

Certified Home Health Agency (CHHA) and Licensed Home Care Services Agency (LHCSA) Requirements

Effective date: 5/15/13

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Article 36 of the Public Health Law, Sections 763.3, 763.6, 763.7, 766.3, 766.4 and 766.9 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivision (b) of section 763.3 is amended as follows:

(b) An agency shall provide at least one of the services identified in paragraph (1) of subdivision (a) of this section [nursing, physical therapy, speech-language pathology or occupational therapy] directly, while any [additional service] other services may be provided directly or by contract arrangement. For purposes of this Part, the direct provision of services includes the provision by employees compensated by the agency or individuals under contract with the agency, but does not include the provision of services through contract arrangements with other agencies or facilities.

Subdivisions (c) and (e) of section 763.6 are amended as follows:

(c) The plan of care shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, need for palliative care, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.

* * *

(e) The plan of care shall be reviewed as frequently as required by changing patient conditions but at least every [62] 60 days.

Paragraph (3) of subdivision (a) of section 763.7 is amended as follows:

(3) medical orders and nursing diagnoses to include all diagnoses, medications, treatments, [and prognosis] prognoses, and need for palliative care. Such orders shall be:

(i) signed by the authorized practitioner within 30 days after admission to the agency, or prior to billing, whichever is sooner;

(ii) signed by the authorized practitioner within 30 days after issuance of any change in medical orders or prior to billing, whichever is sooner, to include all written and oral changes and changes made by telephone by such practitioner; and

(iii) renewed by the authorized practitioner as frequently as indicated by the patient's condition but at least every [62] 60 days;

Subdivision (b) of section 766.3 is amended as follows:

(b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, need for palliative care, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential;

Subdivision (d) of section 766.4 is amended as follows:

(d) Medical orders shall reference all diagnoses, medications, treatments, prognoses, need for palliative care, and other pertinent patient information relevant to the agency plan of care; and

(1) shall be authenticated by an authorized practitioner within thirty (30) days after admission to the agency; and

(2) when changes in the patient's medical orders are indicated, orders, including telephone orders, shall be authenticated by the authorized practitioner within 30 days.

Subdivision (l) of section 766.9 is amended as follows:

(l) appoint a quality improvement committee to establish and oversee standards of care.

The quality improvement committee shall consist of a consumer and appropriate health professional persons [including a physician if professional health care services are provided]. The committee shall meet at least four times a year to:

(1) review policies pertaining to the delivery of the health care services provided by the agency and recommend changes in such policies to the governing authority for adoption;

(2) conduct a clinical record review of the safety, adequacy, type and quality of services provided which includes:

(i) random selection of records of patients currently receiving services and patients discharged from the agency within the past three months; and

(ii) all cases with identified patient complaints as specified in subdivision (j) of this section;

(3) prepare and submit a written summary of review findings to the governing authority for necessary action; and

(4) assist the agency in maintaining liaison with other health care providers in the community.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (“PHL”) §3612(5) authorizes the Public Health and Health Planning Council to adopt and amend rules and regulations to effectuate the provisions and purposes of PHL Article 36 with respect to certified home health agencies. Section 3612(6) and (7) requires the Commissioner of Health to adopt, and amend as needed, rules and regulations to effectuate the purposes of Article 36 regarding quality of care and services.

Legislative Objectives:

PHL Article 36 was intended to promote the quality of home care services provided to residents of New York State and to assure adequate availability as a viable alternative to institutional care.

Needs and Benefits:

On February 24, 2011 Governor Cuomo accepted a report from the Medicaid Redesign Team (MRT) designed to meet the Medicaid savings targets contained in the Executive Budget for 2011-12. The report included 79 recommendations to redesign and restructure the Medicaid program to be more efficient and achieve better outcomes for patients. Included among the recommendations accepted were MRT proposal numbers 109 and 147.

MRT Proposal 109 sought to expand access to palliative care services. In furtherance of that objective, the proposed amendments to the regulations add a requirement that the plans of care and medical orders required for patients of certified home health agencies (CHHAs) and licensed home care services agencies (LHCSAs) address the patient’s need for palliative care.

MRT Proposal 147 aimed to reduce regulatory burdens on providers. Accordingly, the proposed changes to the regulations eliminate the need for a physician to serve on the quality improvement (QI) committee of LHCSAs.

Finally, the proposed changes reflect minor amendments made to align these regulations with federal requirements and to correct errors. First, the amendments eliminate the requirement that CHHAs provide more than one qualifying service directly to coincide with the federal standards as defined in 42 CFR §484.14(a). The current regulation appears to require CHHAs to provide more than one service directly, which the Department of Health does not require, and this has led to confusion among interested agencies.

Second, the amendments change the maximum period of time that may lapse before a comprehensive assessment is reviewed from 62 days to 60 days, as this was an error in the regulations as originally drafted. Federal regulations, at 42 CFR §484.55(d)(1), require review at least every 60 days.

Costs:

The only new requirement imposed on agencies by these regulations is the requirement that the plan of care address palliative care, which is not anticipated to result in any appreciable burden to agencies and should not add additional costs to current operations. All other amendments are cost neutral or will decrease costs.

Local Government Mandates:

There are no mandates in this rule specific to local government. There are 28 existing county-based LHCSAs and approximately 29 county based CHHAs, and these entities will be required to comply with the same requirements as other licensed agencies.

Paperwork:

Providers are not expected to have increased paperwork as a result of these amendments.

Duplication:

The proposed regulatory changes are not duplicative of other requirements.

Alternatives:

The MRT proposals are specific in their mandates. The Department has made only those changes required to implement the MRT proposals.

Federal Standards:

There are no federal health care standards for LHCSAs. This provider type is a New York State construct. Federal regulations governing CHHAs are at 42 CFR Part 484.

Compliance Schedule:

Compliance is expected upon notice of adoption in the State Register.

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REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

Licensed home care services agencies (LHCSAs) and certified home health agencies (CHHAs), including those operated by county health departments, provide public health services in the home as required by Public Health Law. There are approximately 28 county-based LHCSAs and approximately 29 county-based CHHAs. Additionally, based on agency reports, the Department estimates that 860 LHCSAs and 168 CHHAs have less than 100 employees, and would be categorized as small businesses.

Compliance Requirements:

There is one new requirement imposed on home care agencies as a result of these amendments, which is to include the need for palliative care in each patient's plan of care and medical orders.

Professional Services:

No additional professional staff will be required because of these amendments. The requirement that agencies address the need for palliative care will be handled as a part of procedures already undertaken by agencies.

Compliance Costs:

It is not anticipated that there will be any increase in costs incurred by agencies as a result of these amendments. The amendments either remove existing obligations or add a minimal requirement that may be assumed with no increase in cost as part of current operations.

Economic and Technological Feasibility:

These rules can be implemented with no clear economic or technological impact. The only requirement imposed by these regulations is an unappreciable addition to current operations, and no additional technology will be required to comply.

Minimizing Adverse Impact:

The MRT proposals are specific in their mandates. The Department has made only those changes required to implement the MRT proposals.

Small Business and Local Government Participation:

The Department will meet the requirements of SAPA Section 202-b(6) in part by publishing a notice of proposed rulemaking in the State register with a comment period. All agencies and associations that represent such agencies were able to participate in the MRT process.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

All counties in New York State have rural areas with the exception of 7 downstate counties. Approximately 80% of LHCSAs and 86% of CHHAs are licensed to serve counties with rural areas.

Reporting, Record Keeping and Other Compliance Requirements and Professional Services:

There is one new requirement imposed on home care agencies as a result of these amendments, which is to include the need for palliative care in each patient's plan of care and medical orders. This requirement adds only a minimal recordkeeping burden on agencies, as plans of care and medical orders are already required for every patient serviced by a LHCSA or CHHA. No new professional staff is required to comply.

Costs:

It is not anticipated that there will be any increase in costs incurred by agencies as a result of these amendments. The amendments either remove existing obligations or add a minimal requirement that may be assumed with no increase in cost as part of current operations.

Minimizing Adverse Impact:

The MRT proposals were specific in their mandates. The Department has made only those changes required to implement the MRT proposals.

Rural Area Participation:

There is no impact specifically to rural areas as a result of these amendments, and the impact to all agencies is minimal.

JOB IMPACT STATEMENT

Nature of Impact:

The Department has determined that the proposed rules will not have a substantial adverse impact on jobs and employment opportunities.

Categories and Numbers Affected:

None

Regions of Adverse Impact:

None

Minimizing Adverse Impact:

Not applicable.

Self Employment Opportunities:

Not applicable.