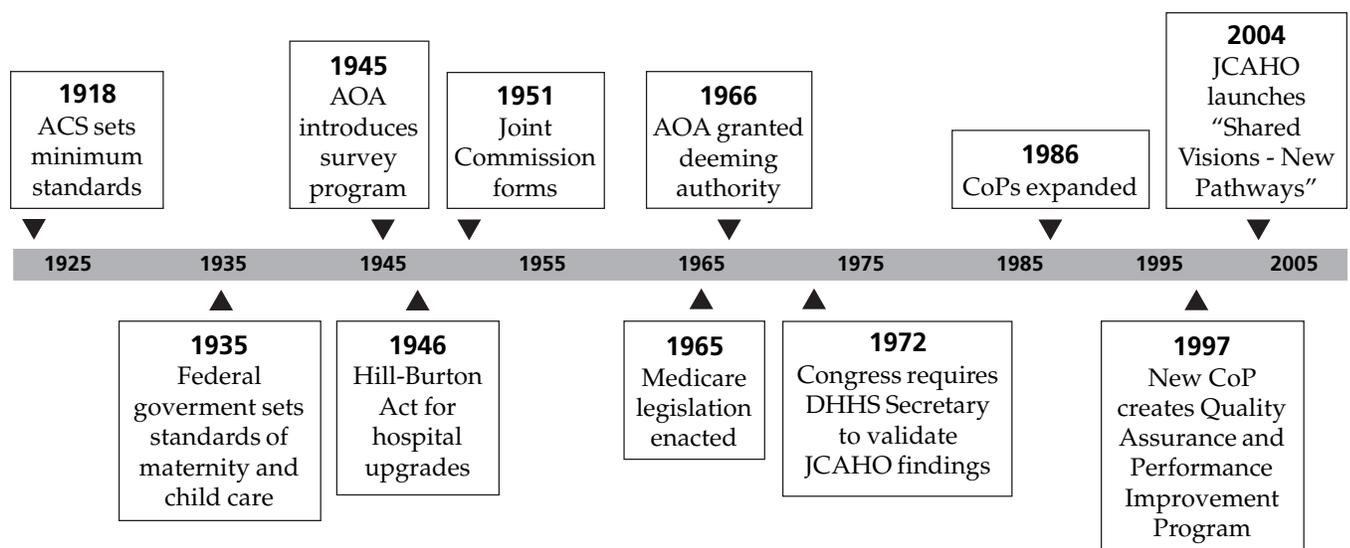
**The concept of deeming authority is not universally endorsed.**

form the Joint Commission on Accreditation of Hospitals in 1951. (The organization later changed “hospitals” to “healthcare organizations”; to avoid confusion, this paper henceforth will use the current acronym, JCAHO.) The American Dental Association (ADA) was added as a sponsor in 1979. In a separate process beginning in 1945—and thus preceding all but the ACS—the AOA introduced a survey program to monitor the quality of care in hospitals providing postdoctoral training for osteopathic physicians.

Governments took small steps to enter the quality arena, but this was a slow process. Most states did not institute hospital licensing until the 1950s. Standards for maternity and children’s services were established at the federal level in 1935. One of the conditions for receiving funds provided under the 1946 Hill-Burton Act for hospital upgrades after World War II was that a hospital establish minimum standards for maintaining and operating the buildings on which these funds would be spent.

The federal government’s role grew considerably with the enactment of Medicare legislation in 1965. The new law authorized the secretary of the Department of Health, Education, and Welfare (now DHHS) to promulgate certain minimum requirements for hospitals, which became the Conditions of Participation. The law required hospitals wishing to participate in the program to undergo a federal regulatory review to certify that they satisfied these conditions. Alternatively, they could be deemed eligible to participate if accredited by JCAHO. The JCAHO standards, in fact, became the original Conditions of Participation. (At that time, JCAHO was already accrediting approximately 60 percent of the nation’s hospitals, and legislators are reported to have assured the hospital community that hospitals meeting JCAHO standards would automatically be eligible for Medicare

**FIGURE 1**  
**Highlights of Hospital Standards Development**



participation.<sup>5</sup>) To get the new Medicare program up and running, and delivering promised benefits, it was advantageous to have as many hospitals as possible approved as participants. In 1966, the AOA was granted deeming authority on a par with that of JCAHO, although AOA's authority was granted by regulation rather than statute.

The original CoPs—16 Conditions broken down into about 100 standards, again emphasizing structure rather than process—actually stood without significant change for 20 years. The agency then known as the Health Care Financing Administration, or HCFA (now the Centers for Medicare & Medicaid Services, or CMS), proposed revisions during the 1970s, but they were never finalized. In the deregulation boom of the Reagan administration, less prescriptive but broader CoPs were adopted, taking effect in 1986. New Conditions included infection control, surgical and anesthesia services, and quality assurance (QA). The latter required a hospital to develop and implement an ongoing, hospital-wide QA program to monitor and evaluate the quality of patient care.

In 1997, CMS issued a final rule on a new CoP that expanded the QA concept by requiring hospitals to develop and maintain a Quality Assessment and Performance Improvement (QAPI) program. The rule stated that a QAPI is not intended to measure a hospital's quality, but it is a minimum requirement that a hospital systematically examine its quality and implement specific improvement projects on an ongoing basis.<sup>6</sup> This change mirrored a general shift in quality philosophy, a movement from "if you find something wrong, fix it" to "strive continuously and methodically to improve."

CoPs were originally minimum standards, that is, statements of what a hospital must do or have in order to make quality care *possible*. They did not guarantee that quality care was, in fact, present. This was the state of the art in 1965, when the CoPs and JCAHO standards were equivalent. In succeeding years, accrediting organizations moved in the direction of performance standards, that is, what a hospital should do and have in order to make the delivery of quality care *likely*. A full-scale revision of the CoPs, which would have incorporated performance standards, was proposed in 1997 but never finalized. JCAHO is currently exploring processes to promote continuous compliance with quality and safety requirements.

## THE SURVEY PROCESS

A hospital seeking JCAHO accreditation must undergo an on-site survey by a JCAHO-trained and -certified team every three years. As JCAHO puts it, "The purpose of the survey is not only to evaluate the hospital, but to provide education and guidance that will help staff continue to improve the hospital's performance."<sup>7</sup> The survey includes meetings with senior management and selected caregivers, medical record review, and an inspection tour of the hospital building. As of 2004, it also includes

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methodology for evaluating actual care processes, an approach JCAHO calls "Shared Visions - New Pathways." As part of the new model, surveyors follow selected patients' paths from service to service through the hospital, in real time if possible, or retrospectively. In these "tracer" studies, surveyors try to speak to the actual patient about his/her experience in addition to getting the caregiver perspective. Surveyors also analyze key operational systems (such as anesthesia or information management) that support patient care and affect its quality. Established guidelines assist the survey team in assessing compliance with standards in the CoPs. The new survey model also obligates all facilities to conduct and report a self-assessment between surveys; currently, self-assessments are done at the halfway point of the three-year cycle but, beginning in 2006, they will be required annually.

The AOA survey process is similar; it also involves a team meeting with hospital personnel, examination of medical records, and inspection of the building. Thirty-eight percent of AOA's standards are tightly keyed to the Medicare CoPs; the remainder are additional quality requirements imposed by the organization. As one manager of an AOA-accredited hospital said, "Their process is very linear. You can tell exactly which person or department should be responsible for each piece."<sup>8</sup>

Both of the accrediting organizations issue final reports with graded ratings. Accreditation does not become effective until deficiencies are dealt with. JCAHO hospitals must address requirements for improvement within 45 days before accreditation becomes effective. Failure to do so puts a facility into provisional and then conditional status, and ultimately leads to denial of accreditation. AOA hospitals must correct cited deficiencies within 30 or 60 days, depending on their severity. If correction necessarily will take longer—for example, if a new sprinkler system must be installed—the hospital's board of directors must acknowledge responsibility to complete the effort. JCAHO recently instituted an interim report requirement for all its hospitals, and AOA requires interim reports from facilities accredited for fewer than three years.

A frequent criticism of the survey process has been that surveys are scheduled in advance, giving facilities ample time to put on their best face for surveyors. Both JCAHO and AOA have responded that their surveyors are sufficiently well-trained to spot a cover-up, and that hospitals are more interested in solving their problems than concealing them. However, both organizations will implement unannounced surveys beginning in 2006.

When a hospital chooses to forego accreditation, it applies to CMS for participation status. CMS authorizes an initial full survey by the appropriate state survey and certification agency<sup>9</sup> and—not incidentally, as discussed later—pays for it. There is no set cycle for surveys thereafter, and, in general, state surveyors are likely to return only to investigate complaints from providers or patients.

## FEDERAL OVERSIGHT

Originally, JCAHO's deeming authority was absolute, but this almost immediately drew objections. Critics said some standards were too low to be meaningful. Others said surveys were too infrequent and focused too much on medical staff issues. Some hospitals were given provisional accreditation despite public clamor about their problems. Lawsuits arose over whether HCFA could legitimately delegate its responsibility. Legislation was introduced to establish a federal accreditation commission.<sup>10</sup>

In 1972, Congress responded by giving the secretary of DHHS the authority to establish higher standards than JCAHO's, to conduct surveys in a random sample of JCAHO-accredited hospitals each year (called "validation" surveys), to investigate complaints about accredited hospitals, and to withdraw deemed status from accredited hospitals found out of compliance with CoPs. The secretary also has the authority to terminate hospitals from the Medicare program entirely, but this rarely, if ever, happens.

Today, validation surveys are conducted on approximately 1 percent of accredited hospitals, randomly selected. Their purpose, to quote from CMS's 2004 report to Congress, is "to determine if the JCAHO accreditation process provides a reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth in subsection 1861(e) of the [Social Security] Act for participation in the Medicare program as hospitals."<sup>11</sup> To conduct these surveys, CMS contracts with a state survey and certification agency, which sends a team to evaluate the specified hospital within 60 days of the JCAHO survey.

Validation surveys may be a more taxing experience than accreditation surveys. One hospital executive reported, "Our JCAHO survey involved three surveyors and was completed in three days. The Medicare [follow-up] survey involved nine surveyors and spanned over five days."<sup>12</sup>

Any facility accredited by an organization with deeming authority is theoretically subject to validation surveys. However, none but JCAHO's accredited facilities are numerous enough to generate a significant sample—for example, AOA's list of accredited hospitals numbers 139—so surveys are not actually ordered.

In fiscal year (FY) 2003, the most recent for which data are available, 71 validation surveys were performed, all in JCAHO hospitals. Of these, 57 were full "look-behind" surveys of accreditations recently granted, as described. The remaining 14 were a pilot test of a new "mid-cycle" survey, intended to determine whether a hospital well into its three-year cycle of review has corrected the deficiencies cited during its most recent JCAHO survey and to evaluate the hospital's ability to remain in compliance with Medicare requirements between JCAHO surveys.

In FY 2003, 23 of the 71 hospitals (32 percent) were found to be out of compliance with one or more of the 22 CoPs. (JCAHO points to the reverse

**The secretary of DHHS has the authority to conduct surveys of JCAHO-accredited hospitals.**

statistic, which is that compliance is found for as many as 1,539 CoPs: 71 hospitals times 22 CoPs, minus 23 CoPs not complied with.) The most frequently cited Condition was physical environment. A hospital may have deficiencies of lesser severity (that is, below the Condition level) and still be considered in compliance.

In addition to validation surveys, CMS conducts complaint investigations. If CMS believes, on the basis of a complaint, that a hospital may have a CoP out of compliance, CMS will authorize the state agency to perform an "allegation" survey. State agencies may also receive complaints and undertake their own surveys on the basis of state law.

In an allegation survey, surveyors do not look at the whole hospital; they review only Condition(s) about which the complaint was made. They are, however, permitted to investigate if they find reason to believe another Condition may be out of compliance. Allegation surveys are more common than validation surveys. In FY 2003, CMS conducted 3,645 allegation surveys in JCAHO hospitals and another 294 in nonaccredited hospitals, finding 18 (0.49 percent) and 24 (8.16 percent), respectively, out of compliance. Here, the most common Conditions cited were nursing services and patients' rights.

An out-of-compliance hospital becomes subject to CMS enforcement. Where there is immediate risk of harm to patients, the hospital has 23 days to correct the problem or face termination of Medicare eligibility. For a less serious deficiency, the correction period may be as long as 90 days. During this period, deemed status is removed and the state assumes oversight responsibility until the organization becomes compliant again.

## CHOOSING ACCREDITATION (OR NOT)

Accreditation is voluntary. It is one, but not the only, route to Medicare participation. What factors influence a hospital's decision to seek accreditation or forego it?

Accreditation connotes something more than fulfilling minimum conditions. As Webster defines it, to accredit is "to put (as by common consent) into a reputable or outstanding category; consider, recognize, or acclaim as rightfully possessing uncontested status." Accreditation may be advantageous in a hospital's marketing to consumers and in negotiating with health plans. In many markets, accreditation is the "done thing," a competitive necessity. To obtain approval of a residency program, a hospital must be JCAHO-accredited. Some hospitals cite accreditation as a factor in access to capital markets. Others caution that, should bad news about the hospital be made public, one of the first questions from the media likely will be about the facility's accreditation status.

Many states, following the federal lead, deem JCAHO-accredited hospitals to meet state licensure requirements. This is in part a reflection of resources, because state agencies' surveying capacity is largely given over

to nursing homes, which are more numerous than hospitals and for which there is no deeming authority.

Quality improvement protocols under the aegis of an accrediting organization (discussed below) may be an attraction to hospital administrators. Certainly hospitals have their own internal quality assurance and quality improvement efforts, but many wish to seek external validation of their efforts. One hospital official explained, "We want the accountability of a regular external review, which our state agency cannot provide."<sup>13</sup>

By far, the bulk of the nation's hospitals choose an accreditation program (Figure 2). In the most recent figures available (2003), the American Hospital Association reports that, of 5,585 hospitals, 4,671 were accredited (more than 80 percent by JCAHO), leaving 914 unaccredited.<sup>14</sup>

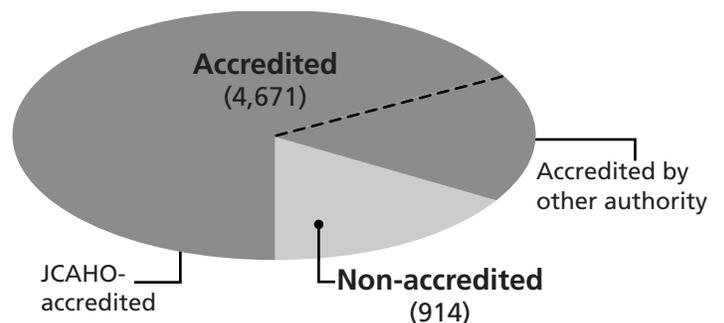
Those who do not seek accreditation tend to be located in sparsely populated areas, particularly in the middle part of the country.<sup>15</sup> When surveyed by Michelle Brasure and colleagues, administrators of unaccredited rural hospitals overwhelmingly cited cost as their primary reason for eschewing accreditation. (JCAHO survey costs for the three-year period beginning in 2005 are \$6,250 for a small hospital and an average of \$26,000 for a large, full-service hospital.<sup>16</sup> AOA does not publicize its survey costs.) Other reasons commonly cited were: there was no value to accreditation in the hospital's market; JCAHO's standards were unrealistic for a small rural hospital; the hospital was surveyed enough by the states, CMS (HCFA, at the time), or insurers; the hospitals had fears related to public release of information or legal discoverability (that is, making hospital information subject to subpoena once documented).<sup>17</sup>

## ACCREDITATION AND QUALITY IMPROVEMENT

As previously noted, a QAPI requirement was added to the CoPs in 1997. CMS has since pursued other quality improvement initiatives, but not as part of the CoPs. The agency contracts with Quality Improvement Organizations (QIOs)—one contract per state—for a broad range of quality improvement activities, some new and some dating back to the QIOs' previous designation as Peer Review Organizations (PROs). Today, QIOs provide assistance to hospitals (as well as other providers, such as nursing homes and home health agencies) undertaking patient safety and care delivery improvements, as well as counsel in collecting and reporting quality data. They played a key role in the voluntary public reporting initiative now known as the National Hospital Quality Alliance.<sup>18</sup>

Beginning in the 1980s, but really gaining momentum in the 1990s, was the shift in accreditation philosophy from a review of structural standards to a

**FIGURE 2**  
Number of Hospitals in the United States, by Accreditation, 2003



Source: American Hospital Association

focus on performance measurement and processes of care. JCAHO has continued to refine its performance measurement and quality improvement programs. For example, its ORYX initiative, long in the planning, was incorporated into the accreditation process in 1998. This program requires hospitals to collect quality data based on the performance measures in the ORYX database. Each hospital selects measurement sets on which to report from nationally standardized “core” measurement sets (for acute myocardial infarction, heart failure, pneumonia, and pregnancy and related conditions), which are also a focus of the survey process. Results are reported to JCAHO quarterly and become an element (called the National Quality Improvement Goals) of its public quality reporting system, Quality Check, which rates JCAHO-accredited facilities.

National Patient Safety Goal measures are another Quality Check element, as well as part of the accreditation survey process. These are designed to help a hospital or other facility avoid problems associated with misidentification of patients, wrong-site surgery, miscommunication among caregivers, medication mix-ups, and the like. Kelly J. Devers and colleagues found that Community Tracking Study data and on-site interviews indicated that hospitals’ major patient safety initiatives are primarily intended to meet JCAHO requirements.<sup>19</sup>

JCAHO has worked—and continues to work—with CMS, the National Quality Forum (a group which endorses consensus-based national standards for performance measurement and reporting), the Leapfrog Group (made up of health care purchasers pushing for quality improvement), and others. JCAHO measures were adopted for CMS’s National Health Quality Alliance hospital quality reporting project. In September 2004, CMS and JCAHO jointly issued a technical manual for hospital quality measures that provides common definitions for each of the quality measures that are being collected and reported to both the agency and the accreditor; future measures, it has been agreed, will be identical for the two organizations. JCAHO has also entered into quality improvement projects with QIOs. One notable example is work with the Colorado Foundation for Medical Care (Colorado’s QIO) on performance measures for heart care. Continuing identification and testing of quality measures is part of JCAHO’s vision of its ongoing role.<sup>20</sup>

Hospital leaders have had mixed reactions to JCAHO’s quality improvement agenda and its increasing emphasis on performance measures. One quality manager—who persuaded his institution to switch from JCAHO to AOA—complained that JCAHO surveyors “were continually changing their focus and methodology: even interpretation of standards seemed to vary from visit to visit.”<sup>21</sup> Another chief quality officer said, to the contrary, “The standards are beginning to mirror best practices and proven, evidence-based medicine. JCAHO is trying to partner with hospitals to find ways to achieve [quality] goals together.”<sup>22</sup>

Conemaugh Memorial Medical Center in Pittsburgh was a pilot site for JCAHO’s tracer methodology. Its chief medical officer called the pilot

“among the most rewarding professional experiences I have ever had.” He found the technique so helpful in revealing problems and finding solutions that the hospital will continue to use tracer patients on its own.<sup>23</sup>

AOA has also moved into performance measurement and quality improvement, although it is not considered particularly influential among policymakers. AOA’s Clinical Quality Measurement Program for hospitals tracks CMS’s Hospital Quality Alliance priorities: heart attack, heart failure, and pneumonia.

## ISSUES IN ACCREDITATION AND DEEMING

Discussions and criticisms of deeming authority repeatedly feature a common set of questions.

### ■ To what extent do accrediting organizations answer to the same people they survey?

In part, this is a matter of governance. Most accrediting organizations were founded by health care industry groups who wanted to improve their own profession’s performance. In many cases, this relationship has continued in the form of board memberships. AOA’s board members are all members of the association’s house of delegates. Twenty-one of JCAHO’s 28 board seats are occupied by its corporate members—the founding organizations plus the ADA.<sup>24</sup> The AHA and the AMA have seven votes each. However, accrediting organizations may allot board seats specifically to consumer representatives; JCAHO gives such representatives six seats.

Accreditation generally has roots in a group’s (hospitals, colleges, or others) desire to demonstrate publicly that it holds itself to certain standards. The payment of fees by group members is a common feature of the accreditation construct. Critics find it disturbing that accrediting organizations derive the bulk of their revenue from fees paid by facilities surveyed. To keep the business coming, it is argued, one must not treat these funders too harshly. There have been allegations of catering to the industry, as when JCAHO in early 2004 was accused of “watering down” proposed emergency department overcrowding standards that hospitals found overly demanding.<sup>25</sup> Further, critics point out, JCAHO derives additional revenue from its consulting arm, which helps hospitals to prepare for accreditation surveys and to address quality improvement.

### ■ Do accreditors stress collegiality to the detriment of enforcement?

This was a main theme in a 1999 report by the DHHS Office of the Inspector General, whose authors felt that the pendulum had swung too far toward collegiality. JCAHO maintains that it was never intended to be an enforcer. An AOA spokesman elaborates, explaining, “We can only tell a hospital ‘here’s where you need to improve,’ and give them some tools to do so. We can’t make the corrections for them. But we won’t accredit them until all the corrections are made.”<sup>26</sup>

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There is a divide between those who would help hospitals improve their performance and those who want to cull bad apples. Those of the former persuasion point out that every hospital (or any other kind of organization) is going to make mistakes at some point; trying to close all of them would hardly be practical.

In the discussion of the final QAPI rule, CMS acknowledged this tension, saying, “We stress improvement in systems in order to improve processes and patient outcomes. This is not meant to suggest that we plan to abandon our regulatory authority. In fact, this approach reinforces our primary responsibility for assuring patient safety and protection through our delegated regulatory authority.”<sup>27</sup>

#### ■ Isn't it true that accreditors rarely deny or terminate accreditation?

Most accrediting organizations do not catalog denials on their Web sites or in promotional materials, so this is difficult to gauge. Some JCAHO statistics are available in CMS's annual financial report. In FY 2003, its decisions were as follows:

Decision	No. of Hospitals
Accreditation	320
Accreditation with requirements for improvement	1,191
Conditional accreditation	13
Accreditation denied	0
<b>Total<sup>28</sup></b>	<b>1,524</b>

Seventy-eight percent of decisions involved mandatory improvements, arguably of more benefit to patients than denial of accreditation. JCAHO has since removed this category and withholds accreditation until all required improvements are made. If they are not made, the facility will go from provisional to conditional status, then to preliminary denial of accreditation with a chance for appeal. It has been JCAHO's experience that hospitals rated conditional or preliminarily denied accreditation often withdraw from the process completely and are not counted as denied.

When JCAHO withdrew accreditation for Los Angeles's troubled King-Drew hospital in early 2005, this was only the second such action in the past year and the 13th since 1998.<sup>29</sup> CMS has not terminated the hospital from participation in Medicare.

#### ■ Don't state surveyors “catch” more problems than accreditors?

According to a July 2004 GAO report, in a sample of 500 JCAHO-accredited hospitals, JCAHO failed to identify 123 of the 157 hospitals with serious deficiencies.<sup>30</sup> Most of these had to do with physical environment and fire safety (what is known as the Life Safety Code). JCAHO took strong issue with the findings, raising questions about GAO's methodology and interpretations of standards in a response published as an appendix to the report. CMS also responded, observing, “While we

regard all deficiencies as serious matters, the overall low rate of identified deficiencies relative to the total number of hospitals is an encouraging sign that the overall accreditation process has merit.<sup>31</sup> It might be noted that state surveyors and JCAHO surveyors regard each other as competitors, each wishing to outperform the other.

## A LEVEL PLAYING FIELD?

The GAO report recommended that Congress consider giving CMS the authority over JCAHO's hospital accreditation program that it has over other accreditation programs. As noted above, this would entail a detailed periodic review. Under scrutiny in this process, by regulation, are an accrediting organization's standards (including a comparison of these with the Medicare CoPs); survey process; instructions to surveyors; surveyors' qualifications and training; complaint procedures, and more, with detailed supporting documentation.<sup>32</sup>

On the same day the GAO released its report, Sen. Chuck Grassley (R-IA) and Rep. Pete Stark (D-CA) introduced legislation to strike JCAHO's statutory deeming authority and subject them to the same rules as other accrediting organizations. There was no action on the bill in the 108th Congress, but its sponsors remain interested in the issue.

JCAHO has said publicly that they have no objection to this suggested statutory change, but it objects strongly to the idea of making such a change on the basis of what it calls "flawed study methodology and erroneous, alarming statistics."<sup>33</sup> JCAHO's corporate member organizations and other accrediting organizations have not taken public positions for or against the proposal, although JCAHO's board as a whole has been strongly critical of the GAO report.

JCAHO has suggestions of its own for leveling the playing field. It would like to see the CoPs updated to reflect current practice more closely. It also wonders why state survey and certification agencies, which vary considerably from state to state, are the only evaluators permitted to carry out validation surveys, and why CMS does not attempt to evaluate state surveyors. It proposes that CMS report to Congress on all accrediting organizations (the current report addresses only JCAHO and the multiple accreditors under the Clinical Laboratory Improvement Amendments of 1988).

## FOR FURTHER CONSIDERATION

With their power to affirm compliance with Medicare's CoPs, accrediting organizations collectively serve as gatekeepers to the Medicare trust fund by determining who will be eligible for reimbursement for services provided to Medicare beneficiaries. It is not surprising, therefore, that Congress and CMS want to hold them to a high standard and to exercise some degree of control over them. Whether the current difference between

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JCAHO's deeming authority and that of others should stand is worthy of debate by policymakers.

The questions of collegiality versus enforcement and of what constitutes a level playing field remain to be resolved. It also may be worth asking how much would actually change in JCAHO's standards and methodologies by virtue of having a more direct CMS imprimatur.

The secretary is given the power to grant deeming authority to accreditors of all types of health care facilities except those treating beneficiaries with end-stage renal disease. No organization has applied for deeming authority with respect to nursing homes, perhaps in part because, by statute, these facilities must be surveyed annually. States therefore have all responsibility for this sector and thus must direct most of their resources to it. It is questionable how much more responsibility for hospital surveys could be assumed by states.

Proponents of greater CMS control must take the agency's capacity into account. CMS administrator Mark McClellan has said that the agency will try to increase the percentage of hospitals tapped for validation surveys and refine its sampling and statistical methodologies.<sup>34</sup> He noted that increasing the validation sample size to 5 percent would require additional survey funding, raising annual expenditure from \$2.6 million to \$4.8 million. With CMS resources (both financial and human) already stretched by responsibilities conferred by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, expecting these changes to occur in the near future may not be realistic.

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## ENDNOTES

1. Not included in the blanket deeming are utilization review requirements, psychiatric hospital special conditions, and special requirements for hospital providers of long-term care services.
2. As quoted in "Stiffer Regulatory Oversight Needed for Hospitals, State Official Tells Hill Panel," *BNA Health Care Policy Report*, May 31, 2004, 737.
3. Government Accountability Office (GAO), *CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals*, GAO-04-850, July 2004.
4. Institute of Medicine (IOM), *Medicare: A Strategy for Quality Assurance*, vol. II, Kathleen N. Lohr, ed. (Washington, DC: National Academy Press, 1990), 300.
5. IOM, *Medicare*, 300.
6. *Federal Register*, 68, no. 16, January 24, 2003, 3435.
7. "Facts about Hospital Accreditation," Joint Commission on Accreditation of Healthcare Organizations, November 2004; accessed February 8, 2005, at [www.jcaho.org/htba/hospitals/facts.htm](http://www.jcaho.org/htba/hospitals/facts.htm).
8. Manager of AOA-accredited hospital (anonymity requested), telephone conversation with author, January 18, 2005.
9. For example, in Maryland it is the Department of Health and Mental Hygiene, in Iowa the Department of Inspections and Appeals, etc.

10. IOM, *Medicare*, 305.
11. "CMS Financial Report for Fiscal Year 2004," Centers for Medicare & Medicaid Services; accessed February 8, 2005, at [www.cms.hhs.gov/contractors/cfo/default.asp](http://www.cms.hhs.gov/contractors/cfo/default.asp).
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