Home Health

BUSINESS REPORT

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

Confidentiality legislation likely to exact huge cost on providers

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

WASHINGTON – The **Department of Health and Human Services** (HHS; Washington) estimates that patient confidentiality regulations will impose a cost of $3.8 billion on the healthcare industry. But according to the **National Blue Cross and Blue Shield Association** (BCBS) and other groups that have poured through the proposed rule the agency issued last November, the cost may be much higher.

In fact, House Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA) cited estimates at a hearing before his subcommittee last week that the final cost may be six, seven, or even 10 times that amount. BCBS's outside consulting firm pegs the cost at more than $40 billion over five years.

Retraining and recertifying employees, hiring privacy officials, upgrading systems, and making other changes in infrastructure would alone cost $23 billion, according to that estimate. The requirement to track all disclosures of information would add another $9 billion while the provision to make providers liable for compliance of their business partners would tack on another $4 billion.

Thomas also warned HHS Assistant Secretary for Planning and Evaluation Margaret Hamburg not to let the confidentiality regulations go the route of the compensation portion of the physician self-referral regulations – otherwise known as Stark II – which have now been in the drafting stage for seven years.

Mary Grealy, president of the **Healthcare Leadership Council** (Washington), who testified at the hearing, said healthcare providers should brace themselves for precisely that scenario. By the time HHS gets the final rule out, Grealy said, the healthcare system will have changed profoundly.

"You are taking a snapshot of what the healthcare system looks like today, but you can't possibly account for what technology is going to allow for tomorrow," she

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Justice Department joins another suit against Columbia

An *HHBR* Staff Report

The **Justice Department** (Washington) joined another whistleblower suit against **Columbia/HCA Healthcare** last week (Nashville, TN), filing a brief in the U.S. District Court in Miami that accused the company of broad breaches of the False Claims Act related to Medicare reimbursement. The allegations have increased pressure for Columbia to settle previous allegations of fraud.

The government said in the complaint that the company "defrauded the United States by filing false claims, specifically hospital cost reports and patient-specific forms, with the Medicare programs pertaining to costs incurred by Columbia for home health services furnished to homebound patients."

The suit, which is one of about a dozen unsealed to date, may be pooled with others the Justice Department is pursuing as part of a still-sealed motion the government

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OIG puts spotlight on true value of physician supply closets

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

Physicians who rent office space to healthcare suppliers and providers should make sure the rental amounts reflect fair-market value for the space actually used by the supplier, according to a special fraud alert issued by the **Department of Health and Human Services'** (Washington) **Office of Inspector General** (OIG) Feb. 22.

Stuart Kurlander, a partner with **Latham and Watkins** (Washington), said the alert is a double-edged sword. On the one hand, he said, it includes a useful clarification that providers can use as an audit tool to ensure their contracts are in compliance. On the other hand, he said, the **Health Care Financing Administration** (HCFA; Washington) could just as easily have accomplished this through a program memorandum.

Kurlander said the alert includes the fair-market-value

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Supply closets

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measurement the industry was hoping for. He noted that it also clarifies the ability to pay certain individuals in the physician's office to administer these programs, as long as that payment is consistent with the actual time spent by that person.

The alert attempts to put to rest a long-running debate over the use of rental space in physician offices otherwise known as supply closets. Physicians and hospitals often keep limited supplies of durable medical equipment prosthetics orthotics and supplies (DMEPOS) on site for convenience purposes and to facilitate patient discharge.

One of the durable medical equipment carriers (DMERC) had interpreted supply closets to be inappropriate because of the supplier standard that the product was not going directly to the beneficiary's home.

"The other DMERCs did not take a similar view," according to Kurlander. But he cautioned that the OIG leaves interpretation of DMEPOS supplier standards to HCFA.

He added that supply closets are popular because they avoid the need to have patients return to the physician's office with products shipped by suppliers.

"It makes infinitely more sense for the physician to be able to pull it out of a closet and fit the patient or show them how the product works," Kurlander said.

The OIG contends, however, that excessive rental payments can be a ruse to disguise kickbacks from the suppliers to physician landlords for referrals and may violate the federal anti-kickback law.

According to the OIG, questionable features of suspect rental arrangements center on the following three primary areas:

• **Appropriateness of Rental Agreements**. The threshold inquiry when examining rental payments is whether payment is appropriate at all. Payments of rent for space that traditionally has been provided for free or for a nominal charge for the benefit of the physicians' patients, such as consignment closets for durable medical equipment, may be disguised kickbacks. In general, rental payments for consignment closets in physicians' offices are suspect.

• **Rental Amounts**. Rental amounts should be at fair-market value, be fixed in advance, and not take into account, directly or indirectly, the volume or value of referrals or other business generated between the parties. Fair market value rental payments should not exceed the amount paid for comparable property. Moreover, where a physician rents space, the rate paid by the supplier generally should not exceed the rate paid by the physicians in the primary lease for their office space.

• **Time and Space Considerations**. Suppliers should only rent premises of a size and for a time that is reasonable and necessary for a commercially reasonable business purpose. Rental of space in excess of the suppliers needs creates a presumption that the payments may be a pretext for giving money to physicians for their referrals. In addition, rental amount calculations should prorate rent based on the amount of space and duration of time the premises are used. The basis for any proration should be documented and updated as necessary.

To read the entire text of the OIG Fraud Alert, go to *www.hhs.gov/oig/frdalrt/index.htm*. ■

Columbia

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made late last year to combine the various suits, reported *Dow Jones Business News*. Like the other actions the Department of Justice is pursuing, the latest suit alleges that senior Columbia officials knowingly filed false paperwork with the government for reimbursements from nine Miami-area hospitals, *Dow Jones* reported.

Columbia officials have denied the charges in the suit. "The issues brought forth in this case are nothing new at all," Jeff Prescott, a spokesman for the firm, told *Dow Jones*. "We expect to see more of these suits."

The government's intervention may increase pressure on Columbia to settle the massive, three-year-old federal fraud investigation by the Justice Department. ■

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COMPANIES IN THE NEWS

AmericanCareGiver.com focuses on home health

AmericanCareGiver.com (Atlanta), an on-line healthcare staffing company, has launched a new site exclusively for home healthcare issues. Consumers can locate all their needs, including caregivers, products, services, support, and information. Use of the site is free. The site is live, effective Feb. 15, the company said.

Beverly sees 4Q99, FY99 net loss

Beverly Enterprises (Fort Smith, AR) reported a 4Q99 ended Dec. 31 net loss of $32.6 million, 32 cents per share, compared to a net loss in 4Q98 of $87.5 million, 86 cents per share. The company saw total revenues in 4Q99 of $644 million, down from 4Q98 total revenues of $707.2 million. Beverly said unusual, pre-tax charges of $60 million and year 2000 remediation costs of $1.73 million recorded in 4Q99 caused the net loss for the quarter.

The company saw total revenues in FY99 of $2.6 million, down slightly from FY98 total revenues of $2.8 million. Beverly posted a FY99 net loss of $134.6 million, $1. 31 per share, compared to a net loss in FY98 of $31 million, 30 cents per share.

Moody's Investor Service (New York) downgraded the ratings of Beverly after the company released its earnings. The company's $375 million senior credit facility due 2001 was downgraded from Ba3 from Ba2, its $180 million 9% senior notes due 2006 to B1 from Ba3, its $20 million 8.8% first mortgage bonds due 2008 from Ba1 to Ba2, and its $30 million 8.6% first mortgage bonds due 2008 from Ba1 to Ba2. In addition, Beverly's senior implied rating was downgraded to Ba3 from Ba2, and it's senior unsecured issuer rating was downgraded to B2 from B1. The rating outlook is stable, said Moody's.

Extendicare to file 4Q99, FY99 results by March 31

Extendicare (Markham, Ontario) said it expects to report its 4Q99 and FY99 ended Dec. 31 by the end of March. The company said it is continuing to assess the valuation of its long-term receivables as of Dec. 31. Because the company has yet to report its earning, its **Extendicare Health Services** subsidiary expects to request and obtain from the **Securities and Exchange Commission** (Washington) an extension for the filing of its results.

IHHI chairman resigns

In Home Health (IHHI; Minnetonka, MN) Chairman Wolfgang von Maack resigned as chairman of the board, effective Feb. 23, the company said. von Maack will remain a member of the board. von Maack resigned as president/CEO of IHHI in December, but at the time said he would remain chairman.

IHHI has appointed Michael Ford chairman and interim president/CEO, effectively immediately. Ford will fulfill von Maack's previous roles, said IHHI. He has served as an outside director of the company since 1998.

Option Care signs agreement with Pacific Health

Option Care (Bannockburn, IL) signed a Participating Ancillary Provider Agreement with **Pacific Health Alliance**, a California mutual benefit corporation. The agreement will service 300,000 members of Pacific Health throughout California, Option Care said.

In addition, Option Care signed a Participating Organizational Provider Agreement with **Regence BlueShield** in the state of Washington. Under the terms of the agreement, Option Care will join other providers in supplying alternate site and home IV services to more than 1 million members throughout Washington. Option Care operates five owned and franchised IV pharmacies in the state, the company said.

Sunrise sells two buildings to Bentley Forbes

Sunrise Medical (Carlsbad, CA) said it sold two of its industrial office, warehouse, and manufacturing buildings, one in Stevens Point, WI, and one in Fresno, CA, to **The Bentley Forbes Group** (Los Angleles). Bentley has simultaneously leased the properties back to Sunrise. A similar sale-leaseback deal for a third Sunrise facility, in the northeastern United States, is expected to close soon.

The total price of all three transactions, Bentley said, is in the $25 million range. **La Salle Bank** (Chicago) financed the deal through its correspondent bank, **Rembrandt Capital** (Atlanta). ■

PPM/MSO NEWS

• **PhyCor** (Nashville, TN) reported a loss in FY99 in part because of charges taken in the sale of eight clinics and the pending sale of 11 others. In addition, Doctors at PhyCor's **St. Petersburg-Suncoast Medical Group** said in November they are working to end their 40-year contract with PhyCor, reported the *St. Petersburg Times*.

• **Integrated Orthopaedics** (Houston) has sold to **Front Range Orthopedic P.C.** and **FROC P.C.** the assets used to manage Front Range's practice. The assets sold for $2.1 million. Integrated Orthopaedics said it has also terminated the management services agreement for that practice.

• **IntegraMed America** (Purchase, NY) posted a net loss in 4Q99 ended Dec. 31 of $1.1 million, 24 cents per share, compared to a net income in 4Q98 of $434,000, 8 cents per share. The company saw revenues in 4Q99 of $12.7 million, a 19.1% increase over 4Q98 revenues. For the year, the company recorded revenues of $46 million, a jump of almost 20% from FY98 revenues. ■

Confidentiality

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warned. "The more prescriptive you try to make the regulations, the more you restrict what may be very valuable uses of patient data."

But Thomas and his colleagues in Congress may have little to say about the matter. Last year, Congress missed its deadline to pass medical record confidentiality legislation mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). That passed responsibility to HHS to write regulations that would cover medical records and health information maintained or transmitted electronically. The comment period for HHS' proposed regulations ended last week.

From a provider standpoint, passing the torch to HHS has two major flaws, according to Doug Peticord of **Washington Health Advocates** (Washington). First, he estimates that roughly 70% of all records are still on paper.

However, Peticord said, the even bigger problem is that the HHS regulations will not preempt state laws. Only a law passed by Congress could have done that, he said. Instead, HHS' federal regulation will only preempt state law when the specific provision is more stringent.

Peticord and others say the result may be a veritable nightmare for healthcare providers. Not only will providers have to master both state and federal confidentiality laws, they will have to determine which law supercedes the other.

The fears harbored by healthcare providers are probably well founded. Hamburg is already on record saying that a healthcare provider that knowingly obtains or uses healthcare information in violation of the standards will be subject to criminal felony penalties. Penalties should be higher when violations are for monetary gain, she added.

Meanwhile, there is no shortage of potential violations that could trip up home health agencies and other providers. Alissa Fox, executive director of BCBS, said the proposed rule has three major problems in addition to the preemption of state law. First, she said, the partnership provisions of the regulation would require providers to enter into prescribed contracts with all of their business partners and would be subject to penalties if they "knew or reasonably should have known" about privacy violations of their business partners.

"The definition of business partner is so broad that physicians could be the business partners of independent laboratories, health plans could be the business partners of their lawyers and accountants, and hospitals could be the business partners of independent physicians that practice within their walls," she said.

Second, Fox said, the proposed regulation instructs providers to use or disclose only the minimum information necessary to accomplish a given purpose and discourages the exchange of the entire medical record.

"At first blush, this standard seems to be a perfectly reasonable, common-sense provision," she said. But operationally, she added, it would be a nightmare. Simply put, she said, it would be impossible to implement a legal standard in which only the minimum information is used or disclosed because the standard applies to the use of information, as well as disclosure, and that definition of disclosure includes broad terms like 'provision of access to.'

"This standard would require a massive reorganization of workflow, as well as a possible redesign of physical office space and would jeopardize the timeliness of patient care, benefit determinations, and other critical elements of the healthcare system," she warned.

Finally, Fox argued that the proposed rule includes a definition of healthcare operations, which are exempt from the regulation, that is far too narrow. "The current definition of healthcare operations misses important functions," she argued. "As a result, covered entities may have to solicit authorizations for certain functions or track disclosures as part of routine operations."

There is no shortage of other potential violations that could trip up hospitals and other providers. The following is a list of requirements providers would be forced to meet.

- Obtain new authorization from consumers before using or disclosing information, except for purposes of treatment, payment, healthcare operations, and other limited circumstances.
- Allow individuals to inspect, copy, and amend much of their medical information.
- Track all disclosures made other than for treatment, payment, and healthcare operations.
- Designate a privacy official and train staff.
- Follow specific rules before using protected health information for research.
- Develop a host of new policies, procedures and notices.

In it's comments submitted last week, the **National Association for Home Care** (NAHC; Washington) said it favors HHS' decision to create a floor, but not a ceiling, on privacy protections afforded by the states because it will allow states to enact stronger privacy protections in an ever-changing environment. But NAHC urged HHS to begin by capturing the costs associated with the rule and ensuring that home health agencies will have the resources necessary to comply.

NAHC also urged HHS to exclude healthcare treatment from the minimum necessary standard included in the proposed rule. It argued that it is not unusual for a patient's condition to change and said that it is unreasonable for an intervention to be delayed because the complete record is not available. The association also argued that the proposed rule would expose providers to civil liability when they unknowingly performed interventions without the benefit of a full medical record.

NAHC also urged HHS to eliminate the provision that creates private right of action for patients to bring civil actions against providers and their business partners. ■

BRIEFLY NOTED

• The **National Hospice Organization** (Alexandria, VA) has changed its name to the **National Hospice and Palliative Care Organization** (NHPCO). The organization represents nearly 2,500 hospice care programs and thousands of professionals in the United States. NHPCO President Karen Davie said the organization made the decision to change its name because "adding palliative care to our name . . . reflects the natural evolution in end-of-life care and fosters recognition of the role of hospices in providing such care." Hospice care and palliative care share the same core values and philosophies, she added.

• Home healthcare stocks showed a major decline in FY99, according to a recent report from **HealthCare Markets Group** (Hilton Head, SC). The segment dropped 10.6% in FY99 after a 43.8% decline in FY98. The huge decline in stock prices was also seen among the physician practice management, assisted living, and hospital industries, said HealthCare Markets.

• Market revenue estimates for healthcare Internet companies are continuing to climb extremely high, according to a report from **Feedback Research Services** (Jacksonville, OR). For example, some analyts forecast that there is a $25 billion Internet healthcare market, with home healthcare potentially accounting for $1 billion of that. The catch is, the company said, that at this point, there is no established means of reimbursement for non-traditional delivery of home care services. In other words, the company asks, who is going to pay for the devices and services? Without any outside sources to pay for services, the only other reason for a healthcare provider to implement electronic delivery of home monitoring, the company said, would be to achieve cost savings in the form of one of the folowing: administrative efficiencies, increased productivity for the home health nurse, or reduced unnecessary use of expensive or scarce medical services, said Feedback Research Services. ■

REGIONAL DIGEST

• New Hampshire's top health official told state legislators that neighbors, friends, and relatives would make better home healthcare aides for some families than workers provided by agencies. **Health and Human Services** Commissioner Donald Shumway testified for a bill to make it easier for consumers in New Hampshire to hire people they know to care for an elderly or disabled family member, reported the *Associated Press*. But several home healthcare providers opposed the bill at a Senate committee hearing. They said it would add an unnecessary layer of bureaucracy to an already over-regulated system, the *AP* reported.

• Patients who use the **Eastern Shore Health Department**'s home healthcare system will have to find other services because the state no longer can afford to run the program, reported the *Associated Press*. The system blames changes in Medicare reimbursement. Federal reimbursement to the state for home care is so low that the local health district saw its revenue fall by more than $500,000 in two years, officials told the *AP*. Officials said 118 patients will be placed with private healthcare services by March 31, when the home care program shuts down.

• Beckley Appalachian Regional Hospital (Beckley, WV), which announced the closure of its home health department last month, plans to continue seeing patients for now, reported the *Associated Press*. The hospital has not yet received approval from the **West Virginia Health Care Authority** to close the department, so it said it will accept new patients until a decision is made. The closure would put 53 employees out of work and leave more than 400 home care patients in eight counties without services, the *AP* reported.

• Rhode Island's attorney general's office has accused the owner and president of **Stone Hill Health Services** (South Kingstown, RI), a home health agency, of defrauding the state's Medicaid program of $49,107. The owner and agency are each charged with 120 counts of Medicaid fraud and one count of obtaining more than $500 under false pretenses, reported the *Providence Journal* of Providence, RI. According to papers the **Medicaid Fraud Control Unit** filed last week in Washington County Superior Court, the defendants billed Medicaid for home health aide services between Jan. 13, 1995, and Jan. 9, 1998, but the attorney general claims Stone Health provided only homemaking services, which are less expensive. ■

CALENDAR

• The **Illinois Home Care Council**'s (Chicago) 2000 annual conference and exposition will be March 29-31 in Oak Brook, IL. More than 300 providers and exhibitors are expected to attend. For information, call (312) 335-9922.

• The **National Association for Home Care**'s (Washington) 2000 National Policy Conference is April 2-5 in Washington, DC. The conference will examine policy changes that will affect home care and hospice in the future. For more information, call (202) 547-7424.

• The 2nd World Congress on Home Care is May 7-10 in Vienna, Austria. The conference, *Home Care – Bridge to the 21st Century*, is sponsored by the **World Homecare and Hospice Organization** and the **European Association of Care and Help at Home**. For more information, go to *www.blaguss.at\icos\homecare.html*. ■