

RESEARCH MEMO

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Memo on The Joint Commission

Introduction

The Joint Commission (“TJC”) is one of the leading accreditation organizations for medical facilities in the United States. It holds a virtual monopoly on U.S. accreditation, with an outsized market share.ⁱ As an accreditation organization, its primary function is to voluntarily survey participating medical facilities and/or equipment for compliance with standards it or the government has created, to “ensure” quality of care. To better understand TJC and the accreditation industry, this memorandum will analyze the history of TJC, its controversies, and the current market of medical accreditation.

renamed TJC).ⁱⁱⁱ The Canadian Medical Association left in 1959 to create its own program,^{iv} but the remaining members would form the core of the current commission today.

Within two years, TJC would begin accrediting hospitals and creating standards that emphasize the “optimal achievable” level of care.^v The push towards optimal achievable level of care rather than the “minimum standards,” emphasized by TJC’s predecessors to TJC was twofold. First, most places already achieved minimum standards. Second, higher standards would place TJC as the trendsetter for accreditation.^{vi}

History of the Joint Commission

TJC is Created

While this memo will discuss some of the predecessors to TJC,ⁱⁱ the relevant scope of history begins on December 15, 1951. That day, the American College of Physicians, the American Hospital Association, the American Medical Association, and Canadian Medical Association joined with the American College of Surgeons to create the Joint Commission on Accreditation of Hospitals (later

TJC begins its monopolistic rise

In 1965, Congress passed the Social Security Amendments of 1965 (Medicare and Medicaid Act), which had the collateral effect of helping ensure TJC had monopoly power. Under the Act, Medicare and Medicaid funding would be given to hospitals that were “deemed.”^{vii} It was necessary for a hospital to be deemed to receive funding.^{viii} There were five hospital types: Hospitals, Psychiatric Hospitals, Tuberculosis Hospitals, Extended Care Facilities, and Home Health Agencies.^{ix}

Written into the statute *was* a provision stating that if TJC accredited the hospital, it was deemed to qualify for funding under the statute.^x While this deeming authority was automatic for TJC, other accrediting bodies were to be given deeming authority under the discretion of the Secretary of Health, Education, and Welfare (“HEW”).^{xi} TJC’s statutory “deeming authority” gave it an edge over any potential competitors. Unlike TJC, competitors would have to go through the review process and could have their deeming authority revoked.^{xii} Given the funding at stake and the heightened risk of alternative accrediting bodies for deeming, hospitals may have been further incentivized to hire TJC for accreditation. This allowed TJC—which already established itself and dealt with few competitors—to solidify its market share.

In addition to being deemed, hospitals in states with licensing laws needed to be licensed for funding eligibility.^{xiii} At around the same time that TJC was given deeming authority, state governments would begin to defer to TJC for licensing. In most states, hospitals that were accredited by TJC would meet their licensing survey requirements.^{xiv xv} Thus, TJC accreditation would fulfill both licensing and accreditation requirements under the Medicare and Medicaid Act. This authority given by both states and the federal government could have further incentivized hospitals to become accredited by TJC. TJC’s increased authority was coupled with the relatively little oversight exercised by the Secretary of HEW.^{xvi}

By the 1970s, TJC would expand power vertically and horizontally. TJC would expand vertically by setting a new ceiling for the accreditation process. Previously, under Medicare and Medicaid, the requirements for being deemed a “Hospital” could not be higher than those imposed by TJC.^{xvii} Thus, when TJC set its own standards, it set the functional ceiling for the entire industry—who would

have very little incentive to go beyond what TJC required. In 1970, after seven years of development, TJC published its accreditation manual for hospitals. This manual would become the bible of hospital accreditation. Each standard was another ceiling set by TJC.

Concurrently with vertical power expansion, TJC expanded horizontally by creating new accreditation schemes for other medical industry sectors, especially those that would need to be deemed under Medicare and Medicaid.^{xviii}

Criticisms and Controversies

While TJC grew throughout the 80s, it came under increasing criticism by the late 90s and early 2000s. These criticisms—which are still under contention today—were levied against the TJC’s monopolistic nature and the accreditation process itself. First, while general problems with monopolies^{xix} might be salient, TJC was particularly criticized over its vertical integration practices. For example, in addition to providing the accreditation process, a subsidiary of TJC sells the services of consultants that guide hospitals to attainment and help them keep it.^{xx} This creates a conflict of interest, as TJC is making hospitals pay for both a supposedly neutral test and the resources to pass that test.

Second, TJC’s was criticized by inherent conflict of interest created by hospitals and doctors themselves running the commission. This was and still is criticized as due to the conflict of interest that would provide a very serious incentive for hospitals to maintain lower standards, not discover problems in their surveys, and/or revoke accreditation.^{xxi} TJC’s monopoly power protects this scheme of self-regulation within the market which might otherwise provide increased independent regulation.^{xxii}

Third, there were and still are very serious non-economic criticisms levied against the accreditation process generally and TJC in particular. For instance, TJC almost never refuses to give accreditation to a regulated entity,^{xxiii} and once given accreditation is rarely revoked—even in cases of serious malpractice.^{xxiv}

These critiques may have contributed to TJC competitors being founded and gaining an increased market share. Furthermore, these critiques may have led to certain states either refusing to give TJC licensing privileges or revoking those previously given. Instead, state surveyors began to perform the licensure requirements or have other organizations do so. By 2008, these controversies came to a boiling point, exemplified by the Medicare Improvements for Patients and Providers Act of 2008 (“MIPPA”). MIPPA increased CMS oversight and removed TJC’s statutory deeming authority, allowing CMS to revoke its authority if necessary.^{xxv}

Even with these changes, the practical effect of oversight and accreditation on quality of care is still controversial. Increased CMS oversight does not seem to have fully resolved TJC’s structural deficiencies. The oligopoly/monopoly structure of the accreditation market and the conflicts of interests that may disincentivize problem discovery by TJC may still persist. For example, in the fiscal year 2019^{xxvi} the disparity rate^{xxvii} was 42% for Hospitals, 45% for Psychiatric Hospitals, 67% for Critical Access Hospitals, 6% for Home Health Agencies, 23% for Hospices, and 19% for Ambulatory Surgery Centers.^{xxviii} Moreover, recent studies cast doubt onto the efficacy of the accreditation process as compared to state survey results, and the efficacy of TJC accreditation as compared to competitors.^{xxix}

TJC Competitors

Many of TJC’s private competitors focus on a few areas of accreditation, rather than operating in many different accreditation areas like TJC. Although TJC does have competitors, many of which gained prominence in the early 2000s, it still remains the biggest force in healthcare accreditation both in general market share as well as the comprehensiveness of its accreditation areas.

Furthermore, certain states perform their own surveys and do not defer to TJC, functionally competing with TJC in two ways. First, there is diminished incentive for seeking TJC accreditation in those states because TJC accreditation does not contribute towards licensing. Second, the Centers for Medicare and Medicaid Services (CMS) allows state surveys to fulfill accreditation requirements when deeming a facility eligible for funding.^{xxx}

Private Competitors

American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)

AAAASF now known as Quad A founded in 1980 for the accreditation of outpatient facilities.^{xxxi} CMS granted Quad A deeming status for Ambulatory Surgery Centers (ASC) in 1998, Outpatient Physical Therapy and Speech-Language Pathology Services (OPT) in 2011, and Rural Health Clinics (RHC) in 2012.^{xxxii}

Accreditation Association for Ambulatory Health Care (AAAHC)

AAAHC was formed in 1979 and exclusively focuses on ambulatory healthcare. It gained deeming authority from CMS in 1996 for ASCs.^{xxxiii} AAAHC accredits ambulatory healthcare centers generally, including ASCs, office-based surgery centers, endoscopy centers, and college student health centers,

as well as health plans, such as health maintenance organizations and preferred provider organizations.^{xxxiv}

Accreditation Commission for Health Care (ACHC)

The Accreditation Commission for Health Care was founded in 1986 by home care health providers to create an accreditation option more focused on the needs of small providers.^{xxxv} It gained deeming authority from CMS in 2006 for home health agencies,^{xxxvi} 2007 for durable medical equipment,^{xxxvii} and 2009 for hospices^{xxxviii} and end stage renal disease in 2019.^{xxxix}

American Osteopathic Association (AOA)

The American Osteopathic Association is the representative member organization for the more than 145,000 osteopathic medical doctors and osteopathic medical students in the United States. The AOA accredits osteopathic medical schools. AOA owned HFAP (see below) until October 2015.^{xl}

Commission on Accreditation of Rehabilitation Facilities (CARF)

CARF was founded in 1966^{xli} and received deeming authority from CMS in 2007.^{xlii} CARF has deeming authority for durable medical equipment. They also accredit aging services, behavioral health, medical rehabilitation, opioid treatment programs, and vision rehabilitation services.^{xliii}

Community Health Accreditation Program (CHAP)

The Community Health Accreditation Program was created in 1965 as a joint venture between the American Public Health Association and the National League for Nursing.^{xliv} By 1988, they became a separately incorporated, non-profit subsidiary of NLN. CHAP was granted deeming authority by CMS for home care in 1992^{xlv} and for hospices in 1999.^{xlvi}

Center for Improvement in Healthcare Quality (CIHQ)

CIHQ was established in 1999 and is a membership-based organization composed primarily of acute care and critical access hospitals. It is approved by CMS to deem hospitals.^{xlvii}

The Compliance Team (TCT)

The Compliance Team was founded in Philadelphia in 1994 as a for-profit organization.^{xlviii} They were granted deeming authority by CMS in 2007 for all types of durable medical equipment.^{xlix} They also offer the proprietary "Exemplary Provider" brand of accreditation, which is granted to those healthcare providers who demonstrate what it considers "outstanding patient care practices" and compliance to The Compliance Team's comprehensive Safety-Honesty-Caring® quality standards¹

Det Norske Veritas Healthcare, Inc. (DNV)

DNV was originally founded in Oslo, Norway in 1864.^{li} While originally setting standards for the insurance underwriting of ships, over the past 150 years DNV has expanded to consult in a variety of areas including but not limited to, energy, automotives, and healthcare. DNV received deeming authority from CMS in September 2008 for hospitals and in 2010 for critical access hospitals.^{lii}

Healthcare Facilities Accreditation Program (HFAP)

HFAP was founded as a non-profit in 1943 by the American Osteopathic Association (AOA). HFAP has a wide range of accreditation programs covering hospitals, clinical laboratories, ambulatory surgical centers, office-based surgery, and critical access hospitals. HFAP also provides certification for primary stroke centers and accredits mental health and physical rehabilitation facilities. HFAP received deeming authority from CMS in 1965 and is authorized to survey clinical

laboratories under the Clinical Laboratory Improvement Amendments (CLIA) for the CDC. As of December 2012, it was accrediting 214 hospitals. In 2015, ownership of HFAP transferred from AOA to the Accreditation Association for Hospitals / Health Systems. HFAP would then merge in 2020 with the Accreditation Commission for Health Care, Inc. (ACHC).^{lviii}

Healthcare Quality Association on Accreditation (HQAA)

The HQAA was founded after the Medicare Modernization Act of 2003 and began accepting applications for durable medical equipment accreditation in 2007.^{lviv}

National Commission on Correctional Healthcare

In the 1970s, an American Medical Association (AMA) study of jails found inadequate, disorganized health services and lack of national standards. Between 1975 and 1979, AMA collaborated with other organizations to found a program that would later become the National Commission on Correctional Healthcare. By 1982, the program moved outside the AMA with funding from the Robert Wood Johnson Foundation, the AMA and 21 other organizations named individuals to participate as an advisory body, and the first prison received accreditation from the National Commission. In 1983, the program became an independent, 501(c)(3) non-profit. In 1984, the first juvenile confinement facilities were accredited, and the first CCHP-Advanced examination was given in 1993. The National Commission published its first set of clinical guidelines for correctional health care in 2001.^{lv}

URAC (formerly Utilization Review Accreditation Commission)

In 1990, the Utilization Review Accreditation Commission incorporated in D.C. as a non-

profit. There were three main factors driving the Commission's inception: significant legislation in Maryland seeking to eliminate health plans' ability to conduct utilization review, health plans identifying a need to develop and update standards, and an absence of accrediting bodies addressing utilization review. The Commission developed the country's first Health Utilization Review Standards in 1991, which it released in 1994. The Commission renamed itself URAC in 1996, because it began accrediting other types of organizations, including health plans, pharmacies, and provider organizations. It began offering first-in-the-nation Health Website Accreditation in 2004 and received CMS deeming authority for Medicare Advantage organization accreditation in 2006.^{lvii} URAC received deeming authority for health plan exchange marketplaces in 2012 and for home infusion therapy in 2020.

State Competitors

California

California licenses facilities through its own state surveyors and generally does not accept TJC as a surveyor. However, California may consult outside bodies, including accreditation agencies, in surveying hospitals.^{lviii}

New Jersey

New Jersey has its own state surveyors conduct licensing surveys in place of TJC or any accrediting body.^{lviii}

Oklahoma

Oklahoma requires community mental health centers providing inpatient services,^{lix} psychiatric residential treatment facilities,^{lx} and child/adolescent partial hospitalization psychotherapy programs,^{lxi} to be accredited by one of a list of accrediting bodies that includes TJC. The Oklahoma Department of Mental Health and Substance Abuse Services may

accept accreditation granted by TJC, CARF, COA, or AOA as compliance with certain Department standards.^{lxii} TJC is not otherwise recognized for state licensure. This differentiation corresponds with TJC’s complete monopoly over CMS deeming authority for psychiatric hospitals, discussed below in Part IV.

Pennsylvania

Pennsylvania does not allow TJC to conduct an initial licensing survey. However, it does allow a national accrediting agency—such as TJC—to conduct compliance surveys for previously licensed hospitals.^{lxiii}

Wisconsin

Wisconsin recognizes accreditation through the Public Health Accreditation Board (PHAB).^{lxiv} Wisconsin once had a policy initiative named “Healthiest Wisconsin 2020,” which set a goal that all Wisconsin health departments would be accredited using established national standards by 2020.^{lxv} The “Healthiest Wisconsin 2020” webpage has since been taken down,^{lxvi} and we are unsure to what extent its goal was met. PHAB was founded in 2007 to implement and oversee national accreditation. PHAB’s National public health department accreditation launched Sept. 14, 2011.

CMS Deeming Authority: Competition within Program Types Over Time

The Joint Commission still monopolizes Medicare and Medicaid deeming authority for psychiatric hospitals and dominates the accreditation of hospitals and critical access hospitals. TJC accredits nearly half of hospice care facilities, as well as over a third of home care agencies and ambulatory surgery centers. TJC’s market dominance in these program types has largely remained consistent between fiscal year 2014 and fiscal year 2019, the

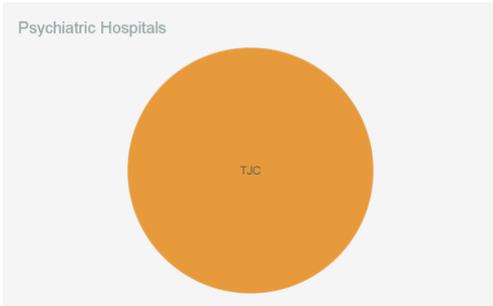
period over which data is publicly available from CMS.^{lxvii}

TJC does not, however, have any presence in outpatient patient therapy and speech-language pathology services (which are monopolized by AAAASF^{lxviii}) and rural health clinics (which were formerly monopolized by AAAASF but have since been overtaken by TCT).

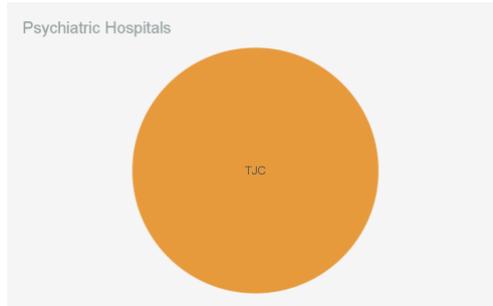
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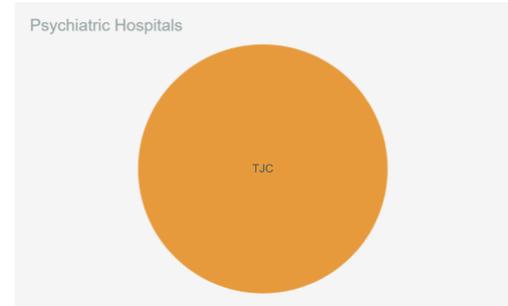
Psychiatric Hospitals



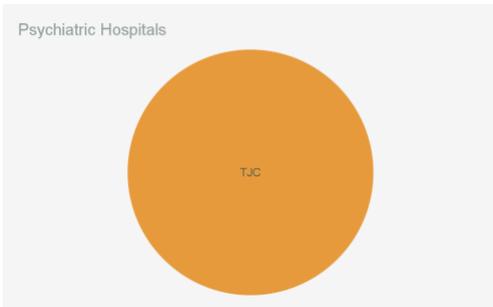
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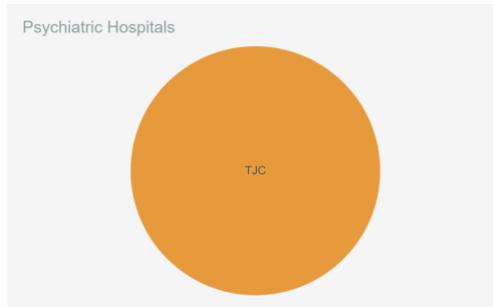
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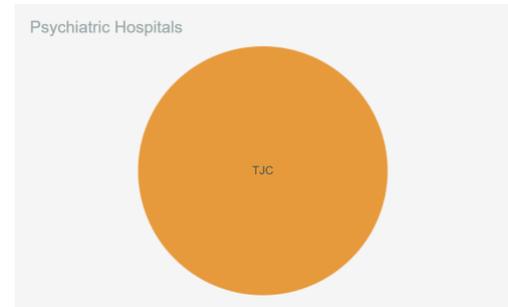
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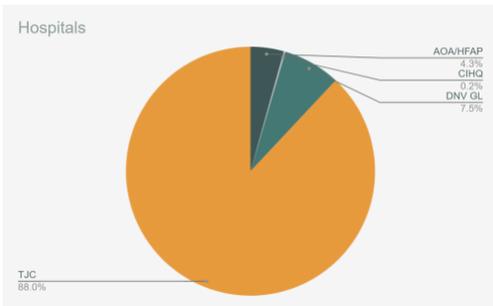


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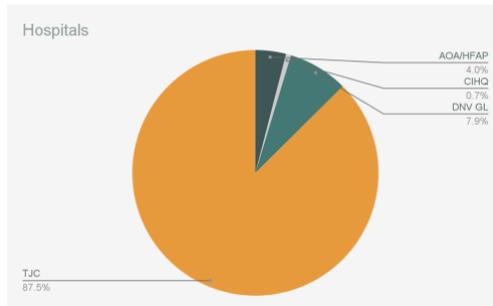


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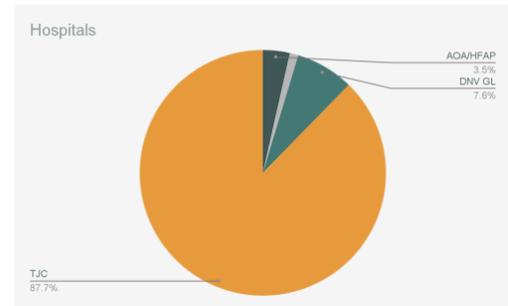
Hospitals



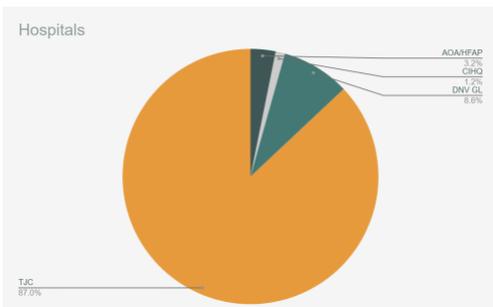
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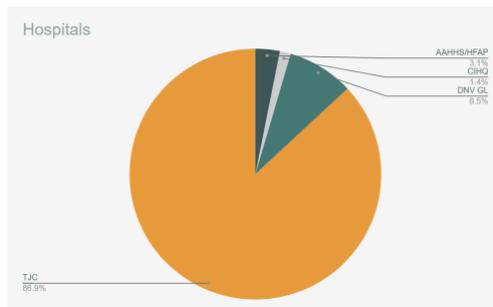
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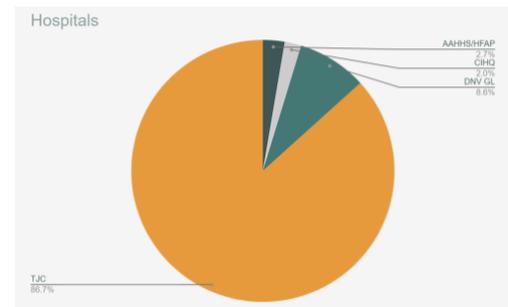
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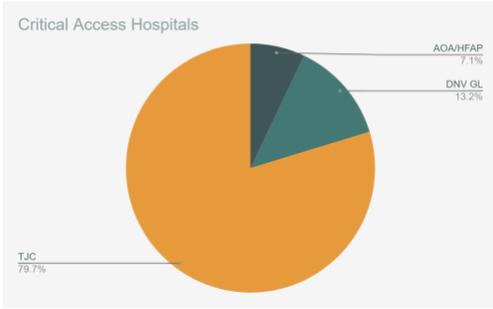


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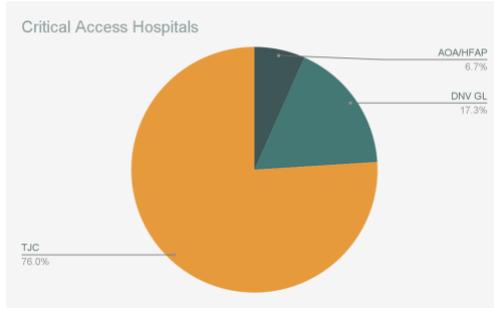


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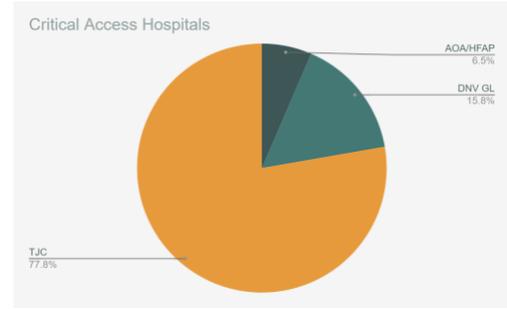
Critical Access Hospitals



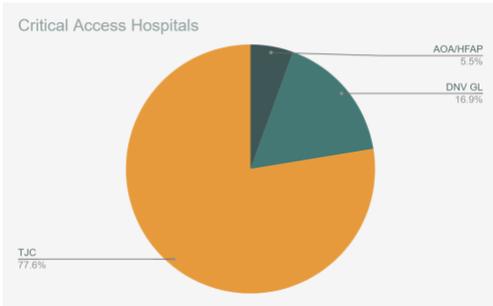
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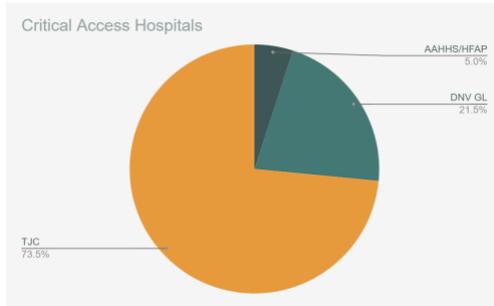
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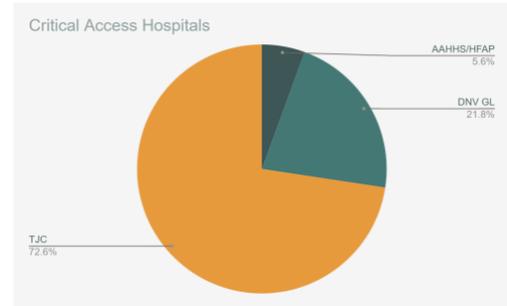
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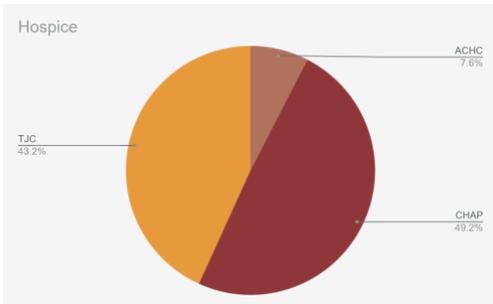


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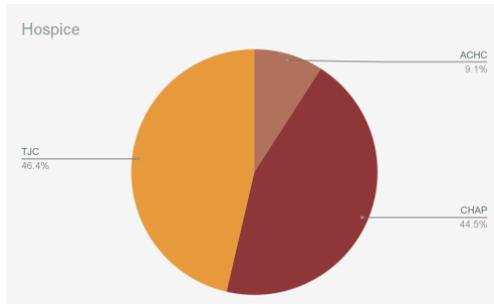


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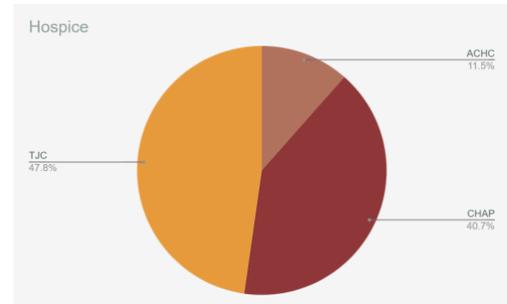
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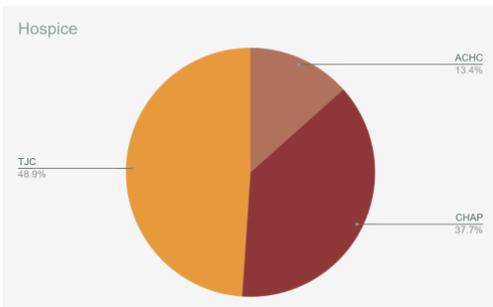
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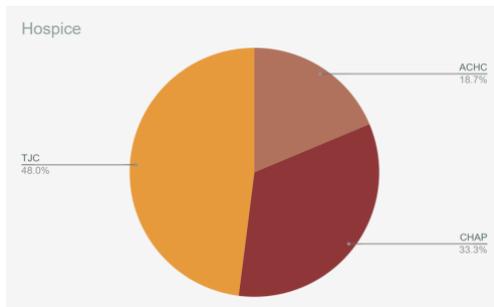
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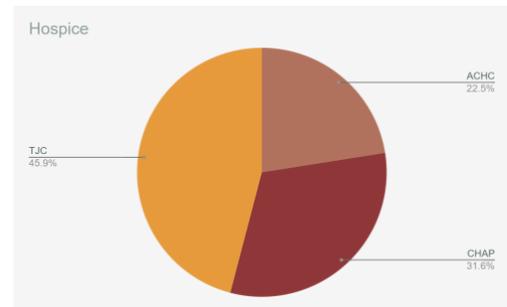
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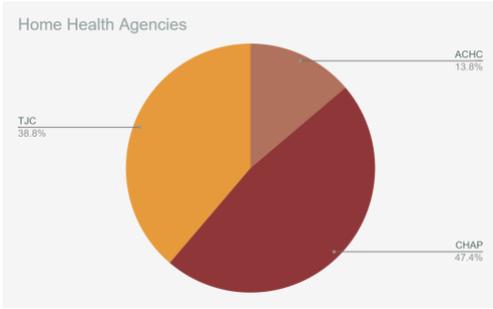


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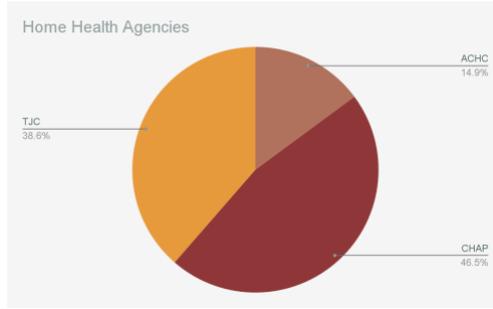


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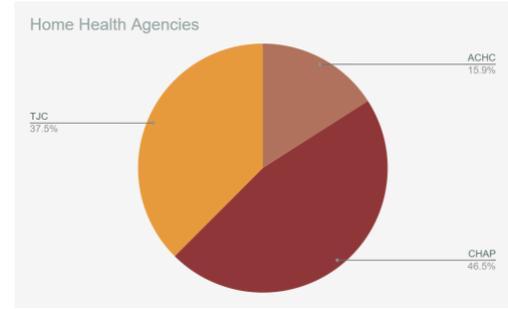
Home Health Agencies



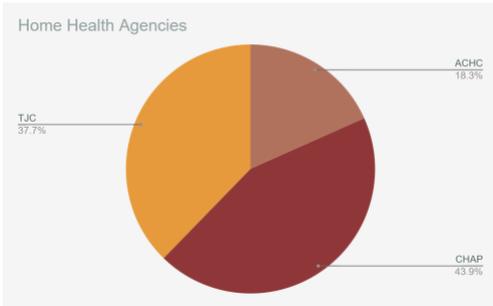
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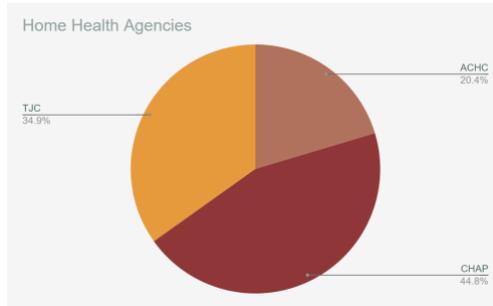
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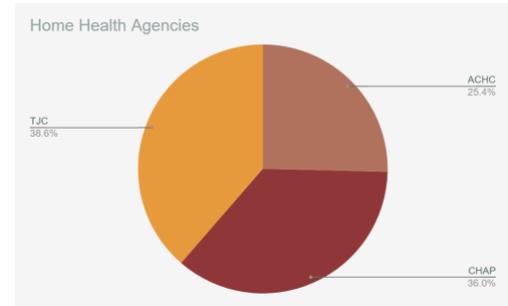
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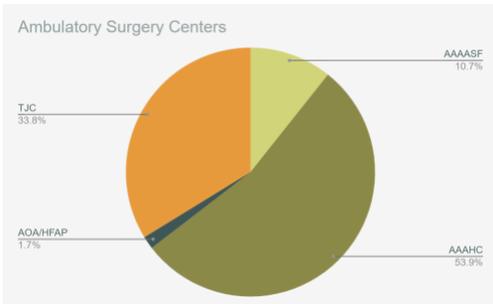


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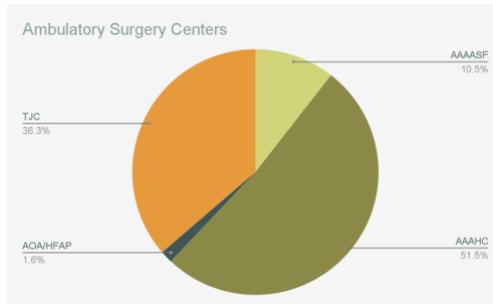


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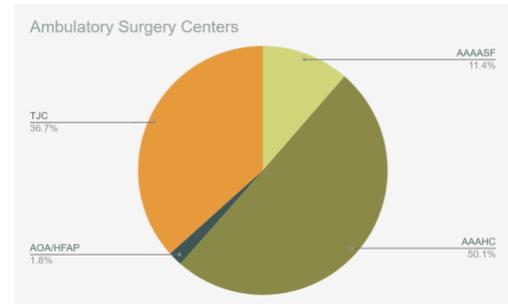
Ambulatory Surgery Centers



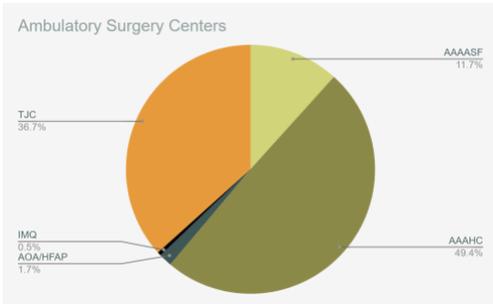
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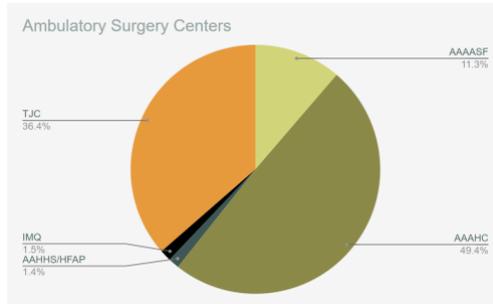
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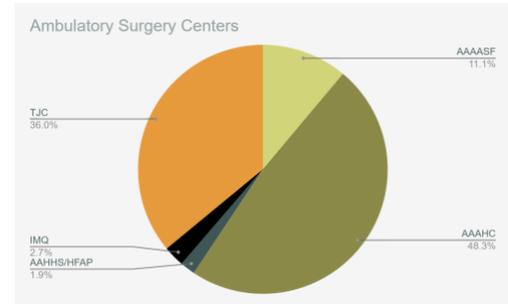
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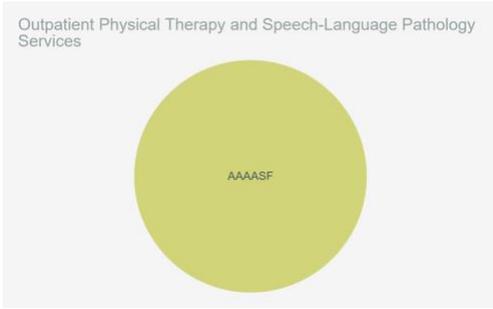


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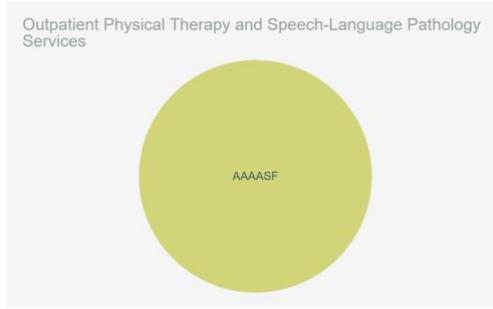


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Outpatient Patient Therapy and Speech-Language Pathology Services



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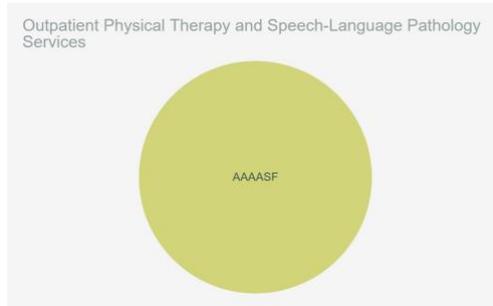
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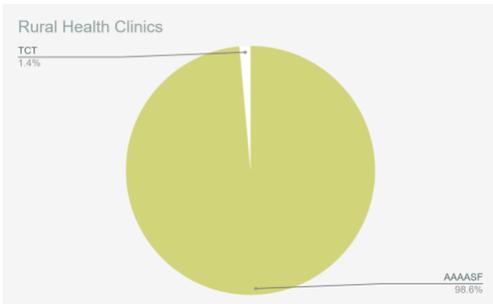


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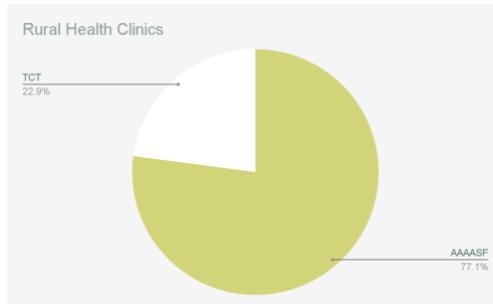


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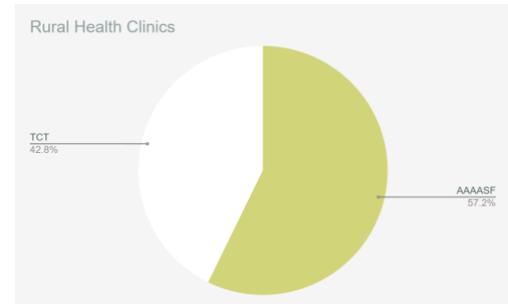
Rural Health Clinics



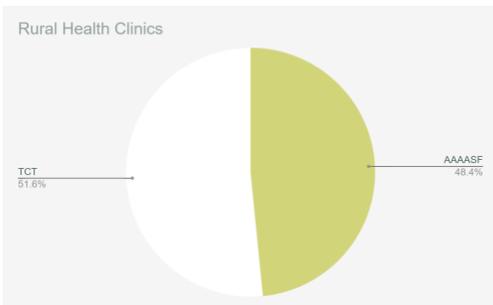
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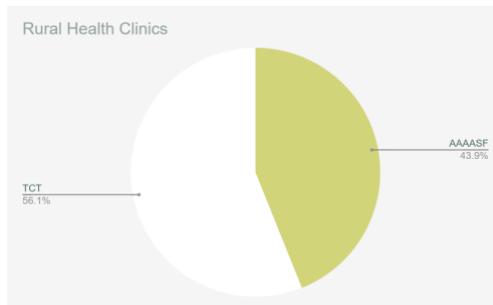
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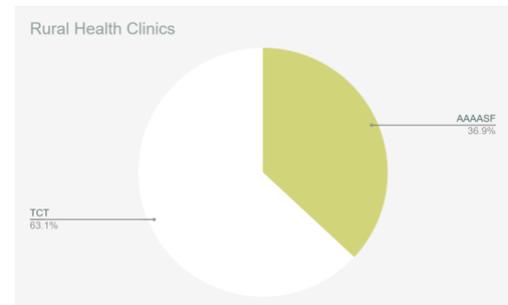
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Appendix A: Citations to Data Sources for Charts in Part III

FY 2019 data: CENTERS FOR MEDICARE & MEDICAID SERVICES, *FY 2020 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (Dec. 15, 2021).

FY 2018 data: CENTERS FOR MEDICARE & MEDICAID SERVICES, *FY 2019 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (Jan. 19, 2021).

FY 2017 data: CENTERS FOR MEDICARE & MEDICAID SERVICES, *FY 2018 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (Aug. 20, 2019).

FY 2016 data: CENTERS FOR MEDICARE & MEDICAID SERVICES, *FY 2017 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (Oct. 4, 2018).

FY 2015 data: CENTERS FOR MEDICARE & MEDICAID SERVICES, *FY 2016 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (July 28, 2017).

FY 2014 data: CENTERS FOR MEDICARE & MEDICAID SERVICES, *FY 2015 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (Jan. 29, 2016).

Endnotes

ⁱ See *infra* pp. 9-14.

ⁱⁱ James S. Roberts et al., *A History of the Joint Commission on Accreditation of Hospitals*, JAMA, 936, 936-938 (1987).

ⁱⁱⁱ *Id.* at 938.

^{iv} *Id.*

^v *Id.*; see also Inst. Med., MEDICARE: A STRATEGY FOR QUALITY ASSURANCE, VOLUME II: SOURCES AND METHODS 304 (Kathleen N. Lohr ed., 1990).

^{vi} Roberts, *supra* note 2, at 938.

^{vii} To be “deemed” means functionally to meet the requirements for definitions laid out in the Medicare and Medicaid Act. See, e.g., Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1865, 79 Stat. 286 (1965).

^{viii} Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1861, 79 Stat. 286 (1965) (codified as amended at 42 U.S. Code § 1395x).

^{ix} Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1861(e-g), (j), (o), 79 Stat. 286 (1965)(codified as amended at 42 U.S. Code § 1395x (e-f), (j), (o) (tuberculosis hospitals were removed as a separate category and extended care facilities became skilled nursing facilities as defined by, 42 U.S. Code § 1395i-3).

^x Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1865, 79 Stat. 286 (1965)

^{xi} HEW would be split up under President Carter and become the Department of Education and the Department of Health and Human Services (“DHHS”).

^{xii} See Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1865, 79 Stat. 286 (1965).

^{xiii} Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1861(e)(7), 79 Stat. 286 (1965) (codified as amended at 42 U.S. Code § 1395x(e)(7)).

^{xiv} With some exceptions, e.g., California, Pennsylvania, Wisconsin, New Jersey, and Oklahoma do not currently recognize or severely limit TJC accreditation for hospital licensing. See *infra* pp. 9-10.

^{xv} For a list of states that recognize TJC for licensing procedures see generally, The Joint Comm’n, *State Recognition*, <https://www.jointcommission.org/accreditation-and-certification/state-recognition/#>. (last visited Oct. 11, 2022).

^{xvi} The agency under HEW (now DHHS) in charge of administering medicare and medicaid would be shuffled until the Healthcare Financing Administration, now the Center for Medicare and Medicaid Services (“CMS”) charged with administration. *Medicare agency renamed as prelude to reforms*, CNN (June 14, 2001) <http://www.cnn.com/2001/HEALTH/06/14/hcfa.changes/>.

^{xvii} Social Security Amendments of 1965 (Medicare and Medicaid Act), Pub. L. 89-97, §1861(e)(8), 79 Stat. 286 (1965)(repealed 1972).

^{xviii} An accreditation program for long-term care facilities was established in 1965, for organizations serving developmentally disabled persons in 1969, and for psychiatric facilities, substance abuse programs, and community mental health programs in 1970. An accreditation

program for ambulatory health care programs was established in 1975 and for hospices in 1983. Roberts, *supra* note 2, at 938.

^{xix} E.g., increased prices, inefficiency, decreased competition, lack of consumer choice, lower quality products, etc.

^{xx}Stephanie Armour, *Hospital Watchdog Gives Seal of Approval, Even After Problems Emerge* Wall St. J. (Sept. 8, 2017)

<https://www.wsj.com/articles/watchdog-awards-hospitals-seal-of-approval-even-after-problems-emerge-1504889146>.

^{xxi} Gilbert M. Gaul, *Accreditors Blamed for Overlooking Problems*, Washington Post (July 25, 2005).

<https://www.washingtonpost.com/archive/politics/2005/07/25/accreditors-blamed-for-overlooking-problems/01cc8e09-0597-46e3-96fe-9055d2c7346c/>.

^{xxii} That is not to say all or even most of the other alternatives to TJC would be devoid of conflict of interest. For example, the AAAHC or the AOA similarly have conflicts of interest regarding those running the program being the regulated industry itself.

^{xxiii}Gaul, *supra* note 19 (“[a]bout 99 percent of the hospitals reviewed by the joint commission win accreditation.”)

^{xxiv} For examples, *see generally* Gaul, *supra* note 19.

^{xxv} Medicare Improvements for Patients and Providers Act of 2008 Pub. L. 110-275, §125.

^{xxvi} This is the most recent data from a report published in December 2021. Centers for Medicare & Medicaid Services, *FY 2020 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (2021),

<https://www.cms.gov/files/document/qso-22-06-ao-clia.pdf>.

^{xxvii} CMS has state inspectors go through the same facilities as an accreditor to double check the work of said accreditor. The disparity rate shows the percentage of accreditor inspections that missed problems found in inspections done by state inspectors.

^{xxviii} Report, *supra* note 24, at 45, 47-49, 51, 53.

^{xxix} Miranda B. Lam et al., *Association between patient outcomes and accreditation in US hospitals: observational study*, *BMJ (Clinical research ed.)*, 363, k4011 (2018); *contra* Stephen P. Schmaltz et al., *Hospital performance trends on national quality measures and the association with Joint Commission accreditation*, *J. Hosp. Med.*, 6(8), 454–461 (2011).

^{xxx} 42 U.S.C § 1395bb; 42 U.S.C § 1395aa; 42 U.S.C § 1395f(1); 42 U.S. Code § 1395x(e)(9).

^{xxxi}Stony Brook Surgical Associates, *AAAASF Accreditation — A “Seal of Approval” Patients Can Count On*, <https://www.stonybrookmedicine.edu/patientcare/surgery/patient-care/clinical/vascular-surgery/aaaasf-accreditation> (last visited Oct. 19, 2022).

^{xxxii}Centers for Medicare & Medicaid Services, *FY 2020 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (2021),

<https://www.cms.gov/files/document/qso-22-06-ao-clia.pdf>.

^{xxxiii} *Id.*

^{xxxiv}*About Us*, <https://www.aaahc.org/about-us/> (last visited Oct. 19, 2022).

^{xxxv} ACHC Through the Years, <https://www.achc.org/about-achc/> (last visited Oct. 19, 2022).

^{xxxvi} Medicare and Medicaid Programs; Approval of Deeming Authority of the Accreditation Commission for Healthcare (ACHC) for Home Health Agencies, 71 FR 9564-65 (Feb. 24, 2006).

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- ^{xxxvii} Medicare Program; Approval of Deeming Authority for National Accreditation Organizations to Accredit Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers, 72 Fed. Reg. 29327 (May 25, 2007).
- ^{xxxviii} Medicare and Medicaid Programs; Approval of the Accreditation Commission for Health Care for Deeming Authority for Hospices, 74 Fed. Reg. 62336-38 (Nov. 27, 2009).
- ^{xxxix} Centers for Medicare & Medicaid Services, *FY 2020 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (2021), <https://www.cms.gov/files/document/qso-22-06-ao-clia.pdf>.
- ^{xl} Healthcare Facilities Today, HFAP Ownership Change Receives Approval from CMS (Feb. 20, 2019), <https://www.healthcarefacilitiestoday.com/posts/HFAP-Ownership-Change-Receives-Approval-from-CMS--20714>.
- ^{xli} CARF International, *History of CARF International*, <http://www.carf.org/About/History/> (last visited Oct. 19, 2022).
- ^{xlii} Medicare Program; Approval of Deeming Authority for National Accreditation Organizations to Accredit Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers, 72 Fed. Reg. at 29327.
- ^{xliii} CARF International, *History of CARF International*, <http://www.carf.org/About/History/> (last visited Oct. 19, 2022).
- ^{xliv} About CHAP, <https://chapinc.org/about/> (last visited Oct. 19, 2022).
- ^{xlv} Medicare Program; Recognition of the Community Health Accreditation Program Standards for Home Care Organizations, 57 Fed. Reg. 22773-80 (May 29, 1992).
- ^{xlvi} Medicare Program; Recognition of the Community Health Accreditation Program, Inc. (CHAP) for Hospices, 64 Fed. Reg. 19376-78 (Apr. 20, 1999).
- ^{xlvii} Centers for Medicare & Medicaid Services, *FY 2020 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (2021), <https://www.cms.gov/files/document/qso-22-06-ao-clia.pdf>.
- ^{xlviii} *Over 25 Years of Healthcare Accreditation Transformation*, <https://thecomplianceteam.org/our-history/> (last visited Oct. 19, 2022).
- ^{xlix} Medicare Program; Approval of Deeming Authority for National Accreditation Organizations to Accredit Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers, 72 Fed. Reg. at 29328.
- ^l The Compliance Team, *What does it mean to be an Exemplary Provider?*, <https://thecomplianceteam.org/about-us/exemplary-provider-accreditation> (last visited Oct. 19, 2022).
- ^{li} *Our history*, <https://www.dnv.com/about/in-brief/our-history.html#dropdown-sector-Healthcare> (last visited Oct. 19, 2022).
- ^{lii} Centers for Medicare & Medicaid Services, *FY 2020 Report to Congress (RTC): Review of Medicare's Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program* (2021), <https://www.cms.gov/files/document/qso-22-06-ao-clia.pdf>.
- ^{liii} Michelle Mellon, *What You Need to Know About the HFAP-ACHC Merger*, Vanguard (June 2, 2022), <https://vanguard-fire.com/what-you-need-to-know-about-the-hfap-achc->

[merger/#:~:text=In%20October%202020%2C%20ACHC%20and,for%20similar%20services%20as%20before.](#)

^{liv} Medicare Program; Approval of Deeming Authority for National Accreditation Organizations to Accredit Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers, 72 Fed. Reg. at 29327.

^{lv} *NCCHC Historical Time Line*, <https://www.ncchc.org/historical-time-line/> (last visited Oct. 19, 2022).

^{lvi} URAC, *history*, <https://www.urac.org/about/history/> (last visited Oct. 19, 2022).

^{lvii} Cal. Code Regs. tit. 22, § 70101 (2022)

^{lviii} N.J. Admin. Code §§ 8:43G-1.2, 8:43G-2.4-2.5 (2018).

^{lix} 450 Okla. Admin. Code § 17-5-95(a)

^{lx} 317 Okla. Admin. Code § 30-5-95(c)(5)

^{lxi} 317 Okla. Admin. Code § 30-5-241.2(e)(3)

^{lxii} 450 Okla. Admin. Code § 1-9-7.3(b)

^{lxiii} 28 Pa. Code §§ 101.41, 101.61-62 (1982)

^{lxiv} Wis. Dep't of Health Servs., *Public Health Accreditation in Wisconsin* (Feb 14, 2022), <https://www.dhs.wisconsin.gov/lh-depts/accreditation/index.htm>.

^{lxv} Wis. Dep't of Health Servs., *Public Health Accreditation In Wisconsin - What Is Happening In Wisconsin Related To Public Health Accreditation* (Mar. 24, 2021), <https://www.dhs.wisconsin.gov/lh-depts/accreditation/news.htm>

^{lxvi} Wis. Dep't of Health Servs., <https://www.dhs.wisconsin.gov/hw2020/report.htm> (last accessed Oct. 19, 2022).

^{lxvii} The data in this section is sourced from Annual Reports to Congress issued by CMS. Please see Appendix A for full citations.

^{lxviii} AAAASF has rebranded to “Quad A,” but is referred to as “AAAASF” in the 2014-2019 CMS Annual Reports to Congress.