National Alliance for Care at Home

# Acceptance to Service Policy and Procedure Toolkit

On November 7, 2024, the Centers for Medicare & Medicaid Services (CMS) finalized a new standard under the Organization and Administration of Services condition of participation, The new standard at **§484.105(i)** requires that home health agencies develop and maintain an Acceptance to Service policy. The policy must include four key considerations and be applied to each referral when determining whether to accept the patient onto services. Additionally, CMS requires that home health agencies (HHAs) 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. The information must be updated whenever there is a change in the information but no less frequently than annually.

HHAs must have an acceptance to service policy that includes, but is not limited to, four elements that are to be considered when determining whether to accept or decline a patient onto service. These elements are:

- The 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.

Although CMS has not yet issued interpretive guidance for the new standard, it does provide insights into what surveyors will be looking for in the preamble of the **CY2025 Home Health Prospective Payment System Rate Update** final rule. CMS expects HHAs to implement the policy consistently to ensure that HHAs only accept those patients for whom there is a reasonable expectation that the HHA can meet the referred patient's needs.

To assist HHAs in operationalizing these new requirements, the Alliance has developed a tool kit that includes:

- A checklist for items to consider when reviewing a referral;
- A template for an admission to service policy which includes the four required elements',
- Guidance for providing information regarding services offered and any limitations related to types of specialty services, service duration, or service frequency; and
- Frequently asked questions.

## Services Offered and Limitations on Services, Duration, and Frequency

The requirement for providers to make publicly available information regarding services offered and any limitations related to types of services, service duration, or service frequency, will vary greatly among home health agencies. CMS' rationale for this requirement is related to reports from referral sources (inpatient facilities and community) that are having difficulty locating an appropriate HHA, and therefore, the initiation of home health services are delayed, placing the patient at risk for decline.

CMS expects 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 (e.g., 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.

The following tips for reporting service limitations may be helpful

- CMS will allow HHAs to provide a link to the CMS Care Compare web site to comply with reporting the services offered by the agency. If the HHA chooses this option, the agency will need to verify the accuracy of the information on the Care Compare website.
- CMS has not provided much guidance regarding expectations for publicly reporting limitations of services, service duration and service frequency. HHAs would need to determine if there are any covered home health services the agency does not provide such as:
  - Specific disciplines that the agency never or rarely is able to provide
  - Daily care or care that is required more frequently
  - Special treatments (e.g. patients requiring ventilators, IVs etc.)
- HHAs would not be expected to list items or services that are not covered under the Medicare home health benefit or typically not covered by private insurers.
- HHAs that offer specialty services might consider publicly listing those services to provide comprehensive information on the services provided. The reporting of the availability of specialty services could also serve to promote the HHAs ability to accept patients requiring complex and/or specialty care.

## Acceptance to Service Checklist

At a minimum, §484.105(i) requires the following four elements be considered in the Acceptance to Service policy.

- Anticipation of patient needs
- Case load and case mix
- Staffing levels
- Skills and competencies of staff

The following checklist is intended to provide examples of the types of information that can be considered for the application of these four elements to each potential patient referred to the home health agency when determining whether to accept a patient onto services.

| | |
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| **Anticipated needs of the patient** | Diagnosis |
| | Visit frequency |
| | Disciplines needed |
| | Caregiver support |
| | Recent hospitalization |
| | New condition versus exacerbation of an existing condition |
| **Case load and case mix** | The average number of patients clinicians are managing |
| | The number of complex patients on service |
| | Specialized treatments that might be required |
| **Staffing levels** | Disciplines available |
| | Case load as above |
| **Staffing competencies and skills** | Staff with specialty certifications |
| | Staff education levels |
| | Staff training and competencies |

## Template for Acceptance to Service Policy

Each agency must develop individualized policies and procedures that include the listed criteria (anticipated needs, case mix and case load, staff levels, and staff skills and competencies).

Most HHAs currently have an admission to services policy to some degree and/or apply the listed criteria when making determinations on whether to admit a patient. These considerations, however, must formally be written into the HHA's policy and procedures.

**Purpose:** To ensure patients' home care needs are assessed and adequately met.

**Policy:** Patients are accepted for treatment on the basis of a reasonable expectation that the patient's nursing, rehabilitative, personal care and/or social needs can be met adequately in the patient's place of residence.

**Procedure:**

- The intake staff will ensure only patients appropriate for care at the time of the referral are accepted onto service.
- The intake staff will evaluate each patient referral against the following criteria.
  - The anticipated needs of the patient
  - The case load of the perspective clinician(s) at the time of the referral
  - The agency's case mix of the patients at the time of the referral
  - The skills of the staff related to the patient's needs
  - Availability of appropriate staff
- The next steps if the referral is accepted
- Criteria for staff assignments
- Process for practitioner notification and plan of care development
- Process for coordination with team members/manager

# Acceptance to Service Frequently Asked Questions

**Q. What is the effective date of the new standard?**

**A.** The new standard is effective beginning January 1, 2025. Home Health Agencies (HHAs) should implement the requirement with referrals received on and after January 1, 2025.

**Q. If the home health agency develops a policy that meets the requirement for the Acceptance to Service standard does this meet the requirement?**

**A.** No, developing a policy is one action required to meet the new standard. The HHA must implement the policy for each referral received and be able to demonstrate to a surveyor how the policy is operationalized by the HHA. One way to demonstrate this is through documentation on each referral record

**Q. Do we need to change the information on the website every time we have a change in service offered by the agency?**

**A.** CMS expects 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.

**Q: Do we need to update our PECOS record to reflect that we do not offer this service?**

**A:** The PECOS record should be updated to reflect any service that has been added or deleted.

**Q. Can you provide an example of a service limitation?**

**A.** The HHA should list any Medicare covered services that it does not provide. For example, the agency does not provide speech language pathology (SLP) or aide services. Therefore, it should be clear to the public that SLP services and aide services are not provided.

**Q. Can you provide an example of a frequency limitation?**

**A.** An example of frequency limitation would be if the HHA is not able to provide daily or twice-a-day services due to staffing constraints. It should be clear to the public that the HHA does not provide these services.