CSIS 325- Project Phase I - Instructions

**Health Care Options, Inc.**

Health Care Options, Inc. (HCO) is a home-health care facility located in the heart of the Blue Ridge Mountains. It supports local residents within a 50-mile radius by providing home health care services that range from medication administration, catheterization, and wound dressing to bathing, dressing, and feeding. These services are administered by skilled nurses and home health aides who are employed by HCO. The management staff includes a receptionist, two co-owners/managers, and an accountant.

Patients receive services based upon a doctor’s written referral. Referrals consist of the type of care needed (i.e. skilled nursing or home health aide), the equipment needed to provide the services (i.e. albuterol and breathing apparatus for breathing treatments, syringes, catheters, etc.), and a description of the care needed (i.e. change wound bandages twice per week, provide baths every other day, etc.). Payment for services can occur in one of four ways: Medicare Part B, Medicaid, private insurance, and private-pay.

In cases where Medicare or Medicaid is used, payment is received based upon a cost-reimbursement basis. This basis is calculated by determining total direct costs for all home visits, plus an allowable amount for overhead. Direct costs include both labor and inventory. Labor consists of a standard rate for a nurse or aide, depending on the services needed. A nurse currently has a standard cost of $150 per hour, while an aide has a standard cost of $47 per hour. Inventory is another direct cost. Inventory consists of items such as various types of syringes, gauze, catheters, etc. All inventory is currently provided by a single medical supplier, Blue Ridge Medical Supplies, which provides a list of all of its medical supplies and prices on a quarterly schedule. Prices are subject to change from quarter to quarter, and the company uses a weighted-average inventory method to keep track of the cost of inventory that is purchased and used.

Using the direct cost data that is accumulated throughout the year, HCO submits an annual cost report to its Medicare/Medicaid Intermediary on December 31. This cost report includes a total of direct costs as well as the indirect costs of the business. Indirect costs include salaries of staff personnel, rent, utilities, and other miscellaneous office supplies. Total direct costs and indirect costs are totaled in the annual cost report, and a per-patient cost reimbursement rate is determined by dividing the total costs (both direct and indirect) by the total number of patient visits. It is this cost-reimbursement rate that is billed to the Medicare/Medicaid home office when a home health care visit is incurred. Note that the direct costs that are accumulated and submitted within the cost report are only those costs associated with Medicare/Medicaid patients. Private pay and insurance patients are excluded from these calculations. Total indirect costs are included in the cost report submission as they cannot be directly traced to any individual patient or patient type.

For patients with insurance, a pre-determined rate per visit is negotiated with each insurance company. The rate-per-visit per insurance company is currently stored in an Excel spreadsheet. This rate per visit is based solely upon the skill level of the care provider. For instance, an RN has a skill level of 10, whereas an LPN has a skill level of 7, and an aide has a skill level of 3. An entry in the spreadsheet indicates that for All-Insurance (a local insurance company), any visit provided by a staff member with a skill level above 5 is reimbursed at a rate of $238 per visit, up to a maximum of 30 visits in a three-month period. Most other insurance companies also provide a rate for a range of skills levels up to a maximum number of visits within a given duration (usually in months). Once this maximum has been exceeded, a patient’s doctor must write a new referral. This referral serves as the basis for a new contract between the patient and HCO.

Private pay patients are unique in that a different rate is negotiated with each patient. That is, a contract is signed with each patient that requires the patient to pay a certain amount for each home health care visit up to a maximum number of visits. This maximum number is also negotiated and included in the patient’s contract.

Contracts are required for every patient who receives services. Contracts include the type of services performed (i.e. wound dressings, bathing, etc.), the number of visits per week, the supplies used in the provision of these services, and the duration of services needed. Naturally, the contract includes the type of payment (Medicare, Medicaid, insurance, or private pay) to be used. Contracts are assigned start and end dates based on the terms of the referral, or in cases where the method of payment is insurance, the duration of the contract is the lesser of the term specified in the referral or the constraints of the insurance company. In most cases, doctors write referrals that are within the allowable duration that most insurance companies stipulate.

Scheduling is a major issue in home health care. It is important to match the needs of the patient with the skills of the nurse or aide. Additionally, the geographic location of the patient must match the geographic location of the nurse or aide providing the services. Currently, zipcode is used to match the locations of patients to their home health care providers. One additional component of the scheduling feature is the availability of the care providers. Some nurses and aides are available seven days per week, while others work a part-time schedule-- perhaps on Mondays, Wednesdays, and Fridays only. An important feature of scheduling is to match not only the skills and geographic locations of patients with providers, but also to match the *availability* of care providers with the frequency of visits needed by the patients. In cases where no match is found for a patient and provider based on these factors (geography and availability), notices are sent to the managers, who must individually assign nurses/aides who are outside of their geographic areas or days of availability. These exceptions are rare, but when they occur, management pays an additional stipend to its nurses/aides who must work outside of their locations and/or days available. No replacements are ever made when skill sets of providers do not match the needs of patients. In these circumstances, a patient’s doctor is immediately notified to allow the patient to receive in-hospital or rehabilitative care, and the existing contract is nullified. This situation only occurs when a nurse/aide who provides a specialized care subsequently leaves the company, and no other health care professionals are available with the same skill set in the company.