



Center for Clinical Standards and Quality

Ref: QSO-26-10-[ALL]

DATE: June 16, 2026

TO: State Survey Agency Directors, Accrediting Organizations

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Publication of the Strengthening Oversight of Accrediting Organizations (AOs) (CMS-3367-FC) Final Rule with Comment Period

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) is providing information on the requirements for the new AO oversight rule that was published on June 16, 2026 (91 FR 36370).
- These regulations are effective 1 (one) year after date of publication at the *Federal Register*.
- CMS is raising awareness to ensure providers and suppliers deemed under a CMS-approved AO become familiar with the upcoming changes that could impact them.

Background:

CMS is responsible for the approval and oversight of national accreditation programs to ensure that providers or suppliers accredited under these programs are deemed as having met the basic quality and patient safety standards required under the Medicare regulations. Generally, to enter into an agreement with Medicare, a provider or supplier must first be certified by a state survey agency (SA) as complying with the Medicare conditions. Thereafter, the provider or supplier is subject to regular surveys by an SA to determine whether it continues to meet these requirements. However, there is an alternative to surveys by SAs. Section 1865(a)(1)(A) of the Social Security Act provides that, if a provider entity demonstrates through accreditation by a CMS-approved national AO's accreditation program that all applicable Medicare requirements are met or exceeded, CMS will deem that provider entity as having met such requirements.

Accreditation by an AO is voluntary and is not required for Medicare participation. These AOs voluntarily submit their accreditation programs for CMS review and approval. A national AO applying for approval of its accreditation program under part 488, subpart A, must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that meet or exceed the Medicare requirements. "Deemed status" means that a certified provider or supplier is in good standing under Medicare because it has been accredited by a CMS-approved accreditation organization and is a deemed to have met the Medicare

requirements. Each AO may also develop its own accreditation standards, which may be more stringent than the CMS requirements.

Variability in standards and survey processes across AOs has resulted in inconsistent survey findings, identification of deficiencies, and remedies for quality-of-care and patient safety concerns. Specific examples of the variability in these processes include: AOs allowing facilities to select periods of time during which surveys would not occur or giving advance notice of surveys to facilities; facilities being involuntarily terminated from participation in the Medicare program for non-compliance with the requirements yet retaining their accreditation; and more. CMS also identified serious concerns related to consulting services provided by AOs to their respective clients, such as conducting mock surveys.

To address these concerns, CMS is finalizing several provisions to strengthen our oversight of AOs and achieve greater consistency between SAs and AOs in their respective survey processes.

Discussion:

Currently, there are nine AOs with CMS-approved accreditation programs for deeming purposes: Ambulatory Surgical Centers, Critical Access Hospitals, Hospitals (including Psychiatric Hospitals), Home Health, Hospice, End-Stage Renal Disease Facilities, Rural Health Clinics, and Outpatient Physical Therapy Programs. The changes outlined below affect all AOs except those that accredit clinical laboratories and noncertified suppliers, which include suppliers of advanced diagnostic imaging, home infusion therapy, and diabetes self-management training, as well as durable medical equipment suppliers and suppliers of durable medical equipment prosthetics, orthotics, and supplies. Overview of the finalized provisions include the following:

1. Strengthening Oversight and Accountability of AOs

Measures aimed at improving CMS's ability to evaluate and hold AOs accountable for their performance.

- Conduct the Validation Program through direct observation surveys.
- Require publicly reported plans of correction in case of poor AO performance.
- Replace the definition of "rate of disparity" with "process disparity rate" and use it to measure AO performance.
- Establish criteria for determining whether an AO meets the definition of "national in scope."
- Update AO hospital program applications to include additional standards for psychiatric hospitals (there will no longer be a separate application for CMS approval of AO psychiatric hospital accreditation programs; must be part of the AO hospital accreditation program application).

2. Aligning AO Standards & Survey Practices with those of CMS

Measures intended to ensure consistency between state survey agencies (SAs) and AOs.

- Require AOs to use the CMS standards to ensure improved evaluation of AO performance.
- Require AO use of survey processes comparable to those of CMS to ensure greater alignment between State Agency (SA) and AO surveys.
- Require AO surveyors to complete the CMS online surveyor training.
- Establish a definition for "unannounced surveys."

3. Addressing Conflicts of Interest and Consulting Relationships

Policies designed to reduce potential conflicts created when AOs provide consulting services to the same entities they accredit.

- Establish a definition of “fee-based consulting services” and place restrictions on consulting services that meet this definition, including the use and timing of mock surveys that AOs provide to providers and suppliers they accredit.
- Require AOs to revise conflict-of-interest policies to include specific information and ensure AOs identify, report, and address conflicts of interest.
- Prohibit AO owners, surveyors, and other employees from participating in survey activities of health care providers in which they have an interest or a relationship (e.g., facilities where they work, have a financial interest, or for which they have consulted).

4. Strengthening Program Integrity and Provider Participation Rules

Provisions aimed at protecting the integrity of the Medicare and Medicaid programs and preventing problematic providers from circumventing oversight.

- Establish limitations on terminated deemed providers/suppliers seeking re-entry into the Medicare and/or Medicaid programs that would require them to remain under the oversight of the SA for a reasonable assurance period.
- Require AOs to withdraw accreditation of providers/suppliers terminated from the Medicare program.

Impact:

These provisions are effective 1 (one) year after date of publication at the *Federal Register*. CMS is engaging with the nine AOs with CMS-approved accreditation programs as we implement the new requirements as well as the revisions to the existing ones. For the provider and supplier community and those facilities deemed under a CMS-approved AO, your respective AO is expected to communicate with your organization regarding these requirements, including the requirement that AOs must adopt the same language in the Medicare conditions for their respective AO program standards.

List of CMS Approved Accrediting Organizations: <https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/accrediting-organizations-aos>

Final Rule Full Text: <https://www.govinfo.gov/content/pkg/FR-2026-06-16/pdf/2026-12069.pdf>

Contact: For questions or concerns relating to this memorandum, please contact AO_Applications@cms.hhs.gov. We also encourage deemed providers to contact their respective AO with questions related to the new changes.

Effective Date: Immediately. Please communicate to all appropriate staff within 30 days.

/s/

David R. Wright
Director, Quality, Safety & Oversight Group

Resources to Improve Quality of Care:

Check out CMS's new [Quality in Focus](#) interactive video series.

The series of 10–15 minute videos are tailored to provider types and aim to reduce the deficiencies most commonly cited during the CMS survey process, like infection control and accident prevention. Reducing these common deficiencies increases the quality of care for people with Medicare and Medicaid.

Learn to:

- *Understand surveyor evaluation criteria*
- *Recognize deficiencies*
- *Incorporate solutions into your facility's standards of care*

See the [Quality, Safety, & Education Portal Training Catalog](#), and select [Quality in Focus](#).

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