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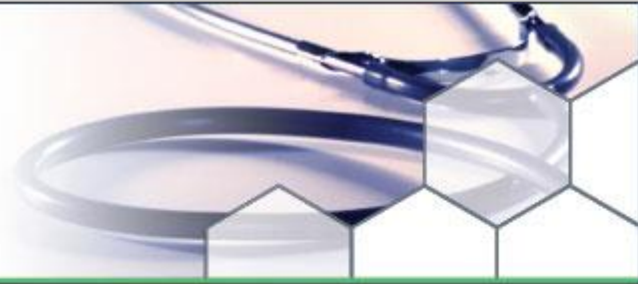

January 2017

CMS Issues Final Rule for Home Health Agency Conditions of Participation

The Centers for Medicare & Medicaid Services (CMS) released a Final Rule (Final Rule), effective July 13, 2017, updating the Home Health Agency Medicare and Medicaid Conditions of Participation (CoPs). The Final Rule focuses on a "patient-centered, data-driven, outcome-oriented process that promotes high quality patient care at all times for all patients." As described in further detail below, the Final Rule updates patients' rights, imposes additional documentation requirements on home health agencies (HHAs), and includes provisions aimed to improve care coordination and quality of care. This is the first update to the HHA CoPs since 1989. Below are highlights of some of the most significant changes.

PATIENT RIGHTS

The Final Rule revises the standard for patient rights by providing a clear and comprehensive list of the type of information HHAs must inform patients and their representatives about and how such information must be communicated. For example, the Final Rule mandates that HHAs must provide written notice to patients and their representatives of the HHA's policies governing admission, transfer, and discharge prior to receiving care from the HHA. Oral notice must be provided by the end of the second skilled visit. CMS intends for patients and their representatives to have an opportunity to ask questions about any of the information provided by the HHA. The Final Rule also requires that patients be informed about all assessments performed by HHA personnel throughout the course of care, which will allow patients to either consent to or refuse certain care. Of note, the Final Rule formalizes the existing right of patients to refuse treatment.

This new standard is accompanied by criteria outlining when and how HHAs can discharge or transfer a patient. The acceptable reasons for discharge include (1) that the HHA can no longer meet the patient's needs, based on the patient's acuity; (2) that the patient or payor will no longer pay for the HHA's services; (3) that the patient elects to be discharged; (4) that the HHA and the patient's physician agree that the HHA's services are no longer necessary; and (5) that the patient is disruptive, abusive, or uncooperative and the HHA has taken reasonable steps to address and attempt to remedy such behavior.

Upon discharge of a patient, the HHA must compile a discharge or transfer summary, which must include (1) a summary of the patient's stay, (2) the patient's current plan of care, and (3) any other documentation that will assist in post-discharge or transfer continuity of care. The Final Rule creates

a new requirement that HHAs provide written instructions to patients and their caregivers regarding future visit schedules, medication schedules and instructions, and other patient care instructions.

CARE COORDINATION

In the Final Rule, CMS places a significant emphasis on the importance of care coordination among HHAs and other health care providers to achieve positive patient outcomes. The current CoPs require HHAs to provide a comprehensive patient assessment. The Final Rule formalizes the content that must be included in a comprehensive patient assessment and adds several requirements, such as an evaluation of the patient’s psychosocial, functional, and cognitive status and an assessment of the patient’s progress toward his or her goals. CMS believes this revised standard will provide a more holistic view of the patient’s overall health.

The Final Rule creates a new “care planning, coordination of services, and quality of care” CoP. Under this CoP, HHAs must provide individualized patient care plans addressing the needs identified in the comprehensive assessments. Among other things, the plan of care must include patient-specific measurable outcomes and goals, and must be periodically reviewed and signed by a physician. The physician review must occur as frequently as the patient’s needs require but no less than once every 60 days. CMS lists a number of other specific items that an HHA must include in the plan, such as the patient’s diagnoses and prognosis, types of services required, functional limitations, and safety measures to protect against injuries.

The new care coordination CoP also requires HHAs to (1) communicate appropriately with, and integrate orders from, all physicians involved in a patient’s plan of care; (2) coordinate care delivery and integrate services provided by the HHA; and (3) provide patients and their caregivers ongoing education and training about the services the HHA is providing.

QUALITY IMPROVEMENT

CMS continues its focus on improving the quality of care provided to Medicare and Medicaid beneficiaries. The Final Rule creates a new “quality assessment and performance improvement” CoP. This CoP requires each HHA to establish a data-driven, HHA-wide quality improvement program designed to improve outcomes, patient safety, and care quality. The program must reflect the complexity of the particular HHA and focus on improved patient outcomes. Specifically, the new CoP requires that the quality improvement program be capable of displaying measurable improvements in areas that are tied to patient outcomes, patient safety, and quality of care. The program must track, measure, and analyze the HHA’s performance in these areas. CMS believes each HHA’s quality improvement program should focus on high-risk, high-volume, or other problem areas within the HHA, as determined by data collected in those areas. CMS is allowing HHAs until July 13, 2018, to collect data before the HHA is required to implement its quality improvement program. HHAs must document the quality improvement of each project they undertake, the reason for choosing such a project, and the progress made over the course of the project.

OTHER CHANGES TO THE CoPs

While the above-described revisions may be the most significant changes to the CoPs, the Final Rule made many additional changes, including the following:

- removing the requirement to provide each patient’s attending physician a written report at least every 60 days

- requiring skilled professionals, such as registered nurses, to supervise skilled professional

assistants, such as licensed practical nurses

- creating a new “clinical manager” role within HHAs, who is responsible for providing oversight of an HHA’s patient care services and personnel. (The clinical manager must be a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or registered nurse.)
- requiring administrators to be responsible for the day-to-day operations of the HHA
- requiring an HHA’s governing body to assume legal authority and responsibility for the HHA’s overall management and operation, including its financial performance and quality improvement program

One of the objectives of the updated CoPs seems to be the desire to align HHAs with many other care coordination and quality improvement initiatives that CMS has recently undertaken. Although some of the new CoPs may require HHAs to invest in additional resources, the CoPs may lead to more efficient and higher quality care provided to patients. HHAs must satisfy the revised CoPs by July 13, 2017, except that, as noted above, HHAs have until July 13, 2018, to implement a quality improvement program.

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