Home Health

BUSINESS REPORT

MONDAY, MARCH 15, 1999 VOL. 6, NO. 11 PAGE 1 OF 7

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

HCFA blocked in competitive bidding project

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

TAMPA – A Federal magistrate in Tampa, FL, last week handed the **Health Care Financing Administration** (HCFA; Baltimore) a major setback in its efforts to implement its competitive bidding demonstration project for durable medical equipment (DME) in Polk County, FL. In a lengthy 42-page report on her findings, Magistrate Judge Mary Scriven found merit in virtually every argument brought by the **Florida Association of Medical Equipment Dealers** (FAMED; Orlando, FL) and recommended approval of the association's request for a temporary injunction that would delay implementation of the project indefinitely.

FAMED and several Florida DME companies filed suit in Florida federal court Feb. 4 contending that HCFA established and utilized an advisory committee – **National Technical Expert Panel** (NTEP) – in violation of the **Federal Advisory Committee Act** (FACA). Specifically, the plaintiffs claimed that HCFA failed to follow FACA's requirements by giving all interested parties proper notification about the meetings.

The decision is a major win for FAMED and much of the DME industry that has fiercely opposed the demonstration project. "We are delighted," FAMED President Brian Seeley told *HHBR*. "The court came down on our side on every key point."

Perhaps even more important than delaying the implementation of the project is the fact that the decision was handed down before HCFA was able to open sealed bids from DME suppliers which were due March 29. The primary concern of the DME industry has long been that HCFA would take the pricing data submitted by DME suppliers and use it as a basis for inherent reasonableness cuts across the country for items included in the demonstration, such as oxygen, hospital beds and enteral nutrition.

HCFA initiated the Medicare Part B demonstration pro-

See HCFA, Page 7

Home care leaders pledge to cooperate on IPS reforms

By MATTHEW HAY and MEREDITH BONNER
***HHBR* Staff Writers**

WASHINGTON – Leaders of the five national home care associations opened the National Policy Conference in Washington last night by pledging to support the unified industry proposal for further reforms to the interim payment system (IPS). Notably, however, **National Association for Home Care** (NAHC) Director of Government Relations Dayle Burke acknowledged there will be no further details beyond the six provisions already announced until a Congressional sponsor agrees to introduce the legislation. She added that NAHC's Bill Dombi and **Home Health Services and Staffing Association**'s (HHSSA; Washington) Jim Pyles have been drafting legislation in recent weeks.

In addition, **Visiting Nurse Associations of**

See Conference, Page 7

Bipartisan Commission ready to recommend 10% copay

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

WASHINGTON – The **National Bipartisan Commission on the Future of Medicare** appears poised to recommend a 10% copayment for home health care. That proposal was included in a plan developed by the Commission's co-Chairman Sen. John Breaux (D-LA). The Commission's final report is already overdue and any final consensus will be hard to reach because of the requirement for an 11 vote "supermajority" of the Commission's 18 members. But home care representatives fear the copay provision might find favor with the Commission's other co-Chairman, Rep. Bill Thomas (R-CA), who leveled sharp criticism at the industry throughout last year's battle over the final shape of the interim payment system (IPS).

Breaux's proposal would hit skilled nursing facilities

See Copay, Page 6

IHS blames decline in rehab demand for 4Q earnings drop

By KAREN PIHL-CAREY
***HHBR* Staff Writer**

A decline in demand for rehabilitation services, as well as the changes in Medicare reimbursement, has caused **Integrated Health Services** (IHS; Owings Mills, MD) to post a sharp drop in earnings for 4Q98.

The company reported a net income of $10.8 million, 21 cents per share, compared to a net loss in 4Q97 of $61.9 million, $1.59 per share. During the quarter, the company incurred about $15 million in severance and transition costs related to the Medicare prospective payment system (PPS). In 4Q97, it recorded an $82.1 million non-recurring charge for its acquisitions of **RoTech** and the **Horizon/CMS** assets and the disposal of certain non-strategic assets. Revenues in 4Q98 were $718.7 million, a 61% increase over 4Q97 revenues of $445.2 million.

For the year, the company saw a net loss of $68 million, $1.08 per share, on revenues of $3 billion, compared to an FY97 net loss of $33.5 million, 60 cents per share, on revenues of $1.4 billion.

Due to the Medicare prospective payment system, there is a smaller demand for therapy services in the company's rehabilitation division. Customers of the division are admitting fewer Medicare patients and reducing their use of rehabilitative services, possibly due to fears of how to cope financially with the new PPS, IHS said. To address this, the company plans to reduce costs and will work with the customers, helping them better understand the system. IHS has also eliminated 1,000 positions and transitioned therapists from salary to hourly.

As announced in February, the company is talking with financial organizations interested in a leveraged buyout of its RoTech division. Market watchers have also speculated that IHS would be taken private in a leveraged buyout, reported *Dow Jones Business News*. Other companies, like **Sun Healthcare Group** (Albuquerque, NM) and **Mariner Post-Acute Network** (Atlanta), have also been the subject of such talk. ■

OASIS under fire over privacy issues; no changes expected

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

WASHINGTON — Reports surfaced last week that even strong supporters of the **Health Care Financing Administration**'s (HCFA; Baltimore) Outcome and Assessment Information Set (OASIS) are disturbed by questions the data collection tool is asking of home care recipients. But don't expect any significant changes soon.

"Sometime this year Congress is supposed to pass privacy legislation and you might see a major effort to include mental health privacy and other measures," a top aide told *HHBR*. "But that is not where Bill Thomas is at and that is not where the majority is," the aide added, referring to **House Ways and Means Health Subcommittee** Chairman Rep. Bill Thomas (R-CA). "They want to make it easier to exchange data, so I think it is a long-shot that things change."

As lead stories in *The Washington Post* and other newspapers reported, the OASIS data set will ask millions of patients questions about their mental stability, financial status, and living arrangements in order to determine if home health agencies are providing appropriate treatment to Medicare beneficiaries, and to ensure that reimbursement for these services is consistent. Data transmission will begin next month.

Meanwhile, HCFA defended the OASIS data set, claiming that it will be extremely limited in accordance with privacy regulations. HCFA spokesman Chris Peacock said medical researchers will not be allowed to see any patient identifiable information, and other government agencies will not be permitted to access the database. But those arguments are not likely to assuage concerns of civil libertarians, health care providers, and consumer groups.

Home care providers also wanted to limit the collection of data to Medicare beneficiaries. But HCFA maintained that data was required about patients who are not Medicare beneficiaries as well in order to gather requisite data to ensure consistent services for both patient populations. ■

Home Health Business Report® (ISSN 1073-9572) is published every Monday by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305.

SUBSCRIBER INFORMATION
Please call **(800) 688-2421** to subscribe or if you have fax transmission problems. Outside U.S. and Canada, call **(404) 262-5476**. Our customer service hours are 8:30 a.m. to 6:00 p.m. EST.

EDITORIAL
Meredith Bonner **(404) 262-5478**
Karen Pihl-Carey **(404) 262-5514**

VICE PRESIDENT/GROUP PUBLISHER
Donald R. Johnston **(404) 262-5439**

INTERNET
http://www.ahcpub.com

COMPANIES IN THE NEWS

American Capital purchases subordinated debt

American Capital Strategies (Bethesda, MD) has purchased $12.1 million of subordinated debt issued by **Auxi Health** – the group organized by **Monterey Capital** to acquire eight home healthcare businesses in eight states in the Midwest and Southeast. The acquisitions will make Auxi Health a dominant home healthcare provider in many of its markets, the company said. Additional financing was provided by **Fleet Capital** (Boston).

Caretenders is moved to Small Cap

Caretenders (Louisville, KY) said last week that its common shares have moved from the Nasdaq National Market System to Nasdaq's Small Cap Market, effective March 11. The shares will continue to trade under the stock symbol CTND. The move, Caretenders officials said, reflects management's decision to transfer following notification by Nasdaq that it did not meet listing requirements regarding the market value of public float.

Dynacare sees FY98 gains from home health sale

Dynacare (Toronto) reported an increase in revenue during FY98 ended Dec. 31. Revenues were $333 million, compared to $260.3 million in FY97. Net income was $9.2 million, compared to the previous year's net loss of $81.6 million. The net loss in 1997 includes impairment and restructuring charges of $95.1 million, as well as a gain on sale of home health care operations of $1.1 million.

Health Care Solutions buys Foley Medical

Health Care Solutions (Ann Arbor, MI), a home respiratory therapy, medical equipment, and infusion company, acquired **Foley Medical** (Youngstown, OH), doing business as **Family Home Medical**. Officials said the decision to sell the home care and home care equipment company "was based on several factors, all of which were to benefit the clients of the Mahoning Valley." By becoming part of Health Care Solutions, officials said, Family Home Medical will have the ability to become a preferred provider with more medical insurance companies. "This means we will now be able to service more families in need of home healthcare equipment and supplies," Family Home Medical officials said.

Mid-South hearing delayed

A federal court hearing concerning back pay for employees of a **Health Staffing Services** (HSS; Fort Lauderdale, FL) subsidiary is delayed until March 30. A temporary restraining order which prohibits the company from moving documents out of its Memphis office will remain in place. The **Department of Labor** (Washington) is trying to gain back pay in the amount of $750,000 for 600 workers of **Mid-South Home Health** (Memphis, TN) who worked four weeks without pay when the company shut down unexpectedly on Feb. 17. Its financier had pulled funding from daily operations. The labor department gained the restraining order claiming the documents – including clinical reports, time sheets and invoices – were illegally produced goods because workers who generated them were not paid, reported *The Commercial Appeal* in Memphis.

Healthdyne division gets new name

Healthdyne Technology's (Marietta, GA) **Healthdyne Information Enterprises** division has changed its name to HIE, the acronym by which the company is best known. The company intends for the name change to reflect the totality of its business, which has broadened from services in the healthcare EAI market to EAI solutions to additional markets, including financial services and banking industries, said President/CEO Robert Murrie. The name change is effective now.

Integra Group receives network accreditation

Integra Group (Mason, OH) has received a two-year network accreditation from the **American Accreditation HealthCare Commission/URAC** (Washington). Among 17 categories of service in the company's network are durable medical equipment, home healthcare services, home infusion, and skilled nursing. The non-profit commission was founded in 1990 to establish accreditation standards for managed healthcare organizations.

Invacare signs lease for new office space

Invacare (Elyria, OH) has signed a five-year lease for 150,754 square feet of space at Golden Springs Business Park in Santa Fe Springs, CA. The lease will cost the company $4 million.

MiniMed stock recommended

BC Ziegler (West Bend, WI) has conducted a research report on **MiniMed** (Sylmar, CA), which tells investors to buy the company's stock. "We continue to feel confident in the growth prospects for the industry and the company," the report said. "We have increased our 1999 EPS estimate by one cent, to $1.37."

Respironics launches new product

Respironics (Pittsburgh) will distribute a noninvasive bilirubin analyzer, called BiliChek, recently approved by the **Food and Drug Administration** (Washington). The BiliChek was produced by **SpectRX** (Norcross, GA), and it uses light beams and other forms of energy to diagnose infant jaundice. Respironics expects to launch the product in the U.S. within 30 days using its home care and infant management sales force. The product is currently available in 45 other countries.

Sparta Surgical buys HME provider

Sparta Surgical Corp. (Pleasanton, CA) signed a letter of intent to buy a private home healthcare equipment company for $17 million in cash, $4 million in a note payable, and 3.4 million common shares. Sparta said it will issue additional common shares if the Stockton, CA, company meets certain sales. The private company had FY98 sales of about $34 million. It has grown 40% annually since 1996 and it serves more than 44,000 home care patients, said Sparta President/CEO Thomas Reiner. ■

MANAGED CARE REPORT

• **Foundation Health Systems** (FHS; Los Angeles) said last week it has signed a letter of intent to sell its Colorado health plan subsidiary, **QualMed Plans for Health of Colorado**, to **WellPoint Health Networks** (Thousand Oaks, CA). Once FHS and WellPoint finalize and execute the definitive agreement for sale, the transaction will be subject to various conditions, including the receipt of all necessary regulatory approvals and other customary closing conditions. As of Dec. 31, FHS' Colorado operations had a total membership of 100,000. FHS also said it would phase out operations performed by its service center in Pueblo, CO. This transaction is expected to be completed by the end of 1999. The center provides support operations to various western FHS health plans. FHS reported FY98 revenues of $8.9 billion, compared to FY97 revenues of $7.2 billion. The company recorded an FY98 net loss of $165.2 million, $1.35 per share, compared to an FY97 net loss of $187.1 million, $1.52 per share.

• Sibley Memorial Hospital in Falls Church, VA, has reached an agreement with **Aetna U.S. Healthcare** (Blue Bell, PA) on a contract that will give members of all Aetna health plans access to all covered services provided at Sibley, said Todd Martin, Aetna U.S. Healthcare's general manager for Washington, DC. The all-products agreement covers members of Aetna U.S. Healthcare's HMO, point-of-service, and preferred provider organization plans. Aetna U.S. Healthcare has contracts with 33 hospitals in the Washington, DC, area. In addition, the company's managed care network includes 1,616 primary care physicians and 4,818 specialists. In other news, The **National Committee for Quality Assurance** (NCQA; Washington) has granted three-year, full accreditation to Aetna U.S. Healthcare's Florida HMO. The accreditation covers Aetna U.S. Healthcare's HMO operations in the Tampa Bay, Orlando, Miami, and Jacksonville metropolitan areas.

• **Blue Cross of California** (BCCA; Woodland Hills, CA), the California subsidiary of **WellPoint Health Networks** (Thousand Oaks, CA), has expanded its inquiry-response system to provide greater and more immediate responses to a variety of provider inquiries. The enhancements made to the BCBA Fax Back system, a component of the company's interactive voice response system, give providers immediate access to eligibility and benefits information, which they can receive in written format through their internal fax machines.

• An Overland Park, KS, physician has sued **Humana** (Louisville, KY) and its Kansas City-area health plans, claiming they and two other defendants tried to force him out of business in a scheme that scrimped on patient care, reported the *Kansas City Star*. The other defendants are the **Women's Healthcare Network**, an association of OB/GYNs in Lenexa, KS, and **OB/GYN Management** in Ohio. The physician claims agreements with the defendants led him to question the quality of patient care and reimbursement for that care and ultimately led to his being removed from an approved physician list, the *Star* reported.

• **Unity Health System**, a strategic service unit of the **Sisters of Mercy Health System** (St. Louis), has selected **Physmark**'s (Dallas) Medicomp software to manage the risk contracts of its various provider networks. Designed specifically from the point of view of providers, Medicomp monitors, administers, and manages risk contracts. This includes maintaining eligibility and benefits; re-pricing, adjudicating, and paying claims; pre-authorization monitoring and case management; and sophisticated financial modeling.

• The **Pennsylvania Medical Society** and the **Pennsylvania Society of Internal Medicine** argued in court last week that the merger that created **Highmark Blue Cross and Blue Shield** seriously undermined competition in the region's health insurance market. The *Pittsburgh Post-Gazette* reported that both organizations also argued that Highmark, a nonprofit corporation, is gradually shedding its social mission by shifting its assets and revenues to for-profit subsidiaries. Highmark spokesman Brian Herrmann told the *Post-Gazette* that the claims, particularly a detailed list of allegations that the internal medicine group submitted to the state **Insurance Department**, "are baseless and inaccurate." The organizations made their remarks before an administrative hearing officer at the Insurance Department. Highmark was created by the merger of **Pennsylvania Blue Shield** and **Blue Cross of Western Pennsylvania**. In other news, Highmark reported a net income for FY98 ended Dec. 31 of $62 million, with revenues reaching $7.5 billion. The company cited improved underwriting results in its health insurance business as the principal reason net income increased substantially over an FY97 net loss from continuing operations of $79 million. President/CEO John Brouse said, "Our underwriting results have improved, but we must continue to focus our attention on this area of our business. ■

REGIONAL DIGEST

• About 200 Los Angeles County children have won the right to intensive in-home mental health services under a ruling last week by a federal judge, reported the *Los Angeles Times*. In some cases, the home care services include around-the-clock counseling by one-on-one aides. Mental health advocates applauded the decision and said they believe it will eventually be extended to benefit children throughout the state who suffer from extreme mental and emotional disorders. The beneficiaries will be Medi-Cal patients under the age of 21 who have failed in traditional psychiatric programs.

• Local home care agencies in Colorado Springs, CO, are complaining that large hospitals are hoarding potential customers, rather than referring them to the smaller agencies. Last year, 60% of Centura Health Penrose-St. Francis Hospital's patients that needed home healthcare received it through the hospital's home health agency. And about 55% of Memorial Hospital's patients needing home health received it through that hospital's home health agency. Smaller providers say the hospitals are keeping financially attractive customers and referring out only the sickest, costliest ones, reported *The Gazette* in Colorado Springs. Hospital employees are legally required to provide patients with a list of local home care agencies, giving them the right to choose, but they can also encourage the patient to use the hospital's agency. The **Home Care Association of America** (Jacksonville, FL) said it is "very concerned that hospitals have captive patients."

• Two Massachusetts legislators recently paid a visit to a **Montachusett Home Care Corp**. (MHCC) patient, reported the *Telegram & Gazette* of Worcester, MA. State Sen. Robert Antonioni (D-Leominster) and state Rep. Brian Knuuttila (D-Gardner) were the guests of Adell Wiita, a client of MHCC. The lawmakers' visit was part of Home Care Family Album Week, which was sponsored by MHCC, a non-profit organization. The visit was designed to give legislators of the Montachusett area an opportunity to see more than "a bunch of facts and figures" regarding home care, MHCC officials said.

• The *Providence Sunday Journal* of Providence, RI, reported that the state **Department of Elderly Affairs** said it has a waiting list of more than 100 people needing home care and that on average, it takes 9.5 days to get a home health aide. In the past year in Rhode Island, one visiting nurse association went out of business and another, the state's largest, laid off 20% of its staff. And just in the past three weeks, the *Journal* reported, two home health agencies closed because they had no money. The shortage has made it impossible for the state to impose higher standards for quality of care, and people unhappy with their aides are afraid to complain because they fear they will end up with no one.

• **Mount Sinai NYU Medical Center and Health System** (New York) and **North Shore-Long Island Jewish Health System** (Manhasset, NY) have formed an exclusive joint venture between their health systems aimed at ensuring the highest quality and accessibility of healthcare across the New York region. Creation of a Quality of Care Institute will be the joint venture's first project, the companies said. The Quality of Care Institute will explore three quality of care issues − one of which will focus on enhancing quality of care in long term care, ranging from home care to nursing home care. Under the terms of the agreement, the two systems will create a stand-alone entity, half-owned by each and governed by a joint planning committee. Initially, the venture will be funded with a total investment of $6 million, $3 million from each institution.

• San Francisco Mayor Willie Brown announced a new program last week that will allow independent home care workers to apply for benefits through the **San Francisco Health Plan**, a nonprofit agency that provides healthcare for low-income residents. Under the plan, home care workers who are employed at least 25 hours a month can pay as little as $3 a month for prenatal and vision care, discounted prescriptions, family planning, and other benefits. The services will be provided at **San Francisco General Hospital** and public health clinics, reported the *San Francisco Chronicle*. As of March 1, as many as 5,500 people working under the auspices of the **In-Home Supportive Services Public Authority** became eligible for the benefits, and so far, the *Chronicle* reported, 1,000 members have signed up for the health plan.

• An Indiana home health agency said it fears having to close its doors. The **Visiting Nurse Association of Southwestern Indiana** (Evansville, IN) has been told it must repay almost $4 million to the **Health Care Financing Administration** (HCFA; Baltimore) as a result of retroactive cost-cutting ordered in the Balanced Budget Act of 1997, reported the *Evansville Courier & Press*. The organization says that is twice the amount it had anticipated having to repay, and it's more than the agency has. Under federal rules, the agency has 15 days to pay the refund or ask for an extended repayment plan over three years with no interest. But board members said the company can't do it in three years. Board members are planning to appeal to area congressmen to change the rules. Late last week, officials at the VNA were assuring patients and employees that the agency will not close in two weeks, the *Courier & Press* reported.

• **General Motors Corp**. (Detroit) is reconstructing its health plans in order to reign in its annual $4.5 billion medical bill, reported *The Globe and Mail*. Beginning April 1, the company will require salaried employees enrolled in certain plans to check with a consultant before undergoing surgery, a hospital stay, home health care or nursing facility care. Patients can reject the consultant's advice, but will face a $200 charge on top of what they already pay. ■

CALENDAR

• The 11th Annual National Managed Health Care Congress is March 29-April 1 at the Georgia World Congress Center in Atlanta. Keynote speakers include industry luminary Reginald Ballantyne, Steve Forbes, and Ann Richards, former governor of Texas. To register, call (888) 882-2500.

• The Homecare Survival Conference will be April 12 and 13 at the New York New York in Las Vegas. Topics for the two-day conference include how to fight overpayments, how to be successful in IPS, establishing a compliance program, and a focused medical review, among others. To register, call (800) 677-4262.

• The **National Association for Home Care** (Washington) is offering a home care business development conference called "Expanding Services Beyond Medicare in a Cost Conscious Environment." The conference, which includes the National Private Pay Home and Community Services Conference, the 14th National Home Care Aide Services Conference, and the National Adult Day Care Symposium, is April 18-21 at the Hyatt Regency Crystal City Hotel in Arlington, VA. For more information, call (202) 547-5050.

• The **Health Industry Distributors Association** (Alexandria, VA) is holding its Home Care Washington Conference April 20-21. Among the issues that will be addressed at the conference are: competitive bidding, inherent reasonableness, home health agency consolidated billing, and managed care reform. For more information, or to register, call (703) 838-6134.

• The **California Association for Health Services at Home** (Sacramento, CA) is holding its 1999 Annual Conference & Home Care Expo May 19-21. The conference will be at the Disneyland Hotel in Anaheim, CA. For more information on the conference, call (800) 622-4724.

• The **National Association for Home Care** (NAHC; Washington) will hold its 18th Annual Meeting & Homecare Expo Oct. 9 to 13 at the San Diego Convention Center. The conference will feature more than 18 "How To" programs, more than 100 educational sessions with continuing education credits, and more than 400 exhibiting companies. Invited speakers are Dr. Patch Adams, Effie Poy Yew Chow, Ken Dychtwald and Dr. Bernie Seigel. For more information, call NAHC at (202) 547-5050.

• **Medtrade Management Group** (Atlanta) will hold the first Home Healthcare Executive Forum on Nov. 2 at the Earnest M. Morial Convention Center in New Orleans. The forum will be the day prior to the opening of the 1999 Medtrade Exhibition and Conference. Issues addressed at the home care forum will relate to workplace liability, negotiating strategic alliances, legal issues involved in creating new marketing strategies, and confronting case management issues. For more information, call (877) 835-7232. ■

Copay

Continued from Page 1

(SNF) the hardest. A House Ways and Means aide close to the process said the last proposal floated by Breaux included a 10% copay for home health care and 20% copay for the first 20 days in a SNF. The 10% figure would translate into roughly a $5 copay for home health and a $9 to $11 copay for skilled nursing.

Breaux's proposal comes in the wake of the **Medicare Payment Advisory Commission**'s (MedPAC; Washington) formal recommendation to Congress to impose a copay on home health visits. It was included in MedPAC's Annual Report to Congress released March 1.

The home care industry found some solace in a groundswell of opposition to the copay led by Rep. Bernard Sanders (I-VT). In a letter signed by 69 of his colleagues last week, Sanders told Breaux and Thomas that the 10% copay proposal would cause "enormous pain and hardship for low-income and sick and elderly people."

According to HCFA's most recent data, the average per beneficiary reimbursement for home health care was $4,074 in 1997, noted Sanders. "A 10% copayment would mean the average Medicare beneficiary would have to pay $470 out-of-pocket per year for home health services," he argued, even though nearly half of all seniors have incomes below $15,000 a year.

While the commission won't offer any formal legislation, Thomas and Breaux said they don't feel bound by the commission's recommendations. One House aide told *HHBR*, Breaux discounted the importance of achieving the support of a "supermajority" on the commission because he has the support of 11 of his fellow members of the Senate Finance Committee. "He's right," predicted the House aide. "It will probably pass out of Senate Finance 15 to 5."

NAHC's Bill Dombi said that the commission's final plan is undergoing significant changes as various factions search for the elusive 11th vote. He also said that the commission's plan has no defined benefit package and eligibility requirements are still up in the air. But Dombi agreed that Thomas and Breaux will introduce their own Medicare reform bills. ■

WHAT THEY'RE SAYING

• Florida lawmakers want a portion of projected budget surpluses to go toward building up the Medicare program. Rep. Dave Weldon (R-FL) told *Gannett News Service* he wants Congress to figure out a way to pay for a new prescription drug benefit for some Medicare enrollees. But Rep. Porter Goss (R-FL) said he doesn't see an immediate need to act. "We've saved Medicare once, we'll keep it solvent," he said. At least 100 home health agencies have closed in Florida. ■

HCFA

Continued from Page 1

ject in 1995 and contracted with Palmetto GBA, the Region C durable medical equipment regional carrier (DMERC) to assist in its development. NTEP meetings began shortly thereafter.

The court found that HCFA's contention that the DME companies failed to demonstrate that their participation in the NTEP would have made a difference in the design of the demonstration project is flawed for several reasons. "Specifically," said the federal magistrate, "it requires th[e] Court to assume that the NTEP and the HCFA would have not considered the comments of plaintiffs had they participated in the meetings despite the time and expense in establishing a panel of experts and holding three meetings."

"It further requires the court to assume that the HCFA would have ignored their statutory obligation to obtain advice and recommendations from specialists prior to engaging in a demonstration project or complied with the obligation in a perfunctory manner," the federal magistrate asserted. "Finally, defendants are correct that plaintiffs were not able to take part in the NTEP due to defendant's alleged failure to comply with FACA." As a result, said the federal magistrate, it cannot be determined with certainty whether plaintiffs would have made a difference.

The court also said that HCFA's claim that the NTEP was insignificant to the overall process is belied by the record. HCFA's affidavit asserts that the NTEP did not have a great impact on the demonstration's design but the federal magistrate noted material passed out at the first meeting said the participation of the organizations present was "crucial to the success" of the project. In addition, materials passed out at the second meeting explained that the objective was to "develop a detailed set of product and service specifications for all items to be bid in the project."

The federal magistrate also rejected HCFA's argument that Palmetto GBA proposed the NTEP rather than the agency itself. "HCFA, by its own acknowledgment, stated that it formed the NTEP," said the federal magistrate. "On balance, the evidence, as it currently exists, tips decidedly in favor of the plaintiffs." Moreover, even if HCFA did not establish the NTEP it utilized it, said the federal magistrate. "For instance, there is evidence that HCFA altered the lists of products to be covered by the demonstration project as a result of the NTEP's advice rendered at the first meeting."

FAMED had argued that HCFA has until Dec. 31, 2002, to complete the demonstration project but HCFA argued that even a short-lived injunction could effect its ability to implement the project. Specifically, HCFA argued that certain information must be entered by October 1999 so it can be reconfigured to the Y2K standard. "As for the defendant's alleged Y2K problem," said the federal magistrate, "it hardly passes the straight face test as an imminent harm. Second, the alleged harm is speculative at best."

The court said that HCFA's argument about savings that will be lost to the Medicare program are also "speculative at best." Noting that the purpose of the demonstration project is to determine whether competitive bidding will result in any decrease in federal expenditures, the court said this: "If the Veteran's Administration's experience on which defendant's rely for this estimate were dispositive of the issue, no demonstration project would be needed."

The court concluded that given the March 29 deadline to submit bids for the demonstration project, any objections to the federal magistrate's finding must be filed by March 17. Absent that action on the part of HCFA, a federal judge is virtually certain to approve the findings. ■

Conference

Continued from Page 1

America (VNAA; Boston) President Carolyn Markey pledged support of all six principles but emphasized that eliminating the mandatory 15% cut scheduled for Oct. 1, 2000, is by far the most important provision for her organization. Markey said her members simply can not survive a 15% cut on top of the 15 to 20% cut they sustained last year. Privately, the other groups fear that the VNAA may throw its support behind legislation that might emerge that includes this provision but falls short on one or more of the other provisions.

Meanwhile, home care leaders are pointing to data released by the Congressional Budget Office (CBO; Washington) last week that show a dramatic reduction in Medicare home health expenditures. When the Balanced Budget Act of 1997 (BBA) was being debated, CBO predicted a $16.1 billion reduction in expenditures between fiscal years (FY) 1998 and 2002. The CBO now projects a $47 billion reduction over the same period. Based on this, the five groups plan to urge an elimination of the 15% reduction. "We have already far far exceeded the $16.5 billion Congress was looking for," said Markey.

When the BBA was debated, Congress pointed to rapidly growing home health outlays that were expected to reach $127 billion between FY98 and FY2002. In August 1997, CBO revised that number downward to $110.9 billion. The most recent CBO estimate released last month dropped the projected five-year expenditure to $79.1 billion.

NAHC's Burke said the leaders of all five groups will personally visit key members of Congress as a group in an effort to generate support. In addition, the five groups plan to address a range of policy issues with **Health Care Financing Administration**'s (HCFA; Baltimore) officials over the next three days. Following the National Policy Conference on Wednesday, the five groups are co-sponsoring a day-long town hall meeting with HCFA representatives on issues ranging from sequential billing to the recoupment of overpayments. ■