DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Admin Info: 19-07-HHA

DATE: **January 23, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Home Health Agency (HHA) Frequently Asked Questions (FAQs)

Memorandum Summary

- **The Centers for Medicare & Medicaid Services is providing a list of FAQs for the Home Health Agency (HHA) Conditions of Participation (CoPs) that became effective on January 13, 2018. Each question includes a response to further clarify the Medicare requirements.**
- The attached FAQ document will be posted on the Centers for Medicare & Medicaid Services (CMS) website to provide clarifications on the requirements of the HHA CoPs.

Background

On January 13, 2017, CMS published the revised CoPs for HHAs, 42 CFR 484, Subparts A, B, and C, effective July 13, 2017. The effective date was subsequently delayed until January 13, 2018. CMS released a draft version of the associated Interpretive Guidelines (IG) in January, 2018 and a final version on August 31, 2018.

Subsequent to the release of the CoPs, CMS received several requests for clarifications of various sections, therefore CMS has compiled a set of FAQs with responses to each of the questions to provide clarity. This list of questions and responses will be posted at on the CMS website at the following location: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs.html

Contact: If you have questions or concerns regarding this information, please send an email to hhasurveyprotocols@cms.hhs.gov.

Effective Date: Immediately. These FAQs should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
Karen Tritz
Acting Director

Attachment - HHA Protocol FAQs

cc: Survey and Certification Regional Office Management

Home Health Agencies

State Operations Manual
Appendix B
Interpretive Guidance

Frequently Asked Questions (FAQs)

Home Health Agency Conditions of Participation Interpretive Guidelines Frequently Asked Questions

Q. Where can I find a copy of the final HHA interpretive guidelines?

A. The HHA interpretive guidelines are published online in the CMS State Operations Manual, Publication 100-07. You can find a copy at the following hyperlink: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107Appendicestoc.pdf

Q. Are HHAs still required to have a Professional Advisory Committee (PAC)?

A. No, CMS no longer requires a Professional Advisory Committee.

Q. Where do I find answers related to questions for OASIS?

A. For items not related to Conditions of Participation, such as clinical coding requirements, you should refer to the current version of the OASIS User Manual and/or contact the Home Health Quality Help Desk mailbox at the following email address: homehealthqualityquestions@cms.hhs.gov

For OASIS questions related to the COPs you may contact the OASIS Education Coordinator (OEC) in your state. A list is at the following hyperlink: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/EducationCoord.html.

Q. Does the requirement to transmit OASIS data apply to all patients seen by the HHA?

A. No. A HHA must transmit a completed OASIS to the CMS system for all Medicare patients, Medicaid patients, and patients utilizing any federally funded health plan options that are part of the Medicare program (e.g., Medicare Advantage (MA) plans). See §484.45(a).

Q. What is the difference between a patient's legal representative and patient-selected representative?

A. A patient's legal representative, such as a guardian, has been legally designated or appointed to make health-care decisions on the patient's behalf. Evidence that there is a legal representative may include guardianship, a power of attorney for health care decision-making, or a designated health care agent. A patient-selected representative participates at the request of a patient in decisions related to the patient's care or well-being but is not legally designated or appointed to do so. The patient determines the role of the patient-selected representative.

Q. Is a physician's verbal order needed at or immediately after the start of care visit to confirm the plan of care before any services can be provided?

A. Yes. Before HHA staff can provide direct care services, those services must be ordered by the physician either verbally or in writing See §484.55(a) & §484.60(a).

Home Health Agency Conditions of Participation Interpretive Guidelines Frequently Asked Questions

Q. Is the expectation that the comprehensive assessment be completed by day 5 or day 6 of the HHA episode of care?

A. Day 6. The comprehensive assessment must be completed 5 days after the start of care (SOC) date. The 5 calendar days to complete the comprehensive assessment would not include the Start of Care (SOC) date. For example, if the SOC date is June 1 then the comprehensive assessment must be completed no later than June 6. See §484.55(a).

Q. What should an HHA do if it cannot meet the timeframe for the initial assessment?

A. If the HHA anticipates that it cannot meet this timeframe, it should not accept the patient for services. 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. See §484.55(a)(1).

Q. Is a family member an acceptable interpreter or does the HHA need the services of a commercially available qualified interpreter via Phone, Video Remote or On-site for a variety of languages including services for the deaf or hard-of-hearing patients?

A. The CoPs do not preclude the use of a family member as an interpreter. When language assistance is provided by the HHA, it must be through the use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation, translation services, or technology and telephonic interpretation services. See §484.50(a)(1)(i).

Q. The previous requirement at §484.55(b)(1) defined SOC as the first billable visit. The new CoPs define SOC differently. Can you explain this change?

A. 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. Generally, this date is the first billable visit. See §484.55(b)(1). Also refer to the Medicare Benefits Policy Manual (CMS Pub 100-02) for information related to billable services.

Q. Can the therapist complete the medication review or must it be done by a nurse?

A. The therapist must submit the list of patient medications to an HHA nurse for review. See §484.55(c)(5).

Q. Can mid-level providers, such as nurse practitioners and physician assistants, write orders for home health services?

A. No, only a physician can write orders for home health services. Section 1861(m) of the Social Security Act requires that the home health plan of care be established and maintained by a physician and does not include other licensed practitioners, such as nurse practitioners and physician assistants. Only physicians may establish and maintain the home health plan of care, including reviewing, signing, and ordering home health services.

Q. If an additional service is added after the initial plan of care has been approved by the responsible physician (e.g. therapy only then adds nursing), what documentation must be completed to add the additional service? Would a separate plan of care be developed for the new service?

A. Patients receive services under a single plan of care that includes all services. The initial plan of care would need to be updated adding the new service and be signed by the responsible physician. This may be completed using a verbal order with the plan of care being signed by the physician at the time of recertification. See §484.60.

Q. How are HHAs expected to describe the patient's risk for hospitalization on the Plan of Care? May the agency use a ranking tool/method to describe the patients risk for hospitalization?

A. The plan of care must include a description of the risk for emergency department visits and hospital admission and all interventions to address risk factors. The Conditions of Participation do not contain requirements for how the HHA describes the patient's risk, such as a ranking tool, for emergency department visits or hospital readmissions. See §484.60(a)(2).

Q. Must "all diagnoses" be documented on the comprehensive assessment to go to the plan of care?

A. All pertinent diagnoses must be included on the plan of care. "All pertinent diagnoses" means all known diagnoses. See §484.60(a)(2).

Q. Is the expectation that a new plan of care (or CMS-485) is sent to the physician responsible for the HHA plan of care each time a verbal order is received in order to meet compliance with §484.60(a)(3)?

A. No. The plan of care does not need to be re-issued and signed by the responsible physician with every verbal order. The HHA must authenticate and incorporate the order into the plan of care but plan does not need to be resigned by the responsible physician until the patient is recertified to continue care or is discharged. See §484.60(a)(3).

Q. Can the physician ordering HHA services and the physician signing the Plan of Care (POC) be different or do these need to be the same person?

A. The CoPs do not require the physician ordering HHA services to be the same physician responsible for the POC. However, the POC must be reviewed and revised by the physician who retains responsibility for the plan. See §484.60(c).

Q. Is there a required time frame for communication and coordination of services to take place between disciplines?

A. There is no stated timeframe for communications to occur between disciplines. Communications are to be conducted as indicated based on clinical circumstances.

Q. Is there a requirement for the patient to receive a hard copy of the Plan of Care (Form CMS-485) as well as written instructions specified at 484.60(e)?

A. The CoPs require that the HHA provide the patient with written instructions regarding home visits, medications, treatments, and HHA clinical manager contact information. The CoPs do not require the HHA to provide the patient with a hard copy of the entire plan of care. See 484.60(e).

Q. When must orders from relevant physicians be approved?

A. Orders from relevant physicians are incorporated into the plan of care and the HHA clinical manager or other staff are responsible for integrating orders from both the responsible physician and any relevant physicians. If the HHA staff have concerns regarding the integration of orders, the staff would work with the relevant physician issuing the order and the responsible physician to resolve those concerns. The revised plan of care may be approved by the responsible physician at the next recertification cycle provided those orders are still active at that time. Short duration orders that are added to the plan of care that are no longer active at the recertification period only need to be approved by the responsible physician if those orders are for services that will be provided by the HHA. The HHA should have policies for the co-signature of orders for services to be provided until the plan of care is signed at the next recertification period. See §484.60.

Q. When the visit schedule, frequency of visits, treatments, or medications change in the plan of care, is the HHA expected to provide the patient with revised written information or is verbal notification enough?

A: The written information provided to the patient, as required at §484.60(e), should be updated in writing as the changes occur for those relevant items from the plan of care.

Q. For HHA aide qualifications, what does the term "good standing" mean in regards to the state nurse aide registry?

A. "Good standing" for home health aides would be determined according to each state's criteria. Contact the state certification agency for information regarding "good standing" for home health aides. See §484.80(a)(1).

Q. If a state does not recognize "certified nurse aides", but instead has state tested nurse aides and a STNA registry, does that meet the home health aide qualifications?

A. A nurse aide who successfully completes a nurse aide training and competency evaluation program, and is found to be in good standing in the state nurse aide registry, is considered to have met the training and competency requirements for a HHA aide. §484.80(a)(1).

Q. With more virtual internet and video home health aide training programs becoming available, will CMS accept these methods of training as "classroom training"?

A. Home health aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse, or a licensed practical nurse who is under the supervision of a registered nurse. Alternative formats for classroom training, such as online course material or internet based interactive formats are acceptable delivery methods for the classroom training. These alternative formats should also provide an interactive component that permits students to ask questions and receive responses related to the training. See §484.80(b).

Q. Can the HHA use a volunteer or pseudo-patient for competency testing of home health aides?

A. The CoPs require that certain aspects of the competency testing be completed on a patient of the HHA. See §484.80(b) & (c)(1) to determine which aspects of the testing must be completed on a patient. When testing is indicated on a patient, a volunteer or pseudo-patient is not permitted.

Q. Can the HHA aide competency testing, required at §484.80(c), be completed on a volunteer or pseudo-patient?

A. The requirement is for the competency testing to be completed on an actual patient of the HHA. See §484.80(c)(1).

Q. If nursing and therapy are both seeing a patient, can the therapist develop the home health aide care plan instead of the nurse?

A. When both nursing and therapy services are involved, nursing staff maintains the overall responsibility for the written patient care instructions, with input from the other skilled professionals as appropriate. It is possible, however, that a skilled therapist may identify a patient need for home health aide services in association with a skilled therapy service only. In these cases, the skilled therapist may develop the plan for the HH aide and may perform the required HH aide supervision. See §484.80(g).

Home Health Agency Conditions of Participation Interpretive Guidelines Frequently Asked Questions

Q. If a patient is receiving home health aide services only, does the required supervisory visit specified at 484.80(h)(2) make the patient a "skilled patient"?

A. No, a patient receiving home health aide personal care services only is not receiving skilled services. When nurse conducts the supervisory visit for non-skilled services, the patient does not become a skilled care patient. §484.80(h)(1).

Q. Is the home health aide annual on-site supervisory visit, specified at 484.80(h)(1)(iii) required to be completed for each aide or each patient?

A. The requirement for the annual supervisory visit is for each aide to have an observation and assessment while performing care. This ensures that each aide is observed during the provision of care at least once annually. See §484.80(h)(1).

Q. If a patient initially required both nursing and physical therapy but only physical therapy remains, which discipline would be appropriate for supervisory visits?

A. The discipline that establishes the plan of care is responsible for the supervisory visit. If therapy is the only service that remains, and the patient has a continued need for aide series, then therapy may assume responsibility for supervision of the aide services. In assuming responsibility for supervision of the service, it is expected that therapy staff would review and update the aide care plan. See §484.80(h)(1).

Q. For patients receiving non-skilled care, how often must there be a supervisor visit by the skilled professional?

A. For patients receiving only HHA aide services, a registered nurse must make an onsite supervisor visit to the location where the patient is receiving care, no less frequently than every 60 days. This visit must occur for each patient in order to observe and assess the aide while performing care. See §484.80(h)(2).

Q. What is the purpose of the skilled supervisory visit at §484.80(h)(2)? Is this to evaluate continued need for aide services or the services provided to the aide?

A. The purpose of this skilled supervisory visit at §484.80(h)(2) is to evaluate the services provided by the HHA aide to the patient.

Q. If an HHA was found to have a condition level deficiency during a partially or extended survey, would the HHA be able to provide their own aide training, competencies, or in-services for two years?

A. If a condition-level deficiency is found during a partially extended or extended survey, then the HHA may complete any training course and competency evaluation program that is in progress; however, the HHA may not:

(1) Accept new candidates into the program; or,

(2) Begin a new program for two years after receipt of written notice from the CMS Regional Office of such condition-level deficiency.

Correction of the condition-level deficiency does not lift the two year restriction identified in this standard. This does not apply to the yearly aide in-service training or supervisory visit at §484.80(d) and §484.80(h)(1)(iii). See §484.80(f). See §484.80(f)(3).

Q. If an HHA is cited for a condition level deficiency under emergency preparedness, does this preclude the Agency from conducting Aide training/competency evaluations?

A. No, the HHA would be permitted to conduct this training. An HHA that was subject to an extended survey (or partially extended survey) as a result of having been found to have furnished substandard care would be restricted from providing the training. Substandard care means noncompliance with one or more conditions of participation identified on a standard survey. The standard survey evaluates a select number of standards and/or conditions of participation in order to determine the quality of care and services furnished by an HHA as measured by indicators related to medical, nursing, and rehabilitative care. Only the COPs evaluated under the standard survey, which does not include emergency preparedness, would result in a restriction from providing the training and competency testing. See §484.80(f)(3) and §488.705 (Definitions).

Q. Can the home health aide care plan contain multiple choices for a particular task? For example, can it specify shower or sponge bath?

A. The home health aide plan of care may include more than one option, indicating the patient may choose, when multiple options exist for the particular task. See §484.80(g).

Q. Can alternative sanctions be imposed for non-compliance with emergency preparedness requirements?

A. No.

Q. The emergency preparation (EP) regulations are still listed as 484.22 on the CMS-2567 survey report. Shouldn't these be 484.102?

A. The EP regulations were initially published as 484.22 and later updated to 484.102 in January, 2018 with the new HHA CoPs. CMS is updating the Automated Survey Process Environment, or ASPEN, to include the updated regulatory citation, which will be reflected on future survey reports.

Q. Can HHAs share an administrator and/or a governing body?

A. The CoPs do not prohibit an administrator or governing body from working at more than one home health agency. However, an HHA must ensure that the responsibilities of the governing body, administrator, and clinical manager (for the day-to-day operation of the HHA) are not relinquished to another person or organization on an on-going basis and must ensure the HHA maintains compliance with all Conditions of Participation. See §484.105.

Q. Does the Administrator have to be supervised by the governing body?

A. No. The Administrator is appointed by the governing body but is not required to be directly supervised by the governing body. See §484.105.

Q. Must the Administrator be an employee of the HHA and must that person's title be Administrator?

A. There is no requirement in the regulation for the Administrator to be an employee of the HHA. All Administrators, whether employees or serving under a written agreement, must meet the Administrator personnel qualifications. HHAs must assure that administrative and supervisory functions are not delegated to another agency or organization. The title "Administrator" is not required for the person assigned to this role however, it should be apparent who serves in this capacity regardless of the title. See §484.105.

Q. Can the Administrator report to a person appointed by the Governing Board, such as the hospital CEO?

A. The administrator must report directly to the governing body with no intermediaries. Although the HHA may have additional management and organization structures, the relationship between the administrator and governing body is a direct reporting structure. See §484.105(b).

Q. Must the pre-designated, alternate administrator have the same qualifications as the administrator?

A. Yes, the alternate administrator must be qualified and pre-designated by the governing body to assume the responsibilities of the administrator. The clinical manager may serve as the alternative administrator if that person meets the qualification requirements for the administrator. See §484.105(b)(2).

Q. Can the HHA Administrator also be the Clinical Manager?

A. The regulations do not prohibit the administrator and clinical manager from being the same individual. However, the regulations are very specific on the qualifications and responsibilities of the administrator and clinical manager that must be fulfilled for the HHA to be in compliance with the CoP. See §484.105 and §484.115.

Home Health Agency Conditions of Participation Interpretive Guidelines Frequently Asked Questions

Q. The requirement at §484.110(b) states that medical record entries are to include a time. Is this the time care is delivered or is the time the documentation occurs?

A. The record should document the time care is delivered. ‘‘Timed’’ means the actual time that an event occurred, which is not necessarily the time when the documentation was entered into the record. The date and time requirement applies to all entries in the record. The record of a visit may be a summary note that includes all of the activities of a visit. In this case, the note is timed at the point it is written. However, in the case of time-specific items or services, such as medication administration, the entry must denote the exact time the activity was accomplished.

Q. Does the physician responsible for the home health plan of care need to sign the discharge summary?

A. There is no requirement for a physician signature on the discharge summary. See §484.110(a)(6).

Q. When does the 4 day clock to supply a copy of the requested medical record to the patient begin?

A. A patient’s clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). The 4 day clock starts from the time that the patient or representative makes an oral or written request for the clinical record. See §484.110(e).

Q. Can the clinical manager be a registered nurse with an Associate’s degree, or does the person need to have a Bachelor's degree in nursing?

A. A clinical manager can be a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a registered nurse. A nurse acting in the role of clinical manager must be a graduate of an approved school of professional nursing and is licensed in the state where practicing. See §484.115(c) & (k).

Q. A HHA administrator with 16 years of experience plans to change jobs but does not meet the new education requirement of having an undergraduate degree. Will CMS grant a temporary waiver to this requirement for individuals in this situation?

A. There is no waiver for this requirement. Administrators that begin employment with an HHA on or after January 13, 2018 must be a licensed physician, a registered nurse, or hold an undergraduate degree. See §484.115(a).