American Association for Respiratory Care's

Home Care Bulletin

September / October 2002

IR Final Rule on the Way

As of this writing in late summer, the Centers for Medicare and Medicaid Services (CMS) was expected to issue a final rule on its inherent reasonableness (IR) authority before the end of the year. According to an article that appeared on the HME News web site in late August, the rule could allow CMS and the DMERCs to slash reimbursement for DMEs up to 15% per year.

The interim final rule on IR, which was issued in 1998, originally came under so much fire that it was put on hold by the Balanced Budget Refinement Act, pending further study. Federal payers have since been restricted from issuing the cuts. DME industry leaders are calling for the final rule to be issued in proposal form first, to allow for additional comments from all interested parties. ◆

HIPPA Regulation Finalized

After several years of debate, a final rule governing the privacy of medical records was published in the Federal Register August 14. The regulation, established by the Health Insurance Portability and Accountability Act, includes the following provisions:

- Patients must give specific authorization before entities covered by this regulation could use or disclose protected information in most non-routine circumstances – such as releasing information to an employer or for use in marketing activities. Doctors, health plans and other covered entities would be

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Notes From The Editor: Competitive Bidding

by James Stegmaier, RRT, RPFT, CCM

Representative Jim McDermott (D-WA) is quoted as saying, "As we search for ways to secure Medicare for the long-term, we need to take prudent, incremental steps to improve the efficiency of the program. Competitive bidding is a part of the equation that will enable Medicare to provide cost-effective, quality health care for seniors in the 21st century."

As respiratory therapists involved in home care, it seems as if we cannot get through the day without the phrase "competitive bidding" being brought to our attention, either by our employers, peers, newspapers, professional journals or professional organizations. Every home care practitioner must remain up-to-date on this momentous topic, which may dramatically change how services are provided to our patients in the home environment in the future.

Medicare is the nation's largest health insurance program, providing health care for over 39 million Americans over the age of 65 or with certain permanent disabilities. Many health care professionals think Section 4319 of the Balanced Budget Act of 1997 was the birthplace of competitive bidding for Medicare. This act granted the Secretary of Health and Human Services (HHS) the authority to conduct competitive bidding for Medicare Part B durable medical equipment and supplies. In reality, the Centers for Medicare and Medicaid Services (CMS) had made two prior attempts at competitive bidding through HMO plans in Baltimore in 1996 and Denver in 1997.

The new competitive bidding program was to start with five testing sites of different-sized populations, with each site operating for a three-year period to work through the many factors of the competitive bidding process. The initial test sites would utilize competitive bidding for the following product categories: oxygen therapy, hospital beds, enteral nutrients and supplies, wound care supplies and urological supplies. To date there have been two demonstration competitive bid projects sites, Polk County, FL, and San Antonio, TX. Both projects are slated for completion in 2002.

CMS created the Competitive Pricing Advisory Committee (CPAC) and the Area Advisory Committees (AACs) to implement this project. The CPAC was put together in early 1998 and met multiple times throughout the year. In January 1999 the CPAC model for competitive bidding was unfolded. The plan called for AACs to make several choices regarding benefit design and risk selection in their area. The CPAC felt that the AACs could make better decisions on specific issues based upon their greater knowledge of the needs of their area. It is also important to note that competitive bidding is being reviewed on a scale much larger than just Medicare Part B and durable medical equipment. The goal of the competitive bidding process is to use this system for all aspects of Medicare reimbursement except physician payment.

As of this writing in late summer, competitive bidding for home care services is now pending under a provision of H.R. Bill 4954, the Medicare Modernization and Prescription Drug Act. This bill has passed the House of Representatives and is currently being debated by the Senate. Under the House version, the bill would allow the Secretary of HHS to create hundreds of competitive areas in the nation and subject an unlimited number of products or services to the competitive bidding process. Rural areas would be exempt from this process.

On June 12, the General Accounting Office testified before the Senate Appropriations for Labor, Health and Human Services and Education Committee regarding the competitive bidding sites in place, stating, "The recent demonstrations that set payments for items through competitive bidding were instructive, but the positive results achieved may be neither appli-

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Promising Practices

The Centers for Medicare and Medicaid Services (CMS) has established a new web site aimed at disseminating information about best practices in the Medicaid home and community care environments. Noting a great need to assist the disabled and elderly in remaining in their own homes or similar community living arrangements as long as possible, the site - dubbed "Promising Practices" - is functioning as a repository of information regarding programs that are already achieving these goals across the country.

The overall goal of the project is to expand Medicaid benefits to disabled individuals living outside of nursing homes. The reports included on the site, says CMS, are intended to stimulate changes in the Medicaid Home and Community Based Services waiver program, regular Medicaid state plan options, programs funded by other federal agencies and state and local resources.

CMS is currently welcoming new ideas for Promising Practices reports and asks that interested parties contact the agency via email at PromisingPractices@cms.hhs.gov. You can check out the site at: www.cms.gov/promisingpractices. ◆

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AARC Addresses Polysomnography Issues

Ensuring appropriate accreditation for polysomnography educational programs took center stage last summer when the AARC took part in a meeting held by the Committee on the Accreditation of Allied Health Education Programs (CAAHEP) to develop an accreditation system for the polysomnographic field.

At issue is a CAAHEP requirement that would require "separate profession" status for polysomnography before an accreditation committee (CoA) could be formed.

AARC President-elect David Shelledy, PhD, RRT, clarified the Association's position on the matter, saying, "It is inappropriate for CAAHEP to recognize as a separate profession areas which are in the scope of practice and included in the standards for an existing CAAHEP recognized profession."

RTs are currently allowed to perform sleep studies by virtue of their license, and RTs have been involved since the beginnings of polysomnography. The AARC holds the position that polysomnography is a subspecialty of the respiratory care scope of practice. Dr. Shelledy pointed out that all accredited respiratory care educational programs already provide some education in the polysomnographic technologist (PSGT) area, and about 50-60 produce graduates capable of entering the PSGT work force upon graduation. In addition, the Committee on Accreditation of Respiratory Care (CoARC) has drafted new Standards for Respiratory Therapy which will include PSGT as an optional add-on for RT programs, similar to a system that exists now for electroneurodiagnostic technologist programs. The AARC supports formal education and credentialing for PSGT. However, the AARC must ensure that RTs are not disenfranchised regarding their ability to provide and be compensated for sleep diagnostics.

Dr. Shelledy attended the steering committee meeting along with AARC Executive Director Sam P. Giordano, MBA, RRT, and representatives from co-committee members, CoARC, the Association of Polysomnographic Technologists (APT) and the American Society of Electroneurodiagnostic Technologists (ASET).

The Association will be working closely with these other groups over the coming year to work out an approach to polysomnography program accreditation that will be acceptable to all concerned. ◆

OSA Linked to Heart Disease

The first long-term, clinic-based epidemiologic study of the development of cardiovascular disease in middle-aged men with or without obstructive sleep apnea (OSA) has found that the sleep problem causes almost a 5-fold increase in heart disease independent of age, weight, blood pressure and current smoking status. Swedish researchers found at least one cardiovascular problem in 22 of 60 men, aged 30 to 69, with OSA, compared with 8 of 122 without OSA.

All of the men were free of heart and pulmonary disease, diabetes, psychiatric disorder, alcohol dependency and malignancy when the study began in 1991. They were then followed over a seven-year period. According to the investigators, the most significant predictor of the development of cardiovascular disease was the presence of OSA at baseline.

The good news is that OSA appears to respond to treatment. Patients with excessive daytime sleepiness were offered treatment with either continuous positive airway pressure, surgery or an oral appliance. In the OSA group, cardiovascular disease was observed in 21 of 37 incompletely treated cases, but it occurred in only 1 of the 15 effectively treated patients.

The study appeared in the second July issue of the American Journal of Respiratory and Critical Care Medicine. ◆

NOVEMBER IS COPD AWARENESS MONTH

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HIPPA REGULATION FINALIZED

required to follow the rule's standards for the use and disclosure of personal health information.

- Covered entities generally will need to provide patients with written notice of their privacy practices and patients' privacy rights. The notice will contain information that could be useful to patients choosing a health plan, doctor or other provider. Patients would generally be asked to sign or otherwise acknowledge receipt of the privacy notice from direct treatment providers.
- Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before sending them marketing materials. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.
- Specifically, improvements to the final rule strengthen the marketing language to make clear that covered entities cannot use business associate agreements to circumvent the rule's marketing prohibition. The improvement explicitly prohibits pharmacies or other covered entities from selling personal medical information to a business that wants to market its products or services under a business associate agreement.
- Patients generally will be able to access their personal medical records and request changes to correct any errors. In addition, patients generally could request an accounting of non-routine uses and disclosures of their health information.

The regulation will go into effect for most entities on April 14, 2003. ◆

Joint Commission Announces 2003 National Patient Safety Goals

The Joint Commission on Accreditation of Healthcare Organizations has announced its first set of six National Patient Safety Goals. Health care organizations will be surveyed on the following goals beginning in January:

Improve the accuracy of patient identification.

- Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
- Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active - not passive - communication techniques.

Improve the effectiveness of communication among caregivers.

- Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.
- Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

Improve the safety of using high-alert medications.

- Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.

Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

- Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site and involve the patient in the marking process.

Improve the safety of using infusion pumps.

- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

Improve the effectiveness of clinical alarm systems.

- Implement regular preventive maintenance and testing of alarm systems.
- Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit. ◆

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NOTES FROM THE EDITOR: COMPETITIVE BIDDING

cable nor practical on a wider scale for many products."

Problems that may arise from competitive bidding include: limiting access to medically necessary products and services, restrictions on choice of durable medical equipment suppliers, retardation of medical innovations, destruction of many small suppliers, cost of competitive bidding and the confusion created by the complexity of the process. Many experts feel that competitive bidding will decrease competition and this has been confirmed in one of the two project sites, where one organization is providing 70%-85% of the oxygen services to Medicare patients.

Questions have also been raised in the Polk County demonstration project regarding substituting lower cost and quality incontinence supplies to the patient; due to the nature of competitive bidding, patient access to a high quality product through other suppliers has been restricted. The use of liquid oxygen, appropriate portable compressed gas systems, decreasing utilization of respiratory therapists and on call availability are issues that are beginning to surface in Polk County as well.

There has been much discussion on competitive bidding on the Home Care Section listserve, and if you are not currently on the mailing list, I would strongly urge you to go to our homepage on www.aarc.org and subscribe. (The service is free with your membership in the section.)

There is still a lot of work to be done on competitive bidding and the debate on whether it is appropriate for the Medicare system will continue for some time. The competitive bidding process is projected to save $7 billion over the next ten years, but the cost of implementing competitive bidding on a national level is still unknown and may be more than the savings realized from the process. The projected savings have been extrapolated from a small number of products in the project sites and may or may not be accurate. Therefore, it is imperative for us all to remain informed on the development of competitive bidding and

CMS Adds Flexibility to "Homebound" Provision

Medicare is finally easing up on restrictions calling for home health patients to be totally "homebound" to qualify for benefits. Acknowledging that patients who occasionally leave their homes to attend family functions or other events still need home care services, the Centers for Medicare and Medicaid Services recently directed home health agencies and Medicare payment contractors to be more flexible in their determination of what qualifies as "homebound." New language in the program manual for home health agencies outlines the increasingly flexible list of occasional absences that meet the criteria as an exception to the rule. ◆

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What's Weight Got To Do With It?

A new study from Spanish investigators has found that COPD patients with low body weight exhibit more muscle atrophy and worse exercise capacity than those with a normal body mass index (BMI) - even when suffering from similar degrees of lung function impairment.

According to the researchers, who published their findings in the second August issue of the American Journal of Respiratory and Critical Care Medicine, skeletal muscle cell death and atrophy were increased in seven COPD patients with low BMI when compared to three other groups: eight normal weight COPD patients, eight healthy volunteers and six sedentary volunteers.

The researchers also discovered that exercise capacity in the underweight patients was better correlated with their BMI than with the degree of their airflow restriction. ◆

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