Home Health

BUSINESS REPORT

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

Home health advocates react to MedPAC's PPS recommendations

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

WASHINGTON – In its semi-annual report to Congress last week, the Medicare Payment Advisory Commission (MedPAC) said it generally supports the **Health Care Financing Administration**'s (HCFA; Baltimore) approach to developing a prospective payment system (PPS) for home health. But the commission also made a series of recommendations intended to improve that system over the long term.

"Although the proposed PPS needs refinement, it represents a substantial improvement over the interim payment system by accounting for case mix," the commission argued in its report delivered to Congress March 1. Home health agencies will be paid a higher rate for patients needing more care, and eligible long term care patients may have unlimited episodes, MedPAC noted.

MedPAC urged HCFA to vigorously monitor behavior under the new system and establish a system that blends fixed-episode payments and per-visit payments. The commission also urged the agency to improve the home health agency wage index and coordinate quality indicators across various post acute care settings.

"There are some positive items in the report, as well as some things I think they left out in their recommendations," said the **National Association for Home Care**'s (NAHC; Washington) Yvonne Santa Anna. She said one of those positive recommendations was the commission's suggestion to vigorously monitor home health agency behavior under PPS.

According to MedPAC, prospective payment for home healthcare raises two related problems. The first is how to assure that home health agencies accurately assess beneficiaries' needs and report case-mix classification assignments. The second is how to monitor services to ensure that beneficiaries are receiving appropriate care, MedPAC said.

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House coalitions write letter to urge repeal of 15% reduction

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

WASHINGTON – The Home Health Working Group and the Rural Health Care Coalition wrote House Budget Chairman John Kasich (R-OH) last Friday asking that language be included in the FY01 budget resolution instructing the committees of jurisdiction to eliminate the 15% reduction in Medicare home health services scheduled to go into effect on Oct. 1, 2001.

"Even without implementation of the 15% mandatory reduction, the Balanced Budget Act of 1997 (BBA) has already drastically reduced access to Medicare home health services," the groups wrote Kasich on March 3.

When the BBA was passed in 1997, the groups pointed out, the **Congressional Budget Office** (CBO; Washington) estimated the savings from the Medicare home

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Option Care signs its third provider agreement in 3 weeks

An *HHBR* Staff Report

Option Care (Bannockburn, IL) signed a Home Infusion Therapy Provider agreement with **Humana**'s (Louisville, KY) Employers Health Insurance Company.

Under terms of the agreement, Option Care will provide home infusion therapy services to more than 1.4 million members of the health insurance company.

The contract is one of several that Option Care has signed in the past few weeks. Earlier in February, Option Care said it signed a Participating Ancillary Provider Agreement with **Pacific Health Alliance**, which brought 300,000 patients to Option Care. In the same week, the company also announced the signing of a Participating Organizational Provider Agreement with **Regence BlueShield** in the state of Washington. That contract gained more than 1 million new patients for Option Care. ■

MedPAC

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The commission argued that because the OASIS assessment will largely determine the episode payment, HCFA must develop a comprehensive plan to ensure the accuracy of reporting. That plan should also include mechanisms to audit providers, according to MedPAC. "Given expected large shifts in payments, some home health agencies will face strong financial incentives to shift Medicare beneficiaries to high-weighted groups to maintain payment levels," the commission asserted.

According to MedPAC, home health agencies will also have the incentives to stint on services in order to reduce costs. "At the same time," the commission added, "the low-episode threshold creates an incentive for home health agencies to provide a few visits more than the threshold to generate payment for an entire episode."

The commission urged HCFA to, in the short term, direct regional home health intermediaries to focus medical reviews on those providers who have many episodes in which the number of visits slightly exceeds the low-use threshold (five or six visits) and also to randomly review selected episodes with visits barely exceeding the threshold to achieve a sentinel effect.

In the future, MedPAC asserted, a blended payment system could address the issue of home health agencies inappropriately maximizing payments or minimizing costs. "Such a system, using a combination of per-visit and fixed-episode payments, could neutralize the financial incentives of both types of payments," the commission concluded.

According to MedPAC, home health agencies have responded strongly to payment incentives in the past and can reasonably be expected to do so under an episode-based PPS as well. To counteract incentives that may negatively affect beneficiary access to care, the commission recommended that HCFA establish a prospective payment that blends fixed-episode payments with per-visit payments, using a standardized rate per visit.

"Although home health agencies would have a greater incentive to add services to increase payment than under a fixed-episode payment, a carefully designed payment system would lessen incentives created by a cost-based system," MedPAC argued.

AFHCP says blending not likely

"We would like to see some kind of blending that would include some historical data," said Ann Howard, executive director of the **American Federation of Home Care Providers** (AFHCP; Washington). But she said that HCFA is probably not inclined to move in that direction absent congressional pressure. The commission's report agrees that a blended payment system would likely require a statutory change.

NAHC's Santa Anna said she was also encouraged that MedPAC pointed out the need to have some normative standards included in the new system. "I think it is important that they recognize that we need clear definitions of eligibility and coverage guidelines." That need has been pointed out in the past, she noted, "but it is important that that message is heard."

She also pointed to MedPAC's recommendation that the **Department of Health and Human Services** (Washington) use routinely collected data to refine case-mix weights over time. The commission said case-mix weights should evolve in response to changes in practice

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CORPORATE LADDER

• **Extendicare** (Markham, Ontario) appointed Mel Rhinelander to its board of directors, effective Feb. 23. Rhinelander will stand for election to a three-year term on the board at the annual meeting in May, Extendicare said.

• **McKesson HBOC** (San Francisco) has named William Graber senior vice president and CFO. Graber was formerly with **Mead Corp**., where he was vice president/CFO. ■

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COMPANIES IN THE NEWS

Coram to be delisted from NYSE

Coram Healthcare (Denver) said its stock will probably begin trading on the National Association of Securities Dealers' over-the-counter bulletin board in the coming weeks. The company said it received notice that trading in its stock will be suspended on the New York Stock Exchange prior to its opening tomorrow, March 7. Coram also said application will be made with the **Securities and Exchange Commission** (Washington) to delist the company from the NYSE.

The delisting is occuring because Coram does not comply with NYSE listing requirements of at least $50 million in stockholders' equity, $50 million in market capitalization, and a stock price of $1.

Mallinckrodt launches reimbursement Web site

Mallinckrodt (St. Louis) launched a Web site devoted to reimbursement issues. The company's new healthcare economics Web site, which can be found at *www.mallinckrodt.com/hce*, went on line in early February, Mallinckrodt said. The site provides general reimbursement information, including source documents from Medicare and links to the sources of information. The site is designed to be particulary useful to providers who interact with Medicare payment policy, like medical equipment providers, said Mallinckrodt.

In other news, Mallinckrodt and **Heller Financial** (Chicago) have signed an agreement for Heller's **Global Vendor Finance** unit to administer a private-label equipment lease financing program for Mallinckrodt. The Mallinckrodt Financial Solutions program is being offered to healthcare equipment providers in the United States and Canada who want to acquire Mallinckrodt's alternate care respiratory products.

3M signs agreement with Fazzi Associates

3M Home Health (St. Paul, MN), a unit of **3M Health Information Systems** (Salt Lake City), signed a sales and marketing agreement with **Fazzi Associates** (Northampton, MA) to market the CORE Research Partnership performance measurement system to home health agencies that are users of 3M Datacron Home Care Management Systems.

The CORE Research Partnership system was developed by the University of Colorado Center for Health Services and Policy Research. It provides for the collection, entry, and tabulating of OASIS assessment data for comparing home care agencies to a national database of home care quality. It also provides appropriate data for quarterly ORYX-compliant reporting to the **Joint Commission for Accreditation of Healthcare Organizations** (JCAHO).

The CORE Research Partnership system is designed to help agencies meet the requirements of the prospective payment system. The CORE Research Partnership system is an ORYX-based and JCAHO-listed system.

Stephen Loes, business unit manager of 3M Home Health, said the 3M-Fazzi marketing agreement "comes at a key moment for U.S. home health agencies. Every agency, regardless of its size or experience, has to anticipate its ability to provide required information to government and oversight organizations." He added, "We hope that by offering 3M customers the CORE Research Partnership, we will help address these concerns." ■

CALENDAR

• The **National Association for Home Care**'s (NAHC; Washington) 2000 policy conference is April 2-5 in Washington. Also, NAHC's 19th annual meeting and HomecareExpo is Sept. 23-27 in New Orleans. For more information, call (202) 547-7424.

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

• Medtrade's Medtrade West is May 3-6 in Las Vegas. New products in the HME arena will be introduced at the meeting. For more information, call (800) 241-9034, or visit Medtrade's web site at *www.medtrade.com*.

• The 15th annual Northeast Healthcare Conference and Exposition is May 10-11 in Mashantucket, CT. The conference is sponsored by *Healthcare Review* and brings together the entire healthcare delivery system. Admission to the expo and conference programs is free. For more information, call (800) 243-9774.

• The home care associations in Louisiana, New Mexico, Oklahoma, and Texas are offering the Southwest Regional Home Care Conference and Exhibition 2000 May 10-12 in Dallas. The conference will offer an exhibition hall and educational workshops. For more information, call (800) 880-8893.

• 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 9th annual meeting for the **National Association of Pediatric Home and Community Care** is Oct. 5-6 in New Orleans. The conference is being co-sponsored by the University of Massachusetts Medical School. For more information on the conference, *Children With Special Health Care Needs: Look Who Grew Up . . . Patients, Families and Providers*, call (508) 856-6743. ■

MedPAC

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patterns and technology that affect the level of resources required to furnish home health services to different types of patients to ensure that those payments are appropriate.

According to the commission, two approaches could be adopted to change the home health resource group (HHRG) weights over time, both relying on standard administrative data to recalibrate the weights. The first would use information home health agencies are required to provide about time spent in providing services in 15-minute increments.

Under this approach, MedPAC said, proxy costs for each visit would be developed by multiplying each increment by the estimated national cost of the discipline providing the services. The costs for an episode would be determined by summing the proxy costs for all visits associated with that episode, the commission added. At that point, HCFA would follow a process similar to that used to recalibrate the diagnosis related groups payment rates.

MedPAC said the second approach would use the charge information on the bill. Under both systems, the weights will automatically account for any shift in admission practice or coding behavior, said the commission.

According to Santa Anna, what MedPAC fails to mention in its report is consideration of the time spent outside the home. "They only talk about the in-home time," she said. "That jumped out at me because that was an issue last year under the (Balanced Budget Refinement Act) that we tried to get the 15-minute increment deleted."

According to Santa Anna, just as a growing number in Congress wanted that provision eliminated, MedPAC recommended that it be retained. "Now we are reading that the reason they wanted to leave it in is that they think it is a good approach to look at the change in the HHRG weights over time," she said. "They are only looking at in-home time and not looking at anything outside the home and comparing the agencies for potential differences in resource utilization."

However, MedPAC did note in its report that differences in wages among geographic areas account for much of the variation in provider's costs for home health services. The commission notes HCFA's estimate that 78% of the home health episode payment is labor-related and, therefore, affected by local variation in wages. As a result, MedPAC said, errors in the wage index used to adjust payment can have substantial effects on the appropriateness of payments.

MedPAC points out that the wage adjustment for the proposed home health PPS is based on wage and hour data from hospitals. But while using the hospital wage index to adjust payment rates for geographic differences is expedient, there are two problems associated with that approach, warns MedPAC.

First, the occupational mix is presumably different in the two settings. Second, the hospital wage index in and of itself does not control for occupational mix, which varies substantially among hospitals according to size and teaching status, MedPAC said.

To remedy that, HCFA should develop an agency-specific wage index, even though that will be no easy task, said MedPAC. Much will depend on the quality of wage and hour data that agencies submit, according to the commission. "If home health agencies supply accurate data, the wage index could be updated for FY02. If not, HCFA must quickly resolve reporting problems to eliminate this source of inaccuracy."

Santa Anna was also encouraged that MedPAC pointed out the need to link the different post acute care settings in terms of quality indicators. "Although HCFA is developing quality monitoring systems for evaluating care provided by skilled nursing facilities and home health agencies," noted MedPAC, "both the Medicare program specifically and the health system in general are ill-equipped to compare the care provided in different post acute care settings and to evaluate the care patients receive when it involves more than one type of provider."

"That would mean similar types of data should be collected, and I think everyone would agree that is important," said Santa Anna. "But at the same time, MedPAC talks about making sure the collection of quality of care indicators is not a burden on providers, and I don't know how they are going to do that."

Finally, Santa Anna noted that where central question of beneficiary access to home health is concerned, MedPAC takes an ambiguous posture. "On the one hand, MedPAC concludes there is not a problem currently," she said. "On the other hand, they say there are some vulnerable populations and say they will look at it annually."

Meanwhile, there has been a 47% decline in home care expenditures between 1997 and 1998, and one in every four agencies has closed, she said.

What impact MedPAC's recommendations will have is far from certain. "Until home health PPS is underway and data is gathered, it is hard to determine," concluded Santa Anna. "A year from October, the impact of the report will be a little more telling because there will be more data."

Scott Lara, director of government relations at the **Home Care Association of America** (HCAA; Jacksonville, FL) was not as sanguine. "I think MedPAC itself is becoming irrelevant," he asserted. "They issue reports and testify before Congress, but it does not amount to much.

"Nine times out of 10, Congress doesn't even take their recommendations," he added. In the case of PPS, he said, it appears HCFA might budge on the 50/50, split-payment and physician-certification requirements, "but I don't think they are going to budge on much else." ■

Coalitions

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health benefit, including the 15% reduction, to be $16 billion over fiscal years 1998-2002.

Instead, HCFA recently projected that Medicare home health outlays will decrease approximately $69 billion over the same five-year period, using the assumption that the 15% reduction would be implemented in FY02.

"Since BBA '97 passage, over 2,500 home health agencies have closed or stopped serving Medicare beneficiaries – 25% of the total closing or no longer serving Medicare beneficiaries," the groups added. "In fact, the CBO has pointed to the decrease in home health spending as a major factor in the decrease in overall Medicare spending for FY98 and FY99."

The groups further contend that failure to address the 15% cut could actually cost the Medicare program money since home health providers would not be able to serve all homebound beneficiaries with care needs. "More often than not, such beneficiaries usually end up in emergency rooms, hospitals, or nursing homes at costs considerably higher than care provided in the home," the groups said.

"Despite last year's legislation that restores some funding to the Medicare home health benefit," the groups added, "the hemorrhaging of the home health benefit persists, agencies continue to go out of business, and certain high-cost beneficiaries are at risk of not receiving care."

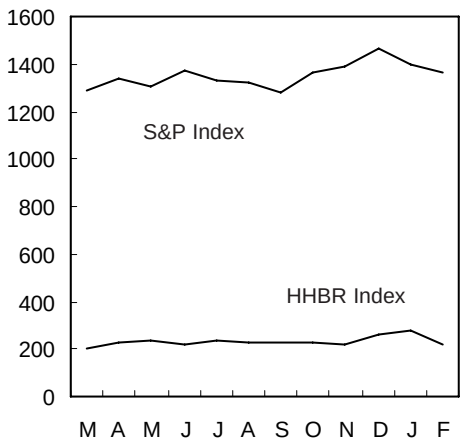
The House Budget Committee took the lead in bringing about a delay of the 15% automatic reduction last year. "We are now urging the Committee to go further and consider language calling for the elimination of the 15% cut in this year's budget resolution," the groups concluded. ■

MONTHLY STOCK INDEX COMPARISON

	Close 01/31/99	Close 02/29/00	Net Change	Percent Change
Home Health Industry Stock Index	281.17	219.01	-62.16	-22.11
Dow Jones Industrial Average	10940.53	10128.31	-812.22	-7.42
N.Y.S.E. Composite	621.73	592.64	-29.09	-4.68
S&P 500 Composite	1394.46	1366.42	-28.04	-2.01
NASDAQ OTC Composite	3940.35	4696.69	756.34	19.19
Dow Jones Health Care Index	532.68	608.17	75.49	14.17

HHBR'S HOME HEALTH COMPOSITE STOCK INDEX

The Home Health Business Report Composite Stock Index represents the collective performance of nine publicly traded companies with primary businesses in the home healthcare industry. Companies included in the Composite Index are denoted with an inverted triangle (▽) in the "company name" column of our monthly stock tables appearing on page 6. The HHBR Composite Stock Index was compiled by Nordby International, and has been constructed to show comparative performance of a selected group of home healthcare stocks with the S&P 500-Stock Index. The Index was calibrated to match the 435.71 closing of the S&P 500 on Dec. 31, 1992.



MAJOR MOVERS IN HOME CARE IN FEBRUARY 2000

TOP FIVE PERCENTAGE GAINERS

Infu-Tech Inc.	215.69
Star Multi Care Services Inc	75.58
Option Care Inc. ▽	51.19
Matria Healthcare	38.03
Respironics Inc.	25.70

TOP FIVE DOLLAR GAINERS

Infu-Tech Inc.	13.75
Invacare Corp.	4.56
Respironics Inc.	2.88
Option Care Inc. ▽	2.69
Star Multi Care Services Inc	2.03

TOP FIVE PERCENTAGE LOSERS

Lincare Holdings Inc. ▽ (s)	-33.86
Columbia HCA Healthcare	-29.29
Apria Healthcare Group Inc. ▽	-28.75
ServiceMaster L.P.	-23.14
Coram Healthcare Corp. ▽	-18.18

TOP FIVE DOLLAR LOSERS

Lincare Holdings Inc. ▽ (s)	-12.00
Columbia HCA Healthcare	-8.00
Apria Healthcare Group Inc. ▽	-5.75
Mallinckrodt	-4.19
ServiceMaster L.P.	-3.31

Market Diary:	Advances	Declines	Unchanged	New Highs	New Lows
	This Month.....14	This Month.....13	This Month.....5	This Month.....5	This Month....3

Public Company Financial Statistics (Feb. 29, 2000, close)

EXCH	COMPANY		TICKER SYMBOL	CLOSING PRICE 02/29/00 $	% CHANGE THIS MONTH	% CHANGE THIS YEAR $	52 WEEK HIGH	52 WEEK LOW	EPS LAST 12 MOS. $	PRICE/ EARN RATIO $	MARKET CAPITAL (1000S)~ $
NAS	Amedisys Inc.		AMED	2.75	22.22	100	2.94	0.75	0	–	8657
NAS	American HomePatient Inc. ▽		AHOM	0.63	11.21	15.74	2.56	0.38	-3.43	–	9475
NYS	Apria Healthcare Group Inc. ▽		AHG	14.25	-28.75	-20.56	22.06	7.13	3.81	4	741599
NAS	Almost Family Inc.	(H)	AFAM	2.56	6.49	13.89	4.13	1.5	-1.49	–	7995
NYS	Chemed Corp.		CHE	29.44	5.13	2.84	34.06	24.63	1.88	16	307563
NYS	Columbia HCA Healthcare		COL	19.31	-29.29	-34.12	32.44	17.25	1.11	17	10878287
NAS	Community Care Services		CCSE	1.13	0	16.22	1.13	0.03	0	–	8120
NYS	Coram Healthcare Corp. ▽		CRH	0.56	-18.18	-43.75	2.63	0.38	-1.06	–	27898
NYS	Fresenius Medical Care		FMS	23.63	-10.43	-16.74	30.38	15.69	0	–	1653750
NAS	In Home Health Inc. ▽ (s)		IHHI	2.5	5.26	17.65	4.25	1.06	0.37	7	13803
NAS	Infu-Tech Inc.	(H)	INFU	20.13	215.69	938.71	21.38	0.44	-0.52	–	65668
NYS	Integrated Health Services Inc.		IHS	0.13	0	0	14.69	0.06	0	–	6646
NAS	Interwest	(L)	IWHM	3.75	-1.64	25	5	2.19	0.53	7	15334
NAS	Invacare Corp.		IVC	24.38	23.03	21.5	26.94	17.44	1.36	18	730689
NAS	Kelly Services Inc.		KELYA	24.06	-4.7	-4.23	32.5	22.88	2.36	10	863651
NAS	Lincare Holdings Inc. ▽ (s)		LNCR	23.44	-33.86	-32.43	40	17.25	1.74	13	1266586
NYS	Mallinckrodt	(L)	MKG	24.63	-14.53	-22.59	37.56	23.88	2.69	9	1688438
NAS	Matria Healthcare		MATR	6.13	38.03	48.48	7.5	2.38	0.77	8	225222
NYS	Mid Atlantic Medical Services		MME	8.19	-18.13	-1.5	11.31	5.13	0.64	13	408442
ASE	National HealthCare		NHC	4.25	-5.56	-19.05	12.5	3.38	-0.77	–	48578
NAS	National Home Health Care Corp.		NHHC	4.03	4.03	5.74	5	2.25	0.39	10	20354
NAS	New York Health Care Inc.		NYHC	1.13	-10	-35.71	5	0.38	-0.06	–	4128
NAS	NuMed Home Health Care Inc.		NUMD	0.13	0	78.57	0.5	0.08	-0.28	–	733
NYS	Olsten Corp. (The) ▽	(H)	OLS	11.94	16.46	5.52	12.25	5.19	0.21	57	970614
NAS	Option Care Inc. ▽	(H)	OPTN	7.94	51.19	159.18	8.75	1	0.22	36	90011
NAS	Pediatric Services of America		PSAI	1.75	16.67	86.67	3	0.72	0	–	11652
NAS	Respironics Inc.		RESP	14.06	25.7	76.47	16.25	7.5	0.27	52	411989
NAS	ServiceMaster L.P.		SVM	11	-23.14	-10.66	20.94	10.13	0.54	20	3415478
NAS	Staff Builders Inc. ▽		SBLI	0.32	0	3.23	0.53	0.13	-3.27	–	7562
NYS	Star Multi Care Services Inc.	(H)	SMCS	4.72	75.58	268.29	6.75	0.75	-0.88	–	8060
NAS	Sunrise Medical Inc.	(L)	SMD	4.31	-9.21	-30.3	9.38	4.25	0.08	54	95884
NAS	Transworld Home HealthCare Inc.		TWH	3	0	60	4.94	1.5	-0.43	–	52653

KEY: (H)=NEW HIGH • (L)=NEW LOW • NYS=NEW YORK • ASE=AMERICAN
NAS=NASDAQ • (s)=STOCK SPLIT • ▽ in HHBR Composite Index • NA=not available

MARKET CAPITAL figure reflects total for this class of stock only. Stock listed is the most actively traded of the company's classes of stock.

Source: Nordby International, Boulder, CO.