Home Health
BUSINESS REPORT

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A WEEKLY REPORT ON NEWS, TRENDS & STRATEGIES FOR THE HOME HEALTHCARE EXECUTIVE

MedPAC readies home care recommendations for Congress

By MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – The Medicare Payment Advisory Commission's (MedPAC; Washington) March Report to Congress will likely recommend several significant changes in the Medicare home health benefit. These changes could include co-pays on home care visits, requirements for independent case managers, and changes that narrow the scope of available home care services and could have a major impact on the industry if adopted by Congress.

As part of the Balanced Budget Act of 1997, Congress merged the Physician Payment Review Commission with the Prospective Payment Assessment Commission to create MedPAC. The permanent advisory panel, which is headed by former **Health Care Financing Administration** (Baltimore) Administrator Gail Wilensky, submits

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M&A activity in home health takes 56% tumble in 4Q98

By MEREDITH BONNER
***HHBR* Editor**

There were 56% fewer mergers and acquisitions reported in the home health sector in 4Q98 than in 4Q97, and industry experts attribute the decline to "unfavorable changes to the reimbursement protocols," which, they say, "have driven many potential acquisition candidates out of business."

According to the results of **Irving Levin and Associates**' (New Canaan, CT) fourth quarter report on the M&A market in the healthcare services industry, there were 11 transactions publicly reported in home health in 4Q98. That number also dropped from 3Q98 by 26.7%.

"It's plain and simple; with the new Medicare reimbursement for home health, all of a sudden it was not profitable to stay in Medicare business, which was a big portion of the industry," Stephen Monroe, a partner at Irving Levin,

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Grassley introduces UPN bill to revamp Medicare billing for DME

BY MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – Sen. Charles Grassley (R-IA), Chairman of the Senate's Special Committee on Aging, and the Committee's ranking Democrat, Sen. John Breaux (D-LA), last week introduced legislation that would require the use of universal product numbers (UPN) for all durable medical equipment (DME) billed to the Medicare program. The bill – the Medicare Universal Product Number Act of 1999 – is designed to improve the **Health Care Financing Administration**'s (HCFA; Baltimore) ability to accurately track the value of DME paid for by Medicare.

"We have medical suppliers giving patients the cheapest products and getting paid for the most expensive products. The whole system is out of whack," Grassley said in introducing the bill. "Better billing codes would help make sure the taxpayers get what they pay for."

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HHS tells Congress PPS on track

WASHINGTON – **Department of Health and Human Services** (HHS; Washington) Secretary Donna Shalala told Congress earlier this month that the **Health Care Financing Administration** (HCFA; Baltimore) is leaning toward a per-episode rather than a per-visit prospective payment system (PPS) for home care. Shalala reported that HHS's per-episode PPS demonstration project reduced the cost per episode by 13% and utilization by 17%, while the per-visit demonstration actually increased the number of visits rendered.

Shalala reassured Congress that PPS will be in place by the Oct. 1, 2000, deadline, but industry observers were immediately alarmed by the timeframes she outlined. For example, HCFA will only have "approximately 30 days of national OASIS data on hand for the standardization of rates" when it must draft the proposed rule. The report indicates that agencies will begin collecting OASIS data next month and reporting that data in April. According to this timetable, the proposed rule would be published in the *Federal Register* in October, followed by a final rule in early 2000. ■

Bill

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Reps. Louise Slaughter (D-NY) and Amo Houghton (R-NY) have already introduced a similar bill in the House. Slaughter called Medicare's current system of tracking DME "a little like the game of Clue." Said Slaughter, "We are never quite sure precisely who got what when."

Grassley pointed to last year's **General Accounting Office** (GAO; Washington) report which recommended major changes are needed in the way Medicare pays for DME including UPNs. In its May 29 report to Grassley's Aging Committee, the GAO concluded that under the current reimbursement methodology for DME, HCFA does not know specifically what products it is paying for because the only product identifiers on its claims are billing codes that cover "a broad range of product types, quality, and market prices."

"Since Medicare pays the same fee for all the products billed under the same HCFA Common Procedure Coding System (HCPCS) code," said the GAO, "suppliers have a financial incentive to provide patients the least costly product covered by the code" but "bill Medicare the full fee schedule allowance regardless of the product provided."

In fact, the DME industry strongly supports this legislation and was instrumental in its development. "We've been involved in the development of the bill," Erin Bush of the Health Industry Distributors Association (HIDA; Alexandria, VA), told HHBR. "We worked with the GAO on their report and we're one hundred percent behind this bill."

The industry's reasons for supporting the bill are twofold, said Bush. First, it would eliminate a lot of the confusion created by HCPCS. "Our members run into this daily when they try to bill medical equipment to Medicare," she said. "They are constantly operating under the threat that if the bill incorrectly they could be charged with a violation of the Small Claims Act which carries up to $10,000 in fines."

In addition, Bush said that UPNs, which are numbers included at the bottom of a bar code, would facilitate the use of bar codes and electronic data interchange (EDI) technology which in turn would greatly improve the movement of product through the distribution chain. According to Bush, this would allow DME suppliers to set up automatic bar scanners at warehouse entries and exits and implement electronic billing, 'in-time delivery', and other modernizations.

Grassley introduced similar legislation last year, but that bill was never passed by Congress. The DME industry is optimistic that Grassley's bill will pass this time around. It might be attached to Medicare reform legislation that might emerge later this year or a fraud and abuse bill that is also considered likely. ■

CORPORATE LADDER

• **Simione Central Holdings** (Atlanta) has named Jack Arthur senior vice president of product management and development, reporting to Chairman/CEO Barrett O'Donnell. Arthur will assume leadership responsibilities for the development and management of product lines as well as technology standards and direction. Prior to joining Simione, Arthur held executive management positions with several healthcare systems companies, the most recent being **Eclipsys** and **Shared Medical Systems**, working with both clinical and financial systems.

• **Home Care Information Systems** (Bloomfield, NJ) has promoted Suzanne Sblendorio, a veteran in the home care industry and a leading business strategist, to chief operating officer from senior vice president of operations and development. In her new position, Sblendorio will oversee the entire operation of HCIS, focusing on the company's product strategy and customer management. In doing so, Sblendorio will look to expand the company and increase its growth in the home care marketplace. Sblendorio's appointment follows the recent resignation of Steven Griff as President.

• **Bindley Western**'s (Indianapolis) Drug Company division has appointed Paul Wagoner to the position of Division Manager. Wagoner will head the operations of Bindley Western Drug Company's new distribution center in Kansas City, MO.

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COMPANIES IN THE NEWS

LTTR to become largest CCSE shareholder

Community Care Services (CCSE; Mt. Vernon, NY) has been advised of the execution of a letter of intent covering the sale of 2.1 million shares of CCSE common stock by the company's former president/CEO, Alan Sheinwald, to **LTTR Homecare** for an undisclosed purchase price. The payment of a portion of the purchase price is contingent upon the purchaser receiving reasonable assurance on or before April 1, 2000, that the ongoing federal investigation involving CCSE is no longer open or active. CCSE continues to cooperate fully with federal authorities, but cannot at this time predict when or if this matter may be resolved.

The transaction is subject to the approval by the board of directors of CCSE on or before Feb. 8, 1999. A closing will occur on or before the 15th business day following board approval. Upon closing and the receipt by LTTR of Sheinwald's 2.1 million shares, LTTR will become CCSE's largest shareholder. LTTR is an affiliate of **Landauer Hospital Supplies** (New York), a supplier of durable medical equipment and respiratory products.

HHCA to trade on Nasdaq SmallCap

Home Health Corp. of America (HHCA; King of Prussia, PA) said last week that its common stock will continue to be listed on the Nasdaq SmallCap Market because the company received an exemption from the $1-per-share minimum bid price requirement. The company said the exemption will expire April 20. While HHCA failed to meet the minimum bid price requirement, the company was granted an exception from this standard. If the company is able to demonstrate compliance with all the requirements for continued listing on or before April 20, it will have met the terms of the exception and will continue to be listed on the SmallCap Market. HHCA officials said the company expects to meet the requirements.

Interim teams with Crosby Marketing

Interim Healthcare (Annapolis, MD) has named **Crosby Marketing Communications** (Annapolis, MD) its agency-of-record following a nationwide review. The agency's first assignment, said Interim, is to create the next phase of Interim's national image and awareness advertising campaign focused on "Trust." Crosby Marketing will also assist with marketing research, targeted promotions, and web site development. Projected 1999 spending is $2 million.

PSAI fails to meet quorum

Pediatric Services of America (PSAI; Norcross, GA) adjourned its annual meeting until Feb. 2 after failing to reach a quorum. PSAI said the lack of sufficient votes was due to unavoidable delays in the delivery of proxy materials to shareholders. The company said it expects to have a quorum by Feb. 2.

Priority Healthcare's spin-off complete

Priority Healthcare (Altamonte Springs, FL) recently announced the completion of the spin-off and distribution of the roughly 82% of Priority Healthcare common stock to the shareholders of its former parent company, **Bindley Western** (Indianapolis). The distribution was completed on Dec. 31. Shareholders of record received .448 shares of Priority Healthcare class A common stock for each share of Bindley Western common stock held on Dec. 15. Bindley Western has received the opinion of **PricewaterhouseCoopers** to the effect that this distribution generally will not be taxable for U.S. federal income tax purposes to Bindley Western and its common shareholders.

Although the class A shares will not be listed on any securities exchange or automated dealer quotation system and their will be no trading market for the class A shares, they are valued the same as the Priority Healthcare class B common stock and will be converted into class B shares on a share-for-share basis when sold. Therefore, it is not necessary to convert the class A shares to class B shares prior to the sale of class A shares. Class A shares carry three proxy votes and class B shares carry one vote. Shareholders holding the class A shares may sell the shares at anytime without restrictions. The two classes of Priority Healthcare common stock vote together as a single class.

Staff Builders records expense of $29M

Staff Builders (Lake Success, NY) said that during 3Q99 ended Nov. 30, the Medicare fiscal intermediary completed and issued the results of audits performed for the fiscal year ended Feb. 28, 1997. Additionally, the company has reached a settlement for a portion of state Medicaid liabilities. Based upon the company's assessment of these matters and its estimate of liabilities for subsequent audit periods, it has recorded an aggregate expense of $29 million in the quarter ended Nov. 30, 1998. The company continues to appeal certain audit findings, which can take several years to resolve, and has engaged outside professional advisors to support the company's positions on these issues, while concurrently negotiating deferred payment terms for amounts payable to the respective agencies, officials said.

As a result of the company's operational restructuring, including the closure and conversion of many home healthcare locations from franchise to company-owned operations, restructuring costs of $4.5 million are included in the quarter's results. Included in this amount is the write-off of goodwill and fixed assets related to closed locations, the write-off or reserve for receivables generated from converted franchise locations, the accrual for employee

severance payments, and other related costs. Additionally, another $4.5 million was recorded, including the write-off or reserve of receivables from existing franchise and other company owned locations and other costs. The total of the foregoing charges aggregate $38 million in 3Q99.

Revenues during Staff Builders' 3Q99 reached $99.4 million, a decrease of 24.3% from 3Q98 revenues of $131.3 million. The company recorded a net loss in 3Q99 of $45.4 million, $1.99 per share, compared to a net income in 3Q98 of $1 million, 4 cents per share.

On Jan. 14, the company's bank, with which it has a secured credit facility, provided Staff Builders with written notification that, in its opinion, the company's non-compliance with certain financial covenants constitutes an event of default under the terms of the credit facility agreement. Those covenants require the company to maintain a minimum level of net worth and a maximum ratio of senior debt to net worth, failures which resulted from the charges to the company's 3Q99 results.

The bank has reduced the maximum amount which can be borrowed under the facility from $50 million to $40 million and has increased the rate of interest to 2% and 2.75% over the prime lending rate on its revolving line of credit and its acquisition line of credit, respectively. The bank has advised the company that while it has no obligation to provide additional advances, it is willing to consider making additional advances to the company under such conditions as it may determine. Staff Builders is in the process of negotiating with the bank as well as exploring other financing alternatives, officials said.

Star Multi Care adopts restructuring plan

Star Multi Care (Hicksville, NY) said that during the quarter ended Nov. 30, the company initiated a restructuring plan primarily to aggressively respond to the new reductions in Medicare reimbursement for the company's Medicare agency, **Star Multi Care Services of Florida**, doing business as **American Healthcare Services**, by fundamentally reshaping the company for long-term growth in the changing environment. Restructuring costs include an accrual for the settlement of a lease at an abandoned facility of $300,000 and severance pay and payroll related benefits of $176,346. After giving effect to these and prior restructuring efforts, combined with service utilization adjustments projected for the remainder of FY98-FY99, the company expects to reduce costs to meet the reimbursement shortfalls without any further material adverse effect to the company.

Net revenues for the quarter decreased 16% to $12.8 million from $15.2 million in 3Q97. The decrease is primarily attributable to a reduction in net revenues from American Healthcare Services due to the restructuring. The company reported a net loss in 3Q98 of $101,336, 2 cents per share, compared to a net income of $496,214, 10 cents per share. ■

M&As

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told *HHBR*. "It made a lot of companies go from the black to the red," which he said is one factor in the significant drop in the number of M&As in the industry. Monroe also said that a lot of companies did not want to make offers to buy other companies' operations, when they could just go into the market and pick up patients being dropped.

Lenders were also nervous about how people were going to pay off loans, he said.

"A lot of people suddenly turned pessimistic in a industry that had recently showed a lot of promise."

Monroe also told *HHBR* that the industry, in such hard times, didn't help itself.

"There has been a lot of true fraud and non-consistency," he said, "but that's not the majority, I don't think.

"All of this has impacted the mergers and acquisition market, as is plain to see in the numbers."

But Monroe told *HHBR* he is optimistic the industry will eventually bounce back.

"Congress is finally seeing that there is more to life than impeachment and that no one intended for home health to be put out of business from the Balanced Budget Act," he said.

But Monroe said that while President Clinton and Congress seem to be paying closer attention to the industry, the attention will not affect the M&A activity in the near term.

"It's great; it needs to be done, but none of it will affect the M&A market for a while," he said. "It will take a while to filter into the M&A market if there are any economic changes. There will still be deals, people will still be buying and selling, but the volume will stay low for at least the first half of 1999."

Monroe calls Clinton's recent long term care proposal "just the tip of the iceberg. It doesn't accomplish anything other than it's a tiny, tiny step in the right direction," he said.

In the healthcare industry as a whole, according to the report, there were 206 transactions that were publicly traded during 4Q98, down 23.1% from the 268 deals in 3Q98.

"This is the lowest level of healthcare merger and acquisition activity since the end of 1995 and the beginning of 1996, when an average of 200 deals were announced each quarter," said Monroe. ■

CALENDAR

• The **Illinois Home Care Council** (Chicago) will hold its 1999 annual conference and exposition on March 3-5 in Springfield, IL. The council expects more than 350 healthcare providers and exhibitors to attend the meeting entitled "Putting the Pieces Together." The conference will offer three workshops and more than 60 exhibitors. ■

REGIONAL DIGEST

• The **Eddy Visiting Nurse Association**'s (Albany, NY) home care division, which received accreditation from the **Joint Commission of Accreditation of Healthcare Organizations** (JCAHO; Chicago) in December 1995, will be issued a re-accreditation survey this week. The purpose of the survey is to evaluate the agency's compliance with national JCAHO standards and to determine whether, and the conditions under which, accreditation should be re-awarded.

• **United Health Group** has completed its affiliation with the home care and hospice services of **Valley VNA Health Systems of Neenah** (Neenah, WI), reported *The Post-Crescent* of Appleton, WI. **United Health Home Care** now includes **United Health Visiting Nurses**, **Valley VNA Homecare and Hospice**; and **Morton Medical**. Valley VNA Homecare and Hospice and United Home Health Care are in the process of integrating services and consolidating operations. The new operating unit will be known as **United Health Visiting Nurses**, pending a corporate name change to be announced later this spring. Both United Health Visiting Nurses and Morton Medical's operations will also be moving into renovated facilities at the current Valley VNA facilities later this year. United Health Visiting Nurses will also open new offices at Appleton Medical Center.

• The **Canadian Association for Community Care** (Ottawa, Ontario) last week released the final report of the National Respite Care Project. The report demonstrates the need to recognize caregivers who tend to be unpaid family or friends as an integral part of Canada's healthcare system. The National Respite Care Project calls on health ministers across the country to bear the financial cost of providing respite programming for caregivers who actually provide the majority of long term care in Canada. In fact, the final report confirms that institutionalization, or the periodic provision of home-based care, is relatively rare. According to the report, most seniors who require help receive it from informal networks, and the respite needs of their caregivers are significant. The report concludes that Health Canada must encompass flexibility and diversity into their policies and guidelines to better serve and address the issues that affect all of its caregivers. The research team found that overall, the healthcare system does a poor job of meeting the needs of caregivers. The federal government must provide support for the millions of Canadians who care for their family members and friends, which these caregivers often do "at risk to their own well-being," according to the report. ■

MANAGED CARE REPORT

• **SelectCare** (Detroit) has named James Forshee senior vice president and chief medical officer. In his new position, Forshee will be responsible for the overall leadership of SelectCare's medical administration and quality management activities. Prior to joining SelectCare, Forshee was medical director for clinical affairs at **Blue Care Network of Michigan**.

• **Merck-Medco Managed Care** (Montvale, NJ) has launched the Optimal Health Inspirations Asthma Management Program. The company hopes, with the new program, to help people ages 6 and above with asthma manage their disease and the events that occur because of it. The program now has 16,000 plan members enrolled. Program interventions include questionnaires to assess current asthma therapy, symptom control and tolerance to the patient's prescribed regimen, newsletters, refill reminders, and peak-flow meters for monitoring. The Inspirations program is based on the 1997 Guidelines for the Diagnosis and Management of Asthma established by the **National Asthma Education and Prevention Program**.

• **PacifiCare Health Systems**' (Santa Ana, CA) foundation has awarded grants totaling more than $1 million to 118 charitable organizations in the United States and Guam. These grants bring the PacifiCare Foundation's donations for 1998 to $2.5 million. **PacifiCare of California**, which covers more than 50% of the HMO's total membership, awarded 69 grants totaling more than $600,000. Four organizations in Oklahoma shared more than $34,000, and in Oregon, grants totaling $51,000 were awarded to seven groups. Nine additional Texas organizations were rewarded with more than $79,000, and in Washington, about $50,000 in grants were awarded to six organizations.

• **Blue Cross and Blue Shield of Massachusetts** (BCBSMA; Boston) has agreed to pay the federal government $4.75 million to settle demands by the U.S. **Department of Health and Human Services** (HHS; Washington) that BCBSMA reimburse the federal government for Medicare overpayments. The claims relate to reimbursement of Medicare payments for healthcare services provided to Medicare beneficiaries whose expenses should have been paid by group health plans insured or administered by BCBSMA. The company also agreed to furnish information to the **Health Care Financing Administration** (HCFA; Baltimore) that would identify instances where healthcare providers may have been reimbursed both by Medicare and private insurers; to maintain procedures that would insure the company properly pays Medicare Secondary Payer claims in the future; and to inform HCFA of situations where the company was the primary payer for Medicare beneficiaries. ■

MedPAC

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recommendations to Congress each year on proposed changes in the Medicare program.

At its Jan. 15 meeting, MedPAC discussed five draft recommendations: 1) Establish clear coverage and eligibility guidelines in law; 2) Medicare bills should describe services provided during visits; 3) Require independent assessment of need for individuals receiving extended care; 4) Implement beneficiary cost sharing for home health services; and 5) Collect common data elements across post-acute care settings.

All of the draft recommendations discussed at the Jan. 15 meeting were already on the table when MedPAC met in December. In fact, many of them have been on the table for years.

"Many of these proposals, and the discussion around them, have remained substantively unchanged over recent years," **National Association for Home Care** (NAHC; Washington) President Val Halamandaris wrote Wilensky following the commission's December meeting. "IPS, physician certification requirements, multiple audits, increased denials, and other concurrent administrative requirements have forced home care providers to carefully consider which patients they can lawfully accept, significantly reduce lengths of stay and visits per patient, and look for other ways to provide care as efficiently as possible," Halamandaris asserted.

At least some commission members acknowledged these changes. "The world has changed because instead of having a payment system whereby people who provided home health services were paid for each visit, there are now limits," said commission member Judith Lave. "In fact, the agency can bump up against its limits, and its payment rates would go down. So that's where the incentives for these long stays that we were concerned about, in fact, have decreased."

MedPAC's home health specialist Louisa Buatti told the commission, however, that setting payment rates that create incentives for providers to furnish clinically appropriate high quality care is difficult. "It's important for payment systems to employ other mechanisms to support the payment rates," said Buatti.

"Current home health eligibility coverage guidelines are "broad and difficult to enforce," she said. "An individual may qualify for the home health benefit if he or she is confined to the home and in need of skilled care as certified by a physician, and once eligible to receive the home healthcare, a beneficiary may receive an unlimited number of services."

Buatti noted that the Secretary of **Health and Human Services** (HHS; Washington) is required by the BBA to submit a report to Congress on the homebound requirement and to develop normative standards for home health claims denials. "These are important first steps in defining the home health benefit," said Buatti, but she added that, "it is likely that any guidelines will be difficult to enforce without a legislative authority."

Wilensky said she would support this recommendation. "It does seem that a different statutory language, however the Congress wants to write it, would be helpful unless they feel that the existing language, in fact, is to their liking."

The most contentious recommendation addressed by the commission was the proposed requirement for case managers. "Although physicians are technically required to certify medical necessity for home care, decisions about that care are made by the provider subject to Medicare rules," Buatti told the commission. "An independent assessment of need, made in consultation with the physician, could help to ensure that appropriate levels and types of services are provided, consistent with the needs of the patient."

Several commission members questioned how a case manager requirement would be implemented once a prospective payment system (PPS) is in place, particularly if it is a per-episode system. "How does this interface with that system?" asked commission member Peter Kemper. "I think we should be looking ahead." The commission discussed the possibility of a demonstration project in this area to assess its long-term viability. This could be accomplished "on a limited basis in a couple of states," Wilensky suggested.

Commission member William McBain agreed that if payment is ever based on a per-case basis or a DRG model, no outside assessment would be needed. "Presumably you wouldn't need to have some outside assessment," said McBain. "If it fit at all, it would probably fit in the context of some sort of outlier assessment."

Wilenski remarked that a "reasonable cut-off" for imposing the case manager requirement would be 60 visits. "Having an individual with expertise in this area provide an assessment after 50 or 60 visits would be helpful," said Wilensky, especially for "a small number of [patients] where all the money is spent as frequently happens."

The commission also was divided over the recommendation of a co-pay for home health visits. "The patients who have services from home health agencies are usually older. They're sicker, and they're poor," said commission member Anne Jackson. "A co-pay, even if it's a small one, would impose a burden on these individuals."

But commission member Alice Rosenblatt countered that "general insurance principles" argue in favor of "some cost-sharing." Again, much of the debate hinged on the indeterminate form that PPS will assume. For example, Lave said she would favor a $5 co-pay under the current system or a system that paid a per-diem prospective payment, but that under an episode-based system, she would favor no co-pay.

The home care industry is working aggressively to have a home care representative appointed to the commission. Those appointments will be made by the **General Accounting Office** (GAO; Washington) this spring. The commission will not meet again prior to the release of its March Report. ■