



HOME HEALTH CONDITIONS OF PARTICIPATION (CoPs) FAQ

BACKGROUND

In January 2017, the Centers for Medicare & Medicaid Services (CMS) published the Home Health Conditions of Participation (CoPs) final rule in the Federal Register. The CoPs are the minimum health and safety standards that a home health agency must meet in order to participate in Medicare and/or Medicaid programs. The regulation, which included amended provisions to a proposed rule that was posted nearly two years prior, will become effective on July 13, 2017, with some elements of the Quality Assurance and Performance Improvement (QAPI) changes scheduled to take effect January 2018.

FREQUENTLY ASKED QUESTIONS

Q. Does the Clinical Manager role encompass QA or is that a separate entity? Does the Clinical Manager replace the Clinical Supervisor or a director level role?

A. The Clinical Manager replaces the person many agencies call the Clinical Supervisor. In the preamble, CMS states, "The Clinical Manager replaces the Supervising Physician or Registered Nurse which is found in the current regulations at 484.14(d)). The Supervising Physician/Registered Nurse are now responsible for "participating in all activities relevant to the professional services furnished..." and, "We believe that the QAPI committee will include the QAPI coordinator, the HHA administrator, and a clinical manager."

CMS defines the role of the Clinical Manager as follows:

Clinical Manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following:

- a) Making patient and personnel assignments,
- b) Coordinating patient care,
- c) Coordinating referrals,
- d) Assuring that patient needs are continually assessed, and
- e) Assuring the development, implementation, and updates of the individualized plan of care.

Q. Can the Administrator be the Clinical Manager also in small rural agencies?

A. This would not be prohibited as long as the individual met qualifications for both roles. CMS responded to this concern as follows: "While we believe that it would be rare for a single individual to be capable of effectively fulfilling all of the responsibilities of the administrator and the clinical manager for an entire HHA, this rule would not prohibit this arrangement, provided that the individual meets the personnel qualifications for both roles as set forth in §484.115 and the quality of care provided to patients is not compromised. However, we believe that in the vast majority of situations, HHAs will find it necessary to have at least two individuals fulfilling the administrator and clinical manager responsibilities separately."

FREQUENTLY ASKED QUESTIONS

Q. So many times patients do not have addresses of their representatives. In addition, we have many patients whose POA lives in another state. They are not always easy to find or locate. How would we deal with this?

A. HHAs should only identify persons as representatives if they meet the following definitions: “the patient’s legal representative, such as a guardian, who makes health-care decisions on the patient’s behalf, or a patient-selected representative who participates in making decisions related to the patient’s care or well-being.” The same information would not be required of emergency contacts who do not serve these functions, and therefore, are not “representatives” or POAs responsible for financial issues.

As with all required information that is collected by interview, you can only record what is available. For example, in the QIES OASIS Q&A, CMS states that during the comprehensive assessment, since “many items that can ONLY be obtained by interview have a response option of ‘unknown’...” Therefore, if information about a representative is unknown, that should be noted in the record. The questions that you need to ask are, “If the person cannot be contacted, are they truly the patient’s healthcare representative and is the patient capable of making their own healthcare decisions?”

Q. Can you please clarify if an RN has to sign after an LVN on verbal orders?

A. CMS clearly allows an LPN, who is categorized as a skilled professional assistant, to accept and document verbal orders as permitted by state law and agency policy. This regulation does not indicate whether the LPN can document this information to the plan of care, which according to the regulation, specifies: “Skilled professionals must assume responsibility for: Development and evaluation of the plan of care...”

However, the plan of care requirements at payment regulations 42 CFR 409.43 remain unchanged and specify that (i) A physician's verbal order that (A) Is recorded in the plan of care; (B) Includes a description of the patient's condition and the services to be provided by the home health agency; (C) Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist...responsible for furnishing or supervising the ordered service in the plan of care.

FREQUENTLY ASKED QUESTIONS

Q. For clarification: The supervisory visits for the HH Aides should be done within the designated timeframe (14 days or 60 days) with the aide present or is the timeframe of yearly when the supervisory visit be in the home with the aid performing the duties?

A. Unless your State HHA licensure regulations has additional requirements. The CoP requires supervision of home health aides:

(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

(iii)(2) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. (i.e. aide must be present)

Q. Regarding patient rights and reasons for transfer and discharge -- Physician and HHA agree that measureable outcomes/goals and services no longer needed. Does this mean there must be documented communication with MD at time of discharge other than discharge summary if goals met?

A. If services are completed and terminated in accord with the plan of care (i.e. discharge date is projected), there would not be a requirement to notify the physician of discharge. However, the regulations do require that, just as with any changes to the plan of care, "Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any)."

FREQUENTLY ASKED QUESTIONS

Q. What information needs to be included in a transfer summary?

A. CMS did not specify content of transfer or discharge summaries as was in the proposed rule. The transfer summary regulation is limited to timing (within two calendar days of planned or knowledge of unplanned transfer). Their rationale (which applies to both discharge and transfer) is as follows: “In order to meet the requirements of the IMPACT Act for HHAs, we have decided to withdraw our proposals related to the content of the discharge summary. In its place, we are proposing a separate rule (Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, November 3, 2015 (80 FR 68126)) that would implement the discharge planning provisions of the IMPACT Act and would address the content of the HHA discharge summary.” It is unknown when, or if this proposed rule will be finalized.

Q. Can an OT now do the initial and comprehensive assessment?

A. If Medicare is the payer, an OT may not do the initial or comprehensive assessment because OT is not a qualifying service for Medicare payment. However, if other payers do not impose similar limitations, then the CoPs allow for an OT to perform all required assessments.

Q. Can the Administrator or other agency staff be members of the governing board?

A. CMS does not specifically address make-up of the governing body (board) but does require that an agency have “an independent governing body. The notice does elaborate that “the 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. Those individuals could be members of the previously-required Professional Advisory Committee, but that is not a requirement.” However, in view of the requirement that the HHA employment of “qualified personnel’ is the responsibility of the HHA administrator,” and that the administrator “be appointed by and report to the governing body,” it seems counterintuitive that an administrator or staff member could be a member of the governing body.

FREQUENTLY ASKED QUESTIONS

Q. Regarding the CoP 484.80 Home Health Aide Services, it outlines a variety of elements that must be demonstrated by the aides (following the patient's plan of care for the completion of tasks assigned, honoring patient rights, etc.). Do these need to be on the annual competency supervision visits or on the aide supervisory visits, or both?

A. The regulation related to annual supervisory visit states: "A registered nurse or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care."

Since this provision is found under the regulation for supervision of home health aides, the annual supervisory visit should address the same elements as the every 14 day supervisory visits: "Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; Maintaining an open communication process with the patient, representative (if any), caregivers, and family; Demonstrating competency with assigned tasks; Complying with infection prevention and control policies and procedures; Reporting changes in the patient's condition; and Honoring patient rights."

Q. Are the Emergency Disaster requirements going into effect July 13, 2017 or November as previously announced?

A. The CoP notice reads: "Section 484.22 was implemented as part of the Emergency date, on November 16, 2017."

Preparedness final rule published on September 16, 2016 (81 FR 63859)." According to the CMS Emergency Preparedness website: "On September 8, 2016 the Federal Register posted the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. The regulation goes into effect on November 16, 2016. Health care providers and suppliers affected by this rule must comply and implement all regulations one year after the effective."

Q. If an aide meets the state CNA licensure requirements, is there no longer need for the additional 16 hours?

A. That is correct, as long as your state does not impose this additional requirement.

FREQUENTLY ASKED QUESTIONS

Q. What if the interim verbal order is NOT from the doctor signing the POC? For example, a cardiologist changes a medication but POC is signed by and Internist? Also, how do you have the POC updated with new orders if it was already signed? Is the POC more of "Care Plan" as opposed to "orders"?

A. The updated CoP require an updated version of a plan of care if orders are changed and for HHAs to have all versions, initial and updated plans of care, signed by the responsible physician. The plan of care includes orders, diagnoses, goals, and all other elements found on slide 26. If orders are accepted from other physicians, this may necessitate signatures by both physicians depending on State law, agency policy, and the willingness of the "physician responsible for the plan of care" to sign for verbal orders issued by other physician. If the physician responsible for the plan of care is willing to sign for medications and treatments ordered by other physicians, then the responsible physician assumes the role of care coordinator, and the HHA is required obtain signatures and copy plans of care to other physicians. Medicare CoP require only the signature of the one "physician responsible for the plan of care."

The following excerpt from the notice provides details of CMS' intent:

"The plan of care is an evolving document that outlines the patient's journey throughout HHA care and treatment. It is essential that the plan of care be reflective of past orders and current orders that are actively ongoing. As new orders are given to initiate or discontinue an intervention, the plan of care is updated to reflect those changes. New versions of the plan of care are created. The physician that is responsible for care of the condition that led to the initiation of home health care, and is thus the main physician responsible for the home health plan of care would have the opportunity to review all orders because all orders from all physicians must be included in the plan of care (§484.60(a)(3)) and the plan of care must be reviewed and signed by the physician responsible for the HHA plan of care (§484.60(a)). We have also added new requirements within §484.60(d), Coordination of care, to specifically address the role and responsibility of the HHA when it chooses to accept orders from more than one physician. Specifically, in addition to the proposed requirements that HHAs would be responsible for coordinating HHA services and ensuring patient education and training, we have added new requirements within §484.60(d) that HHAs that choose to accept orders from multiple physicians are responsible for: (1) Assuring communication with all physicians involved in the plan of care. (2) Integrating orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient."

FREQUENTLY ASKED QUESTIONS

Q. Regarding LNA supervision and care planning, do the regulations imply that an OT can complete the care plan and do the supervision or is it still that if nursing is involved in the care that they must do the intro and supervision every 14 days?

A. Effective July 13, 2017, any skilled professional may supervise a home health aide as follows: (h) Standard: Supervision of home health aides. (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions.

CMS also added a regulatory requirement for supervision of assistants: (c) Supervision of skilled professional assistants. (1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist that meets the requirements of §484.115(f) or (h), respectively. Medical social services are provided under the supervision of a social worker that meets the requirements of §484.115(m).

Q. Can you clarify the no use of mannequins in orientation?

A. The only prohibition to the use of mannequins in related to home health aide training and testing requirements for aide certification. An HHA may use mannequins for orientation or additional in-service training once an aide is certified. However, if a deficiency in aide services is noted during a supervisory visit, and a new competency evaluation is needed, use of an "individual," rather than a mannequin, for testing of skills would be required.

Q. Does the OASIS privacy notice have to be given if data is only collected and not submitted? Sometimes we fill out an OASIS but don't submit it.

A. The OASIS Privacy Notice is not limited to OASIS transmission. According to the State Operations Manual, Chapter 2: On or after July 19, 1999, HHAs were required to provide existing patients with privacy notifications. To properly inform patients of their rights under the Privacy Act, the provider must furnish each patient with information required by the Privacy Act. Under the authority of the Privacy Act, one reason for several reasons for the notice is: "The right to be informed that OASIS information will be collected and the purpose of collection"

FREQUENTLY ASKED QUESTIONS

Q. Does the physician have to time an order that they sign and return to the agency?

A. No, CMS did specify in the notice that they do not intend to require timed physician signatures.

Q. When a physician order is created, does the plan of care need to be updated every time and sent to the physician for signature?

A. Yes it does. Therefore, it is recommended that all interim verbal orders be documented on an updated plan of care and that sent to the physician for signature. Doing so will relieve physicians from having to sign one document that contains the verbal order and then sign the revised plan of care.

Q. I am concerned about all of the information that we have to do at the initial admission visit and how the patient's will be receptive or just be plain worn out.

A. This same concern was expressed by commenters to the proposed rule, to which CMS responded in the notice: "HHA staff members are not required to read the notice word-for-word to the patient. Rather HHA staff members have the flexibility to provide comprehensive and accurate summaries of each right in conversational language and tone in order to engage patients and representatives in this discussion."

Q. Where is the best place to find your state regulations?

A. The Community Health Accreditation Partner provides links to the licensure requirements for home health agencies in each state at: <http://www.chapinc.org/home-health/home-health-licensing.aspx>.

Q. Regulation 484.105-Are they removing the requirement to have a PAC Committee?

A. Yes, the PAC or Professional Advisory Committee was the designation given by many HHAs for the present CoP "Group of Professional Personnel" that were responsible for the agency evaluation. This regulation has been replaced with a much expanded Quality Assessment Performance Improvement Program (QAPI) requirement.

FREQUENTLY ASKED QUESTIONS

Q. Can a parent can be the home health aide for their own child, assuming that the parent is a certified nursing assistant or home health aide? Can we bill Medicaid for home health aide if the parent is the one providing the care to their own child?

A. For Medicaid patients, use of a family member to provide services is a question that you must pose to your State Medicaid program as it varies from state to state.

Medicare policy discusses this topic when related to “charges” by an entity (e.g. HHA), but does not specifically address employees of an agency servicing their family members. In light of potential problems that may occur under this type of arrangement, close consideration should be given by a Medicare provider before doing so.

The following is the policy statement on this issue as found in the Medicare manual: “Charges Imposed by Immediate Relatives of the Patient or Members of the Patient’s Household (Rev. 1, 10-01-03) A3-3161, HO-260.12, B3-2332 A. General These are expenses that constitute charges by immediate relatives of the beneficiary or by members of their household. The intent of this exclusion is to bar Medicare payment for items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s) of the provider. It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s) of the supplies.”

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Q. Is HEALTHCAREfirst making any enhancements to fit the new CoP changes?

A. HEALTHCAREfirst is currently researching and writing requirements for the necessary product changes to our EHR system, *first*HOMECARE. We will host additional product specific webinars prior to June, to demonstrate these enhancements and announcements/communications will go out to clients in the next few weeks.

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