



## Centers for Medicare & Medicaid Services

[CMS-3479-PN]

### Medicare and Medicaid Programs; Application from Joint Commission (JC) for Continued CMS-Approval of its Home Health Agency (HHA) Accreditation Program

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

**ACTION:** Proposed notice.

**SUMMARY:** This proposed notice acknowledges the receipt of an application from Joint Commission for continued recognition as a national accrediting organization for home health agencies that wish to participate in the Medicare or Medicaid programs. It also provides the public with the opportunity to submit comments on the applicant's request.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

**ADDRESSES:** In commenting, refer to file code CMS-3479-PN. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the "Submit a comment" instructions.
2. By regular mail. You may mail written comments to the following address ONLY:  
Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-3479-PN,  
P.O. Box 8013,

Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-3479-PN,  
Mail Stop C4-26-05,  
7500 Security Boulevard,  
Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

**FOR FURTHER INFORMATION CONTACT:**

Joy Webb, (410) 786-1667.

Kristen Shifflett, (410)-786-4166.

**SUPPLEMENTARY INFORMATION:**

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments. CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post

acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

## **I. Background**

Under the Medicare program, eligible beneficiaries may receive covered services from a home health agency (HHA) provided certain requirements are met. Sections 1861(m) and (o), and 1891 of the Social Security Act (the Act) establish criteria for entities seeking to participate in Medicare as an HHA. Regulations concerning provider agreements are at 42 CFR part 489 and those pertaining to activities relating to the survey and certification of HHAs and other entities are at 42 CFR part 488. The regulations at 42 CFR part 484 further specify the minimum conditions that an HHA must meet to participate in the Medicare program. Generally, to enter into a provider agreement with the Medicare program, an HHA must first be certified by a state survey agency (SA) as complying with the conditions or requirements set forth in 42 CFR part 484 of our regulations. Thereafter, the HHA is subject to regular surveys by an SA to determine whether it continues to meet these requirements. However, there is an alternative to survey by SAs.

Section 1865(a)(1)(A) of the Act provides that, if a provider entity demonstrates through accreditation by an approved national accrediting organization (AO) that all applicable Medicare conditions are met or exceeded, we must deem that provider entity as having met the requirements. Accreditation by an AO is voluntary and is not required for Medicare participation.

A national AO applying for CMS approval of its accreditation program under 42 CFR 488.5 must provide CMS with reasonable assurance that the AO requires the accredited provider entities to meet requirements that meet or exceed the applicable Medicare conditions. The regulation at § 488.5(e)(2)(i) permits CMS to approve or re-approve an AO application for a period not to exceed 6 years.

Joint Commission's (JC's) current term of approval for its HHA program expires March 30, 2026.

## **II. Approval of Deeming Organization**

Section 1865(a)(2) of the Act and § 488.5 require CMS' review of an AO's application consider, among other factors: the applying AO's requirements for accreditation; survey procedures; resources for conducting required surveys; capacity to furnish information for use in enforcement activities; monitoring procedures for provider entities found not in compliance with the conditions or requirements; and ability to provide CMS with the necessary data for validation.

Section 1865(a)(3)(A) of the Act further requires that the Secretary, through CMS, publish, within 60 days of receipt of an organization's complete application, a notice that identifies the national accrediting body making the request, describes the nature of the request, and provides at least a 30-day public comment period. We have 210 days from the receipt of a complete application to publish notice of approval or denial of the application.

The purpose of this proposed notice is to inform the public of JC's request for continued CMS-approval of its HHA accreditation program. This notice also solicits public comment on whether JC's requirements meet or exceed the Medicare conditions of participation (CoPs) for HHAs.

## **III. Evaluation of Deeming Authority Request**

JC submitted all the necessary materials to enable us to make a determination concerning its request for continued CMS approval of its HHA accreditation program. This application was determined to be complete on September 2, 2025. Under section 1865(a)(2) of the Act and § 488.5, our review and evaluation of JC may include:

- The equivalency of JC's standards for HHAs as compared with Medicare's CoPs for HHAs.
- The assessment of JC's survey process.

- The comparability of JC’s processes to those of State agencies, including survey frequency, and the ability to investigate and respond appropriately to complaints against accredited facilities.

- JC’s processes and procedures for monitoring an HHA found out of compliance with JC’s program requirements.

- JC’s capacity to report deficiencies to the surveyed facilities and respond to the facility's plan of correction in a timely manner.

- JC’s capacity to provide CMS with information extracted from each accreditation survey for a specified provider as part of its data submission.

- An assessment of JC’s financial viability.

- JC’s agreement to provide CMS with a copy of the most current accreditation survey together with any other information related to the survey as CMS may require (including corrective action plans).

#### **IV. Collection of Information Requirements**

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

#### **V. Response to Public Comments**

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the “DATES” section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Dr. Mehmet Oz , having reviewed and approved this document, authorizes Chyana Woodyard, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register.**

**Chyana Woodyard,**

*Federal Register Liaison,*

*Centers for Medicare & Medicaid Services.*

[FR Doc. 2026-06508 Filed: 4/2/2026 8:45 am; Publication Date: 4/3/2026]