Home Health Conditions of Participation (CoPs) — 2025 Guide

A comprehensive overview of all Medicare Home Health Conditions of Participation

Introduction: What Are CoPs and Why They Matter

The Conditions of Participation (CoPs) are federal regulations established by the Centers for Medicare & Medicaid Services (CMS) that every home health agency must meet in order to participate in the Medicare program. These regulations set the minimum standards for patient care, organizational management, quality assurance, and operational procedures. They exist to protect patients and ensure that agencies deliver consistent, safe, and effective care. If your agency wants to bill Medicare for home health services, you must demonstrate compliance with every CoP during your initial certification survey and every subsequent recertification survey.

Non-compliance with the CoPs carries serious consequences. At the lowest level, surveyors will issue deficiency citations requiring a formal plan of correction. At more severe levels, CMS may impose Civil Money Penalties (CMPs), deny payment for new admissions, or — in the most extreme cases — terminate your agency's Medicare certification entirely. Termination from Medicare is the functional equivalent of closing your home health agency, because Medicare is the primary payer for home health services nationwide. Understanding each CoP thoroughly and building your policies, procedures, and day-to-day operations around them is not optional — it is the foundation of a sustainable home health business.

Complete Overview of Medicare Home Health CoPs

1. Patient Rights (§484.50)

The Patient Rights CoP is one of the most frequently cited areas during surveys. It requires that every patient (or their legal representative) is informed of their rights at the time of admission and throughout the course of care. These rights are fundamental to the patient-agency relationship and form the ethical bedrock of home health services. Agencies must not only provide patients with a written copy of their rights, but must also ensure that staff members understand and actively uphold those rights in every interaction.

Key requirements under this CoP include:

- Patients must be informed of their rights verbally and in writing at the time of admission, in a language and manner they can understand
- Patients have the right to be treated with dignity, respect, and consideration at all times
- Patients must be actively involved in their plan of care, including the right to participate in care planning decisions and to refuse treatment

- Patients have the right to voice grievances without fear of discrimination, reprisal, or interruption of services
- The agency must maintain a formal process to receive, investigate, and resolve all patient complaints in a timely manner
- Patients have the right to be informed of the agency's policies regarding advance directives
- Patients must be advised of the extent to which payment may be expected from Medicare, Medicaid, or any other payer

2. Release of Patient Identifiable OASIS Information (§484.45)

This CoP addresses the collection, use, and release of patient-identifiable information gathered through the Outcome and Assessment Information Set (OASIS). OASIS data is the standardized assessment tool used by Medicare-certified home health agencies to measure patient outcomes and inform the quality reporting process. Because this data contains sensitive personal health information, CMS requires agencies to have strict protocols for its handling and transmission.

Key requirements include:

- The agency must inform patients that OASIS data is collected as part of the assessment process and explain how it will be used
- Written consent must be obtained from the patient before any release of patient-identifiable OASIS information to anyone other than CMS
- All OASIS data transmission must follow CMS-specified security requirements, including encrypted electronic submission
- The agency must have policies in place to protect the confidentiality of OASIS data throughout its lifecycle — from collection to storage to transmission

3. Comprehensive Assessment of Patients (§484.55)

The Comprehensive Assessment CoP is one of the most operationally demanding requirements for home health agencies. It governs the initial and ongoing assessment of every patient admitted to the agency and requires that assessments be thorough, timely, and accurately documented. The assessment forms the foundation of the patient's plan of care and directly impacts the quality of services delivered. Surveyors pay close attention to assessment timeliness and completeness because deficiencies in this area often lead to downstream care quality problems.

Key requirements include:

- The initial assessment must be completed by a qualified clinician within 48 hours of the referral, or within 48 hours of the patient's return home, or on the physician-ordered start-of-care date

- OASIS data must be incorporated into the comprehensive assessment for all Medicare and Medicaid patients
- The assessment must address the patient's full range of needs: clinical status, functional abilities, psychosocial factors, cognitive function, and the home environment
- A drug regimen review must be completed as part of the comprehensive assessment to identify any potential adverse effects or drug reactions
- Reassessment must occur at specific intervals: at least every 60 days, upon return from a hospital stay, and whenever there is a significant change in the patient's condition

4. Care Planning, Coordination of Services, and Quality of Care (§484.60)

This CoP requires that every patient receiving home health services has an individualized, written plan of care that is developed, reviewed, and updated in collaboration with the patient, their physician, and the care team. The plan of care is the central document that drives all clinical decision-making, and it must be specific enough to guide every discipline providing services to the patient. Surveyors will review plans of care closely to determine whether services are being delivered as ordered and whether the plan reflects the patient's current needs.

Key requirements include:

- A written plan of care must be established and periodically reviewed by a physician in collaboration with agency staff
- The plan must include all pertinent diagnoses, the patient's mental status, types of services and equipment required, frequency of visits, prognosis, and rehabilitation potential
- The plan of care must be reviewed and updated at least every 60 days, or more frequently if the patient's condition changes
- All services must be furnished in accordance with physician orders and the written plan of care
- Care must be coordinated among all disciplines involved in the patient's treatment (nursing, therapy, medical social work, home health aides)
- The agency must ensure that care meets accepted standards of practice and achieves measurable outcomes

5. Organization and Administration of Services (§484.105)

The Organization and Administration CoP addresses the agency's governance structure, administrative leadership, and overall organizational accountability. It ensures that every home health agency has a clear chain of command, qualified leadership, and the organizational infrastructure needed to deliver services safely and effectively. This CoP is foundational because it establishes who is responsible for the agency's operations and compliance at every level.

Key requirements include:

- The agency must have a governing body (or designated persons) that assumes full legal authority and responsibility for the agency's operations
- The governing body must appoint a qualified administrator who is responsible for the day-to-day management of the agency
- The agency must maintain an organized professional staff that operates under written bylaws or policies
- The agency must comply with all applicable federal, state, and local laws and regulations
- If the agency provides services through a parent organization or under contract arrangements, the agency retains responsibility for the quality of all services

6. Group of Professional Personnel (§484.115)

This CoP requires that the agency establish and maintain a group of professional personnel that advises the agency on its professional policies and practices. This advisory body serves as a clinical governance mechanism, ensuring that the agency's policies are informed by qualified healthcare professionals and that clinical standards are reviewed and updated regularly. While this is one of the simpler CoPs to comply with, agencies that overlook it are cited for the deficiency during surveys.

Key requirements include:

- The advisory group must include at least one physician and at least one registered nurse (RN)
- The group is responsible for establishing and annually reviewing the agency's clinical policies governing the scope and nature of services offered
- The group must meet at least annually, with meeting minutes documented and maintained
- The group's recommendations should guide the agency's clinical practice, training, and quality improvement efforts

7. Agency Staffing (§484.80)

The Staffing CoP ensures that the agency employs or contracts with enough qualified personnel to provide all services to all patients in a safe and effective manner. This CoP covers the qualifications, training, and supervision of all clinical and non-clinical staff, with particular emphasis on home health aides. Home health aide requirements are among the most frequently surveyed areas because aides provide the majority of hands-on patient care and are often less closely supervised than other clinical staff.

Key requirements include:

- The agency must have sufficient staff to adequately serve all accepted patients
- All staff members must be properly licensed, certified, and qualified for their respective roles under state and federal requirements

- Home health aides must complete a competency evaluation (or a state-approved training program and competency evaluation) that meets federal minimum standards
- Home health aides must receive at least 12 hours of in-service training per 12-month period
- Clinical managers and supervisors must have the required qualifications, including appropriate clinical licensure and management experience
- Skilled professionals must supervise home health aides on-site at least every 14 days (or every 60 days if only personal care is being provided)

8. Reporting OASIS Information (§484.45)

This section of the CoPs governs the agency's obligations regarding the electronic reporting of OASIS data to CMS. Accurate and timely OASIS submission is critical because it directly affects the agency's reimbursement under the Patient-Driven Groupings Model (PDGM), its performance on Home Health Compare quality measures, and its eligibility for the Home Health Value-Based Purchasing (HHVBP) program. Agencies that fail to transmit OASIS data accurately and on time face both financial penalties and survey deficiencies.

Key requirements include:

- The agency must electronically transmit OASIS data to the CMS OASIS system (QIES ASAP) in accordance with CMS specifications
- OASIS data must be submitted within 30 days of the assessment completion date
- All clinical staff responsible for completing OASIS assessments must receive training on accurate data collection and coding
- The agency must implement quality control processes to ensure the accuracy and completeness of OASIS data before submission
- The agency must be able to demonstrate that OASIS data is used to inform care planning and quality improvement activities

9. Clinical Records (§484.110)

The Clinical Records CoP requires that the agency maintain comprehensive, accurate, and accessible clinical records for every patient. The clinical record is the primary source of documentation that surveyors review during a survey, and it serves as the legal record of all care provided. Incomplete or disorganized clinical records are one of the most common survey deficiencies because they make it impossible for surveyors to verify that care was provided as planned and documented.

Key requirements include:

- A complete clinical record must be maintained for each patient, containing all assessments, plans of care, physician orders, progress notes, and discharge summaries

- Clinical records must be retained for a minimum of 5 years after the date of discharge (or longer if required by state law)
- Records must be accessible to all appropriate agency personnel and must be available for review by authorized government agencies
- All entries must be legible, complete, dated, timed, and authenticated by the person providing the service
- The agency must have policies governing the safeguarding of clinical records against loss, destruction, and unauthorized use

10. Compliance with Federal, State, and Local Laws (§484.100)

This CoP establishes that the home health agency must be in compliance with all applicable federal, state, and local laws and regulations at all times. While this may seem like a broad catch-all requirement, it has specific implications for licensure, workplace safety, anti-discrimination compliance, and privacy protections. Surveyors will verify that the agency maintains current licenses and certifications and that its policies reflect compliance with relevant laws.

Key requirements include:

- The agency must maintain a current, valid state license to operate as a home health agency (in states where licensure is required)
- The agency must comply with Occupational Safety and Health Administration (OSHA) requirements for workplace safety, including bloodborne pathogen standards
- The agency must comply with the Civil Rights Act, the Americans with Disabilities Act (ADA), the Age Discrimination Act, and all other applicable anti-discrimination laws
- The agency must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules governing the protection of patient health information
- The agency must maintain compliance with the False Claims Act and Anti-Kickback Statute as they relate to Medicare billing and referral relationships

11. Evaluation of the Agency's Programs (§484.65)

The Program Evaluation CoP requires every Medicare-certified home health agency to maintain an ongoing, agency-wide Quality Assessment and Performance Improvement (QAPI) program. This CoP reflects CMS's expectation that agencies are not merely meeting minimum standards but are actively working to improve the quality and safety of care they deliver. A strong QAPI program demonstrates to surveyors that the agency has systems in place to identify problems, analyze root causes, implement corrective actions, and measure the effectiveness of those actions over time.

Key requirements include:

- The agency must develop, implement, and maintain an effective, data-driven QAPI program that is agency-wide in scope
- The QAPI program must collect and analyze data on quality indicators, including patient outcomes, adverse events, and process measures
- The agency must implement at least one Performance Improvement Project (PIP) at all times, targeting a specific, measurable area for improvement
- Performance improvement activities must be documented with clear goals, interventions, data collection methods, and measurable results
- The overall QAPI program must be evaluated at least annually for effectiveness, with results reported to the governing body
- The agency must use OASIS-based outcome data and Home Health Compare results to inform its quality improvement priorities

Common CoP Violations

Top 5 Most Common CoP Violations — and How to Avoid Them

1. **Failure to complete comprehensive assessments within required timeframes.**

   The 48-hour assessment window is strictly enforced. Build scheduling systems that flag new referrals immediately and ensure a qualified clinician is available to complete the initial assessment within the required timeframe. Track assessment completion dates in your EMR and audit them monthly.

2. **Plan of care not updated when patient condition changes.**

   Surveyors will compare the plan of care against clinical notes. If a nurse documents a significant change in condition but the plan of care remains unchanged, this is an automatic deficiency. Train all clinicians to recognize triggers for plan-of-care updates and establish a process for immediate physician notification and order changes.

3. **Home health aide competency evaluations not documented.**

   Every home health aide must have a documented competency evaluation on file that meets federal standards. Review all aide personnel files quarterly to ensure competency evaluations are current and complete. Missing documentation is a common deficiency even when the aide is fully competent.

4. **Clinical records incomplete or missing required elements.**

   Every visit note, physician order, assessment, and plan of care must be complete, signed, dated, and timed. Implement a chart audit program that reviews a random sample of records monthly. Common missing elements include physician signatures on orders, discharge summaries, and medication reconciliation documentation.

5. **QAPI program not actively implemented.**

   Having a QAPI binder on a shelf is not enough. CMS expects an active, living program with regular meetings, current data analysis, and at least one active Performance Improvement Project with documented results. Assign a QAPI coordinator, schedule monthly meetings, and maintain a dashboard of quality indicators that is reviewed and updated regularly.

Preparing for Your CoP Survey

The best way to prepare for a CoP survey is to operate as if surveyors could arrive any day — because they can. Unannounced surveys are the norm for Medicare-certified home health agencies. Build internal audit processes that mirror the survey process, conduct mock surveys at least annually,

and ensure that every staff member understands the CoPs relevant to their role. Agencies that integrate CoP compliance into their daily operations — rather than treating it as a periodic event — consistently perform better during surveys and deliver higher-quality care to their patients.