Home Health

BUSINESS REPORT

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

HCFA outlines PPS case mix and other key components

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

BALTIMORE – The **Health Care Financing Administration** (HCFA; Washington) last week detailed key provisions of its 376-page draft proposal for a home health prospective payment system (PPS), which is to replace the highly controversial interim payment system (IPS) on Oct. 1, 2000.

HCFA officials noted that the Balanced Budget Act of 1997 (BBA) permits the agency to transition to PPS by mixing the current cost-based system with the new prospective system. But agency officials declined that option due mainly to concerns about IPS.

The BBA also establishes the total amount of money that will be paid out by the new system. In FY01 that amount is equal to the amount that would have been paid out under the current IPS with both the per visit and per beneficiary limit reduced by 15%. That required HCFA to apply a budget neutrality factor to the rate that would have been paid in order to reach the budget target established by the statute.

According to agency officials, budget neutrality was especially difficult to meet given the multiple changes taking place in the home health industry. But on the whole, HCFA officials argued that the PPS is preferable to the current system because it allows payment to be adjusted to case-mix based on patient needs and maximizes the ability of agencies to stay within a budget to deliver the services a patient needs. Agency officials also point to the outlier provisions included in the new methodology as an additional protection for agencies and beneficiaries.

The payment system would use national payment rates with adjustments to reflect area wage differences and the intensity of care required by each beneficiary. Home health agencies will receive 50% of the payment as soon as it establishes a case-mix with the balance paid at the end of

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M&A activity continues to be slow in 3Q99, new report says

By MEREDITH BONNER
***HHBR* Editor**

With a clear cut prospective payment system (PPS) now in sight, the home health industry might begin to see a resurgence in merger and acquisition (M&A) activity, said Sanford Steever, editor of the **Irving Levin Associates** (New Canaan, CT) 3Q99 *Health Care Merger & Acquisition Report*.

Activity, however, remained low in 3Q99. According to the report, there were 8 publicly announced transactions in 3Q99 in the home health segment – down 50% from 3Q98, and down 60% from 2Q99.

Steever told *HHBR* that since the PPS proposal has been released, people should be able to calculate what their earnings will be and where their strengths and weaknesses will be once it is in place.

"The industry is driven by the BBA (Balanced Budget

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Home care payments plummet; MedPAC sets 2000 work plan

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

BALTIMORE – Medicare home health payments fell a staggering 38% from 1997 to 1998, according to new data from the **Health Care Financing Administration**'s (HCFA; Baltimore) Customer Information System. Total payments decreased from $16.7 billion in 1997 to $10.5 billion in 1998 while visits dropped 40%.

On a per-patient basis, reimbursement decreased from $4,705 to $3,412 from 1997 to 1998. Meanwhile, visits per patient dropped from 73 to 51.

These latest data are the most dramatic evidence to date of the impact of the Balanced Budget Act of 1997 (BBA). Home care representatives are hoping the numbers will help fuel congressional efforts to eliminate the additional 15% across-the-board cut scheduled for Oct. 1, 2000.

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M&As

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Act of 1997), and until relief from that trickles down to the providers, it is still going to be a thick market," he said. "People are obviously making a living doing this, but it's tight." He added that BBA relief is going to take some time to reach the level of providers.

Agreeing with Steever, Dexter Braff of **The Braff Group** (Pittsburgh) told *HHBR* that the light at the end of the tunnel will come from a rebirth of the home health agency (HHA) side of the business.

"We firmly believe that will happen once the PPS program is fully vetted," Braff said. "Once it hits and people understand it, even if it's horrible, there will be an increase in activity in the HHA sector because now providers will be able to see what the future holds for them; there will be more stability in the market. Then we will see companies buying again."

Some providers, Steever also said, see the slow activity as an opportunity to buy.

"Pricing is going to be low, and obviously there are a lot of small companies on the market," he said. "The problem is financing the deals. The companies have to be really good to convince bankers to do the deals."

A good M&A market, Braff told *HHBR*, is good for the industry because that means all the players are seeking to get better, grow, get profitable, and gain more share. When that happens, there is a lot of competition and opportunity for making money, he said.

"A good M&A market encourages innovation and growth, and encourages people to then create companies that can be acquired," he said. But Braff added that when activity becomes greater, there can be major consolidation, and there could end up being two or three major players, which would reverse the competition level.

Steever said that when and if the industry does start to see some relief, he thinks a lot of growth will be achieved through acquisitions or mergers. But he said that won't happen in the near future.

"I have heard that **Coram** (Denver) is going to step up its acquisition program, which has been dormant in the recent past. So there are acquirers out there, but it will be a while. There might be buyers, but they don't have the financing." But Steever added, "Once they come back to some financial help, they will be buying."

There were 163 publicly announced mergers and acquisitions in the entire healthcare services market during 3Q99, the report showed, 19 fewer than in the previous quarter. The total number of transactions was down 42%, from those in 3Q98, the report showed, and the number represents the lowest activity since 1995. Most of the transactions involved physician medical groups, hospitals, and long term care organizations, accounting for 52% of the total deals reported. According to the report, rehabilitation services saw the least amount of activity, with only two transactions for the quarter. ■

CALENDAR

• The **Missouri Alliance for Home Care** (Jefferson City, MO) is offering a seminar, *Private Duty/Private Pay; Key Elements for a Successful Agency*, Wednesday, Nov. 10, in Jefferson City. The seminar is from 8:30 a.m. to 4:30 p.m., with a luncheon provided. For more information or to register, call (573) 634-7772.

• **Global Business Research**'s (Stamford, CT) conference, *Prosper Under PPS: Successfully Balancing Finance and Clinical Operations*, is Dec. 9-10 in Orlando, FL. The conference will address how to learn to live with PPS now. For more information, call (800) 868-7188.

• Medtrade Europe, the trade event in Europe that focuses exclusively on the home care market, has been postponed to 2001. The conference was scheduled for April 12-14, 2000. For more information on Medtrade Europe, call (800) 241-9034.

• The **California Association for Health Services at Home**'s (Sacramento) 2000 annual conference is May 17-19 in Pasadena. For more information, call (916) 554-6117. ■

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COMPANIES IN THE NEWS

Apria sees profit in 3Q99

Apria Healthcare Group (Costa Mesa, CA) reported a net income for 3Q99 ended Sept. 30 of $18.9 million, 35 cents per share, compared to a net loss in 3Q98 of $194.7 million, $3.76 per share. The company saw revenues of $237.4 million in 3Q99, up from 3Q98 revenues of $219.4 million. Apria's gross profit margin increased to 71.9%, compared to 55.8% in 3Q98.

Apria said the lawsuit against **Coram Healthcare** (Denver) and certain of its subsidiaries to collect $2.1 million of unpaid invoices is continuing. As of Sept. 30, all amounts owed by Coram and its subsidiaries have been fully reserved, Apria said.

Beverly moves to new building

Beverly Enterprises' (Fort Smith, AR) employees have begun moving into a new facility in Fort Smith, AR, that will become the company's headquarters, housing employees from some of the company's nearly 30 locations in Fort Smith. The move will continue during an eight-week period, Beverly said. Chairman/CEO David Banks said he thinks the move has squelched rumors that Beverly plans to move its corporate headquarters.

Amaral to return to Coram

Coram Healthcare's (Denver) chairman and former CEO, Donald Amaral, will return as the company's interim CEO. Coram is currently searching for a new CEO, following the departure of Richard Smith.

GF's refinancing is terminated

Graham-Field Health Products (GF; Bay Shore, NY) said that its previously announced $50 million refinancing from **BankBoston NA** will no longer happen. The new facility was to refinance the company's current indebtedness under its credit facility with **IBJ Whitehall Business Credit Corp**. as agent and provide for the ongoing working capital needs of the company.

GF is pursuing other sources of financing and the sale of certain non-core assets, and is considering other alternatives, including a restructuring or a reorganization.

Infu-Tech teams with Access Med Plus

Infu-Tech (Englewood Cliffs, NJ) said that health insurer **Access Med Plus** has selected it as the distributor for specialty pharmaceuticals, including Synagis. Synagis is a specialty drug for the treatment of Respiratory Syncytial Virus.

In other news, Infu-Tech reported last week its FY99 and 4Q99 financial results, recording a FY99 net loss of $1.1 million, 35 cents per share, compared to a net income in FY98 of $196,000, 6 cents per share. The company saw FY99 total revenues of $25.5 million, down 3% from FY98 revenues of $26.5 million.

The company saw revenues in 4Q99 of $6.6 million, up only slightly from FY98 revenues of $6.5 million. Infu-Tech posted a net loss for the quarter of $1.1 million, 35 cents per share, compared to a net loss in 4Q98 of $275,000, 8 cents per share.

The company is experiencing a slowdown of payments from managed care organizations, as is the whole home health industry, said Infu-Tech. This has resulted in the company recording a higher bad debt expense in 4Q99 that has contributed to a decrease in that income. While revenues from the specialty pharmaceutical business are increasing, they do not yet offset the costs of services associated with the traditional infusion business that the company continues to work on reducing, Infu-Tech said.

Mallinckrodt introduces new oxygen product

Mallinckrodt's (St. Louis) new Puritan Bennett Aeris 590 oxygen concentrator is another of the company's growing line of products designed for patients with chronic obstructive pulmonary disease. The Aeris 590 provides supplemental oxygen primarily to patients in a home setting, but it can also be used in subacute settings, such as nursing homes. The Aeris 590, Mallinckrodt said, is lighter, quieter, and easier to move and handle than the Puritan Bennett Companion 590, the Aeris 590's predecessor. The company said its customers were asking for certain changes to the Companion 590, and that it responded with the new product. Other improvements to the Aeris 590, Mallinckrodt said, include: a modular sieve bed design that integrates connectors and fittings in a manifold for easy maintenance and a newly designed valve system for increased reliability and serviceability.

McKesson HBOC sees growth in 2Q99

McKesson HBOC (San Francisco) recorded a net income in 2Q00 ended Sept. 30 of $59.3 million, 21 cents per share, compared to a 2Q99 net income of $26.3 million, 10 cents per share. The company saw total revenues in 2Q00 of $9.1 billion, up from 2Q99 revenues of $7.3 billion.

McKesson said the growth rate in net income and earnings per share was dampened in 2Q00 compared to 2Q99, as it was in 1Q00, by higher financing costs associated with prior year acquisitions funded by cash, working capital increases tied to strong supply management growth, and lower cash flows from the company's **Information Technology Business** due to the decline in that segment's revenues.

Mediflow introduces new product line

Mediflow (Markham, Ontario) introduced a new line of backrests and lumbar supports with patented Adjust-Air technology and a vertically adjustable support for personal

customization. The adjustable air bladder found inside the backrest can be inflated with a palm-size pump/release valve to allow users appropriate lumbar support, the company said. In addition, the pull straps located on the back of the backrest allow for vertical adjustments to customized comfort according to the user's height and build.

Nursefinders acquires Houston agency

Nursefinders (Houston) has acquired **Gulf Coast Medical Personnel** (Kingwood, TX). This latest location, noted for its highly trained staff of 100 nurses, increases Nursefinders' presence to five locations in greater Houston and a record 126 locations across the United States.

Gulf Cost has become a leading home healthcare provider, specializing in the care of patients with neurological disorders, such as Lou Gehrig's disease and multiple sclerosis. Mary Beth Parks, founder of Gulf Coast, will continue to serve as the location's branch director, Nursefinders said.

Respironics' 1Q00 sales down

Respironics (Pittsburgh) saw net sales in 1Q00 ended Sept. 30 of $80.6 million, down 7% from net sales of $86.4 million in 1Q99. The company recorded a net loss in 1Q00 of 4.6 million, 15 cents per share, compared to a 1Q99 net income of $6.3 million, 19 cents per share. The net loss of 1Q00 included charges totaling $14.7 million, 29 cents per share, relating to Respironics' restructuring that was first announced in early July.

Sun Healthcare to restructure debt

Sun Healthcare Group (Albuquerque, NM) signed an agreement in principal with representatives of its bank lenders and holders of two-thirds of its outstanding senior subordinated bonds on the terms of an overall restructuring of Sun's capital structure. The bank and senior bond debt represents more than $1.3 billion of Sun's capital structure.

Implementation of the agreement in principal is subject to appropriate documentation, including a Chapter 11 plan of reorganization and approval by the bankruptcy court, among other things, Sun said. If approved, the agreement would provide Sun's bank lenders with cash, new senior long-term debt, new preferred stock, and new common stock.

There is a shareholders lawsuit, filed recently against the company, pending that contends company officials should have known how changes in Medicare reimbursement would hurt operations, and that top Sun executives repeatedly misled investors through reports and statements to securities analysts, a Sun spokesman told the *Associated Press*. The company has until Nov. 10 to respond to the lawsuit.

Despite its financial troubles, the company said its is still planning to hold a shareholders meeting this year. The *Albuquerque Journal* reported that the company has not yet set a date for the meeting.

Sunrise's 1Q00 sales down 4%

Sunrise Medical (Carlsbad, CA) posted a net income in 1Q00 ended Oct. 1 of $1.5 million, 7 cents per share, compared to a net income in 1Q99 of $3.6 million, 16 cents per share. Sunrise said the 1Q00 earnings represent a significant improvement on a sequential quarterly basis, primarily as a result of its cost reduction program. Sales in 1Q00 were $155.5 million, down 4% from 1Q99 sales of $164.8 million.

Sunrise's search for a new CEO is well under way, officials say. The company aims to complete the selection process by the end of the year. ■

MedPAC

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Last week, the House Commerce Committee opted not to mark up the BBA reform bill introduced by Commerce Committee Chairman Rep. Tom Bliley (R-VA). Instead, a committee spokesman said Bliley has been promised that his bill will receive equal consideration with the BBA reform bill approved by the House Ways and Means Health Subcommittee.

Meanwhile, the Medicare Payment Advisory Commission (MedPAC; Washington) has developed its work plan for home health for the year ahead. According to MedPAC's Louisa Buatti, MedPAC has three studies planned. The first is an evaluation of HCFA's proposed rule for the prospective payment system (PPS) and will include a letter of comment for the Secretary of Health and Human Services.

Buatti noted concern by some MedPAC commissioners regarding "the generalizability" of the demonstration projects that HCFA has conducted. Part of that concern stems from demonstrations conducted before the implementation of the interim payment system (IPS) but that PPS rates will be based on IPS levels, she said.

"Another issue is the ability of the case mix adjuster to predict resource use," according to Buatti, "particularly because there appears to be great variation among home health users."

In addition, she said, the commission expressed interest in the size of the payment unit and the need to develop special payment provisions for very high-cost patients.

Buatti said the second study will compare PPS payment rates for 60-day periods of time with the payments that occurred for 60-day periods of time prior to PPS.

The third study will examine home health use over time, according to Buatti. "This will provide us with baseline information to evaluate the PPS," she explained. ■

TECH UPDATE

• **Standard Register** (Dayton, OH) has signed a three-year Integrated Print Management contract with the **Visiting Nurse Association of America** (VNAA; Boston). The agreement, which includes a two-year renewal option, is worth up to $40 million. Standard Register will deliver a total print management program consisting of traditional business forms printing, and commercial and digital on-demand printing to the more than 400 VNAA member locations. VNAA plans to establish Standard Register's Internet-based Smartworks as a central forms repository and provide member agencies with a direct link from the VNAA home page to the next generation document management and electronic commerce service. Through a secure Web server, VNAA member agencies accessing Smartworks will be able to print VNAA forms or place production orders for a variety of VNAA documents, including stationery, government-regulated documents, new-hire kits, and patient oriented literature. After receiving production orders, Standard Register will produce and deliver select documents locally by printing them nearest each ordering VNAA member agency via a nationwide network of more than 30 Stanfast digital print centers.

• **C-Phone Corp**. (Wilmington, NC) reported 2Q99 ended Aug. 31 revenues of $380,499, down from 2Q98 revenues of $549,889. The company saw a net loss in 2Q99 of $899,615, 11 cents per share, compared to a 2Q98 net loss of $896,399, 13 cents per share. The company said the decrease in sales for the quarter reflects the change in its marketing emphasis to the business and special applications marketplace. In introducing earlier in the year C-Phone's higher-end, higher-priced products, President/CEO Daniel Flohr said, the company's sales and marketing efforts have been focused at rebuilding and expanding distribution. As a result, he said, the company now has more than 100 domestic and international distributors, resellers, systems integrators, and OEMs.

• **Sims Communications'** (Irvine, CA) name has changed to **MedCom USA**, effective immediately. The name change was approved by the company's board in August and by the shareholders of the company in mid-October. The company's shares began trading on Nasdaq Oct. 19 under its new symbol, EMED.

• **HomMed** (Brookfield, WI) and **SkyTel**, an **MCI WorldCom** company, have partnered to allow HomMed patients using the company's HomMed Monitoring System, a new home heart monitoring system for patients with congestive heart failure, to connect directly to their healthcare providers via a wireless data network. The HomMed monitoring system collects true clinical data on the patient's condition using two main components: the HomMed Sentry, which collect s and transmits data from the patient, and the HomMed Observer, which receives the data, stores it, and presents it to clinical personnel. The HomMed Sentry devices are within the company's coverage areas, HomMed said, but if the patient is out of coverage range, SkyTel and HomMed have teamed to provide packet switched telephone network services for the Sentry to call, and the data is moved to the same central repository.

• **Healthcare Automation** (Warwick, RI) announced recently plans for its newest software offering, HAI HomeCareNET. The new software integrates operational and financial software features for providers in all facets of the alternate site healthcare market, including home infusion, ambulatory infusion, home health, hospice, respiratory therapy, and HME/DME. Home care organizations with multiple sites can connect their sites to a central copy of HAI HomeCareNET through a private intranet, the Internet, or a direct connection to HAI. ■

REGIONAL DIGEST

• Employees at **Heritage Home Health Care** (Roanoke, VA), reluctant to leave their patients and persuaded by their boss, have been partial paychecks, checks that bounced, or no checks at all until the agency closed in September. Heritage was in deep financial trouble because of decreased Medicare payments, reported the *Roanoke Times & World News*. The agency's closing left 15 patients behind to find new care. The *Times & World News* reported that now, employees of the former agency say they wish they had not stayed with the agency.

• One of three national pilot projects to examine the home care needs of mental health patients will take place in Taber in Canada, reported the *Lethbridge Herald*. The Alberta South region of the **Canadian Mental Health Association** (CMHA) announced its participation in the project at its annual general meeting last week. A director at the association, Deb Chenery, told the *Herald* that in doing the pilot, the association is not trying to say where home care is not working, but rather what is happening and what is working. The project, funded through **Health Canada** through the national office of the CMHA, is focusing on the rural model, she said.

• Officials at **Elder Services of Worcester Area** last week projected revenues will exceed $10 million next year for the first time in the agency's 25-year history. The agency said revenues are expected to be at least $500,000 more than this year's $9.5 million and would be nearly double the $5.5 million in revenues earned by the agency in 1993. But the agency said despite the higher revenues, it is still struggling to meet challenges brought on by the cuts in Medicare reimbursement. The agency's board was concerned that its home care patients' services would be negatively impacted by the Medicare cuts and cause safety problems for the patients.

• The 370 home care agencies and companies in Pennsylvania need more oversight, and their workers should be registered with the state, said Auditor Robert Casey. According to the *Associated Press*, no home healthcare agency was sanctioned from April 1996 through April 1999, despite explosive growth in home care services and the 1997 death of a Delaware County girl who was cared for by a home health nurse, Casey said. Casey faulted political leaders for failing to fully anticipate the needs of the elderly in the state, the *AP* reported. He also said the **Department of Health** failed to sanction agencies that did not follow doctors' orders about infections and other problems. The *AP* reported that Casey also said he objected to the department's failure to sanction the agency whose nurse was caring for the girl who died. But Health Department spokesman Richard McGarvey said serious complaints are now investigated within 24 hours. ■

MANAGED CARE REPORT

• **Aetna U.S. Healthcare** (Blue Bell, PA) has named Kevin Enterlein general manager for the company's south Florida market. In this position, Enterlein is responsible for sales and marketing, as well as building strong relationships with the local healthcare providers and medical communities in the region. In other news, Aetna U.S. Healthcare and **Clarian Health Partners** (Indianapolis) have established a long-term agreement that would allow Clarian to provide healthcare services to members of Aetna U.S. Healthcare. The agreement was announced jointly by William Loveday, president/CEO of Clarian, and Jim McNaughton, general manager for Aetna U.S. Healthcare in Indiana. Effective Dec. 1, all Aetna U.S. Healthcare members will be able to receive both inpatient and outpatient services at Methodist Hospital of Indiana, Indiana University Hospital, and Riley Hospital for Children. The agreement covers members enrolled in all of Aetna U.S. Healthcare's health benefits products, including its Preferred Provider Organization, Point of Service, and Exclusive Provider Organization networks.

• **PacifiCare Health Systems** (Santa Ana, CA) reported total revenues of $2.5 million in 3Q99 ended Sept. 30, compared to 3Q98 revenues of $2.4 million. The company recorded a net income in 3Q99 of $69.3 million, $1.54 per share, compared to a 3Q98 net income of $53.2 million, $1.16 per share. During 3Q99, PacifiCare said, two transition agreements were signed with QualMed Plans for Health of Colorado and QualMed Washington Health Plans, both subsidiaries of Foundation Health Systems. The company has agreed to provide replacement healthcare coverage for up to 140,000 commercial members in 2000. QualMed employer cxlients and their employees will be able to select PacifiCare coverage in early 2000, PacifiCare said. The company expects 35% to 55% of these members to choose PaifiCare. A per member price will be paid to QualMed based on retained membership. In addition, PacifiCare finalized its acquisition of Antero Health Plans of Colorado, which added 36,000 members as of Sept. 1.

• **United Wisconsin Services** (Milwaukee) said it is expecting to post another loss in 3Q99, blaming higher-than-expected medical costs. The company expects to report a 3Q99 loss of 27 cents per share to 32 cents per share, reported *Best's Insurance News*. That would be an improvement over 2Q99, when United Wisconsin posted a net loss of $8 million, 47 cents per share. The company attributes the decrease to higher medical costs stemming from greater utilization by patients, an increase in pharmacy costs, and higher-than-expected Medicaid costs. United Wisconsin said it is looking at increasing premiums and has spoken with state officials about increasing Medicaid reimbursements. ■

PPS

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the 60-day episode.

Agency officials note that the BBA gave HCFA broad discretion in developing the PPS. Here are some of the specific areas highlighted in a technical briefing by HCFA officials last week:

Case mix adjusted payment. HCFA officials report that research revealed that a per-visit PPS did not achieve any of the desired affects but that a per-episode PPS would achieve the desired affect. Under the latter, the number of visits and costs were both reduced while quality was maintained, agency officials said.

The demonstration used a 120-day episode, but agency officials report that 60% of the episodes ended at 60 days or less. That prompted HCFA to opt for a 60-day episode, especially in view of the fact that physician certification, plan of treatment, and OASIS data are all already required at 60-day intervals.

However, instead of paying agencies strictly on a 60-day episode of care, the agency proposed a series of adjustments to create "positive incentives." Those include a low utilization payment adjustment to provide a low-end threshold. If an episode consists of four visits or fewer, agencies will receive a payment based on the number of visits actually provided.

In addition, the agency concluded that a strict 60-day episode of care would not respond readily to significant changes in patient condition. For example, a patient might suffer a stroke and suddenly require physical therapy and speech therapy. To address that problem, the agency developed a significant change in condition adjustment that breaks the episode into two or more segments.

The agency also proposed a partial episode payment adjustment to split payment among multiple agencies if a patient transfers from one agency to another. In some cases, that means agencies will be required to share an episode payment based on an assessment made by the first agency.

As a result, when sequential transfers occur, the agency will make a proportional payment to the initial agency and begin a new episode under the new agency based on that agency's own assessment and case-mix.

Outliers. The BBA requires that HCFA limit that to 5% of the total payments projected based on the PPS in that year. The agency determined that it would not require length of stay outliers because it would pay for as many 60-day episodes as required by the patient. That preserved the 5% funding for high-cost outliers.

In order to distance the new payment methodology as far as possible from the current cost-based system, the agency will make payments based upon the utilization of the patient. HCFA will multiply the actual visits a patient receives by discipline by a standardized prospective payment per visit rate to determine the approximate costs for that case.

Maximizes the number of agencies that would be eligible for outlier payments. HCFA based that decision on concerns that patients that require extensive care might be avoided.

The case-mix settled on by HCFA includes 80 groups based upon the assessment of the patient in three broad areas: clinical severity, functional status, and service intensity. Each one of those domains is broken into sub-categories.

The clinical domain is broken into four categories from minimal to high. The functional status domain is broken into five categories, from minimal to maximum. Finally, service intensity is broken into four groups, from minimal to high.

That gives HCFA 80 possible cells. According to HCFA officials, the results were similar to what the agency finds in PPS' developed for hospitals and skilled nursing facilities.

According to HCFA officials, the wage index adjustment included in the PPS allows for an appropriate adjustment to recognize differences in salary costs across the country. The statute also required that HCFA build the system from the most recent audited cost report data. To accomplish that, the agency drew a statistical sample from 645 home health agencies nationwide, stratified by census region. HCFA officials report they will perform another review of those cost reports to make sure they have the most complete file of audited cost report data prior to completing the final rule.

Included in that rate are all the discipline costs and overhead costs of home health agencies as well as all routine and non-routine medical supply costs. However, according to the consolidated billing provision, durable medical equipment (DME) will not be rolled into the rate. Instead, agencies will be required to bill Medicare regardless of who supplies the DME.

According to agency officials, that creates the potential for disruption in the provision of DME because there is no requirement that home health agencies deal with all DME suppliers or that home health agencies pass 100% of the payment they receive to DME suppliers.

The 60-day comment period on the proposed rule will expire Dec. 27. A final rule is expected in February 2000. The proposal was published in the Federal Register Oct. 28. ■