Home Health

BUSINESS REPORT

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

MedPAC says it's too early to tell impact of IPS on beneficiary access

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

WASHINGTON – The Medicare Payment Advisory Commission (MedPAC) issued its June 1999 Report to Congress last week that included both good news and bad news for the home care industry. In short, MedPAC concluded that the jury is still out over whether beneficiary access has been impaired by the interim payment system (IPS) for home healthcare. And home care advocates say that conclusion does nothing to bring further relief to the industry.

At a press briefing at the National Press Club in Washington June 2, MedPAC Chairperson Gail Wilensky said the Medicare home health benefit is "a big political issue" that requires further analysis to effectively gauge the impact of changes imposed by the Balanced Budget Act of 1997 (BBA). Wilensky appeared to soften in her view of how the BBA has affected the U.S. healthcare delivery system, as well as to what extent corrective measures may be required.

While Wilensky said that MedPAC is still trying to determine the impact of the BBA, she added that the assessment is more difficult because of poor data. She said there does appear to be a reduction in the number of home health agencies, the number of beneficiaries served, and services received by those patients, as stated in MedPAC's report. Wilensky added that it is difficult to determine if the changes have been good or bad without clinical information on both the patient population and the services provided to them.

In addition to finding fewer agencies, visits, and services, MedPAC stated that "some agencies report that they are no longer accepting or are likely to discharge earlier certain types of patients." MedPAC reported that providers say "some beneficiaries are having more difficulty obtaining services to which they believe they are entitled under Medicare's benefit."

But the commission concluded that it cannot yet deter-

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HCFA's revised ventilator policy scares the respiratory industry

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

Respironics (Pittsburgh) and other manufacturers of ventilators used in home health settings may experience a decline in revenues if new guidelines proposed by the **Health Care Financing Administration** (HCFA; Baltimore) are implemented.

Late in May, HCFA withdrew guidelines proposed last July in a move that pleased the industry. But the agency's revised policy for respiratory assist devices interrupted any celebration, reminding the industry that a fight is still ahead. The initial guidelines proposed last year called for requiring patients to submit to clinical testing before qualifying for ventilators, and to attain the ventilators through a prescription from a board-certified pulmonologist. Pressure from the durable medical equipment regional carriers (DMERCs) convinced HCFA to drop the requirements.

But in a statement issued last week, Respironics President/CEO Dennis Meteny said the DMERCs forgot certain conclusions laid out by physicians. In the new guidelines, for instance, HCFA is recommending that doctors prescribe cheaper ventilators, something that would hurt Respironics' revenues.

"Respironics believes that the current draft proposal is still overly restrictive for patients and administratively burdensome for clinicians and healthcare providers," Meteny said.

The new guidelines also suggest limiting how long patients using ventilators would be reimbursed. As of now, they receive $500 a month for as long as they need it. Analysts believe HCFA is considering a cap at about 15 months. Once finalized, the policy will take effect Oct. 1.

Respironics is a company that designs, develops, manufactures and markets respiratory therapy products used in hospitals and clinics, as well as home healthcare settings. It is one of the largest home medical device companies in the respiratory market.

The company's shares fell 12% one day last week, and

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three times the average daily volume of shares were traded that same day. According to Respironics Vice President Dan Bevevino, Medicare patients using the company's ventilators account for 7%-8% of the company's sales.

Parker/Hunter (Pittsburgh) analyst Richard Lawrence downgraded the company's stock to "market performer," and reduced his earnings estimate to $1.05 per share from $1.16 per share for FY2000 ending June 30, 2000.

Phil Porte, executive director of the **National Association of Medical Direction of Respiratory Care**, said that the DMERCs and HCFA still have some work to do, but that they're heading in the right direction. "For physicians to adopt all of the clinical aspects of this revised policy is extremely problematic," Porte said, "not only for the clinical community, but most certainly for Medicare beneficiaries."

Mary St. Pierre, director of regulatory affairs for the **National Association of Home Care** (Washington) told *HHBR* she had not yet seen the policy and could not comment. "What we will have to do is get in touch with one of our providers, a DME affiliate, and have them take a look at it," she said.

Meteny said he believes HCFA wants the coverage policy done right, "albeit on a slower timeframe than many of us would have liked." The company plans to continue its discussions with HCFA and Congress to keep the ventilators from being classified in the capped rental category. All industry professionals will receive the opportunity to comment before final guidelines are issued in late summer. An open meeting will be scheduled in the near future at HCFA in Baltimore. HCFA will accept written comments about the policy until 5 p.m. June 15 at the following address: Health Care Financing Administration, Division of Community Post-Acute Care, ATTN: Joel Kaiser, C5-06-27, 7500 Security Blvd., Baltimore 21244-1850. The comments may be emailed, with no attachments, and including full names, addresses, and affiliations, to jkaiser@HCFA.gov.

The policy itself can be accessed through the DMERC Web site, *www.astar-federal.com*. ■

GF restates FY96, 97 earnings

An *HHBR* Staff Report

Graham-Field Health Products (Bay Shore, NY) reported its financial results for 1Q99 ended March 31, as well as FY98 ended Dec. 31. The FY98 results included restated financial results for FY96 and FY97. The results are consistent with preliminary results announced May 18.

For 1Q99, the company reported revenues of $85.5 million, compared to restated revenues of $98.3 million in 1Q98. The revenue decline is due to the company's tighter credit policy, as well as other factors.

The company posted a net loss of $7.4 million, 24 cents per share, in 1Q99, compared to a 1Q98 net loss of $1.7 million, 6 cents per share.

"We are focused on increasing cash flow from operations through a series of initiatives designed to improve the company's performance," said President/CEO John McGregor, who was just appointed in March. "And at the same time, we are evaluating the feasibility of selling all or parts of the business. As previously announced, the company has retained Warburg Dillon Read LLC to assist in that evaluation."

For FY98 ended Dec. 31, the company reported revenues of $380.9 million, and a net loss of $49 million. The net loss includes all non-recurring, restructuring, and merger-related charges of $20.6 million, and a charge of $18.3 million relating to the write-off of the company's deferred tax asset.

The company restated financial results for 1Q, 2Q, and 3Q98 to correct for certain improperly recorded transactions. The adjustments are not related to the company's audit committee investigation, announced in March. The adjustments relate primarily to previously unrecognized stock compensation charges and previously recorded estimated separation charges, which increased the net loss in 1Q98 by $971,000, and in 2Q98 by $249,000, and which decreased the net loss in 3Q98 by $739,000.

Restated results for FY97 and FY96 revenues were $262.8 million and $143.3 million, respectively. Including charges, the restated net loss in FY97 was $26.4 million, and the restated net loss in FY96 was $13.6 million. ■

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COMPANIES IN THE NEWS

Allied sells hospital division

Allied Healthcare Products (St. Louis) has sold its **Hospital Systems** (Oakland, CA) division to the group's management team. Financial details were not released, and the sale is not expected to impact Allied's financial results.

Chad reports net loss for FY98

Chad Therapeutics (Chatsworth, CA) recorded a net loss in FY98 ended March 31 of $1.5 million, 15 cents per share, compared to a net income in FY97 ended March 31 of $797,000, 8 cents per share. The company's sales declined 15% to $14.1 million from FY97 sales of $16.6 million.

In 4Q98, the company saw sales of $3 million, compared to 4Q97 sales of $3.5 million. Chad posted a 4Q98 net loss of $679,000, 7 cents per share, compared to a net loss in 4Q97 of $10,000, less than I cent per share.

Chad's CEO, Thomas Jones, said that sales of the company's Oxymatic conserver and related products continue to be affected by previously reported factors, "primarily a highly competitive environment and 30% in reimbursement cuts over the past two years."

Flagship finalizes acquisition of Shands' branches

Flagship Healthcare (Miami Lakes, FL) has finalized its acquisition of 10 **Shands HomeCare** branches. The 10 branches serve more than 1,000 patients throughout Florida, providing home infusion and home nursing services.

HCR offers software for home health operations

HCR Manor Care (Toledo, OH) has selected the **Dial-n-Document** (Cincinnati) clinical documentation system as the foundation of its new integrated information system for its home care division, **Heartland Home Health and Hospice**. In the agreement, Dial-n-Document and **Provider Solutions Corp**. (Tampa, FL), a healthcare software development company, will work in partnership with HCR to create a custom interface, combining Dial-n-Document's voice-response clinical documentation system with provider Solution's ProviderFirst software suite. The software will offer scheduling, clinical documentation, billing, and other financial management systems modules. When fully operational, the software will be implemented across all HCR home health operations.

HHCA asks for more time for reorganization plan

Home Health Corp. of America (King of Prussia, PA) is requesting its first extension to its exclusive periods to file a reorganization plan and solicit plan acceptances to Sept. 16 and Nov. 15, respectively, according to *Federal Filings Newswires*. The May 24 motion filed in U.S. Bankruptcy Court in Wilmington, DE, stated: "In light of the size and complexity of the debtors' 35 cases and the progress that they have already made in laying a foundation for the formulation of a consensual plan of reorganization as set forth hereafter, the debtors believe that the requisite cause exists for a grant of the requested extensions."

Invacare receives EDI Innovation Award

Invacare (Elyria, OH) received its fourth EDI Innovation Award from **Enterprise Development** for its Gearless-Brushless GB motor for its Arrow Storm Series power chairs. The award recognizes for-profit, non-profit, and government entities in northeast Ohio that have successfully created a product or service. The motor took about seven years of research and development before it was realized, said Invacare Chairman/CEO A. Malachi Mixon III. The motor features a 7.25 mph speed with a 300-pound capacity and a two-year warranty.

McKesson expects deeper revision to FY98 results

McKesson HBOC (San Francisco) expects a further downward revision of FY98 ended March 31 results. The company previously announced it would be restating results due to the discovery of certain improper revenue recognition relating to software sales at its **Healthcare Information Technology Business** unit, formerly **HBO & Company**. Since that discovery, additional instances of improper revenue recognition were found. It is also possible that the results for prior years may have to be restated as well, the company said. It is working with its auditors, **Deloitte & Touche** to resolve the situation quickly. Once the audit is finished, the company will issue its results for FY98.

PGA to look for FY99 revenues of $1B

Personnel Group of America (PGA; Charlotte, NC) Chairman Edward Drudge, speaking at the company's annual shareholders meeting last week, said PGA is on target to reach $1 billion in revenues by the end of FY99, one year ahead of schedule, and $2 billion in revenues by the end of 2003. "Our business plan," he said, "calls for us to grow our company 25% a year through the year 2003, in terms of earnings per share and shareholder value. We also want to improve our operating margin to 11% in 2002 and 12% in 2003."

At the meeting last week, shareholders re-elected Ken Bramlett, senior vice president/general counsel/corporate secretary, and James Hunt, senior vice president/CFO/treasurer, to the board for terms of three years.

VNAA partners with CVS Pharmacy

The **Visiting Nurses Association of America** (VNAA) has partnered with **CVS Pharmacy** to offer low cost flu immunizations in the fall. The two will offer influenza clinics in more than 2,000 locations, focusing on immunizing working adults and seniors who might not normally have access to low cost flu immunizations. ■

REGIONAL DIGEST

• **Baptist Health Systems of South Florida** lost $750,000 on operations during its first six months of FY99, even though the hospital is the busiest it has ever been. Executives expect a shortfall of $4 million by the end of the fiscal year. The problem can be attributed to HMOs, Medicare cutbacks and other healthcare changes, reported the *Miami Herald*. Federal reimbursement cuts to home health prompted the health system to merge its two home health agencies. Medicare payment cuts resulted in a 20% drop in the number of home health visits for the agencies during the first six months of FY99.

• The **Florida Hospital Association** recently released a report that indicates the state's hospitals are heading toward disaster, reported the *Tampa Tribune*. Over the next five years, **Tampa General Hospital** will notice a $53 million reduction in Medicare payments, and **Morton Plant Hospital** in Clearwater will suffer a $79 million loss, the association says. The report is based on a survey of 209 Florida hospitals, with 189 responding. Morton Plant was listed as being the most severely affected by changes to Medicare. About $33 million of the total $79 million loss will come from its home healthcare services, the association data shows. But a spokeswoman for **BayCare Health System**, Morton's father company, said BayCare might come up with different numbers than the association. The report predicts that Florida hospitals will see the following decline in Medicare spending: $616 million in 1999, $789 million in 2000, $950 million in 2001, and more than $1 billion in 2002.

• The **Oklahoma Department of Human Services** will not have to cut spending or programs in its home care program, agency officials learned recently. About $2 million will be transferred from unbudgeted federal revenues into personal care and nontechnical medical care programs, both of which have been running more than 30% over budget. The services have had an increase in enrollment due to changes in Medicare law, reported the *Daily Oklahoman*.

• A Vanderburgh County (IN) Critical Issues Survey conducted recently found that residents of the area are concerned greatly with the need for in-home services for elderly people. The 1,324 residents surveyed ranked it as the most crucial issue facing the community. It has never been ranked before since the first survey was conducted in 1987. When the survey was last taken in 1996, alcohol and drug abuse, as well as teenage pregnancy, topped the list. Community leaders believe that government cutbacks in home healthcare services and aging baby boomers faced with caring for elderly relatives may have brought the issue to the top of the survey, reported the *Evansville Courier & Press*. The findings of the survey help groups like the **United Way** decide on how to allocate funds and plan for the future.

• An estimated 50,000 older people in Florida depend on a state program for help at home, but another 5,000 who need the care are still waiting for it because of a money shortage, reported the *Tampa Tribune*. State lawmakers did not put enough money into the budget, even though the increase in spending for home care services was the largest in years. The costs will continue to grow, analysts say. There are 316,000 people over age 85 now living in Florida, but by 2015 that number is expected to climb to 586,000. The state Legislature added about $19 million to home and community care services this spring, cutting the waiting list by two-thirds. The governor's new chief of the **Elder Affairs Department**, Gema Hernandez, wants to expand the role of state workers who screen people for Medicaid nursing home care, having them follow clients from the first home services. Hernandez also wants businesses to take a greater role in providing the care, the *Tribune* reported. ■

WHAT THEY'RE SAYING

• With Carol Raphael appointed as the first person from the home health industry to serve on the Medicare Payment Advisory Commission (MedPac), many may believe she will push for higher home health reimbursements. But it's hard to tell, stated *Modern Healthcare* in a commentary. The publication quoted Raphael as saying: "I really want to learn as much as I can about the whole set of post-acute care issues. I do think it's important that MedPAC have someone who understands the Medicare home care benefit and reimbursements...." Congress raised the number of MedPAC commissioners by two to 17, adding Raphael, president/CEO of the **Visiting Nurse Service of New York**. In response to the quote, *Modern Healthcare* stated: "Safe enough. Sounds like she's learning politics quickly."

• The founder of the **Delaware Valley Geriatric Society** in Pennsylvania says home care is not only preferred by aging seniors, but it is a remedy for today's large healthcare costs. Dr. Charles Ewing is a medical director for the non-profit **Friends Life Care at Home**, which provides home care services to 1,200 people. To become a member of Friends, a person must be 60 years old and in reasonably good health. Members pay about $6,000 in an entry fee, then about $290 a month thereafter, in return for home health services when needed. "There is enormous potential for reducing family financial burdens by arranging for round-the-clock individualized home health services that are assured for life despite changes in health status that could be catastrophic," Ewing said. ■

MANAGED CARE REPORT

• **Senior Care Action Network** (SCAN; Long Beach, CA) has named George Garnett medical director. Prior to joining SCAN, Garnett was medical director of ProMed Health Care Administrators, a physician management organization.

• **Humana** (Louisville, KY) has appointed Arthur Lazarus vice president and corporate medical director of behavioral health. In the newly created role, he will develop and devise strategies to better integrate primary care and behavioral healthcare services to enhance early treatment of behavioral disorders among Humana health plan members. Lazarus will also be responsible for expanding disease management programs and preventative services related to mental health.

• **Blue Cross and Blue Shield of Florida** (BCBSFL; Jacksonville, FL) last week reported consolidated revenues in 1Q99 grew nearly 20% to $1 billion from $874.2 million in 1Q98. Chris Doerr, senior vice president/CFO, said," Strong enrollment gains, including our acquisition of **Principal Healthcare of Florida**, reflected favorably on our revenues and helped strengthen our market leadership in Florida." Overall, the company enrolled more than 250,000 new members in 1Q99, he said. About 60% of this member increase, Doerr said, was due to the company's acquisition of Principal Health Care of Florida. During 1Q99, the company also reported, policyholders' equity increased by $26.1 million, from $818.2 million during 1Q98 to $844.3 million during 1Q99. Policyholders' equity enables BCBSFL to meet its obligations when claims or expenses are higher that expected or during times of economic uncertainty.

• **HIP Health Plans** (HIP; New York), to keep pace with the competitive healthcare environment, said last week that it continues to make a number of strategic operating changes in New York and Florida. HIP Health Plan of Florida, HIP said, will not renew its Medicare+Choice contract for the Tampa area, which includes Hillsborough, Pasco, Pinellas, and Hernando counties, effective Jan. 1, 2000. HIP says about 2,000 current members will be affected, but will have until Jan. 1 to find a new healthcare plan. The reason for withdrawing, HIP said, relates to medical costs in the Tampa, FL, area significantly exceeding the reimbursement increases authorized by Medicare.

• **Blue Cross and Blue Shield of South Carolina**'s (BCBSSC; Columbia, SC) Adie Fuentes will be awarded the 1999 Beneficiary Services Certificate of Merit at the annual **Health Care Financing Administration** (Baltimore) conference in Miami. Fuentes is a senior ombudsman at Palmetto Government Benefits Administrators, which is the official name for all government programs administered by BCBSSC, working in Puerto Rico and the Virgin Islands. ■

CORPORATE LADDER

• **SCAN** (Long Beach, CA) has named Deborah Miller director of **Independent Living Power**, which gives seniors personal care services at home. Miller, a licensed clinical social worker, held several management and operational positions at **Vitas Healthcare**. Prior to that, she worked at the University of California-Irvine Medical Center, where she supervised social workers.

• Kwan-Moon Leung will become vice president of HealthCare Informatics at **SCAN** (Long Beach, CA). Leung is a nationally recognized expert in biostatistics and clinical informatics. He most recently worked as director of data management and information analysis for **Foundation Health Systems** (Woodland Hills, CA).

• **Tenet Healthcare Corp**. (New Orleans) has appointed Gregory Burfitt vice president and regional director, and Curtis Dosch vice president of finance, for the Southern States Region. Both will be based in Atlanta and will provide operational and financial oversight for nine acute care hospitals and related services in North Carolina, South Carolina, and Georgia. Burfitt joined Tenet in 1986, serving as CEO of a hospital in Birmingham, AL. Dosch served as CFO of Tenet's Memorial Medical Center in New Orleans.

• **Sutter Health** (Sacramento, CA) named Scott Parker, retired CEO of **Intermountain Health Care**, to its board of directors, replacing Paul Feldstein who retired after more than 10 years of service. Parker is the past chairman of the **America Hospital Association**, and he received the American Hospital Association's Distinguished Service Award in 1995. ■

PPM/MSO NEWS

• The California **Department of Corporations** received an order from the state court that extends the time period for finalizing a settlement agreement with **Medpartners**' (Birmingham, AL) California physician management operations. The order extends the agreement until June 9. The company has also signed agreements to sell some of its medical units in California, including **U.S. FamilyCare Medical Center** in Montclair, and two small physician groups: **Inland Empire Medical Group** in Riverside and **High Desert Primary Care Group** in Hesperia. Sales of the physician groups must receive approval from the U.S. Bankruptcy Court. MedPartners' spokesman Robert Mead would not identify the buyers of the groups, reported the *Business Press* in Ontario, CA. ■

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mine to what extent the payment system caused these trends because concurrent policy changes and other factors have also contributed to the changes. The commission maintained that a lack of clinically based standards for home healthcare make it impossible to assess the degree to which these changes are appropriate.

According to Wilensky, the **Health Care Financing Administration** (HCFA; Baltimore) has had "a data problem," but she predicted the agency will have better data within the next six months.

According to MedPAC, other factors that may explain decreases in use include antifraud initiatives targeting home healthcare, the removal of venipuncture as a qualifying service for home health eligibility, more stringent Medicare claims review and sequential billing policies, and market forces affecting the supply of home health agency employees. The commission added that agencies might be modifying their behavior in anticipation of a prospective payment system (PPS).

Wilensky also qualified the reduction in the overall number of home health agencies over the past year by pointing out the "enormous growth" the industry experienced in the years prior to that decline. "A reduction in the base is not necessarily a bad thing," she said. "After all, the average 31% increase for a decade was extraordinary."

According to MedPAC, Medicare payments for home health services rose from roughly $2 billion in 1988 to $17 billion in 1998. During the same period, annual visits increased from 23 to 79. "While payments per visit remained relatively stable during this period – increasing less than 2% annually – payments per user increased about 18% annually."

MedPAC recommends changes

"It is impossible to determine the degree to which the changes in use of home health services that have occurred in the past two years are appropriate," MedPAC concluded, in part because Medicare's standards for eligibility and coverage are "too loosely defined." In order to remedy these problems, MedPAC recommended the following legislative and regulatory changes:

• That **Health and Human Services** (Washington) Secretary Donna Shalala "speed the development of regulations that outline home healthcare coverage and eligibility criteria based on clinical characteristics of beneficiaries" and propose legislation to implement these regulations. MedPAC pointed out that current Medicare policy merely requires patients to be homebound, according to a recently issued HCFA report. While that report did not recommend adopting a new definition, the commission argued that separate standards should be developed for patients with chronic care needs and those with acute care needs.

"Once HCFA establishes clinically-based coverage standards for use of home health services," MedPAC said, "the agency also should use these standards to monitor access to home healthcare and appropriate use of services."

• That HCFA "explore the feasibility of establishing a process for agencies to exclude a small share of their patients from the aggregate per-beneficiary limits," if Congress is not confident that HCFA can implement a PPS for home health services by 2000. The commission said that prior to implementation of a PPS, an exclusion policy for "very expensive patients" could be implemented. MedPAC suggested that agencies be allowed to exclude a small portion of their patients from the aggregate per-beneficiary payment limits to ensure that these beneficiaries will have access to needed services. MedPAC added that Medicare could reimburse care for these excluded patients based on the lesser of actual costs or the aggregate per-visit limits.

• That HCFA establish a nationally uniform process to ensure that fiscal intermediaries (FI) have the training and ability to provide timely and accurate coverage and payment information to home health agencies. The commission said that by the time some FIs notified agencies of their payment limits under IPS, many agencies were well into their FY98 cost-reporting periods.

• And that HCFA improve the Medicare fee-for-service appeals process for beneficiaries that use home healthcare, as well as mechanisms that inform them about their rights to appeal determinations on non-coverage. ■

GAO says beneficiary access not impaired by IPS

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

The MedPAC report issued last week follows a **General Accounting Office** (GAO; Washington) report a week earlier that already had the home care industry up in arms.

"Although approximately 14% of agencies have closed and the number of visits provided to Medicare beneficiaries has declined since 1997, we found little evidence that appropriate access to Medicare's home health benefit has been impaired," the report stated.

According to the GAO, roughly 14% of existing home health agencies closed between October 1997 and January 1999. However, the GAO said, many of them shared the characteristics of agencies that opened in the 1990s. "They were disproportionately urban, freestanding, and for-profit," said the GAO. "Agencies that closed also tended to be newer, treated a smaller number of beneficiaries, and provide more services per user than agencies that remained open.

"Such agencies are the types of agencies that would have difficulty adjusting to the revenue caps in the IPS, suggesting that the system is reducing the number of high-uti-

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lization, low-volume agencies," the GAO added.

Like MedPAC, the GAO cast these closures in view of the explosive growth that preceded this period. "The home health industry experienced tremendous growth from 1990 through 1997," said the GAO. "During this period, the number of Medicare certified agencies almost doubled to 10,524." During this same period, the number of freestanding and urban agencies doubled, while the number of proprietary agencies tripled.

The GAO estimated that even after the 14% reduction, there are still more than 9,000 agencies or "approximately the same number that were available in 1996." About 40% of the closures were concentrated in three states. "The recent spate of closures has been concentrated in a few states that had the most growth in agencies and that had utilization experience above the national average," said the GAO.

The GAO pegged the exact number of Medicare-certified agency closures between Oct. 1, 1997, and Jan. 1, 1999, at 1,436. "However, because of growth in the industry since 1990, there were still 9,263 Medicare-certified agencies in January 1999." The GAO conceded that recent closures are now being accompanied by "relatively few" openings.

"The pattern of HHA closures suggests a response to the IPS," especially among agencies that provided more visits per user, the GAO said. "Although we found that agency closures had accelerated, the rapid growth in the number of agencies of the past several years overshadowed the recent retrenchments. Furthermore, the number of Medicare-certified agencies alone is a poor measure of capacity."

The industry has seen a substantial decline in use nationwide since 1996, the GAO said. "Visits per beneficiary have now returned to about the same level as 1994, the base year for the IPS revenue caps. The decline in visits per user between 1996 and 1998 is consistent with IPS incentives and does not necessarily imply a beneficiary access problem."

The GAO reported that most of the state survey agency representatives interviewed responded that "adequate capacity exists despite agency closures." There have been almost no complaints registered by consumers, and a few state survey agencies went so far as to characterize the closures as a market correction.

Access is not a problem even in rural areas, the GAO said. "Closures in rural areas can be a major concern because of the smaller number of agencies located there. Interviews in 34 primarily rural counties, however, generated little evidence that access had been impaired by closures."

The GAO report is among the issues expected to be addressed at a hearing this week before the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee. ■

BRIEFLY NOTED

• In honor of Health Care Education Week '99, **Pritchett & Hull Associates** (Atlanta) is offering a packet of materials to help healthcare providers celebrate the week Dec. 5-11. The packet, available after Aug. 1, will recognize what health educators do for staff, patients, and the community. There will be no charge for members of the **Health Care Educators Association** (HCEA). To order the packet, call Pritchett & Hull at (800) 774-1078. For information on joining HCEA, call Marcie at (888) 298- 3861. ■