CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 245 **Date: August 5, 2026**

SUBJECT: Revised Appendix B, Interpretive Guidelines for Home Health Agencies: New Acceptance-to-Service requirements for home health agencies at 42 CFR 484.105(i).

I. SUMMARY OF CHANGES: Adding new standards and guidelines at 42 CFR 484.105(i) concerning acceptance-to-service requirements that home health agencies must follow. Separately, guidance for 42 CFR 484.115 is revised to clarify frequently asked questions.

NEW/REVISED MATERIAL - EFFECTIVE DATE: August 5, 2026
IMPLEMENTATION DATE: August 5, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Appendix B/484.105(i)(1) Standard: HHA acceptance-to-service (Tag G990)
N	Appendix B/484.105(i)(2) Standard: HHA acceptance-to-service (Tag G992)_
R	Appendix B/484.115(a) Standard: Administrator, home health agency (Tag 1052)

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.
Or
Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements

	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

State Operations Manual
Appendix B- Guidance to Surveyors: Home Health Agencies

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(Rev. 245; Issued:08-05-26)

Transmittals for Appendix B

G990

(Rev. 245; Issued: 08-05-26; Effective: 08-05-26; Implementation:08-05-26)

§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

(Rev. 245; Issued: 08-05-26; Effective: 08-05-26; Implementation:08-05-26)

§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.

§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. 245; Issued: 08-05-26; Effective: 08-05-26; Implementation:08-05-26)

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

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Interpretive Guidelines §484.115(a)

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