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IN THIS ISSUE

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Cultural competence and sensitivity is more than just learning a language

For good care, home health staff must respect customs, religious beliefs

A culturally insensitive remark to the grandchild of a patient not only resulted in the home care nurse being thrown out of the home, but also resulted in a major change in the way that Catholic Health Service (CHS) of Long Island's Home Care and Hospice program addressed cultural differences among patients and employees.

Although the remark was bad enough, the worst part of the situation was the nurse was clueless about why the fuss was being made and refused to apologize to the family, says **Keith Kertland**, president and chief executive officer of CHS Home Care and Hospice in Hauppauge, NY.

In the three years since the incident, CHS Home Care has implemented a one-day cultural sensitivity seminar that all 450 employees are required to attend and has added members of the minorities represented in the community to the board, he says. "We are also translating patient information into more languages and developing a resource book that identifies cultural issues that home care employees are likely to encounter," Kertland adds.

While home care agencies have looked at the need to address language barriers, there is more to consider than just language when your patients have a different cultural background, points out **Mary Jo Clark** RN, BSN, MSA, home care management consultant for RBC Limited, a management consulting firm in Staatsburg, NY. "Sometimes, your nonverbal communication can offend," she says. For example, in many Asian cultures, direct eye contact is disrespectful, she points out.

The need for cultural competence is growing, Clark says. "It is no longer just the metropolitan areas that have a variety of cultures." With resettlement of refugees from different parts of the world, even smaller towns and rural areas have people with different languages and customs, she adds.

It is even more important for home care employees to be aware of cultural differences than hospital employees, says **Ann Hutchinson**, RN, BSN, clinical supervisor of the Downriver Office of Henry Ford Home Health in Lincoln Park, MI. "In the hospital, patients surrender

themselves to the hospital routine because they are the guests of the hospital," she says. "In home care, we are guests in the patients' homes, so we need to respect their customs," she explains.

In addition to cultural competence seminars that all employees must attend, Henry Ford Home Care employees take a cultural competence exam each year, Hutchinson says.

The exam follows a review of the health system's *Multicultural Resource Guide* that contains detailed descriptions of different customs, beliefs, religions, and practices for more that 20 different groups, she says.

Language barriers are handled in a variety of ways. "We use family members, staff members, or Language Line," Hutchinson says. **(See list of resources, p. 27.)**

"Our branch office has a number of Hispanic patients, so all of our staff members have learned some rudimentary Spanish," she adds.

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THOMSON
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It's important to find out if there is a language barrier when the referral is first received, says Hutchinson. "This gives you time to make arrangements before the first visit."

You not only should ask about language during the initial referral but about religion and nationality as well, Clark points out.

"Although you can't put every patient in a box and expect them to act exactly like everyone else with the same language, religion, or nationality, you can research the traditional customs prior to the first visit so you won't be surprised," she says. For example, an Asian family may expect the nurse to remove her shoes and wear slippers, she points out. "The nurse should be prepared for this so that her reaction doesn't offend the family," she adds.

Understanding different beliefs also improves communications, Kertland points out. "One of our hospice nurses wanted to report a Muslim family to adult protective service because they had the patient lying on a mattress on the floor rather than a bed," he says. "It wasn't abuse. Muslims believe that you should be close to the earth and facing Mecca when dying, so the family was following their religious practice," he says.

Cultural-related questions are raised at case conferences, Hutchinson says. "In addition to reviewing the patient's progress, we take the opportunity to discuss cultural issues that may have arisen during the visits so we can all learn from them" she says.

"In the Arab culture, it is rude to expose the soles of the feet," she says. "This presents a problem when the nurse is conducting a diabetic foot exam." Situations like this rely on the development of a trusting relationship so that the nurse can explain the rationale for the exam and make sure it is conducted in a private place, she adds.

Find open-minded staff

Hiring employees from the same populations as your patients also will help your agency, Clark points out. "Although you won't always be able to assign only Jamaican nurses to Jamaican patients, just having the diversity on staff will help everyone learn more about different cultures," she says. Be sure you hire staff members who are open to experiencing new things, no matter what their backgrounds are, she adds.

Although hiring aides and nurses is a challenge all by itself, Clark suggests that home care agencies work with local community and religious groups

Cultural Diversity Resources

- ✔ **Henry Ford Health System *Multicultural Resource Guide*** contains background, family, social, food, spiritual, and health practice information on more than 20 cultural, racial, and religious groups. Copies of the book can be purchased for $29.95. For more information, or to order the book, contact Karen Giovannini at (313) 874-3766 or kwierci1@hfhs.org.

- ✔ **Language Line Services**, One Lower Ragsdale Drive, Building 2, Monterey, CA 93940. Telephone: (800) 752-0093, ext. 441. E-mail: prod info@languageline.com. Web site: www.languageline.com. Provides over-the-phone interpretation and document translation services in more than 140 languages. Interpreters are available 24 hours a day, seven days a week, 365 days per year. A variety of subscription plans are available depending on how much time is needed per month.

to promote their own agency and talk about the need for aides and nurses.

As you evaluate your agency's ability to provide care to patients of different cultures and backgrounds, be sure that you don't forget about the different backgrounds of your own employees, Hutchinson says. "The easiest way to make sure we are respectful of our patients' differences is to make sure we respect our colleagues' differences," she says. **(See article on workplace diversity, at right.)**

Even with resource guides, research, and preparation before the first visit, sometimes, the best way to make sure you don't offend patients and their families is to ask what their preferences are, Hutchinson says.

"Not every family has the same beliefs that other people of the same background have. When we ask their preferences, we show that we are aware of differences and want to respect the families customs," she adds.

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Work force diversity leads to cultural sensitivity

Understanding starts within your agency

One tactic to improve your agency's cultural sensitivity is to make sure your work force reflects the diversity of your patient population, according to experts interviewed by *Hospital Home Health*.

Workplace diversity, however, means that efforts to improve cultural sensitivity should apply to the workplace as well as your patients' homes, says **Mary Jo Clark**, RN, BSN, MSA, home care management consultant for RBC Limited, a management consulting firm in Staatsburg, NY.

Something as simple as culturally themed lunches help employees get to know each other's background, she says.

"An agency can sponsor a Caribbean or Italian lunch day and have employees bring in foods related to the theme," she suggests. Finding out about traditional foods can lead to finding out about climate, crops, and customs, she adds.

Remember to recognize religious practices as well, says **Ann Hutchinson**, RN, BSN, clinical supervisor of the Downriver Office of Henry Ford Home Health in Lincoln Park, MI.

"We have a clerical employee who is a Jehovah's Witness, so he does not celebrate any Christian holidays," she says.

Gift exchanges and celebrations for Christmas in the office still occur, but they are more subdued, and colleagues accept the fact that the employee cannot participate, she adds.

Henry Ford Health System also produces a diversity calendar that explains a different culture each year, Hutchinson says.

In addition to the calendar, seminars, and inclusion of cultural difference situations in case management meetings, Henry Ford Home Care has a storyboard that travels from branch to branch, she says.

"The storyboard discusses different holidays and explains the customs related to each," she

explains. Martin Luther King Day, Kwanzaa, and Cinco de Mayo are a few of the observances addressed by the display, she adds.

Sometimes, you need to take cultural differences into account when you receive complaints about your employees, Clark points out.

"Once, I had a Jewish patient complain that her Caribbean aide did not know how to cook," she says.

After talking with the aide, Clark learned that the aide had been preparing Caribbean food because that's what she knew how to cook.

"I suggested to the patient that she teach the aide how to prepare foods she liked. Not only did this involve the patient in food preparation, but the aide learned new skills, and the patient liked her food, she explains.

Taking a stand against intolerance

Stand by your employees and your employment policies, Hutchinson recommends. "We do encounter patients who state that they don't want nurses or aides of certain races, nationalities, or genders. In fact, one patient stated that he did not want any black people taking care of him when an African-American aide made her first visit," she says.

The nurse who had been seeing the patient and had developed a good rapport, told the patient that the agency did not discriminate and could not assign him aides based on their race, she explains. Then the nurse went with the aide on several visits, making sure the patient saw that the aide was competent and provided good care. Soon the patient became comfortable with the aide and the agency had no complaints, she adds.

Be sure to give employees the tools to deal with situations they encounter, Hutchinson suggests. "One nurse was caring for an Arab patient who insisted that she drink coffee when she first arrived."

"This nurse did not normally drink coffee but was afraid to decline the offer because it would offend the patient," she explains.

Hutchinson says that after the nurse described her dilemma, a supervisor at the case conference pointed out that the home care agency's policy is that employees do not eat or drink anything in the patient's home.

"This gave the nurse the ability to respectfully decline the coffee and explain that she was following the rules of her employment and in no way wanted to offend the patient," she says. ■

It takes how long to get paid? AR days can be cut

File clean claims to get money faster

Just four years ago, accounts receivable days outstanding for HomeReach Homecare in Worthington, OH, reached 116 days. After investigating reasons for the delays in payment and implementing changes that solved problems, the agency now enjoys an average of only 43 days.

With no hope of increasing reimbursement levels, home health agencies need to carefully evaluate their claims processing and collection activities to ensure that they maintain optimum cash flow, say experts interviewed by *Hospital Home Health*.

"Our first step was to get our clinical and billing staffs working together," says **Michael S. Ellis**, RN, BSN, director of clinical services for HomeReach.

Opening the lines of communication

When researching the accounts receivable process, Ellis and other staff members discovered that not only did the clinical and billing staffs not talk to each other, neither group understood what the other one did in terms of collecting information needed to file claims. **(For more on changes made in billing process, see article, p. 31.)**

Another key to reducing accounts receivable days is to verify coverage up front, says **Terry Cichon**, CPA, director of homecare operations for FR&R Healthcare Consulting in Deerfield, IL.

"I believe that the 85% of all claims that are paid with no problem are more a matter of luck than a matter of a good billing process," she says. "I frequently encounter agencies that don't verify eligibility for coverage," she explains.

Medicare-approved agencies should be checking the Common Working File that is accessible on-line through the Centers for Medicare & Medicaid Services' (CMS) web site, Cichon says.

"This site will show you if the patient is covered and eligible. You'll also find out if the patient already is in an open home health episode, which may mean that the former agency neglected to discharge the patient in a timely manner," she adds.

Make sure to identify Medicare patients who are members of an HMO, Cichon warns. While patients or family members may not be aware

Know most common RTP codes to avoid costly errors

Understanding why claims are returned to providers for correction will help home health staff members better check claims before they are submitted, says **Terry Cichon**, CPA, director of homecare operations for FR&R Healthcare Consulting in Deerfield, IL. The most common return-to-provider reason codes are:

- Reason Code 38107/Causes for return:
  - — A final claim has been submitted, but no request for anticipated payment (RAP) exists.
  - — A RAP exists, but the final claim doesn't match one or more of these fields on the UB92.
- Reason code 30720/Cause for return:
  - — Outcomes and Assessment Information Set (OASIS) matching key is missing from the RAP or final claim (Field 63 on the UB92).
- Reason code 31018/Causes for return:
  - — Final claim is submitted for less than 60 days, but patient status code is 30 in field 22 of the UB92.
  - — Statement covers period is for more than 60 days.
- Reason code 32907/Cause for return:
  - — Line item date is not within the from and through dates of the claim.
- Reason code 11801/Cause for return:
  - — Source of admission (field 20 on UB92) is not on the RAP or final claim.
- Reason code 31755/Causes for return:
  - — The admission date of the claim is equal to the statement from date; the date of the revenue code 0023 also should match.
  - — Revenue code 0023 was not found.
  - — The 0023 service date must equal a visit date.
- Reason code 30715/Cause for return:
  - — The patient last name and/or first initial on the claim does not match the beneficiary record.
- Reason code 12100/Causes for return:
  - — Patient status on RAP is not 30.
  - — Patient status on final claim is invalid.
- Reason code W0452/Cause for return:
  - — Primary diagnosis code is invalid.
- Reason code W0453/Cause for return:
  - — 2nd diagnosis code is invalid.
- Reason code W0454/Causes for return:
  - — 3rd diagnosis code is invalid.
  - — Date shown is the first day of the next certification period.

that they are a part of an HMO, the easiest way to find out is to ask who pays for their prescription medication, she suggests.

"If the patient says that Medicare pays, then he is in an HMO," she says. If you do provide service for an HMO patient, the claim will be denied and there is no appeal, Cichon adds.

If your patient is not covered by Medicare, be sure to check with the private insurance company to verify coverage as well, points out **Nancy L. Boyd**, senior consultant with Boyd & Nicholas, a Rohnert Park, CA-based financial consulting firm that specializes in home care. With Medicare or other insurers, be sure that you don't just accept the word of your referral source, she adds. "If you don't check coverage and eligibility, you will have a hard time appealing your denial," Boyd says.

Be thorough with claim forms

"Be sure that you file a clean claim," Cichon adds. Remember to include the Social Security number, patient birth date, and relevant dates related to the start of service, she says. Also, be sure you submit your patient's name exactly as it appears on the Medicare card, she points out.

"Even if the name is misspelled on the card, submit it misspelled the same way until Medicare corrects the records and issues a new card." Otherwise, the claim will be rejected, Cichon explains. Be aware, too, of the most common reason for CMS returning claims to providers, she suggests. **(See return-to-provider reason code list, above.)** Knowing what to double-check helps prevent the mistakes in the first place.

The HomeReach staff submits claims twice a month, Ellis says. "Although we've been told that we should submit daily or weekly to improve cash flow, we believe that the extra time we take to double-check our claims and documentation is the reason we have a claim error rate of less than 1%." "For us, it is more efficient to submit the claim correctly the first time rather than having to correct errors later." he adds.

A big mistake made by many home health agencies is not responding to additional development requests (ADRs) from Medicare, Cichon says.

"ADRs are requests for additional information related to the claim. If you don't respond within 30 days of the date of the ADR, the claim is automatically denied and there is no way to justify your actions, so you've lost," she explains.

Hospital-affiliated home health agencies, in

particular, are vulnerable to mishandling ADRs because they may not be the recipient of the ADR letter, Cichon says. "The hospital billing department may receive the request but not forward it in a timely manner to the home health agency," she says.

If the ADR makes it to the home health agency, the deadline may have passed, or there may not be enough time left to collect the information and send it to the Medicare intermediary, she adds.

To avoid these problems, check the status of your claims on-line one to three days after submission, Cichon says.

"You will see if an ADR is issued, even before you would receive it in the mail." After ascertaining the request has been issued, start collecting the documentation you need to provide and mail it 10 to 15 days before the deadline, she suggests.

Keep extra copies of what you send

If you are responding to more than one ADR in a single package, include a cover sheet that lists all of the patients included in the package, adds Cichon.

"If you list five patients on your cover sheet but only enclosed four records, you will get a call to let you know that a record is missing," she says. This is why mailing the response 10 to 15 days early is important because you have time to send the extra record, she adds.

When mailing your response to an ADR, make two copies of what you send, Cichon says. One copy will remain in your file, and the extra copy is on hand in case your first package isn't received. Having the extra copy shortens the amount of time you need to send the second package.

"Also, be sure you send your response by courier or certified mail so that you have a signed receipt showing when the package arrived and who accepted it," she says. The intermediary has 60 days to review and decide on the claim, she adds.

Hospital-affiliated home health agencies also need to work with the hospital's billing department to make sure that lines of communication are open, Cichon suggests.

"Only the home health agency knows when a request for anticipated payment can be sent, or when the documentation for the final claim is ready," she says. Another hurdle to overcome is hospital software often can't track the items needed for home health claims. Cichon recommends that home health agencies use software that can track the following items:

- all signed physician's orders;
- therapy downcodes;
- therapy upcodes;
- unplanned low utilization payment adjustments (LUPA);
- verified documentation for all visits;
- all nonroutine medical/wound supplies billed.

If your software doesn't check for these items, someone on staff should, she recommends.

The billing process doesn't end with submission of the claim, Boyd points out. You can keep track of Medicare claims status on-line, but private insurers require more effort, she says. "If you submit your bill through an automated system, rebill every 15 days." If you must mail the claim, be sure to send follow-up bills through certified mail, she adds.

On the 45th day that claims have been with a private insurer, call to check on the claim. "Be organized and have all claims that have been submitted to the same insurer grouped together," Boyd suggests.

You want to be able to ask about all claims that are outstanding for 45 days in one phone call, she says.

If the company has a policy that the customer service representative only can check on a certain number of claims in one phone call, check that number of claims, hang up, and immediately call back, Boyd adds.

"If you're organized, the process of calling insurers can be handled efficiently," she says.

While paying attention to accounts receivable days and putting processes in place to track claims and make sure they are submitted properly takes time, it is well worth it, Ellis says.

"When we started our efforts to reduce accounts receivable days, we were not in great financial shape," he says. "Now, we are financially stable with a positive cash flow."

[For more information on speeding up collection, contact:

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Technology can reduce days outstanding

Small changes can yield big results

Cutting accounts receivables days from 116 to 43 is a monumental accomplishment. Cutting the days at the same time your gross revenue grows from $770,000 per year to $1.6 million per year without adding extra staff to the billing process may sound like a plot for a new "unreality" TV show, but it did happen at HomeReach Homecare in Worthington, OH.

"We've experienced tremendous growth since we first looked at our accounts receivable days and billing process in 1999, but the changes we implemented mean that we can handle the growth," says **Michael S. Ellis**, RN, BSN, director of clinical services for the home-care agency.

"We've become more efficient, and activities related to filing claims flow smoothly," he adds.

Teams get the job done

HomeReach management started the performance improvement project to reduce accounts receivable days by setting up an overall coordination team composed of the billing supervisor, medical records supervisor, director of clinical services, and two nurse managers. This committee handled the overall implementation of communications and process changes, Ellis says.

"We relied upon smaller 'issue' teams to work with the specific tasks we identified as problems in our process," he adds.

Ellis says specific issues addressed by the smaller teams that comprised staff members involved in the process, on both the clinical and billing sides, included:

- physician order tracking;
- electronic signatures;
- electronic medical records;
- data entry;
- billing schedules;
- funds transfer.

The most dramatic changes occurred in the medical records and signature process, he points out. "Although our information system had the capability to record electronic signatures, we had been relying on paper copies of records and field personnel traveling to the office to sign the paper," he says.

"Now we're making full use of our system that enables field clinicians to use their point of care system to document the visit and 'sign' the record," he says.

Because the system uses passwords and login codes to verify the user's identity, the electronic signature is accepted as proof that the proper clinician prepared and filed the document, Ellis adds.

Not only did this save time because the paperwork no longer sat in the clinician's inbox waiting for signature, but it saved time for the medical records staff that no longer had to print out paper records, he says.

"Because the record is on the database shared by medical records and billing, the billing staff no longer had to wait for medical records to send the records," he adds.

By making sure that all home health staff members were kept up to date on findings of the task forces and changes as they were implemented, everyone was very positive and very receptive to the changes, Ellis adds. ■

HIPAA Q & A

[Editor's note: This is a periodic column that will address specific questions related to the Health Insurance Portability and Accountability Act (HIPAA) implementation. If you have questions, please send them to the column editor, Sheryl Jackson, Hospital Home Health*, American Health Consultants, P.O. Box 740056, Atlanta, GA 30374. Fax: (404) 262-5447. E-mail: sherylsmjackson@cs.com.]*

Question: Can we use a different Notice of Privacy Practices than they do in the hospital?

Answer: Yes, says **John C. Gilliland II**, an Indianapolis attorney specializing in home care. A covered health care provider is only required to have one Notice of Privacy Practices, but it can have more than one if it wants to do so, he adds.

Question: Can we leave messages on our patients' answering machines?

Answer: According to Gilliland, you can leave messages on a patient's answering machine if you have complied with the privacy rule's requirements concerning incidental disclosures and the patient or the patient's personal representative has not instructed you not to do so.

The privacy rule is not intended to impede customary and essential communications and practices, Gilliland says. "However, in doing so, you must comply with the privacy rule's incidental disclosure rule," he adds.

That rule permits incidental disclosures (such as someone else hearing the message on the answering machine) as long as you have implemented reasonable safeguards to guard against the incidental disclosure and have complied with the minimum necessary standard, he points out.

This means that when leaving messages on answering machines, you need to limit the amount of information disclosed on the answering machine to only what is necessary to accomplish the purpose of the message, he says.

For example, that could be leaving only your name and number and information necessary to confirm the appointment, or asking the individual to call back, he explains.

The privacy rule permits individuals to request confidential communications. This includes asking that you communicate with them by alternative means or by alternative methods, Gilliland says. "You must accommodate any reasonable request in this regard. So, if a patient asks that you not leave messages on his or her answering machine, you should accommodate that request.

"Do not forget that if you intend to give appointment reminders that must be mentioned in your Notice of Privacy Practices," he says.

"Although not required, it can be useful to also mention how you will give the reminders so individuals are aware of the manner and means you will use unless they request otherwise," Gilliland adds.

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LegalEase

Understanding Laws, Rules, Regulations

Medicaid reimbursement crisis: How it affects you

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

(Editor's note: This is the first of a two-part LegalEase column that addresses home health agency concerns related to changes in state Medicaid programs. This column presents background on the Medicaid reimbursement crisis and describes program changes that can affect home health agencies with charges of fraud and abuse, risk of legal liability, and loss of professional licensure. Next month's column will look at nursing implications and violation of ethical principles.)

There is a growing fiscal crisis in state Medicaid programs. Those programs have increasing concerns about the fiscal burden of caring for elderly and chronically ill patients.

The New York Times reported Feb. 2, 2002, that at a conference for governors, participants pleaded with the federal government for financial help with ever-increasing spending for Medicaid programs.

The *Washington Post* subsequently reported on June 5, 2002, the following relevant statistics:

- State individual income tax collections in the first three months of the year dropped 14% from the same period in 2001, a loss of $14.5 billion.
- In April 2002, a key month for receipt of tax revenues, collections were down 21%, a loss of $8.5 billion.
- Payment of estimated taxes in the first quarter of 2002, a frequent early indicator of receipts for the remainder of the year, were running 27% behind those in 2001.
- Refunds processed during the first quarter of 2002 were 14% higher than last year, a $3.5 billion hit to states' budgets.

The issue surfaced again in *The New York Times* May 26, 2002, when the United States Courts of Appeals for the 4th and 6th Circuits ruled that

Medicaid beneficiaries may sue state officials to compel them to provide benefits mandated by federal law.

These revenue reductions and court rulings, among other factors, have undoubtedly contributed to states' concerns about funding Medicaid programs. Since state Medicaid programs cannot save money by cutting benefits because many benefits are mandated by the federal government, programs likely are to turn to other mechanisms to reduce spending.

State Medicaid programs may use a variety of mechanisms to reduce spending for home care services to help address fiscal shortfalls. Some mechanisms that programs are already using have serious implications for home care agencies, including allegations of fraud and abuse, risk of legal liability, loss of professional licensure, and potential violations of key ethical principles.

Allegations of fraud and abuse

State Medicaid programs recently have attempted to implement changes to reimbursement for home care services that include allegations of fraud and abuse.

For example, North Carolina's Medicaid program recently proposed the following two changes in reimbursement:

- If agencies initiated services based on attending physicians' verbal orders, these verbal orders must be signed by physicians and returned to agencies within 30 days of the date of admission. If agencies do not receive the signed verbal orders within the 30-day time period, agencies would not be paid for services provided to patients.
- If patients eligible for services paid for by both the Medicare and Medicaid programs — called dually eligible patients — begin receiving Medicare home care services, they no longer can receive home care services paid for by the Medicaid program even though those services were not provided on the same day as services paid for by Medicare.

Agencies in North Carolina first learned of these changes in reimbursement when they were published in bulletins from Medicaid.

At the same time, the Medicaid program in North Carolina conducted a series of audits and attempted to recoup monies retrospectively based on the above changes.

Providers should be concerned that Medicaid programs in other states will follow the lead of the program in North Carolina as they shoulder ever-increasing costs.

Instead of direct cuts to benefits or reimbursement rates, programs may attempt to save money through the back door by changing payment criteria and auditing retrospectively to recoup monies based on modified-payment criteria.

When these audits result in allegations of fraud and/or abuse, the potential consequences for providers are even more serious.

For example, representatives of state Medicaid programs may allege fraudulent/abusive activity in the form of false claims when agencies provide services that do not meet the modified-payment criteria described above.

To the extent that such allegations may result in even greater recoupments in the form of collections of penalties and/or interest based on fraudulent submission of false claims, regulators may be tempted to make these claims.

Liability risk and license loss

State Medicaid programs may require prior or preauthorization of services. When services are not preauthorized, programs typically have no obligation to pay for such services.

Difficulties arise, however, when the authorization process does not occur as promptly as necessary to ensure appropriate care. For example, patients' plans of care (POC) may require relatively frequent visits.

When agencies do not receive authorizations to make additional visits on a timely basis, they are left with two choices, neither of which is acceptable from the point of view of risk management and fiscal responsibility.

Agency managers can decide not to make the visits for which they have not received authorization prior to the scheduled visit. This means that patients will not receive care consistent with their POCs. Deviations from POCs always equal greater risk of legal liability for both agencies and their staff members.

The second choice is that agency managers could decide to make the visit and accept nonpayment from the Medicaid program because they did not obtain appropriate authorization prior to making the visits. While agencies may be able to absorb the cost of loss of reimbursement for an occasional visit, they cannot afford to do so on a regular basis.

In order to avoid liability and loss of licensure by deviating from patients' POCs, agencies may

choose to forego reimbursement. Thus, state Medicaid programs may successfully reduce expenditures by placing agencies and their staff members between a rock and hard place with a choice between legal liability and loss of licensure vs. nonpayment for services.

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MedPAC: Cut rural add-on, keep 15% cut

New recommendations made by the Medicare Payment Advisory Commission (MedPAC) Jan. 16 contradict the unanimous vote made one year ago, which proposed that Congress implement a two-year extension of the 10% rural add-on to the Medicare home health benefit, provide a full marketbasket update, and eliminate the 15% cut.

Because Congress failed to pass legislation during the 107th session that would enact any of these recommendations in 2002, MedPAC's 2003 recommendations now jeopardize any remaining chances for home health to have a period of stability, according to representatives of the American Association for Homecare (AAHomecare) in Alexandria, VA.

During its Jan. 16 meeting, MedPAC officials adjusted their recommendation so that only a one-year extension be made to the rural add-on, that it be 5% and not 10%, and that the marketbasket update to payment rates for fiscal year 2004 be eliminated.

These cuts, which would come on top of the 15% reimbursement reduction and a 1.1% cut to the marketbasket update [implemented Oct. 1, 2002, by the Balanced Budget Act of 1997 (BBA '97)], further would limit access to home health for many Medicare beneficiaries and cause greater instability within the industry.

According to 2002 AAHomecare-funded report developed by the North Wales, PA-based Polisher Research Institute, *Impact of Further Payment Reduction in the Medicare Home Health Benefit,* approximately 1 million Medicare beneficiaries have been eliminated from the home health benefit since the initial cuts were imposed in 1997. Further, the report also shows that the volume of participating providers has been cut by 40%.

"The fact that we are still learning about the effects of the Oct. 1, 2002, cut to home health providers, and that final cost reports under the home health [prospective payment system] are still not available, underscores the fact that MedPAC is not making sound, informed decisions," stated AAHomecare's President and CEO **Tom Connaughton**.

"If further cuts are made to the home health benefit, it will be the sickest and neediest of the beneficiaries who will suffer, as they are also the costliest," he added. "More than any other benefit, home health needs a period of stability to recover from the damage created by BBA '97.

"Somehow, policy-makers need to learn that home care is a solution to many of the problems we will face as the baby boomers age. We should be expanding benefits for home care — not taking steps to undermine it," Connaughton said. ▼

JCAHO changes ORYX home care requirements

Home health agencies no longer need to submit ORYX performance-measurement data to the Joint Commission on Accreditation of Healthcare Organizations or participate with a listed performance-measurement system.

Medicare-certified home heath agencies can choose one of the two following options:

- Share Outcome and Assessment Information Set (OASIS)-based quality indicator and quality measure data and reports with surveyors, and discuss their relationship to performance-improvement activities. This option does not require agencies to submit data to the Joint Commission and uses the same data to satisfy both federal performance data reporting requirements and ORYX requirements.
- Continue to participate with a performance-measurement system and submit monthly data to the Joint Commission on six performance measures.

Non-Medicare-certified agencies have the following options:

- Discontinue submission of ORYX performance-measurement data through a listed performance measurement system. If the home care organization selects this option, it will need to identify six performance measures from the universe of measures, collect data internally, and generate either run charts or control charts on each measure at least quarterly for use in internal quality improvement activities. No data are required to be submitted to the Joint Commission, but data reports will need to be available for review by surveyors during on-site surveys and produced upon request. At the time of survey, the organization will need to discuss how the data were used in identifying priorities for performance improvement activities.
- Participate in a listed performance-measurement system and submit aggregate monthly data to Joint Commission on six performance measures.

The new requirements will remain in effect until both the Joint Commission and the Centers for Medicare & Medicaid Services establish core performance measures for home health agencies. ▼

More deaths from flu than previously thought

The Centers for Disease Control and Prevention (CDC) in Atlanta has released data indicating that an average of 36,000 people die from influenza-related complications each year in the United States.

This represents an increase compared to previous estimates of 20,000. The findings note that about 11,000 people die each year from respiratory syncytial virus, a virus that causes upper- and lower-respiratory-tract infections in children and older adults.[1]

CDC researchers say the increase in deaths can be explained in part by the aging of the U.S. population, and the most virulent of influenza viruses in recent years has been the most common strain circulating during the past decade.

CDC director **Julie Gerberding**, MD, says the new findings indicate that the magnitude of the problem is larger than once thought, adding that officials must stress the importance of high-risk people getting their flu shots every year. **(For more on flu vaccination programs, see *Hospital Home Health*, December 2002, p. 133.)**

Reference

1. Thompson WW, Shay DK, Weintraub E, et al. Mortality associated with influenza and respiratory syncytial virus in the United States. *JAMA* 2003; 289:179-186. ▼

Cost of care for the aging may be lower

Research in this month's edition of *The Journal of Gerontology* showed aging baby boomers won't run up health care costs as they reach their 80s and 90s by as much as experts forecasted.[1]

The researchers found that medical costs for seniors who died relatively young were considerably higher near the end, than the costs for people who died at age 85 and older. The research, sponsored by the National Institute on Aging, came from a detailed analysis of 25,954 elderly people enrolled in Medicare between 1982 and 1998.

The average monthly health care expenditure per person in the group was $720 in 1998 dollars, of which Medicare paid $429. Among those who died, the cost was about $3,170 monthly, while those who survived incurred about $590 a month in health expenses. In the month before death, the cost for people ages 65 to 74 averaged about $7,580, while the cost for those 85 and older was $5,254.

Reference

1. Yang Z, Norton EC, Stearns S. Longevity and health care expenditures: The real reasons older people spend more. *J Gerontol B Psychol Sci Soc Sci* 2003; 58:S2-S10. ■

COMING IN FUTURE MONTHS

- Need staff? Try growing your own
- Tips for avoiding LUPAs
- Act early to head off workers' comp problems
- How to improve a relationship with your hospital
- These mistakes lead to charges of fraud/abuse

CE *questions*

This concludes this CE semester. A CE evaluation form has been included with this issue. Please fill out the evaluation and return in the envelope provided. If you have any questions, call customer service at (800) 688-2421.

21. According to Ann Hutchinson, RN, BSN, clinical supervisor of the Downriver Office of Henry Ford Home Health, why is it more important for home health employees to be culturally competent than other healthcare employees?
    A. Home health employees see patients for longer periods of time.
    B. Federal laws mandate cultural competence.
    C. Home health employees see more people.
    D. Home health employees are guests in the patients' homes.

22. A performance-improvement project to reduce accounts receivables days at HomeReach Homecare, has decreased days by what number in four years?
    A. 183 to 65
    B. 116 to 43
    C. 103 to 70
    D. 95 to 32

23. What does Terry Cichon, CPA, director of homecare operations for FR&R Healthcare Consulting, suggest that home health agencies do to check patient eligibility?
    A. Check the Common Working File on CMS's web site.
    B. Rely upon information provided by referral source.
    C. Find out how prescription medicines are paid for.
    D. A and C

24. According to John C. Gilliland II, an Indianapolis attorney specializing in home care, can you leave messages for your patients on an answering machine?
    A. no
    B. yes, if the patient has not requested confidentiality
    C. yes, if you limit the information in the message
    D. B and C

Answer Key: 21. D; 22. B; 23. D; 24. D

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. ■