Home Health

BUSINESS REPORT

MONDAY, NOV. 15, 1999 VOL. 6, NO. 46 PAGE 1 OF 5

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

Congress completes BBA relief bill; vote expected tomorrow

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

WASHINGTON – Congress is expected to vote tomorrow on a package of Balanced Budget Act of 1997 reforms agreed to by House and Senate negotiators that would delay the 15% reduction in home health Medicare reimbursement scheduled for Oct. 1, 2000, until one year after the prospective payment system is implemented, a House Ways and Means Health Subcommittee spokesman confirmed this morning. The agreement also makes that cut contingent on examination of its necessity.

The agreement also includes nearly all of the regulatory relief measures the industry was seeking, including a $10-per-beneficiary payment to offset the costs associated with OASIS and a reduction in surety bond values to $50,000 or 10% of Medicare program revenues, whichever is less. The agreement would also eliminate consolidated billing for durable medical equipment and freeze the **Health Care Financing Administration**'s (Baltimore) inherent reasonableness authority until the **General Accounting Office** (Washington) completes its study of the agency's methodology.

In addition, per-beneficiary limits below the median would be brought closer to the median. However, House and Senate negotiators were still trying to calculate that adjustment as of Friday. Hospice providers would receive a market basket update of -75% instead of -1%.

The final agreement does not rescind the 15-minute incremental billing requirement. Last-minute changes to the deal are possible, but not likely.

Home care providers expressed overall satisfaction with the agreement, but noted that major problems still confront high-cost, medically complex patients (*see GWU story below*).

"They could have done something tailored to insuring that long term, medically complex, high-cost patients were going to get services, but they tied their own hands on the issue of beneficiary access," said **American Federation of Home Care Providers** Executive Director Ann Howard. ■

HH industry says OIG error rate report politically charged

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

WASHINGTON – The home care industry is sharply criticizing the **Department of Health and Human Services** (Washington) **Office of Inspector General**'s (OIG) Nov. 1 report that purported to find a 19% error rate in home health claims across four major states, including California, Illinois, New York, and Texas.

The OIG argued that because the rate setting methodologies the **Health Care Financing Administration** (HCFA; Baltimore) used to develop the new home health prospective payment system (PPS) did not adequately adjust for these improper payments, the PPS rates are likely to be inflated.

The OIG urged HCFA to consider the 19% rate of improper or highly questionable services as a factor before making any changes to the current home health payments.

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GWU releases preliminary findings of phase II IPS study

By MATTHEW HAY
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WASHINGTON – The **George Washington University**'s (GWU) **Center for Health Services Research** last week released preliminary findings of the second phase of its study on the impact of the interim payment system (IPS) on beneficiary access to Medicare home health services. According to the study, 62.5% of hospital discharge planners reported increased difficulty in initial placement of Medicare beneficiaries in home care. About half of the hospitals surveyed estimated increases in hospital length of stay resulting from these difficulties.

According to the latest findings, discharge planners say difficulty in placement is almost always found among patients with short-term, high-intensity needs; patients requiring two visits per day; patients requiring more complex wound care; and patients suffering from chronic ill-

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GWU

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nesses, such as chronic obstructive pulmory disease, congestive heart failure, and diabetes.

GWU's Barbara Smith released the findings of the initial study earlier this year in what was widely considered to be the most comprehensive examination of the impact of IPS to date. GWU researchers noted that the findings of this phase of the study, which surveyed 40 hospital discharge planners in eight states, are limited to beneficiaries seeking home care immediately after a hospitalization.

This phase of the study also found that 48% of respondents reported increased readmissions to the hospital among beneficiaries initially discharged to the home, almost always attributed to insufficient duration and intensity of care. ■

WHAT THEY'RE SAYING

• Tipper Gore was chosen recently as an honorary representative of the massive baby boom generation to testify at a hearing of the Senate Special Committee on Aging meant to jolt baby boomers into thinking about future necessities, such as how to pay for home care or nursing home care. Vice President Al Gore's wife said at the hearing, "Despite all the medical advances, people still age . . . , and there are some plain truths that go along with that. That is that as people age, they begin to need help, particularly with a lot of daily tasks." Gore added that she thinks "it's probably a natural part of the human condition to not really think about that too much, unless you are really forced to do it."

• A recent editorial piece in the *Allentown Morning Call* asked readers to consider whether "you would like to be interrogated while you are sick and have your information labeled with your Social Security number" and stored forever in a government database. "This is happening right now," the *Morning Call* added, referring to the collection of OASIS data from patients. ■

CALENDAR

• The **National Association for Home Care** (Washington) is offering a one-day workshop on the prospective payment system (PPS) to provide attendees with analysis and detailed information about how to successfully implement PPS. The worksop will be offered at different locations, starting in Washington, DC, Nov. 30. The next meeting will be in Las Vegas on Dec. 8. More locations will be announced. For more information, call (202) 547-7424.

• **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.

• The **American Federation of Home Care Providers**, in conjunction with **U.S. Health Networks** and **Health Services Publishing & Management**, will be conducting several one-day workshops on *Understanding and Managing Under PPS*. The first workshop will be Feb. 1 in St. Petersburg, FL. Other programs are in planning. For more information, call (800) 525-5577.

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

TECH UPDATE

• **HomMed** (Brookfield, WI) appointed Robert Crockett chief operations operator. As the new COO for HomMed, Crockett will oversee many facets of the company, including customer service, technical support, human resources, logistics, and purchasing. Most recently, Crockett was director of logistics for **Karl Storz Endoscopy** (Culver City, WI), a medical company. ■

Home Health Business Report® (ISSN 1073-9572) is published every Monday by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Home Health Business Report® is a trademark of American Health Consultants®, a Medical Economics Company.

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COMPANIES IN THE NEWS

AHOM's 3Q99 revenues down

American HomePatient (AHOM; Brentwood, TN) saw 3Q99 ended Sept. 30 total revenues of $89.3 million, down from $90.4 million in FY98. The company posted a 3Q99 net loss of $5.2 million, 34 cents per share, compared to a 3Q98 net loss of $9.9 million, 66 cents per share.

Net patient accounts receivable decreased to $90 million at the end of 3Q99, AHOM said, compared to $91.6 million at the end of 2Q99. Net days sales outstanding was 96 days at the end of both 3Q99 and 2Q99, the company said.

Coram's 3Q99 impacted by subsidiaries' losses

Coram Healthcare (Denver) said that despite sequential improvements in the company's infusion therapy business during 3Q99, the period's financial results were impacted by losses in the subsidiaries that operate its **Resource Network** division, and by a charge and incremental expenses related primarily to the wind-down of this division.

Coram recorded a net loss in 3Q99 ended Sept. 30 of $15.2 million, 30 cents per share, compared to a 3Q98 net income of $2.8 million, 6 cents per share. Total revenues in 3Q99 were $143.2 million, up slightly from 3Q98 revenues of $143.6 million.

In other news, Coram said its Resource Network subsidiaries have filed voluntary petitions under Chapter 11 of the U.S. Bankruptcy Code. The filings do not include, and should not affect, other Coram operations, the company said.

IHHI's 3Q99 earnings down

In Home Health (Minnetonka, MN) reported a FY99 ended Sept. 30 net income of $4.2 million, 30 cents per share, compared to a FY98 net income of $3.5 million, 15 cents per share. The net income available to common shareholders in FY99 was $1.6 million, compared to FY98 net income available to common shareholders of $803,000.

The company recorded net revenues in FY99 of $80 million, down from revenues in FY98 of $97 million. IHHI said that the earnings improvements reflect its response to the regulatory changes in the healthcare industry. Cost-reimbursed revenue decreased in FY99 because of cost reduction initiatives required to operate within the new Medicare per-beneficiary cost limits. IHHI Chairman/CEO Wolfgang von Maack said the company successfully achieved its key objectives in FY99, despite the turmoil in the industry. He said the company has met the challenge of operating under the prospective payment system and has reduced its participation in the cost-based Medicare program to 48% of revenues in FY99 from 55% in FY98, reducing its reliance on Medicare as a major payer source.

McKesson Medical Group implements OneWorld

McKessonHBOC Medical Group (Richmond, VA) has begun to implement OneWorld, software developed by **J.D. Edwards & Company** (Denver). McKesson Medical Group said it needed an enterprise solution that had robust functionality and the agility to rapidly respond to business changes. With the changing face of the healthcare marketplace, McKesson Medical Group said, the company needed to have real-time access to information across the enterprise in order to continue to successfully service its diverse customer base. OneWorld's Web-enabled applications allow McKesson Medical Group to access information anytime, anywhere, the company said. The Medical Group is live on OneWorld General Ledger, Budgeting and Fixed Assets. The company is also implementing other financial applications, as well as the logistics/distribution suite.

Option Care sees highest earnings in history in 3Q99

Option Care (Bannockburn, IL) reported 3Q99 ended Sept. 30 net income of $1.3 million, 11 cents per share – the highest in its history, Option Care said. The 11 cents per share earned exceeded the financial community expectation of 8 cents per share by 38%. The results compare to a 3Q98 net loss of $356,000, 3 cents per share. Option Care recorded 3Q99 revenues of $30.1 million, slightly lower than $30.3 million in 3Q98.

Option Care President/CEO Michael Rusnak said the 3Q99 financial results "are an affirmation of the new management team's direction, begun approximately one year ago, which is to maintain Option Care's philosophy of patient first, while refocusing on the basic fundamentals of revenue management, cash collection, and strong communication."

Star Multi Care drops to SmallCap Market

Star Multi Care Services' (Huntington Station, NY) common shares last week moved to the Nasdaq SmallCap Market from the National Market, the company said. Star Multi Care no longer met the minimum market value of public float of at least $5 million.

In other news, Star Multi Care said it expects to report a profit for 2Q00 ending Nov. 30. In 2Q99, Star Multi Care posted a net loss of $101,000, 2 cents per share, on revenues of $12.8 million. The company saw a net income of $91,203, 2 cents per share, on revenues of $10.4 million, in 1Q00 – its first profitable quarter after a financially rough FY99.

Star Multi Care said it has purchased 89,800 common shares on the open market since it started a share repurchase program in August. ■

OIG

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It also urged HCFA to consider making an equitable adjustment to the proposed home health PPS rates or update factors to take into account the improper and highly questionable payments that were included in the rate calculations.

HCFA responded that it lacks the statutory authority to make changes to current payments under the interim payment system. The agency also defended its payment methodology under PPS. In addition to conducting a statistically representative sample of home health agency cost reports, the agency pointed out that it conducted comprehensive audits of those cost reports.

"The scope of these audits went well beyond our usual level of effort, and the industry has complained that this level of audit resulted in a higher level of disallowances than ordinarily would be the case," said HCFA Deputy Administrator Mike Hash. As a result, the agency concluded that the rates do not reflect significant excess cost.

Home care representatives say the OIG's findings are politically motivated. "In the past we have tried to give the OIG the benefit of the doubt," said the **National Association for Home Care**'s (NAHC; Washington) Bill Dombi, "but this study seems to have been almost a political exercise."

The report, *Results of Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*, contends that 19% of the services in the four states during the nine-month period ending Sept. 30, 1998, were improper or highly questionable and did not meet Medicare reimbursement requirements.

That is a dramatic decline from the OIG's previous audit, which estimated that 40% of the services in the same four states during the 15-month period ending March 31, 1996, did not meet Medicare reimbursement requirements. "Our current review found the error rate in home health claims has been significantly reduced," concluded the OIG, "but remain way too high.

"In our opinion, the majority of the unallowable services continued to be provided because of inadequate physician involvement," the OIG said. "We found physicians did not always review or actively participate in developing the plans of care they signed."

The OIG also noted that the error rate for all Medicare fee-for-service payments in FY98 was estimated at only 7.1%.

The OIG said its review estimated the intermediaries approved unallowable or highly questionable claims with charges totaling about $675.4 million out of the four-state universe of $2.3 billion in charges. When comparing the results of the two reviews, the OIG noted a dramatic decrease in the error rate for services that were not reasonable and necessary from 18% in the prior review to 6% in the current review.

For services rendered to beneficiaries who were not homebound, the error rate dropped from 11% to 3%, and for services without valid physician orders, the error rate dropped from 10% to 4%.

NAHC's Dombi took strong exception with those findings, however. Nearly 6% of the 19% relates to claims that they had no documentation on because the agencies had closed, according to Dombi. Roughly another 3% were for claims for existing home health agencies where the OIG was unable to get the documentation, he added. "Now, instead of 19%, we are somewhere closer to 9% for an error rate," said Dombi.

Dombi also pointed out that the OIG makes no reference to the level of reversals that have occurred on home health claims both at reconsideration and before an administrative law judge (ALJ). "Those rates of reversals are very high," said Dombi – over 30% for reconsideration and nearly 80% before an ALJ. "We have no way of assessing the accuracy of those decisions," Dombi added.

The OIG recommended that HCFA revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services, and see the patient at least once every 60 days and instruct the intermediaries to collect the overpayments identified in our sample. The agency concurred with those recommendations. ■

Types of Findings	**Current Review** (Percentage)	**Prior Review** (Percentage)
Services Not Reasonable and Necessary	5.51%	18.33%
Beneficiary Not Homebound	3.00%	10.67%
Services Without Valid Physicians' Orders	3.57%	10.38%
Services Not Documented	0.96%	00.19%
No Documentation at Terminated HHAs	5.80%	N/A
Total	**19%**	**40%**

MANAGED CARE REPORT

• **Capital Blue Cross** and **Pennsylvania Blue Shield** (Harrisburg, PA) will offer healthcare coverage to any or all employers in south central Pennsylvania and the Lehigh Valley covered by Physicians Care PPO, with the same benefits, rates, and underwriting standards that apply to its other customers. Working with the state **Insurance Department** and Physicians Care PPO, the company stepped in to offer continuous coverage to the PPO's employer groups after its net worth fell below state requirements, forcing the PPO under the control of the Insurance Department.

• **Scan** (Long Beach, CA) has been selected a member of the **National Chronic Care Consortium** (NCCC; Bloomington, MN). NCCC and Scan share a vision of integrated care for individuals with chronic health conditions, the NCCC said. In addition, Sam Ervin, president/CEO of Scan, has been named to the NCCC board. In other news, Scan received an Honorable Mention from the **American Association of Health Plans** for its immunization outreach program for seniors.

• **PacifiCare of Texas** (Dallas) and **Texas Health Resources** (Dallas), parent company of **Harris Methodist Health Plan** (Arlington, TX), have signed a definitive agreement under which PacifiCare will purchase Harris Methodist. The transaction is subject to regulatory approval and the completion of normal closing conditions, which are expected in the next 90 days. Once approved, PacifiCare said, the transaction will add about 300,000 HMO members to PacifiCare and will boost PacifiCare's HMO membership in Texas to 500,000, making it one of the largest health plans in the state. In addition to acquiring Harris' HMO membership, PacifiCare has established a long-term agreement with Texas Health Resources' hospitals. The healthcare networks of both plans will jointly consist of about 6,500 doctors and specialists, 54 hospitals, and other primary and specialty care clinics with a potential to serve more than 4 million consumers.

• **Cigna Corp**. (Philadelphia) reported 3Q99 ended Sept. 30 total revenues of $4.7 million, compared to 3Q98 revenues of $4.3 million. The company reported an operating income from continuing operations in 3Q99 of $286 million, $1.47 per share, compared to 3Q98 operating income from continuing operations of $237 million, $1.12 per share. Cigna's 3Q99 operating income excludes an after-tax gain of $1.2 billion for the sale of the property and casualty (P&C) business to **ACE Limited**, a $400 million after-tax charge attributable to certain Brazilian investments, and $10 million of after-tax restructuring charges for cost reduction initiatives subsequent to the sale of P&C.

• **Oxford Health Plans** (Norwalk, CT) President William Sullivan resigned from the company to pursue other interests. Sullivan joined Oxford in 1988 and helped build the company. He was named president in 1998, Oxford said. Kevin Hill, senior vice president of sales, has been promoted to executive vice president and will assume responsibility for sales and marketing. Oxford reported 3Q99 ended Sept. 30 revenues of $1.1 billion, compared to $1.2 billion in 3Q98. As of the end of 3Q99, Oxford's total membership was 1.6 million, compared to 1.7 million at the end of 2Q99. The company recorded a net income in 3Q99 of $28.3 million, 34 cents per share, compared to a 3Q98 net loss of $47 million, 58 cents per share. The quarter's results were impacted by non-recurring items and changes in prior period estimates of medical costs, Oxford said. The company recorded cash flow from operations of $90.2 million for 3Q99, and as of Sept. 30, Oxford had $1.1 billion in current cash and marketable securities and more than $230 million in cash in the parent company. ■

REGIONAL DIGEST

• The **Visiting Nurse Association of Central Massachusetts** (VNAMA; Worcester, MA) will merge with another non-profit home healthcare agency, **VNA Care Network of Waltham**, effective Jan. 1. The Worcester *Telegram & Gazette* reported that the combined agency will have the largest service area of all visiting nurse organizations in the state, serving more than 200 communities in five counties in eastern and central Massachusetts. The area has a population of more than 3.5 million, the *Telegram & Gazette* reported. The agencies said the merger will allow them to share clinical expertise, better respond to community health needs, and increase access to a broad range of specialty programs. In addition to home care and wellness programs, the combined agencies operate three of the four hospice residences in Massachusetts, including **Coes Pond** (Worcester), **Chilton House** (Cambridge), and the **Stanley R. Tippett Home** (Needham).

• A new regulation in Maine from the **Bureau of Elder and Adult Services**, which is meant to reserve the state's home care funds for those who need them the most, denies state-funded care to those who receive home care funded by Medicaid. The regulation is causing trouble for some in the state who need the funding from the state, but also rely on home care services paid for by Medicaid, reported the *Associated Press*. The bureau says it is not fair to have someone on a state-funded program who has access to some other funding source, when there are people on a waiting list for state-funded services. "They're taking up a spot for someone who doesn't have that option," the bureau said. ■