# Home Health Update: CMS Finalizes New Acceptance-to-Service Requirement

## What Organizations Need To Do Now

The final rule published on November 7, 2024, included a new standard as part of condition § 484.105 that most of us did not expect.

Condition § 484.105 (organization and administration of services) now specifies that "the agency 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 additional standard attached to this condition is an effort to reduce avoidable care delays by helping ensure that referring entities and prospective patients can select the most appropriate HHA based on their care needs. Referrals are often made to home health agencies with little thought as to whether or not the clinical condition of the patient, the competency of the staff or other needed resources are available to actually have the ability to produce positive outcomes for that patient.

Many organizations continue to struggle with assuring patients can be seen within the 48-hour time requirement identified in the OASIS rules. There are many home health organizations reporting 14-day and longer delays in assuring patients can be admitted. While lack of capacity is the main issue, often the skill level of the staff is not adequate for the unique needs of the patient being referred. With that understanding, CMS has laid out some specific guidance that organizations must follow and have related policies in place for implementation by January 1, 2025.

## New Policy Requirements

1. This new standard requires organizations to 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 healthcare. The policy, at a minimum, must address the following criteria related to the HHA's capacity to provide patient care:
    - The anticipated needs of the referred prospective patient
    - The organization's caseload and case-mix
    - The organization's staffing levels
    - The skills and competencies of the organization's staff

**Recommendation:** Ensure that all patient intake processes are well-documented and include a plan that evaluates the current availability of staff and resources to adequately care for the patient with an expectation of positive outcomes at discharge.

2. Organizations must make available to the public accurate information regarding the services offered by the HHA and any service limitations related to types of specialty services, service duration, or service frequency.

**Recommendation:** Ensure websites and all public-facing materials are updated with any limitations or restrictions. For instance, if you do not have a wound care program, that should be clearly stated in any public information about the organization's programs. Quarterly updates are recommended to keep this information current and accurate.

3. The HHA must review public-facing information as frequently as the services are changed, but no less often than annually. CMS indicates that a change in service may include an employee taking an extended leave of absence (that is, to care for a family member, recover from a serious illness or procedure, take maternity leave, etc.) or the addition of a new contract employee that provides speech-language pathology services, which an HHA may not have provided before.

**Recommendation:** The Board of Directors should specifically identify this standard and any updates in their annual board meeting minutes as they do annual review of policies and procedures.

The organization's policy should be written in a way that ALL patients are evaluated for admission equally. Therefore, there must be no exceptions with the patient's need for care from one to another so long as the organizations have the capacity to provide care within limitations as indicated in public information provided.