Home Health

BUSINESS REPORT

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

Planning for new payment system should begin now, experts say

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

WASHINGTON – Home health agencies may have received a much-needed reprieve when Congress delayed the 15% across-the-board cut in reimbursement scheduled for Oct. 1, 2000. But the operational challenges they confront under the home health prospective payment system (PPS) proposed by the **Health Care Financing Administration** (HCFA; Baltimore) last month require immediate planning, according to several PPS experts that have been studying the agency's proposed regulation.

The consensus opinion is that success under the new system will depend significantly on the accurate use of Outcome and Assessment Information Set (OASIS) data, adequate cash flow, revised strategic planning and budgeting, and, above all, immediate planning.

Experts say home health agencies should begin modifying their budget and planning systems as soon as possible. Because their budgets and strategic plans will no longer be based on the number of visits they are going to perform, agencies will have to start basing those plans on the number of episodes.

Within that number, agencies will have to determine how many episodes will be short episodes, where they will be paid by the visit, and how many will be full episodes. Those two methodologies require entirely different ways of planning and budgeting, experts say.

Under PPS, agencies will also have to care for patients for 60 or 90 days, sometimes spread out over a longer period. That means home health agencies will have to come up with a method to spread the revenue out over that period. When home health agencies exceed a fiscal year, they will have to develop a deferred revenue calculation.

Some experts also predict a high degree of medical review under PPS. Not only will home health agencies have to make sure that all their clinical staff are familiar with the proper completion of OASIS forms, but that all the clinical doc-

See PPS, Page 4

First of former Columbia/HCA executives on trial gets jail time

An *HHBR* Staff Report

The long-running federal fraud investigation of **Columbia/HCA Healthcare** (Nashville, TN) has led to the first jail term for one of the former executives accused of being part of a $3.5 million fraud scheme. Robert Whiteside, a former director of reimbursement for Columbia hospitals in Fort Meyers, FL, was sentenced last week to two years in jail. He was also ordered to pay the government $645,796 in restitution and a $7,500 fine.

The federal probe into Columbia's Medicare billing practices began in March 1997 and included Columbia home care operations in Texas and Florida. Since the probe, Columbia has sold all of its home care operations.

Whiteside was photographed and fingerprinted last week and agreed to report to federal marshals Jan. 12. But his attorney said Whiteside will appeal the July conviction soon and will ask to remain free pending that trial. ■

NHIA takes Bayer to task over its new Bayer Direct system

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

ALEXANDRIA – The **National Home Infusion Association** (NHIA; Alexandria, VA) is spearheading an effort to have the **Bayer Corp**. immediately suspend **Bayer Direct**, the company's new distribution system for Prolastin, a single-source IV drug used for the treatment of Alphal antitrypsin deficiency.

According to NHIA Executive Director Lorrie Kline Kaplan, NHIA has been inundated with phone calls, faxes, and e-mails opposing the program since Bayer Direct was announced Oct. 26. With almost no notice, she said, Bayer suspended all existing distribution channels for Prolastin. "Basically, it was available to any physician who had a patient and could buy it, and, with three days notice, they said physicians could only get it directly from them and their agent **Express Scripts**," Kaplan explained.

See NHIA, Page 2

NHIA

Continued from Page 1

But Bayer Direct representative attorney Doug Bell says he thinks providers' concerns might be more over the fact they can no longer purchase Prolastin for resale to their infusion clients than over whether they will be able to get it. Bell told sister publication *Home Infusion Therapy Management* (IVT) that the Bayer Direct/Express Scripts distribution system was designed to ensure equal distribution to all alphal patients.

"Essentially, the (Prolastin) patients came to Bayer, the media, and folks on Capitol Hill complaining about product hoarding (by infusion service providers who purchased Prolastin for resale to patients) and exorbitant prices being charged where the product was in short supply," Bell told IVT.

Kaplan said the lack of notice from Bayer Direct meant that providers and patients were forced to rely on inventory still available under existing distribution channels. "There is no guarantee that any inventory existed," said Kaplan. "And these are patients some of whom have 10% lung function."

She also argued that Bayer's program will set a dangerous precedent if it is allowed to stand. "We fear this system would completely remove price and quality competition from the market and lead to dramatic increases in price," she asserted.

"There are serious product allocation issues," she added. "Our view is they could have developed an improved product allocation system that still allowed patients freedom of choice to select their own provider." But instead, said Kaplan, Bayer opted to establish their own (system) where patients must register with Bayer directly".

In a letter to Bayer dated Nov. 8, Kaplan wrote, "NHIA is well aware of the product shortages that have plagued Prolastin and other plasma-derived products during the past year. These medication shortages have been hard on patients, clinicians, and manufacturers." But Kaplan argued that Bayer's program raises significant policy and ethical issues, especially when the medication involved is available only from one manufacturer.

"As the primary nursing and pharmacy care providers for Prolastin, IV immune globulin, and other infusion therapies, NHIA members have valuable expertise that could help Bayer to develop a truly fair and equitable solution for our patients," Kaplan added.

NHIA urged Bayer to take the following steps: 1) suspend immediately Bayer Direct for at least 60 days and reinitiate product allocation to current providers; 2) develop a representative working group of patients, infusion providers, home health nursing providers, physicians, or other key care team members to re-examine strategies for improved product distribution and pricing stabilization for Prolastin; 3) develop a patient registry to improve product allocation while still allowing patients to select their own healthcare provider, and; 4) establish a leadership position in the pharmaceutical community with an ethical commitment to quality patient care, patient freedom of choice, and a fair and equitable marketplace. ■

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COMPANIES IN THE NEWS

CCSE shareholders approve Landauer merger

Community Care Services' (CCSE; Mount Vernon, NY) shareholders have approved the merger of the company with a subsidiary of **Landauer Hospital Supplies** (New York), a supplier of home healthcare products. Pursuant to the merger, each CCSE shareholder will receve $1.20 per CCSE share. As a result of the merger, CCSE's common stock will no longer be publicly traded, and the company will cease to be subject to the reporting reqirements of the Securities and Exchange Act of 1934.

Continental names investor relations counsel

Continental Home Healthcare (Glendale, CA) named Hume Kieran of Toronto its investor relations counsel. Continental will give Kieran a fixed monthly fee of $3,000 in Canadian dollars and will grant him an option of 100,000 shares of Continental. The company's investor relations program will focus on investor communications and interaction with the financial community, Continental said.

In other news, Continental reported 3Q99 ended Sept. 30 revenues of $4.7 million, compared to $3.8 million in 3Q98. The company recorded a net income of $7,000, 0 cents per share, compared to a net income in 3Q98 of $284,000, 1 cent per share.

Continental President/CEO Rob Thornton said the company's acquisition program that started in October 1997 and included thre additional purchases in the subsequent periods, has resulted in a moderate increase in operating expenses for the company.

HAHI to buy back its stock

Help At Home (HAHI; Chicago) said it will buy back up to $50,000 of its common stock at market price over the next two months. HAHI said it expects to begin purchasing the stock as soon as possible. Management instituted the buy-back because it believes the company's common stock is currently undervalued and does not represent its true value.

HHCA gets approval for new CEO

The U.S. Bankruptcy Court has approved **Home Health Corporation of America**'s (King of Prussia, PA) appointment of David Geller as its new president/CEO.

Invacare building receives award

The building that holds **Invacare**'s (Elyria, OH) corporate headquarters won the 1999 AIA Ohio Design Award. The building was designed by **van Dijk Pace Architects** (Westlake, OH) in 1997, said Invacare.

Lincare new competitive bidding demonstrator

Lincare Holdings (Cleawater, FL) has become a demonstration supplier in the **Health Care Financing Administration**'s (HCFA; Baltimore) Medicare competitive bidding project in Polk County, FL. Lincare said its acquisition of **Home Care Medical Services of Polk County** (Lakeland, FL) and its receipt of approval from HCFA gained the company participation in the project.

Manor Care reduces line of credit

Manor Care's (Toledo, OH) 364-day credit pact with a group of banks was amended in September, decreasing it from $300 million to $200 million, Manor Care said. According to the company's quarterly report, the pact matured on Sept. 24 and was amended to $200 million. New borrowings under the amended agreement will mature on Sept. 22.

Manor Care CFO Geoffrey Meyers said the company reduced the line of credit because it didn't need it following the merger of **Health Care and Retirement Corp**. and Manor Care in September 1998. He said the company has also maintained a separate $200 million revolving credit facility for about a year with **Alterra Healthcare** (Brookfield, WI), an assisted living provider, for a joint venture to develop and construct specialized assisted living residences.

Manor Care also said early estimates about its 4Q99 results might be too high, saying that information on 4Q99 operating trends indicates this. The company said it expects to report 4Q99 earnings between 28 cents per share and 32 cents per share, instead of a **First Call** estimate of 35 cents per share.

In addition, Vice President Jeffrey Ferguson exercised options for 64,399 common shares on Nov. 18 and sold them all the same day, according to a filing with the **Securities and Exchange Commission** (Washington). Ferguson exercised an option for 34,399 shares at $5.35 per share, 7,500 shares at $6.13 per share, 7,500 shares at $9.63 per share, 7,500 shares at $11.58 per share, and 7,500 shares at $18 per share, according to the filing. Ferguson sold the shares on Nov. 18 for $19.94 per share. At the end of the month, Ferguson directly owned 19,866 common shares and indirectly owned an additional 716 shares.

Olsten names new health services unit

Olsten Corp. (Melville, NY), which announced in August plans to merge its staffing and information technology businesses with **Adecco S.A.** (Switzerland), renamed its Olsten Health Services unit **Gentiva Health Services**. The unit will be spun off as a stand-alone company as part of the merger agreement with Adecco, Olsten said.

The new health services company will have more than 400 offices, 38 pharmacies, including two national distribution centers and four regional network management locations, and a caregiver staff of more than 50,000 people. ■

MANAGED CARE REPORT

• **Health Options**, a subsidiary of **Blue Cross and Blue Shield of Florida** (BCBSFL; Jacksonville, FL), has introduced BlueCare, a new line of healthcare plans designed to meet the needs of Florida businesses. BlueCare offers companies with fewer than 50 employees a choice of 20 new health plans, as well as customized health plans for larger companies. BlueCare features include affordable prescription coverage and wellness and preventative care.

• **HIP Health Plan of New York** (New York) has formed an alliance with Montefiore Medical Center and Lenox Hill Hospital and is working to develop an alliance with Mount Sinai Medical Center and NYU Medical Center to give HIP's members unprecedented access to four of New York City's premier medical institutions. HIP Chairman/CEO, calling the announcement a major development, said the deal is a "unique affiliation between a healthcare company and outstanding members of the provider community. It will provide an integrated and systematic approach to the delivery of healthcare services." ■

CALENDAR

• **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.

• The **National Association for Home Care** (Washington) is offering a series of one-day workshops on the prospective payment system (PPS) to provide attendees with analysis and detailed information about how to successfully implement PPS. Locations and dates will be announced. For more information, call (202) 547-7424.

• The **American Federation of Home Care Providers** 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. ■

PPS

Continued from Page 1

umentation that supports the OASIS assessment is provided.

Home health agencies must also learn how to select OASIS items they believe they will need and price them out to determine which one of the resource groups they fall into. Experts recommend that agencies begin to apply this system on a random basis within their own organizations immediately.

In addition, agencies should begin working on a grouper schedule now as opposed to waiting for HCFA to provide the software grouper, they say. Aside from the fact that it is not available, the software HCFA uses might require refinements.

Home health agencies that are operating on a high per-beneficiary cost basis should anticipate making significant changes. HCFA's PPS proposal assumes that on average, home health agencies will perform roughly 36 visits per patient at about $58 a visit. Any home health agency that exceeds that number of visits or has higher costs will have to find a way to bring that down, experts advise.

The biggest immediate challenge agencies will face under the new system is cash flow, experts say. Some predict that accounts receivable will soar much as they did in HCFA's PPS demonstration. Part of that problem will stem from the likelihood that agencies will be forced to bill 50% at the beginning of an episode and 50% at the end. But increased medical review and additional documentation requests are likely to exacerbate payment delays as well.

As a result, experts are advising home health agencies to obtain additional capital or establish additional lines of credit. Home health agencies that are undercapitalized or have too much money already tied up in accounts receivable may not survive, they warn.

Under the PPS demonstration, it was clear from the very beginning that cash flow was a major problem, and HCFA was forced to offer home health agencies the opportunity to go back on periodic interim payment. The other cash flow problem will be related to sequential billing, which was suspended under the interim payment system, but will be in place under PPS

HCFA is likely to make at least marginal changes in the proposed regulation. The original rates established by HCFA are being revised since Congress postponed the 15% reduction scheduled to coincide with implementation of PPS. Several other factors might also have an impact on the numbers used by HCFA. For example, HCFA could change the number of episodes they are projecting, which would increase or decrease the rate.

Likewise, HCFA or the **Congressional Budget Office** could also change the target number because that number is tied to an amount no greater than the number that would have been spent by Medicare under the interim payment system in 2000. In addition, changes could be made if the OASIS data HCFA accumulates before the final rule indicates that their original assumptions require modification. ■