

Public Policy

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TO: HCA HOME CARE MEMBERS

FROM: HCA POLICY STAFF

RE: CHANGES IN FINAL INTERPRETIVE GUIDELINES FOR MEDICARE HOME HEALTH CONDITIONS OF PARTICIPATION

DATE: SEPTEMBER 14, 2018

Changes Highlighted in Final Medicare Home Health Interpretive Guidelines

As mentioned in the September 10 edition of HCA's *Situation Report* newsletter, the U.S. Centers for Medicare and Medicaid Services (CMS) has released the final home health agency (HHA) Conditions of Participation (CoPs) Interpretive Guidelines (IGs) which provide surveyors – in New York's case, the state Department of Health – with clarification and protocols for enforcing the newly expanded CoPs. The Interpretive Guidelines also provide information and guidance for HHA compliance with the CoPs.

The final CoP Interpretive Guidelines are at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-25-HHA.pdf>.

Background

The new Medicare CoP requirements were effective on January 13, 2018, except for the Quality Assessment and Performance Improvement project requirements which were effective on July 13, 2018 and the emergency preparedness provisions that were effective on November 16, 2017. Since these periods, HHAs and surveyors to date have been instructed to use the draft guidelines while CMS was preparing them for finalization.

HCA conducted a preliminary review of the now-final guidelines which were posted on August 31. The purpose of this new memo is to highlight some specific areas where the final version differs from the draft guidelines as well as other important areas for home care providers. We strongly suggest that home care providers read the **entire** guidelines, and HCA will provide any updates as needed throughout our continuing analysis and discussions with regulatory officials.

We first highlight some new requirements that affect home health aide training, competency, evaluation, duties, and supervision. HCA recommends reviewing the full citations for each section identified in this memo, with any new guidelines or clarifications provided here for those relevant sections.

Home Health Aide Training Program – 484.80(b)(3)

As described in the draft IGs, two additional areas have been added to the home health aide training requirements beginning on January 13, 2018: (i) communication skills in regard to the aide’s ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff; and (ii) recognizing and reporting changes in skin condition.

For individuals who met the qualification requirements for HHA aides prior to January 13, 2018, new training content in these requirements may be completed via in-service training.

Competency Evaluation of Home Health Aides – 484.80(c)

Newly revised language in the final Interpretive Guidelines that cover the competency evaluation includes the following:

The HHA may not allow an aide to provide services to patients independently until they have successfully completed competency testing either at that HHA or at another training facility and successful completion is verified through documentation provided by the applicant or the training facility.

Evaluation of Home Health Aide’s Skills – 484.80(c)(1)

The final guidelines state that the areas on which the aide’s competency evaluation is based have to “be evaluated by observing an aide’s performance of the task with a patient.” These include: communication skills; reading and recording temperature, pulse and respiration; appropriate and safe techniques in performing personal hygiene and grooming tasks that include bed bath, sponge, tub and shower bath, hair shampooing in sink, tub and bed, nail and skin care, oral hygiene, toileting and elimination; safe transfer techniques and ambulation; and normal range of motion and positioning.

This is similar to the prior regulatory language under which the IGs allowed HHAs to use a “pseudo-patient” for the competency evaluation. However, even though the regulations are essentially the same, CMS has revised the language in its final Interpretive Guidelines to indicate that the skills listed in the prior paragraph “must be evaluated by observing the aide’s performance **while carrying out the task with a patient.**”

Furthermore:

A registered nurse, in consultation with other skilled professionals (as appropriate) must observe the HHA aide candidate perform each of the previously mentioned tasks in its entirety to confirm the competence of the candidate.

*HHA aides who successfully completed a competency evaluation prior to January 13, 2018, do not need to repeat the portions of the competency evaluation required to be done while providing services to a patient under §§484.80 (b) (i), (iii), (ix), (x), and (xi) (above tasks). For all HHA aides who receive a competency evaluation after January 13, 2018, however, these skills must be tested **while the aide is providing care to a patient.***

HCA has reached out to DOH to determine how this final IG will be read and applied by DOH, and whether, in the absence of affirmative IG language, DOH retains interpretative authority to apply the regulation (which has not

changed) the same as previously, and thus maintain the status quo in allowing continued use of a pseudo-patient to test an aide's skills.

HCA had previously raised this issue in discussions with the National Association of Home Care and Hospice (NAHC) for advocacy to CMS during the review and comment on the IG to maintain status quo on the ability to utilize pseudo patients in the competency evaluation. Also at that time, our similar outreach to DOH resulted in the Department's stance to continue status quo on pseudo-patients pending final guidelines, and to take the issue up directly with CMS.

HCA will inform members immediately upon learning the Department's position on this change. In the absence of DOH discretion to maintain status quo, the omission of the use volunteer patients for the competency evaluation would appear to apply.

Documentation of Competency Evaluation – 484.80(c)(5)

Similar to the draft, the final IGs stipulate that documentation of the competency evaluation must: (i) include a description of the competency evaluation program, as well as the qualifications of the instructors; (ii) confirm that competency was determined by direct observation and the results of those observations; (iii) distinguish between skills evaluated during patient care and those taught in a laboratory (e.g., skills evaluated through use of a volunteer or direct observation of patient care versus a skill lab demonstration); and (iv) describe how additional skills beyond the basic skills listed at 484.80(b)(3) were taught and tested.

A **new** section states that an HHA aide that is unable to provide the above documentation will be required to successfully complete a competency evaluation before providing care to patients.

Home Health Aide Duties – 484.80(g)(3)

Under the duties of a home health aide, CMS has added **new** language (items one, three and four below) to define "assistance in administering medications." This includes:

1. Bringing a medication to the patient either in a pill organizer or a medication container as requested by the patient or caregiver;
2. Providing fluids to take with the medication;
3. Reminding the patient to take a medication; and
4. Applying a topical product, such as a non-prescription cream, to intact skin per instructions to the home health aide in how to apply it.

Supervision of Home Health Aides – 484.80(h)(1)

The following includes some **new** language related to the requirement that an RN or other appropriate skilled professional makes an onsite visit to the patient no less than every 14 days:

If, during a supervisory visit described in §484.80(h)(1)(i), a concern is identified at a patient's home, but the aide is not present, then the supervising registered nurse or other appropriate skilled professional must go

on-site with the aide at the next scheduled visit in order to observe and assess the aide while he or she is performing care. Generally, the “appropriate skilled professional” that conducts the supervision of the aide is the same skilled professional that identified the need for personal care services, assigned the aide to the patient, and developed the written patient care instructions.

Verbal Notice of Patient’s Rights – 484.50(a)(3)

CMS clarifies that an oral explanation under the regulatory requirement to “provide verbal notice of the patient’s rights and responsibilities in the individual’s primary or preferred language . . . no later than completion of the second visit from a skilled professional . . .” does not satisfy the requirement that the HHA provide written notice of a patient’s rights and responsibilities in advance of providing care.

Verbal, Mental, Sexual and Physical Abuse – 484.50(c)(2)

The following **new** interpretive language is added under the patient’s right to “be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property”:

The HHA should address any allegations or evidence of patient abuse to determine if immediate care is needed, a change in the plan of care is indicated, or if a referral to an appropriate agency is warranted. (State laws vary in the reporting requirements of abuse. HHAs should be knowledgeable of these laws and comply with the reporting requirements.) In addition, the HHA should intervene immediately if, as indicated by the circumstances, any injury is the result of an HHA staff member’s actions. The HHA should also immediately remove staff from patient care if there are allegations of misconduct related to abuse or misappropriation of property.

Confidential Clinical Record – 484.50(c)6

Under the patient’s right to have a confidential clinical record, **new** interpretive language is added to indicate that “each covered entity and business associate is responsible for ensuring its compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, as applicable, including consulting appropriate counsel as necessary.”

Reporting Patient Mistreatment, Neglect and/or Abuse – 484.50(e)(2)

A **new** Interpretive Guideline is added to clarify what is meant by “immediate” reporting by HHA staff to the HHA of patient mistreatment, neglect and/or abuse:

Immediately means reporting without delay. The interim time between discovery and reporting an incident may be influenced by the individual situation. However, the reporting must be accomplished as soon as possible following the discovery.

Initial Assessment Visit – 484.55(a)(1)

CMS has added the following **new** interpretive language to the regulatory requirement that an RN must conduct an initial assessment either within 48 hours of referral, or within 48 hours of the patient’s return home, or on the physician-ordered start of care date:

In instances where the patient requests a delay in the start of care date, the HHA would need to contact the physician to request a change in the start of care date and such change would need to be documented in the medical record.

Completion of the Comprehensive Assessment – 484.55(b)(1)

CMS has added **new** Interpretive Guideline language to the requirement that the comprehensive assessment must be completed in a timely manner, consistent with the patient’s needs, but no later than 5 calendar days after the start of care:

The start of care date is considered to be the first visit where the HHA actually provides hands on, direct care services or treatments to the patient. If an initial assessment is completed without any direct care services being provided by the HHA during the assessment visit, the date of that initial assessment visit would not be the start of care date. The comprehensive assessment must be completed within 5 calendar days of the first visit where the HHA provides hands on, direct care services/treatments to the patient.

Update of the Comprehensive Assessment – 484.55(d)(3)

The following **new** language is added to the regulatory requirement that the comprehensive assessment must be updated and revised as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status, but not less frequently than at discharge (and other designated instances):

The update of the comprehensive assessment at discharge would include a summary of the patient’s progress in meeting the care plan goals.

Plan of Care – 484.60(a)

CMS **adds a definition** for “patient-specific measurable outcome” under the requirement that each patient receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes:

It “is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention that provides end-result functional and physical health improvement/stabilization.”

Recording Orders in the Plan of Care – 484.60(a)(3)

Under the requirement that all patient care orders, including verbal orders, must be recorded in the plan of care, CMS has added a **new** interpretive guideline that states:

All patient care orders, including verbal orders are part of the plan of care. The plan should be revised to reflect any verbal order received during the 60 day certification period so that all HHA staff are working from a current plan. It is not necessary for the physician to sign an updated plan of care until the patient is recertified to continue care and the plan of care is updated to reflect all current ongoing orders including any verbal orders received during the 60 day period.

Note: Pulse oximetry is a ubiquitous assessment tool, often used as a part of routine vital signs across health care providers. Routine monitoring of vital signs, including pulse oximetry, do not require a physician order.

Written Information to the Patient – 484.60(e)

In the section that covers written instructions that the HHA must provide to the patient and caregiver, CMS **clarifies** in the final guidelines that certain listed documents “must be provided to the patient and/or his/her caregiver and representative (if any) no later than the next visit after the plan of care has been approved by the physician. The written information should be updated as the plan of care changes.”

Responsibilities of Skilled Professionals – 484.75(b)(9)

Under the requirement that skilled professionals participate in HHA-sponsored in-service training, CMS **removed** draft guideline language that stated: “Each skilled professional discipline attends all in-service training sessions and programs required by the HHA.” Now, there is no guideline under this section.

Emergency Preparedness – 484.102

While the final Interpretive Guidelines include the emergency preparedness regulations, the guidelines refer to State Operations Manual, Appendix Z for interpretive guidelines.

Parent-Branch Relationship – 484.105(d)

Under 484.105(d)(2), the parent HHA provides direct support and administrative control of its branches. The final guidelines include a **new** section that states:

A “branch” is an approved location or site (physically separate from its parent’s location) from which an HHA provides services within a portion of the total geographic area served by the parent agency. A branch provides services under the same CMS certification number (CCN) as its parent agency. The parent location must provide supervision and administrative control of its branches on a daily basis to the extent that the branches depend upon the parent’s supervision and administrative functions in order to meet the CoPs, and could not do so as independent entities. The parent agency must be available to meet the needs of any situation and respond to issues that could arise with respect to patient care or administration of a branch. A violation of a CoP in a branch would apply to the entire HHA. Therefore, it is essential for the parent to exercise adequate control, supervision, and guidance for all branches under its leadership.

Conclusion

HCA will continue to provide any updates as needed. We also will be reaching out to DOH and other administrative officials about the consequences and implications of certain new guidelines, including the requirement that the home health aide candidate must be observed in performing certain tasks on an actual, not a pseudo-patient, and that the associated costs of the new CoPs be reflected in both agency and Managed Long Term Care (MLTC) reimbursement.

For further information, please contact a member of HCA’s Policy staff.