Health Law Daily Wrap Up, HOME HEALTH—PROPOSED RULES: Home health CoPs to get first renovation since 1999, (Oct. 9, 2014)

By Harold M. Bishop, JD

CMS is proposing to revise the home health agency (HHA) conditions of participation (CoP) to focus on a more patient-centered, data-driven, outcome-oriented process that promotes a higher quality care. CMS’ Proposed rule offers a set of fundamental requirements for HHA services that encompass patient rights, a comprehensive patient assessment, and patient care planning and coordination by an interdisciplinary team. Central to these requirements would be a quality assessment and performance improvement program based on the philosophy that a provider’s own quality management system is the key to improved patient care (Proposed rule, 79 FR 61164, October 9, 2014).

The home health benefit. Currently there are more than 5 million people with Medicare and Medicaid benefits that receive home health care services each year from approximately 12,500 Medicare-certified HHAs. Home health services are covered for the elderly and disabled under the Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B) benefits of the Medicare program. These services, provided under a plan of care that is established and periodically reviewed by a physician, must be furnished by an HHA that participates in the Medicare or Medicaid programs, and are provided on a visiting basis in the beneficiary’s home.

Current regulations. The Secretary of HHS has established the requirements that an HHA must meet to participate in the Medicare program. These requirements are set forth in regulations at 42 CFR Part 484, Home Health Services. In addition, current regulations at 42 CFR sec. 440.70(d) specify that HHAs participating in the Medicaid program must also meet the Medicare CoPs. To implement the CoPs, State survey agencies and CMS-approved accrediting organizations conduct surveys of HHAs to determine whether they are in compliance.

Guiding principles. Before CMS began development of its new proposed CoPs for Medicare and Medicaid participating HHAs, it considered recommendations from home health providers, professional associations and practitioner communities, consumer advocates and state and other governmental agencies with an interest in HHA oversight. It also considered comments that were submitted by the public on prior proposed rules and suggestions submitted by the HHA industry, as well as recent developments within the industry. Based on this information, CMS developed the following principles to guide its development of the new HHA CoPs:

- To develop a more continuous, integrated care process across all aspects of home health services, based on a patient-centered assessment, care planning, service delivery, and quality assessment and performance improvement.
- To use a patient-centered, interdisciplinary approach that recognizes the contributions of various skilled professionals and their interactions with each other to meet the patient’s needs.
- To stress quality improvements by incorporating an outcome-oriented, data-driven quality assessment and performance improvement program specific to each HHA.
- To eliminate the focus on administrative process requirements that lack adequate evidence that they are predictive of either achieving clinically relevant outcomes for patients or preventing harmful outcomes for patients.
- To safeguard patient rights.

The new proposed CoPs. Based on these guiding principles, CMS is proposing to establish four new CoPs, in addition to retaining the current requirements at 42 CFR sec. 484.55, Comprehensive Assessment of Patients:
• **Patient rights** would emphasize a HHA’s responsibility to respect and promote the rights of each home health patient.

• **Care planning, coordination of services, and quality of care** would incorporate the interdisciplinary team approach to provide home health services focusing on the care planning, coordination of services, and quality of care processes.

• **Quality assessment and performance improvement (QAPI)** would charge each HHA with responsibility for carrying out an ongoing quality assessment, incorporating data-driven goals, and an evidence-based performance improvement program of its own design to affect continuing improvement in the quality of care.

• **Infection prevention and control** would require HHAs to follow accepted standards of practice to prevent and control the transmission of infectious diseases and to educate staff, patients, and family members or other caregivers on these accepted standards. The HHA would be required to incorporate an infection control component into its QAPI program.

**Referencing current guidelines and standards.** In the proposed CoPs, CMS retains process-oriented requirements that are predictive of ensuring desired outcomes, but it proposes to eliminate many of the current process details where they do not achieve this goal. For example, CMS proposes removal of the process requirement under current 42 CFR sec. 484.12(c) that a HHA and its staff comply with accepted professional standards and principles. Instead, CMS proposes modification of this requirement by referencing current clinical practice guidelines and professional standards specific to home care (for example, the American Nurses Association Scope and Standards of Practice for Home Health Nurses) as factors to be considered in the HHA’s overall QAPI program. CMS, however, is not proposing to incorporate by reference any specific clinical practice guidelines or professional standards of practice. The HHA would be responsible for identifying its own performance problems through its QAPI program.

**Shared commitment to quality of care.** CMS also proposes removal of the requirements that the HHA send a summary of care to the attending physician at least once every 60 days, that the HHA have a group of professional personnel to advise its operation, and that the HHA conduct a quarterly evaluation of its program via chart reviews. This is because CMS believes that the proposed CoPs reflect a new shared commitment between CMS and HHA providers to achieve improvements in quality of care. According to CMS, the proposed HHA CoPs will prompt HHAs to invest internally in their responsibility to continuously improve performance, rather than relying solely on an external approach in which prescriptive federal requirements are enforced through the survey process.

**Survey changes.** The proposed regulations also contain two important improvements that support CMS’ focus on patient-centered, outcome-oriented surveys.

• The proposed regulations would allow surveyors to look at outcomes of care, because the regulations would specify that each individual receive the care which his or her assessed needs demonstrate is necessary, rather than focusing on services and processes that must be in place.

• The addition of the QAPI requirement would afford the surveyor the ability to assess how effectively the provider was pursuing a continuous quality improvement agenda.

**Additional provisions.** The proposed rule would also: (1) revise the Outcomes and Assessment Information Set (OASIS) requirements to update applicable electronic data transmissions to meet current federal standards; (2) expand the current patient rights to clarify the rights of each patient, the process for conducting investigations of patient rights violations, and the process for addressing verified violations; (3) focus the patient assessment requirement on each patient’s physical, mental, emotional, and psychosocial condition; (4) require a HHA to maintain a system of communication and integration to identify patient needs, coordinate care provided by all disciplines, and effectively communicate with physicians; (5) condense nursing and therapy services into a single requirement that focuses on integrated patient care planning and delivery; (6) reinforce the current home health aide supervision requirements by requiring additional supervision and training when an agency suspects that home health aide skills are insufficient; (7) clarify the management and administrative structure of HHAs by...
allowing the administrator to designate an individual to act in his or her absence; and (8) continue to allow HHAs to have branch offices, but eliminates “subunits,” allowing parent agencies to have greater control over all of their offices by placing all locations under the direct management of the parent agency.