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Hospital Home Health®

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What to do with returned supplies: A home health safety dilemma

Can you — should you — use them again?

Have you ever wondered whether you can return a patient's unused supplies? If you have, you're not alone. Everyday, countless home health agencies are finding themselves in the same position, wondering what to do with unopened packages of sterile gauze, syringes, and the like. Considering the cost of supplies and the barely there reimbursement policies, the idea of a return policy can certainly be appealing. But is it legal? Read on to find out how other home health agencies are dealing with the case of the returned supplies.

Is it legal?

Robert B. Thornburg, a Seal Beach, CA-based consultant for the home medical equipment industry, is unaware of any current regulations that prevent home care agencies from returning unused supplies, namely those such as disposable items, nutrition-related supplies, items worn next to the body, creams, powders, and so forth. However, he cautions, "that does not mean that there aren't any."

To be sure, there are agencies out there who take back unused supplies, given certain parameters. An Illinois-based home care agency, for example, will take back dressings if they are unopened. Returned supplies are put into a "donated supplies" closet and given free of charge to patients with decreased monetary resources.

Naomi Rubenstein, RN, QA/clinical research specialist with Palliative CareCenter and Hospice of the North Shore in Evanston, IL, notes that her home care agency's patients are always offering to return unused and unopened supplies. "It's our policy not to accept any supplies," she says, "because we cannot [take] them from one patient's house to another due to possible cross-contamination." However, she adds, "Our vendors will take back supplies that have not been opened and remain in the original, closed packaging."

Other home care agencies, depending on the source of their supplies, can send them back for a refund, provided that the supplies in question are unopened, in their original packaging, and the agency still has the

original invoice from the time of purchase.

On the flip side, of course, not every home care agency can or will accept unused home care supplies. Some agencies refuse to take back these items because of fears of contamination. A nurse can wash her hands thoroughly, but it gets a little trickier when it comes to washing unopened packages of gauze.

Thornburg says his "universal precautions policy prohibits retrieval of any single-use item from a patient residence. Our policy states that single-use items like lancets and needles, disposable [items], items worn next to the skin, creams, powders, drugs, solutions, and nutrition-based items are not returnable to our facility and are to be left at the patient residence."

Is that item factory-fresh?

He explains, "Common sense dictates that any home health agency's policy state only factory-fresh items will be delivered, and that no single-use item be picked up from a patient residence, even if it is still in its original packaging.

"A good rule of thumb," he adds, "is to ask yourself: Would you want this product delivered to your home?"

As he points out, unlike medical equipment, "Which is nonporous and can be disinfected with appropriate virucide solutions and then thoroughly cleaned by a technician and tagged as such, supplies are packaged in porous and sometimes partially open boxes and bags."

Detroit's Henry Ford Home Health Care's official policy does not allow staff to recycle any supplies to other patients, "even if the supplies have never been opened, have not expired, or could be given to a patient with no means to obtain supplies," says **Greg Solecki**, vice president.

Lorraine Waters, BSN, MA, CHCE, director of Southern Home Care in Jeffersonville, IN, says that infection control is definitely an issue with her agency and its policy against taking back returned supplies.

"Even though sterile containers are unopened, the wrapping can act as a vector for infection," she says. "What's more, determining if the containers are truly intact might be very problematic as well."

Once these items have been left in an uncontrolled environment such as a patient residence, Thornburg explains, they are susceptible to insect infestation, pet dander, and contamination from infectious body fluids or drugs.

CE questions

For your convenience, *HHH* will be printing CE questions in each issue, beginning this month. Subscribers will receive a complete test and Scantron sheet in October 2001.

1. One of the most frequently cited reasons for home care agencies to not take back returned supplies has to do with the risk of cross-contamination.
   A. True
   B. False

2. Phase I of the Stark regulations states that as long as all of the following criteria are met, nonmonetary compensation will not be violated:
   A. The annual aggregate value of nonmonetary gifts to a physician does not exceed $300.
   B. Agencies who provide nonmonetary gifts to physicians must have requests for gifts in writing.
   C. Agencies who provide nonmonetary compensation to physicians make it available to all similarly situated physicians, regardless of whether physicians refer patients to the agency for services.
   D. The compensation is not determined in any way that takes into account the volume or value of a physician's referrals to the agency.
   E. A, C, and D.

3. Among the suggestions for operating home care education programs on a budget are that educators make use of community resources and guest lecturers.
   A. True
   B. False

4. Researchers found that disabled women received about a third fewer hours of informal care than their male counterparts because women are less likely to ask for help than their husbands.
   A. True
   B. False

From this point, he says, "proper disinfection and cleaning of these items is difficult, if not impossible. Asking staff to retrieve these items can further result in infestation of vehicles, organization storage areas, and future patient residences."

As for patients and their families who insist on giving back unused supplies, Thornburg suggests that agency staff should make it clear that they are willing to assist patients in disposing of items, as appropriate, but that they won't take them back.

Nor will Southern Home Care accept supplies once they have been in a patient's home. "Our policy," explains Waters, "is that we do not take any disposable supply or medication back that has been in the patient's home. The family is either to dispose of the items or contact one of the free health care clinics to see if they accept donations."

While Henry Ford does not allow the reuse of unopened, unexpired supplies, it has managed to find alternate uses for them, specifically on training mannequins. "I don't think our risk of contamination or infection is too great with this population," Solecki jokes.

On a serious note, though, Henry Ford has continued to seek outlets for its returned supplies. As Solecki explains, "We used to be able to donate them to local charitable organizations to be kept in a supply closet for patients in need. Those organizations slowly discontinued the practice," he says, noting that there are one or two left who will accept returned supplies. "We then donated the supplies exclusively to World Medical Relief, who will no longer accept the supplies. Currently, we have a sister organization in the Ukraine who gladly and gratefully accepts the supplies. We make sure we only are sending unopened packages that have not expired."

Like Solecki, Rubenstein says that her agency staff "encourage our patients to donate the supplies to shelters or other organizations that can use free supplies."

Not quite a bargain

Rubenstein says staff should estimate as accurately as possible what supplies they will need, and in what quantities, and order appropriately. Waters agrees and notes that her staff are encouraged to carefully monitor supply use so that only enough items are brought into the home to last until the next home visit.

In fact, says Thornburg, "Third-party payers and / or the patient have already paid for these [supplies], so they belong to the patient they were delivered to originally. It is uncommon in the industry for organizations to grant credit to third-party payers or patients for return of these items, and it is considered unethical for an organization to sell them more than once." The bottom line? Keep close tabs on what you dole out because once they enter a patient's home, they no longer belong to the agency.

"Return of supplies to an agency, for whatever eventual disposition, could easily look like fraud," acknowledges Waters. "It could appear that the agency was reselling the items by re-issuing them to another patient. While careful documentation could prevent that charge, it hardly seems worth the risk."

Supply Fact or Fiction?

In today's climate of no reimbursement for supplies, there are certainly incentives enough to take them back. But what are the consequences? Here's snapshot look at what some agencies are doing and why you may or may not want to follow their lead.

✔ **Do unto others**
Some agencies are taking back those unopened supplies and offering them to patients who are of low or moderate financial means. Sounds like a good idea? Your agency isn't out the full cost of the supplies, and your low-income patients have received quality products and saved money at the same time. Problem: Even unopened sterile packaging can act as a vector for contaminants. If you want to follow this plan, consider sponging plastic wrapped items with a disinfectant solution, but be wary of passing on supplies in other types of packaging.

✔ **Give them away**
Just because you can't use them doesn't mean no one else can. Some agencies have found that while they cannot accept returned supplies, nothing stops them from encouraging their clients to donate them. Sounds like a good idea? Homeless shelters, centers for abused women and their children, and other organizations are always looking for free supplies. Problem: See above. Before donating supplies, make sure that recipients understand the facts and any risks associated with them. Sometimes it's good to look a gift horse in the mouth.

✔ **Ration them out**
If you don't take a large stash of supplies to a patient's house, you're less likely to find yourself in the position of having a lot left over. Follow the Boy Scouts' motto and be prepared, but also be prepared to use what you brought. Sounds like a good idea? It is. Keeping careful tabs on what supplies are needed and brought into the home is the best way to make sure that everyone wins. ■

And contrary to what one might think, Thornburg notes, taking back unused medical supplies isn't the bargain you might think.

"Actually, it can be more costly to accept returns," he argues. "One can imagine patients becoming outraged at finding out these items have first been in another residence and are soiled, infested, or otherwise contaminated. One of the administrator's Ten Commandments is 'Stay off the evening news and the front page of the paper with negative news.'"

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LegalEase

Understanding Laws, Rules, Regulations

Phase I Stark rules set new limits on gift giving

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

Historically, home care agencies have given physicians and/or their immediate family members noncash items that have a relatively low value and are not part of a formal, written agreement.

Home care agencies may, for example, provide lunch to physicians and their staff members at their offices. And, in this vein of giving, agency staff have also routinely left items of limited value such as pens, notepads, etc. at physicians' offices. While seemingly acceptable, agency managers should question whether such items are legally acceptable.

When evaluating this issue, there are two areas of the law that must be considered: The first includes prohibitions against illegal remuneration or kickbacks and rebates, and the second involves provisions of the so-called Stark laws.

With respect to the latter, Phase I of the final regulations under the Stark laws was recently published and directly address this issue.

Limited risk with low-value items

Specifically, the regulations indicate that free items of relatively low value are unlikely to cause overutilization, if provided within reasonable limits. The regulations further state that as long as all of the following criteria are met, such nonmonetary compensation will not violate the Stark laws:

• **The annual aggregate value of nonmonetary gifts to a physician does not exceed $300.**

• **Agencies who provide nonmonetary compensation to physicians make it available to all similarly situated physicians, regardless of whether physicians refer patients to the agency for services.**

• **The compensation is not determined in any way that takes into account the volume or value of a physician's referrals to the agency.**

Under these regulations, it is now clear that agencies that meet these criteria for nonmonetary compensation can avoid violation of the Stark laws. However, that doesn't mean agencies can give gifts with impunity.

Agencies should also be aware of the following limitations:

• **Protection from violations of the Stark laws is not available for gifts that are solicited by physicians or group practices.**

The reason for this limitation is to prevent physicians from making such gifts a condition or expectation of doing business.

The classic example of solicitation of gifts from agencies may be insistence by physicians that they will only meet with staff to discuss patients receiving services, etc., if agency staff bring lunch with them. Such requirements may amount to solicitation that will preclude protection from agencies that supply lunch under these circumstances.

• **The exception for nonmonetary compensation up to $300 only protects gifts to individual physicians.**

Thus, gifts given to a group practice will not qualify for this exception. Noncash gifts could, however, be given to one member, several individual members, or each member of a group practice, if each such gift meets all of the conditions of the exception for nonmonetary compensation up to $300. The exception does not apply to gifts, such as at holiday parties, or office equipment or supplies that are valued at not more than $300 per physician in the group, but are, in effect, given or used as a group gift.

When agencies comply with the above requirements and avoid these limitations, they may gain protection from allegations that they violated the Stark laws in order to encourage referrals from physicians.

Agencies must bear in mind, too, that the federal statute that prohibits illegal remuneration or kickbacks and rebates also applies to the issue of nonmonetary compensation to physicians who make referrals to agencies.

No gifts for referrals

This federal statute generally prohibits anyone from offering to give or actually giving anything to referral sources in order to induce them to make referrals.

At least in theory, agencies could comply with the requirements of the Stark laws regarding nonmonetary compensation to physicians but still violate the kickback and rebate statute through their use of nonmonetary gifts to physician referral sources.

At this point, though, it seems unlikely that the Office of the Inspector General of the Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions, will conclude that agencies provided kickbacks and rebates to physicians if the requirements of the Stark regulations as described above are met.

In other words, compliance with the requirements of the new final Stark regulations will probably provide protection to agencies with regard to all nonmonetary compensation provided to physicians.

Agencies should bear in mind, however, that Phase II final regulations under the Stark law will be published in the near future. Stay tuned for more guidance on these issues.

[A complete list of publications is available from Elizabeth E. Hogue's office. Telephone: (301) 421-0143. Fax: (301) 421-1699.] ■

Continuing education on a shrinking budget

Low-cost suggestions for employee education

Coming up with new ways to make learning within the home care environment fun and effective has never been easy. And with shrinking funds — assuming employee education still has a line in your agency's budget — it's even more difficult.

Textbooks and expensive visual aids are out of the question, leaving instructors facing a class armed with little more than some flip charts, an easel, and a handful of Magic Markers. Even so, there's no reason that a lack of materials must translate into a lack of educational opportunities for your home care agency staff.

That's the quandary **Shirley Parks**, RN, MSN, director of education of SunPlus Home Health Services in San Diego, recently found herself in. Her supplies are limited — namely a Dry-Erase board, a TV/VCR, and herself — and as she put it, "I think the nurses are tired of looking at me, and there are only so many ways to reinvent *Jeopardy* into health care questions."

Parks knows firsthand the difficulty involved in overcoming a total lack of high-tech teaching materials and how that only makes getting and keeping the staff interested all the more difficult, lessening the chances that staff will absorb and retain the lessons. No matter the grade or education level, teachers everywhere can attest to the impact of eye-catching learning materials.

"I think that people are used to being visually stimulated. They are constantly being bombarded with television, video games, computers, etc.," she notes, "so without the high-tech learning materials it is sometimes difficult to keep up a high level of interest."

Jerry Cleveland, president and CEO of Ministry Home Care in Marshfield, WI, agrees, saying that he has "found it is important to use a variety of visuals to keep the education interesting."

Is that your final answer?

Parks has found several creative ways to present material to her staff, among them, the aforementioned game-show format. To give the game an extra boost, she "divided the group into two teams to foster a sense of competition," she

explains. While game-show formats are often a fun and low-budget means of getting information across, don't overlook some basic games that come from your childhood.

In one instance, Parks relied on a matching memory card game. She gave each team a set of nursing and medical abbreviations, each of which was printed on an index card. "They had to find the index card that matched the abbreviation that was on the table," she explains. "They were timed, and the first group to finish was the winner. That was a lot of fun."

In another example of Parks' creativity, she used a luminescent powder to illustrate the importance of hand washing in a clinical setting. As she explains, "I was presenting a lecture on hand washing. While I lectured, I passed around a candy dish that I had previously coated with a powder that glows when exposed to black light. Everyone handled the dish. At the end of the presentation I sent everyone out to wash their hands. They all had confused looks on their faces. When they returned I used the black light to demonstrate their poor hand-washing techniques. They were horrified, but they all commented that they had learned from this experience."

Community resources

As Parks noted, there are only so many ways to reinvent the *Jeopardy* format. Now, of course, with the popularity of *Who Wants to Be a Millionaire*? educators can expand their game show repertoire, but that only goes so far. Then what do you as an educator do?

For starters, look outside your agency for free or low-cost resources, Parks suggests. Check into health care and education grants that might be given out by various associations or companies in the area. If you have any health care organizations in your area — pharmaceutical manufacturers, HMO company headquarters, medical equipment/supply manufacturers — check with their public relations and communications departments to see whether they have any kind of program to sponsor health care education in the community. If not, draft an outline of what you would like to teach your employees and present it to the company — remember, it's great PR for the company to be involved in advancing education within the industry.

If that fails or isn't an option, don't give up. Cleveland, for example, suggests home care agencies look toward local community support. "Many times you can have your educational meetings in a church hall or library where access to equipment comes at no charge or at very little charge," he says.

If you have a local university, you might want to consider asking some of the professors to come in for guest lectures. If you're not in an area with universities or colleges, don't despair. Professors-for-a-day come in all shapes and sizes, and from all areas of the health care continuum. Consider asking some of the local medical establishment — clinical and administrative — to come and present courses on infection prevention, the latest in Parkinson's treatment, what the Health Insurance Portability and Accountability Act of 1996 means to home care, and so on. As an added benefit, many of these guest lecturers come not only with first-hand experience in these issues but with PowerPoint presentations as well. You'd be surprised how much asking for help can accomplish.

While outside resources can prove to be a wealth of information, don't overlook your own staff as teachers. Have any attended or plan to attend a conference? Make sure they take good notes and bring back some ideas to share with the class. It might not be the most sophisticated presentation, but sometimes hearing it from a peer makes information sink in a little deeper, not to mention what happens when you realize you will have to present the conference material to a group of your peers — you listen more closely.

Words of wisdom

Parks knows firsthand the hardships that come with being a home care agency educator without a budget. At times, she says, "It's almost impossible to do my presentations. . . . It has tested my powers of creativity many, many times."

She recommends that agency managers and educators do whatever it takes to "set aside something, even if it is minimal, in the budget for education. I have the advantage of being affiliated with a local nursing program, and "it lets me borrow videos and such." She suggests looking to a local community college with a nursing program, who might be willing to do similar things for other facilities. Also, she advises that agency educators "go out into the community . . . talk to community health-based organizations and see if they are willing to do educational programs at your facility.

"United Way puts out a resource manual called *Reflections*, which lists all the agencies in a given

area," she explains. "Also, look at what's happening in your risk management/quality assurance departments for ideas for educational presentations. Then ask yourself, 'What about patients' family members?' They may have ideas from firsthand knowledge. Not only can they point out problems, but they may have special information that they might be willing to share with the nurses in a presentation."

No matter what your approach to broadening your educational resources, keep in mind that there are facilities that are ready, willing, and able to help home care agencies improve the education levels of their staff. No one promised it would be easy, but that's not why you're involved with home care in the first place.

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HHS launches National Family Caregiver program

$113M in grants given to states

Tommy G. Thompson, Department of Health and Human Services (HHS) secretary, recently approved the release of $113 million in grants to states under the new National Family Caregiver Support Program, which helps family members provide care for the elderly at home.

The grants will be used by states to run programs that provide critical support, including home and community-based services and help families maintain their caregiver roles. This is the largest new support program under the Older Americans Act since 1972, when Congress established nutritional programs to serve the elderly.

"We must do all we can to ensure that our older residents can remain at home and receive care from loved ones for as long as possible," Thompson said. "This money will allow states to develop systems of support to ease the burden on hundreds of thousands of family caregivers nationwide."

National Family Caregiver Support Program Grant Allocations

State	Grant	State	Grant
AL	$1,739,242	AK	564,300
AZ	1,956,318	AR	1,125,177
CA	11,359,851	CO	1,245,978
CT	1,509,874	DE	564,300
District of Columbia	564,300	FL	8,721,584
GA	2,305,333	HI	564,300
ID	564,300	IL	4,732,281
IN	2,331,599	IA	1,391,731
KS	1,139,251	KY	1,516,043
LA	1,535,025	ME	564,300
MD	1,843,229	MA	2,766,510
MI	3,848,418	MN	1,875,522
MS	1,031,878	MO	2,337,876
MT	564,300	NE	732,458
NV	603,803	NH	564,300
NJ	3,496,629	NM	594,433
NY	7,612,334	NC	2,916,628
ND	564,300	Ohio	4,739,721
OK	1,388,901	OR	1,396,517
PA	6,097,763	RI	564,300
SC	1,421,896	SD	564,300
TN	2,083,754	TX	6,147,379
UT	573,563	VT	564,300
VA	2,354,500	WA	2,083,944
WV	854,259	WI	2,203,655
WY	564,300		

U.S. Possessions	Grant
American Samoa	$70,538
Guam	282,150
Northern Marianas	70,538
Puerto Rico	1,203,867
Virgin Islands	282,150

In November 2000, Congress created the new caregiver program as part of the Older Americans Act Amendments of 2000. The program distributes grants to states through a congressionally mandated formula and includes innovative competitive grants and a new Native American caregiver support program.

For more information on the grant programs, visit the Department's Administration on Aging's web site at www.aoa.gov. **(See list of state and territorial allocations under the grant program, above.)** ■

AHCA gives Bush the lowdown on home care

(Editor's note: The following letter was sent by the American Home Care Association Inc. to President Bush's transition team earlier this year at the behest of the new administration.)

To: George Bush transition team

The following are priority issues of concern to the home health industry for 2001:

The home health industry needs further refinement of the new Medicare prospective payment system (PPS) so that cash flow is not disrupted by glitches in the fiscal intermediaries' (FIs) operations. The Health Care Financing Administration (HCFA) worked diligently to ensure that all systems were ready for the Oct. 1, 2000, implementation of PPS.

Some FIs, however, are seriously lagging in payments to providers, thereby endangering their financial viability. Home health agencies experiencing cash flow disruptions must be able to obtain accelerated payments from their FIs. In addition, eliminating the mandated 14-day delay before payment can be made is essential to ensuring adequate cash flow.

The Balanced Budget Act of 1997 (BBA) has resulted in a decrease in home health expenditures of over 50%. The BBA also called for an additional 15% reimbursement reduction, which Congress has now postponed for the second time. The cut is currently scheduled for implementation on Oct. 1, 2002. An additional blow of this magnitude would further destabilize the home care infrastructure and threaten access to care for numerous Medicare home care patients. Home health providers are united in support of permanent elimination of this gratuitous reduction.

The PPS methodology mandated by the BBA 1997 makes it difficult for home health agencies to provide services to Medicare beneficiaries who are most in need of such care, in particular longer-term, medically complex, and high-cost patients. Per BBA, only 5% of expenditures are set aside for "outliers." PPS requires that home health agencies (HHAs) lose over $2,300 on an outlier case before receiving 60% of the loss beyond that threshold amount.

Providers can afford to admit few if any beneficiaries fitting this profile without risking financial destabilization. The industry supports infusing funding back into the benefit so that access will be restored for outlier patients who, in the absence of home health, will be forced to seek care in institutional settings at a much higher cost to the U.S. taxpayer.

Home care providers support removal of nonroutine medical supplies from the base PPS reimbursement rates, a requirement mandated by the BBA 1997. In lieu of "consolidated billing," they advocate payment on a fee schedule basis. This change is essential to protect patients with high-cost medical supply needs.

Currently, all PPS rates include the average cost of nonroutine supplies. However, the cost of some supplies, e.g., wound care and ostomy items, far exceeds the amount included in the base payment.

The current methodology overpays agencies for patients who have no supply requirements and discriminatorily underpays for beneficiaries with complex medical needs.

Home care agencies feel besieged by HCFA contractors, who are not held accountable for the accuracy of their decision making or for honoring the due process rights of providers. Failure to penalize this behavior leads to arbitrary claims denials and cost report disallowances, as well as to citations for alleged condition of participation (COP) deficiencies not substantiated by the record. Providers urge action to address this situation, by:

- Delineating in writing the due process rights of health care providers.
- According providers the right to exhaust appeals prior to decertification by a state survey agency and before recoupment of funds from the universe of claims in audits involving statistical sampling.
- Establishing an alternate dispute resolution process for COP surveys, akin to the process accorded skilled nursing facilities, through which the survey agency and the HHA can resolve COP disputes.
- Holding contractors accountable for accuracy and for fair and ethical treatment of providers; requiring contractors to pay interest, and in some cases penalties, to providers wrongly deprived of their reimbursement.
- Establishing a HCFA oversight board, consisting in part of representatives of the different segments of the health care industry.
- Establishing a body of independent certified public accountants to perform peer review on cost report audits performed by HCFA's contractors. ■

NEWS BRIEFS

ECRI announces 2001 telephone seminars

ECRI in Plymouth Meeting, PA, recently announced the topics for its upcoming lineup of interactive telephone seminars to be held this year.

The seminars are similar to a call-in radio show; participants listen to three speakers and then have a chance to call in during a question-and-answer period.

The series will include the following seminars:

• **Final HIPAA Privacy Regulations: What Must You Do Now?** (April 11)

• **Picture Archiving and Communication Systems (PACS): Lessons Learned** (Sept. 12)

• **Wireless Technology and the Healthcare Facility: Where Is It Useful?** (Nov. 14)

The registration fee for each individual seminar is $199. To participate in or for more information on ECRI's 2001 telephone seminar series, contact the company at 5200 Butler Pike, Plymouth Meeting, PA 19462-1298, or call (610) 825-6000, ext. 5888. ▼

Fake invoice scam continues to spread

A new round of fake invoice scams is continuing to flourish, according to a report in *AHA* (American Hospital Association) *News*. The association received reports from at least three organizations saying that they had received fake invoices from an organization calling itself Direct Supply and claiming to be based in Los Angeles. Elkhart (IN) Hospital, Good Hope Hospital in Ervin, NC, and the Long Prairie (MN) Memorial Hospital and Home, as well as companies in Oregon and Kentucky, each reported receiving an invoice for approximately $74. The company uses a box at a Mailboxes Etc., with this address: Direct Supply, 8391 Beverly Blvd., #345, Los Angeles, CA 90048-2633.

A company in Milwaukee named The Direct Supply Network, dealing primarily with nursing homes and managed care issues, emphatically denied being part of the organization mailing invoices from Los Angeles. The Direct Supply Network also said it had received more than 1,500 copies of the fake invoices from clients and that it is working with the Los Angeles office of the U.S. Postal Inspection Service to track down the source of the fraudulent invoices.

Sheryl Lynch, legal assistant for Direct Supply Inc. in Milwaukee, requests anyone receiving the invoices to fax them to her attention at (800) 250-1961.

Lynch says that dates on the invoices range from Feb. 1, 2000, to Dec. 18, 2000, a few have been dated Jan. 4, 2001, and many have a Las Vegas postmark. ▼

JAMA study: Women receive less home care

Even though women in the United States live longer than their male counterparts, elderly disabled women may not be receiving as much home care as men in similar circumstances, according to an article in the Dec. 20, 2000, issue of the *Journal of the American Medical Association*.

The study examined data from a nationally representative survey taken in 1993 among 7,443 noninstitutionalized people ages 70 or older. Included in the sample were 3,109 respondents who said that they either had difficulty or received help with activities such as eating, dressing, bathing, preparing meals, making telephone calls, and managing money.

Researchers found that disabled women received about a third fewer hours of informal care than their male counterparts. Among the reasons attributed to this discrepancy were that women are more likely to be living alone (75% of disabled men lived with a spouse), and in situations where both spouses are still living at home, women tend to take on the traditional caregiving role more than their husbands.

Even when researchers allowed for the fact that until 1997 there was not a great wave of paid home care services, women still received significantly less home care regardless of whether it was paid for. The study also found that adult daughters were found to be the primary caregivers of disabled women, whereas wives, even if they were disabled,

provided the majority of care for their disabled husbands.

Additionally, researchers found that elderly disabled women were more likely than elderly disabled men to be too poor to afford home care services without the help of Medicare or Medicaid. ▼

AHA looks to the Hill for changes to HIPAA

The American Hospital Association (AHA) has taken two steps to garner government action with respect to the Health Insurance Portability and Accountability Act (HIPAA): It has asked Congress for support in implementing the final rule on HIPAA privacy while also asking the Department of Health and Human Services (HHS) to reopen the final rules.

During his testimony before the Health, Education, Labor, and Pensions Committee of the U.S. Senate on behalf of the AHA, **John Houston**, information services director, data security officer, and assistant counsel for the University of Pittsburgh's UPMC Health System said: "Congress should examine the high costs associated with implementing the privacy regulation and take the necessary steps to ensure that implementation does not put hospitals in financial jeopardy by supplying the necessary funds."

In a separate action, AHA sent a letter to HHS Secretary Tommy Thompson, asking him to reopen the final rule implementing HIPAA privacy requirements.

AHA asked that the following points be reviewed:

• The implementation schedule, because of the high cost associated with a health care organization making the extensive changes necessary to meet the new privacy rule.

• Requirements that could impede patient care or disrupt essential hospital operations, if state law on the issue of patient privacy is allowed to pre-empt federal regulations. Under the final rule, if a state law is contrary to and more stringent than the federal standard, it cannot be preempted. This translates to the need for hospitals and other health care organizations to know the state laws in every state in which they do business and then compare them to the federal law to determine which law they should follow.

• The cost involved with becoming compliant. According to HHS figures, the regulation will have a 10-year cost of $17.6 billion for the entire field, including hospitals, insurers, clearinghouses, and pharmacies and costs will be offset over the course of a decade by savings accrued as a result of HIPAA's transactions standards. It is the opinion of the AHA that HHS has underestimated these costs. An AHA-commissioned study, looking at hospital costs alone, found that the cost of only three key provisions of the proposed rule (minimum necessary, business partners, and state law preemption) could be as much as $22.5 billion over five years. This estimate depended on whether hospitals could comply by simply modifying existing information systems, or if replacement or significant reconfiguration of those systems was required.

• Administrative requirements that will, according to Houston, create a host of new administrative duties, among them the creation of departments, which will coordinate consents, authorizations, and disclosures; evaluate and coordinate requested changes to patients' medical records; and make significant changes to policies, procedures, and processes.

• A new provision on patient consent issued by HHS, which is required when protected health information is used or disclosed for purposes of treatment, payment, or health care operations. Patient consent forms must be separate from privacy notices, signed by the patient and retained by the hospital. If a patient subsequently revokes his/her consent, hospitals must discontinue using the protected health information and advise business associates to do the same. Since this provision was not included in the proposed rule, it was not subject to comment. ▼

COMING IN FUTURE MONTHS

- What's the future for home care?
- Avoiding medical errors (In English and Spanish)
- Managing a patient's pain
- Using home health care aides
- When patients are verbally abusive

New management team at Gentiva

Gentiva Health Services, the nation's leading provider of specialty pharmaceutical and home health care services, announced the management team for its newly organized home health division.

Ron Malone, Gentiva's executive vice president and president of nursing services, is moving to the position of executive vice president and president for the home health division and will assume executive management responsibility for both nursing services and the company's network management division, now known as CareCentrix.

Reporting to Malone will be Al Perry, formerly senior vice president of CareCentrix, now the senior vice president of nursing services, where he will be responsible for Gentiva's nursing services operations.

Also as part of the unveiling of the company's new home health division management, Gentiva announced the promotion of Susan D'Amelio from assistant vice president of CareCentrix, to vice president of corporate accounts. ▼

Pro-home health bill introduced in Senate

Sen. Susan Collins (R-ME) recently introduced a bill into the Senate that would permanently eliminate the 15% home health reimbursement reduction, which is slated to go into effect on Oct.

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1, 2002. Moreover, this bill, S. 326, the Home Health Payment Fairness Act of 2001, would also make permanent the 10% add-on for services to rural patients.

Currently, the bill has these co-sponsors in the Senate: Christopher "Kit" Bond (R-MO), John F. Kerry (D-MA), Jack Reed (D-RI), Jim M. Jeffords (R-VT), Pat Roberts (R-KS), Carl Levin (D-MI), Tim Hutchinson (R-AR), Patty Murray (D-WA), Michael B. Enzi (R-WY), Barabara A. Mikulski (D-MD), Robert C. Smith (R-NH), Frank H. Murkowski (R-AK), Olympia Snowe (R-ME), John W. Warner (R-VA), Judd Gregg (R-NH), Jean Carnahan (D-MO), Richard G. Lugar (R-IN), and Thad Cochran (R-MS).

If your senator is not currently a co-sponsor, you may wish to contact his or her office via letter or e-mail to urge support for S. 326 and protect the home health care industry.

To find contact information for your state's representatives, go to the web site: http://Thomas.loc.gov. ▼

Medicare paid too much for drugs

According to federal auditors, if Medicare had been able to purchase two popular prescription medications in 1999 at prices, which were made available to the veterans' health system, Medicare and its beneficiaries would have saved $1.6 billion.

Paying the actual wholesale price for the same drugs would have saved $761 million, the Department of Health and Human Services' inspector general said in a recent report.

Currently, most over-the-counter or outpatient prescription drugs are not covered by Medicare. Only in specific circumstances — vaccines, drugs used with medical equipment covered by Medicare, and those drugs associated with organ transplants, dialysis, chemotherapy, and pain management — are prescription medications for the elderly covered.

Under current law, Medicare recipients pay 95% of the average wholesale price for such drugs, and Medicare reimburses them 80% of the total. All told, Medicare and its beneficiaries paid $3.9 billion for covered drugs in 1999.

Meanwhile, the Department of Veterans Affairs is free to negotiate with individual drug manufacturers and suppliers for bulk discounts. "At the prices the Veterans Department paid in 1999 for the 24 most widely used drugs covered by Medicare, the agency would have saved more than half the $3.1 billion it spent," the audit found. ■

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Describe practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■

THE EXECUTIVE'S SUPPLEMENT TO *HOSPITAL HOME HEALTH*

HOME HEALTH BUSINESS QUARTERLY

Are Medicare and Medicaid victims of pricing fraud?

OIG says average wholesale prices were inflated

Investigations by the Office of Inspector General, the Department of Justice (DOJ), and state groups coordinated by the National Association of Medicaid Fraud Control Units found Medicare and Medicaid have been overpaying for certain prescription drug products because average wholesale prices (AWPs) were inflated.

The DOJ says AWPs published by First DataBank, a San Bruno, CA, company that provides the information to state Medicaid programs, don't reflect actual acquisition costs in the marketplace and called the discrepancies a deliberate attempt to defraud Medicare and Medicaid.

Medicare program officials are evaluating whether the revised Medicaid AWPs could be adopted for Medicare reimbursement as well.

State fraud control units recalculated Medicaid AWPs based on a survey of wholesale prices, and many Medicaid programs implemented the new prices on May 1, 2000. Medicaid programs were told they are legally obligated to "reimburse providers true acquisition costs."

"With the imposition of reductions ranging from 30% to 90%, it is difficult to discern anything sound or sustainable about this policy," says **Lorrie Kline Kaplan**, executive director of the National Home Infusion Association (NHIA), joined in its protest by five pharmacist organizations.

"Everyone in the provider community should take this as an earsplitting wake-up call," she advises. "We can no longer afford to let our public officials remain ignorant about the significant level of services we are providing, the cost savings these services are delivering to payers, and the outstanding patient outcomes that we are achieving."

On Dec. 18, 2000, President Clinton signed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (H.R. 5661), which restores more than $35 billion in Medicare spending over five years to health care providers affected by the Balanced Budget Act of 1997.

The bill also placed a moratorium on arbitrary use of lower drug pricing for Medicare-covered infusion, injectable, and inhalation therapies, and authorized the General Accounting Office to study the need to reimburse for home infusion services.

The Act states, "Effective for drugs and biologicals furnished on or after Jan. 1, 2001, the Secretary may not directly or indirectly decrease the rates of reimbursement (in effect as of such date) for drugs and biologicals under the current Medicare payment methodology" until the secretary has reviewed a report submitted by the comptroller general no later than September 2001.

The report is to identify average prices that physicians and other suppliers pay for drugs and biologicals, quantify the difference between these prices and the reimbursement amount, and determine if the payment adequately compensates physicians, providers, and suppliers for costs incurred.

The legislation would prevent Medicare from implementing the lower reimbursements. The NHIA says the effort to re-establish AWPs for pharmaceuticals will reduce Medicare and Medicaid reimbursements and increase the programs' average costs since patients will be forced into more expensive inpatient settings.

"NHIA will continue to closely monitor these developments and work with members, state and federal officials, and consumer and provider groups to put a stop to this ill-conceived initiative — at least long enough to study its impact," an association spokesperson says. ■

Head of HCFA resigns

Michael M. Hash, acting chief of the Health Care Financing Administration (HCFA), was forced to resign in December for violating the Hatch Act by hosting a fundraiser for a congressional candidate. The federal law prohibits political fundraising by federal employees.

Hash voluntarily reported the violation to the Office of Special Counsel (OSC), which didn't seek to prosecute. Hash said he did not know he was violating the act by throwing the fundraiser for his former neighbor. He resigned as part of a settlement with the OSC. Michael McMullan will serve as acting administrator of the agency until the Bush administration confirms a new administrator. According to an *AHA* (American Hospital Association) *News* report, Tom Scully, president of the Federation of American Hospitals, is expected to be installed as HCFA chief. ■

New JCAHO rules given on free-flow pumps

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has warned hospitals and other facilities that some infusion pumps can deliver lethal bursts of medicine — called free-flow — and that the facilities could lose Medicaid accreditation if they can't document the safe use of the pumps.

More than 30 models without free-flow protection are still marketed by dozens of medical device companies. Most new pumps have the protection, but facilities may continue to use older models because staff are familiar with them and because intravenous tubing is less expensive. JCAHO plans to require facilities to eliminate pumps that don't have free-flow protection. Facilities will also have to document the training health personnel receive on using the pumps. ■

COMPANIES IN THE NEWS

Anthem Insurance goes public

Anthem Insurance Co., Inc. in Indianapolis will take its stock public by the end of the year to raise money to buy Blue Cross health care plans in more states.

"This industry is consolidating, and we want to be sure we have the financial resources to create a larger company," says **Larry C. Glasscock**, Anthem's president and chief executive.

In the last 10 years, Anthem, formerly Blue Cross/Blue Shield of Indiana, has acquired Blue Cross plans in Kentucky, Ohio, Connecticut, New Hampshire, Colorado, Nevada, and Maine, and now has over 7 million customers. ■

Respiratory provider accredited

Lincare Holdings Inc. in Clearwater, FL, an in-home provider of oxygen and other respiratory services, has begun a formal relationship with the Community Health Accreditation Program (CHAP), a home care accrediting body based in New York City and one of two national bodies with deeming authority from the federal government. Lincare's accreditation process at the corporate level has been completed, and site visits are currently taking place. ■

Medtronic offers on-line training

Legal Research Center Inc., a provider of outsourced legal research and writing services, and Integrity Interactive Corp., which delivers web-based compliance training solutions, will create and deliver an on-line compliance training program for Medtronic Inc. in Minneapolis, which offers products, therapies, and services for people with chronic diseases. The training program will benefit the medical technology company's employees worldwide. ■

NHC leaves Florida, settles suit

Florida has approved change of ownership licensing for 12 National Healthcare Corp. (NHC) skilled nursing facilities. The facilities became newly formed, nonrelated companies effective Oct. 1, 2000.

The Murfreesboro, TN-based company — which operates 77 long-term health care centers, 33 home care programs, six independent living centers, and 16 assisted living centers for itself and third parties — decided to leave Florida after it was unable to locate any insurance carrier to provide medical liability coverage.

In December 2000, the company settled a qui

tam lawsuit alleging it had submitted cost reports that misallocated routine nursing services between Medicare and other payers. The total settlement was $27 million, less a credit of almost $9.4 million for money the company's self-audit program disclosed was owed by the government to NHC and its managed centers. The company said the settlement amount has previously been reserved and will have no negative impact on the company's reported earnings. ■

For the third quarter, **Paracelsus Healthcare Corp.** (PHC) in Houston, a public company that owns the stock of hospital corporations in seven states, reported net revenue of $93.2 million compared with $138.2 million. The parent corporation has filed for Chapter 11 bankruptcy protection in the Southern District of Texas; its hospital subsidiaries are not included in the plan, and PHC intends to continue normal business operations of the subsidiaries while restructuring its debt.

Other third-quarter results included earnings before interest, taxes, depreciation, and amortization (EBITDA) — excluding unusual items and reorganization costs — of $6.8 million for the third quarter compared with $13.6 million. Same hospital net revenue was $93.2 million compared with $91.2 million. Same hospital EBITDA was $10.1 million or 10.8% of net revenue compared with $13.7 million or 15% in 1999. The company reported a net loss of $11.5 million or 20 cents per diluted share for 2000 compared with a net loss of $4 million or 7 cents per share.

For the nine-month period, net revenue was $279.3 million compared with $432.4 million in 1999. EBITDA was $28.9 million, compared with $54.3 million previously. Same hospital net revenue was $277.7 million compared with $277.8 million in 1999. Same hospital EBITDA was $37.5 million or 13.5% of net revenue in 2000, compared with $47.1 million or 17% in 1999. Net loss was $29.2 million or 50 cents per diluted share for 2000, compared with a net loss of $13.2 million or 24 cents per share in 1999. ■

Pediatric Services of America Inc. (PSAI) in Norcross, GA, which provides pediatric home health care services in 22 states, announced financial results for the fourth quarter and fiscal year 2000. Net income for the fourth quarter was $1.2 million compared with a net loss of $17.8 million in the same quarter previously. There was an 8% expected decline in net revenue from $49.6 million in the 1999 quarter to $45.5 million in 2000, due to the elimination of noncore services. Diluted net income per share was 17 cents for the quarter compared with a net loss per share of $2.68.

Net revenue for the fiscal year was $186.4 million compared with $211.4 million previously. Net income was $28.6 million compared with a net loss of $55 million for fiscal 1999. Basic and diluted net income per share was $4.30 for the fiscal year compared with a net loss per share of $8.29 for the previous year. ■

CORPORATE LADDER

H. Stanley Eichenauer, retired president and CEO of Eastway Corp., a community-based provider of behavioral health, rehabilitation, and housing services in West Central Ohio, will become chair of CARF's (The Rehabilitation Accreditation Commission) board of trustees for the 2001 term.

The board voted Jane Dorval, senior vice president of medical affairs and quality oversight with the Good Shepherd Rehabilitation Hospital in Allentown, PA, to succeed Eichenauer as chair-elect and elected Herb Zaretsky, administrator and clinical associate professor at Rusk Institute of Rehabilitation Medicine of New York University Medical Center, as secretary-treasurer. The members' one-year terms began Jan. 1. ■

McKesson HBOC Inc. in San Francisco, a supply management and health care information technology company, has appointed **Keith Mallonee** its first chief privacy executive.

Mallonee will be responsible for all privacy polices and practices governing the security, confidentiality, and quality of patient information, as well as safeguarding operations and business practices within the company. ■

Barbara Dybnis, LivHOME director of professional outreach, won the "Exceptional Women in Elder Care" award from the Santa Monica Chamber of Commerce Women's Business Council. Dybnis is a licensed marriage and family therapist and certified care manager with over 20 years experience working with the terminally and chronically ill, disabled, and geriatric populations. ■

Michael S. Ness is the new vice president of sales and marketing for Briggs Corp. in Des Moines, IA, which provides products and services for long-term care, assisted living, home care, hospital, and other health care markets. Ness worked in executive positions for Essilor International, a manufacturer of eyeglass lenses, and has experience in the pharmaceutical instrumentation and medical device markets. ■

ASSISTED LIVING UPDATE

MI law protects residents' right to stay

In January, Michigan governor John Engler approved legislation protecting residents' right to choose to stay in assisted living facilities as their health needs increase.

The statute prohibits state regulators from ordering residents to be discharged from licensed Homes for the Aged (assisted living facilities serving over 21 people) if the resident, his or her doctor and family, and the home's operator disagree with the need for discharge. The owner, operator, and governing body of the home also must agree to ensure that the resident receives the necessary additional services.

Before this ruling, consumers had little access to a formal appeal process and the state Department of Consumer and Industry Services, Bureau of Regulatory Services had the right to initiate a resident discharge. The legislation, in which the Assisted Living Federation of America's state affiliate played a key role, ensures a team approach to the decision process and affirms the rights of the elderly and disabled to receive services in the residential setting of their choice. ■

HUD awards assisted living grants

The U.S. Department of Housing and Urban Development (HUD) awarded almost $20 million in grants under a new program to convert senior housing to affordable assisted living.

The Assisted Living Conversion Program will provide owners of HUD section 202 senior housing with a grant to modify or convert facilities for assisted living, which will help low-income seniors remain in residential settings and in their own homes for as long as possible.

"ALFA [the Assisted Living Federation of America] views this important new grant program as a next and necessary step in helping providers fulfill their promise to seniors — particularly very low-income seniors," said **Gerard Holder**, executive director of ALFA's Senior Housing Council, in an announcement. ■

Capital Senior Living ends merger

Capital Senior Living Corp. in Dallas, which develops and operates senior living communities nationwide, has terminated an agreement to merge with ILM II Senior Living Inc. A built-in gain tax issue disclosed in ILM II's Form 10-K filed in January could cause a material adverse change under the merger agreement. ILM II might be liable for up to $2.7 million in penalties and interest.

"In ordinary circumstances, we would put our financing on hold and would await the resolution from the IRS of this issue," says **Lawrence Cohen**, Capital's CEO. "However, awaiting the IRS resolution would certainly make completion of our financing impossible by March 31, 2001, the termination date under the merger agreement with ILM II. Thus, we believe we have no other choice than to terminate the merger agreement."

The company will continue to manage five ILM II communities under an existing agreement. ■

Sunrise closes sale of 9 properties

Sunrise Assisted Living Inc. in McLean, VA, which operates 163 assisted living communities in 25 states and the United Kingdom, signed an agreement to sell nine properties for $131 million to Prudential Real Estate Investors (PREI). It also sold two properties to Aureus Group LLC for $28.1 million. Sunrise maintains long-term management contracts in both sales.

The nine properties — located in Pennsylvania, New Jersey, and Virginia with a total of 666 units and resident capacity of 798 — will be owned by Senior Housing Partners, LLP, a limited partnership formed by PREI with five major pension funds and Sunrise.

The two properties in Rockville, MD, and San Mateo, CA, — with 133 units and a resident capacity of 160 — were sold to Aureus, a Dallas-based real estate company. ■