

the management report

an update for home care providers produced by the home care association of colorado

HCFA PUBLISHES FINAL HOME HEALTH PPS RULE

INSIDE

Congressional Reform	3-5
Rural Health Concerns	5-8
Late Breaking PPS Updates	6-7
Medicare Regs Update	8-9
Olmstead, Disability Appeals	10
Medicare Study Released	11
Hospice News	11-12

SPECIAL NATIONAL ISSUES EDITION - JULY 2000

SPECIAL ALERT

◆The Health Care Financing Administration (HCFA) published the long-awaited home health PPS rule in the July 3, 2000 issue of the *Federal Register*. The rule can be accessed at www.nara.gov (browse to Federal Register) or www.access.gpo.gov/nara.

◆HCFA's 22-page summary comparing changes between the proposed PPS regulation and the final version is available at: www.hcfa.gov/medicare/hhppssum.pdf.

◆National Association for Home Care staff has prepared an analysis that is posted on HCAC's web site at www.hcaonline.org. Following are highlights of this analysis:

EPISODE PAYMENT RATE

- ◆National standardized rate = \$2,115.30 per episode
- ◆Case-mix adjusted
- ◆Adds one time OASIS adjustment for PPS classification

SERVICES IN EPISODE PAYMENT

- ◆Medical equipment not subject to consolidated billing
- ◆HHA responsible for all supplies within scope of home health benefit
- ◆HCFA rejected the use of a fee schedule for supplies

CASE-MIX ADJUSTMENT

- ◆Lowest case mix weight = .5265 multiplier
- ◆Highest case-mix weight = 2.8113 multiplier
- ◆Refinements regarding wound care and diagnoses for burns and trauma
- ◆Limited secondary diagnosis recognition

Continued...

VISIT HCAC'S NEW WEB SITE FOR UPDATES AND NEW INFORMATION INCLUDING VIRTUAL TRADE SHOW AND FINAL PPS RULES ANALYSIS FROM NAHC!

www.hcaonline.org

- **Browse through exhibits from Annual Convention 2000
- **Read NAHC's PPS Rules Analysis
- **Read article by Dan Nicholson, President "The Miracles of Homecare"
- **Make use of PR and media templates
- **Browse updated member information (please let us know if your organization has a website and we will link to it through the member section)
- **Get updated dates and place of HCAC's 2000 education programs

The management report is published in January, April, July and October by the Home Care Association of Colorado. Subscriptions are included in association dues. Deadline for the receipt of news items, classified advertising copy and sponsorship orders is the 10th of the month prior to publication. Submit to the Editor, *the management report*, 7853 East Arapahoe Court, #2100, Englewood, CO 80112-1361. Rates are available from association headquarters.

Executive Committee

President: Dan Nicholson
Vice President: Judi DeVore
Secretary: Suzanne Hamilton
Treasurer: Sheryl Bellinger

Directors

Cecile Alderman
Susan Birch
Sue Brown
Marie Caselnova
Crystal Day
Erin Denholm
Susan Grayson
Kim Oliver
Linda Sours

Editor/Executive Director:

Ellen Caruso

EPISODE DEFINITION

- ◆Basic unit = 60 day episode
- ◆Unlimited episodes
- ◆Exceptions unchanged

EPISODE DEFINITION EXCEPTIONS

- ◆Beneficiary elects transfer; Discharge of patient with goals met with later readmission during 60 day period; Significant change in condition with case-mix assignment; Transfer or discharge exceptions lead to prorated payment (PEP) and new episode. Significant change exception leads to blended episode payment reflecting status before and after change.
- ◆No change from proposed rule except allows transfers to related HHA if outside MSA or non MSA

PARTIAL EPISODE PAYMENT (PEP)

- ◆PEP still determined based on portion of episode from first billable visit to date of last billable visit prior to transfer or discharge

SIGNIFICANT CHANGES IN CONDITION (SCIC)

- ◆Payment is a blended proration of case-mix adjusted rate prior and subsequent to change
- ◆Proration based on portion of episode from first billable visit to last visit prior to change
- ◆Combined with proration of rate subsequent to change until 60th day

LOW UTILIZATION PAYMENT ADJUSTMENT

- ◆Significant increase in per visit payment (+ 20%)
Aide - \$34.44 increased to \$43.37
SN - \$76.32 increased to \$95.79
PT - \$83.39 increased to \$104.74
SLP - \$90.79 increased to \$113.81
OT - \$83.57 increased to \$105.44
MSS - \$123.31 increased to \$153.56

OUTLIER PAYMENT

- ◆Cost outlier
- ◆Fixed dollar less amount for eligibility (\$2115.30 x 1.13)
- ◆Shared loss ratio (20 percent HHA share of loss)

BILLING PROCESS AND PAYMENT METHOD

- ◆Two bills "request for anticipated payment" at start of care
- ◆Final claims at end of episode
- ◆60% initial payment for initial episode
- ◆50% initial payment for subsequent episodes
- ◆Initial billing on verbal orders with conditions

Continued...

The Mission of the Home Care Association of Colorado is to strengthen the prominence of the home care industry as a core component of the integrated health care system.

CONGRESS CONTINUES REFORM EFFORTS

- ◆Final billing requires signed and dated POC and certification
- ◆No physician certification of HHRG required
- ◆14 day payment floor not applicable to initial bill

CoPAYMENT TRANSITION

- ◆OASIS grace period remains for post 9/1 patients
- ◆Pre 9/1 OASIS - allow HHA to perform new OASIS throughout September
- ◆Plan of care can cover as long as 90 days

COST REPORTING TRANSITION

- ◆Full 12 month cost report
- ◆Statistical break at 9/30/2000
- ◆No change in HHA fiscal year
- ◆No proration of IPS per visit or per beneficiary limits
- ◆More details to come in Manual

MEDICAL SUPPLIES

- ◆Average supply cost bundled into episode rate
- ◆Further recognition of supply costs
- ◆HHA required to provide all supplies within scope of home health benefit

OASIS COST REIMBURSEMENT

- ◆Added one time OASIS adjustment for PPS transition costs (\$5.50)
- ◆\$4.32 per episode reimbursement



It's time once again for every home care administrator, nurse, therapist and patient to contact members of our state's congressional delegation to support legislation to help home care get back on its feet. Write a letter, make a call, send a fax. Our congressional delegation is listed on the next page.

It's always best if you speak from your own experience but if you need a prompt on what to address, keep reading. The five national home health associations (of which the National Association for Home Care is one) have agreed on the following top two legislative priorities to restore and preserve the home health benefit:

- 1. Eliminate (rather than delay) the pending 15% cut in home health expenditures currently scheduled for October 1, 2001.**
- 2. Restore access to care for high needs and vulnerable patients as follows:**
 - a) authorize \$500 million in each of the next five years to be used as outlier payments under the prospective payment system for services to the most medically complex and costly patients;

Continued...

Congressional Addresses

Sen. Ben Nighthorse Campbell
380 Russell Senate Office Building
Washington, DC 20510
(202) 224-5852; Fax (202) 224-1933

Sen. Wayne Allard
513 Hart Senate Office Building
Washington, DC 20510
(202) 224-5941; Fax (202) 224-6471

Congresswoman Diana DeGette
(1st Congressional District)
1339 Longworth
Washington, DC 20515
(202) 225-4431; Fax: (202) 225-5657

Congressman Mark Udall
(2nd Congressional District)
128 Cannon House Office Building
Washington, DC 20515
(202) 225-2161; Fax (202) 226-7840

Congressman Scott McInnis
(3rd Congressional District)
320 Cannon House Office Bldg.
Washington, DC 20515
(202) 225-4761; Fax: (202) 226-0622

Congressman Bob Schaffer
(4th Congressional District)
212 Cannon House Office Building
Washington, DC 20515
(202) 225-4676; Fax (202) 225-5870

Congressman Joel Hefley
(5th Congressional District)
2230 Rayburn House Office Bldg.
Washington, DC 20515
(202) 225-4422; Fax (202) 225-1942

Congressman Tom Tancredo
(6th Congressional District)
1123 Longworth House Office Bldg.
Washington, DC 20515
(202) 225-7882; Fax (202) 226-4623

b) increase payments for home health services in rural areas by 10% to address the higher costs of delivering care in these areas; and, **c) remove medical supplies from the per episode payments under the prospective payment system** and create a budget neutral fee schedule for only the supplies that are actually used by patients.

In addition, the national associations agreed that Congress should direct the Health Care Financing Administration to:

- 1) Confine the OASIS data collection and reporting requirements to only Medicare and Medicaid patients;
- 2) Limit the OASIS assessment items to only 20 questions that are actually needed to implement the new PPS unless the costs associated with performing the full 80 question assessments during a 60 day episode of care are fully reimbursed; and
- 3) Provide for an emergency payment mechanism during at least the first six months of the new payment system to ensure that there is no interruption in payments for services.

(See separate handout on these priorities enclosed with the Spring/Summer issue of **the management report**)

Several pieces of legislation have been introduced this congressional session. It is hoped that the "best" provisions of several of the following bills will be in final legislation passed before the end of the year:

April 2000: Companion bills in the senate and house, S. 2365/H.R. 4219, call for the elimination of the 15 percent cut. Sen. Wayne Allard, Rep. Joel Hefley and Rep. Bob Schaffer are already co-sponsors of these bills. Still to sign on are Sen. Ben Nighthorse Campbell and Reps. McInnis, Udall, DeGette and Tancredo.

June 22, 2000: Two U.S. Senators and four members of the House of Representatives introduced the "Equal Access to Medicare Home Health Care Act of 2000" (S. 2766/H.R. 4727). These bills call for elimination of the 15 percent cut, provide an add-on to the base payment for patients in rural areas, a pass through for security costs, IPS overpayment relief and recognition of telehomecare as a legitimate home health expenditure.

June 21, 2000: President Bill Clinton set in motion efforts to simultaneously repair some of the unintended and harmful consequences of the Balanced Budget Act of 1997 (BBA) while at the same time enacting a new prescription drug benefit. In his proposal, the President specifically earmarked \$3 billion for home care, including a one-year delay (not the elimination) of the 15 percent cut and a full market basket update of 3.4 percent in fiscal year 2001. The President identified a total of \$21 billion

Continued...

**NEW YORK TIMES
TAKES AIM AT HOME
HEALTH CUTS**

*(excerpted from NAHC Report,
Number 859)*

**NAHC AND HOSPICE
ASSOCIATION OF
AMERICA TESTIFY
ON RURAL HEALTH
PROVIDERS TO
CONGRESSIONAL
SMALL BUSINESS
COMMITTEE**

that would be made available for additional Medicare rollbacks.

July 5, 2000: The "Medicare Home Health Refinement Act of 2000" (S. 2835) aims to provide transition assistance for home health agencies as they move from IPS into PPS. Provisions include cash flow assistance, reimbursement for unfunded PPS-related costs, reimbursement for OASIS labor costs, and creating of a fee scheduled for non-routine medical supplies.

Make your calls or write your letters today!



The prestigious news organization *New York Times* galvanized home care advocates twice in April, first with a front-page story by veteran health reporter Robert Pear entitled *Medicare Spending for Care at Home Plunges by 45%*, followed by a strongly-worded editorial condemning the "alarming" plunge in home health outlays, ascribing it to "good intentions gone awry." Pear is highly respected by health policy experts and by his media colleagues.



The House of Representatives' Small Business Committee, chaired by Representative Jim Talent (R-MO), held a hearing on the impact of the Balanced Budget Act of 1997 (BBA) on small business health care providers in rural areas, including home care and hospice. At the hearing, lawmakers heard from a panel of witnesses including William Dombi, Vice President for Law at the National Association for Home Care (NAHC), and Karen Woods, Executive Director of the Hospice Association of America (HAA), who provided detailed testimony on the impact of the BBA on home health and hospice providers and beneficiaries. In his opening remarks, Rep. Talent noted that, "Small businesses involved in the provision of ancillary services to nursing facilities, hospices, and home health patients were failing or reducing service in rural areas at a record pace." It was Rep. Talent's hope that the testimony provided at the hearing will "start a dialogue to restore the small business sector of the health care industry."

In his testimony, Dombi told the committee that as a result of BBA, **thousands of agencies across the country have closed and beneficiaries' access to care has been restricted. Moreover, as Dombi explained, many agencies are subsidizing Medicare in order to provide care to needy beneficiaries.**

Recent studies have shown that the impact of BBA is worse on rural home care providers. In his written testimony, Dombi cited a report by Project HOPE's Walsh Center for Rural Health in which they examined the

Continued...

LATE BREAKING PPS NEWS!

Relationship of submission of the request for payment (RAP) under PPS to OASIS

- ◆ The OASIS does not have to be transmitted to the state PRIOR to the submission of the RAP.
- ◆ Agencies can submit the RAP based on verbal orders.
- ◆ Agencies will have to complete the OASIS in order to generate the grouper, or HIPPS code.

HCFA has stated publicly that agencies are only required to transmit OASIS data monthly and that it is not their intent to delay billing due to this requirement.

###

characteristics of the interim payment system (IPS) and analyzed its impact on rural home health agencies and beneficiaries. **The study, entitled “*Rural Home Health Agencies: The Impact of the Balanced Budget Act,*” concludes that the reductions in reimbursement associated with IPS resulted in many home health agencies being forced to close and access to home health services in rural areas compromised.** While not making specific recommendations, the report concludes that policy makers should focus on various issues such as an agency’s case-mix and the impact of a prospective payment system (PPS) on rural areas that are served by urban home health agencies. Finally, the report notes that the impact of PPS on small, hospital-based nonprofit agencies will determine how rural agencies, most of which are smaller, hospital-based, and nonprofit, and rural beneficiaries will fare under this reimbursement environment.

Dombi urged the lawmakers to take steps to help home care providers, including those in rural areas. One recommendation was to add additional funds to establish an add-on to increase reimbursement to small volume and rural agencies. According to Dombi, both IPS and PPS reimbursement is based on national average costs and costs in rural areas often exceed national averages. Dombi also advocated for allowing rural home health agencies to adopt the urban wage index to help hire and retain employees. More flexibility is also needed in HCFA’s policy in classifying branch offices. By allowing home health agencies to establish branch offices, rural home health agencies will be able to expand their service area and serve more patients.

Karen Woods, HAAs executive director, identified the following areas as barriers to care for rural hospices. These provisions include:

- ◆ shortages of nurses, home care aides, therapists and social workers making the recruitment and retention of Medicare defined “core service” personnel (nurses, social workers, counselors) extremely difficult;
- ◆ the impact of BBA97 decrease in hospice market basket updates affects the overall functioning of hospice programs;
- ◆ insufficient reimbursement to allow for appropriate wage and benefit packages to recruit and retain qualified staff;
- ◆ lack of funding for innovative modalities such as telehealth;
- ◆ restrictive regulations that prevent a hospice provider from contracting for services of specialized nurses for infrequent hi-tech nursing procedures;
- ◆ requiring that supervision of home care aides be performed only by a registered nurse and not a licensed practical nurse; and
- ◆ restrictive regulatory definitions of hospice programs service areas based on mileage and driving time, rather than quality of care outcomes, make it

Continued...

MORE LATE BREAKING PPS NEWS!

PPS Transition & Grace Period

A beneficiary that is under a home health plan of care as of September 1, 2000 -- or a new patient that comes on service on or after September 1 -- may have a one time grace period allowing for a plan of care that lasts up to 90 days (through and including November 29, 2000).

For patients under a home health POC on or after September 1, 2000, the agency may either do a follow-up OASIS assessment or use the most recent OASIS assessment on file for September to generate a grouper for the first PPS episode, obtain orders to cover through 11/29 and create a POC. The POC, however, must document services provided before 10/1 (these will be paid under current IPS system) and those services provided after 10/1 (these will be paid the per episode rate under PPS.)

For patients on service on or after August 1, agencies can complete a followup OASIS assessment at any time during the month of September to establish the grouper to case-mix adjust the patient for the first PPS episode.

(See *Federal Register*, beginning on page 41166)

extremely difficult and sometimes, even impossible for a hospice program to provide services in rural areas.

In response to these issues, the HAA's Advisory Board has developed the following recommendations to help hospices, both rural and urban, survive and expand their Medicare services. These recommendations include:

- ◆ Funding grant programs for training therapists, medical social workers, nurses, home care aides and other hospice personnel with a focus on providing home and community based practice in areas where shortages exist;
- ◆ Amending § 1861(dd)(2)(A)(ii)(I) of the Social security act by including a provision allowing certain specialized high -tech nursing services to be provided by contract, under the direction and supervision of the hospice;
- ◆ Enacting legislation to allow LPNs to supervise home health aides under the general supervision of an RN when permitted by state nurse practice acts;
- ◆ Providing that federal programs that finance hospice services adjust reimbursement to allow for appropriate wage and benefit levels for all clinical staff;
- ◆ Clarifying the definition of hospice multiple sites service area, establishing a uniform, reasonable, and up-to-date policy that focuses on the ability to provide quality care and positive outcomes rather than imposing arbitrary and ineffective time and distance requirements;
- ◆ Clarifying legislatively that telehealth constitutes a service provided by a hospice and Medicare should provide appropriate reimbursement for technology costs for rural hospice providers; and
- ◆ Restoring the reductions in the market basket updates enacted in BBA97 and the 1999 omnibus appropriations measure to the Medicare Hospice Benefit.

Testifying on behalf of HCFA was Kathy Butto, Deputy Director for Health Plans and Providers, who told the panel that access to rural care was a priority. She disputed assertions that the BBA has created access issues in rural areas and outlined a number of recently enacted legislative provisions designed to alleviate some of the unintended consequences of the BBA. For home care, these provisions include: delaying the 15% reduction in reimbursement until one year after implementation of the prospective payment system (PPS), an adjustment to the per beneficiary limits for certain agencies, assistant payments to agencies to help cover OASIS costs, and excluding consolidated billing from PPS.

Continued...

***A Vision
for the
Home Care Association
of Colorado***

*By the year 2000,
home care will be
the primary choice
in the integrated
health care system.*

**MEDICARE
REGULATORY
UPDATE**

Butto also outlined various recent administrative actions taken by HCFA to assist home care providers. These actions include extending the time frame for agencies to repay overpayments resulting from the interim payment system (IPS) from one year to three, with the first year interest free. In addition, HCFA has postponed the surety bond requirement for home health agencies until October 1, 2000. Finally, HCFA eliminated the "sequential billing" requirement that created cash flow problems for many agencies.

HCFA has launched a new Rural Health Initiative to evaluate access to rural care and to better coordinate services. HCFA has also stepped up its efforts in the area of telehealth. HCFA recently completed a \$2.3 billion technology assessment of telemedicine that explored the cost-effectiveness of telemedicine, specifically looking into the areas of store and forward, patient self-testing and monitoring, and potential telemedicine applications for nonsurgical medical services. HCFA is also conducting a demonstration project to test expanded coverage for telemedicine to include teleconsultations in Medicare.

Both NAHC and the HAA commend the House Small Business Committee and its chairman, Rep. Talent, for holding a hearing on this important issue. NAHC and HAA are committed to working with Chairman Talents and the other members of the Small Business Committee to help ease the administrative burdens and low reimbursement rates that hamper the ability of rural home health agencies and hospices to provide quality services to eligible Medicare beneficiaries.



Physician Electronic Signatures

Most home health fiscal intermediaries, including Colorado's primary intermediary CAHABA, will accept physician electronic signatures if the following criteria are met:

1. Appropriate authentication and dating of the signature;
2. Safeguards to prevent unauthorized access; and
3. The ability to reconstruct the records in the event of a system breakdown.

In addition, most FIs require the agency using physician electronic signatures to submit a copy of its policy in writing for the FI's file.

The National Association for Home Care advises home health agencies that in the event the FI does not know the agency is accepting electronic signatures, and the FI denies a claim based on "no physician signature" the

Continued...

agency should attempt to get the denial reversed on reconsideration by submitting the appropriate documentation, including a copy of its electronic signature policy.

HCFA Issues Guidance on Itemized Statements for Beneficiaries
The Health Care Financing Administration (HCFA) recently announced that home health agencies must provide an itemized statement of services within 30 days after receiving a written request from a beneficiary or risk a civil monetary penalty of \$100.

HCFA suggests that the following information be included: beneficiary name, date(s) of service, description of item or service furnished, number of units furnished, provider's charges, and an internal reference or tracking number. If Medicare has adjudicated the claim, HCFA suggests that additional information be included, such as amounts paid by Medicare, beneficiary responsibility for coinsurance, and Medicare claim number. Finally, the statement should include a name and telephone number for the beneficiary to call if there are further questions.

Influenza and Pneumococcal Vaccine Payment Changes
Payment to home health agencies for flu and pneumonia vaccine and their administration will be made by Medicare under the Out Patient PPS. Home health agencies will be required to submit 34X bills and payment rates will be based on the national average which will be cost-adjusted by geographic area. The current national average payments are:

Type	Vaccine Administration	Vaccine
Influenza	\$ 4.44	\$3.88
Pneumococcal	\$11.77	\$3.91

OASIS User's Guide

The Health Care Financing Administration (HCFA) updated the OASIS User's Manual and changed it to a three part format. The manual is available at the HCFA website: www.hcfa.gov/medicaid/oasis/usermanu.htm#guide and includes:

Part 1 - Implementation Manual - Changes are expected now that the PPS regulation has been published

Part 2 - System User's Guide Version 1.2 and error Messages and Description Guide

Part 3 - HAVEN system Reference Manual. Updated April 2000 and contains information about HAVEN 3.0 that also can be printed from the HAVEN 3.0 CD that was distributed to all agencies registered to receive it.



**SECRETARY OF
HEALTH AND
HUMAN SERVICES
(HHS)ISSUES
DIRECTIVE TO
GOVERNORS
REGARDING
OLMSTEAD
DECISION**

The National Association for Home Care reports that Donna Shalala, Secretary of the Dept. of Health and Human Services (HHS), has issued a directive to governors across the country regarding a state's responsibility to prevent discrimination against individuals with disabilities through unnecessary institutionalization.

According to NAHC, the directive was triggered by the recent Supreme Court decision in *Olmstead v. L.C.* which held that states are required, subject to certain limitations, to provide community-based services for persons with disabilities who would otherwise be entitled to institutional-based services. The Supreme Court ruled that placing an individual with disabilities in an institutional setting would violate the Americans with Disabilities Act (ADA) when treatment professionals would reasonably determine that community-based placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services. The Court also determined that each state should have a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings unless a "fundamental alteration" of a program would be required to achieve community-based integration of the disabled individuals.

Shalala's letter to the governors was supplemented by a letter to all state Medicaid directors which outlines a series of recommendations from HCFA setting out principles for compliance with the ADA. HCFA has announced it intends to establish an ongoing consultation process which allows the federal agency and state Medicaid programs to address issues and questions regarding ADA compliance consistent with the *Olmstead* decision.



**COURT RULES
ON DISABILITY
APPEALS**

The U.S. Supreme Court handed down a 5-4 decision in mid-June that should help claimants who appeal denials for disability benefits to Federal District Court. The decision said claimants can raise issues about their disability that were not discussed during previous administrative appeals. Prior to The Supreme Court's decision, claimants had to exhaust all issues during appeal hearings with administrative law judges. Issues about their disability could not be raised at Federal District Court if those issues were not initially heard by an ALJ. The ruling applies to appeals filed for Social Security Disability Insurance and Supplemental Security Income. The case is *Sims v. Apfel*, Commissioner of Social Security.

VANDERBILT U RELEASES STUDY

WASHINGTON, May 2 - Wide gaps between policy makers and health care leaders about the problems facing Medicare are drastically affecting any chance of reforming the Medicare system - which currently provides health care for more than 40 million Americans - according to a study released in May by Vanderbilt University Medical Center (VUMC). These gaps, which exist in beliefs about the impact reduced reimbursement has on the quality of patient care, the accuracy of government data as compared to commercial data, and even the future validity of the program, are driving wedges into any potential reform efforts.

The first-of-its kind leadership survey queried top leaders in the government, health, finance, academic and private sector, to ascertain areas of agreement and discord related to reforming the Medicare system. Among the critical findings were:

- Three of four physicians and more than half of non-physician leaders polled have seen patient care compromised due to cutbacks mandated by the 1997 Balanced Budget Act (BBA).
- Nine of ten respondents express an extreme lack of confidence in the data used by HCFA to establish and evaluate Medicare policy.
- More than any other group surveyed, physician leaders and policy makers overwhelmingly support expanded Medicare benefits to include prescription drug coverage.
- All groups except policy makers and insurers believe the American public shows a serious lack of concern about the future of Medicare.
- Sixty five percent of policy makers believe that reimbursement schedules ensure that beneficiaries receive quality care, while only 21 percent of physicians believe this to be true.
- Almost all employers surveyed (90%) believe that geographic variability of health care will greatly impact the costs of the insurance they provide to their employees and retirees.



HOSPICE NEWS

The Hospice Association of America is seeking input from home health agency-based hospice providers regarding the proposed hospice cost report worksheets, schedules and instructions that are part of the proposed Home Health Agency Cost Report (HCFA-1728-94). The proposed changes can be found in the June 5, 2000 *Federal Register* (Vol.65, No.108) pp.35652-35653 or by visiting www.hcfa.gov/regs/prduct95.htm. Formal comments must be sent to HCFA by August 4th. Send copies of comments to HAA at kpw@nahc.org.

* * *

HCFA sources state that the revisions to the Hospice Conditions of

Continued...

Participation should be released for comment by October/November, 2000.

* * *

HCFA has a website specifically for hospice material related to survey and certification issues. (See page 18 of the Spring/Summer 2000 issue of the management report for the link.)

* * *

HCFA has notified regional offices that Medicare certified hospice providers are bound by Advance Directive requirements and may not refuse to have staff skilled in resuscitation or refuse to revive a patient who desires to be resuscitated.

**HCFA PUBLISHES SUMMARY OF
UTILIZATION
PATTERNS
BY STATE**

Colorado followed the rest of the nation in an alarming reduction in numbers of visits and reimbursement per Medicare patient in 1998, compared to the previous year.

The number of visits and total reimbursement were both down by almost 50% in 1998 while the total number of patients was down by only about 15 percent.

In 1998, Colorado providers performed less visits per patient at less cost per patient than the national average. Colorado agencies averaged 42 visits per Medicare patient in 1998 vs. 67 in 1997. Average reimbursement per patient was \$2,949 in 1998 vs. \$4,739 in 1997.

