# Home Care Advisory Work Group: Recommendations to Change Regulations that will Maintain and Improve the Quality and Delivery of Home Care Services to Minnesotans

Report to the Minnesota Legislature

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## Minnesota Department of Health

**January 1, 2005**

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# Home Care Advisory Work Group: Recommendations to Change Regulations that will Maintain and Improve the Quality and Delivery of Home Care Services to Minnesotans

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## January 1, 2005

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# Contents

## EXECUTIVE SUMMARY

This report is the result of a 2003 legislative directive that charged the Commissioner of Health with convening a work group to review state and federal home care regulations to identify barriers to efficient service delivery and regulatory burdens and to make recommendations to fix the problems.

The perception of the provider community is there is increased emphasis on regulatory compliance. The belief of the provider community is that some regulations create compliance issues that do not contribute to the over all quality of care for consumers. The reality is that consumers want a system of care that responds to their needs, is affordable, accessible and provides care that consistently meets minimum quality standards.

With the aforementioned in mind, Work Group members came together out of a desire to provide quality care to consumers by identifying issues and specific regulations that did not optimally serve consumer interests.

The report is organized into 4 sections: Section 1, Recommendations Requiring No Change to State or Federal Regulations; Section 2, Recommendations for Changes in Federal Regulations; Section 3, Recommendations for Changes in State Regulations; and Section 4, notation of Other Related Issues mentioned during work group discussions but not a part of the charge to the group.

Section 1, Recommendations Requiring No Change to State or Federal Regulations, is a compilation of concerns raised during work group meetings that were determined to be "systems communication" issues. It was agreed that these concerns could be resolved without opening the home care rule or addressed through changes in federal regulations.

Section 2, Recommendation for Changes in Federal Regulations, reviews areas the Work Group identified where they would like to see specific changes made to the Medicare Conditions of Participation (CoPs). These proposed changes are contained in a letter which the Commissioner of Health sent to Mark McClellan,M.D., PhD., at the Centers for Medicare and Medicaid Services (CMS) and copied to Minnesota's Congressional delegation (Appendix A). These recommended changes to the CoPs are coming from provider and consumer representatives.

Section 3, Recommendations for Changes in State Regulations, brought a significant amount of discussion and is devoted to recommendations that would require the state to open the current home care rule in order to implement. Thus, one major recommendation is the conclusion of Section 3:

**The Minnesota Department of Health shall consider revising the home care rule making it more contemporary with what consumers want and creating better overall alignment and simplification.**

It was not the charge of the Work Group to revise state home care rule language.

Section 4, Other Related Issues, addresses those areas of concern raised beyond the charge of the Work Group.

## BACKGROUND

The 2003 Legislature directed the Minnesota Department of Health to convene a working group to consist of home care providers and other interested individuals. The charge to the Work Group was to identify federal barriers to the delivery of home care services, review the current state licensure process and evaluate the appropriateness of the process. The charge to the Commissioner of Health was to work with officials of the federal government and with members of the Minnesota congressional delegation to achieve necessary changes in the law. An additional charge within the legislation directed the Commissioner of Health to consider federal certification regulations and hospice and the need to have separate licensure provisions for certified facilities.

Hospice was formally Class D under state home care regulations. As of September 26, 2004, Minnesota Rules Chapter 4664, the Hospice Rule, became effective. Hospice is now a stand-alone rule and Class D no longer exists. A copy of the legislation authorizing this report is included as Appendix B.

Three key goals guided the Work Group:

**- Review regulations to identify where changes are needed to provide overall simplification and to better align with requests of consumers without jeopardizing their health and safety;**

**- Any proposed changes would be consistent with current legal scope of professional practice acts;**

**- Identify ways to ensure that when home care interfaces with Medicaid waivered services the regulations remain in compliance with Medicare requirements so that consumers are able to access a full array of services that are safe and affordable.**

Consumers want a home care system that is accessible, affordable and reliable. The Work Group believes the recommendations made in this report will help accomplish this goal.

The Work Group decided early in the process that issues and resulting recommendations might best be addressed by dividing them between recommendations for state licensure and rule changes and federal Medicare Conditions of Participation (CoP) changes. Proposed revisions to the Medicare CoPs are being discussed on a federal level, and a draft of those revisions may be released for comment in upcoming months. The work of the Home Care Work Group has been shared with federal officials with respect to its recommended changes in the CoPs. Commissioner Mandernach's letter to Mark Mc Clellan, M.D., Ph.D., at CMS is included as Appendix A. The Minnesota Department of Health, in conjunction with the Minnesota Home Care Association (MHCA) will work to inform and encourage federal lawmakers on the need to support the recommended

changes. The MHCA can enlist the assistance of other state's professional trade associations for home care in supporting the recommended changes**.**

## RECOMMENDATIONS

The report is organized into 4 sections: recommendations requiring no change to state or federal regulations, recommendations for changes in federal regulations, recommendations for changes in state regulations, and notation of other related issues mentioned during work group discussions but not a part of the charge to the group.

**Section 1:**
**Recommendations Requiring No Change to State or Federal Regulations**

During the course of meeting, there were five specific concerns raised that were determined to be "systems communication issues." It was agreed that these five concerns could be resolved without opening the home care rule or addressed through changes in federal regulations. These are detailed as follows:

**1. Home Health Aide inservice hours to 12 hours annually**.

Home health aides are required to complete 12 hours of inservice each year for Medicare certified agencies and 8 hours for Class A licensed only. The federal interpretive guidelines, under 484.36(b)(2), allow the home care provider to use either the calendar year or employee's anniversary date as a basis to calculate the hours. Providers indicated that this requirement does generate discussion during the survey process, however, it has been cited only 4 times during 2004. If MHCA and MDH worked in conjunction to clarify the requirements of the CoP, how those are interpreted by the surveying agency (MDH) and they discuss the variety of ways the inservice hours could be met (such as counting employee orientation toward inservice hours their first year), this would no longer be an issue.

**2. Develop a communication plan to better inform agencies of changes in CoPs and Interpretive Guidelines.**

Work Group members identified some issues that were problematic and thought to need changes in regulation. However, during discussions it became apparent that these could be resolved without regulatory changes and at no additional cost. A coordinated effort between the MDH, MHCA and other parties as needed is required.

This is part of a "systems communications issue". MDH posts changes and updates on its website and places the responsibility with providers to regularly check the website for updates. It appears this may not be a sufficient approach. MDH will work with the MHCA, and other stakeholders as necessary, to develop and evaluate the best mechanisms for getting this information out.

**3. MDH to improve education outreach efforts with periodic reminders of resources available and summaries of deficiencies issued.**

Some agencies, including larger and more established ones, are not aware of state resources available for technical assistance or the degree to which deficiencies are issued. The thinking is that this information, if more deliberately distributed, would be quite beneficial to the providers. MDH will work with the MN Home Care Association, and other stakeholders as necessary, to provide this information in an effective and economical format. Educating providers about survey issues could potentially raise the level of compliance with the probability of improving service to consumers enhanced.

**4. MDH should evaluate, by January 1, 2006, the feasibility of developing a pre-licensing tutorial and exam for Class A home care providers (identify potential pre-licensing requirements that must be met before issuing a license, for example a basic 101 course for agency administrator). MDH will work with stakeholders to explore the feasibility of this recommendation.**

During Work Group discussions it was noted that too many individuals with too little understanding of their obligations as a home care provider are able to obtain a home care license. If MDH was to require some basic requirements prior to issuing the license there would be some assurance that providers have a minimal knowledge base. The Work Group's belief is that the quality of services provided to consumers would be better overall as a result of implementing this recommendation.

**5. Educate home care licensure applicants about the Nurse Practice Act and the nurses' legal responsibilities with respect to assessment, supervision, delegation, etc.**

There is a need to inform or reinforce for home care administrators the nurse's role with respect to the practice of nursing, particularly the function of delegation. The state home care regulations cross reference the nursing practice regulations, however, the Work Group recommends highlighting this information in pre-licensing materials. MDH can work with the Board of Nursing to develop appropriate materials. Consumers will benefit from this additional pre-licensure education of providers.

**Section 2:**
**Recommendations for Changes to Federal Regulations (Medicare)**

Following are the recommended changes the Work Group identified as specific to federal regulations and Medicare Conditions of Participation (CoPs). These proposed recommendations are contained in a letter the Commissioner of Health sent to Mark McClellan, M.D., PhD., at the Centers for Medicare and Medicaid Services (CMS) and copied to Minnesota's Congressional delegation (Appendix A).

**1. OASIS data collected on Medicare clients only.**

The **O**utcome and **AS**essment **I**nformation **S**et (OASIS) is a program of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI) and is a Medicare requirement for prospective payment that depends on the data acquired by the OASIS system. Collecting data on all clients, rather than just Medicare clients, is time consuming and the data on Medical Assistance and other clients is not analyzed or utilized at the federal or state level for any known apparent purpose. The collection of OASIS data on Medicare only clients would provide a truer picture of skilled acute clients rather than chronic or custodial care. Medicare clients will show more significant improvement because the services are skilled care, whereas Medical Assistance (MA) clients are likely to stabilize and require ongoing custodial care. Permanent elimination of the need to collect data on non-Medicare clients would eliminate inconsistencies from agency to agency, reduce visit costs, and free up nurse time to serve more clients.

**2. Remove the lock date and require agencies to submit the OASIS 30 days from the day of completion.**

There has been mention that Medicare will propose dropping the lock date requirement some time in 2005. The Work Group supports Medicare in its efforts to drop this requirement since Medicare already receives this information when the consumer is recertified. This is a paper work requirement that provides no additional benefit to the consumer.

**3. Change the 5 calendar day window to 10 calendar days for recertifying Medicare clients to coincide with the comprehensive assessment no later than every 60 days.**

Currently, providers are required to re-certify clients within the last 5 days of every 60 day episode. This is not efficient when not combined with a nursing visit. The requirement allows such a limited time frame to complete the OASIS that it often requires home health agencies to make extra, un-reimbursable visits to the patient's home. This frequently happens when home health agencies are managing patients who do not require frequent visits for acute episodes of care, but who still meet the "skilled" requirement for OASIS data.

A couple of examples to illustrate the difficulties with the current 5 calendar days and the benefits of extending the window to 10 calendar days include: 1) a patient who has a neurogenic bladder that requires monthly catheter changes that would normally be seen twice during the 60 day episode for the catheter change. Very often these visits do not coincide with the required 5 calendar day window, so an additional visit is necessitated purely for the purpose of conducting a comprehensive assessment and collecting OASIS data, or 2) a patient who is being seen weekly for medication set-ups. The 5 calendar day window may not coincide with the weekly visits and would then require an extra visit for the comprehensive assessment.

It would be more effective as well as cost efficient for the client to permit an expansion of this 5 calendar days in order to re-certify in conjunction with a scheduled nursing visit. Expanding the time frame continues to allow enough time to judge if the client will need re-certification. It will better utilize the client's and nurse's time, and will also reduce the number of non-billable visits for the agency. Since Medicare clients receive a fixed episodic payment for care, this will not increase costs to Medicare.

**4. Change the requirement that the home health agency must complete a performance review of each home health aide every 12 months to the home health agency must complete a performance review of each home health aide annually.**

Currently, in Medicare CoPs, the frequency is "no less frequently than every 12 months". This requirement is burdensome for agencies because an agency has to have an administrative tracking system in place that identifies the specific date each home health aide has had a performance review in order to ensure that the next review is completed no greater than 12 months from that last date. Annual performance evaluations would accomplish the same objective without creating as complicated a tracking system.

**5. Recognize all authorized prescribers under state law to order medications and treatments**.

Scope of practice is defined for each licensed profession in MN. If prescribing and writing orders is within a licensee's scope of practice it is logical that the home health agency be able to take direction from those individuals. In many instances those licensed practitioners are the primary provider, are likely to be more accessible, often at a lesser cost and provide efficient care.

Presently, federal law allows nurse practitioners to prescribe and order in Medicare certified hospice programs.

**6. Home Health Aide supervision every calendar month.**

There is a need to create one combined supervisory period for consumers receiving either skilled or maintenance services. Consumers receiving skilled services are seen more frequently by professionals. Persons receiving maintenance services may be receiving services exclusively from unlicensed personnel. Monthly supervisory visits for all home health aide services allows for more consistent oversight of consumers receiving custodial services and more efficient use of staff resources. In addition, not receiving RN reimbursement for the every 14 day supervisory onsite with the home health aide is a hardship for most agencies. This hardship may be compounded by the RN shortage in parts of MN. Depending on the care needs of the home health client, an RN must see the client more frequently than monthly if needed.

**7. Revise the standards (CoP 484.55(a)(b) related to patient assessment to allow for a skilled rehabilitation professional to make the initial evaluation visit as well as the comprehensive assessment, even when nursing is involved.**

At times the therapy role is the most important reason the consumer is receiving home care, even though nursing may also be needed. A person recovering from a hip replacement, who also needs nursing services for INR draws, will need physical therapy more immediately than nursing. However, the nurse is required to make a visit to complete the initial assessment and the comprehensive assessment prior to implementing physical therapy. Allowing a therapist, in this example the physical therapist, to complete an initial and comprehensive assessment will make the more pressing therapy available in a more timely manner.

**8. Share with Medicare officials administering the home health program the success Minnesota has had with telehealth care and promote Medicare reimbursement of the service.**

Telehealth care is reimbursed by Medical Assistance (MA) but not Medicare. It is an efficient augmentation to face to face visits, and does not replace, but can enhance client care. The Minnesota Department of Human Services, through Community Services Service Development Grant funds (CS/SD), has funded a variety of telehealth projects and equipment covering 22 counties in Minnesota. Grant recipients report that telehealth services are in demand and have been used to manage disease, improve quality of care, promote consumer autonomy, and meet functional and psychosocial needs of seniors. Contact information regarding telehealth projects is available in Appendix D.

**9. All information notifying consumers of covered and non-covered Medicare services should be on ONE Advance Beneficiary Notice form.**

Prior to the formal implementation of Advance Beneficiary Notices, home health agencies notified clients of non-coverage via the Medicare Non-Coverage Notice. That was replaced by the HHABN, the Medicare Advantage Beneficiary Notice and now the proposed Notice of Exemption of Medicare Benefits. Consumers find the notices duplicative, burdensome and confusing. It is important that this information be conveyed to consumers, however, it will be most beneficial to consumers if it is communicated on ONE form.

**Simplification Overall**

Aligning requirements across various regulations, informing and educating providers on compliance and reducing paper work in documenting compliance to what is essential and minimal has a direct connection with quality of client care. If this is done, the outcome will positively benefit consumers as a result of providers being able to spend their time more efficiently and effectively on direct care to consumers.

**Section 3:**
**State Licensing Recommendations**

A significant amount of discussion was devoted to recommendations that would require the state to open the current home care rule. Following are those recommendations.

**1. The Minnesota Department of Health shall consider revising the home care rule to better address what today's consumers want and creating better overall alignment and simplification.**

Much of the Work Group's discussion was about needed changes in the home care regulations. It was beyond the scope of the Work Group to develop the recommended language changes.

**2. Adopt the prescriber's rubber stamp signature and consider electronic signatures.**

The prescriber's rubber stamp signature is allowed under Centers for Medicaid and Medicare Services (CMS) federal memo S&C –04-35, issued July 8, 2004. Adopting these practices should be pursued in consultation with the Boards of Pharmacy, Medical Practice and Nursing to assure it is permitted by state law.

**3. Home Health Aide supervision every calendar month.**

There is a need to create one combined supervisory period for consumers receiving either skilled or maintenance services. Consumers receiving skilled services are seen more frequently by professionals. Persons receiving maintenance services may be receiving services exclusively from unlicensed personnel. Monthly supervisory visits for all home health aide services allows for more consistent oversight of consumers receiving custodial services and more efficient use of staff resources. In addition, not receiving RN reimbursement for the every 14 day supervisory onsite with the home health aide is a hardship for most agencies. This hardship may be compounded by the RN shortage in parts of MN. Depending on the care needs of the home health client, an RN must see the client more frequently than monthly if needed. **(NOTE: Changing this language for both the federal and state regulatory requirement would decrease the complexity of regulations)**

**4. Promote "coordination of services" using hospice regulations as a model and expand to all affected licensees.**

This change would focus on the accountability of the home care agency to coordinate services with other licensed home care entities.

**5. Review and consider terminology in state licensure of "service agreement" across settings.**

It is desirable to promote consistent terminology across community based programs for terms such as service agreement and service plan. In the state home care licensure rule, "service agreement" means a description of services to be provided, by whom and at what fee. For purposes of reimbursement, the Department of Human Services authorization form for payment is called a "service agreement". This is confusing for both consumers and providers. New state hospice regulations provide a model for changing this. Actual services could be identified in a plan of care and the agency would provide a "charge for services" written notice.

**6. Define "essential services" in state licensure.**

There is not agreement about what constitutes "essential vs. non-essential" services and the requirement for developing a contingency plan is a potential deficiency issue. This is an especially problematic requirement for private duty nursing agencies, especially when the client refuses the nurse and there is no nurse backup.

**7. Update requirements on TB screening to follow the most current CDC guidelines and eliminate the requirement for a repeat chest x-ray.**

If a Mantoux is positive current regulations require a chest x-ray. The problem is people with documented positive results working in multiple agencies have had repeated x-rays and this conflicts with current medical practice. A change in the state home care rule to adopt current CDC protocol for TB screening will allow the person to provide documentation of a negative chest x-ray performed at any time during or since the evaluation of the positive tuberculin skin test.

**Section 4:**
**Other**

The issues noted in this section were mentioned during the Work Group meetings. However, these issues were outside the legislative charge of the Work Group. Work Group members agreed that the issues should be noted in the report, in a separate section. If there is a desire to take action on any of the issues, those issues could be directed to the appropriate venue for review.

**Review the need for Class B, C, E and Review the Board and Lodging with Special Services registration.**

Changes in the development of home care service delivery system in Minnesota and the introduction of the Assisted Living Home Care Provider license has had an effect on the kinds of services consumers are demanding and the number of providers in these home care classes. Stakeholders in the classes noted above must be included in any review. Current numbers of providers licensed in these classes may be found in Appendix C.

**Regular survey of Class A only agencies**.

Without a regular survey, systems problems are perpetuated and quality of care compromised. Poor performing agencies would be known to consumers via survey results. The Minnesota Department of Health is in the beginning phases of transitioning survey activity for Class A Licensed Home Care Agencies from its Licensing and Certification Section to the Department's Case Mix Section. The implementation date for the surveys will be determined once orientation and training of Case Mix staff has occurred. The transition does not include federally certified Medicare home health agencies.

**Revisit the need for licensing Personal Care Provider Organizations (PCPOs) with an expanded group of stakeholders.**

The types of services that PCPOs offer are the same or very similar to home care services yet the regulatory oversight between the two groups differs markedly.

**Explore development of a master Registry similar to the Nursing Assistant Registry, that is a single point of entry of all aide types. Background check requirements should be reviewed to minimize or eliminate duplication of checks on the same subject.**

This Registry would be a resource for consumers who want to hire their care assistants. The Department of Human Services is currently developing a listing of Personal Care Attendants. Any effort toward creating a Registry would involve coordination between the Departments of Human Services and Health.

**Fund a study of criminal background requirements.**

**Evaluate state licensing fees for home care**.

Appendix A

December 30, 2004

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I am writing to you to request your review and adoption of several proposed changes to Conditions of Participation (CoPs) for Medicare Certified Home Health Agencies.

A Work Group of highly regarded consumer advocates and home care providers has been meeting to identify federal and state regulatory barriers to the effective and efficient delivery of home care services to consumers. This Work Group was established by directive of the Minnesota legislature to advise me on changes that could be made to improve home care service delivery to consumers without compromising the quality of those services.

It is our understanding that the Centers for Medicare and Medicaid Services will be reviewing Medicare CoPs for Home Health in the near future, and we believe the recommendations I share with you are timely and necessary. I concur with the recommendations of this Work Group and we in Minnesota are committed to working with CMS to implement them.

Three key goals guided the Work Group:

1) A review of regulations to identify where changes are needed to provide overall simplification and to better align with requests of consumers without jeopardizing their health and safety;

2) Any proposed changes would be consistent with current legal scope of professional practice acts;

3) State regulations remain in compliance with Medicare requirements so that consumers are able to access a full array of services that are safe and affordable.

Medicare CoPs require certified home care agencies to meet a minimum level of quality standards to assure the provision of safe services to consumers. Work Group members identified portions of the CoPs that created additional work for providers with no corresponding benefit to consumers. It is believed that changing these CoPs will redirect professional and financial resources currently expended on these CoPs to better use such as providing more direct

and cost effective care to consumers. We recommend CMS look at making the following changes to Medicare CoPs for Home Care Agencies:

**OASIS data collected on Medicare clients only.**

The collection of OASIS data on Medicare only clients would provide a truer picture of rehabilitation services. Medicare clients will show more significant improvement because the services are skilled care, whereas Medical Assistance (MA) clients are likely to stabilize and require ongoing custodial care. Collecting data on all clients, rather than just Medicare clients, is time consuming and the data on MA and other clients is not analyzed. Permanent elimination of the need to collect data on non Medicare clients would eliminate inconsistencies from agency to agency, reduce visit costs, and free up nurse time to serve more clients.

**Remove the lock date and require agencies to submit the OASIS 30 days from the day of completion.**

There has been mention that Medicare will propose dropping the lock date requirement some time in 2005. The Work Group supports Medicare in its efforts to drop this requirement since Medicare already receives this information when the consumer is recertified. This is a paper work requirement that provides no additional benefit to the consumer.

**Change the 5 calendar day window to 10 calendar days for recertifying Medicare clients to coincide with the comprehensive assessment no later than every 60 days**.

Currently, providers are required to re-certify clients within the last 5 days of every 60 day episode. This is not efficient when not combined with a nursing visit. The following are two examples of why extending the window to 10 calendar days would be beneficial: 1) a patient who has a neurogenic bladder that requires monthly catheter changes would normally be seen twice during the 60 day episode for the catheter change. Often these visits do not coincide with the 5 calendar day window, and an additional visit is needed purely for the purpose of conducting a comprehensive assessment and collecting OASIS data, and 2) a patient being seen weekly for medication set-ups. The 5 calendar day window may not coincide with the weekly visits and would require an extra visit for the comprehensive assessment. It would be more effective as well as cost efficient for the client to permit an expansion of this 5 calendar days in order to re-certify in conjunction with a scheduled nursing visit. Expanding the time frame continues to allow enough time to judge if the client will need re-certification. It will better utilize the client's and the nurse's time and reduce the number of non-billable visits for the agency. Since Medicare clients receive a fixed monthly payment for care, this will not increase costs to Medicare.

**Change the requirement that the home health agency must complete a performance review of each home health aide every 12 months to the home health agency must complete a performance review of each home health aide annually.**

Currently, in Medicare CoPs, the frequency is "no less frequently than every 12 months". This requirement is burdensome for agencies because an agency has to have an administrative tracking system in place that identifies the specific date each home health aide has had a performance review in order to ensure that the next review is completed no greater than 12 months from that last date. Annual performance evaluations would accomplish the same objective without creating as complicated a tracking system.

**Recognize all authorized prescribers under state law to order medications and treatments**.

Scope of practice is defined for each licensed profession in MN. If prescribing and writing orders is within a licensee's scope of practice it is logical that the home health agency be able to take direction from those individuals. In many instances those licensed practitioners are the primary provider and are likely to be more accessible, often at a lesser cost and provide efficient care.

Presently, federal law allows nurse practitioners to prescribe and order in Medicare certified hospice programs.

**Home Health Aide supervision every calendar month.**

There is a need to create one combined supervisory period for consumers receiving either skilled or maintenance services. Consumers receiving skilled services are seen more frequently by professionals. Persons receiving maintenance services may be receiving services exclusively from unlicensed personnel. Monthly supervisory visits for all home health aide services allows for more consistent oversight of consumers receiving custodial services and more efficient use of staff resources. In addition, not receiving RN reimbursement for the every 14 day supervisory onsite with the home health aide is a hardship for most agencies. This hardship may be compounded by the RN shortage in parts of MN. Depending on the care needs of the home health client, an RN must see the client more frequently than monthly if needed.

**Revise the standards (CoP 484.55 (a)(b)) related to patient assessment to allow for a skilled rehabilitation professional to make the initial evaluation as well as the comprehensive assessment, even when nursing is involved.**

At times the therapy role is the most important reason the consumer is receiving home care, even though nursing may also be needed. A person recovering from a hip replacement, who also needs nursing services for INR draws, will need physical therapy more immediately than nursing. However, the nurse is required to make a visit to complete the initial assessment and the comprehensive assessment prior to implementing physical therapy. Allowing a therapist, in this example the physical therapist, to complete an initial and comprehensive assessment will make the more pressing therapy available in a more timely manner.

**All information notifying consumers of covered and non-covered Medicare services should be on one Advance Beneficiary Notice form.**

Prior to the formal implementation of Advance Beneficiary Notices, home health agencies notified clients of non-coverage via the Medicare non-Coverage Notice. That was replaced by the HHABN, the Medicare Advantage Beneficiary Notice and now the proposed Notice of Exemption of Medicare Benefits. Consumers find the notices duplicative, burdensome and confusing. It is important that this information be conveyed to consumers, however, it will be most beneficial to consumers if it is communicated on ONE form.

Minnesota has had considerable experience and success with the practice of telehealth care. Our state Medical Assistance program reimburses for this service. We find that it is an efficient augmentation to face to face visits, and we strongly encourage Medicare to reimburse for this service. Consumers, providers, and state staff are available to share Minnesota's results with CMS staff and I invite you to contact my office to discuss this valuable medical service.

We thank you for your serious consideration of these recommendations, and we look forward to being active participants in revising Medicare Home Care CoPs.

Sincerely,

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, MN 55164-0882

Cc: The Honorable Mark Dayton
The Honorable Norm Coleman
The Honorable Gil Gutknecht
The Honorable John Kline
The Honorable Jim Ramstad
The Honorable Betty McCollum
The Honorable Martin Olav Sabo
The Honorable Mark R. Kennedy
The Honorable Collin C. Peterson
The Honorable James L. Oberstar

Appendix B

Authorizing legislation for this Report was found at
http://revisor.leg.state.mn.us/slaws/2003/c055.html

Sec. 6 (CHANGES TO THE MEDICARE CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES.)

(a) The commissioner of health shall convene a working group to consist of home care providers and other interested individuals. The first purpose of this group is to develop a summary of federal home care agency regulations and laws that hamper state flexibility and place burdens on the goal of achieving a high quality of services, such as provisions requiring rigid time frames for the completion of supervisory visits by registered nurses and for the submission of home care client assessment information. The commissioner shall share this summary with the legislature, other states, and national groups that advocate for state interests. The commissioner shall work with officials of the federal government and with members of the Minnesota congressional delegation to achieve necessary changes in the law.

(b) The commissioner of health shall also review with this working group the current licensure process for home care providers and evaluate continued appropriateness of that process. This review shall consider federal certification regulations for home care and hospice and the need to have separate licensure provisions for certified facilities. The commissioner shall make recommendations to the legislature by January 1, 2005.

Appendix C

Current Number of Home Care Licenses by Class as of December 1, 2004

Class A (licensed only) has 345 licenses issued.

Medicare Certified Home Health Agencies number 211 (these agencies also have a Class A license, there are a total of 556 Class A providers).

Class B has 15 licenses issued.

Class C has 61 licenses issued.

Class E has 4 licenses issued.

Appendix D

Telehealth Information

The Minnesota Department of Human Services has awarded grants for telehealth activity. The telehealth technology has been used to manage disease, improve quality of care, promote consumer autonomy and meet functional and psychosocial needs of seniors. Projects funded to date:

- Volunteers of America of Minnesota, Hennepin County
- Granite Falls Hospital Home Care, Yellow Medicine, Chippewa, Renville, Lyon Counties
- The Housing Link, Hennepin County
- St. Francis Health Services of Morris, Inc, Grant, Stevens, Traverse Counties
- Neighborhood Health Care Network, Hennepin and Ramsey Counties
- Carlton County Public Health and Human Services, Aitkin and Carlton Counties
- Horizon Health Med Dispensers, Morrison County
- Mayo Clinic, Faribault, Freeborn, Olmsted, Mower, Waseca, Winona Counties
- The Good Shepard Community, Benton, Stearns, Sherburne Counties
- Goodhue Public Health Med Dispensers, Goodhue County

For more information about these projects or telehealth use in Minnesota contact:

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Appendix E

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