

CMS Takes on Stronger Oversight of Accrediting Organizations

June 17, 2026

To participate in Medicare, healthcare providers must meet certain federal health and safety standards. Providers may be inspected by state survey agencies (SAs) or Accrediting Organizations (AOs) for compliance with the Medicare Conditions of Participation. On June 12, 2026, CMS published a [final rule](#) that increases AO oversight. This rule takes effect June 16, 2027. The intent is to ensure that AOs are held to the same standards in as SAs in conducting Medicare surveys.

The rule highlights, among others, three main concerns about how AOs have been operating: conflicts of interest, inconsistent inspection standards, and accreditation after involuntary Medicare termination.

Conflicts of Interest

CMS found that some AOs were both inspecting providers and selling them consulting services, concluding that an AO likely cannot objectively evaluate a provider it is also being paid to advise. Going forward, (a) personal conflicts within the last two years are to be disclosed and 'firewalled' off, and (b) fee-based consulting has new restrictions including reporting requirements.

Inconsistent Inspection Standards

CMS also found gaps between AO and State standards, with AOs frequently missing problems that state surveyors later found. To fix this, AO standards must now: meet the 'Medicare floor,' provide a detailed crosswalk comparing their standards to the corresponding Medicare requirements, and complete CMS basic training programs also required for state surveyors.

Accreditation After Involuntary Medicare Termination

Lastly, CMS found that sometimes, when a provider is terminated from Medicare (typically for serious health and safety failures), the provider has occasionally been allowed to keep its AO accreditation, which means it may continue holding itself out to the public as meeting high-quality standards. This rule closes that loophole in two ways: when CMS terminates a provider, the AO must revoke accreditation within five business days, and for re-entry, there must be a "reasonable assurance period" where it is monitored exclusively by state surveyors and AO accreditation will not be accepted as a substitute.

Additional Requirements

Two other important additions are no-notice inspections and public accountability. Under longstanding CMS policy, accreditation inspections must be "no-notice," meaning providers should not learn about an inspection until it happens. This rule makes the requirement explicit. On the accountability side, when results fall below acceptable levels, CMS will publish an AO's written correction plan. This plan must identify what went wrong, what steps will be taken for corrective action, and who is responsible for monitoring corrective action which aligns with the requirements for corrective action plans required in response to CMS survey deficiencies cited by SAs.

What this means to Our Clients

This new rule will undoubtedly put pressure on AOs to be stricter in conducting surveys. As a result, this is a good time to make sure that compliance with the Medicare Conditions of Participation will stand up against scrutiny by both SAs and AOs.

For questions regarding the new rule or steps to consider in preparing for the impact of the new rule, please contact the Hancock, Daniel & Johnson's Accreditation and Certification Survey Team at (804) 967-9604 or visit hancockdaniel.com

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