

EDITORIALLY SPEAKING

**By Larry L. Breeding
IAHC Executive Director**

MEDICAID UPDATE/ROTUNDA REPORT

During the 2005 Legislative Session, I will use this column to combine the ongoing update on Medicaid as well as legislative activities relative to home health care. The Medical Assistance Crisis Intervention Team (MACIT) report as well as DHS initiatives have been presented to the legislature for their consideration.

Iowa Medicaid Enterprise (IME)

You should have received information from DHS regarding the start of the conversion from ACS to IME, effective July 1, 2005. The physical move of all the contractors and department personnel to a single location on Army Post Road, Des Moines, should be accomplished this month. It is my understanding all of the ACS computer systems, previously housed in Pittsburgh, PA, have been transferred to the state's system in Des Moines. One of the very next steps will be a phase in of new computer software to transfer from ACS to IME. As previously advised, members should pay very close attention to this transition as it has the potential to be very disruptive, business-wise.

Medicaid Prospective Payment System

As of this writing, the IAHC office has received no information from DHS regarding conversion of the home health Medicaid payment system from retrospective to prospective. The department is significantly behind their original time schedule but anything is possible. As soon as the IAHC office receives any information regarding this matter, members will be so advised.

Medicaid Funding

It has now been determined that the state Medicaid program will be short \$65 million for the current fiscal year. Governor Vilsak has presented a supplemental appropriations bill to cover the shortfall, which will be made up from tax revenues exceeding state estimates. The legislature understands this, will provide the funding, thereby avoiding any reduced reimbursement for this fiscal year. For fiscal year 2006, beginning July 1, 2005, DHS estimates they will need an additional \$185 million just to maintain the program. By maintaining, they mean the 3% reimbursement cut imposed 3 years ago will be extended for a fourth year. Based on current revenue estimates and previously agreed to salary increases for state employees, the state does not have the money to fund the \$185 million. Thus the task the legislature will be to either cut the Medicaid program or find additional revenue.

To address this, the legislature has established a bi-partisan group of senators and representatives just to address Medicaid. In my years of watching the legislature, this is a first. They will look at Medicaid, not just from a funding perspective, but from a services perspective to determine if current spending is the most appropriate. While they will have no legislative authority, the make up of the committee is key players in the Medicaid program. It is anticipated the legislature will look to this group to give them guidance on Medicaid funding and services in the next fiscal year and beyond.

Legislation

Following is introduced legislation that IAHC is monitoring:

House Files

HF 12

A bill for an act relating to the reimbursement for services provided under a medical assistance home and community-based services waiver for the elderly. (Human Resources)

HF 22

A bill for an act relating to establishing standardized requirements for long-term care insurance policies. (Commerce)

HF 120 GUARDIANS AND CONSERVATORS (Smith)

Creates the state Office of Substitute Decision Maker within the Department of Elder Affairs with local office by July 1, 2015. Specifies the duties of the office, the decision maker, and local offices. Has other related provisions. (Human Resources)

HF 140 SENIOR LIVING TRUST (Hauser & Swaim)

Strikes the end of the limitation period (June 30, 2005) for the DHS to use the money appropriated for the conversion of nursing facilities to long term care alternatives. Requires that money in the Senior Living Trust fund be used only for the purposes specified in the Code until the fund has more than \$200 million. See SF 29 (Human Resources)

SF 16 ELDERLY CARE REIMBURSEMENT RATE (Kreiman)

Requires an annual July 1 recalculation of the reimbursement rate for Medicaid providers under home and community-based services waiver for the elderly. (Human Resources); Companion to HF 12

SF 19 LONG TERM CARE INSURANCE (Kreiman)

Directs the Insurance Commissioner to set standards related to terms and benefits for long-term care insurance policies. (Commerce) Companion to HF 22

SF 29 LONG TERM CARE ALTERNATIVES (Krieman)

Strikes the end of the limitation period (June 30, 2005) for the DHS to use the money appropriated for the conversion of nursing facilities to long term care alternatives. Requires that money in the Senior Living Trust fund be used only for the purposes specified in the Code until the fund has more than \$200 million. (Appropriations)

IAHC Annual Meeting Notice

Pursuant to article VII, Section I A, notice is hereby given that the 2005 Annual Meeting of the Iowa Association for Home Care (IAHC) will be held March 9, 2005 from 12:30 p.m. – 1:00 p.m. at the Holiday Inn – Airport, 6111 Fleur Drive, Des Moines, IA.

The following elections will be conducted at the annual meeting:

Proprietary Section - 2 year term

Official Government Section - 2 year term

Health Care Facility Based Section - 2 year term

Home Care Aide Discipline - 2 year term

At-Large Representative – 1 year term

A nomination form for these board positions is included on the following page. Any member seeking a board of director position is encouraged to complete the nomination form and return it to the IAHC office no later than March 1, 2005.

**IOWA ASSOCIATION FOR HOME CARE
BOARD OF DIRECTOR
2005-2006 NOMINATION FORM**

(Name of Nominee)

(Current Position)

(Name of Member Agency)

(Street Address)

(City, State and Zip Code)

(Telephone Number)

Board position nominee is seeking:

- _____ At-Large (1 year term)
- _____ Proprietary Section (2 year term)
- _____ Official Government Section (2 year term)
- _____ Health Care Facility Based Section (2 year term)
- _____ Home Care Aide Discipline (2 year term)

*Biographical information of nominee including experience, education, organizational memberships and IAHC activities:

* Please limit any biographical attachments to 2 pages.

Return Nomination Form by March 1, 2005 to:

IAHC
1520 High Street
Des Moines, IA 50309-3110
FAX (515) 282-8034



Spring District Meeting Dates

Listed below is the location, date and time of the six respective IAHC Spring District meetings:

CENTRAL

*Boone County Hospital
105 S. Marshall
Boone, IA
Date: April 6, 2005
Time: 9:30 a.m. – 12:30 p.m.*

*District Rep.:
(Meeting in Home Care office bldg,
directly west of the Hospital)*

EAST

*Professional Home Health Services
4080 1st Ave NE, Ste. 110*

*Cedar Rapids, IA 52402
Date: April 13, 2005
Time: 9:30 a.m. – Noon
District Rep.: Julie Tow*

NORTHEAST

*Pinicon Restaurant
South Highway 63
New Hampton, IA
Date: April 7, 2005
Time: 9:30 a.m. – Noon
District Rep.: Joyce Friederich*

NORTHWEST

*Cherokee Library
215 South Second Street
Cherokee, IA
Date: April 5, 2005
Time: 10:00 a.m. – 12:30
p.m.*

District Rep.: Angie Cook

SOUTHEAST

*Wapello Co. Public Health
108 E. Main (Wapello
Building)
Ottumwa, IA
Date: April 14, 2005
Time: 9:30 a.m. – Noon
District Rep.: Ronda Watson*

SOUTHWEST

*Montgomery County Hospital
Pioneer/Heritage Room
2301 Eastern Ave.,
Red Oak, IA
Date: April 12, 2005
Time: 9:00 a.m. – Noon
District Rep.: Lorilyn Schultes*

A district meeting packet, including meeting agenda will be mailed prior to the meeting. The Central, Northeast and Southwest Districts will elect Board of Director representatives for terms through June 30, 2007. All members are encouraged to attend their district meeting.

“Reversals’ big payback; Mortgage option allows seniors to borrow, not repay”

By Adam Geller, The Associated Press, September 2004, The Sun Herald

When Koula Chumley and her husband paid \$25,000 for a four-bedroom split-level 35 years ago, it was an investment in family. Buy Chumley’s children have families of their own now, she’s widowed and is counting on that same house – worth much more – to ease life in retirement.

Chumley, however, is not selling. She’s one of a small but growing number of older homeowners opting for a reverse mortgage, an arrangement that allows seniors to borrow against the equity in their homes. It gives seniors ready access to money without having to make monthly payments, and the loan doesn’t have to be repaid as long as they continue to live in the house.

“I thought now is the time,” said Chumley, 78, who is using the arrangement to pay off the remainder of the old mortgage on her Odenton, MD home, help with monthly bills, update a bathroom and make plans for travel to Europe. “So far, so good. Life is good, and I hope to stay healthy to enjoy some of it.”

Gaining popularity **Reverse mortgages** are still largely unknown to many seniors, but they are gaining in popularity. And lenders are eyeing the potential for an even larger market as millions of baby boomers, less skeptical than their parents about relying on debt, approach their 60s.

The number of federally insured **reverse mortgages** has risen from fewer than 8,200 in 2001 to 21,600 last year. At the current pace, the number should almost double this year to nearly 40,000, industry executives estimate.

Reverse mortgages can be difficult to understand, and the arrangements vary widely. But all stem from Congress’ 1987 vote to start a government-backed loan program to let older homeowners more easily tap the equity in their homes. Borrowers must be 62 to participate.

Private lenders structure the loans almost like annuities – estimating how long a person is likely to live in their homes to calculate how much cash a homeowner can obtain and how much of the home’s equity must be reserved as interest. When the homeowner moves out, the combination of borrowed principal and interest must be repaid.

The loans are not for everyone. They require borrowers to shoulder substantial fees, which are not always readily visible since they’re built into the loan itself. The amount of cash available to homeowners can also vary greatly, depending on their age, the value of their home, where they live and fluctuations in interest rates.

But with careful consideration and advice from a counselor – a free service – they can be quite valuable and their appeal to homeowners in a variety of situations is broadening, consumer advocates say.

“These loans can really dramatically improve the quality of life for many, many peoples,” said Bronwyn Belling, a reverse mortgage specialist for the AARP Foundations, the tax-exempt affiliate of the advocacy group for older Americans. “But they need to go into the transaction wit their eyes open.”

Federally insured **reverse mortgages**, which account for the overwhelming share of the market, have been around since 1989. But they’ve taken a long time to catch on among a senior population wary of being scammed, fearful that such a loan might mean forfeiting their homes, and reluctant to depend too much on borrowed cash.

That has started to change, though, partly because of positive word-of-mouth among seniors, and with the economic uncertainties of the past few years providing particularly strong incentives.

“You’ve had a strong housing market and a faltering stock market that leaves people with more of their wealth tied up in their home,” said Greg McBride, a senior financial analyst wit Bankrate.com, a personal finance Web site. “At the same time, low interest rates have slashed the income that they (seniors) get on their interest bearing accounts. And **reverse mortgages** really work to solve many of those problems for retirees.”

Tapping the market there are some signs the market is already starting to broaden. The typical reverse mortgage customer has long been a widow in her late 70’s.

But the past few years of very low interest rates have begun drawing in somewhat younger borrowers, including more single men and couples, lenders say.

In a bid to tap the market, reverse mortgage lenders have stepped up advertising on talk radio, the Weather Channel and elsewhere on cable television and magazines geared to older readers. Lenders continue to make the rounds of senior centers and other community groups to talk up the advantages of **reverse mortgages**.

“We have barely scratched the surface of the number of seniors who are out there who have equity in their homes and who could be taking advantage of this program,” said John Lucas, a vice president and branch manager of Anaheim, CA based Pacific Republic Mortgage Corp.

Most homeowners who secure a reverse mortgage take it in the form of a credit line, with only about one in 10 also choosing to draw a monthly advance. In theory, a homeowner who lives much longer than expected and stays in the home could pocket payments exceeding the value of the home. Even in such a case, the homeowner keeps the home. But when the owner dies or moves, there would be no remaining equity left in the home, and the loan would be satisfied when it was sold.

Bob Pepper, 78, of Mill Valley, CA, was having trouble paying his bills. But the retired artist who now gets by doing odd jobs was skeptical even after he heard a lending officer speak about **reverse mortgages** at a local community center. It was only after asking plenty of questions that he was able to put to rest fears that taking out such a loan might mean giving up his home.

“If I happen to live to 103, it will still be my house,” se said.

Pepper used part of the proceeds for a \$55,000 renovation of his home, and a monthly check to supplement Social Security and other income. He’s drawing down on a credit line to pay for travel, and is considering buying a boat.

Seniors considering a federally insured reverse loan, called a Home Equity Conversion Mortgage, are required to talk it over with a counselor. The U.S. Department of Housing and Urban Development maintains a list of all counselors, and AARP has its own list.

For more information on Reverse Mortgages, or to inquire about application, contact Jon Rutter at (515) 237-2863 or toll-free at (866) 317-1923.



Jon Rutter

**Reverse Mortgage Specialist
Wells Fargo Home Mortgage
4505 Douglas Avenue
Des Moines, Iowa 50310
Toll-Free: (866) 317-1923
Office: (515) 237-2863**

E-Mail: jon.a.rutter@wellsfargo.com



The Benchmark Email

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January 6, 2005

Probability, Implications and Planning for 2005

Question:

As we move into 2005, are there any suggestions for issues that we need to pay attention to as we begin our planning process?

Answer:

Yes, but before naming them, it might be helpful to understand how we approach planning.

When planning for 2005, there are hundreds of issues a home care agency may want to think about but the real question is which ones warrant your attention and action. There are two simple questions you can ask yourself. How you answer these questions should give you a clear sense of what actions you need to take. Start by asking yourself these two probing questions:

Probability Question: What is the probability that a particular issue will occur? If it is high, then you need to consider it. If it is low, put it on the back burner. You have too many other things to worry about. If you feel the probability is high, go to the implication question.

Implication Question: If there is high probability that a specific event will occur, how significant will the implications be to your agency. If it is high, you better start planning and paying attention to this issue now. If it is low, you may want to continue paying attention to it but immediate action is probably not warranted....at least for now.

Once you have made a determination that there is a high probability (the reality will most likely occur) and you've determined that it has high implications (it will **significantly** impact your agency), you should determine what you need to do to prepare for it and be ready to act.

So, in looking ahead to 2005, there are three realities that the answers to our two probing questions would indicate actions are needed.

Issue I. Pay-for Performance: MedPac is in favor of it. Congress is receptive. **Trials** are expected in 2006. It is being used in other segments of health care.

Probability: High!

Implications: Agencies' Home Health Compare and OBQI scores will have a direct effect on funding levels.

Action: Initiate efforts to reduce adverse events, improve **outcomes** and ensure OASIS accuracy. Conduct OASIS audits and training.

Issue II. Federal Budget Cutbacks or Level Funding: Reduction in federal revenue due to federal budget cuts. Increased funds going to war efforts. Projected dramatic growth in federal deficit to 2.3 trillion dollars in next five years! President saying that he is going to further cut taxes and also cut services! MedPac says home care has excess profits, 16.9%.

Probability: High!

Implications: Major attack on home care revenues and potential budget cuts.

Action: Ensure that case mix weights are accurate, that you are getting correct reimbursement for your patients, and focus on lowering cost/visit and cost/episode. Look at best practice services and increased accuracy on OASIS.

Issue III. Managed Care Growth: Medicare Prescription Drug Improvement and Modernization Act of 2003 is providing managed care companies with a financial incentive to **participate in the Medicare program**. Patients, many on fixed incomes, will get access to cheaper drugs only through managed care. Government **will be** doing major push to get patients in managed care.

Probability: Medium to High in certain areas of the country, particularly urban areas.

Implications: Managed care getting more patients, restricting patients access to home care and those who get it will receive less visits and agencies will receive lower **reimbursement**/visit.

Action: Lower your cost/visit. Lower number of visits/episode. Determine your marketing capacity with managed care. Use best practice to lower cost **and reduce emergent care and hospitalization utilization**, and patient satisfaction systems to prove your quality to managed care companies.

By the way, these are simply issues that we know about. Most seasoned home care leaders (especially the long term leaders) can readily attest that there are very often unexpected "surprises" that agencies must cope with throughout the year. As you look to 2005, it might be worth reading a new book on the market, David Allen's "Ready for Anything (2003)."

"Something is coming-- probably within a few days-- that's going to change your world. You don't see it yet. You don't know what it's about. But it's there, rolling inexorably forward, destined to throw you a curve that you do not expect. It could show up sooner or later-- but it will show up. Trust me. Write down these words exactly four weeks from today in your calendar: "David Allen said a month ago that something was coming I couldn't foresee that would affect me significantly."

The challenge is to deal with what you know and be prepared to assertively respond to new realities. In terms of today's realities, if you recognize the changes coming and prepare now, you may be able to do more than simply survive the changes, you may thrive in the changes. These issues are only threats if you don't know how to handle them or if you don't prepare for them. The resources to support you are available. The challenge is to recognize the changes, assess the probability and implications and take the right actions. Good luck in 2005!

* * * * *

If you have any questions, are interested in information on any of our services or would simply like to share some insights, please call (800-379-0361) or email the Benchmark Email Manager, Molly LePage mlepage@fazzi.com.

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**Iowa Department of Public Health
Bureau of Health Care Access
Center for Health Workforce Planning
December 15, 2004**

Current Activities

The center has recently prepared and posted the following items on the Web:

- Health Workforce Projections 2002 -2012
- Best Practices in Safe Patient Handling: A Compilation of Resources to Minimize Health Worker Injuries
- Trends in Nursing Supply and Education in Iowa - 2004 Update
- Nursing and Nursing Assistive Personnel Recruitment and Retention: Replicating Best Practices Across Iowa 2004
- Profile of Registered Dietitians in Iowa – a Report to the Iowa Board of Dietetic Examiners
- Status of Nursing Supply and Demand in Iowa 2004 – A Report to the Government Oversight Committee

The center is preparing a collaborative *Trend Analysis of the Hospital-Based Health Workforce* based on the 2004 Iowa Hospital Association (IHA) Health Professional Work Survey. The report will include new 5-year trend data about 19 professions experiencing the highest vacancy rates reported by Iowa hospitals between 2000 and 2004. The trend analysis, which identifies the highest vacancies among the RN, Nursing Assistants/Home Health Aides, and LPNs, will be posted center's web page in January 2005.

The center is updating a collaborative report on *Trends in Nursing Education* based on annual statistics submitted by the nursing programs to the Iowa Board of Nursing in November 2004. The report will include current data on admissions, graduations, and enrollments, and faculty vacancies by specialty. The report and companion fact sheet will be submitted to the Iowa Board of Nursing and posted on the center's web page in January 2005.

The center is developing a new project with the Iowa State University Department of Economics to analyze the nursing workforce from the labor market perspective. Beginning in February 2005, the project will study net export of RNs and LPNs at the county level, and various aspects of the RN labor supply. Content will address secondary employment, commuting patterns, and RN choices to remain in the non-nursing labor force. Data will be collected in the 13 county region of North Central Iowa that served as the 2003-2004 pilot project for the RN tracking inventory initiated by the University of Iowa, Carver College of Medicine, Office of Statewide Clinical Education Programs.

The center is analyzing data in order to prioritize and report the health professions at greatest risk for shortage in Iowa due to retirement in the next 10 years. Health professional licensure data is being utilized to determine the percentage of licensees who are age 55 and older and who can be expected to retire in the next decade. All departments with licensure information are participating. The report will be posted on the center's web page in February 2005.

The center is funding a two-semester internship experience in the IDPH Office of Multicultural Health to identify and communicate existing programs to retain racial and ethnic minority students in Iowa's health occupation programs. The outcome of the project will be a compendium of resources for use by students, parents, educators, employers and other state agencies in spring 2005. In partnership with the State Office of Rural Health, the center is identifying best practices in Iowa's middle and high schools to encourage entry and success in health occupations programs.

The center is working in partnership with a RN doctoral candidate to survey approximately 1,400 nursing faculty in Iowa in March/April 2005 to learn about their use of E-Learning methodologies and barriers to implementation. Findings will be used to inform a strategic plan to increase the use of E-Learning to accommodate increasing enrollments and relieve the faculty shortage.

The center will work in partnership with the federally funded HRSA Workforce Analysis Center at the University of Illinois Chicago, and the Iowa Board of Nursing, in spring 2005, to apply new federal RN supply and demand models in two Midwestern states, using data from Iowa and Illinois.

PARTNERS	CURRENT ACTIVITIES
State Office of Rural Health (SORH)	Guiding a joint project to collect and report demographic data about middle and high school racial/ethnic minority students, and identify statewide strategies to promote entry into health occupations. Work plan through 8/31/05 completed. Monthly planning session 12/10/04.
Bureau of Professional Licensure (PL)	Analyzing data on selected categories of licensed health professionals who are age 55 and older to prioritize those at greatest risk for shortage due to retirement in the next 10 years. Preparing final report of 2004 online survey of nursing home administrators. Developed a template for annual reporting about licensed health professionals. Funding expansion of social worker database and data entry into the IDPH licensure system by 2/01/05.
IDPH Office of Multicultural Health	The center is supporting an intern who is compiling resources in Iowa's secondary/post-secondary health occupations programs that increase representation of racial and ethnic minorities, immigrants and refugees. Monthly planning session 12/10/04.
Iowa Department of Education	Represented on the center's advisory committee. Serving on the Dept. of Education's Health Occupations Program Management Team. Exploring methodology to track outcomes of high school health occupations programs.
Department of Iowa Workforce Development (IWD)	Serving as a data source to the center and its partners re: federal funding opportunities, and RN wages by work site and county. Represented on the center's advisory committee, education forecasting group, and OSCEP advisory group.
University of Iowa, Carver College of Medicine, Office of Statewide Clinical Education Programs (OSCEP)	Managing a contract for the OSCEP Regional RN Tracking project to sustain and expand activities in 28 counties in NE/North Central Iowa by 7/31/05. Advisory met 12/09/04. Joint meeting to explore sustained funding on 12/17/04. OSCEP will present information about RN tracking in 2005 at the annual Public Health Conference, and Barnraising V.
University of Iowa Colleges of Nursing (CON) and Public Health (CPH)	CON represented on the center's advisory committee and OSCEP advisory group. CON providing a visiting nurse scholar for the center's project to survey nursing faculty about the use of/ perceptions about teaching via distance/E-learning. CON provided input about staff educational needs identified by Directors of Nursing in rural Iowa hospitals.
Iowa State University Dept. of Economics (ISU)	Identifying new project with input from center's advisory committee for implementation by 8/31/05 to address RN demand using wage, work effort, migration and labor supply data, and RN/LPN out-migration. ISU will conduct a concurrent session at Barnraising V.
University of Northern Iowa Center for Health Disparities (UNI)	Represented on the center's advisory committee. Center is managing a contract for a project through 8/31/05 that will create a strategic plan to increase diversity in Iowa's health workforce. Joint planning session with SORH and center intern on 11/19/04. UNI will conduct concurrent session at Barnraising V.
Upper Midwest Public Health Training Center (UMPHTC) State Public Policy Group (SPPG)	Serving on a SPPG advisory group to identify Iowa's plan during the current UMPHTC project period. Exploring opportunities to incorporate new public health workforce education and development activities into IDPH. The bureau presented information to UMPHTC on 12/09/04 re: center activities to increase diversity in the health workforce.
HRSA Workforce Analysis Branch	Joint planning session on 12/13/04 with the PI and staff of the HRSA-funded Illinois Regional Health Workforce Center at UIC to insert Iowa and Illinois RN licensure data into the new federal supply and demand models scheduled for release in 2005.
Iowa Hospital Association (IHA)	Coordinating new collaboratives between health occupations education programs and practice institutions through a center project to increase access to E-learning. Center and IHA incorporated data from the 2004 IHA Health Professions survey into a 2000-2004 Trend Analysis in partnership with IHA. This item will be posted on the web in 2005.
Iowa Council of Nurses (ICON)	ICON is serving as the advisory committee for the center's E-learning project to provide practice and education perspectives. Teleconference 12/06/04.
Iowa CareGivers Association (ICA)	Represented on the center's advisory committee. Serving on the BJBC stakeholder coalition, steering committee and two workgroups: Direct Care Worker Profiling (Interim Chair) and Education. Center staff participated in several meetings in Nov/Dec 2004.
Iowa Board of Nursing (IBON)	Current document and related Fact Sheet posted on the web. Will incorporate education/faculty data into report and Fact Sheet, and post on web in January 2005.
Iowa Association of Colleges of Nursing (IACN) and the Iowa Community College Nursing Education Directors Association. (ICCNEDA)	Represented on the center's advisory committee and education forecasting group. Provide programs current information about funding sources and data. Conducting faculty survey to identify understanding, use and perceptions re: E-learning as a teaching method. IACN meeting 11/18/04. ICCNEDA teleconference 12/16/04.
Iowa Nurses Association (INA)	Represented on the center's advisory committee and OSCEP advisory group. INA Foundation (INF) is seeking funds to support preparation of nursing faculty. Center prepared issue synopsis re: safe patient handling for <i>Nurse Reporter</i> .
Center for Local Public Health Services (CLPHS)	Ongoing communication about health workforce needs at the local level, including updated training materials (tapes, CDs) for home health aides in Medicare-certified agencies.

MedPAC Endorses Home Health Pay-for-Performance, Discusses Rural Add-on

Recently, the Medicare Payment Advisory Commission (MedPAC) examined a number of key home health payment issues, including moving toward a "pay-for-performance" reimbursement model and a proposed freeze on the home health market basket update for calendar year 2006. A number of commissioners also raised concerns about rural providers, opening the door for possible consideration of an extension of the Medicare home health rural add-on currently scheduled to expire March 31, 2005.

In lengthy discussion about establishing performance-based payment systems under the Medicare program, the commission indicated strong support for congressional action in this area relative to home health, hospitals, and physicians. The commission envisions a budget-neutral system under which 1 percent to 2 percent of payments to a provider type would be used as a pool to reward better-performing providers. Over time, a larger portion of payments could be channeled into such a pool, it was suggested.

As background for the commission's discussion, MedPAC staff presented its most recent calculations of profit margins for home health agencies. MedPAC estimates that the average 2003 profit margin for all freestanding agencies is 13.6 percent, and projects that this figure will drop to 12.1 percent in 2005.

When broken down by category, agencies show significant variance in overall margins, according to the data presented. MedPAC estimates that in 2003, voluntary agencies had average margins of 10.6 percent, proprietary agencies had margins of 15.8 percent, and government-sponsored agencies had margins of 5.0 percent. Projections for 2005 show decreases across all categories, with voluntary profit margins averaging 9.1 percent, proprietary averaging 14.3 percent, and government-sponsored projected at 3.3 percent.

Significant differences also were indicated when agencies were divided according to location of patients served--for 2003, urban agency margins averaged 14.1 percent, whereas agencies serving a mixed population averaged 13.2 percent and rural agency margins were estimated at 10.6 percent. When projected for 2005, estimates were 13.2, 11.6, and 6.1 percent, respectively. Hospital-based agencies averaged margins of negative 4.6 percent in 2003. National Association for Home Care & Hospice data also shows this drop in margin from urban to rural agencies, as well as the average margin for hospital-based agencies.

MedPAC's calculations indicated that in 2003, 20 percent of home health agencies had negative margins. Meanwhile, 25 percent of agencies had profit margins of 25 percent or more, MedPAC contended.

Following is a breakdown of margin data presented by MedPAC:

Freestanding home health agency profit margins	2003	2005 (projected)
ALL	13.6 percent	12.1 percent
Voluntary	10.6	9.1
Proprietary	15.8	14.3
Government-sponsored	5.0	3.3
Urban	14.1	13.2
Mix urban/rural	13.2	11.6
Rural	10.6	6.6

Further study by MedPAC staff indicated that between 2001 and 2003, aggregate costs per episode fell 1 percent; however, when broken down by size, these figures showed that large agencies' costs fell 6 percent, while the smallest agencies' costs actually grew by 4 percent. MedPAC staff also indicated their analysis shows that rural agencies' costs fell, on average, by 13 percent between 2001 and 2003.

As occurred at MedPAC's November meeting, commissioners expressed some concern regarding the ability of the existing Medicare prospective payment system (PPS) to reflect care inputs accurately, calling into question the validity of the system as it stands. MedPAC is in the process of conducting a study of the home health PPS case-mix adjuster, and is scheduled to submit that report to Congress in November 2005.

Of particular interest was discussion initiated by members of the commission that covered concerns about the financial viability of rural providers in the event of a possible freeze on the market basket update for 2006. Several commissioners raised questions about a possible recommendation to extend the rural add-on.

GAO Finds Need to Improve Response Accuracy of 1-800-MEDICARE Helpline

In March 1999, the Centers for Medicare & Medicaid Services (CMS) implemented a telephone helpline--1-800-MEDICARE--to provide information about program eligibility, enrollment, and benefits. The helpline has seen surges in beneficiary inquiries since implementation of the sweeping Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) began; CMS decided earlier this year to route all enrollee calls on specific claims to the phone number.

The Government Accountability Office (GAO) recently released a report that raises questions about the accuracy of the information provided through the helpline and recommends steps to improve monitoring of the accuracy of answers as well as the information available to helpline staff to respond to inquiries. In addition, certain call topics often were transferred to other contractors that were closed at the time of the call, GAO found. Earlier this year, GAO released a report that found serious problems with the accuracy of responses given to provider inquiries at Medicare contractor call centers.

In evaluating the 1-800-MEDICARE helpline, one of the areas of Medicare coverage GAO evaluated for response accuracy concerned coverage criteria for power-operated wheelchairs, an area that has come under increased scrutiny this year. In addition to finding improper re-routing of those calls to closed contractors, GAO noted instances of inaccurate responses. GAO felt it was crucial to provide information that coverage for the wheelchairs is dependent upon a physician's prescription for them, and that the beneficiary would be obligated to pay a significant co-payment (approximately \$1,000). GAO noted that the script provided to call center staff needed better content in order to answer questions more appropriately.

As an example, GAO referenced a response it received to one of its test calls. The call center representative misread the requirement related to upper body strength, or "trunk strength," of the Medicare beneficiary, GAO noted. The call center staff mistakenly informed GAO that the beneficiary must have adequate "trunk space" in order to qualify for a power wheelchair, explaining that there must be adequate trunk space in his or her car to hold the power wheelchair. In actuality, the coverage criteria are meant to distinguish between individuals who can operate a standard wheelchair--those with adequate "trunk strength"--and those who would require a power wheelchair.

The Medicare helpline is open 24 hours a day, seven days a week. Each year, it handles millions of phone calls from across the country from beneficiaries inquiring on the gamut of Medicare issues. Home health agencies and hospices have indicated that incorrect understandings of coverage criteria by beneficiaries or their families could be related to inaccuracy of responses from the Medicare helpline.

Nevertheless, the helpline provides a starting point for consumers and their families to understand a very complicated Medicare program. In its response to the GAO recommendations, CMS indicated its ongoing efforts to improve the accuracy and accessibility of the helpline continually.

The GAO report is entitled "Medicare: Accuracy of Responses from the 1-800-MEDICARE Helpline Should Be Improved," ([GAO-05-130, December 2004](#)) and is available on GAO's website at www.gao.gov/new.items/d05130.pdf.

Medicaid and Other Health Care Costs Top Concerns for States in 2005, Study Finds

State Fiscal Experts Polled to Determine Biggest Issues Looming on State Legislatures' Agendas

State legislatures will face a host of complex issues and fiscal difficulties as they work to resolve budget demands this year, and paying for Medicaid and health care are high on that list, according to the National Conference of State Legislatures (NCSL). The organization recently publicized results from a study, "State Budget Update: November 2004," that sought to determine the top fiscal issues for states at present. Results from the study echo similar observations and warning flags raised by the National Governors Association.

The study asked state's fiscal experts to identify the primary issues their respective states are expected to address in the 2005 legislative sessions. Consistently cropping up among those issues were Medicaid and other health care costs and additional health-related matters, which are anticipated to top legislative agendas in some 30 states.

Most of the concerns focus on Medicaid, e.g., reductions in the Federal Medical Assistance Percentage (or FMAP, the rate at which the federal government matches each state's Medicaid expenditures, as well as rapidly rising costs due to caseload growth, benefit increases, and medical cost inflation. Several states also report that employee health insurance costs will be a key fiscal issue in 2005. Budget overruns in mental health services reportedly must be addressed in some states as well.

Regarding fiscal year 2005 spending overruns, Medicaid is the category most commonly over budget, NCSL notes. Thus far in fiscal 2005, Medicaid spending already is exceeding appropriations in 16 states. NCSL has posted specific information for each state, including budget gaps, spending overruns, revenue performance, and the top three fiscal issues, on its website at www.ncsl.org.

Details Released on 'Home Health Compare' **Updates for 2005**

The Centers for Medicare & Medicaid Services (CMS) supplies information about quality of provider services through its www.medicare.gov website. Medicare home health agencies (HHAs) can be located, and information on them accessed, via CMS's "Home Health Compare" tool on the site; users scroll down the page and click on a link that reads, "Compare Home Health Agencies in Your Area."

CMS updates the site on a regular basis. HHA demographic information is updated monthly as new and corrected information is received from state agencies. Home health quality information is updated quarterly; the schedule for those specific 2005 updates is:

Date of Release (2005)	Outcome Data Collection Time Frames
March 3	December 2003 through November 2004
June 3	March 2004 through February 2005
September 1	June 2004 through May 2005
December 1	September 2004 through August 2005

Information about Medicare-certified HHAs available through Home Care Compare includes:

- Name, address, and phone number of the agency,
- Medicare-covered services offered by the agency (nursing care, physical therapy, occupational therapy, speech pathology, medical/social services, and home health aide),
- Date of agency's initial Medicare certification, and
- Type of agency's ownership (for-profit, government, or non-profit).

Home Health Compare provides information on HHAs' performance on quality measures, which is intended to indicate to users how well an agency provides care for patients. Those measures track information about patients' physical and mental health, and whether their ability to perform basic daily activities is maintained or improved. Users can compare data on the quality measures among HHAs.

The quality measures tracked include:

- Four measures related to improvement in mobility,
- Four measures related to meeting the patient's activities of daily living,
- Two measures related to patient medical emergencies, and
- One measure related to improvement in mental health.

CMS announced a recent Home Health, Hospice, and Durable Medicare Equipment Open Door Forum that plans are underway to change the quality measures now publicly reported on Home Health Compare. The planned changes are to be based on the draft recommendations of the National Quality Forum (NQF), the CMS contractor charged with identifying quality measures for public reporting.

In the next iteration of Home Health Compare, due to be released sometime this year, CMS will cease reporting on patient improvement in upper body dressing, confusion, and toileting, as well as stabilization in bathing. In place of those measures, CMS will add improvement in surgical wounds, dyspnea, and urinary incontinence, and discharge to the community.

Editors Note: *The March 9, 2005 IAHC Spring Meeting Seminar is devoted to the "Home Health Compare Initiative". It will be presented by the Iowa Foundation for Medical Care.*

Health Care Spending Growth Ebbbed for 2003, But Still Outpaced Economic Growth, CMS Reports

Growth in total health care spending slowed in 2003 for the first time in seven years, according to a report from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary. Health expenditures grew by 7.7 percent for the year, down from a rate of 9.3 percent in 2002.

While the rate at which health care costs grew for 2003 moderated compared with increases in the six years prior, grow they did nonetheless--at a rate almost three percentage points higher than economic growth, the report finds. Health care expenditures accounted for \$1.7 trillion or 15.3 percent of the gross domestic product in 2003. On a per capita (individual) basis, health spending was \$5,670, an increase of \$353.

Decelerated growth in hospital spending, which comprises the largest chunk of overall health expenditures, drove the slowdown in overall 2003 health spending growth. Hospital spending grew 6.5 percent for the year, compared with 8.5 percent the prior year. For freestanding home health agencies, spending grew by 8.5 percent in 2003, up from 7.5 percent in 2002.

According to the report, all the growth in home health spending came from the private sector. Legislation cut Medicare home health payments by 7 percent, and a 10 percent home health rural add-on also expired, so that Medicare spending growth for home health dropped from 14.7 percent in 2002 to 9.9 percent in 2003. An enacted 5 percent Medicare rural add-on is still in effect, but only until the end of March; efforts have begun in Congress to extend this add-on.

In the public payer sector, the Medicare and Medicaid programs together funded (in nearly equal part) one-third of the nation's health spending for 2003, according to the report. Medicaid spending was \$267 billion, and Medicare spending was \$283 billion. Public sector health spending slowed "significantly," from 9.7 percent in 2002 to 6.6 percent in 2003, largely driven by less growth in Medicaid spending and the expiry of supplemental funding provisions under the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). BBRA was enacted to mitigate some of the "unintended consequences" of the Balanced Budget Act of 1997 (BBA), which exacted a severe toll on home care and hospice.

Meanwhile, overall private sector payer spending (including private health insurers and individuals' out-of-pocket expenditures) was less changed for 2003. The report finds private sector spending growth was 8.6 percent, down only 0.4 percent from 9.0 percent growth in 2002. Private health insurance premiums rose 9.3 percent in 2003, compared with 10.7 percent in 2002. Notably, individuals' out-of-pocket spending grew at a higher rate in 2003, 7.6 percent, than it had the previous year, 6.0 percent.

CMS maintains that a number of initiatives it has undertaken in recent years have helped contain health care costs. Department of Health & Human Services (HHS) Sec. Tommy Thompson said in a release that "we have more to do before we can declare victory over rising health care costs."

Many would consider such a victory far off indeed. Rising health care costs, particularly in Medicaid, top the list of concerns and budgetary challenges for states, according to a report from the National Governors Association (NGA) and the National Association of State Budget Officers. NGA recently sent a letter urging the Bush Administration and Congress to enact Medicaid reform rather than cuts to the program through budget reconciliation efforts.

MedPAC to Recommend that Congress Freeze Home Health Payments for 2006

The Medicare Payment Advisory Commission (MedPAC), the panel that provides advice and direction to Congress regarding Medicare payment policy, recently voted on a series of recommendations it will make for Medicare-related payment actions in 2006. Among those that got the green light is one that Congress eliminate the scheduled home health market basket index inflation update for the forthcoming payment year (calendar year 2006).

Note that under a provision of the 2003 Medicare reform legislation, the annual update is reduced by 0.8 from the level that would otherwise occur. In the 2005 rates, for example, the 3.1 percent update was reduced by 0.8 to 2.3 percent. To sum up the process, the Centers for Medicare & Medicaid Services (CMS) proposal for 2005 was to increase home health payments by 3.3 percent; the corresponding final rule lowered the proposal by 0.2 to 3.1 percent. From there, 0.8 is subtracted to arrive at the 2005 2.3 percent increase for home health payments.

MedPAC supports the "home health pay freeze" recommendation for the third consecutive time, citing internal studies that show access to care is "good," quality of care has improved slightly, and home health agencies are entering the Medicare program (the rationale is that business under the program is lucrative). Since 2003, 500 new Medicare-certified home health agencies have been certified, although MedPAC acknowledges that some of those may be "reconfigured" organizations rather than "totally new" home health agency additions.

The commission also finds that 99 percent of beneficiaries live in an area served by at least one home health agency. That same percentage of home health patients reports little or no difficulty in accessing care, MedPAC noted. In addition to the quality, access, and market reasons, MedPAC references "continued double digit profit margins" for supporting its recommendation. The specific Medicare margin for freestanding home health agencies MedPAC cited was 13.6 percent for 2003, which it projected will dip to 12.1 percent for 2005.

However, for the first time, MedPAC appears to recognize the wide variation in agency profit margins. It was noted at the hearing that according to the commission's data, 20 percent of home health agencies show a negative margin over a three-year period, while another 25 percent have profit margins exceeding 25 percent.

Agencies appear to be maintaining margins through cost controls, MedPAC speculated, which the commission said is reflected in an 8 percent decline it tracked in the number of service minutes and visits per episode. NAHC notes that this information appears inconsistent with Medicare cost reports. At the same time, MedPAC notes that the number of home health users increased to 2.6 million in 2003 from 2.4 million in 2001.

With respect to rural home health agencies, MedPAC will make no recommendation to Congress regarding continuation of the 5 percent rural add-on. The commissioners expressed some concern, however, regarding the fragility of access to rural home health services. MedPAC staff report that rural agencies served fewer zip code areas in 2003 than they did in 2002. So while no recommendation will be made regarding the add-on, the commission's data demonstrate service declines in rural home health. A bill to extend the sunset of the 5 percent rural add-on (which currently is set to expire March 31, 2005) was one of the first bills filed in the 109th Congress.

Although it was not a formal recommendation issued by MedPAC, great concern was expressed regarding the need to reform the home health prospective payment system (PPS). MedPAC staff indicated that costs may vary widely within payment groups, and that some patient characteristics that are not in the case mix system appear to correlate with high costs. The commission specifically was critical of the system's failure to address (1) informal caregiver availability, (2) patient obesity, and (3) the impact of heavy smoking on resource utilization. MedPAC plans to explore PPS alternatives in the coming months and issue a report later in the year.

MedPAC's recommendations and a transcript of the hearing proceedings are available on its website, www.medpac.gov. The commission will issue its formal report to Congress in March.

Congress Should Support Pay-for-Performance (P4P) in Medicare, MedPAC Votes

The Medicare Payment Advisory Commission (MedPAC) has jumped on the growing bandwagon of supporters for payment policy reforms that focus on pay for performance, also known as "P4P". In the recommendations recently voted on, MedPAC supports Congress authorizing the establishment of an incentive payment policy based on performance for home health, hospitals, and physicians. These recommendations echo similar ones made last year for managed care organizations and renal dialysis services providers under Medicare.

The details of any pay-for-performance system were not addressed in MedPAC's recommendations. Instead, a formal process to implement pay for performance would be left to be developed by the secretary of the Department of Health & Human Services (HHS). MedPAC does suggest that the performance measures, once set, should be improved continually, that the use of information technology be folded into any incentive program, and that the pool of incentive cash for pay for performance be enlarged over time.

In analysis by MedPAC staff, home health is ready for performance-based payment. Staff point to existing functional improvement/stabilization measures and other clinical measures in home health, with 10 items already endorsed by the Centers for Medicare & Medicaid Services (CMS) and more on the way through the efforts of the National Quality Forum.

Those measures can differentiate between high-performing and other home health agencies, according to MedPAC staff. Still, staff proposed that these measures should be used only as a "starter set," and other factors such as adverse event measures and process measures could enhance future performance evaluation. To that end, the MedPAC commissioners will recommend that the secretary of HHS develop valid measures of home health adverse events with appropriate risk adjustments. Discussion of that recommendation indicated a focus on re-hospitalizations and emergent care.

A final MedPAC recommendation links performance measures with the use of information technology, or IT. Both the MedPAC staff and commissioners indicate strong support for the belief that information technology has considerable potential to improve the quality of care and, at the same time, cost efficiencies.

Staff expressed that IT use and uptake are slow, identifying significant barriers to IT adoption such as cost, difficulty of implementation, and misaligned financial incentives. Exploring possible actions, MedPAC staff considered:

- Offering financial incentives,
- Helping providers navigate the IT market,
- Promoting information-sharing among providers,
- Establishing a loan fund, and
- Mandating minimum levels for the use of information technology.

More general ultimately, the recommendation approved by the MedPAC commissioners is that CMS include in its pay-for-performance measures the use of information technology to reward providers financially on the basis of care quality. The recommendation envisions no special funding for information technology, but instead relies on incentives already included in a pay-for-performance financial pool.

Policy Discussions Advance at 'Convening' on Consumer Direction in Aging Services

Consumer-directed care, while a growing trend in many areas of health care, often elicits apprehension from home health providers. With consumer-directed care already entrenched in delivery of services to the developmentally disabled, senior advocates increasingly have been examining the role that the consumer direction model might play in delivery of long-term care services to older adults.

As part of that effort, the National Association of State Units on Aging (NASUA) and the National Council on the Aging (NCoA), with funding from the Robert Wood Johnson Foundation, have embarked on a three-year project to increase opportunities for consumer direction in home and community-based services for seniors. NASUA and NCoA called in the stakeholders to provide their input this week, hosting a "National Convening on Consumer Direction" that drew policy leaders from government (federal, state, and local), the provider/caregiver community, academia, and consumer advocacy organizations.

A defining characteristic of the consumer-directed model of service delivery is to allow the patient more choice and control over how, and from whom, they receive supportive services. Some consumer direction programs expand the client's control further by providing a cash benefit with which the participant can purchase services or pay caregivers, including family members.

Clients must be able (and willing) to take on the responsibilities inherent in this care model, Forster pointed out, which could include payroll and claims management, background screening and training of caregiver applicants, and other administrative tasks. In large part, attendees of the meeting agreed that consumer direction is not appropriate for all seniors, and that choice of care delivery models is important to maintain in long-term care services to older adults.

A number of the consumer direction models described at the meeting did incorporate important safeguards, such as requiring a comprehensive assessment to determine whether a client is able to self-direct care and undertake all the responsibilities involved, or setting requirements for training and screening hired caregivers. The bulk of self-directed care programs for seniors currently are financed through state and local funds, the Older Americans Act, and Medicaid waiver and personal care option programs.

Ask the Experts: Medicare/Medicaid Dual Eligibles and IV Therapy Coverage

NAHC Responds to Members' Inquiries and Concerns

Q: We (a home health agency) have a dual-eligible client who will be discharged from a hospital with IV antibiotics. Before we resume care, what should we know about Medicare coverage for IV therapy? The hospital had indicated Medicaid would pick up IV costs; what about supplies?

From National Association for Home Care & Hospice Regulatory Affairs:

Coverage of IV solutions and supplies under the Medicare Part B durable medical equipment (DME) benefit is dependent on whether a pump is medically necessary. When a pump is medically necessary, the DME company may bill and be paid under Medicare Part B for the pump, the drug, medical supplies, and flush solutions. This has been the longstanding policy of the Centers for Medicare & Medicaid Services (CMS).

IV fluids, medications, and flush solutions are never the responsibility of the home health agency since they are considered "drugs" or "biologicals," and therefore are not part of the home health benefit. Note that this is a change to the pre-prospective payment system (PPS) practices of some fiscal intermediaries (FIs), which in the past allowed home health agencies to bill for flushes and hydration solutions.

In cases where a pump is not medically necessary, the home health agency's responsibility for IV supplies is based on whether (1) the agency is administering the IV or (2) the IV is being administered by another party.

Agency administration of IV. IV supplies are part of the home health benefit if home health personnel are providing the IVs during the course of a home visit as part of the plan of care. In this case, the cost of IV supplies used during the visit are the responsibility of the home health agency and are bundled in the home health payment.

IV administered by another party. IV supplies that are not being used by a home health agency's personnel to carry out the plan of care but rather are used by the patient and/or another provider are not covered by Medicare, and therefore are not bundled under the home health benefit.

For example, for a patient or family administering fluids via IV (not using a pump) for hydration on a PRN (Latin *pro re nata*, "according to need") basis, the IV supplies would not be the responsibility of the home health agency, unless an RN is required as part of a skilled visit to infuse the fluids or to instruct the family on administering the IV.

Again, the home health agency is never responsible for IV solutions, flushes or pumps. CMS has further stated that, in cases where a physician or patient chooses to use a pump for IV delivery when it is not medically necessary, the home health agency is not responsible for medical supplies associated with those infusions.

Medical supplies needed by patients must be provided only if they are approved Medicare Part B supplies. For instance, ostomy supplies are covered under Part B, and therefore are bundled under the home health PPS even if the patient is responsible for the ostomy care. IV supplies, where no pump is necessary, are not covered under Part B, and these would not be bundled under the home health PPS unless the supplies are used by the agency during a visit.

Pilot Run of Medicare Provider Satisfaction Surveys Underway

The Centers for Medicare & Medicaid Services (CMS) plans to request participation in pilot surveys of about 7,400 Medicare fee-for-service providers this month to determine their level of satisfaction with Medicare fiscal intermediaries (FIs) and carriers. The initiative is required under a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that calls for measurement of provider satisfaction levels.

Providers will be able to access the survey via a secure Internet website or, if they prefer, can request that a copy be faxed or mailed to them. CMS is urging providers to participate in the pilot because the results--although they will not be used to evaluate Medicare contractor performance--will be used to fine-tune the survey and refine processes.

Once applied nationally, the survey process will help CMS contractors identify and implement best practices to improve the quality of their services, according to the agency. CMS also will be able to measure provider satisfaction as part of performance-based contracting. Questions included in the survey are aimed at assessing areas such as ease of access, contractor response time, level of knowledge of contractor staff, and value of information provided by contractors, CMS says.

The pilot of the survey will give Medicare providers an opportunity to rate FIs and carriers on:

- Provider communications,
- Handling of provider inquiries,
- Claims processing,
- Appeals processing,
- Provider enrollment,
- Medical review, and
- Provider reimbursement.

The pilot survey will target a broad audience, including hospitals, skilled nursing facilities, rural health clinics, home health agencies, end-stage renal disease clinics, physicians, non-physicians, durable medical equipment suppliers, laboratories, and ambulance providers. Once implemented nationally, what will be called the "Medicare Contractor Provider Satisfaction Survey" (MCPSS) will include all provider types.

The pilot MCPSS will be limited to 12 contractors, including two Regional Home Health Intermediaries. CMS plans to send out pre-notification letters one week prior to official notification of the pilot MCPSS web address.

Providers who do not respond to the letters will be contacted by telephone; CMS expects key personnel at the provider organizations to disseminate the various sections of the survey to appropriate individuals within their facilities. CMS contractors will be asked to disseminate information about the surveys and encourage provider participation.

Final reports for surveys beginning in January are expected to be completed by June 2005. Rockville, MD-headquartered research organization Westat, the CMS contractor charged with conducting and overseeing the MCPSS survey process, will hold all identifying information of provider respondents in strict confidence. Information will be masked with a pre-coded identification number.

Contractors' access to survey results will be presented so that privacy is maintained; for example, results will show "total scores" for each area and identifier-masked comments received to open-ended format questions. Once the pilot is completed, contractors will receive a report of their satisfaction scores for each area evaluated. CMS indicates it does not intend to formally share results of the pilot with the public.

Ask the Experts: New Home Health HCPCS Codes for Wound Vac Supplies

NAHC Responds to Members' Inquiries and Concerns

Q: The latest list of HCPCS (Healthcare Common Procedure Coding System) codes used for home health consolidated billing, effective January 2005, included new codes 97605 and 97606. The description of these codes is "negative pressure wound therapy" (i.e., vacuum-assisted drainage collection). Does the addition of these codes mean that home health agencies must now pay for wound vac supplies and equipment?

From National Association for Home Care & Hospice Regulatory Affairs:

No. Wound vac equipment and supplies are not part of home health consolidated billing; they continue to be paid under the durable medical equipment (DME) benefit. DME supplies will continue to submit claims for wound vac equipment and supplies, using the same codes that they have always used when billing Medicare:

Canister set: **A6551**

Dressing set: **A6550**

Pump: **E2404**

The confusion surrounding this issue arose because the Centers for Medicare & Medicaid Services (CMS) assigned codes 97605 and 97606 to wound vac treatments when provided by therapists. These codes were established because certain therapy providers (other than home health agencies) are required to use HCPCS codes to describe treatment modalities on Medicare claims. The two new codes are limited to use by these therapy providers when billing for clinical services. They are not intended for billing equipment and supplies.

CMS included the wound vac therapy codes on the bundled service list and added them to claim edits. This was intended to ensure that if claims are submitted by therapy providers for these services while a patient is under a home health plan of care, the claims will be rejected since therapy services must be bundled under the home health prospective payment system (PPS).

However, home health providers must keep in mind that contracted services provided outside of the home are limited to those provided at a hospital, skilled nursing facility, or rehabilitation facility when a beneficiary's care requires equipment too cumbersome to bring into the home. Despite the fact that codes 97605 and 97606 appear on the consolidated billing list, wound vac is not a treatment that requires "equipment too cumbersome to bring into the home." Therefore, if wound vac therapy is the sole therapy it does not qualify as a service that may be provided outside of the home.

Job Corner

Position Available:

Community Health Services Administrator

Regional Health Services of Howard County in Northeast Iowa is seeking an RN with leadership experience to oversee all aspects of Public Health, Home Health and Hospice. Responsible for supervision of staff, operations, budgeting, scheduling, planning and development. Bachelor's degree preferred. Send resume to HR Dept., RSHHC, 235 8th Ave. W, Cresco, IA 52136. EOE