DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality

Ref: QSO-26-13-HHA

DATE: July 15, 2026

TO: State Survey Agency Directors

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

SUBJECT: Acceptance-to-Service Requirement for Home Health Agencies and updated Guidance

Memorandum Summary

- Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) final rule amended the Home Health Agency (HHA) Conditions of Participation (CoPs) at 42 CFR part 484.
- Specifically, this final rule adds a new standard for an acceptance-to-service policy in the HHA Conditions of Participation (CoPs), effective January 1, 2025.
- Conforming revisions are being made to the regulatory tags and interpretive guidelines to the State Operations Manual (SOM) Appendix B - Guidance for Surveyors: Home Health Agencies. Additional clarifying guidance is being added to a single, unrelated tag that surveyors and HHAs frequently question.

Background:

The Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) final rule was issued on November 1, 2024, titled *Calendar Year 2025 Home Health Prospective Payment System Rate Update and Home Infusion Therapy and Home IVIG Services Payment Update* (89 FR 88354, Nov. 7, 2024). Among other things, this final rule updates the Home Health Agency (HHA) Conditions of Participation (CoPs) by adding a new standard for acceptance-to-service policy requirements to address concerns regarding the HHA's referral and acceptance process and their implications for prospective and current patients.

Effective as of January 1, 2025, HHAs are required to develop, implement, and maintain through annual review a patient acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care. This policy governs which patients the HHA will accept for care. These changes are necessary to improve the referral process and reduce avoidable care delays and will help to ensure that referring entities and patients can select the most appropriate HHA based on their care needs.

Lastly, clarifying guidance has been added to one additional tag that surveyors and HHAs frequently ask about.

Discussion:

Admission to an HHA for services is a critical step in ensuring patients receive timely, appropriate care that meets their needs. HHAs are required to furnish skilled nursing services and at least one other therapeutic service, for example, physical therapy or occupational therapy, on a visiting basis and in a place of residence that is used as a patient's home. These services provided by each HHA vary, creating challenges for individuals seeking to find the right HHA to meet their unique care needs. Similarly, the unique mix of services provided by an HHA also necessitates an HHA-specific approach to accepting referrals for care to ensure that the HHA is capable of meeting the needs of the referred patient, in accordance with 42 CFR § 484.60. To address these needs, a new standard was added to the HHA CoPs at §484.105(i) that requires HHAs to develop, implement, and maintain an acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care.

Additionally, HHAs must ensure that the policy is reviewed annually and addresses, at a minimum, the following criteria at § 484.105(i)(1)(i) through (iv) related to the HHA's capacity to provide patient care:

- the anticipated needs of the referred prospective patient,
- the HHA's case load and case mix,
- the HHA's staffing levels, and
- the skills and competencies of the HHA staff.

Implementing acceptance-to-service requirements ensures that HHAs accept only those patients for whom there is a reasonable expectation of meeting the patient's care needs. These new requirements will reduce the delay between when a patient is identified as an eligible candidate for home health care and when care is initiated, thus improving patient outcomes.

Consistent with these new requirements, two new G-tags are being added to Appendix B (G990 and G992) with interpretive guidelines for surveyors. Noncompliance with these new requirements should be cited using these tags.

In addition to the two new tags added reflecting the updated CoP requirements, we are clarifying guidance to tag G1052 for §484.115(a) Standard: Administrator, home health agency. Although nothing has changed with the requirement since it became effective in 2018, we added a note that individuals acting in the administrator role with the HHA before January 13, 2018, must meet the requirements in standard §484.115(a)(1) to continue in their current role as administrator. Individuals hired into the administrator role after January 13, 2018, must meet the requirements in standard §484.115(a)(2). This was not previously clear to HHAs and surveyors, as we frequently receive questions about the regulation. This additional guidance was noted in the preamble to the 2017 final rule at 82 FR 4556 (Jan. 13, 2017).

SOM Updates
An advanced copy of Appendix B of the State Operations Manual (SOM) is attached. The revisions to Appendix B, which indicate the regulatory changes made by the final rule and updated guidance, will be reflected in the SOM's online version shortly after the release of this memorandum.

Contact:
For questions or concerns relating to this memorandum, please contact HHAsurveyprotocols@cms.hhs.gov.

Effective Date:
Immediately. Please communicate to all appropriate staff immediately.

/s/

Karen L. Tritz
Director, Survey & Operations Group

Melissa C. Daly
Acting Director, Quality, Safety & Oversight Group

Attachments:
- Summary of changes to SOM Appendix B
- Advance Copy of SOM Appendix B - Guidance to Surveyors: Home Health Agencies

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

Get guidance memos issued by the Quality, Safety and Oversight Group by going to CMS.gov page and entering your email to sign up. Check the box next to "CCSQ Policy, Administrative, and Safety Special Alert Memorandums" to be notified when we release a memo.

Summary of Changes to the State Operations Manual (SOM), Appendix B: Home Health Agencies (HHAs)

Condition	Guidance/ Topic / Tag	Status	Link to the Code of Federal Regulations	Reason for the update	Summary of Revisions/Updates
§ 484.105 Condition of participation: Organization and administration of services	G990	New	42 CFR 484.105(i)(1) Standard: HHA acceptance-to-service	Regulatory Calendar Year (CY) 2025 Home Health Prospective Payment System final rule (89 FR 88354)	Reflects a new standard requiring HHAs to develop, implement, and maintain (through annual review) a patient acceptance-to-service policy applied consistently to each prospective patient. The policy must address: (1) anticipated needs of the referred patient, (2) HHA case load and case mix, (3) staffing levels, and (4) skills and competencies of HHA staff.
§ 484.105 Condition of participation: Organization and administration of services	G992	New	42 CFR 484.105(i)(2) Standard: HHA acceptance-to-service	Regulatory Calendar Year (CY) 2025 Home Health Prospective Payment System final rule (89 FR 88354)	Home Health Agencies (HHAs) are required to make information about their services publicly available and must review and update this publicly facing information whenever services change, but no less than annually.
§ 484.115 Condition of participation: Personnel qualifications	G1052	Revised	42 CFR 484.115(a) Standard: Administrator, home health agency	Clarification	Adds a clarifying note to the existing Administrator standard (§484.115(a)): individuals acting as administrator before January 13, 2018 must meet requirements under §484.115(a)(1); individuals hired after January 13, 2018 must meet requirements under §484.115(a)(2).

Advance Copy of SOM Appendix B - Guidance to Surveyors: Home Health Agencies

***NOTE**: This attachment contains an advance copy of selected revisions to the State Operations Manual (SOM). It includes only those sections that are new or revised, with new and revised language shown in red italics. This attachment should be read in conjunction with the current version of the SOM available on the CMS website. Once these revisions are incorporated into the official SOM, users should refer to the updated online version for the complete and current manual.*

G990
(New)

§484.105(i) Standard: HHA acceptance to service.

An HHA must do both of the following:

(1) Develop, implement, and maintain through an annual review, a patient acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care, which addresses criteria related to the HHA's capacity to provide patient care, including, but not limited to, all of the following:

(i) Anticipated needs of the referred prospective patient.

(ii) Case load and case mix of the HHA.

(iii) Staffing levels of the HHA.

(iv) Skills and competencies of the HHA staff.

Interpretive Guidelines §484.105(i)(1):

Admission to HHA services is a critical step in ensuring patients receive timely, appropriate care to meet their needs. As part of this process, agencies must develop, implement, and maintain a patient acceptance-to-service policy that is applied equally and consistently when evaluating each prospective patient referred for home health care.

The acceptance-to-service policy includes four minimum requirements related to the HHA's capacity to provide patient care that are clinical factors that influence whether an HHA should accept or decline a referral, ensuring the health and safety of the referred patient by matching HHA services to patient needs. The policy must be reviewed annually and include, at a minimum, the following information:

- *the anticipated needs of the referred prospective patient;*

- *the HHA's case load and case mix, which generally means the number (volume) and types of patients (complexity) of patients currently receiving care at the HHA which informs what the HHA expects it can reasonably care for at any time;*
- *the HHA's staffing levels; and*
- *the skills and competencies of the HHA staff.*

These elements inform an HHA's assessment of its capacity and determine its suitability to meet the anticipated needs of the prospective patient referred for HHA services. Within this structure, HHAs may tailor their policy to address additional concerns, procedural delays, and challenges that they typically face in the referral and acceptance process. It is the responsibility of the HHA to work with its referral sources by educating them on the HHA's acceptance-to-service policy and the services it offers, with the goal of minimizing communication gaps (see the related requirement at G992).

While all of a prospective patient's needs may not be known at the time of referral, general information regarding the patient's diagnosis and recent hospitalization (as appropriate), and specific orders from the patient's medical provider should provide a reasonable basis for HHAs to anticipate the overall needs of the patient and determine whether, in light of the described elements that must be present in the policy, the prospective patient is or is not appropriate for the HHA to accept for service.

- *Surveyors must review the HHA's acceptance to service policy to ensure it meets all the elements within this regulation.*
- *Surveyors should confirm the HHA's acceptance to service policy includes at a minimum the four criteria listed in this requirement:*
    - *Anticipated needs of the referred prospective patient.*
    - *Case load and case mix of the HHA.*
    - *Staffing levels of the HHA.*
    - *Skills and competencies of the HHA staff.*

  This policy is HHA-specific and separate and distinct from the patient's individualized plan of care at §484.60.

G992
(New)

§484.105(i) Standard: HHA acceptance to service.

[An HHA must do both of the following: ...]

(2)(i) Make available to the public accurate information regarding the services offered by the HHA and any limitations related to types of specialty services, service duration, or service frequency.

(ii) Review the information specified in paragraph (i)(2)(i) of this section as frequently as the services are changed, but no less often than annually.

Interpretive Guidelines §484.105(i)(2):

HHAs must make the specified information available to the public; however, CMS does not specify a method for public availability (89 FR at 88455 (Nov. 7, 2024)). HHAs provide information regarding their services in multiple formats (for example, Care Compare, agency websites, brochures). To ensure that the information presented to the public is accurate, we are requiring HHAs to review publicly facing information whenever services are changed, but no less often than annually. We expect HHAs to update information on the services they provide and any service limitations if they anticipate not having a service available for 3 to 6 months. Changing a service means the HHA has formally altered the services it offers, whether by adding, discontinuing, temporarily pausing, or restricting a service. For example, a change in service may include an employee taking an extended leave of absence (that is, care for a family member, recovery from a serious illness or procedure, maternity leave) or the addition of a new contract employee that provides speech language pathology services, which an HHA may not have provided before.

CMS extracts information about an HHA's services offered (including whether they provide Skilled Nursing Care, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Worker Services, and Home Health Aides) from the CMS-1572 survey report form, where the "Services Provided" information is captured directly from facility staff. The information from this form is entered into the CMS iQIES database and serves as the source for certain CMS public reporting, such as the CMS Care Compare website. This form is completed and updated during a CMS initial and recertification survey. States may also create these forms outside a survey cycle. HHAs should ensure this information is completed in PECOS, then outreach to their OASIS Education Coordinator or OASIS Automation Coordinator to request that their data in iQIES be updated.

Surveyors should note that updates to home health agency provider demographic information do not occur in real time and may take up to six months to appear on Care Compare. Therefore, as long as the HHA can provide you with evidence that they requested corrections/updates, this would not trigger a citation if Care Compare was incorrect.

G1052

(Rev.)

§484.115(a) Standard: Administrator, home health agency.

(1) For individuals who began employment with the HHA before January 13, 2018, a person who:

(i) Is a licensed physician;

(ii) Is a registered nurse; or

(iii) Has training and experience in health service administration and at least 1 year of supervisory administrative experience in home health care or a related health care program.

(2) For individuals who begin employment with an HHA on or after January 13, 2018, a person who:

(i) Is a licensed physician, a registered nurse, or holds an undergraduate degree; and

(ii) Has experience in health service administration, with at least 1 year of supervisory or administrative experience in home health care or a related health care program.

Interpretive Guidelines §484.115(a)

*As noted in the 2017 Final Rule revising the HHA CoPs (82 FR at 4556 (Jan. 13, 2017), individuals acting in the administrator role with the HHA before the effective date of the rule (January 13, 2018), must meet the requirements in standard §484.115(a)(1) to continue in their current role as administrator. Individuals hired into the administrator role after January 13, 2018, must meet the requirements in standard §484.115(a)(2). We note that a*n "undergraduate degree" means a bachelor's or associate degree.