Home Health Line Fact sheet

Survey Guidance: Acceptance-to-service policy

CMS has issued an update for its survey guidance around home health agencies, adding details surveyors should look for in your acceptance-to-service policy. Requirements at §484.105(i) have been in effect since January 2025, but CMS held off on updating the interpretive guidance for surveyors until July 15, 2026. The changes were effective immediately.

Below, see the new G tags and interpretive guidance for surveyors.

G990

Admission to agency 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 agency's capacity to provide patient care that are clinical factors that influence whether an agency should accept or decline a referral, ensuring the health and safety of the referred patient by matching agency 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 agency's case load and case mix, which generally means the number (volume) and types of patients (complexity) of patients currently receiving care at the agency which informs what the agency expects it can reasonably care for at any time;
- the agency's staffing levels; and
- the skills and competencies of the agency staff.

These elements inform an agency's assessment of its capacity and determine its suitability to meet the anticipated needs of the prospective patient referred for agency services. Within this structure, agencies 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 agency to work with its referral sources by educating them on the agency'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 agencies 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 agency to accept for service.

- Surveyors must review the agency's acceptance-to-service policy to ensure it meets all the elements within this regulation.
- Surveyors should confirm the agency'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 agency.
  - Staffing levels of the agency.
  - Skills and competencies of the agency staff.

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

G992

Agencies must make available to the public accurate information regarding services offered and any limitations related to types of specialty services, service duration or service frequency. This should be reviewed as frequently as necessary, but at least annually.

Agencies must make the specified information available to the public; however, CMS does not specify a method for public availability. Agencies 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 agencies to review publicly facing information whenever services are changed, but no less often than annually. We expect agencies 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 agency 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 agency may not have provided before.

CMS extracts information about an agency'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 data base 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. Agencies 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 agency can provide you with evidence that they requested corrections/updates, this would not trigger a citation if Care Compare was incorrect.