# Home Health

## BUSINESS REPORT

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

# Home care groups knock PPS split payment, LUPA, outlier

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

BALTIMORE – The national home care associations weighed in favorably on the **Health Care Financing Administration**'s (HCFA; Baltimore) decision to include a 60-day episode of care in its proposed rule for a home health prospective payment system (PPS), but faulted the agency for its proposed split payment reimbursement methodology, Low Utilization Payment Adjustment (LUPA), and inadequate outlier payment. Those and other shortcomings were detailed in comments submitted immediately prior to the Dec. 27 deadline.

The **American Federation of HomeCare Providers** (AFHP; Washington) endorsed the 60-day continuous episode of care included in the proposed rule, but said that it was offset by HCFA's outlier provision, LUPA, failure to provide for adequate consideration of wound care patients, and failure to consider the absence of a caregiver.

The **National Association for Home Care** (NAHC; Washington) told HCFA the proposed 60-day episode definition is in line with the findings that the PPS demonstration project's 120 day episode is too long to properly manage, but faulted the agency's methodology in numerous other areas.

The **Home Care Association of America** (HCAA; Jacksonville) agreed that the 60-day episode is an accurate measurement of most, but not all home health visits. But it added that unlimited consecutive episode recertifications should be included in the final rule to ensure adequate access to home health services.

**Split payment**

All the groups criticized HCFA's split payment approach to reimbursement with only 50% payment for the initial claim, but differed slightly in their suggested remedy. NAHC urged HCFA to modify the split payment to 90% on

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# Layoffs and budget cuts reign as Coram attempts a new focus

**An *HHBR* Staff Report**

**Coram Healthcare** (Denver) said it will save $15 million a year by trimming its operating expenses, cutting back on positions, and consolidating services. Part of the new focus for Coram will be rededicating itself to its core business, home care for those using intravenous medication.

Coram officials have yet to say how many positions will be cut, according to the *Associated Press*. The announcement of cutbacks follows a November report from the company, saying that it expects 3Q99 losses of $15.2 million. The realignment involves a top-shelf corporate shuffle of vice presidents who will be responsible for nutrition, hemophilia, and transplant-related therapy.

"To try to recreate shareholder value, we're going to have a top down, total corporate focus to try to grow these key therapies and change the mix of Coram's infusion business," said Coram's chairman/president/CEO, Daniel Crowley.

Crowley said after initially reviewing internal operating costs, it was clear that change was necessary. He added that he plans to reduce operating expenses through a primary case management model to improve efficiency and maintain quality.

"This market will be dominated by low-cost, efficient providers of high-quality services," he said. "We are moving quickly to identify challenges, focus on key therapies, cut costs, and install strong management. There remain, however, significant challenges facing the company and uncertainties that could materially affect our success."

Pending a company review by outside auditors, Coram officials said, charges of $25 million to $30 million will be taken in 4Q99 to reflect the new changes, including severance costs and various balance sheet

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## Coram cuts

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adjustments. Also, Coram's **Resource Network** lost about $3.8 million in 3Q99 and has filed for bankruptcy.

Resource Network and **Coram Independent Practice Association** managed a network of contract providers for managed care associations, according to the *Associated Press*. Company officials say Resource Network crashed into the shoals when it signed an agreement with **Aetna U.S. Healthcare** (Blue Bell, PA). Aetna contracted for home health services through Coram in the agreement. Both have since filed lawsuits against the other, Coram alleging that customer demand was underestimated by Aetna by half and Aetna countering that Coram could not duck out of the agreement and must keep providing services.

Vice presidents with new responsibilities are Michael Saracco heading nutrition, Eric Hill leading hemophilia, and Linda McBride in charge of transplant-related therapies. ■

## REGIONAL DIGEST

• A West Des Moines, NE, man and his son received jail terms for defrauding Medicare and Medicaid of about $15 million, reports the *Omaha World-Herald*. Curtis Churchill and his son, Shane, pleaded guilty to submitting false costs and fictitious invoices from their agency, **Universal Home Health Care**, the *World-Herald* reported. Prosecutors said the money was laundered through shell corporations, then sent to Panama and Liechtenstein.

• The Benson County, ND, home nursing program is being discontinued because federal reimbursements don't cover the costs. "Our general-fund reserves were basically getting pretty slim," County Commission Chairman John Grann told the *Associated Press*. "It was either cut the program or make a long-term financial commitment to it, and we just didn't feel we had the financial resources." ■

## TECH UPDATE

• **HomMed** (Brookfield, WI) signed a deal with **Motorola** (Schaumberg, IL) as its hardware provider for HomMed's two-way wireless messaging. The system allows congestive heart failure patients have their daily clinical readings taken at home, then takes the data and transmits it to the HomMed Observer, which then receives, processes, and presents the data to heart clinic personnel on a computer. A two-way transceiver from Motorola will be placed in all HomMed Sentries so the data can be transmitted. ■

## BRIEFLY NOTED

• A recent study of average hourly wages in 20 occupations that are projected to provide the most jobs in Wisconsin from 1996 to 2006 shows home health aides at $7.52 an hour. The *Milwaukee Journal Sentinel* survey showed other occupations with workers at less than home health aides as cashiers ($6.73 per hour), waiters and waitresses ($5.68 per hour), child care workers ($7.05 per hour), and food preparation workers ($6.81 per hour). Highest on the list were general managers and top executives ($26.57 per hour).

• This past August, the **Georgia Association of Home Health Agencies** broke up, unable to retain a membership that dwindled due to closures or budget cuts. The association had only 35 members when it closed. Georgia's 63 freestanding home health agencies now have an offer to be represented by the Georgia's hospital association. The **Georgia Hospital and Health Systems Association**, according to *Modern Healthcare*, represents Georgia's 38 hospital-based home health agencies. ■

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## COMPANIES IN THE NEWS

**Second Columbia/HCA prison term**

Jay Jarrell, who led **Columbia/HCA**'s (Nashville, TN) southwest Florida division, was sentenced to 33 months in jail and must pay $1.7 million in fines and restitution, according to the *St. Petersburg Times*. Jarrell is the second Columbia/HCA official to be sentenced to jail. The first, Robert Whiteside, the company's former director of reimbursement, was sentenced to two years in jail and must pay fines and restitution of about $660,000. Both were found guilty of six counts of defrauding the federal government. The *Times* quoted Assistant U.S. Attorney Robert Mosakowski as saying Jarrell was the ringleader in the case and that "he came up with the idea, and he directed it."

**Shuffle at Infu-Tech**

Jack Shapiro is the new vice chairman of **Infu-Tech** (Carlstadt, NJ). Company officials said Shapiro's promotion will allow Jack Rosen, Infu-Tech's chairman/CEO, to concentrate on the launch of **SmartMeds**, a Web site for its specialty pharmacy business. Shapiro has held a variety of senior management positions in operations, sales and marketing, and mergers and acquisitions at **Magellan Health Services**.

**MedCom teams with Executive Healthcare**

**MedCom USA**'s (Irvine, CA) **MedCard** division reached an agreement with **Executive Healthcare Services** (EHS; Calabasas, CA) to market MedCom's MedCard System, a service package for physicians, clinics, and hospitals in 50 states. EHS placed an initial purchase order for 500 MedCard transaction processing terminals for product demonstrations. MedCom also operates **Med Store**, an e-commerce site for selling home medical equipment products.

MedCom also has entered into agreements to retire all 1,745 shares of the company's series C convertible preferred stock. Outside investors have agreed to buy 1,000 preferred shares and convert them into 2 million shares of common stock. In 1998, MedCom sold its series C convertible preferred stock to finance its acquisition of MedCard Management System's assets and acquire an exclusive license for the MedCard System.

**PSA gets extension**

**Pediatric Services of America** (PSA; Norcross, GA) said it has filed a notice with the **Securities and Exchange Commission** (Washington, DC) to extend the filing date of its annual report on Form 10-K for its fiscal year ended Sept. 30, 1999. The original filing date, Dec. 29, was missed because information that was unavailable regarding sale of PSA's paramedical testing business and accounting for the business as a discontinued operation, company officials said.

**Samsung creates home care division**

**Samsung America** (Ridgefield, NJ) has entered home healthcare with the introduction of its line of blood pressure monitors. The home health spinoff is part of Samsung's Korean operations, which provides equipment to Korean hospitals. There will be three versions of the monitor: a wrist unit, two arm-cuff units, and one with a memory feature.

**Zevex Selected by IHC**

**Zevex International** (Salt Lake City) will supply enteral nutrition delivery products throughout Utah and Idaho for **IHC Home Care**, a division of **Intermountain Health Care** (Salt Lake City). Zevex's product line includes an ambulatory enteral feeding pump. ■

## 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.

• The **Missouri Alliance for Home Care** presents *"Practical Strategies for Managing PPS"* on Feb. 8 in Columbia, MO. The daylong conference is to familiarize home care administrators and staff with critical elements of the prospective payment system. Topics include a review of PPS, a discussion of the case mix adjusters, and strategies for tracking revenue and determining a budget under PPS. For more information, call (573) 634-7772. ■

## Associations

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the initial claim and 10% on the final claim.

"A 90/10 split allows Medicare to recognize delays inherent in payment while balancing those cases where additional payment is due with claims where the home health agency has been overpaid," said NAHC. "With 73% of visits provided in the first 30 days of an episode and the front-loaded administrative costs, a 90% initial payment is necessary to meet the cash flow needs of a home health agency."

HCAA went one step further. "We would like to see 100% of the payment upfront instead of getting only 50% up front and the balance of payment at the end of the 60 day episode," the agency said. "At worst, we feel a 90% up front and 10% at the end or 80% up front and 20% at the end of the episode period [is required]."

Because the agency's fiscal intermediaries will be able to perform any adjustments in payment in real time instead of waiting for year-end cost reports to settle with agencies, argued HCAA, there is no need to delay payment to the end of the 60 day episode. HCAA contended that agencies will actually be waiting 74 days to receive the balance of payment. "Unlike large hospitals and even skilled nursing facilities, most home health agencies do not have the capital necessary to float such delays in payment," argued HCAA.

NAHC pointed out that under the current proposed rule an initial claim can be submitted only after a home health agency has received signed and dated physician's orders for care, a signed and dated physician's certification that the patient meets the Medicare conditions for payment, and a physician's certification. "It is not unusual for it to take 10 to 30 days for home health agencies to secure this documentation," NAHC asserted.

AFHP contended that at least two-thirds of care is rendered in the first 30 days while reduced acuity, fewer skilled visits, and fewer total visits are characteristic as a patient nears discharge. The initial visit should also be weighted differently, AFHP argued, because it requires extensive patient assessment and completion of OASIS.

NAHC reported that its analysis of claims nationwide also shows that "the vast majority" of services to home health patients within a 60-day episode occurs early in that episode. "It is NAHC's information that 73% of all visits are rendered within the first 30 days," said the association. "By day 20, 59% of the visits from the 60-day episode are rendered." Moreover, NAHC argued that since most home health services costs are payroll-related, a 50% initial payment level will fall far short of the costs accrued prior to the receipt of payment.

### Outlier

According to NAHC, the proposed rule for PPS includes the use of an outlier payment that is statutorily authorized, but not required. NAHC pointed out that under the BBA, if HCFA proceeds with an outlier payment, the total estimated expenditures must not exceed 5% of total home health services payments. To meet that expenditure limitation, HCFA proposed an outlier eligibility threshold using a fixed-dollar loss and calculated the outlier payment using a loss-sharing ratio. HCFA chose a fixed-dollar loss of 1.07 and loss-sharing ratio of .60, which together are estimated to affect 7.5% of total episodes with an average outlier payment per episode at 62% of the standard episode payment amount.

"While it is understood that HCFA proposes an outlier payment that merely supplements the standard episode payment rate rather than covers the true cost of serving patients with extraordinarily high resource needs, the result from the proposed outlier payment methodology falls far short of mitigating the disincentives to serve high-cost patients," said NAHC.

According to NAHC, two particular classes of patients stand out as candidates for outlier payments, including insulin-dependent diabetics who cannot self-inject insulin and have no alternative caregivers, and patients with intense wound care needs over a finite period of time. "Many of these patients' care needs are met in one to three episodes with the cost of care between $10,000 and $40,000 over that period," said NAHC. As a result, it said the outlier payment methodology should be modified to provide a full standardized cost payment for patients in those two patient classes. In addition, NAHC argued that the methodology should be modified to raise the eligibility threshold and reduce the loss-sharing ratio in order to provide a level of payment that meets the cost of caring for patients with extraordinary needs.

According to AFHP, the fixed dollar loss amount that must be met for every case mix category before qualifying for outlier payments combined with the guaranteed loss of 40% of reimbursement beyond that threshold figure guarantees a significant financial loss on every outlier patient. AFHP argued that home health agencies will know that certain patients, such as wound care or blind diabetics, are likely to result in significant underpayment and avoid those patients.

"HCFA has developed a system geared to discriminate against those beneficiaries who constitute the most complex and costly cases," AFHP argued. On low reimbursement cases, AFHP said the outlier payments may be especially inadequate because agencies must first incur a fixed dollar loss of $2179 before receiving 60% of the amount beyond that threshold. "The inclusion of LUPA makes it very difficult for home health agencies to balance high cost patients with lower cost ones," argued AFHP. "If patients are sick and need home health services in order to remain at home, the required care should be adequately reimbursed."

AFHP said HCFA should remedy that by reimbursing reasonable costs incurred on outlier patients based on capped per-visit rates similar to national LUPA per-visit rates while also clarifying how and when outlier payments

will be made. Absent home health services, those patients will have to obtain care in higher cost hospital or nursing home settings, AFHP added.

**LUPA**

According to AFHP, per visit LUPA rates are significantly lower than current costs per visit for many home care providers and will cause additional financial losses as agencies incur additional costs related to OASIS, 15 minute incremental reporting, new PPS-related training, as well as administrative procedures and reporting systems. The group argued that for the PPS outlier system to preserve and restore access for medically complex patients, home health agencies must be able to offset losses with lower cost case mix payments. Otherwise, some agencies may be tempted to increase frequencies to qualify for a full episodic payment, the group warned.

AFHP argued that HCFA should eliminate the LUPA except for cases involving one or two visits. For cases that involve LUPAs, AFHP said HCFA should reduce per-visit costs by allowing a short form OASIS or increase the LUPA per visit rates by a minimum of 20%.

NAHC agreed that LUPAs should be eliminated from the system, particularly for first episodes. At a minimum, NAHC said the LUPA payment amounts should be increased to reflect the true costs of episodes with less than five visits by basing payments on the average cost of low volume episodes. "These amounts will more accurately affect the cost of providing these visits and the increased administrative overhead costs associated with them, such as conducting both an OASIS admission assessment admission at the beginning of the episode and discharge assessment at the conclusion of the episode.

NAHC said the LUPA is destined to create inefficiencies in patient care and cause serious financial hardships for agencies because it is not case-mix adjusted and is based on the average visit amount for full 60-day episodes. "Without case-mix adjustment, LUPAs are a greater financial risk for agencies than episode-based payments," argued NAHC. "They also discourage agencies from reducing unnecessary visits."

According to NAHC, agencies are reporting that LUPAs will account for 20% or more of total episodes, well above the 12% of episodes that HCFA estimates. "HCFA has no data to support its assumptions regarding the LUPA as this element of the proposed PPS was not part of the HCFA per-episode demonstration," the association added.

Calculating the average per visit amounts of low-volume episodes is particularly important for LUPAs because there is no case-mix adjustment built into the payment, NAHC added. "If HCFA's goal is to encourage agencies to make fewer visits without sacrificing quality, then the PPS must not interfere with this goal," argued NAHC. "LUPAs as they are currently designed will create disincentives to provide low-volume episodes because agencies will want to avoid falling into the LUPA payment category."

NAHC said HCFA could reduce unnecessary episodes through oversight and review of low-volume episodes or consider using LUPAs only for second or subsequent episodes to reduce the incentive to stretch a single episode into a second.

AFHP also argued that the loss of periodic interim payment (PIP) will have a significant impact on providers and that small agencies will be particularly hard hit. "Small home health agencies, many of them not currently on PIP, will not have borrowing power to sustain operations through cash flow disruptions, whereas many larger home health companies will," said the group.

AFHP urged HCFA to eliminate the payment floor of 14 days, provide for payment within five to seven days after submission of data electronically, and allow payment of a final episode claim where discharge occurs before the end of 60 day episode period. In addition, the group said HCFA and the fiscal intermediaries must modify their systems to allow for daily billing, the processing of initial billings, and multiple billings in a single month.

"HCFA needs to have contingency plans ready to provide for uninterrupted cash flow in the event of systems failure next October, including accelerate payments made at the start of services," concluded FAHP. "Short of these changes, AFHP said PIP must be retained.

NAHC also urged HCFA to allow for billing upon receipt of verbal orders and certification from the physician, establish a maximum standard for processing of claims under medical review and allow submission of final bill prior to close of 60-day episode period. ■

## MANAGED CARE REPORT

• The **Health Care Financing Administration** (Washington, DC) said that certain hospitals in New Jersey will receive additional Medicare payments totaling several hundred million dollars. The payments relate to a technical issue of how to calculate New Jersey hospitals' Medicare disproportionate share hospital reimbursement. The decision represents between $250 million and $370 million spread across approximately 60 of the state's hospitals.

• **Sierra Health Services** received a hold rating with a moderate risk from **Prudential Securities**. The managed care company said last week that it will take a charge of $40 million to $47 million in 4Q99, Prudential said. ■