**Conditions of Participation Changes between the Proposed Rules and Final Rules**

- Revised §484.50(a)(3), requiring that the HHA must provide verbal (emphasis added) notice of the patient's rights no later than the completion of the second visit from a skilled professional.

- Added new §484.50(a)(4), requiring that the HHA provide written notice of the patient's rights and the HHA's discharge and transfer policies to a patient-selected representative within 4 business days after the initial evaluation visit.

- Revised 484.50(b) to replace the term "incompetence" wherever it appears with the more precise term "lack legal capacity to make health care decisions."

- Revised §484.50(c)(4)(i) to clarify that patients have the right to participate in and be informed about all assessments, rather than just the comprehensive assessment.

- Removed the requirement at §484.50(c)(4)(iii) regarding providing a copy of the plan of care to each patient. But must be made available on request.

- Revised §484.50(c)(10) to require HHAs to provide contact information for a defined group of federally-funded and state-funded entities and includes a specific mandated list.

- Revised §484.50(d) to remove the requirement for HHAs to provide already admitted patients with information regarding HHA admission policies and clarified that the "transfer and discharge policies" are those set forth in paragraphs (1) through (7) of this standard.

- Revised §484.50(d)(1) to clarify that HHAs are responsible for making arrangements for a safe and appropriate transfer. CMS-3819-F 244

- Revised §484.50(d)(3) to clarify that discharge is appropriate when the physician and the HHA both agree that the patient has achieved the measurable outcomes and goals established in the individualized plan of care.

- Revised §484.50(e)(1)(i) to clarify that the subject matter about which patients may make complaints is not limited to those subjects specified in the regulation. HHAs must investigate all such complaints.

- Revised §484.50(e)(1)(iii) to specify that HHAs must take action to prevent retaliation while a patient complaint is being investigated.

- Revised §484.50(e)(2) to specify that circumstances of mistreatment, neglect, abuse, or misappropriation of patient property must be reported in accordance with the requirements of state law

. - Added a requirement at §484.55(c)(6)(i) and (ii) that the comprehensive assessment must include information about caregiver willingness and ability to provide care, and availability and schedules.

- Added a requirement at §484.60 that patient and caregiver receive education and training including written instructions outlining medication schedule/instructions, visit schedule and any other pertinent instruction related to the patients care and treatments that the HHA will provide, specific to the patient's care needs.

• Moved proposed §484.60(a)(3) to §484.60(a)(2)(xii), (risk of ER or hospitalization) making it applicable to all patients, and removed the terms “low,” “medium,” and “high.”

• Revised §484.60(b)(1) to permit drugs, services and treatment to be ordered by any physician, not just the one responsible for the patient’s plan of care. CMS-3819-F 245

• Revised §484.60(b)(4) to permit any nurse acting in accordance with state licensure requirements to receive verbal orders from a physician.

• Added requirements at §484.60(d)(1) and (2) that HHAs must assure communication with all physicians involved in the plan of care, and integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.

• Added a requirement at §484.60(e), Written information to the patient specifying content.

• Revised §484.65 to require that QAPI program indicators include the use of emergent care services.

• Revised §484.75(b)(7) to require skilled professionals to communicate with all physicians involved in the plan of care

. • Revised §484.80(b)(3)(xiii) by withdrawing part of the provision under home health aide training requirements for aides to recognize and report changes in pressure ulcers.

• Revised §484.80(g)(1) by removing the requirement that the skilled professional who is responsible for the supervision of a home health aide must be the individual who prepares written patient care instructions for the home health aide. CMS-3819-F 246

• Revised §484.80(h)(1)(i) by adding a requirement that the registered nurse or other appropriate skilled professional who conducts supervision of a home health aide must be familiar with the patient, the patient’s plan of care, and the written patient care instructions described in §484.80(g).

• Revised §484.80(h)(1)(ii) by removing the word “potential deficiency” and replacing it with “area of concern” in the section requiring an on sight vision by supervising professional for aide.

• Revised the requirement at §484.105 to clarify that an HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient’s plan of care, for each patient’s medical, nursing, and rehabilitative needs.

• Added a requirement at §484.105(b)(1)(i) that the administrator must report to the governing body.

• Revised §484.105(b)(1)(iii) to require that the administrator assures that a clinical manager is available during all operating hours.

• Added a requirement at §484.105(b)(1)(iv) that the administrator must ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies.

• Revised §484.105(b)(2) to clarify that an individual that is pre-designated to fill the administrator role in the absence of the administrator (including the clinical manager) must be qualified to do so.

- Revised §484.105(c) to specify that one or more qualified individuals must provide oversight of all patient care services and personnel.

- Revised §484.105(c) Clinical manager by retaining a description of the clinical manager's duties while relocating the personnel specifications for this role to new §484.115(c), which sets for the specific personnel requirements for the clinical manager.

- Removed §484.105(c)(6). (Assuring the development of personnel qualifications and policies.)

- Added a requirement at §484.110(a)(4) that the clinical record must include contact information for the patient's primary caregiver(s).

- Revised §484.110(a)(6)(i) by changing the discharge summary deadline for completion from 7 calendar days to 5 business days.

- Revised §484.110(a)(6)(ii) by changing the transfer summary deadline for completion from 2 calendar days to 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility.

- Added §484.110(a)(6)(iii), requiring that a completed transfer summary must be sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

- Revised §484.110(e), requiring that a patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first).

- Revised the personnel qualification requirements for HHA administrators at §484.115(a) to grandfather in currently employed HHA administrators

. - Added §484.115(c) to specify personnel qualifications for clinical managers.

- Revised the proposal at §484.115(e) licensed practical nurse to utilize existing regulatory language regarding vocational nurses, and align the requirement with state practice acts.

- Made technical changes to the requirements at §484.115(f) through (i) to align with current personnel qualification requirements for occupational therapists, occupational therapy assistants, physical therapists, and physical therapy assistants.

VNAA appreciates fully the challenges involved in the implementation of these substantial rules within such a tight time frame and will be working with CMS and Congress as necessary to achieve a more reasonable time table. It is also noteworthy that CMS itself estimates the additional cost of these rules to be in excess of $240 Million which surely is an underestimate of actual additional costs. And this is happening at a point when cuts to home health payments continue to be made. We will be seeking payment adjustments in our rates to offset CMS' estimate of additional provider costs for implementation of the COPs. We also will be seeking a briefing from CMS on these rules to enable our members to obtain a direct explanation of the rules and respond to questions from the members. We hope to schedule that meeting as quickly as possible.