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HCFA releases interim payment system cost limits for fiscal year 2000

Balancing the old and the new

The Health Care Financing Administration has released the updated cost limits for the interim payment system (IPS) for FY 00. These changes are effective for cost reporting periods beginning on or after Oct. 1, 1999, through Oct. 1, 2000.

Per-visit changes emanated from a database, which included cost reports starting on or after Oct. 1, 1994, and ending by March of this year. Per-beneficiary changes took into account the base year of FY 94 when looking at "old" agencies and cost reporting periods beginning before Oct. 1, 1998, for examining "new" agencies.

Agencies deemed "old" with a full 12-month cost reporting period

Standardized Per-Beneficiary Limit by Census Regions, Labor, and Nonlabor

Census Region	Labor	Nonlabor
New England (CT, ME, MA, NH, RI, VT)	$2,797.47	$804.37
Middle Atlantic (NJ, NY, PA)	$2,073.06	$596.06
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	$3,127.39	$899.23
East North Central (IL, IN, MI, OH, WI)	$2,535.84	$729.14
East South Central (AL, KY, MS, TN)	$4,808.31	$1,382.55
West North Central (IA, KS, MN, MO, NE, ND, SD)	$2,435.65	$700.32
West South Central (AR, LA, OK, TX)	$4,667.91	$1,342.17
Mountain (AZ, CO, ID, MT, NM, NV, UT, WY)	$3,076.15	$884.49
Pacific (AK, CA, HI, OR, WA)	$2,383.00	$685.20

Source: Health Care Financing Administration, Baltimore.

FY 00 Per-Visit Cost Limits

MSA (NECMA) location	Labor	Nonlabor	Total
Skilled nursing care	$78.91	$21.90	$100.81
Physical therapy	$90.16	$25.40	$115.56
Speech therapy	$91.40	$25.66	$117.06
Occupational therapy	$90.46	$25.51	$115.97
Medical social services	$110.13	$31.27	$141.40
Home health aide	$36.39	$10.04	$46.43
Non-MSA location	**Labor**	**Nonlabor**	**Total**
Skilled nursing care	$90.28	$20.79	$111.07
Physical therapy	$103.15	$24.00	$127.15
Speech therapy	$107.68	$25.32	$133.00
Occupational therapy	$107.01	$25.49	$132.50
Medical social services	$141.49	$32.61	$174.10
Home health aide	$37.98	$8.68	$46.66

Source: Health Care Financing Administration, Baltimore.

from FY 94 would receive a per-beneficiary limit based on agency-specific costs from 1994 in addition to regional adjustment. Those with per-beneficiary limits less than the national median will receive an additional adjustment.

New agencies fall under one of two categories: those with a cost-reporting period ending before Oct. 1, 1998, and those that fall after. The former will receive the national median adjusted according to an area wage index and cost-reporting period, while the latter will receive 75% of the national median per-beneficiary limit.

The unadjusted national median for federal FY 00 is $2,786.53 (labor) and $801.21 (nonlabor). ■

'State of the Industry' seminar comes to Chicago

Hospital home care is the focus

Chicago plays host to a full-day conference, "Hospital Home Care: State of the Industry," Dec. 6. The seminar will be held at the Holiday Inn O'Hare International in Rosemont, IL, and is sponsored by the Center for Hospital Homecare Management of Memphis, TN, and *Hospital Home Health*.

The conference will provide an in-depth, inside look at how hospital-affiliated home care agencies are faring and what can be done to ensure their long-term success.

"We think there is a strong need for a full-day conference on hospital home care, which addresses the state of the industry across the multiple home care product lines such as private duty, infusion, retail pharmacy, and retail centers," explains **Dan Lerman**, MHSA, president and founder of the Center for Hospital Homecare Management.

"We think there is a need for a program focused exclusively on hospital home care. After two difficult years under IPS, there are ways hospitals can learn how to restructure, turn around, and make home care profitable," he adds.

Among the topics to be addressed **(see box, p. 123)** are strategic management, financial and operational efficiency, home infusion, and private-duty marketing strategies targeted at providing home care and hospital professionals with solid, usable information on making hospital home care a profitable venture.

Addressing the various issues, in addition to Lerman, will be these speakers:

❒ **Bill Cabin**, JD, MA, president of Cabin Associates and a senior associate with the Center for Hospital Homecare Management;

❒ **Lea Wilson**, RN, MBA, executive director of private duty and staffing services with Henry Ford Extended Care of Henry Ford Health System in Detroit;

❒ **John C. Gilliland**, JD, a Covington, KY, attorney specializing in home care and health law and a member of *Hospital Home Health*'s editorial advisory board;

❒ **Larry Brothers**, RT, MBA, vice president of Genesys Health System, a leading diversified hospital system in Grand Blanc, MI.

For more information or to register, contact Dan Lerman at the Center for Hospital Homecare Management, 111 S. Highland St., Suite 286, Memphis, TN 38111. Telephone: (800) 266-3583. E-mail: hospitalhc@aol.com. The cost of registration (payable by check only) is $225 per attendee if registered before Dec. 3. On-site registration is $250. ■

'State of the Industry' Agenda

- ✔ 7:30 a.m. Registration
- ✔ 8:30-9:00 a.m. **Strategic Management — The National Home Care Marketplace**, Dan Lerman, MHSA.
  An examination of competitive industry dynamics, financial pressures, key business tends and Wall Street perspectives along with key business and clinical success factors.
- ✔ 9:00-10:30 a.m. **Financial and Operations Efficiency Under the New Medicare Home Health Reimbursement System — IPS & PPS**, Bill Cabin, JD, MA.
  An overview of: the interim payment system and proposed Medicare home health prospective payment system (PPS) regulations, financial and operational coping strategies, how to develop reasonable financial goals and identify typical operational pitfalls, and other relevant regulatory and legislative updates.
- ✔ 10:45-11:45 a.m. **Private Duty Market Strategy, Services & Profit Secrets**, Lea Wilson, RN, MBA.
  Learn how a major hospital system has been profitable in the private duty market, what services they offer, how they are organized and structured, and what opportunities this may imply for your marketplace.
- ✔ 11:45 a.m.-1:15 p.m. Break for lunch.
- ✔ 1:15-2:45 p.m. **Restructuring Your Hospital Home Care Business(es)**, John Gilliland II, JD.
  How the home health PPS regulations will influence choice of structure (if published) and how to identify the reasons the current structure of most hospital-based home care operations makes it difficult for them to compete and be profitable. This seminar describes how the hospital's goals influence its home care operations structure as well as how the advantages and disadvantages of the emerging models for restructured hospital-based home care.
- ✔ 3:00-3:35 p.m. **Home Infusion, DME, and Retail Center Business Strategy and Operations**, Larry Brothers, RT, MBA.
  A look at the market dynamics (changing profit margins and business upside opportunity and risk potential), Medicare cutbacks and key management responses and the lessons that can be learned from them, along with HCFA DME competitive biding project.
- ✔ 3:45-4:30 p.m. **Panel — Open Forum**
- ✔ 4:30 p.m. Adjournment

How to spread the word on National Home Care Month

Get out the message about home care

November is National Home Care Month (NHCM) and with it comes a host of ways to celebrate. **Valerie Tulley**, director of public relations for the National Association for Home Care (NAHC) in Washington, DC, points out that this month is a "great opportunity to concentrate on building awareness in the community about what home care is and how it benefits local residents."

She suggests using NHCM as a forum in which to "build excitement about home care and the services we provide." Fliers are one way of doing this, she says, as are activities with home care patients. "Anything providers can do to ease the burden on a patient's family, such as giving them time to go out on the town or simply provide a listening ear so they can talk, is great," she says.

Of course, you shouldn't just limit yourself to celebrating within your agency. Take this opportunity to show those in your community and local government who may not be aware of the benefits of home care just how important the services you offer are.

One idea, says Tulley, is to hold an open house. "Because so many people are facing the issue of caring for their elderly parents, anything you can do to get the public to notice the issues in home care is worthwhile. We are always talking to the media about what's going on in the industry. Now it's the agencies' chance to get the media's attention. One way is to invite their congressmen along on home visits so they can better see what it is all about."

If you haven't started making preparations yet, don't despair. There are plenty of low-cost options that don't require too much planning. And there's always next year's celebration. "It's never too early to start planning," she says, "especially if you want to do something like get people from the community involved or even cooperate with other home care agencies in your community to put on something really spectacular."

Here are several suggestions from NAHC geared to target groups:

❒ Potential customers

• Launch a ribbon-wearing campaign promoting NHCM.

• Host an open house to bring new people into your office. Use this time to answer any questions they may have about home care.

• Coordinate a "Walking Home" walk-a-thon to raise funds for low-income individuals who need home care. Charge an entrance fee to participate and ask a local television or radio station to sponsor the event.

• Display banners and signs announcing NHCM. Major intersections and areas near hospital entrances are good locations.

• Organize a silent auction to raise community funds. Try auctioning donated items such as artwork, hotel accommodations, restaurant certificates, and gift certificates.

• Construct NHCM bulletin boards or information booths at your local health departments and shopping centers.

• Work with local public libraries to feature books and other materials spotlighting home care.

• Ask local businesses and utility companies to print or insert home care information in their November bills.

• Organize a resource fair and seminar series for your community's caregivers.

❒ Staff and volunteers

• Consider honoring different types of home care providers on different days or weeks during the month of November. For example, set aside a few days to honor your administrative personnel. And don't forget: Nov. 14-20 has been designated as National Home Care Aide Week.

• Decorate your office with NHCM posters, banner, and balloons for the month.

• Enlist the help of local businesses in placing a public service announcement with your local television or radio station thanking your agency's employees.

• Ask patients and families to sign a giant thank-you card for your staff and volunteers.

• Distribute cookies or other treats to your staff and volunteers thanking them for their commitment to home care.

• Post a message on your company's e-mail system and on your paychecks thanking your staff for their time and dedication.

• Create an in-house bulletin board profiling each of your employees.

• Host an "Employee/Volunteer of the Year" awards event to recognize someone who has gone the extra distance.

• Host a breakfast, luncheon, or picnic to honor all your employees and volunteers.

❒ Area physicians and referral sources

• Distribute home care information packets to all appropriate physicians.

• Let them know that your agency's staff are available to visit the doctor personally and work under the physician's supervision.

• Provide them with copies of the thank-you letters your agency has received from patients and family members who have benefited from your care.

• Provide physicians and referral providers with a free subscription to your newsletter, if you have one. If you don't, consider creating a quarterly publication targeted at educating physicians to the benefits of home care.

• Present a "Physician of the Year" award to a local doctor who has been the most supportive of home care in your area.

• Distribute novelty freebies such as pens, calendars, or prescription pads with your agency's name and logo on them.

• Offer to teach a free home care course at an area medical center or volunteer to speak at a staff meeting on the merits of home care.

• Work with area teaching hospitals to develop a home care rotation.

• Encourage your hospital to establish a home care residency program to give physicians a greater understanding of what home care is and what providers do.

• Send e-mail greetings to local managed care and insurance companies wishing them a happy "National Home Care Month" and briefly describing how your agency provides a full spectrum of home care services to area residents.

• Arrange to have home care information distributed with Meals on Wheels outreach programs.

• Sponsor a program of free seminars on what home care does and how to select a home care provider.

• Invite members of the clergy to your agency and teach them about the services you provide.

❒ Patients and their families

• Develop NHCM "fun sheets" such as crossword puzzles or story games that staff can give to children during home care visits.

• Help families create "stress gloves" by filling latex gloves with colored sand. Encourage them to squeeze the gloves whenever they are anxious or in pain.

• Create a "partnership quilt" out of fabric or paper squares donated by patients, family members, and staff. Glue or weave them together and

put the quilt on display in your agency.

• Develop and distribute a parent's or children's guide to discussing serious illness and disability-related issues. Include quotes from a home care book to answer the most-frequently asked caregiver questions.

• Honor one of your agency's most outstanding information givers.

• Sponsor a series of basic first-aid and infant and adult CPR classes for friends and family members of home care patients.

• Coordinate a "Parents' Night Out" during which agency staff and volunteers care for pediatric patients while parents get together with other parents for an evening away from home.

• Cater a special meal for your elderly patients.

• Ask employees and the local Humane Society to participate in "Share-a-Pet Day" but only bring carefully screened pets into homes as companions.

• Organize a holiday party or other celebration for patients and their friends and families.

• Host a caregiver talent show to highlight the hidden talents of families. Invite your staff and volunteers to participate as well.

❒ **Public officials**

• Share positive information about your agency, including awards and recognition, with legislators and their staffs.

• Host an annual legislative breakfast to hear legislators' concerns and to voice your perspective on home care and the most critical issues it faces as an industry.

• Sponsor an NHCM luncheon or banquet honoring national, state, and city legislators who have actively supported home care.

• Volunteer to work on the campaigns or serve on the health ad hoc committees of your most supportive legislators or promising candidates.

• Contribute to the campaigns of home care's strongest supporters and, if possible, offer to host a fundraiser for them.

• Mobilize a coalition of groups in your community that share home care's views and concerns. Meet regularly to develop strategies for lobbying your local politicians. ■

SOURCE

- **Valerie Tulley**, Director of Public Relations, National Association for Home Care, 228 Seventh St. SE, Washington, DC 20003. Telephone: (202) 547-7424.

Bring your staff up to date on fighting infections

A field guide to VRE and MRSA

By **Michelle F. Boasten**, RN
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It would seem that something so tiny and undetectable to the naked human eye could never win a fight against a human being. This army is powerful. Without guns, airplanes, or stealth bombers, they deliver a deadly blow to hundreds of thousands of human beings every day. The fight is between microorganisms and human beings.

Antibiotic-resistant organisms are dangerous

Since the discovery of penicillin, antibiotics have long been regarded as miracle drugs with the ability to eradicate infection. But what the scientists didn't know is that antibiotics have the ability of inadvertently promoting the development of organisms that can kill.

Microbes try to survive just like any other living creature and because of the indiscriminate and prolific use of antibiotics for both prophylaxis and treatment, overuse of antibiotics has given bacteria the chance to develop defenses against their use. This new capability allows resistant strains of microorganisms to flourish when antibiotics control their more sensitive strains.

Preventing overuse of antibiotics lies largely in the hands of physicians. As nurses, it is important to recognize exactly why antibiotics are prescribed. Two of the most prevalent antibiotic-resistant microbes are vancomycin-resistant *enterococcus* (VRE) and methicillin-resistant *Staphylococcus aureus* (MRSA). Hospitals in more than 40 states have reported VRE, with rates as high as 14% in oncology units of large teaching hospitals.

Once limited to large teaching hospitals and tertiary care centers, MRSA is now endemic in nursing homes, long-term care facilities, and even community hospitals. Both *enterococci* and *staphylococcus* are part of the body's normal flora. Normal flora are the bacteria that we acquire after birth that help ensure survival.

Normal flora are essential for good health and

generally not harmful when the immune system is functioning properly. Enterococci, for example, are primarily found in the intestine, where they join other bacteria to protect the body from potentially harmful microbes.

As long as bacteria stay in their assigned places, everything is fine. But if the body's natural defense system breaks down during invasive procedures, surgery, trauma, or chemotherapy, these normally benign bacteria can invade tissue, proliferate, and cause infection.

Enterococcal infections were once easily treated with high doses of penicillin or ampicillin. After enterococcus started to develop resistance to those drugs, clinicians treated infections with aminoglycosides such as gentamicin. When enterococcus also became resistant to aminoglycosides, clinicians started treating them with vancomycin. It is highly suspected that an overreliance on antibiotics has led to the development of VRE; it is not easily treated with any known antibiotic available today.

Once hailed as a 'miracle drug'

Penicillin was considered the miracle drug for staphylococcal infections. In 1941, virtually every strain of *S. aureus* was susceptible to penicillin. Today, up to 90% of staphylococcal isolates or strains are penicillin-resistant, and about 27% of all *S. aureus* isolates are resistant to methicillin, a penicillin derivative. These strains may also resist cephalosporins, aminoglycosides, erythromycin, tetracycline, and clindamycin. As you can see, when the microbes become resistant, it places us right back where we started prior to the discovery of antibiotics.

Several groups carry a moderate risk of infection, but infants, the elderly, and immunocompromised populations are most vulnerable to infection. Additionally, those with severe underlying disease and those with a history of taking vancomycin, third-generation cephalosporins, or antibiotics targeted at anaerobic bacteria, such as *Clostridium difficile,* are also at high risk for infection.

Other populations that should be regarded at moderate to high risk include patients or staff in these situations:

- indwelling urinary or central venous catheters;
- prolonged or repeated hospital admissions;
- malignancies or chronic renal failure;
- cardiothoracic or intra-abdominal surgery;
- organ transplants;
- wounds with an opening to the pelvic or intra-abdominal area, including surgical wounds, burns, and pressure ulcers;
- endocarditis;
- exposure to contaminated equipment;
- exposure to a VRE-positive patient.

Spreading and stopping VRE and MRSA

Like the normal chain of infection, VRE enters through an infected or colonized patient or colonized health care worker known as the host. Someone with no signs or symptoms of infection is considered colonized if VRE can be isolated from stool or a rectal swab. If a patient is colonized, they are 10 times more likely to become infected with VRE if there's a breach in the immune system.

VRE is spread through direct contact between the patient and caregiver or patient to patient. It can also be spread through patient contact with contaminated surfaces such as an over-the-bed table. Capable of living for weeks on surfaces, VRE has been detected on patient gowns, bed linens, and handrails.

Recently, the Centers for Disease Control and Prevention and the Hospital Infection Control Practices Advisory Committee proposed a two-level system of precautions to simplify isolation. The first level calls for standard precautions, which incorporate features of universal blood and body fluid precautions and body substance isolation precautions to be used for all patient care.

The second level calls for transmission-based precautions, implemented when a particular infection is suspected. As a prevention measure, some hospitals perform weekly surveillance cultures on at-risk patients in intensive care units or oncology units and those who've been transferred from a long-term care facility. Any colonized patient is then placed in contact isolation until he or she is culture-negative or discharged. Colonization can last indefinitely, and no protocol has been established for the length of time a patient should remain in isolation.

Because no single antibiotic currently available can eradicate VRE, natural healing methods are used. In these cases, all antibiotics will be stopped and the treatment is to wait for normal bacteria to repopulate and replace the VRE strain. Another option is to try one of several drug combinations, depending on the source of the infection.

Patients most at risk for MRSA include those

who are immunosuppressed, burn victims, intubated patients, and those with central venous catheters, surgical wounds, or dermatitis. Others at risk include those with prosthetic devices, heart valves, and postoperative wound infections.

Other risk factors include prolonged hospital stays, extended therapy with multiple or broad-spectrum antibiotics, and close proximity to those colonized or infected with MRSA. Also at risk are patients with acute endocarditis, bacteremia, cervicitis, meningitis, pericarditis, and pneumonia.

As with VRE, MRSA enters through a host, such as an infected or colonized patient or colonized health care worker. Although MRSA has been recovered from environmental surfaces, it's transmitted mainly on the hands of health care workers.

Many colonized individuals become silent carriers. The most frequent site of colonization is the anterior nares — 40% of adults and most children become transient nasal carriers. Other sites include the groin, axilla, and gut, though these sites aren't as common. Typically, MRSA colonization is diagnosed by isolating bacteria from nasal secretions.

To eradicate MRSA colonization in the nares, topical mupirocin is applied inside the nostrils. Other protocols involve combining a topical agent and an oral antibiotic. Most institutions keep patients in isolation until surveillance cultures are negative.

To attack MRSA infection, vancomycin is the drug of choice. But it can have serious adverse effects, mostly caused by histamine release; reactions range from itching to anaphylaxis. Some clinicians also add rifampin, but whether rifampin acts synergistically or antagonistically when given with vancomycin is controversial.

It takes teamwork to prevent the spread

Preventing the spread of dangerous infections is a team effort. With help from physicians, infection control, lab personnel, and other staff, you can go a long way toward stopping these malicious microbes. Whether you care for a patient with MRSA or VRE, you're responsible for containing the infection.

Along with your facility's protocol, follow these guidelines:

• **Wash your hands** before and after caring for any patient. Good hand washing is the most effective way to prevent VRE and MRSA from spreading. Wash your hands even if you wear gloves — enterococci have been recovered from hands that had been gloved.

• **Use an antiseptic soap** such as chlorhexidine. Enterococci have been cultured from health care workers' hands after they've washed with a milder soap. One study showed that without proper hand washing, MRSA could survive on health care workers' hands for up to three hours.

• **Institute contact isolation precautions.** This includes wearing gloves and a gown if you might be in direct patient contact, giving the patient a private room, using dedicated equipment, and disinfecting the environment.

• **Use standard precautions**, being sure to wear a face shield and mask to prevent infection spreading from splashes. After you remove your gown and gloves, don't touch any potentially contaminated surface, such as a bed or bed stand. This is especially important for VRE.

If your patient is incontinent or has diarrhea, change gloves when moving from a dirty area of the body to a clean one, especially with VRE patients. Be particularly prudent in caring for a patient with an ileostomy, colostomy, or draining wound not contained by a dressing. Again, this is especially important with VRE patients.

• **Teach staff and patients' families about infection control and universal precautions**. Make sure family and friends know why they need to wear protective garb when they visit the patient, how to put it on, and how to dispose of it. Assure them that the chances of their becoming infected are remote but that the facility doesn't want germs spread to other patients. Before they leave the room, make sure they remove protective equipment and wash their hands. Be sure to provide teaching and emotional support.

• **No sharing.** Don't use shared equipment, such as electronic thermometers, stethoscopes, and blood pressure cuffs. Each patient should have his own glass or disposable thermometer. If you bring in other equipment, such as a pulse oximeter, don't lay it on the bed or bed stand and wipe it with appropriate disinfectant before you leave the room.

• **Group patients with like infections.** Consider grouping people with the same infection near one another and assign designated staff to decrease the chances of cross-contamination.

• **Use aseptic technique.** As always, use aseptic technique for such procedures as suctioning, catheterizing and inserting intravenous lines. Any breach in aseptic technique may allow pathogens to gain a foothold.

• **Know your institution's policies and procedures for antibiotic use.** Your pharmacy and therapeutics, drug utilization, and infection control committees can provide guidelines for matching the narrowest-spectrum antimicrobial with the infective organism.

• **Communicate tactfully.** In the role of patient advocate, encourage physicians to limit the use of antibiotics. Don't hesitate to speak up if you think they are prescribing antibiotics indiscriminately.

• **Educate patients.** Be sure to tell your patient that he should take his antibiotic for the full prescription period, even if he begins to feel better. Also make sure he understands that not all diseases can be treated with antibiotics.

Unfortunately, new antibiotic-resistant organisms continue to appear. Recently, for example, clinicians have witnessed the rise of penicillin-resistant *Streptococcus pneumoniae* and *Neisseria gonorrhoeae*, as well as antibiotic-resistant mycobacterium tuberculosis.

Perhaps most alarming, however, is the recent discovery of an *S. aureus* intermediately resistant to vancomycin (known by the acronym VISA). In mid-1996, clinicians discovered the first such microbe in a Japanese infant's surgical wound. Closer to home, similar staphylococcus aureus isolates were reported in Michigan and New Jersey.

Both patients had received multiple courses of vancomycin for MRSA infections. The appearance of this isolate signals a dangerous new development. That's because since the emergence of MRSA in the 1980s, vancomycin has been the drug of choice for treating serious MRSA infections. Now, with the emergence of VISA, the arrival of *S. aureus* fully resistant to vancomycin (VRSA) is much more likely. This will leave clinicians with virtually no antibiotic to combat this microbe.

To prevent the rise of VRSA and other antibiotic-resistant organisms, use similar techniques for preventing the spread of VRE and MRSA. Among the most important measures: good hand washing, barrier precautions and continued vigilance against the spread of these organisms.

[To receive 2.0 continuing education credits for reading this article, call Michelle Boasten at (330) 253-6368 for further information.] ■

LegalEase

Understanding Laws, Rules, Regulations

Free services may equal trouble

By **Elizabeth E. Hogue**, Esq.
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Home care providers are understandably concerned about recent changes in Medicare reimbursement that have radically altered the home care landscape. Based upon their overriding commitment to patients, staff may be tempted to take up the slack by providing free or voluntary services to their patients. They may return to patients' homes in the evenings and on weekends, for example, to provide additional services for which they will not be compensated. Case managers and/or patients and their families may ask for free services in addition to those for which the provider bills the payer source.

Staff who engage in these activities and agencies that allow staff to do so run the risk of the following types of liability:

✔ It is extremely difficult, if not impossible, for patients to draw distinctions between when staff are acting on behalf of the agency and when they are acting strictly of their own accord. Consequently, if any risks are incurred, even when staff aren't acting on behalf of agencies, patients and their families are likely to turn to agencies and their insurers and hold them responsible for damage that may have been caused by the actions of staff.

Although agencies can certainly argue that they're not responsible because staff were acting independently, it's always time-consuming and expensive to be drawn into a lawsuit, even if the agency is ultimately found not liable.

✔ To the extent that free or voluntary services are perceived as an inducement to patients to initiate, continue, or reinstate services with a particular agency, home care providers may run the risk of violating Medicare/Medicaid fraud and abuse prohibitions on kickbacks and rebates.

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS), a primary source of enforcement activity, has clearly indicated that the provision of free services to beneficiaries may constitute a

violation of these prohibitions.

This position may strike some home care professionals as confusing and perhaps contradictory. Since the point of fraud and abuse enforcement is to prevent unnecessary costs, shouldn't the government welcome the provision of free services to beneficiaries? After all, they are free and how much more money can you save than that?

Savings aside, the government's point of view is that when services that are free result in additional utilization of services, that constitutes a fraud problem. The government is faced with the question of whether those free services induced beneficiaries to utilize the services paid for by the Medicare program — services which they otherwise would might not have utilized. It's certainly a tricky question to answer. When this issue is considered in light of the current environment of hypersensitivity to fraud and abuse issues, along with some of the other concerns raised in this article, the best course of action for the providers is undoubtedly to avoid the provision of free services altogether.

✔ There are professional boundaries that should be established and maintained between nurses, social workers, and therapists and their patients. When practitioners violate these limitations, it calls into question their professionalism. Whenever the standards of professional conduct are violated, practitioners should be concerned about the disciplinary action by state licensure boards that may take the position that the provision of free or voluntary service to home care patients amounts to unprofessional conduct.

In response to these concerns, agencies may wish to develop and implement a policy that prohibits staff from providing free or voluntary services to patients. Although the intentions are certainly the best, the risks are potentially substantial. If agencies elect to adopt such a policy, the legitimate needs of Medicare home care patients should still be met to the fullest degree possible. The good intentions and fine motivations of practitioners must also be acknowledged. But the bottom line is that for all of the above reasons, the provision of free services is problematic in today's health care environment.

[To receive a copy of Legal Liability*, a publication that provides further information regarding these issues, send a check for $25 payable to Elizabeth E. Hogue to 15118 Liberty Grove, Burtonsville, MD 20866.]* ■

GW University study shows how home care is suffering

Diabetics hardest hit among patients

In "An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System in Access to and Quality of Care," a study conducted by the George Washington University Center for Health Services Research and Policy, one-fifth of the home health agencies surveyed admitted to overtly screening high-cost patients because of reduced Medicare reimbursement.

The study, which was partially funded by the National Association for Home Care (NAHC) in Washington, DC, also found that Medicare patients make up a lower percentage of agencies' patient bases in 1998 than in 1996.

Phase II will look at affect of IPS

In the final analysis, the study's authors recommended that the 15% reduction in home care payments scheduled to being next October be eliminated. The study's second phase will examine how the interim payment system has affected other segments of the medical community, including nursing homes, hospitals, and Medicaid.

The study surveyed home health agencies in California, Florida, Indiana, Iowa, Louisiana, Massachusetts, Mississippi, Pennsylvania, and Texas — states selected for their mix of urban/rural populations as well as their geographic diversity. In all, information was collected from 28 agencies: nine freestanding, for-profit agencies; 11 freestanding, nonprofit agencies; and eight hospital-based or affiliated agencies.

Among the study's other findings:

- Of the nonprofit agencies, 50% reported subsidizing care for Medicare patients with endowment or grant contribution funds.
- On average, agencies have spent $423,576 in donations and from other sources to subsidize caring for Medicare home health patients.
- Southern agencies are more likely to rely on reducing levels of services and are less able to change their case mix characterized by more chronic illness.
- Agencies in other regions are more likely to rely on patient screening or the altering of marketing patterns to control their case mix and

reduce the number of visits.

• Nearly all agencies surveyed reported significant cuts in clinical and administrative staff as part of their cost-containment strategies. Since 1994, skilled nursing staff declined 23%, health aides staff declined 43%, and total clinical staff declined 37%.

• Diabetics, especially those with complex cases, were most affected by changes in admission practices made in order to meet with the Balanced Budget Act of 1997 budgetary constraints.

• The total number of unduplicated Medicare patients dropped 30% since 1996.

• Medicare revenues for the study agencies in 1998 were 25% lower than 1994 levels and 35% lower than 1996 levels.

• Medicare patients accounted for 21% less of the total patient census for study agencies since 1994. ■

NEWS BRIEFS

Is BBA relief in sight?

Despite testimony from the Health Care Financing Administration (HCFA), Congressional Budget Office (CBO), and the General Accounting Office (GAO) claiming that there is a lack of evidence pointing to the ill effects of the Balanced Budget Act of 1997 (BBA) on patients' access to care, Rep. Michael Bilirakis (R-FL), chair of the House Commerce Subcommittee on Health and the Environment, has vowed to aid those providers who have been negatively impacted by the BBA.

The Subcommittee recently heard testimony from a group of home care-related agencies as to the impact of the BBA. HCFA testified that it is increasing the length of time in which agencies have to repay IPS-related (interim payment system) overpayments to three years, one year of which will be interest-free. Additionally, HCFA will cap surety bond values for home health agencies at $50,000 and will also delay the surety bond requirement until Oct. 1, 2000.

One of the testimonies came from Nancy Roberts, president and CEO of Kent County Visiting Nurse Association in Warwick, RI. Among her recommendations: eliminate the 15% payment cut scheduled for Oct. 1, 2000, create an outlier provision under IPS to allow home health agencies to serve higher cost patients, increase the per-visit limits, offer relief from overpayments, and repeal the 15-minute incremental visit billing requirement.

To a similar end, Sen. Richard Durbin (D-IL) introduced S 1582, the Health Care Preservation Act of 1999. The overall effect of this bill would be to restore some $20 billion to $10 billion for hospitals and $10 billion to other health care providers

COMING IN FUTURE MONTHS

- Gift-giving policies
- 1999 article index
- A look back at the year in *Hospital Home Health*
- Tests for hire
- Errors and omission insurance

such as home health agencies in Medicare funding over the next five years.

The proposed legislation includes a delay in the 15% home health spending reduction to Oct. 1, 2001, if PPS isn't implemented on Oct. 1, 2000; the elimination of the 15-minute incremental billing requirement; an increase in the per-visit cost limits to 112% of the median; and a 36-month, interest-free period in which to repay IPS-related overpayments. ▼

Organizations announce mergers and acquisitions

Eaton Rapids (MI) Community Hospital has signed a letter of intent to merge with Flint, MI-based McLaren Health Care Corp. sometime within the next six months. Eaton has 27 beds, and the merger would give McLaren, which is pursuing an affiliation with the 222-bed North Oakland Medical Center in Pontiac, MI, for a total of five hospitals.

UniMed Management Co., a subsidiary of UniHealth Foundation in Burbank, CA, is selling three of its six Southern California medical groups. The groups in Oxnard and Buenaventura are to be purchased by Premier Practice Management in San Diego. Also, Epic Management bought back UniMed's 50% stake in the third group, Beaver Medical Group in Redlands, for which it acts as an operating company. ▼

Home health closings: 2,500 and counting

The Health Care Financing Administration (HCFA) recently released the findings of its Online Survey Certification and Reporting System (OSCAR) which say that 2,486 home health parent agencies have closed since the implementation in October 1997 of the interim payment system.

This figure is considerably higher than previous estimates, which placed closings somewhere

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PS Form **3526**, September 1999 *(Reverse)*

in the neighborhood of 1,400 as of Jan. 1, 1999. Not only is the number of closings higher than believed, but it also seems that the rate of closings is accelerating. In December 1997, 36 agencies a month were closing; by August 1999 that number had risen to 108 closures per month, according to an analysis of the study's findings conducted by the National Association for Home Care. ■

CE objectives

After reading this issue of *Hospital Home Health*, CE participants will be able to:

1. List several characteristics of VRE.
2. Explain three things health care workers can do to stop the spread of VRE and MRSA.
3. Discuss some of the possible liabilities associated with providing "free" services.
4. Identify the findings of a recent home care study conducted by George Washington University and NAHC. ■