Home Health

BUSINESS REPORT

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

House leader introduces bills on self-referral and appeals

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

WASHINGTON – Home care providers might see a rollback of a major portion of the self-referral laws passed by Congress in 1993. Last week, House Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA) unveiled legislation that would strip the compensation portion of the so-called Stark II laws. That follows a bill he introduced a week earlier that would revise the Medicare coverage and appeals processes. Notably, Thomas decided to introduce these measures as freestanding bills and not part of a larger Medicare reform package he is known to be working on.

Thomas signaled he would try to rein in the self-referral laws at a May 13 Health Subcommittee hearing where he grilled **Health Care Financing Administration** (HCFA; Baltimore) Deputy Director Kathy Buto over the

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Two HH companies announce bankruptcy protection filing

By MEREDITH BONNER
***HHBR* Editor**

Two major players in the home health sector had to file for Chapter 11 protection last week, showing more effects of the major financial cuts the Balanced Budget Act of 1997 brought with its passage.

Medshares (Memphis, TN) and its **Soleus Healthcare Services** affiliated home healthcare companies filed for U.S. Bankruptcy Court protection last week after running out of cash and being cut off by their lender, reported the *Commercial Appeal* of Memphis.

And in another part of the country, **HealthCor Holdings** (Dallas) filed for Chapter 11 bankruptcy protection in a U.S. Bankruptcy Court in Dallas, also saying it has run into cash problems due to the Medicare reimbursement cuts.

HealthCor, which was delisted from Nasdaq last year

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Respironics to restructure; closes sites, lays off 10% of staff

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

Respironics (Pittsburgh) has outlined its plans for a restructuring that will cost 200 people their jobs when it closes facilities in Colorado and around the nation.

It also will record over the next several quarters a pretax charge of about $25 million as a result of the restructuring.

The company reported its sales and net earnings last week for 4Q99 and FY99 ended June 30. Net sales for 4Q99 were $90.1 million, compared with $85.2 million in 4Q98. Net income was $1.1 million, 4 cents per share, compared to $3.6 million, 11 cents per share, in 4Q98.

For the year, net sales were $357.6 million, compared with $351.6 million in FY98. Net income was $23.1 million, 72 cents per share, compared to a net loss in FY98 of $1.8 million, 6 cents per share.

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Republican leader Rep. J. C. Watts introduces home care bill

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

WASHINGTON – Rep. J.C Watts (R-OK) last week introduced the latest in what has become a deluge of home care bills now before Congress. But Watts' legislation, the Medicare Home Health Services Equity Act of 1999, carries extra weight because of his role as chairman of the House Republican Conference.

Like most of the bills already introduced, Watts' bill would eliminate the 15% reduction scheduled to go into effect Oct. 1, 2000. But it would also give home health agencies retroactive relief from overpayments related to the interim payment system (IPS) and prohibit the **Health Care Financing Administration** (HCFA; Baltimore) from attempting to recoup any overpayments that were accrued prior to the fiscal year in which the agency received notice of its per-beneficiary limit.

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Bankruptcy

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because it couldn't keep the required minimum share price and now trades over the counter, did not disclose further information about the filing, according to a *Wall Street Journal* report. But HealthCor has been divesting certain nursing and medical equipment operations in the last few months. In June, HealthCor sold its Texas community care service offices to **Auxi Health** (Nashville, TN) and all of its HME operations to **Lincare Holdings** (Dallas). In addition, last week, HealthCor sold its second unit to **ComTech Consolidation Group**'s (Houston) **Unique Drawing** subsidiary. Unique Drawing acquired HealthCor's Medicare and commercial home healthcare operations in League City, TX. The purchase was made in exchange for cash. The League City operations had revenues of $1.9 million in FY98. Unique Drawing acquired its first HealthCor unit in early July, buying HealthCor's home health nursing operation in Beaumont, TX.

Medshares was forced to restructure its operations recently – just 10 months after buying 70 home health agencies from **Columbia/HCA Healthcare** (Nashville, TN) and six months after acquiring the home nursing division of **Integrated Health Services** (Owings Mills, MD), which is now called Soleus Healthcare Services.

The cash crunch came after the acquisitions were complete, but at a time when federal and state regulatory authorities have been delaying reimbursements for services for 210 days, said Robert Leech, senior vice president for government relations with the management firm **TBN of TN** (Memphis, TN), which manages Medshares. Supplementing company reserves with borrowed funds, the company recently hit its banker's lending limit, he told the *Commercial Appeal*.

The reorganization included 160 home health affiliated agencies, with 103 petitions filed under Chapter 11 of the U.S. Bankruptcy Code. Those companies include affiliates of Soleus; **Tibian Health Care Services** of Houston; **Centerpoint Corp.**, Medshares and **Medshares Holding**, all of Memphis, TN; and their management firm, TBN of TN. ■

Watts

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Watts, who introduced the bill with House Ways and Means Committee member Rep. Wes Watkins (R-OK), unveiled his bill at a press conference along with **National Association for Home Care** (NAHC; Washington) President Val Halamandaris. Watts argued that the goal of reigning in fraud and abuse in home care has largely been accomplished and predicted that Congress will pass a bill this year that rolls back at least parts of the Balanced Budget Act of 1997.

Also like most of the earlier bills introduced so far this year, Watts' bill includes an outlier provision for high-cost medically complex patients. In addition, it would increase per-visit limits from 106% to 108% of the median and provide exceptions from the per-beneficiary limit for agencies that provide care in a medically-underserved area or who qualify as a sole community provider. An exception from the per-beneficiary limit is also provided if an agency can show reasonable costs above the limits owed to regulations passed after 1994. ■

New JCAHO compliance guidebook is available

Leaping the Joint Commission's hurdles to accreditation for your home care agency can be made easier with the newest edition of *Strategies for Successful JCAHO Homecare Accreditation 1999-2000*.

This newest edition is a step-by-step guide to compliance with the **Joint Commission on the Accreditation of Healthcare Organizations'** 1999-2000 standards. Its 573 pages provide strategies and documentation tools to help you prepare for accreditation.

If you have a home care survey coming, don't wait to order this guide. Call (800) 688-2421 for more information, or send an e-mail to American Health Consultants at *customerservice@ahcpub.com.* ■

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COMPANIES IN THE NEWS

AHOM gets delisted

American HomePatient (AHOM; Brentwood, TN) has been delisted from the Nasdaq National Market, effective at the close of business Aug. 31. The company will be taken off the market because it failed to meet the minimum bid price requirement of $5 per share. AHOM said it is currently pursuing the listing of its common stock on the American Stock Exchange (Amex).

Unless Amex has approved AHOM for trading by Sept. 1, trading of AHOM's common stock will be conducted on the over-the-counter market at that date. The company's trading symbol, AHOM, will remain the same, officials said.

Apria reports profit for 2Q99

Apria Healthcare (Costa Mesa, CA) reported a net income for 2Q99 ended June 30 of $17.8 million, 33 cents per share, compared to a net loss in 2Q98 of $9 million, 17 cents per share. The company's revenues for 2Q99 totaled $232 million, down slightly from 2Q98 revenues of $240.6 million.

As of June 30, net accounts receivable were $142.9 million, with net days sales outstanding at 55 days, Apria said. In addition, the company used available cash to make a $50 million prepayment to reduce bank indebtedness during 2Q99.

Baxter launches at-home kidney dialysis system

Baxter International (Deerfield, IL) has launched HomeChoice PRO with PD Link, an advanced, at-home kidney dialysis system designed to improve patient care, while making home dialysis easier and more convenient. HomeChoice PRO is a home-based dialysis treatment option that leverages advanced computer technology to communicate critical therapy data to clinicians via a data card or modem. This new monitoring system is the latest innovation in home dialysis. It enables clinicians to monitor patient data on a daily basis, allowing them to adjust prescriptions and identify potential problems between clinic visits.

Dispute with Aetna leads to Coram layoffs

Coram (Denver) has laid off 114 employees in its Whippany, NJ, office because of its dispute with **Aetna U.S. Healthcare** (Blue Bell, PA). Coram blamed the lay offs on the termination of the master agreement between Aetna and Coram, Aetna's failure to pay amounts due thereunder, and misrepresentations by Aetna. The employees managed Coram's five-year agreement with Aetna to provide and manage home healthcare services for its members in eight states. In late June, Coram filed suit against and terminated its contract with Aetna, alleging the company understated the amount of home health services used by the more than 2 million enrollees in Aetna's HMO-based healthcare plans in the eight covered states. During the term of the contract, Aetna refused to properly compensate Coram, officials said. Coram also notified Aetna on June 30 that it was terminating the master agreement between the two, but that it would work with Aetna to insure the continued and uninterrupted authorization of services for patient care. Coram said late last week that it has largely completed an orderly transition of its management responsibilities for the home healthcare network back to Aetna.

Coram also sued Aetna for more than $50 million, alleging fraud, misreprentation, and breach of contract. Aetna has called the claim frivolous, reported the *Wall Street Journal*. As a result of the suits, Coram has said it expects to report a loss for 2Q99.

Healthcare acquires Life Line

Healthcare Development Corp. (Tampa, FL) has acquired **Life Line Home Services** (Tampa, FL). It will add $1.1 million in projected revenues during the next year, increasing the company's expected revenues to $9.3 million. Healthcare is a wholly owned subsidiary of **Asgard Alliance Corp**.

Interwest reports results for 3Q99

Interwest Home Medical (Salt Lake City) announced record earnings for 3Q99 ended June 30. Revenues were $7.9 million, a jump of 3% over revenues of $7.7 million for 3Q98. Net income was $393,000, 10 cents per share, compared to $361,000, 9 cents per share, in 3Q98. President/CEO James Robinson said the company's results are satisfying considering the Medicare oxygen reimbursement reduction.

Kelly exceeds growth expectations

Kelly Services (Troy, MI) announced sales of $1.1 billion for 2Q99 ended July 4. It is a 6.5% increase over $1 billion reported for 2Q98. Net earnings were $20.7 million, 58 cents per share, compared to $20.6 million, 54 cents per share, in 2Q98. Chairman/President/CEO Terence Adderley said the company has exceeded its expectations of 4% to 6% growth.

Matria sees 86% increase in 2Q99 revenues

Matria Healthcare (Marietta, GA) reported that its revenues for 2Q99 ended June 30 were $62.3 million, an 86% increase over revenues of $33.5 million for 2Q98. Net earnings available to common shareholders for 2Q99 were $3.1 million, 9 cents per share, compared to a net loss in 2Q98 of $5.3 million, 14 cents per share.

National HealthCare reports decrease in revenues

National HealthCare Corp. (Murfreesboro, TN) announced earnings for 2Q99 ended June 30. Net income

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was $2.3 million, 20 cents per share, compared to $2.8 million, 25 cents per share, in 2Q98. Revenues were $107.7 million, compared to $111 million in 2Q98. The decline was due to reductions in Medicare reimbursement for home care, nursing home, and rehabilitation services.

PSA sells HME division to private investor

Pediatric Services of America (PSA; Norcross, GA) has sold its predominately adult home medical equipment branch in Fort Worth, TX, to a private investor. Healthcare merger and acquisition firm **The Braff Group** (Pittsburgh) represented PSA in the transaction. "The divestiture of this branch is part of PSA's strategic initiatives to focus on its core competencies," said Tim Binkley, associate of The Braff Group.

Justice Department won't join Simione lawsuit

The **Justice Department** has decided not to join claims against **Simione Central Holdings** (Atlanta) in a whistleblower lawsuit alleging Medicare fraud. Former **Olsten Corp**. (Melville, NY) Vice President Donald McLendon filed the lawsuit. The justice department recently said it has joined part of the suit involving **Columbia/HCA Healthcare Corp**. (Nashville, TN). About $41 million of Olsten's $51 million civil settlement involved allegations in the McLendon lawsuit, reported the *Wall Street Journal*. Simione's CEO Barrett C. O'Donnell said Simione did not know about the lawsuit and will cooperate with the government in its investigation. It is unclear, company officials said, whether McLendon will pursue the suit against Simione.

Sunrise contracts with wheelchair basketball star

Sunrise Medical (Carlsbad, CA) has signed wheelchair basketball star Jeff Glasbrenner to Team Quickie, an organization of top wheelchair athletes who compete in everything from basketball, tennis, quad rugby, and racing, using Sunrise's products. Glasbrenner has competed in tournaments all over the world as part of the U.S. national basketball team since 1997. He received a gold medal at the Gold Cup Championships in Sydney, Australia.

Tenet posts losses of 44 cents per share in 4Q99

Tenet Healthcare Corp. (Santa Barbara, CA) has announced its results for 4Q99 and FY99 ended May 31. The company reported a net loss of $137 million, 44 cents per share, in the quarter, compared to a net loss of $141 million, 46 cents per share, in 4Q98. Revenues for 4Q99 were $2.94 billion, a 14.4% increase compared with 4Q98 revenues of $2.57 billion. For FY99, the company reported a net income of $249 million, 79 cents per share, on revenues of $10.88 billion, compared to a net income of $261 million, 84 cents per share, on revenues of $9.89 billion in FY98. Tenet's chairman/CEO, Jeffrey Barbakow said that Medicare reimbursement cuts reduced the company's earnings by 20 cents per share for the year. The company is experiencing rising bad debt expenses and is pursuing initiatives to solve the problem. During 4Q99, the company recorded impairment and restructuring charges of $363 million, which includes losses on the sale or closure of certain hospitals and home health agencies. The company estimates that more reductions in government-funded programs will cost the company about $100 million on a pre-tax basis in FY2000. ■

Respironics

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All 4Q99 and FY99 results include restructuring charges of $2.4 million, 4 cents per share, and a special addition to the company's allowance for uncollectible receivables of $5 million, 10 cents per share.

Part of the company's plan is to restructure its operations into four divisions, being that of home care, hospital, asthma/allergy, and international. In addition, it will close the Westminster, CO, manufacturing facility and its 19 customer satisfaction centers around the nation. It will reduce in size its Marietta, GA, manufacturing facilities, which will focus only on oxygen and monitoring. The company will open within two months a centralized distribution and repair center in Youngwood, PA, which will employ about 90 people. The PLV ventilator manufactured in Westminster will be transferred to the Murrysville, PA, facility.

"I sincerely regret that the actions we are taking ... will impact some of our people negatively," said President/CEO Dennis Meteny. "I do believe that we have cushioned any effects to these individuals to the best of our ability, and I know that these actions were necessary for the viability of the company."

The company plans to reduce its workforce by about 10%, or 200 people.

Meteny also appointed Craig Reynolds, executive vice president and chief operating officer, to lead the operating management team. The team will consist of CFO Daniel Bevevino, Richard Gruber of corporate quality assurance, Corporate Secretary Dorita Pishko, and the senior vice president of new ventures and corporate services, Robert Crouch. Reynolds will also be in charge of the four officers heading the divisions: John Miclot for home care, Paul Woodring for hospital, Susan Lloyd for asthma/allergy, and Geoffrey Waters for international.

"The new organization structure, with a reduced number of direct reports for me, will allow me to focus more directly on the future opportunities and strategic initiatives of the company," Meteny said.

Respironics was once a star performer in the industry, but has faced lower earnings due to cost-cutting in healthcare and acquisition-related problems, reported the *Pittsburgh Post-Gazette*. The company has traded between 9 5/8 and 21 3/8 over the past year. ■

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MANAGED CARE REPORT

• **Wellpoint Health Networks** (Thousand Oaks, CA) recorded 2Q99 earnings of $71 million, $1.03 per share, compared to a net loss in 2Q98 of $47 million, 66 cents per share. The company's revenues increased nearly 19% to $1.85 billion. The mean estimate of analysts surveyed by **First Call** was for 2Q99 net income of about $1.02 per share. Wellpoint said 2Q99 membership increased in California by nearly 14%, or 586,000, with membership outside of California falling 14.3% on attrition in previously acquired large-group businesses.

• **Ceres Group** (Cleveland) announced sales of $74 million of annualized new premium in 2Q99, compared to $15.6 million in 2Q98. The increase was due to a larger agent force representing the company's insurance subsidiaries as a result of new acquisitions. The increase was also attributed to new product introductions. One of the most significant changes for Ceres Group in 1999, said Chief Sales Officer Bruce Henry, has been its entry into the senior age life and health insurance market. "Our **Continental General** subsidiary provides an excellent platform from which we expect to expand our senior age operations. In 3Q99, we plan to roll out our new Senior Power Portfolio, which includes long term care, home healthcare, Medicare supplement, Medicare Select, wealth accumulation annuities, and senior cancer coverage," Henry said.

• **RightChoice Managed Care** (St. Louis) reported a 2Q99 net income of $3.9 million, 21 cents per share, compared to a net income in 2Q98 of $1.2 million, 6 cents per share. The company's medical margin was $22.74 per member per month, a 13% increase over $20.16 per member per month in 2Q98.

• **PacifiCare Health Systems** (Santa Ana, CA) total membership as of June 30, 1999, was 3.6 million members, about 2% below the year-ago membership. The drop was primarily attributable to the sale of the company's Utah HMO plan, a continued focus on achieving targeted commercial price increases, and the exit of Medicare programs in selected counties, PacifiCare said. For 2Q99, operating revenue was $2.5 billion, which was comparable to 2Q98 and 1Q99. The company reported a net income available to common shareholders in 2Q99 of $68.9 million, $1.49 per share, compared to a 2Q98 net income available to common shareholders of $46.2 million, $1.06 per share. During 2Q99, PacifiCare announced a definitive agreement to acquire **Antero Healthplans of Colorado**, which will add about 38,000 members when the transaction closes later in 1999.

• **Humana** (Louisville, KY) said, effective Aug. 1, it will assume operational responsibility for the major PPO provider network that its small-group business uses, which previously was managed by **Private Healthcare Systems**. About two-thirds of Humana's small group members use the network. The new provider network will be named ChoiceCare Network and will include more than 300,000 physicians and 2,500 hospitals in 46 states. The network management responsibilities Humana will be assuming from Private Healthcare Systems are a natural extension of Humana's business, officials said. In other news, Humana has entered into partnerships with three medical organizations to operate five Orlando-area medical centers formerly operated by **FPA Medical Management**. The agreements are effective between Aug. 1 and Sept. 1. The three Orlando-area medical groups that have entered into partnerships with Humana are **GeriMed of America**, **Family Physicians of Winter Park**, and **Associated Family Medicare**. Humana assumed operational responsibility for 50 former FPA centers June 1 on a transitional basis as part of an agreement with FPA, approved by the federal bankruptcy court overseeing FPA's Chapter 11 reorganization. The partnerships are consistent with Humana's intention to transfer operation of the former FPA centers to other provider groups, enabling Humana to focus exclusively on its core business of health insurance.

• **Blue Cross and Blue Shield of Maine** (BCBSME; Portland, ME) has selected **Blue Pumpkin Software**'s (Mountain View, CA) PrimeTime workforce management software to streamline its primary call center operations. Prior to using PrimeTime, BCBSME's challenges in the call center were long holding time, resource retention, and controlling costs.

• Rhode Island House Majority Leader Gerard Martineau is accusing **Blue Cross and Blue Shield of Rhode Island** (BCBSRI; Providence, RI) of violating its agreement with general assembly leaders not to pursue certain networks for at least three months. Matineau is upset that BCBSRI is moving forward with plans to limit some 88,000 subscribers to selected networks of laboratories and home health agencies, reported the *Associated Press*. BCBSRI officials told the *Providence Journal*, however, that there was never any such agreement. Vice President for Legislation and Community Affairs Thomas Lynch said BCBSRI agreed to the moratorium only if the other health insurers would do the same, and he said the other insurers refused. Martineau said the first step would be to meet with the affected parties and discuss the issues, and then weigh the possibility of a special legislative session. Meanwhile, the *AP* reported, hospitals are worried that BCBSRI's plans will threaten their survival, as most of the hospitals own home health agencies, and if BCBSRI requires its subscribers to use out-of-hospital home health agencies, it will siphon business away from the hospitals. ■

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REGIONAL DIGEST

• Home health agencies in the Tampa Bay, FL, area are facing severe shortages of home health aides. Susan Dietrich, director of nursing at the **Visiting Nurses Association of Florida**, said she spent $1,200 on advertising and another $200 on balloons and food for an employment drive, seeking home health aides. "I offered bonuses," she told the *St. Petersburg Times*. "I had one applicant show up." Home health providers say that paying wages higher than the standard $8 to $10 an hour might entice more workers, but that they are limited because of what Medicare and Medicaid pays.

• Authorities charged the operators of **Faith Home Health Services** in Baton Rouge, LA, with pension plan embezzlement and fraud for taking $8,000 from employee pensions to pay for business expenses. The women also allegedly misapplied Medicare reimbursements from August 1996 to February 1998 by using them for operating expenses. If found guilty, they could receive as many as 10 years in prison or fines of $250,000 or more.

• The **Tucson Loan Chest** in Tucson, AZ, provides low-cost home health equipment for people whose insurance won't cover it. An 89-year-old woman, for instance, rents a multiposition electric hospital bed for $4 a month, instead of the $160 a month a medical supply business would charge. A 24-year-old car accident victim rents a tub transfer bench for $3 a month, reported the *Tucson Citizen*. The organization's fees are based on a federal guideline sliding scale. They are waived for those who can't pay anything.

• Memorial Hospital in Colorado Springs, CO, may cut its home care operations because the division lost $503,000 last year. The hospital's executive director, Bob Peters, said the hospital can't afford to subsidize services that don't pay their keep, reported the *Gazette*. He intended to first meet with managers to try to make the services more efficient. The hospital is seeing the deficit because of reduced Medicare reimbursements and an influx of patients who are unable to pay.

• About $250,000 in renovations to the Harrington Memorial Hospital's Home Care and Hospice Department in Southbridge, MA, was completed in June. The renovations added a conference room, staff room, medical records office, and hospice office. The department has become busier in recent years because insurance companies now inch people out of hospitals sooner than they can care for themselves, reported the *Telegram & Gazette* of Worcester, MA.

• Trouble keeping home health nurses on staff has forced agencies to decline services to some very needy patients. In Grand Rapids, MI, a 9-year-old boy has lived at the DeVos Children's Hospital for more than three months because of problems with the state's home care payments, reported the *Grand Rapids Press*. The boy could have returned home weeks ago, but social workers could not find a nursing agency willing to take his case. State officials gave the family permission to hire nurses from a non-Medicaid agency, as it was the only choice. Nursing shortages may be due to the fact that nurses did not receive a pay increase in seven years until January. Now, the state reimburses agencies $26 an hour for registered nurses and $22 for licensed practical nurses. But reimbursements were decreased for off-hour workers, and agency officials need 42% of the reimbursement to cover administrative costs and make a profit. That leaves LPNs, for instance, with about $13 an hour. A pilot voucher program in which a public agency handles the money, but relatives hire and schedule nurses may be a solution to the problem. Nurses become independent contractors. One registered nurse who had made $14.25 an hour through an agency was able to make $18.50 an hour working for herself.

• The **Cincinnati Health Department**'s home health agency has been owed about $600,000 in unpaid Medicare claims from 1994-96 and may never see the money, reported the *Cincinnati Post*. The 10,200 claims not paid were mishandled by **Health Care Services Corp**., also called **Blue Cross Blue Shield of Illinois**, the company assigned by the government to process them. That company pleaded guilty last year to defrauding Medicare. It was fined $144 million, but it has never paid the health department.

• **Verdugo Hills Hospital Homecare** in the Los Angeles area has been accredited by the **Joint Commission on Accreditation of Healthcare Organizations**. Some of Verdugo Hill's services include skilled nursing and psychiatric care, home health aides, and medical social work services. ■

PPM/MSO NEWS

• **IntegraMed America** (Purchase, NY) has hired John Hlywak Jr. as its new senior vice president and chief financial officer. Hlywak previously worked as senior vice president and CFO of **MedSource** (Nashville, TN). He also worked as a principal with **The J. William Group** from 1995 to 1997.

• **Tessa Complete Health Care** (Oakbrook Terrace, IL) has acquired **Fox Valley Chiropractic Physicians** in St. Charles, IL. The clinic generated revenues of $500,000 in 1998. As part of the agreement, Dr. Mark Glesener, owner of the clinic, may receive as many as 100,000 shares of Tessa stock. ■

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House bills

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agency's failure to publish regulations for Stark II.

Self-referral is the term used to describe situations in which a healthcare provider refers a patient to a medical facility in which the physician has a financial interest. In the Omnibus Reconciliation Act of 1989 (OBRA 89'), Congress passed what became known as Stark I after the law's main sponsor, Rep. Pete Stark (D-CA) to restrict such arrangements. OBRA 93' extended the law to 10 designated health services, including home health, durable medical equipment (DME), parenteral and enteral nutrients, and orthotic and prosthetic devices.

The second physician self-referral law had two parts, ownership and compensation. But Thomas said the compensation portion of Stark II has been "a vexing area" for some years. "We have a statute on the books that is unenforceable," he said at a press conference on Capitol Hill July 29. "The whole intent of (the law) was to draw bright lines to allow people to have guidelines about what was and what was not permissible," he added. "The problem is that since 1993 HCFA has not been able to write the regulations dealing with that compensation portion."

Instead, Thomas said HCFA should use the anti-fraud tools included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA). There were more than five dozen specific provisions to empower **Health and Human Services** (HHS), the **Office of Inspector General** and the **Department of Justice** to go after fraud and abuse included in those two measures, Thomas said. But the portion of the 1993 self-referral legislation dealing with compensation has never been used and has only created mayhem, he added.

Thomas noted that earlier this year the administration announced it had sliced fraud and abuse in Medicare and Medicaid in half — from $24 billion a year to $12 billion a year. While $12 billion a year is still unacceptable, he said, reduction reduction demonstrates the usefulness of the anti-fraud tools provided in both HIPAA and the BBA.

Thomas said the **Congressional Budget Office** scored his bill at $100 billion to $200 billion over five years, but argued that the increased flexibility would lead to increased services. "Cost is not necessarily an evil," he said, "but rather an indication government is not allowing creativity."

Stark offers alternative

Stark wasted no time blasting Thomas' bill and introducing his own on the same day.

"The Thomas bill will return us to the days of massive patient abuse by unscrupulous doctors," said Stark. "Total repeal of the compensation provisions is a loophole you can drive an armored division through." He said his bill, the Medicare Physician Self-Referral Improvement Act of 1999, would simplify and streamline the law by creating a fair market value exception or safe harbor for providers who have compensation relationships with entities to which they refer Medicare and Medicaid beneficiaries for health services.

Under the fair market value test, an agreement must be in writing for a definite period of time and not be dependent on the volume or value of referrals and the compensation in the contract must be a reasonable fair market rate.

Stark said his bill also addresses concerns that providers have expressed about the law's direct supervision requirements by replacing this standard with one that requires providers to "assume full and direct legal, financial, and professional responsibility for the services that are provided." His bill would also remove ambulatory surgical centers or hospices from the list of designated health services that are covered by the self-referral ban and eliminate the current ban that prohibits providers from providing DME and parenteral and enteral nutrients as part of the in-office ancillary exception.

Thomas and Stark join forces on appeals bill

While Thomas and Stark are worlds apart where self-referral is concerned, the two joined forces a week earlier when they introduced the Medicare Patient Appeals Act of 1999. That bill would establish a 60-day deadline for HCFA's intermediaries and contractors to review appeals and a 90-day deadline for administrative law judge (ALJ) appeal decisions and Departmental Appeals Board reviews. It would also task the HHS Appeals Board with reviewing HCFA's coverage decisions.

"Patient disputes are often resolved quicker in private health plans than they are in Medicare," said Thomas. "We want to give Medicare patients the right to hold the federal government accountable in the same way that the private health plans are accountable.

The **National Association for Home Care** (NAHC; Washington) strongly endorsed the bill. "Currently there is no procedure for appealing national and local coverage policy decisions," NAHC said. "Often delays exceed three months for reconsideration decisions by intermediaries and a year or longer for scheduling of ALJ hearings. This bill will go far in improving the rights of Medicare beneficiaries appealing medical decisions."

Because all of these bills were introduced as freestanding bills, they will have to be attached to a larger Medicare reform bill or other legislation that Congress acts on later this year. ■

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