December 30, 2014

Ms. Marilyn Tavenner

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-3819-P

P.O. Box 8016

Baltimore, MD 21244-8016

RE: Request for Comments: CMS-3819-P

Dear Ms. Tavenner:

We appreciate the opportunity to provide comment on the proposed rules on the Conditions of Participation for Home Health agencies issued October 9, 2014 in the Federal Register.

In general, we commend CMS for undertaking the task of revising and reorganizing these conditions with a greater focus on a patient-centered, interdisciplinary approach. Our primary concern with the proposed rule relates to the implementation and time frames as specified below. Because of the extensiveness of the changes and new conditions being proposed, we request that CMS allow a reasonable time to phase in any new provisions. Many of these changes may be particularly burdensome to home health agencies, specifically those that are smaller as they do not have the overhead and staffing available to successfully implement these changes in a short timeframe. We believe that a two to three year phase-in of these changes would be equitable. While many of the proposed changes will be good for patient care and patient outcomes, time is needed for home health agencies to implement the changes and be successful in meeting patient needs as well as regulatory requirements.

§484.65 The Minnesota Home Care Association supports the replacement of regulation §484.16, ‘‘Group of professional personnel,’’ and §484.52, ‘‘Evaluation of the agency’s program,’’ with a single, new CoP, at §484.65, ‘‘Quality Assessment and Performance Improvement’’ (QAPI). However, we are requesting additional guidance in regards to the new QAPI standard. We are requesting clarification as to who is required to act as a member on the “governing body” i.e. “HHA’s governing body assumes responsibility for the agency’s QAPI program.” Could an agency choose to keep the Professional Advisory Committee (PAC) active and consider them the “governing body?” Are there expectations as to which disciplines should serve on the governing body i.e. the medical director or board member? Are there requirements for how often the governing body needs to meet? Additionally, clarification is requested on whether home health agencies are required to have a medical director and what the role of the medical director is as it relates to the governing body. Lastly, further explanation of “full legal authority” of the governing body and what their legal responsibility is needed We fully support the elimination of the quarterly evaluation of the HHA’s program through chart reviews as the QAPI programs will identify quality and compliance concerns.

The Minnesota Home Care Association supports the elimination of the Home Health Agency to send the attending physician a summary of care notification every 60 days. We are, however, requesting clarification as to whether it will be expected that this information is provided to the physician by some other means or format.

§484.50 We support that the home health agency should make every attempt to provide written and verbal communication in a way that the patient understands their rights.

Although for each HHA to provide a written notice to the patient in their preferred language is an undue burden to each home health agency. There are many different languages encounter by the HHA while servicing patients in the community. This creates a significant cost for each agency to create printed notices in all possible languages. We request clarity on the following items:

• Responsibility of the home health agency to accommodate all possible spoken languages.

• Responsibility of the agency if after reasonable attempts to arrange for an interpreter in patient preferred language is not available in the community.

• Responsibility of each agency to have written notices in each possible language the agency may encounter in the community.

We request further review and revisions to this requirement due to the additional cost and burden to the agency. We do not support the statement that there would be no undue burden to the agency as there would be additional cost in resources as well as printing documents in many different languages to accommodate all patient’s preferred languages.

§484.55 We applaud the statement that completion of the comprehensive assessment now allows Occupational Therapy to establish eligibility. We do request reconsideration that it only applies when Occupational Therapy is the only service provided. We propose that OT can, as well as PT and SLP, complete the comprehensive assessment for multi therapy only cases. In the rural community timely availability of an SLP can be challenging therefore OT could establish eligibility and then SLP to follow. This would allow effective and timely care to the patient. We propose to allow PT/OT/SLP, if all ordered at SOC, could do the initial assessment as they are qualified therapists. Additionally, we recommend that it be permitted for either an RN or qualified therapist to conduct the initial and comprehensive assessment when both disciplines are ordered at the initiation of care.

We primarily support the changes to the comprehensive assessment of patients but ask CMS to clarify the intent and meaning of the proposal to identify a patients’ “strengths and care preference”. That language is vague and we feel that home health clinicians, as well as patients, are going to struggle with trying to identify strengths and care preferences. We are in support of the proposed change to allow physicians to order a resumption of care date as an alternative to the fixed 48 hour time frame. This will provide more patient specific orders as well as allow flexibility for patients who request home care to resume outside of the 48 hour time frame.

§484.60 The Minnesota Home Care Association would like clarification regarding the need for, and benefit of, including ALL orders, including verbal orders, in the patients plan of care. Including all orders may cause confusion in cases where orders have changed several times over the course of an episode. We agree that all orders obtained for patient care be recorded and authenticated appropriately in the patient’s clinical record, but do not see value to including ALL orders on the plan of care. We recommend that item (4) regarding patient care orders be removed from 484.60 (a).

CMS proposes that when care plans are revised, these changes must be communicated to the patient and MD. Sending care plans to patients will require additional expenses to agencies. This will cause undue burden as more agencies are electronic which would necessitate for the care plan to be printed and mailed. It is questionable on whether patients would find this beneficial or cause confusion. We suggest that the plan of care be sent to patients upon their request instead of being mandated.

The Minnesota Home Care Association does not support requiring HHA staff to include “time” when documenting orders in the patient’s clinical record. The rationale for the HHA to include the time a verbal order is received is unclear, and does not seem beneficial or relevant in the home health care environment. The date a verbal order is received by a home health agency should be sufficient. The Minnesota Home Care Association recommends leaving the current standard that verbal orders to be signed and dated with the date of receipt by the RN and or qualified therapist.

CMS has proposed that HHA’s compile a discharge or transfer summary containing listed items. We do not agree with the proposal to add the initial reason for referral to the discharge/transfer summaries. Some patients are on home care services for long time and this information may be difficult for the HHA staff to retrieve. Further, the information at start of care can be irrelevant to the current status. The other items that CMS is proposing to require in the summary are more detailed than what we feel is necessary for an effective transfer or discharge summary. This level of detail in the summary would take a considerable amount of time for the HHA staff, resulting in an increased financial burden. We recommend that CMS allows the HHA’s to develop their own process for communicating discharge and transfer information to the next level of care.

Section V. K.- ICRs Regarding Condition of Participation: Clinical Records 484.110 (a)(5)- Discharge/transfer summaries- CMS has proposed that a HHA would be required to send a discharge or transfer summary to the patient’s primary care provider within seven days or to a facility where patient is receiving care within two calendar days. While we agree that this could provide a better transition, we do not support this proposal the way in which it is written for the following reasons:

• Many agencies already have a process of giving and documenting a verbal report to the receiving facility or physician.

• Often times, a patient may enter into a facility without the HHA staff aware of this. Therefore, the agency would not be able to meet the required timeframes of 2 days to send the transfer summary.

• There would be an increased financial and time burden on HHA’s to send out discharge and transfer summaries, as this would be a new process to many HHA’s. This would be especially difficult for smaller HHA’s that do not have an electronic medical record.

We request CMS to consider allowing the HHA to develop their own policy on how to best communicate patient information at the time of transfer and discharges, which could include a verbal or written report. If CMS finalizes the proposal as it is written, we ask that consideration be made to state the HHA would be required to send a transfer summary within 2 days of when a HHA becomes aware of the transfer. Finally, if the HHA is not able to meet the timeframe requirements, we are requesting for allowance to document the reasons in the medical record.

Under the requirement for HHAs to develop, implement, evaluate and maintain effective, ongoing, HHA-wide, data-driven QAPI programs we offer the following:

* How the QAPI program is conducted to be determined by the Governing Body with specific requirements of being data driven with on-going evaluation.
* Meeting frequency to be determined by the Governing Body.
* Members of the QAPI team to be determined by the Governing Body.

We recommend a “phase in” approach over a 2-3 year period as this will require additional expenses for staff time and will likely be a burden for smaller agencies.

We do not support that agencies should be required to have “clinical manager”. We recommend that it should be up to the agency to ensure that oversight of personnel and patient care is being met. If this clinical manager role is finalized as proposed, can agencies have more than one person meeting the requirements of the role? For instance, one clinical manager is responsible oversight of personnel and another manager responsible for patient care services.

Additionally, for smaller agencies, can the administrator and clinical manger responsibilities be managed by one person.

§484.110 The Minnesota Home Care Association agrees that all clinical record entries be legible, clear, complete, authenticated and dated. We do not agree that each entry require a “time.” HHA staff already record the start date & time and end date & time for each visit made by HHA staff. Including “time” on entries may be beneficial in facility care settings where multiple staff members care for a patient over a period of time (such as a shift) and chronology of events may be significant. However, in the home health setting, health care encounters are customarily made on a daily, weekly, or monthly basis. Requiring “time” on each record entry would provide little, if any, value to patient care, while increasing paperwork burden to HHA staff. Including “date” should be sufficient for authenticating clinical record entries made by HHA staff providing care during separate and distinct home visits. HHA’s that utilize an electronic medical record may be able to date and time stamp entries made in the patient’s clinical record, however, HHA’s not utilizing a EMR may have much more difficulty achieving compliance with this standard.

Recommendation: The Minnesota Home Care Association recommends eliminating “time” from the Clinical Records Authentication standard.

§484.80 We mainly support the changes CMS has proposed for the supervision of home health aides. We do ask that CMS clarify the requirements for supervision of home care aides caring for both patients receiving skilled care and patients not receiving skilled care. The current proposal reads that the minimum requirement for supervision of a home care aide performing direct cares for a skilled patient is at minimum annually, with a non-direct supervision every 14 days. For patient’s not receiving skilled care, the requirement reads that they need to have a supervision of the aide providing direct cares at minimum every 60 days. We ask that CMS clarify these requirements so agencies fully understand the proposed requirements.

The Minnesota Home Care Association appreciates the opportunity that CMS has afforded it to provide feedback on the proposed revisions. We applaud CMS for its conscientiousness regarding quality patient care and ensuring that agencies are current with regulations. While many of the revisions are supported, we do ask for CMS to take into consideration the recommendations put forth to encourage successful implementation.