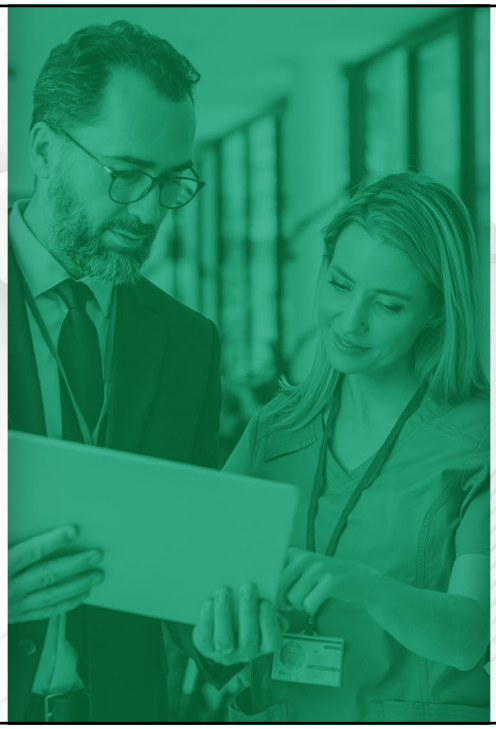
New CoP: HHA Acceptance to Service



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1

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Jennifer Osburn is a credentialed OASIS and ICD-10 expert with over 30 years of home health experience. She brings a wealth of knowledge and expertise which includes education and training, agency management, quality, clinical case management, and software technology.

Jennifer has led numerous seminars for state and national associations, accrediting bodies, and agency clients for the past 12 years. She frequently authors industry publications and has assisted home health software companies with Medicare compliant solutions. Jennifer enjoys translating technical guidance into easily deployed information to facilitate quality care delivery and payment. Her areas of expertise experience include OASIS, ICD-10-CM Coding, Case Management, Medicare Home Health Conditions of Participation, Billing Requirements, Documentation Compliance for Quality and Payment, Emergency Preparedness, Agency Operations, and PDGM.

2

New HH Condition of Participation

Acceptance to Service

3

Location of New Condition of Participation

- The 2025 Home Health Final Rule codified a new home health CoP
- Located in Section §484.105 Organization and administration of services
- This section of the CoPs addresses the roles of the governing body, administrator and clinical manager in the big picture of the day-to-day operations of the home health agency
- §484.105(a): Governing Body
- The governing body is responsible for the agency's overall management and operation
  - Provision of services
  - Fiscal operations
  - Budget and operational plans (Annual Operating Budget, Capital Expenditure Plan)
  - QAPI Program
  - Emergency Preparedness

4

Location of New Condition of Participation

- The Administrator, who is appointed by and must report to the governing body, is responsible for all day-to-day operations of the agency
  - Ensures qualified personnel are hired
  - Assures development of personnel qualifications and policies
- The Clinical Manager is responsible for oversight of
  - Patient and personnel assignments
  - Coordination of patient care
  - Coordinating referrals
  - Assuring patient needs are continually assessed
  - Assuring development, implementation and updates of the individualized plan of care

5

Location of New Condition of Participation

- The Agency assumes responsibility for services provided whether those services are provided by direct hire staff or under arrangement with other organizations or contracted staff
  - Must ensure services are provided according to current clinical practice guidelines and accepted professional standards of practice
  - State practice acts
  - Standards established by National organizations, boards, and councils (example, American Nurses' Association, American Physical Therapy Association, etc.)
  - The agencies own policies and procedures

6

Location of New Condition of Participation

- Located in Section §484.105 Organization and administration of services
  - §**484.105(i) 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

7

New Condition of Participation Location

- §484.105 Organization and administration of services
  - §**484.105(i) 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 delivery
      - (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.

8

Why This New CoP?

- Each agency chooses what services they are going to provide
  - Must furnish SN and at least one other therapeutic service (PT, OT, ST , MSS or HHA)
  - Services provide by agency vary
  - Makes it challenging for the person seeking to find the right HHA to meet their needs
  - Also necessitates an HHA-specific approach to accepting referrals for care to make sure the agency can meet the needs of the patient
  - A timely, appropriate admission process serves the prospective patient and ensures the HHA accepts only those patients for whom they are able to meet needs of

9

Why This New CoP?

- Research has found that timely admission to home health services are key to good HH outcomes
- Having up to date information regarding the services your agency provides helps patients choose the agency that best fits their needs
- Agencies should not accept patients they cannot serve
- The standards at §484.105 Organization and administration of services, require the HHA to "organize, manage and administer its resources to attain and maintain the highest practible functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's POC, for each patient's medical, nursing and rehabilitative needs." (2025 Final Rule)
  - Patient Rights state the patient has the right to receive all services on their plan of care

10

CMS Comments on Acceptance to Service

- "Each agency should already be well versed in understanding staff ability and skills, current workloads, and other circumstances that may affect case load. These are well established concepts that we are formalizing within a policy that we expect will be applied equally and consistently when evaluating prospective referred patients."------2025 Final Rule Response to Comments
- "while all the prospective patient's needs may not be known at the time of the referral, general information regarding the patient's diagnosis and recent hospitalization, 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 factors, the patient is or is not appropriate for the HHA to accept for service."

11

CMS Comments on Acceptance to Service

- "acceptance to service should not be based on payment source"
- "when accepting patients, the primary consideration of all HHAs must be whether the HHA has the resources available to meet the needs of the prospective patient…"

12

Comments RE Making Information Public on Offered Services and Service Limitations

- Agencies select the services they furnish and the geographic areas they serve
- Knowing the services provided and geographic service areas will assist referral sources, patients and caregivers engaged in a search for HH services in identifying the most suitable HHA
- Likewise, each HHA has fluctuating staffing levels and staffing competencies affecting it capacity to deliver care and provide its typically offered services
- The new requirement at 484.102(i)(2) requires the HHA make ***public*** accurate information regarding the services offered by the HHA, such limitations on specialty services, service duration, and service frequency to further inform the search efforts of all referral sources.
- This information must be reviewed at least annually

13

CMS Responses to Comments

- "We would expect HHAs to update the information regarding their services provided and service limitations if the HHA anticipates it will not have 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, or 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 a HHA may not have provided before."

14

CMS Responses to Comments

- HHAs are already required by § 484.105 to document, in writing, the services that they furnish. The governing body is responsible for assuring that this is done as part of their oversight responsibilities set forth in § 484.105(a). As such, we would expect to see evidence of governing body decision making on the services offered, corresponding revisions to the written list, and corresponding updates to its public facing information. After publication of this final rule, CMS 109 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8197411/.will provide additional guidance on enforcement through memoranda and updates to the State Operations Manual (Pub. 100-07), as needed.
- To date, we are still awaiting publication of the Surveyor's Guidance, Appendix B of the State Operations Manual for how these new requirements will be assessed.

15

Addressing the Requirement

- Your agency should have an Acceptance to Services policy
- This policy should be reviewed by and approved by the Governing Body
  - Policy must be reviewed as often as information in the policy changes and at least annually
  - How do you prove compliance with the oversight of agency operations, including how patients are accepted?
  - What is the standard criteria used for acceptance or denial of referrals?
- Be sure the policy has a creation date
  - Add revision number and date as the policy is revised, but keep the original for reference as needed
  - Document staff training on your policy
  - Monitor for compliance

16

Addressing the Requirement

- "…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 delivery"
- Where is your information made public
  - Brochures
  - Website
  - Referral forms
  - Admission forms
  - Other
- Who is responsible for the accuracy of this information?

17

Addressing the Requirement

- Review and revise referral intake process as needed
- Evaluate the process and if criteria for acceptance is applied properly
- Do public-facing voices understand the policy? Can they explain to potential referral sources, patients, or family/caregivers?
- How do you handle staffing challenges, especially those long-term needs?

18

Surveyor Guidance as of April 1, 2025

- Still pending as of April 1, 2025
- Last updates to Surveyor Guidance Manual was April 12, 2024
- Was primarily focused on updates to Home Health Survey Process
  - Survey Team Size
  - Types of Surveys
  - Protocols for Standard, Patial, and Extended Survey
  - Survey Tasks

19

Surveyor Guidance as of April 1, 2025

- Surveyor may discover noncompliance unrelated to Level 1 standards during a standard or partially extended survey.
- In this case, the surveyor would determine any additional standards and conditions to examine based on findings of noncompliance.
- If non-compliance is identified in a non-Level 1 standard, the finding is documented on the CMS-2567, Statement of Deficiencies and Plan of Correction, and the survey may continue as a standard survey.
- Level 1 Tags related to Acceptance to Service Policy:
  - 484.105 Organization and Administration of Services G982 Services Provided
  - 484.105 Organization and Administration of Services G984 Services Provided with Current Clinical Practice Guidelines and accepted Professional Standards of Practice

20

Surveyor Guidance 484.105: Organization and Administration of Services

The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.

- The roles of the governing body, administrator and clinical manager may not be delegated.

21

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(a): Governing Body. A governing body (or designated person so functioning) must assume full legal authority and responsibility for the agency's overall management and operation the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program.

- An HHA may establish a governing body composed of individuals of its choosing. The individuals that comprise the governing body are those who have the legal authority to assume responsibility for assuring that management and operation of the HHA is effective and operating within all legal bounds (as noted in 82 FR 4548). .

22

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(b)(1): Administrator. The administrator must (i) be appointed by and report to the governing body; (ii) Be responsible for all day-to-day operations of the HHA; (iii) Ensure that a clinical manager…is available during all operating hours; (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies

- The administrator is actively involved in the daily responsibilities of running the HHA
- The administrator acts as a liaison between the daily functions of the HHA and the governing body
- The administrator is required among other things to be responsible for day-to-day operations of the HHA and to be available to receive patients, representatives, and caregivers' complaints.
- Each HHA should be able to demonstrate such involvement

23

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(b)(2): When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager…

- "Pre-designation" means that the individual who is responsible for fulfilling the role of the administrator in his/her absence is established in advance and approved by the governing body.
- Pre0designation needs to be both by the administrator and governing body.
- The goal is to provide management continuity within the HHA
- Staff should know and be able to verbalize on survey interview who the pre-designated individual(s) is/are for this role/

24

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(b)(3): The administrator or a pre-designated person is available during all operating hours,

- "Available" means physically present at the agency or able to be contacted via telephone or other electronic means

484.105(c): One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following: (1) Making patient and personnel assignments, (2) Coordinating patient care, (3) Coordinating referrals, (4) Assuring that patient needs are continually assessed, and (5) Assuring the development, implementation, and updates of the individualized plan of care.

25

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(d): Parent-branch relationship.

(1) The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, ad at the time the patient proposes to add or delate a branch.

A "branch" is an approved location or site (physically separate from its parent's location) from which an HHA provides services within a portion of the total geographic area served by the parent agency. A branch provides services under the same CMS certification number as its parent agency.

26

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(d): Parent-branch relationship.

(2) The parent HHA provides direct support and administrative control of its branches.

The parent location must provide supervision and administrative control of its branches daily to the extent that the branches depend upon the parent's supervision and administrative functions to meet the CoPs and could not do so as independent entities.

The parent agency must be available to meet the needs of any situation and respond to issues that could arise with respect to patient care or administration of a branch.

A violation of a CoP in a branch would apply to the entire HHA. Therefore, it is essential for the parent to exercise adequate control, supervision, and guidance for all branches under its leadership.

27

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(d): Parent-branch relationship.

- "Direct support and administrative control" of a branch includes that the parent agency maintains responsibility for:
  - The governing body oversight of the branch
  - Any branch contracts for services
  - The branch's quality assurance and performance improvement plan
  - Policies and procedures implemented in the branch
  - How and when management and direct care staff are shared between the parent and branch, particularly in the event of staffing shortfalls or leave coverage
  - Human resource management at the branch
  - Assuring the appropriate disposition of closed clinical records at the branch and
  - Ensuring branch personnel training requirements are met

28

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(e): Services under arrangement.

- (1) The HHA must ensure that all services furnished under arrangement provided by other entities or individuals meet the requirements of this part and the requirements of section 1861(w) of the [Social Security] Act.
- (2) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program.

29

Surveyor Guidance 484.105: Organization and Administration of Services

484.105(e): Services under arrangement.

- (3) The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients.
- The HHA retains overall responsibility for all services provided, whether provided directly by the HHA or through arrangements (i.e., under contract). For example, in contracting for a service such as physical therapy, an HHA may require the contracted party to do the day-to-day professional evaluation component of the therapy service. The HHA may not, however, delegate its overall administrative and supervisory responsibilities (see also §484.105(d)). All HHA contracts for services should specify how HHA supervision will occur.

30

Interpretive Guidance for Sections Related to Acceptance to Service

- Guidance for this specific CoP is not yet published
- **G982** related to 484.105(f) Services Furnished: SN services and at least one other therapeutic service (physical therapy, speech-language pathology, or occupational therapy; medical social services; or home health aide services are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide the second service and additional services under arrangement with another agency or organization.
- **Interpretive guidance:** The HHA must provide SN services and at least one other therapeutic service. However, only one service must be provided directly by the HHA.
- An HHA is considered to provide a service "directly" when the persons providing the service for the HHA are HHA employees.

31

Interpretive Guidance for Sections Related to Acceptance to Service

- How "directly" vs "Under Arrangement" is defined:
  - Directly = works for the agency directly if the agency is required to issue a W2 on the individual's behalf with no intermediaries.
  - Under Arrangement = the agency provides the service through contractual or affiliation arrangements with other agencies or organizations, or with an individual(s) who is not an HHA employee.
- Contracted staffing may supplement, but may not be used in lieu of, HHA staffing for services provided directly by the HHA.
- In addition, the use of contracted staff in a service provided directly by the HHA may occur only on a temporary basis to provide coverage for unexpected HHA staffing shortages, , or to provide a specialized service that HHA employees cannot provide.

32

Interpretive Guidance for Sections Related to Acceptance to Service

- G984 related to 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice.
- Accepted standards of practice include guidelines or recommendations issued by nationally recognized organizations with expertise in the field.
- Clinical practice guidelines and accepted professional standards of practice may be found in, but are not limited to:
  - State practice acts;
  - Standards established by national organizations, boards, and councils (e.g., the American Nurses' Association); and
  - The HHAs own policies and procedures
- HHAs should consider identifying the clinical practice guideline or standard of practice used when developing and updating core policies and procedures.

33

Example DRAFT Acceptance to Service Policy

Healthcare Provider Solutions, Inc.
Your Total Home Care & Hospice Resource

(Agency Name) Acceptance-to-Service Policy

Effective Date: 01-01-2025

Review Date: 12-31-2024

Next Review Date: no later than 12-31-2025

Example Draft Policy

Purpose

1. The purpose of this policy is to maintain, through an annual review, a patient acceptance to service policy that is consistently applied to each prospective patient referral for home health care, which addresses the criteria related to (Agency Name)'s capacity to provide patient care, included but not limited to, all of the following:
   a. The anticipated needs of the prospective patient
   b. Case load and case mix of the home health agency (HHA)
   c. Staffing levels of the HHA
   d. Skills and competencies of the HHA staff

34

Example DRAFT Acceptance to Service Policy

2. (Agency Name) will 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 delivery.

3. (Agency Name) will review the information available to the public as frequently as the services are changed, but no less often than at least annually.

35

Example DRAFT Acceptance to Service Policy

Scope

This policy applies to all patient referrals made to the home health agency for home health services, including skilled nursing, physical therapy services, occupational therapy services, speech-language pathology services, medical social services, and home health aide services, regardless of payment source.

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36

Example DRAFT Acceptance to Service Policy

Definitions

- Referral: A formal request for home health services typically initiated by a physician or allowed provider or facility discharge planner.
- Capacity: The home health agency's ability to meet the anticipated care needs of a referred patient considering factors such as managers' case load, staffing availability, and available resources.
- Case Load: The total number of patients currently under care by the home health agency at any given time.
- Case Mix: The type and complexity of patients currently under care, which may impact the ability of the agency to accept new patients.
- Competencies: The knowledge, skills, abilities, and experience level(s) of agency staff members relative to the types of services being requested of and/or delivered by home health agency staff.
- Services: Skilled and unskilled, therapeutic care delivered by the home health agency which may include skilled nursing, physical therapy, occupational therapy, speech-language pathology, medical social services or home health aide care and/or treatment under a plan of care established by and periodically reviewed by a physician or allowed provider.

37

Example DRAFT Acceptance to Service Policy

Policy Overview

The HHA will accept patients for home health services when there is a reasonable expectation that the agency has the capacity to meet the patient's anticipated care needs. The decision to accept or deny a referral will be made based on an evaluation of the following criteria:

1. Anticipated Needs of the Referred Patient
    - Referrals will be received through [list referral channels such as phone call, facsimile, electronic facsimile, shared electronic referral portal, etc.]
    - Upon receiving a referral, the agency's Intake Coordinator(s) and/or Clinical Manager(s) will initiate a preliminary review, ensuring all necessary information is provided on which a decision regarding acceptance is possible. This may include, but is not limited to, patient address and contact numbers, services being requested, physician or allowed provider orders, diagnoses, recent history and physical, discharge summary, clinic visit note(s), and/or progress notes relative to services being requested or ordered.

38

Example DRAFT Acceptance to Service Policy

2. Agency Case Load and Case Mix
   - The Intake Coordinator and/or Clinical Manager, in collaboration with the clinical team, will assess the patient's anticipated care needs, case load, case mix, staff competencies and staffing availability.
   - If the patient's anticipated needs are within the abilities and capacity of the home health agency, the referral will be moved forward for scheduling and in-home evaluation for admission to services.
   - If the agency determines it cannot meet the patient's needs, the referred patient will be notified, and referral source will be contacted in a timely manner. The referral will be declined, and alternative home health services may be recommended.

39

Example DRAFT Acceptance to Service Policy

3. Staffing Levels and Capacity
   - The HHA will assess whether it has sufficient qualified staff to provide timely and appropriate care to the referred patient without compromising the care of existing patients.
   - Staffing levels must meet the regulatory requirements and needs of the agency's patient population.

40

Example DRAFT Acceptance to Service Policy

4. Skills and Competencies of the HHA Staff
   - Assessment of whether the HHA staff has the necessary skills and competencies to meet the specific care needs of the referred patient will be completed at the time of the referral
   - IF specialized services are required, such as but not limited to wound care, IV therapy, or other specialized services/therapies, the agency must ensure it has appropriately skilled, competent staff to provide these services.

***Note**: at the time of this sample policy creation, February 2025, the Home Health Surveyor's Guidance has not been released. Review and/or revision is suggested at which time this is made available from CMS.*

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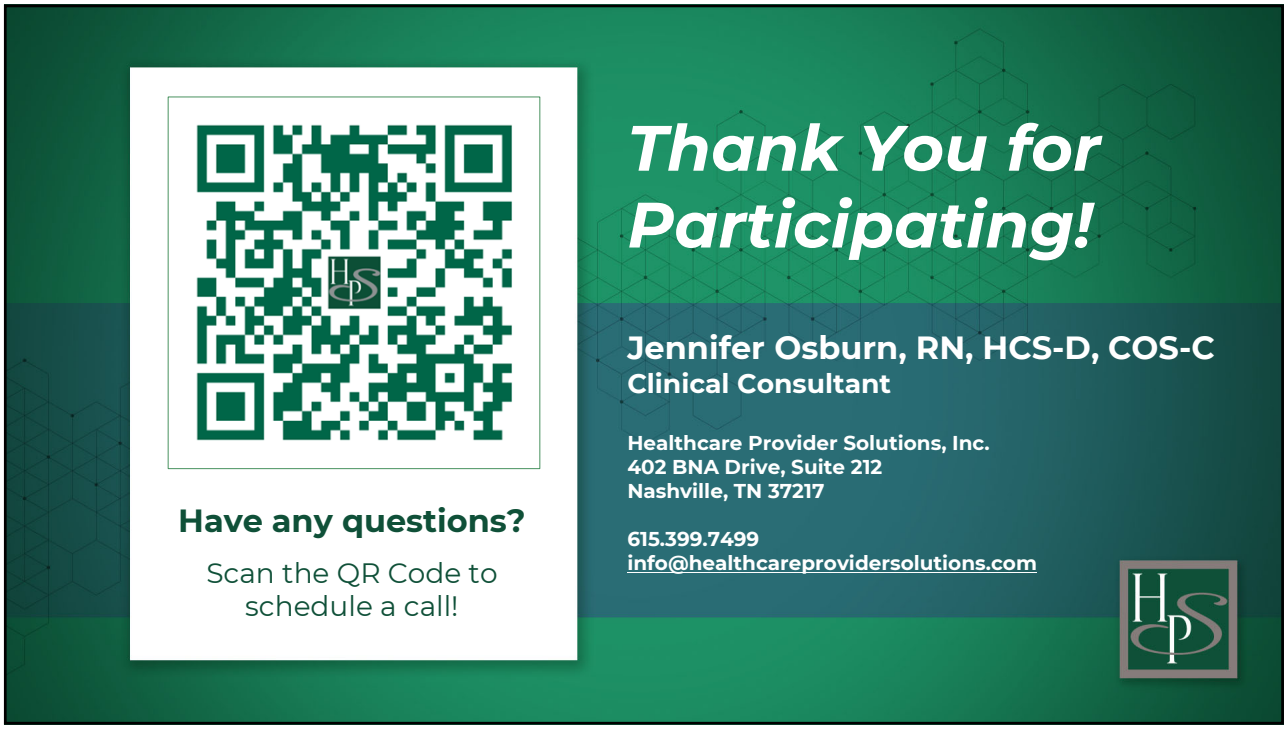
41

42


Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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43