January 7, 2015

Ms. Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-3819-P Proposed Rule Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies

Dear Ms. Tavenner:

I write on behalf of LeadingAge New York to comment and offer recommendations on the proposed regulation published in the October 9, 2014 Federal Register on changes to the Conditions of Participation (CoPs) for Home Health Agencies (HHAs).

LeadingAge New York's nearly 500 members represent the entire continuum of not-for-profit and public providers of continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs and Managed Long Term Care (MLTC) plans. LeadingAge New York is an affiliate of the national organization, LeadingAge, and we support the comments submitted by LeadingAge. We offer these additional comments to emphasize issues of particular concern in New York State.

We are pleased to see that the proposed regulations are moving away from a problem-focused quality assurance approach to a more outcome-oriented approach. Overall, the intent to modernize HHA CoPs to ensure safer delivery of high quality service to patients through interdisciplinary actions and performance improvement programs is most welcomed. However, we are concerned that the regulations do not take into consideration dramatic changes taking place in the health care delivery system in New York and other states and do not go far enough in promoting flexibility and eliminating duplicative requirements. We are also concerned that the regulations assume the existence of a robust health information technology, data analytics and health information exchange infrastructure, when in fact that infrastructure is in its infancy among providers of long-term/post-acute care.

Specifically, New York State is experiencing a major expansion in enrollment in managed care plans among Medicare and Medicaid beneficiaries. As part of New York's Medicaid Redesign initiative, the State is implementing mandatory enrollment of all Medicaid beneficiaries into managed care plans and managed long term care (MLTC) plans. New York has also begun to roll-out a capitated managed care demonstration for dual eligibles under the CMS Financial Alignment Initiative, known as the Fully-Integrated Duals Advantage (FIDA) program. Approximately 4.5 million Medicaid beneficiaries are enrolled in managed care plans in New

York State. In addition, approximately 36 percent of New York's Medicare beneficiaries are enrolled in Medicare Advantage plans. As a result of growing managed care penetration, HHAs and other providers are subject to expanded contractual, credentialing, reporting and billing requirements. Medicaid beneficiaries receiving long term care services are subject to new comprehensive assessments by managed care plans, in addition to the OASIS. We have seen first-hand the need for greater regulatory flexibility and streamlining in order to reduce duplication, control costs and create greater efficiencies. The growth in managed care enrollment in New York State demands major changes in the operations and finances of HHAs and other providers. It also calls for changes in the way state and federal agencies oversee HHAs and other providers.

We provide comments below on the following sections of the proposed rule: Patient Rights – Plan of Care (484.50(c)(4)(iii)); Patient Rights – Transfer and Discharge (484.50(d)); Care Planning, Coordination of Services and Quality of Care (484.60); and Clinical Records (484.110).

I. Issue: Patient Rights – Plan of Care (484.50(c)(4)(iii))

The proposed regulation provides that each patient would have the right to receive a copy of their Plan of Care (PoC) to be kept in their home and the HHA would educate the patient and patient's family how to safely store the information in the home. This would also include all updates to plans of care as outlined in 484.60.

Comments: LeadingAge NY supports the concept of patient's right to receive a copy of his/her PoC. However, the PoC may be a lengthy document with frequent updates (i.e., at least every 60 days). Repeated delivery of the PoC along with all updates may be costly and administratively burdensome. Further, if the HHA is required to provide the written PoC and all updates in the patient's preferred language, it may not be feasible, especially in areas of New York where dozens of languages and dialects are spoken. Additionally, the patient and his/her representative might be overwhelmed by the volume of material. We join the LeadingAge recommendation that CMS require a copy of the initial PoC to be given to the patient, and that any changes be communicated verbally to the patient, with the communication documented in the patient's chart by the HHA staff.

II. Issue: Patient Rights – Transfer and Discharge (484.50(d))

The proposed regulations provide that the patient and representative (if any) have the right to be informed of the HHA's policies on admission, transfer and discharge. The standard sets forth seven reasons that justify transferring, discharging or terminating a case: (1) when the HHA can no longer meet the patient's needs based on the patient's acuity; (2) when the patient or payer will no longer pay for the services provided by the HHA; (3) when the physician and HHA agree that the patient no longer needs HHA services because the patient's health and safety have improved or stabilized sufficiently; (4) when the patient refuses HHA services or otherwise elects to be transferred or discharged (including if the patient elects the Medicare hospice benefit); (5) when the patient or other person's behavior is disruptive, abusive or uncooperative; (6) when a patient has died; or (7) when the HHA ceases to exist.

Comments: We recommend a revision to the fifth justification – discharge for cause – in order to incorporate situations in which hazardous conditions in the patient's home, such as vicious

animals, criminal activity, or firearms, prevent the HHA from securing personnel to provide care to the patient, as follows:

> "(5) The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(i) through (iii) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired; or that conditions in the patient's home present a threat to HHA personnel and prevent the HHA from securing sufficient personnel to meet the patient's needs."

We also support the LeadingAge recommendation that CMS allow stakeholders to submit additional types of behaviors or conditions that would justify a discharge.

III. Issue: Care Planning, Coordination of Services and Quality of Care (484.60)

CMS proposes a new CoP, which is part of the revision of 484.18 and 484.14(g), to "incorporate the interdisciplinary team approach to provide home health services focusing on care planning, coordination of services, and quality of care process." 79 Fed. Reg. 61166. The regulation includes five standards under this new CoP to reflect the interdisciplinary team approach. Subdivision (d) (Coordination of Care) of this condition requires the HHA to integrate services, "whether provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness, the coordination of care provided by all disciplines and communication with the physician."

Comments: LeadingAge NY supports the concept of an interdisciplinary team approach to home health services that engages the patient and his/her representative and health care practitioners and focuses on care planning, coordination of services, and quality of care. However, carrying out these activities is growing increasingly complex with the emergence of new models of care.

As managed care penetration grows, and new accountable care models gain traction, patients with complex needs are experiencing care management and care coordination on a number of fronts. Medicaid and Medicare beneficiaries may receive care management and care coordination services from their managed care plan, health home, patient-centered medical home and/or ACO, in addition to their HHA. There is a risk of duplication of effort and confusing or inconsistent communications to patients and health care professionals. We do not have a solution to this problem, but we ask CMS to be aware of these developments as it goes forward with the regulations and to support efforts to streamline requirements and increase flexibility in implementing them.

Further, as CMS appears to recognize in its preamble, engaging health care professionals, who are not employed by or under contract with the HHA, in care planning and coordination presents significant challenges. Electronic health information exchange and new payment models will in the future help to support such engagement. However, as discussed below, these strategies are in their infancy in the long-term/post-acute care sector.

IV. Issue: Clinical Records (484.110)

This proposed CoP requires a clinical record containing past and current information for every patient accepted by the HHA. The clinical record must be available to the physician who is responsible for the plan of care and to the HHA staff. It must also be authenticated so that the identity of the person who made each entry can be verified. In the preamble to the proposed regulations, CMS writes: "In light of the decentralized nature of HHAs (that is, patient care is not furnished in a single location), we believe that members of the interdisciplinary team must have access to patient information in order to provide quality services. Many HHAs maintain electronic records, and we recognize that this technological change in home health care industry can provide all members of the interdisciplinary team access to important patient care information on an ongoing basis." 79 Fed. Reg. 61184.

Comments: Based on the proposed regulation and its preamble, CMS appears to suggest that HHAs satisfy the proposed requirement to make clinical records available to physicians and HHA staff using electronic health records (EHRs). EHRs and health information exchange would also support some of the other conditions set forth in the proposed regulations, including care planning, coordination of services, and QAPI.

Although LeadingAge NY welcomes HHS's policy to accelerate interoperable health information exchange, EHR adoption and health information exchange is not likely to be feasible for many HHAs in the short run, absent an investment of public dollars. As CMS recognizes in its preamble to the regulation, long-term/post-acute care providers have not benefitted from incentive payments for EHR adoption. As a result, EHR adoption and health information exchange in this sector have lagged.

Many of the not-for-profit and public HHAs in the LeadingAge NY membership face significant challenges in raising the funds for large scale investments in EHRs. Even those that have invested in EHRs have found that building the electronic connections to enable health information exchange require additional investments.

LeadingAge NY appreciates the opportunity to provide comments on the proposed revisions to the HHA Conditions of Participation. We are supportive of the majority of the revisions, but remain concerned about additional administrative responsibilities in a managed care environment with shrinking reimbursement, short time frames for implementation, and the lack of resources for the adoption of health information technology and health information exchange. Please contact us if we can provide additional clarification or answer any questions.

Sincerely,

Daniel J. Heim
Executive Vice President