Home Care Bulletin

Issue No. 2

American Association for Respiratory Care

Notes From The Guest Editor

by Heidi Weston, RRT

Once again it is my pleasure to serve a guest editor of the Bulletin. I would like to thank those who contributed to this issue.

As I was reviewing old Bulletins to prepare for this issue, I noticed that at this time in 1996 we were projecting ten percent cuts in oxygen from Congress. Who would have thought we would wind up with a 25% cut all at one time? Also included in that issue was a history of oxygen cuts/freezes from 1985 to 1994. The article noted that Congress or HCFA reduced payments 13 times for oxygen therapy, and HCFA made five other program changes that had the effect of reducing reimbursement.

Does this latest round of cuts mean that we will not see any action towards further reductions? If history is any indicator, probably not. (For a look at how companies are dealing with the current cutbacks, see "Surviving The Cuts" elsewhere in this issue.) In summary, we will never be able to take a relaxed view of our reimbursement issues. As budgets get tighter and money becomes more scarce, we will always be a potential target. ■

HCFA Ultrasonic Nebulizer Issue

by Cheryl West, MHA, AARC director of government affairs, Washington, DC

At the request of Congressman Christopher Smith (R-NJ), the AARC recently attended a meeting at the Congressman's office to discuss the DMERCs' current policy on ultrasonic nebulizers. As it stands now, the policy has eliminated Medicare coverage for large volume ultrasonic nebulizers and reduced to a minimum reimbursement for small volume ultrasonic nebulizers. The Medicare policy further requires physicians to first consider use of a metered dose inhaler (MDI) and to document and make available upon the DMERCs' request the reason supporting their decision to prescribe a nebulizer.

It is Medicare's desire and intention that beneficiaries use the MDI in nearly all circumstances. However, MDIs and the spacer often needed for proper use are non-covered items and must be paid for by the beneficiary. Congress-man Smith requested that the Health Care Financing Administration (HCFA) attend this meeting to explain the policy change. HCFA officials were unable to offer any clinical or other justification for this policy change. Nor were they able to provide Congressman Smith with satisfactory answers to his questions.

As a result, Congressman Smith and a number of other congressional supporters are again calling for their colleagues to support HR 2671, the Senior Citizen Respiratory Care Preservation Act, which would, in their words, restore "Medicare coverage for ultrasonic nebulizers as an item of durable medical equipment under the same terms and conditions that existed prior to HCFA's 'stealth'change." ■

HCFA Withdraws Notice of Special Limits for Home Oxygen

According to a recent article in "Medicare and Medicaid Guide," HCFA officials have confirmed that the agency will withdraw a proposed notice of special payment limits for home oxygen. The move, which comes in light of the 25% payment reduction in the Medicare home oxygen benefit contained in the Balanced Budget Act of 1997, was instigated by the National Association for Medical Equipment Services (NAMES).

NAMES requested withdrawal of the regulation last fall, criticizing the agency for failing to act promptly to withdraw the regulation despite the clear statement of Congress's intent and HCFA's own assertions that it would not impose payment reductions under its "inherent reasonableness" authority if Congress enacted payment reductions. ■

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Government Researchers Look At Home Oxygen Use

In an effort to obtain descriptive data on the use of home oxygen by Medicare patients, government researchers have looked at beneficiaries with at least one claim for home oxygen in 1991 and 1992. According to an article in a recent issue of CHEST, they found that:

- There were 21,489 beneficiaries in 1991.
- There were 8,418 new beneficiaries in 1992.
- Among new beneficiaries in 1992, 26% died that year.
- Factors associated with death included: 76 years old or older, pneumonia, lung cancer, male gender, heart failure, and diagnoses suggestive of COPD.
- Seven percent of new beneficiaries discontinued use of oxygen after one month.
- 28% of new beneficiaries discontinued use after six months.
- 19% of users in 1991 and 14% percent in 1992 used liquid oxygen.
- Liquid oxygen use was significantly associated with portable oxygen claims, non-metropolitan resident, and white race.

The researchers believe the latter finding supports previous claims that the current payment policy may discourage suppliers from providing liquid oxygen to underserved populations. ■

Surviving the Cuts

by Heidi Weston, RRT

Now that we are into our 25% oxygen cuts, it is time to find out how everyone is adjusting to the decrease in reimbursement. Since we did have some warning, many providers proactively made adjustments that allowed them to maintain their standards of care while protecting their bottom line. I made some inquires as to how these cuts have affected a cross section of companies, and the results follow. Thanks again to all of you who participated.

Heidi Weston, RRT, general partner, Alliance Home Care, Manchester, KY:

This is a small "mom and pop" company with a large respiratory mix. While we have felt the effects of the cuts, we have actively sought to make up the difference by increasing our "top line": (i.e., make up the difference by increasing the business). There were a few

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areas where we could tighten the belt. We are not as free to run portables as we once were. As a jack of all trades, I perform equipment checks and assessments at the same time.

In a nutshell, we are making more of an effort not to waste time and make unnecessary trips. Portables are delivered at the time the concentrators are serviced. Customers are encouraged to come into the store for additional portables and miscellaneous supplies.

Lori Bartunek, RRT, clinical coordinator, Lutheran Health Systems, Detroit Lakes, MN:

I feel our company has tried to approach the oxygen fee reduction by educating our staff and providing additional education to the patients who are admitted into our service. We first educated the staff on how the change in oxygen fees might impact the future of our business. We then continued to focus on the team (respiratory therapist and service technician) approach of providing follow up service for existing customers. The service technician does the majority of home follow up visits for patients who are not experiencing any problems, thus leaving the respiratory therapist to provide follow up visits to patients needing their expertise. This allows the therapists to focus on program development, as well as marketing.

We also focused on educating the patients to better utilize their oxygen supplies and cylinders. Patients who are capable of picking up cylinders in our offices are encouraged to do so, which eliminates wasted trips. In addition, we streamlined our purchasing of disposable supplies and started to pay closer attention to the amount of disposable supplies left in the patient's home. We are also evaluating the possibility of using self-fill oxygen concentrators for specific patients.

Allan Saposnick, RRT, Jordan Reses Home Health Care, Sharon Hill, PA:

When it became obvious that some sort of cut in Medicare oxygen reimbursement would be enacted in the 1997 Balanced Budget Act, we knew that we would have to make some changes. We were determined to institute changes that had the potential to increase productivity and maximize efficiency, yet would have no negative effects on patient care. To do this, we first needed to know, in real numbers, what we were currently doing and whether or not it was profitable. An in-depth look at our oxygen business, totally separate from the rest of the company's products, was the first step.

We ran reports and gathered data on how much equipment of every type we owned, how many patients we were servicing, and exactly what equipment they had. We did a detailed analysis of all the factors involved in making a delivery of any type of oxygen and determined that $34 was our average cost. We took this information and a lot more, and with the assistance of our DeVilbiss sales representative, plugged the data into an oxygen modeling PC program. This program told us that what we were currently doing was profitable and that after a 25% reduction in revenue we would be considerably less profitable. What we had intuitively expected was confirmed. But what would be our best move to regain our higher profitability?

The oxygen modeling program now allowed us to explore multiple "what if" scenarios. What if we provided conserving devices for all our ambulatory patients using cylinders, or maybe only to the top 50% of the cylinder users? How about using low loss liquid oxygen for portability for our highest cylinder users? We explored these questions and many others.

We eventually decided, based on the information from the program, that we would provide conservers on every gaseous and liquid portable system and liquid stationary unit possible. This would have the maximum effect on reducing deliveries of both cylinders and liquid refills. That was the key to increasing profitability without generating a negative effect on quality care.

We also reviewed our service records and troubleshooting records and decided that routine in home visits to check concentrators and perform preventative maintenance could be done twice a year. Another policy which has been implemented is an ongoing reevaluation of all liquid oxygen patients every 90 days to assure the patient's condition still warrants the use of liquid.

Greg Spratt, BS, RRT, CPFT, national director of respira - torservices, Rotech Medical Corporation, Kirksville, MO:

Over the past 20 years, respiratory care practitioners have been employed by home medical equipment companies in increasing numbers to provide patient assessment, evaluation, and education regarding home respiratory equipment and services. Much of the RCP's time has been directed toward the maintenance of patients using home oxygen. Changes such as the recent reduction in oxygen reimbursements often serve as an impetus to reevaluate the most effective use of the RCP's talents in terms of our organizational goals.

I don't see this as a negative, but rather as an opportunity for us to strengthen our position within the home care setting. Forward thinking RCPs will move to activities that better utilize their training and talents to provide better patient care and improve outcomes (both

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"Surviving" continued from page 3

clinical and fiscal). Also, this will increase our company's profitability more than if we spent our time performing more mundane tasks. There are several long term trends that are very much in favor of the home care RCP:

• Epidemiological studies reveal increasing prevalence of both asthma (estimated at 15 million in the U.S. alone) and COPD (estimated at 30 to 35 million, only half of which have been identified) - the two conditions most likely to benefit from the services of home care RCPs.

• As people live longer due to advances in other areas of medicine (e.g., cancer, heart disease), more people will develop COPD.

• The graying of the baby boomers will lead to higher numbers of people prone to develop COPD.

• RCPs are well positioned to provide cost-effective disease management programs for costly diseases such as asthma , COPD, cystic fibrosis, and sleep apnea.

• Managed care will continue to move more services to lower, less expensive levels of care like the home.

• Studies have shown that people prefer to receive care in the home setting whenever possible .

• Advances in technology (e.g., telemedicine) will make it possible to perform more services in the home care setting.

• Several clinical studies have shown that many services currently performed in the hospital setting (e.g., sleep diagnostics, pulmonary rehab) can be performed as effectively, or even more effectively, in the home setting.

This period in home care is not dissimilar to the early/mid-'80s in the acute care setting when Diagnostic Related Groups (DRGs) replaced fee for service reimbursement. Some hospital departments failed to make adjustments and saw difficult downsizings. Others flourished by better utilizing the skills of their personnel to meet the new market requirements. In a period when some companies are reducing the number of RCPs in their organizations to cut costs, I see great opportunity for highly motivated respiratory therapists in the home care setting. In fact, in our hundreds of locations across the country, we can't seem to find enough.

Closing Thoughts

In addition to the therapists featured above, I spoke with a few other managers from some regional companies. They reiterated the same general ideas. The majority were utilizing service technicians for as many services as possible and all equipment checks. The equipment checks were per manufacturer's specs - not the traditional monthly checks us old timers once knew. Therapists are sent out via an acuity type of system or a calculated formula based on need. Some stated that they have heard of therapists being laid off, but no one I spoke with admitted that this has happened in their facilities.

I also spoke with some vendor representatives. They stated that they have seen a longer payment period for invoices. The average days of outstanding sales, which used to be under 30, is now 60-90 days or even longer. They also stated that they understand the situation and are being patient. But this is not easy for anyone.

So, in summary - yeah , we have all felt the effects of the cutback, and we once again have had to modify the way we do business. I guess it takes things like this to make us reanalyze our costs and profitability while maintaining our standards of care. Greg Spratt probably summed it up best with this quote: "A bend in the road is not the end of the road - unless you fail to make the turn." ■

FYI . . .

Report highlights home care data

The national median salary for home care company executive directors last year was $62,000, says the 1997-98 Homecare Salary and Benefits Report published by Hospital & Healthcare Compensation Service and the National Association for Home Care. That represents a 2.39% increase over last year's figures.

The annual survey this year questioned some 2,035 home health agencies employing over 192,000 full-time workers. In addition to the executive director salary results, the report contains salary, bonus, and hourly and per visit rates for 68 other job titles. Data on staffing trends and cost saving measures are included as well.

The report also contains figures on turnover rates for home health companies, which remain high. According to the survey, home health aides had the highest turnover rate last year at 21.46%, followed by social workers at 20.80%.

To obtain a copy of the 420-page report ($250), call (973) 616-5722.

HHS issues new anti-fraud and abuse regs for DME

The Department of Health and Human Services (HHS) has published a new regulation aimed at preventing DME fraud and abuse. Under the new regulation DME supplies would be:

• Required to obtain surety bonds of at least $50,000.

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"FYI..." continued from page 4

• Banned from supplier telemarketing.
• Required to have a physical office and listed phone number.

In addition, the regulation would codify a requirement that suppliers reenroll in Medicare every three years, prohibit suppliers from reassigning a supplier number, and apply criminal and civil sanctions for misrepresentations on billing number applications. (HCFA Press Release, 1/20/98)

Outside contractors to assist in fraud and abuse efforts

As part of its ongoing effort to fight fraud and abuse in health care, Medicare will begin hiring special contractors to work with government contractors who process claims. Until now, only insurance companies whose primary responsibility is to process Medicare claims have been able to conduct audits, medical reviews, and other activities that attack waste, fraud, and abuse. New authority provided by the Health Insurance Portability and Accountability Act, however, is allowing the government to go outside its own agencies for contractors who will be able to assist with this process. (HCFA Press Release 3/17/98) ■

Call for Articles

Through our Home Care Section meeting at the AARC Respiratory Congress in New Orleans, you have come up with some topics you would like to spotlight in upcoming issues of the *Bulletin*. Our next issue will focus on liability and risk management. It will also cover issues regarding reimbursement. Our fourth issue of the year will cover JCAHO and regulatory affairs and compliance. Our fifth issue will focus on disease management (including noninvasive ventilation) and the CQI process. Our final issue is still without a topic, so any suggestions would be greatly appreciated. I have a list of those who volunteered in New Orleans to write articles and rest assured that all of you will hear from me during the year. But you don't have to wait for me to contact you! If you have something to contribute, please feel free. ANYONE may contribute an article at any time! See the following article on "Submission Guidelines" for instructions on how and where. ■

Submission Guidelines for Articles Written for the Home Care Section Bulletin

Article length: Bulletin articles should be between 500 and 1000 words (about 1-3 typed, double-spaced pages).

Format: In addition to a paper copy, all articles should be submitted on a 3-inch floppy disk saved in Microsoft Word or TEXT ONLY (ASCII) formats, or e-mailed to the editor in one of those formats.

Deadlines: The deadline for issue 3 is June 1 and issue 4's deadline is August 1.

Article Review: All authors may review a copy of their article before it goes to press. If you would like to review a copy of your article, please include a FAX number when you submit it to the editor. **It is the responsibility of the author to 1) request the opportunity to review the article before it goes to press and 2) contact the editor by the stated deadline if any changes need to be made before the article goes to press.** ■

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