

# Introduction

Agencies often build a strong compliance program but drift away from the requirements under the Home Health Conditions of Participation (CoPs), particularly as clinical and office staff are replaced and new staff are taught practices that run against CMS rules.

To meet the challenges of a compliant operation and avoid survey citations, agencies must implement a simple, three-point strategy:

1. Staff must know the requirements for service delivery
2. Staff must deliver services according to the regulations
3. Staff must document appropriately

It is the first point in that strategy that creates the biggest obstacle for agencies. Exactly what rules govern the survey process? How can an agency obtain these regulations?

In April 2024, CMS released a comprehensive update to its guidance to surveyors. While there was no change in the CoPs, the update consolidated and expanded survey guidance.

This manual pulls together one concise, up-to-date set of the rules and interpretations that agencies can use in the orientation and training of staff and as a reference during care delivery. It also includes interpretive guidelines for a separate emergency preparedness rule, which have been extensively updated with infection control guidance due to the COVID-19 pandemic.

Also in 2024, CMS released updated survey protocols for home health agencies. That information is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_b\\_hha.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf).

You can see more survey tips in DecisionHealth's *Home Health Survey Trainer*, available at <https://store.decisionhealth.com>.

## ***What's in this manual:***

All 2024 updates to the interpretive guidance, including changes to G tags and tips for surveyors, are included in this edition. These guidelines can be found cross-referenced with the corresponding CoPs and G tags in **Section 1**.

CMS also publishes interpretive guidelines for its emergency preparedness requirement. These guidelines can be found cross-referenced with the corresponding CoPs and E tags in **Section 2**.

***Updated CoPs for 2025:***

In November 2024, CMS finalized a new CoP targeting an acceptance to service policy.

The new language at **§484.105** reads:

Condition of participation: Organization and administration of services.

(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.

(2) 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 is reviewed at least annually.



**Section One**  
G-tags, CoPs and  
Interpretive Guidelines



# Home health interpretive guidelines for CoPs

The interpretive guidelines for the Home Health Conditions of Participation (CoPs) are provided to state survey agency directors by the director of CMS' Quality, Safety & Oversight Group. Changes in recent years have included rules around discharge planning, emergency preparedness, aide supervision, infection control and more. Those changes are incorporated throughout this section.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
G325	<p>Subpart A—General Provisions</p> <p>§484.1 Basis and scope.</p> <p>(a) Basis. This part is based on:</p> <p>(1) Sections 1861(o) and 1891 of the Act, which establish the conditions that an HHA must meet in order to participate in the Medicare program and which, along with the additional requirements set forth in this part, are considered necessary to ensure the health and safety of patients; and</p> <p>(2) Section 1861(z) of the Act, which specifies the institutional planning standards that HHAs must meet.</p> <p>§484.1(b) Scope. The provisions of this part serve as the basis for survey activities for the purpose of determining whether an agency meets the requirements for participation in the Medicare program.</p>	<p>To qualify for a provider agreement as a home health agency under Medicare and Medicaid, an entity must meet and continue to meet all the statutory provisions of §1861(o), 1891 and 1861(z) of the Act, including the Condition of Participation (CoP) requirements.</p> <p>This, in part, means the HHA:</p> <ul style="list-style-type: none"> <li>is primarily engaged in providing skilled nursing services and other therapeutic services [§1861(o)(1) of the Act; 42 CFR 484.105, Organization and administration of services];</li> <li>has policies to govern the services which it provides and provides for supervision of such services [§1861(o)(2) of the Act; 42 CFR 484.75, Skilled professional services and § 484.65 Quality assessment and performance improvement (QAPI). See also 82 FR 4542];</li> <li>maintains clinical records on all patients [§1861(o)(3) of the Act; 42 CFR 484.110, Clinical records];</li> <li>for any HHA in a state or local jurisdiction with a law that requires agencies or organizations like HHAs to be licensed, is licensed pursuant to such law, or is approved, by the State or local agency responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing [§1861(o)(4) of the Act; 42 CFR 484.100, Compliance with Federal, State and local laws and regulations related to health and safety of patients];</li> <li>has in effect an overall plan and budget [§1861(o)(5) of the Act; 42 CFR 484.105, Organization and administration of services];</li> </ul>

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TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
<p>G325 (cont.)</p>	<p>§484.2 Definitions.</p> <p>As used in subparts A, B, and C, of this part—</p> <p><b>Allowed practitioner</b> means a physician assistant, nurse practitioner, or clinical nurse specialist as defined at this part.</p> <p><b>Branch office</b> means an approved location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The parent home health agency must provide supervision and administrative control of any branch office. It is unnecessary for the branch office to independently meet the conditions of participation as a home health agency.</p> <p><b>Clinical note</b> means a notation of a contact with a patient that is written, timed, and dated, and which describes signs and symptoms, treatment, drugs administered and the patient's reaction or response, and any changes in physical or emotional condition during a given period of time.</p> <p><b>Clinical nurse specialist</b> means an individual as defined at §410.76(a) and (b) of this chapter, and who is working in collaboration with the physician as defined at §410.76(c)(3) of this chapter.</p> <p><b>In advance</b> means that HHA staff must complete the task prior to performing any hands-on care or any patient education.</p> <p><b>Nurse practitioner</b> means an individual as defined at §410.75(a) and (b) of this chapter, and who is working in collaboration with the physician as defined at §410.75(c)(3) of this chapter.</p> <p><b>Parent home health agency</b> means the agency that provides direct support and administrative control of a branch.</p> <p><b>Physician</b> is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function under paragraph (d) of this section. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)</p>	<ul style="list-style-type: none"> <li>meets the conditions of participation specified in section 1891(a) and such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization [§1861(o)(6) of the Act; 42 CFR 484.1, Basis and Scope, et seq.];</li> <li>provides the Secretary with a surety bond [§1861(o)(7) of the Act; 42 CFR Part 489, Subpart F];</li> <li>meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program) as the Secretary finds necessary for the effective and efficient operation of the program [§1861(o)(8) of the Act; 42 CFR 484.1, Basis and Scope, et seq.];</li> <li>except that for purposes of part A “home health agency” shall not include any agency or organization which is primarily for the care and treatment of mental diseases. The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law [§1861(o) of the Act; 42 CFR 484.1, Basis and Scope, et seq.].</li> </ul> <p>CMS is required to determine whether an HHA is complying substantially with the Medicare participation requirements established by the Act and regulations. Section 1866(b)(2)(B) of the Act states in part that a provider's participation agreement may be terminated if CMS determines that “the provider fails substantially to meet the applicable provisions of section 1861.” To remain a Medicare participating HHA, the HHA must remain in substantial compliance with all conditions of participation.</p>