# Inside Home Health Care

**Clears Ways and Means**

## 'Any willing provider' gaining some ground

*by Herbert P. Weiss*

WASHINGTON — Small home medical equipment suppliers who want to do business with managed care networks under national health care reform may be able to breathe a little easier: An "any willing provider" clause has been given a thumbs up by the House Ways and Means Committee.

Gingrich Gephardt Mitchell

When the dust settled in Room 111 of the Longworth House Office Building, managed care payer and HME supplier lobbyists alike were stunned when the Ways and Means panel unexpectedly passed an amendment offered by Rep. William Jefferson (D-LA).

The "any willing provider" (AWP) concept opens managed care contracts to anyone willing to meet the price, thus preventing exclusive supplier arrangements. Managed care payers contend that dealing with a sole source for products and services effectively controls costs. They have vigorously fought the AWP measures at the state level with mixed results.

Various provider groups maintain that exclusive provider arrangements could bankrupt numerous small suppliers and damage the quality of patient care. The Ways and Means Committee passage gives the issue national prominence.

Jefferson's AWP provision allows any qualified health care provider to render services to a managed care program if the provider is willing to meet the quality and cost criteria of the health plan. However, nothing in the committee bill would prevent a managed care network from instituting credentialing criteria, requiring fee discounts or es-

*See* ***Willing provider,*** *p. 76.*

## Report predicts tripled sales for home diagnostics market

The U.S. home diagnostic and monitoring product market will triple from $1.2 billion in 1993 to nearly $4 billion by the year 2000 — an 18% compound annual growth rate, according to a new study by Frost & Sullivan.

The home diabetic glucose monitoring market will pace growth, the study noted, increasing its already dominant 66% share of the market to 72% by 2000. Another top performer will be home cholesterol testing, debuting this year. According to the study, home cholesterol testing will grow significantly to 4% of the total market within two years.

Conversely, pregnancy and ovulation testing will dip from 13% to 10% and temperature monitoring from 12% to 9%, the study concluded.

The study, titled "U.S. Home Diagnostic and Monitoring Product Markets: Cost Containment Pressures Motivate Self Testing," is based on interviews with marketing and technical experts from companies in each market segment.

Fueling the growth of in-home testing products are demographics and rising medical care costs. "Inexpensive home testing [is becoming] increasingly attractive, while demographic patterns are creating an expanding target population of older persons," researchers observed. "Americans, meanwhile, have generally become more educated about the workings of the body and the significance of various conditions."

### Technological improvements

In response to what they perceive as a favorable demographic environment, home diagnostic products manufacturers are simplifying the tests, investing more in technology and concentrating on designs that require fewer steps and offer quicker results, according to the Frost & Sullivan study.

Other design improvements are products that are smaller, lighter, and feature large, easy-to-read digital readouts. "Products are getting generally more user-friendly so that less specific skills are needed to employ them," the study maintained.

Home diagnostic devices also feature more user options to facilitate application, the study noted. For instance, blood pressure kits are being manufactured with memory and printing capabilities.

By developing multiple products in the same market to address varying customer requirements, manufacturers are increasing revenue and market share, researchers learned.

### 'Painless' products

There is a high demand for less invasive technology, and it has manufacturers scrambling to develop new products, the study noted.

Current diabetes and cholesterol tests require fingersticks to draw blood and users may need to do this two or three times a day. However, a painless, noninvasive method of monitoring blood glucose encourages more frequent testing. This technology will then be applied for the broad range of tests that require blood sampling, the study maintained.

Manufacturers of professional diagnosis and monitoring products are also targeting self-monitoring for revenue expansion, according to the study. Nevertheless, it will be difficult to enter the market without some sort of strategic alliance because existing distribution systems are well-developed.

"Technological advances will be crucial for those firms without established distribution," the study proclaimed. "Already well-established vendors will broaden their product lines, dominate shelf space and seek to ward off new competitors." ❑

*Frost & Sullivan is a research firm owned by Market Intelligence Research Corp., Mountain View, CA. This report is available for $1,995 (Code #5060-54). For more information, call (415) 961-9000.*

### Total diagnostics and monitoring product markets: Revenue forecasts (U.S.), 1992-1997

| Year | Revenues ($ billion) | Revenue growth rate (%) |
|---|---|---|
| 1992 | 1.01 | 15.8 |
| 1993 | 1.18 | 16.8 |
| 1994 | 1.40 | 19.2 |
| 1995 | 1.68 | 19.3 |
| 1996 | 1.98 | 17.9 |
| 1997 | 2.32 | 17.4 |

Compound annual growth rate (1993-2000): 18.4%
Note: All figures are rounded.

Source: Frost & Sullivan

# Willing provider

*Continued from page 64.*

tablishing any other measure designed to control costs.

Just one hour before the markup session began, Jefferson reportedly weakened his "pure" AWP provision. "It was watered down because it exempted nonprofit HMOs from the provision," said one pro-AWP lobbyist. "It also had some caveats for selecting providers."

According to Jefferson health care legislative aide Darlene Davis, the modification addressed several problems that payers had with state AWP laws. "The author and supporters of the amendments felt that the modifications provided a reasonable basis on which plans can include or exclude providers," she said.

Following the lead of 19 states that already allow AWP provisions and 25 others considering them, Jefferson's amendment squeaked by the Ways and Means Committee panel by a 20-17 vote. Fourteen Democrats and six Republicans favored the measure.

**Bipartisan effort**

An odd coalition of Democrats and Republicans comprised the winning majority. AWP supporters included liberal and conservative members representing rural and urban districts. Black members also voted for the proposal because they feared that managed care networks would discriminate against black doctors, sources said.

"We walked into the bill markup not even knowing that we had the Republican votes to pass the amendment," Davis said. Overwhelming constituent concern over their lack of choice in selecting providers at their local HMO forced the six Republicans to side with the Democratic majority, she said.

Davis added that Jefferson became a staunch supporter for the AWP provision because 40% of his constituent mail asked him to address the choice issue.

The amendment passage caught many staffers by surprise because the provision wasn't even in the initial chairman's mark. Moreover, the staffer said AWP is not as visible as debate over health care financing and is considered a secondary issue.

"It's not like employer mandates, an issue that has already generated a lot of discussion," the staffer said.

Furthermore, the AWP issue is complicated and "extremely controversial," said Ed Cutler, director of policy and strategy for Minority House Whip Newt Gingrich (R-GA). According to Davis, other health care bills did not even include AWP provisions because bill sponsors didn't think their bills would pass if they included such provisions.

> ***The 'any willing provider' concept opens managed care contracts to anyone willing to meet the price, thus preventing exclusive supplier arrangements.***

Cutler has been meeting with various health care groups to gather input, but admitted that "it's not something we've spent a lot of time on."

Still, Gingrich is interested in the AWP concept and is exploring ways to find common ground that ensures consumer choice in selecting providers while allowing managed care payers to control costs.

"In a general way, the congressman has talked about point-of-service access as being a way to bridge the divide between the two goals," Cutler said, adding that a patient can receive care outside an HMO plan's coverage at a "reasonable" added cost.

**The debate rages**

With a pep talk from President Clinton, Congress began its consideration of health care reform in early August by calling on both chambers to stay in session until they passed legislation.

Recognizing the need to publicize their pro-AWP positions to gain congressional support, 12 health care provider groups sent a joint letter to House and Senate leadership calling for AWP and point-of-service language to be included in the final bills offered by the Democratic leadership on the House and Senate floors.

The bills to watch are those sponsored by Senate Majority Leader George Mitchell (D-ME) and House Majority Leader Richard Gephardt (D-MO), said Jefferson aide Davis.

"The Gephardt bill picks up the AWP language from the Ways and Means bill, while the Mitchell bill is totally opposed to the concept," she said. "It doesn't allow states to have AWP laws on the book."

If the Mitchell and Gephardt bills pass their respective chambers, the conferees will have to iron out the differences, especially their differing views on the AWP issue, Davis said.

The final outcome for the AWP provision is likely to be constituent opinion. If enough voters call for consumer choice, AWP will be included in health care reform, she said. ❑

*Herbert P. Weiss is a Providence, RI-based free-lance writer covering health care and aging issues.*

# Inside Home Health Care

# Better funding, carrier 'flexibility' key to Medicare savings

**Medical review in Indiana, 1989-92**

| | 1989 | 1990 | 1991 | 1992 |
|---|---|---|---|---|
| **Beneficiary population (thousands)** | **725.8** | **737.2** | **748.8** | 803.4 |
| **Benefit payments (millions)** | **$468.4** | **$510.9** | **$527.7** | $572.4 |
| **Claims volume (millions)** | **7.6** | **8.5** | **9.6** | 10.6 |
| **Administrative cost (millions)** | **$16.8** | **$15.2** | **$17.1** | $18.5 |
| **Medical review cost (millions)** | **$2.6** | **$2.1** | **$2.3** | $2.3 |
| **Medical review staff** | | | | |
| Prepayment | | | | |
| Nurses | **7.0** | **7.0** | **7.0** | 6.0 |
| Other | **4.0** | **5.0** | **5.5** | 7.0 |
| Post-payment | | | | |
| Nurses | **8.0** | **5.0** | **5.5** | 7.0 |
| Other | **2.0** | **2.0** | **2.0** | 2.0 |
| Total staff | **21.0** | **19.0** | **19.5** | 21.0 |
| **Medical review savings (millions)** | **$12.6** | **$18.7** | **$23.4** | $22.8 |
| **Medical review savings/benefit payments (%)** | **2.7** | **3.7** | **4.4** | 4.0 |
| **Medical review savings per claim** | **$1.66** | **$2.19** | **$2.43** | $2.14 |

Source: General Accounting Office

*by Herbert P. Weiss*

Not all federal reports end up on bookshelves collecting dust. Results from a recent Health Care Financing Administration (HCFA) demonstration project have led the agency to modify the way it conducts payment safeguard activities.

Greater funding and flexibility over medical review allowed three carriers to save the Medicare program more than $50 million over three years in a demonstration project, according to a Government Accounting Office (GAO) report issued last March.

During the pre-Durable Medical Equipment Regional Carrier (DMERC) period between January 1989 and September 1991, HCFA allowed three carriers in Indiana, North Carolina and Louisiana greater flexibility in their medical review operations. The carriers were also given a minimum 12% increase in funding for medical review activities. As a comparison, two additional carriers performed their medical review functions with no changes in their review operations and no increased funding.

According to GAO, the demonstration carriers were far more successful than the comparison carriers in avoiding payments for inappropriate, medically unnecessary or excessive medical services. The government watchdog agency found that each demonstration carrier saved about twice as much as the comparison carriers, or about $2.84 compared with $1.34 per claim.

### Indiana cuts costs

"We believed that the demonstration project would be a foreteller of things to come," said Ken Christiansen, vice president for carrier operations at AdminaStar, Indianapolis, the Region B DMERC. Many carriers were watching from the sidelines hoping for positive results, he noted.

Christiansen estimated that over the life of the project, the carrier received additional funds of about $1.1 million. The funds were used to develop a database for analyzing payment practices and to purchase new statistical software in order to generate improved medical review reports and to develop reporting systems to flag unusual spending patterns.

*See* ***Savings,*** *p. 33.*

# Savings

*Continued from page 28.*

Funds were also used to hire an assistant to Medical Director Adrian Oleck, M.D., for medical policy development; a computer programmer for the medical review area; and additional managers and medical review staff.

Once the project began, it became clear that a medically oriented person needed to be in charge of the claims review process, Christiansen said. "In essence, it comes down to professional judgment regarding the medical necessity of services."

***Greater funding and flexibility over medical review allowed three carriers to save the Medicare program more than $50 million over three years.***

**Glaucoma tests decrease**

Under the new computer prepayment screen, the carrier (then known as Indiana Blue Cross/Blue Shield) identified payments that could be lowered by implementing new medical policies and prepayment screens.

For example, the medical review process found an unexpected increase in billings for a specialized glaucoma test that was higher than the national average. By developing a clear medical policy, reimbursement dropped from $229,772 in 1988 to just $10,497 in 1992.

At the beginning of the project, the carrier had only 12 medical policies in place. By 1990, more than 110 new medical policies had been developed with the blessing of the carrier's advisory committee along with the Indiana medical society and specialty groups.

As a result, more than 60 carrier-specific computer screens were also put in place this year. By 1992, the Indiana carrier was spending about 10% of its medical review budget on medical policy development and the total number of policies had reached 170.

The demonstration project also allowed the carrier to use post-payment reviews to target providers for comprehensive medical review audits (CMR), Christiansen added.

Through statistical analysis, medical review staff were able to selectively pick areas to perform more intensive reviews, he said. In one instance, a CMR audit enabled the carrier to identify a physician who billed from multiple locations for an unusually high number of services. The data showed that the physician must have worked more than 24 hours per day to render all of those billed services, which was "totally impossible to do," Christiansen noted, adding that thousands of dollars were recovered from the physician.

**Reviews constantly evolving**

A key finding of the study revealed that the medical review process is "a constantly evolving one," Christiansen said. Once prepayment screens and physician education reduce inappropriate medical care, CMR will eventually become unnecessary and reviewers will be able to move onto the next procedure that might be aberrant, he said.

According to Christiansen, the demonstration project findings have supported HCFA's decision to mandate that all carriers perform focused medical reviews on those areas with the highest probability of "medically unnecessary" service through the utilization of data analysis, medical policy development and focused screens.

The agency also requires carriers to develop effective local medical policies and prepayment screens and to conduct CMR audits.

By the end of the project, Indiana's medical review savings were about 4.4% of its total Medicare benefit spending — about $22.8 million. While the number of claims medically reviewed in fiscal year 1994 is less than it was during the project, the carrier expects to still recover between $16 to $18 million due to the lessons it has learned.

Despite the large payoff to Medicare, HCFA has had to reduce program administration costs for carriers, reducing per-claim medical review funding, Christiansen observed.

"The importance of a focused medical review is more important now than it has ever been," he said. ❑

*Herbert P. Weiss is a Providence, Rhode Island-based free-lance writer covering aging and health care issues.*

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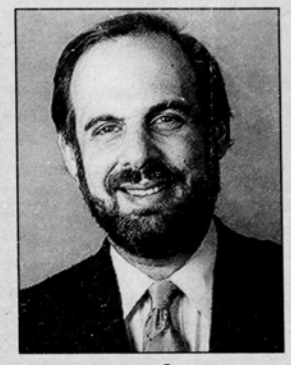
## This month in MPS:





Kessler

The Newsmagazine of Health Care Products Marketing • A McKnight Medical Communications Publication

# Manufacturers see GATT pact as boon

*By Herbert P. Weiss*

With the new year, tariff walls tumbled in 130 foreign countries as the General Agreement on Tariffs and Trade (GATT) kicked in. Industry experts said that GATT would increase the competitiveness of U.S. medical product manufacturers in global markets by eliminating tariffs and lowering trade barriers.

The GATT trade pact was ratified by the U.S. Congress in early December 1994, with a House vote of 288-146 and a Senate vote of 76-24.

Starting Jan. 1 with a five-year phase in, virtually all tariffs currently paid by manufacturers to government customs authorities will be eliminated. Under GATT's "zero-for-zero" agreement, tariffs on medial equipment will be eliminated in major markets, including the European Community, Japan, Singapore and Hong Kong. Korea, Australia and Thailand also have agreed to significant tariff cuts.

In addition, the new GATT accord also gives the medical device industry strong intellectual property protection, including 20 years of protection and limits on compulsory licensing for patents. Producers also gained indefinitely renewable terms of at least seven years for trade-

*See **GATT pact,** p. 16.*

# GATT pact

*Continued from page 1.*

marks, as well as a ban on their compulsory licensing.

**More overseas competition**

"Taking down tariffs increases your margins and allows you to become price competitive," said Dave Williams, spokesperson for the Elyria, Ohio-based manufacturer Invacare Corp. The company exports medical products to 80 foreign countries and has manufacturing plants in Great Britain, France and Germany and distributing operations in Scandinavia and Spain.

Williams told **MPS** that the new GATT trade pact levels the playing field between U.S. and foreign medical product manufacturers, enabling U.S. companies to become more competitive in their efforts to equip clinics, hospitals and other major health care facilities in foreign markets. Before GATT's passage, U.S. companies were forced to raise product prices to cover tariff costs, he said, often putting U.S.-made medical devices at a price disadvantage with foreign competitors.

Pre-GATT tariffs outside the United States were higher in virtually every other nation except Japan, said Ed Rozynski, the Health Industry Manufacturers Association's (HIMA) vice president of global strategy and analysis. Trade barriers forced many U.S. medical device manufacturers to build plants in foreign countries to avoid paying tariff fees.

"Not having to pay a 5% tariff in a tough fight to sell your equipment to a hospital in France gives you a 4% wider margin to play with in order to underprice your competitor," Rozynski said.

With GATT's passage, "Once you take those trade barriers down, there is no reason to move your manufacturing plant to another country just to move it behind the tariff wall," he said.

> ***'Taking down tariffs increases your margins and allows you to become price competitive.'***

Once the medical device tariffs (ranging from 5% in industrialized nations to 100% in some developing nations) are eliminated, U.S. medical equipment manufacturers will save roughly $1 billion a year in tariffs, Rozynski added. "Once all of the tariff cuts kick in for all the countries, and with expanding trade flows, the potential savings could reach $2 billion a year," Rozynski predicted.

The agreement will save money not only for the medical device industry, but also for governments that typically procure such devices for use in national health care systems, he added.

**Bringing home the bacon**

The U.S. Department of Commerce reported that U.S. companies exported more than $8.1 billion worth of equipment in 1993 with a $3.2 billion trade surplus. Exports now account for an estimated 22% of the U.S. industry shipments and are growing more rapidly than domestic sales. The agency noted that 37% of the growth in U.S. medical device production since 1987 is attributed to exports.

"GATT really focused on getting rid of tariff barriers, but also should help us in addressing regulatory and other barriers to high technology," Rozynski said. He noted that a grant of more than $420,000 from the U.S. Commerce Department will help HIMA establish its first overseas office in Singapore. The office will work to improve regulatory and trade environments for U.S. manufacturers in Asia. The trade group is also exploring the possibility of setting up an office in Tokyo as well, he added. ❑

*Herbert P. Weiss is a Providence, RI-based free-lance writer who covers health care and aging issues.*

## 1993 U.S. exports to regions

**(in millions of dollars)**

| Regions | Value | Share |
|---|---|---|
| Canada and Mexico | 1,380 | 17% |
| European Community | 3,080 | 38% |
| Japan | 1,140 | 14% |
| East Asia | 594 | 7% |
| South America | 360 | 4% |
| Other | 1,566 | 19% |

Note: East Asia consists of China, Hong Kong, Indonesia, South Korea, Malaysia, Singapore, Taiwan and Thailand. South America data relate to countries on the South American continent only.

Source: U.S. Department of Commerce

# FDA red tape doesn't stick to distributors

**Overcoming the FDA dilemma**

**by Herbert P. Weiss**

Even with a faster turnaround in Food and Drug Administration product approval, medical product manufacturers and distributors still see hot regulatory issues ahead. But distributors concede that they see little of the agency's rules and red tape.

"Other than having to comply with the FDA's tracking requirements, the agency is really invisible to us," said Ted Almon, president of Claflin Co., a medium-sized medical/surgical distributor in Rhode Island.

"We are required to track product code numbers to end users and to maintain records — that's it," he said. The process is considered routine and not onerous to distributors, he added. Almon questions the effectiveness of the tracking rule, calling it unnecessary. "People have access to the courts and that is where they will go to," he said, if they suffer wrongful injury. But one issue that is of growing concern to medical product distributors is the FDA's enforcement of the storage temperature requirement for certain solutions, said Steve Azia, associate director of government affairs for the Health Industry Distributors Association.

Azia said that the FDA requires warehouses across the country to maintain low temperatures to store injectable solutions, such as sterile water, sodium chloride and other sterile intravenous solutions that do not degrade with heat.

"It is uneconomical in many regions of the country to air condition warehouse facilities for these products," Azia said, noting that stability data has been submitted to the agency stating that these products can withstand normal warehouse storage temperatures.

## Hot regulatory issues

"There is no question that the most critical issue to entrepreneurial medical device companies is the unpredictability of the FDA's 510(k) approval process," said Jeff Kimbell, executive director of the Washington-based Medical Device Manufacturers Association, that represents 110 small medical device companies.

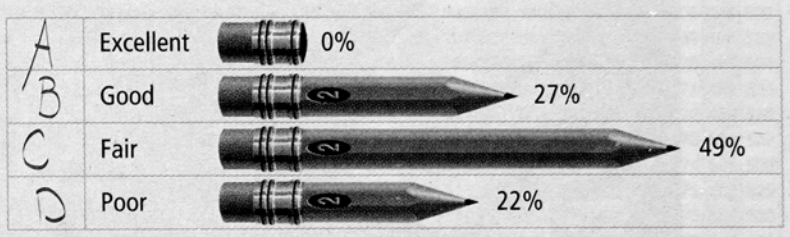
Prior to 1990, by law, the FDA had 90 days to determine whether a product was safe and effective to consumers. As the result of federal law eliminating the review time requirement, the approval process currently hovers between 140 and 180 days, Kimbell said.

Meanwhile, "Venture capital groups and private investors simply steer clear of investing

*See* ***Red tape,*** *p. 14*

### Mediocre report card for FDA

How would you rate the FDA's work at improving the process by which medical devices are cleared for marketing?




Source: **Medical Products Sales** survey of distributors, 1996

## Snapshot

### Where's the hottest sales growth for distributors?

| | Hospital Distributors | Physician Distributors | Long-Term Care Distributors |
|---|---|---|---|
| Increased penetration of existing accounts | 45% | 51% | 38% |
| New markets | 15% | 17% | 27% |
| Geographic expansion | 12% | 16% | 27% |
| New products | 21% | 11% | 6% |
| "Other" | 2% | 4% | 3% |

ource: **Medical Products Sales** Survey of distributor sales managers, 1996

**Market coverage legend**

Home Care · Hospital · Long-Term Care · Multimarket · Physician

## DEPARTMENT INDEX

# MPS survey

*Continued from page 1.*

(mentioned by 26% of respondents) and adult apnea monitors grew 6% (listed by 25% of respondents).

The perrenial specialty product leader is the pediatric apnea monitor, which also notched 4% growth from 1995. In general, respondents were bullish on pediatrics, as 16% indicated they had a stronger presence in that market.

### Concentrated concentrators

Another revelation from the survey is a 10% jump in the number of respondents who claim that concentrators comprise virtually all of their business. However, that statistic only applies to concentrators, because the percentage of suppliers who furnish only high pressure gas or liquid remained static.

Still, oxygen itself is apparently securing a larger share of the HME dealer's business, as the number of respondents who said it comprised 41% to 60% of overall business doubled from 13% last year to 26% in 1996.

Concurrently, the number of respiratory manufacturers HME companies are dealing with appears to be shrinking. This development is most evident in the liquid oxygen sector, as 73% of respondents listed one vendor as their source, compared with only 57% last year. High pressure gas dealers reported the same pattern, as 79% said they deal with only one vendor, as opposed to 62% last year. More concentrator dealers — 23% — listed a single vendor, but it was only slightly more than last year's 20%.

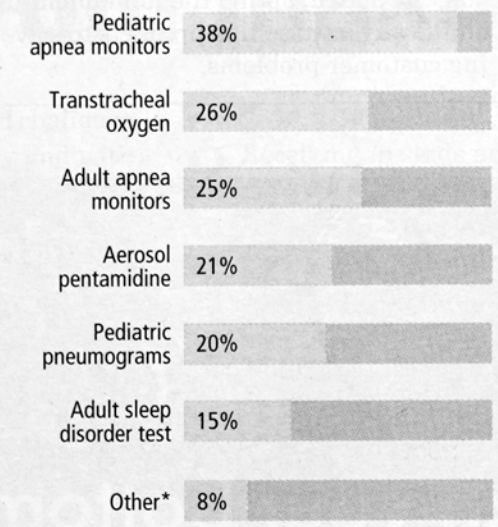
### Measuring margins

Despite various cuts in respiratory reimbursement levels in the past few years, oxygen is still the bread-and-butter product for suppliers. Seventy-four percent listed it as the product that yields the highest margin. **MPS**

*Coming next month: How are respiratory suppliers dealing with the pressures of Medicare and managed care?*

## Branching out in respiratory products

**Ancillary respiratory products are showing solid growth as the following list indicates:**




*Responses included ventilator rentals, pediatric nebulizers and home phototherapy.

Source: **Medical Products Sales** Respiratory Survey, 1996

## The $O_2$ Top Three

**A question in the 1996 Medical Products Sales Respiratory Products Survey about the top three margin-generating product lines drew the following replies:**

**74%** of respondents said oxygen (liquid, gas and concentrate) produced the highest margin.

**40%** said nebulizers produced the second-highest margin.

**23%** said nasal continuous positive airway pressure devices generated the third-highest margin.

*Other responses named sleep studies, medications and apnea monitors as top margin producers.*

Source: **Medical Products Sales** Respiratory Survey, 1996

# Red tape

*Continued from page 3.*

in small medical device companies, especially start-ups, unless they have plans to market in Europe first, because there is essentially no deadline that the FDA has to abide by," he added.

Another critical issue facing medicae product manufacturers is the increasing scarcity of raw materials to make medical devices.

Large companies like Dow Corning and DuPont are making the choice not to sell their raw materials to medical device manufacturers because of litigation involving breast implant and subsequent court settlements, according to Kimbell.

"It's a simple business calculation to them," Kimbell noted, stating that 1% of these company's total sales are to medical device companies and yet result in 99% of their legal liabilities.

### Solutions in sight

One way to trim the long waiting period for the FDA's 510(k) approvals is through third-party help with device reviews, Kimbell told **Medical Products Sales.**

This concept was endorsed by MDMA, the Health Industry Manufacturers Association and the National Electrical Manufacturers Association more than a year and a half ago.

"It is important that you bring in expertise outside of the federal government working with people inside government to ensure that the best available medical technology gets on the market as expediently as possible," Kimbell said.

This year there is pending FDA reform legislation in Congress. MDMA endorses the proposal (H.R. 3201) supported by Reps. Joe Barton (R-TX) and Bill Richard (D-NM) because it helps medical device manufacturers to stay competitive, Kimbell stated. "While we consider Sen. Nancy Kassenbaum's (R-KS) proposal in the Senate (S.1477) a step in the right direction, it lacks provisions that small companies need, such as the implementation of a third-party review system for all 510(k) products," he noted.

**'It is important...to ensure that the best available medical technology gets on the market as expediently as possible.'**

**— Jeff Kimbell**
**MDMA**

Kimbell predicted a Senate vote by July.

Finally, HIMA is circulating its prescription for FDA reform. The Washington-based group, representing 700 manufacturers of medical devices, diagnostic products and health information systems, calls on the FDA to target its limited resources on its statutory mandate and focus its efforts where they are needed.

Such efforts include:

- Exempting low-risk devices from the 510(k) requirement.
- Allowing modifications that do not adversely affect devices.
- Making safety and effectiveness decisions without submission of a premarket assessment notification or a PMA supplement.
- Streamlining the PMA review process.
- Reducing mandatory postmarket reporting requirements. **MPS**

*Herbert P. Weiss is a Providence, RI-based freelance writer specializing in health care and aging issues.*

# MARKETPLACE

MEDICAL PRODUCTS SALES®
Business information for the sale and distribution of health care products





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## MPS This Month:



# SNFs await consolidated billing

### Skilled nursing facilities prepare for July 1 implementation

**by Herbert P. Weiss**

With its July 1 implementation date fast approaching, nursing home providers called on the Clinton administration to delay for one year the start up of the controversial Medicare consolidated billing rule for skilled nursing facilities (SNFs). They warned that SNFs will face regulatory overload when staff are required to implement simultaneously Minimum Data Set automation, a new Prospective Payment System, Part B fee schedules and consolidated billing.

As mandated by the Balanced Budget Act of 1997, SNFs must submit all Medicare claims for Part B services and supplies. But the federal law exempts facilities from billing for services and supplies provided by physicians, physician assistants, nurse practitioners, certified nurse-midwives, qualified psychologists, and certified registered nurse anesthetists. Home dialysis supplies and services are excluded. Finally, only in 1998 will SNFs be exempt from billing for transportation costs of electrocardiogram equipment and test services.

A January 26, 1998, draft memorandum to intermediaries and carriers, circulated by HCFA to trade groups to solicit comments, heightened concerns about the adverse impact of consolidated billing to SNFs. Less than two months later, in a March 11 letter to Health and Human Services Secretary Donna Shalala and HCFA Administrator Nancy Ann Minn-DeParle, the American Association of Homes and Services for the Aging urged for a one year delay, charging that the new consolidated billing requirement posed severe problems to SNFS and could ultimately threaten access of Medicare beneficiaries.

At press time, a HCFA official told s that the July 1 implementation of HCFA's consolidated billing requirements is still on track. No delays. The agency has no choice to go forward because the "law is the law," he said.

"The draft program memorandum was circulated very early in the process so we could benefit from comments. We received a bunch of comments and we will make a bunch of changes," he said.

*See* ***SNF,*** *p. 6*

## AT PRESS TIME

**HCFA sets transition period for consolidated billing**

In its release of the final Program Memorandum for consolidating billing, HCFA set a transition period from July 1, 1998, through Dec. 31, 1998, only for those skilled nursing facilities that do not transition to the prospective payment system until Jan. 1, 1999. Suppliers may continue to bill and receive payment directly from the Part B DMERC for items not billed by the SNF to the Part A fiscal intermediary. See related story at right.

**Apria Healthcare settles lawsuit**

Apria Healthcare Group Inc. and the investor group headed by Joseph Littlejohn and Levy have agreed to settle the lawsuit filed by Apria against JLL on March 24. Both sides agreed to terminate the Stock Purchase Agreement and Stockholder Agreement previously entered into by the parties on February 3, thereby leaving both parties free to explore other strategic directions. Neither party will pay any financial consideration to the other under the terms of the settlement.

**Allegiance acquires biopsy device manufacturer**

Allegiance Healthcare Corp. has acquired privately held Bauer Medical Inc., a Clearwater, FL-based manufacturer and marketer of single-use biopsy devices. The company also manufactures fully automated biopsy devices, needles, bone and bone-marrow biopsy instruments, and related supplies. Bauer\rquote s products are marketed worldwide primarily under the Temno brand. Allegiance manufactures and markets a complementary line of manual and automated biopsy systems under the Tru-Cut and Jamshidi brand names. Bauer was founded in 1989 and has a staff of 70.

*SNF from p. 1*

**Unprepared for consolidated billing**

"We feel very strongly that SNFs don't have the technology to develop a consolidated billing system and negotiate contractual arrangements with Part B service providers until we have had clear program regulatory and programmatic guidance," said Mike Rogers, senior vice president for government and regulatory affairs for the American Association of Home and Services for the Aging. With less than three months before implementation, SNFs will not be able to develop software billing packages, negotiate contractual relationships with Medicare Part B providers and train staff, he said.

According to Rodgers, the consolidated billing requirement unfairly makes SNFs responsible for billing for any Part B supplies or services rendered outside the facility, like in an emergency room or outpatient setting. He said that even though SNFs have no mechanisms for monitoring billing at other sites, facilities will be required to validate the medical necessity of any Part B service that the resident received (e.g., lab tests and x-rays).

Rodgers expects SNFs to make amends for any billing errors, but he urged federal regulators to not label honest billing mistakes as "fraud" and hold SNFs liable for hefty fines. "Given the complexity of Medicare Part B rules and definitions, it is critical that providers who unintentionally make mistakes not be penalized," he said.

It is too late to stop the implementation of the consolidated billing. Now only Congress can fix the problems, Rodgers said, noting that AAHSA is seeking changes by pushing for a technical corrections act.

**Medical suppliers, manufacturers watch and wait**

Although the draft memorandum to intermediaries and carriers describing the operational details of the consolidated billing rule stated that Medicare Part B claims would be processed by Part A fiscal intermediaries rather than the durable medical equipment regional carriers (DMERCs), HCFA has asked for feedback on other options for processing claims.

Both the Health Industry Distributors Association (HIDA) and the Health Industry Manufacturers Association (HIMA) question HCFA's preferred option of processing claims through the Part A fiscal intermediaries.

With the release of the draft memorandum there has been a lot of internal debate within HCFA as to who should process the claims, said Mark Hobratschk, HIDA's associate director of government relations. "Fiscal intermediaries do not have the same software capabilities to process Part B claims to capture information as the DMERCs," he said, stressing that most fiscal intermediaries do not even have any of the fraud and abuse controls and utilization controls or Certificate of Medical Necessity requirements as the DMERCs.

If fiscal intermediaries take the lead in processing Medicare claims, Hobratschk warned that serious program integrity problems may jeopardize the accuracy of the claims billing process and that fiscal intermediaries will not be ready to begin processing by the implementation date.

According to Hobratschk, HCFA is expected to publish its final program memorandum on consolidated billing by March 30. This will implement the sections of the federal law that mandate only SNFs to receive payment for Part B services and supplies provided to Medicare SNF beneficiaries.

"You have the Office of the Inspector General, the program integrity section within HCFA, DMERC medical directors [all] pretty much now against fiscal intermediaries processing claims starting on July 1," Hobratschk said. "We expect that they will not require the claims to be initially processed by the fiscal intermediaries until the fiscal intermediaries claims processing capabilities can be sufficiently upgraded."

Another major concern for HIDA is HCFA's possible limitation on the number of billing services that an SNF can use to process Medicare Part B claims.

Candy Littell, HIMA's senior health policy advisor, said "Because SNFs are going to only get paid a specific amount of money under PPS, now they will have an incentive to negotiate with suppliers for the best price." **MPS**

*Herbert P. Weiss is a Providence, R.I.-based freelance writer covering medical, health care and aging issues.*

MEDICAL PRODUCTS SALES®
Business information for the sale and distribution of health care products

The industry's only multimarket newsmagazine

# MPS®

May 1998 Volume 29, No. 5

## MPS This Month:



## *AT PRESS TIME*

**HCFA clarifies consolidated billing memo**
HCFA tells nursing home groups that its Consolidated Billing Program Memorandum Transmittal released in April has been misinterpreted. Industry widely believed ñ and MPS reported - that the memo allowed a six-month transition for SNFs that were unable to submit claims for services rendered on or after July 1, 1998. HCFA now clarifies there is a six month transition for all services and supplies except for therapy services and ambulance services. As of July 1, all SNFs will be required to bill directly for these two services. In addition, those nursing homes scheduled to implement the prospective payment system on July 1 will be required to bill Medicare directly for all services provided to Part A patients to the best of their ability.

**Apria names Whitworth chairman as Argyros resigns**
Apria Healthcare Group Inc. announced that George Argyros resigned as chairman of the board, as well as from the three-person board committee formed to direct an assessment of Apriaís future course. Ralph V. Whitworth, 42, was elected as chairman. He is a principal and managing member of Relational Investors, LLC, Apriaís largest institutional shareholder with 5.1 million shares.

## HCFA's surety bond rule generates controversy

**by Herbert P. Weiss**

With home care agencies up in arms over the Health Care Financing Administration's new surety bond final rule, durable medical equipment (DME) suppliers expect a similar fate as they await the release of the final surety bond rule intended to keep unscrupulous DME suppliers from entering the Medicare marketplace.

Under the Jan. 5 surety bond final rule - enacting provisions of the Balanced Budget Act of 1997 - all home health agencies in the Medicare program were required to obtain surety bonds of $50,000 or 15 percent of annual Medicare payments received, whichever is greater. Originally, agencies were required to obtain bonds by Feb. 27 for coverage beginning Jan. 1, 1998. However, HCFA extended the February date to April 30.

HCFA's final rule also established minimum capital requirements to make certain that new home health agencies have enough funds to operate for at least three months before initiating service to Medicare patients.

The requirements were harshly criticized by home-care providers, many of whom said they simply could not afford the bonds.

Several surety bond industry associations also opposed the rule. Such groups specifically balked at the "cumulative liability," where surety bond writers could be held liable to HCFA for a home health agency's overpayments for up to the full amount of the bond for every year of coverage. Their liability could continue for an indefinite number of years.As reported, widespread industry criticism spurred HCFA to rethink its approach and extend the deadline.

*See **HCFA**, p.6*

## *HCFA* *continued from p. 1*

### DME suppliers watch and wait

Meanwhile, DME suppliers are faced with a near parallel regulatory experience. HCFA released a proposed DME surety bond rule on Jan. 20 under which suppliers of DEM, prosthetics, orthotics, and supplies would be required to obtain surety bonds of at least $50,000 and a maximum value of $3 million. The bond value must equal at least 15 percent of the supplier's previous year's Medicare revenue. The Bond requirements will be effective after HCFA issues a final rule, expected later this summer.

"Surety bonds are needed to weed out unscrupulous providers," said HHS Inspector General June Gibbs Brown. "The actions will help protect Medicare by ensuring that suppliers are legitimate business enterprises, not rip-off artists."

For its part, HIDA has supported the surety bond concept, but says the HCFA proposal is over-reaching. "Our number one concern is how this regulation will have a larger disproportionate impact on smaller suppliers because of the 15 percent threshold," said Mark Hobratschk, HIDA's associate director of government affairs. "Since only one surety bond must be obtained per tax identification number, that 15 percent requirement is a very small amount for a very large company to pay. But for the smallest suppliers who make up the overwhelming majority of all suppliers, the financial impact is large."

Based on the difficulty of home health agencies to find surety bond companies willing to write a bond, HIDA has told HCFA that the 15 percent requirement may be too high. "Congress mandated that the bond be set at a minimum of $50,000. Why not go with the flat $50,000 amount - it is simpler, less costly to determine and maintain, and equally effective in achieving the legislative goals of the Balanced Budget Act," Hobratschk said, referring to the recent test of the bond program in Florida.

Hobratschk said that HCFA gives surety bonds too much credit for influencing Florida's success in eliminating illegitimate suppliers. "On site inspections and other efforts, along with requiring surety bonds, may have impacted the successful results."

HIDA has provided HCFA with suggestions to help the agency ensure the integrity of the Medicare marketplace. These include HIDA's Medicare Part B supplier standards, on-site inspections, a corporate compliance program, and new application and verification procedures.

At press time, no date had been set to implement the DME surety bond rule. Suppliers can wait to obtain the bonds until they receive a memo from the National Supplier Clearing House. A final rule is not expected before May. **MPS**

MEDICAL PRODUCTS SALES®
Business information for the sale and distribution of health care products



# MPS®

June 1998 Volume 29, No. 6

## MPS This Month:



## AT PRESS TIME

**HCFA Announces First CB Demonstration Site**
The Health Care Financing Administration has selected Polk County, Fla., as the first of three competitive bidding demonstration project sites in DMERC Region C. The rural area east of Tampa will begin the new payment rates in Spring 1999, with the bidding process beginning this Fall.
The demonstration will include five product categories: enteral nutrition, hospital beds, incontinence items, oxygen, and surgical dressings. While the legislation authorizing this demonstration allows HCFA to contract with as few as one supplier for any or all of these items, HCFA's announcement stated that "the number of winning bidders selected will be more than sufficient to supply the quantity of medical equipment and supplies covered by the demonstration." The announcement also states that geographic distribution capability will be a consideration in the evaluation of bids..

# Gramm Champions Competitive Bidding

### Industry groups rally to oppose Texas Senator

by Herbert P. Weiss

With the deadline fast approaching for the Health Care Financing Administration (HCFA) to release a Request for Bids for the upcoming competitive bidding demonstration project, U.S. Senator Phil Gramm of Texas went public with his strong support for the controversial cost-containment strategy.

As part of the 1997 Balanced Budget Act, the U.S. Department of Health and Human Services will pick three sites in DMERC Region C, comprising 14 states in the Southern United States, to test a competitive bidding program. Consumers in these areas will be limited to receiving home oxygen services, hospital beds, wound care supplies parenteral nutrition, and incontinence supplies only from Medicare's chosen supplier. All other providers will be barred from receiving payment for these items.

**"We took the fact that Senator Gramm was interested in competitive bidding to be an opportunity to educate him as to its true effect."**
**— Erin Bush, HIDA**

In three press conferences held in Southern Texas in early April, the senior Republican Senator and member of a national commission charged with protecting Medicare's solvency called for the federal government to get the best price for its durable medical equipment purchases. He also pushed for Texas to be one of the chosen test sites.

**Do the Numbers Add Up?**

Using home medical equipment companies as a backdrop for these events, Gramm used a shopping list of common medical equipment items purchased by the U.S. Department of Veterans Affairs and the Health Care Financing Administration to prove his point

*See **BILLING**, p. 8*

## SURVEY *from pg. 1*

for all respondents. For a more exact understanding of typical levels of compensation, MPS further tabulated results to produce ranges for each experience category. The ranges outlined in **Table 1** comprise 60 percent of all reps, e.g., 20 percent of contractors with 1 to 4 years experience earn less than $40,000 per year and 20 percent earn more than $60,000 per year.

**Table 1**

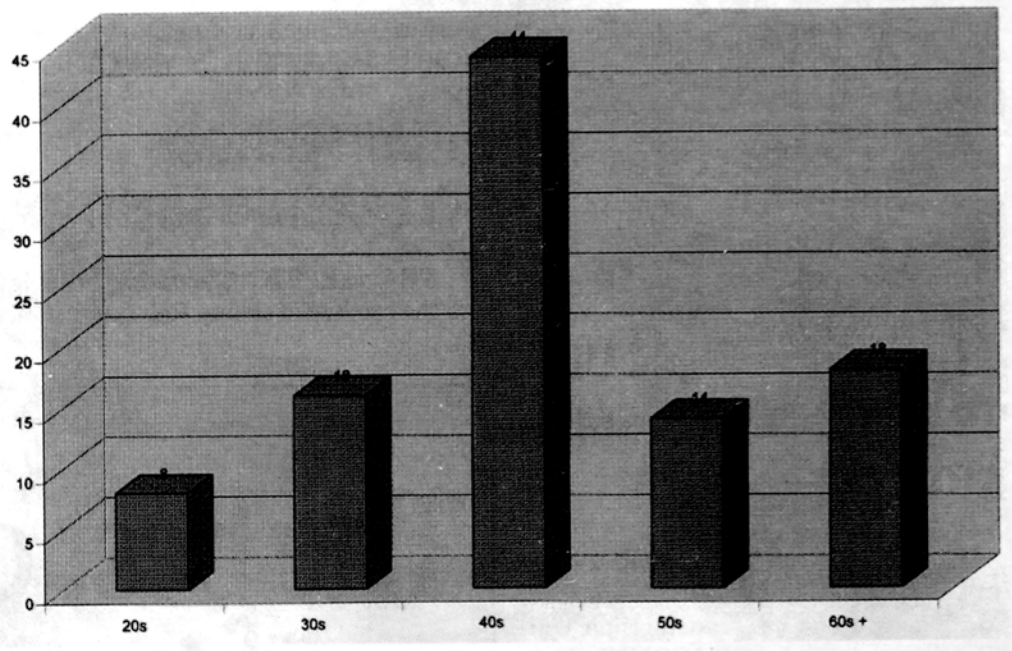
| Earnings Ranges According to Sales Experience | |
|---|---|
| **Sales Experience** | **Compensation Range (comprising 60% of reps)** |
| 1-4 years | $40,000 - $60,000 |
| 5-8 years | $55,000 - $70,000 |
| 9-14 years | $60,000 - $75,000 |
| 15-20 years | $85,000 - $105,000 |
| 21-29 years | $90,000 - $110,000 |
| 30+ years | $60,000 - $90,000 |

Not surprisingly, the widest compensation ranges occur among reps with the least (1-4 years) and most (30+ years) experience. Newcomers, of course, are most likely to earn less than $30,000, though a significant number post earnings of more than $50,000. At the other end of the scale, the varied job descriptions of reps with more than 30 years' experience result in a scattered compensation range. For example, part-time consultants, semi-retirees and reps who double-time as managers account for the more modest earnings, those in the $30,000 to $50,000 range. However, reps with 30 years of uninterrupted service typically earn from $80,000 to more than $120,000. The combination of the two types of veterans results in the average figure of $71,000.

### Forty Somethings on Top

**Graphs 2** and **3** illustrate the extent to which reps in their 40s control the industry. Specifically, as shown in Graph 2, nearly half (44%) of all medical products sales reps are in their 40s.

**Graph 2** **Sales Reps By Age**




More importantly, Graph 3 shows that the forty somethings demand the industry's top dollars, earning an average of $84,000 per year. Average earnings decline for reps in their 50s and 60s, to $74,000 and $68,000, respectively. While the two eldest age categories represent some of the most experienced reps, their ranks also contain a significant number of individuals embarking on second or third careers, resulting in lower earnings due to less experience. In addition, reps in their 50s and 60s are increasingly cutting back – working part-time or as lower-paid consultants.

Not coincidentally, the figures in Graph 3 closely match those in Graph 1. Here's why: It can be assumed that a majority of reps started in the medical products field in their mid-20s. As such, their experience levels coincide with those in **Graph 1**. For example, "thirtysomething" reps earn an average of $67,000 per year (**Graph 3**), closely resembling the $67,000 - $70,000 average earnings of reps with 5-14 years' experience (Graph 1).

### Sales Experience and Compensation

**Graph 4** illustrates that experience as a medical products sales rep is rather evenly distributed among the six cate-

# Gramm Champions Competitive Bidding

***BILLING** from pg. 1*

– that the federal government could buy more efficiently and save Medicare dollars. According to the *Dallas Morning News*, Gramm said the VA spends $50 on a walker while Medicare pays $80.

For hospital beds the VA spent an average of $945, while Medicare paid a hefty $1,922. Finally, Medicare pays a whopping $2,942 for oxygen compared to the VA's price of $615.

But Erin Bush, associate director of government relations for the (HIDA), countered that Gramm was comparing apples to oranges. She said the lower VA prices do not include the cost of servicing the equipment, which Medicare requires.

Meanwhile, HIDA circulated to Gramm's staff a study of VA contract prices showing that, with service costs included, the VA's payments were roughly equivalent to those of Medicare.

The group also highlighted the additional costs incurred by the required Medicare paperwork.

Gramm's press spokesperson, Larry Neil, acknowledged to *MPS* that the price comparisons made by Gramm were for the direct cost of products alone and not for any services. "The controversy over competitive bidding mostly comes from those people who don't want to bid against each other to sell products to the government," he said. "It works everywhere else in the government. We use competitive bidding in every facet of the U.S. government."

"We took the fact that Senator Gramm was interested in competitive bidding to be an opportunity to educate him as to its true effect," Bush said. She noted that HME providers attending the events held in Eastern Texas had warned Gramm's staff of adverse consequences of competitive bidding (e.g., stifled free market competition, reduced access to high-quality services, reduced ability of Medicare beneficiaries to choose their provider and adverse fiscal impact on a large number of small home medical equipment companies).

The education of Senator Gramm was a success, according to Bush. By the final press conference, the Republican Senator acknowledged the controversy surrounding competitive bidding and called on HCFA to include assurances that supplier services would be maintained and reimbursed during the demonstration projects.

Bush said that HCFA is gaining sophistication in its lobbying of Congress. "They are now reaching out to the legislators where they are going to launch the demonstration projects and shoring up their political support prior to announcement of selecting the three demonstration project sites."

HCFA's Request for Proposals is required by July 1, and the first test site must be up and running by January 1, 1999, according to Bush. "It is ambitious considering the great administrative burden of evaluating each bid, choosing the winning bidders and making sure the company can meet the needs in the surrounding areas."

### A Call for Action

In a special alert to members, the National Association for Medical Equipment Services (NAMES) has called for a "holy war" to defeat any efforts to implement competitive bidding. The Alexandria, Va-based group also urged members to write letters to their local papers on competitive bidding to local newspapers.

Steve Harcznak, vice president of communication for NAMES, predicts that competitive bidding in its current form could chase a lot of small suppliers out of business. "This is a major issue for our membership," even more significant than oxygen cuts, surety bond requirements and inherent reasonableness. "If you don't get to bid, you cannot provide equipment under the Medicare program in your region." **MPS**

## Tyco To Pay $3.3 Billion for U.S. Surgical

Tyco International Ltd. continues its aggressive growth in the medical products industry by announcing its planned acquisition of U.S. Surgical Corp. for $3.3 billion in stock. The deal, expected to close in the fall, would boost Tyco's annual revenues from medical products to $4.5 billion.

The acquisition marks the combination of two of the industry's most active consolidators. In January, Tyco purchased the American Home Products unit of Sherwood-Davis & Geck for $1.77 billion. In February, U.S. Surgical acquired Pfizer Inc.'s Valleylab unit for $425 million. Tyco's current strength in wound care and vascular products, combined with U.S. Surgical's prowess in disposable sutures, staples and products for minimally invasive operations, led Tyco chairman and CEO L. Dennis Kozlowski to tell the Wall Street Journal that "we basically own the operating room."

*Kozlowski said U.S. Surgical chairman Leon Hirsch will continue in that role until the deal is closed and thereafter is expected to stay on to help run the company.*

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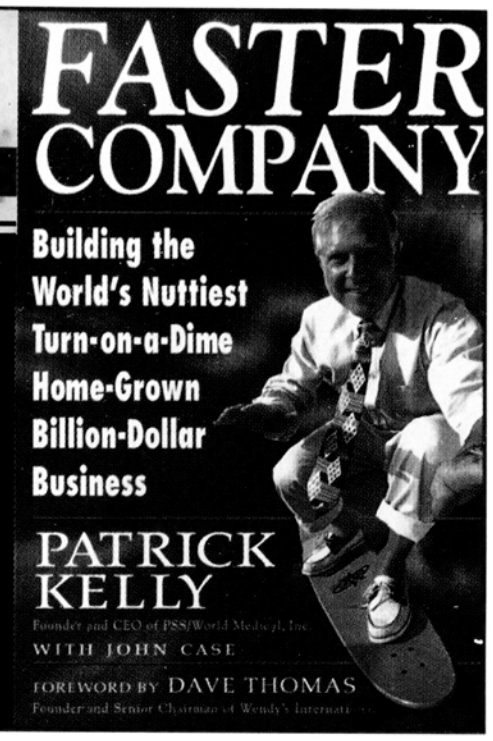
## MEDICAL PRODUCTS SALES®

July 1998 | THE INDUSTRY'S **ONLY** MULTIMARKET NEWSMAGAZINE | Volume 28, N°. 7

## MPS Book Review




***Faster Company*** - Building the World's Nuttiest Turn-on-a-Dime Home-Grown Billion-Dollar Business
by Patrick Kelly, Founder and CEO of PSS/World Medical, Inc.
*Reviewed from an industry perspective by Alan Grogan, competitor and confessed sour-graper.*

Pat Kelly's book, Faster Company, is great support for "The Law of Unintended Audiences," also known as the "Locker Room Chalkboard Postulate," a recent product of the information age. The law holds that given the impossibility of keeping your message restricted to its intended audience, you should always expect that anything you say or write will get to its worst possible audience and end up being used in the worst possible way. Surely, Pat Kelly weighed that downside against the benefits of being published.

*(Continued on page 15)*

## INSIDE MPS



# PPS Kicks In

*by Herbert Weiss*

It's the beginning of a new era, at least for skilled nursing facilities (SNFs), with the Health Care Financing Administration releasing its guidelines for implementing a prospective payment system (PPS). Not since the creation of Medicare and Medicaid have facilities faced such massive payment reforms. Before the release of the 65-page interim final rule in the Federal Register on May 12, 1998, nursing home groups had called for delays in implementing PPS and consolidated billing because of the adverse regulatory impact.

After backpedaling, HCFA has relented and included all Medicare Part B services, including therapy services, in the consolidated billing transition period. Initially, when announcing the six- month delay, from July 1 to January 1, 1999, the agency had required nursing home providers to begin billing for therapy services on July 1.

### PPS

Under HCFA's new payment system, SNFs will be reimbursed on a facility-specific and federal per diem rate that will be blended and phased in over a four-year period. At the start, a facility's 1998 rate will be based on 75 percent facility-specific costs combined with a 25-percent federal per diem rate. By the year 2001, SNF payments will reflect a 100-percent federal per diem rate. The facility-specific rate will be based on 1995 capital, ancillary and routine costs plus an amount allocated for Part B Services. This rate will be adjusted for inflation. The new federal rate also starts with the average 1995 Medicare costs for free-standing and hospital-based SNFs and is adjusted for inflation and for average facility wage levels and case-mix. Urban and rural facilities will be under a separate rate calculation.

Under PPS, SNFs will be paid a fixed daily rate based on the acuity of each resident. However, under the current payment system, nursing home providers are paid retroactively for actual and allocated costs. The lower the provider's costs, the more profit they will make.

Finally, PPS bundles services into a case-mix adjustment federal per diem for Medicare Part A. In addition, beginning January 1, 1999, an annual cap of $1,500 for outpatient occupational therapy and $1,500 for physical therapy and speech-hearing pathology services per Medicare beneficiary under Part B will be implemented.

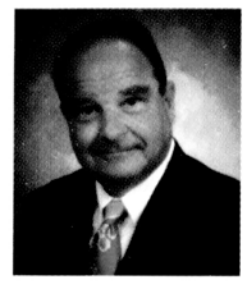
### Red Flags in Rules

"We're still digesting the PPS regulation," said Judy Peres,

*(Continued on page 8)*









## PRODUCT NEWS

**PPS** continued from Page 1

director of health policy at the American Association of Homes and Services for the Aging, noting that her double-spaced typed copy is well over 300 pages. But a beginning read of the rule's impact statement reveals major problems for nursing home providers, according to Peres. Specifically, PPS cuts $12.8 billion in Medicare payments to SNFs over a five-year period, not the initial $9 billion initially estimated by the Congressional Budget Office.

Peres added that the recently released PPS rule is troubling because it does not provide for an appeals or exception process. While hospitals have recourse to dispute DRG payments, SNFs can't request exceptions for routine cost limits or bill for increased payments for extraordinary care. For example, when treating AIDS patients, drug costs might sour to $600 a day, with the facility being forced to absorb the costs.

"We understand everybody is concerned these days about not wanting to game the system and not open doors for loopholes, but there are very legitimate costs that are not captured by the RUGs case mix payment system and industry experiences not captured in the base year," Peres said.

Meanwhile, AAHSA is concerned that fiscal intermediaries have not yet announced how they plan to train nursing homes on the new system. Peres is concerned that some AAHSA state affiliates have not yet heard from their fiscal intermediaries or have been notified that their training begins on June 28, just days before the PPS implementation date.

"It is obviously very difficult for nursing facilities to be held responsible for something they haven't been trained on," Peres said.

## New Role for SNF's

According to Peres, with consolidated billing the PPS rule puts SNFs in a quasi-managed care contractor role. "We're in a new role with the vendors. We're sort of Part A people on a very steep Part B learning curve now," she said, noting that nursing home staff are now forced to learn the intricacies of medical necessity rules and the different rules associated with various fee schedules.

With consolidated billing rules holding SNFs accountable for the accuracy of the submitted claims, Peres said that AAHSA has directed its attorneys to draft a contract for use by member facilities to require that liability be shared if a supplier submits a false claim.

"We are trying to determine if we can share the legal liability even though the statutory mandate makes us responsible," Peres said.

But its a whole new world, added Peres. "We're looking to forge a strong relationship with our Part B friends. For sure, each will be dependent on each other in ways they have never been before." **MPS**

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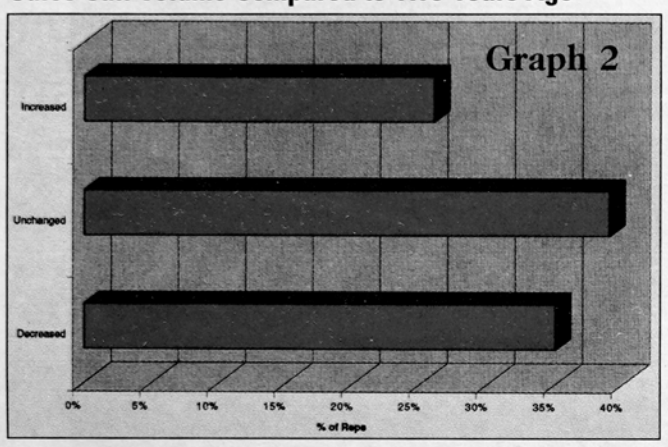
**Survey** continued from Page 1

**Sales Call Volume Compared to Two Years Ago**



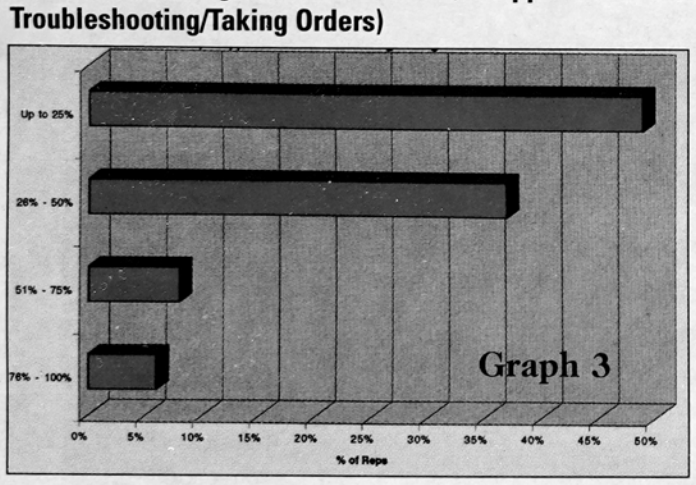

ucts - in other words, selling. Rather, the bulk of time is dedicated to customer service activities, such as troubleshooting or taking orders.

Despite the fact that their role has changed, sales reps continue to serve as valued consultants to their customers. As illustrated in **Graph 4**, when queried as to their influence over customers' brand purchases, 94 percent of reps measured it as "great" or "moderate," while only 6 percent reported "limited" influence.

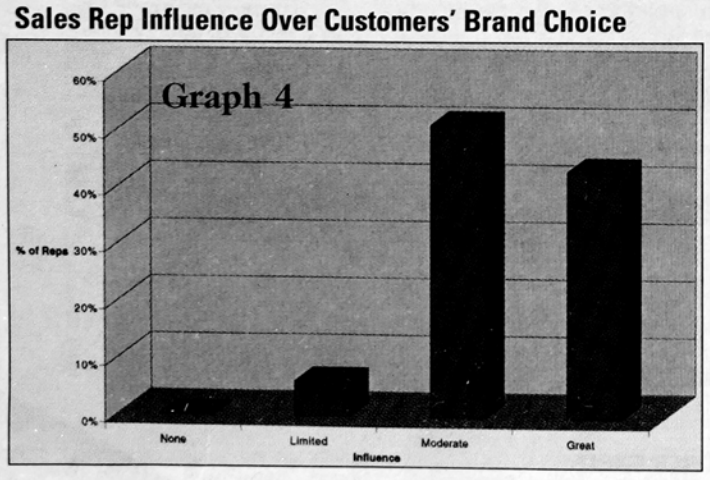
## Company and Customer

The MPS Survey reveals several interesting facts about companies' efforts to serve their customers and, more importantly, the impact those efforts have on sales reps.

**Percentage of Selling Time Spent Introducing New Products/Detailing Product Features (as Opposed to Troubleshooting/Taking Orders)**




**Sales Rep Influence Over Customers' Brand Choice**



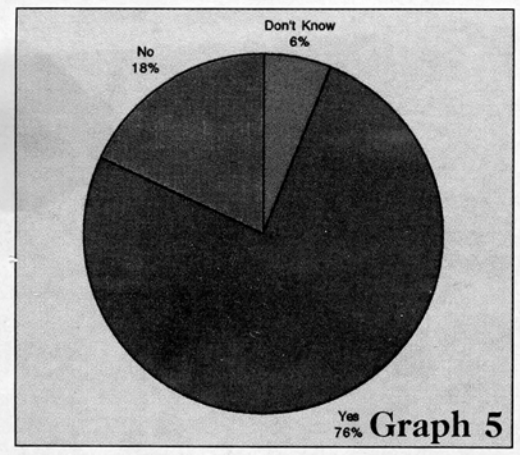

Cutting into the "independence" of the independent distributor, **Graph 5** shows that 76 percent of reps report that their companies have begun to cut back on the number of

**Table 1: How Integrated Healthcare Networks Purchase**

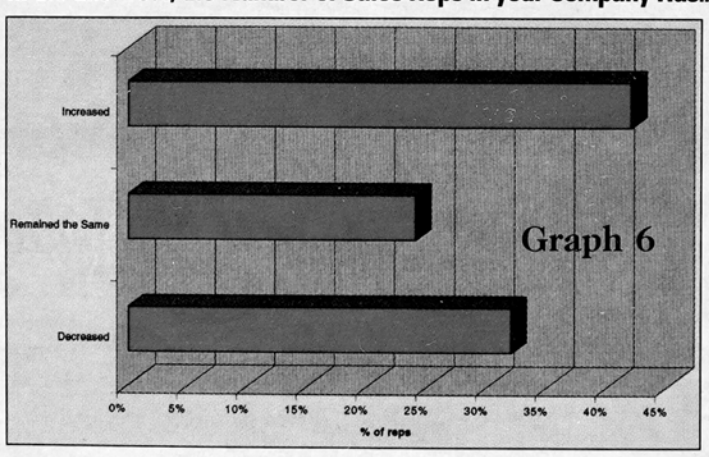
| Method | % of Reps Citing |
|---|---|
| Group Purchasing Contracts | 89% |
| Centralized Purchasing Through the Hospital | 43% |
| Independent Purcasing at the Physician Practice/Office Level | 40% |
| Purchasing Agent/Committee | 29% |

Note: Percentage do not total 100 due to respondents checking all applicable choices

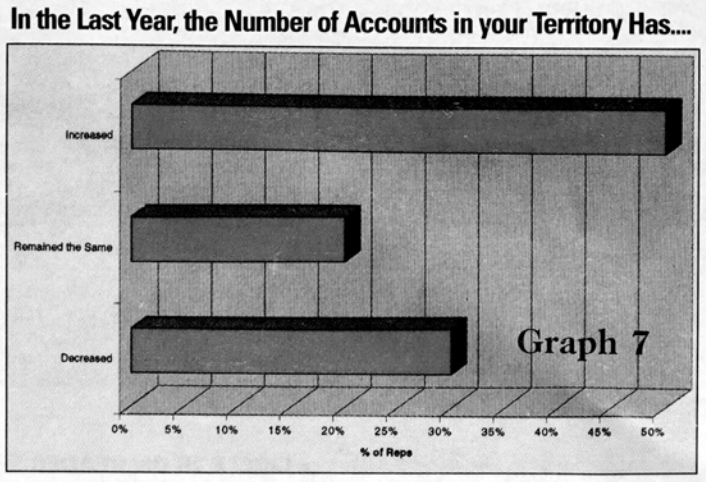
**Has Your Company Cut Back on Its Similar Product Lines To Gain Better Prices from Manufacturers?**




**In the Last Year, the Number of Sales Reps in your Company Has....**



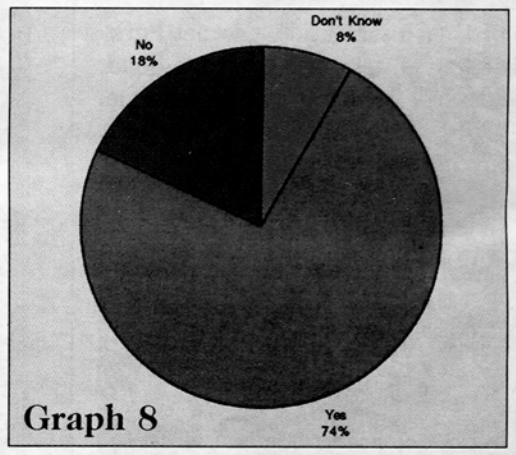

**In the Last Year, the Number of Accounts in your Territory Has....**




similar products and/or lines in order to gain better prices or benefits from manufacturers.

But while product offerings may be diminishing, the number of sales reps and their accounts is increasing. Forty-two percent of reps say their companies increased the number of reps they employ (**Graph 6**). A third report a decrease and a quarter say there's no change. There is greater consensus as to changes in reps' accounts (**Graph 7**). A full 50 percent report an increase, as opposed to the 30 percent who have experienced a reduction.

**Does Your Company Do Business With Integrated Healthcare Networks?**




**Was Your Employer Involved in a Merger or Acquisition Last Year?**

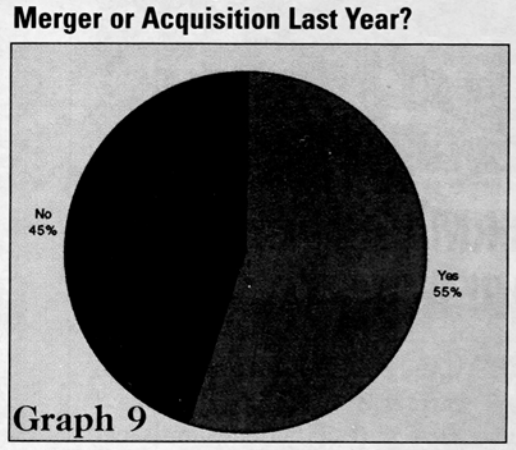



**Table 2: Impact of Managed Care**

| Effect | % of Reps Citing |
|---|---|
| Greater Emphasis on Price | 47% |
| Customer Buying More products on Contract | 30% |
| More Decision-Makers Involved | 17% |
| Few Sales Opportunities | 15% |
| Longer Customer Decision-Making Time | 11% |
| Greater Involvement of Upper Management (Customer) | 6% |
| Greater Time Investment per Sale | 6% |
| Greater Purchasing Commitment from Customer | 4% |

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INSIDE MPS



# GAO Flogs HCFA

*by Herbert P. Weiss*

## Report Calls for Vast Billing System Reforms

A GAO report strongly criticizes the Health Care Financing Administration's (HCFA) durable medical equipment billing system and calls for widespread reforms, including bar coding and UPN.

The GAO concludes that HCFA's Common Procedures Coding System (HCPCS) fails to provide useful information on which products Medicare pays for. The report charges that codes and fee scale allowances do not reflect changes in products and prices driven by improved technology and a more competitive market place.

The GAO report, titled "Medicare: Need to Overhaul Costly Payment System for Equipment and Supplies," was requested by Senate Aging Committee Chairman Charles Grassley (R-Iowa) and Ranking Minority Member John Breaux (D-Louisiana), who introduced a bill (S. 1363) last fall that would establish universal product numbers for all medical equipment billed through Medicare. More than two months later, Rep. Amo Houghton (R-NY) and Rep. Louise M. Slaughter (D-NY) introduced a similar bill in the House (H.R. 3255).

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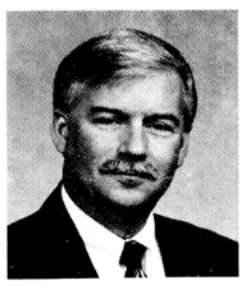








PRODUCT NEWS

# NEWS

## Competitve Bidding Arrives in Florida

*by Herbert P. Weiss*

With the Health Care Financing Administration's (HCFA) announcement of Polk County, Fla., as the agency's first of three competitive bidding demonstration sites, the agency anticipates issuing a Request for Application in the fall and actual payments to the winning bidders for the new rates beginning in spring 1999.

According to HCFA, competitive bidding for durable medical equipment, prosthetics, orthotics and supplies will help stop wasteful and unnecessarily high payments. Tighter standards and controls will help keep "fly-by-night" suppliers from being able to sell or rent poor quality medical equipment to Medicare beneficiaries.

But William D. Coughlan, President and CEO of the National Association of Medical Equipment Services, counters: "It is truly illogical for HCFA to claim that one of the four major objectives of the demonstration project is to improve beneficiary access to high-quality medical equipment and supplies when the long-term effect of the demonstration project will be a substantially reduced number of home medical equipment services providers in a specific area, resulting in less consumer choice, higher prices and lower quality of service."

In its press release, HCFA said it selected Polk County, a rural area located east of Tampa, because of its relative small population of about 450,000 people, including 92,000 Medicare beneficiaries; high expenditure per Medicare enrollee for medical equipment and supplies; and a large number of suppliers servicing the area.

Starting April 1999, when the two-year pilot project begins, Medicare will require companies to compete to sell certain medical supplies (oxygen supplies and equipment, hospital beds and accessories, surgical dressings, enteral nutrition products, and urological supplies). As for oxygen, a beneficiary may maintain an ongoing existing relationship with an oxygen supplier who is not a demonstration supplier. But such suppliers will be paid at the price set by the bidding process.

Those persons with existing rental agreements for enteral pumps and hospital beds may continue to rent through their current supplier, whether or not they are demonstration suppliers. In these cases, suppliers will be paid the prevailing rate rather than the bid price. To transition into the pilot project, HCFA will accept the prevailing rate, because start up of new rental agreements to replace existing agreements would be too costly to Medicare.

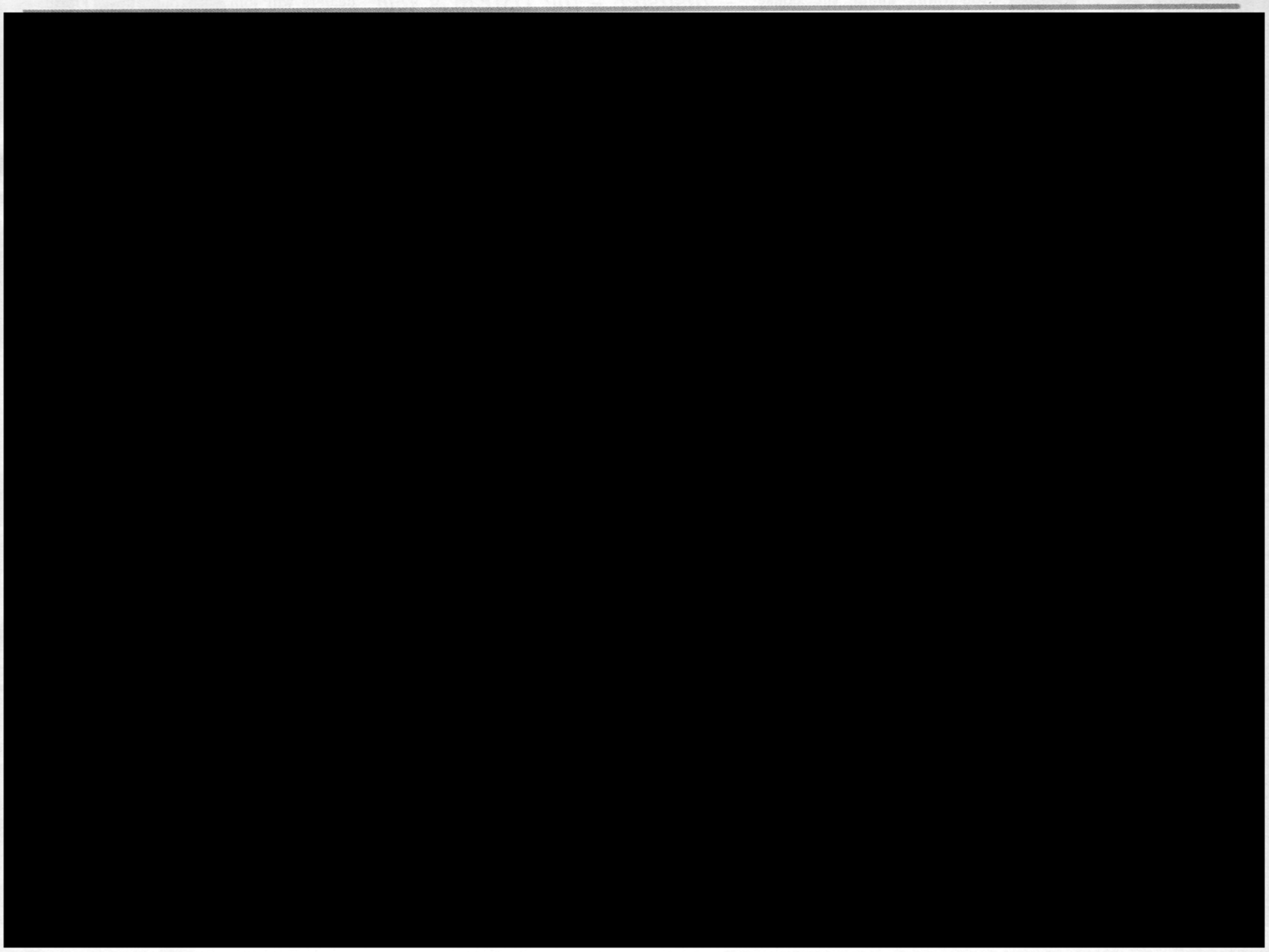
Finally, for all other equipment and supplies, current coverage and payment policy will be in effect in the demonstration area. HCFA expects the number of winning bidders selected will be more than sufficient to supply the quality of medical equipment and supplies covered by the demonstration.

"It's not a done deal yet," says Sheldon Prial, president of the Homecare Providers Co-op, if medical equipment distributors flex their political muscle. With the Request for Application going out in the fall, "we have more than five months to organize ourselves to get the message out to Congress that increased quality and savings to Medicare won't happen by issuing a contract to the lowest bidder," he said.

The urgency of this issue has united key industry groups, Prial says. The National Association for Medical Equipment Services, the Health Industry Distributors Association, the Homecare Providers Co-op, VGM and the Florida Association of Medical Equipment Distributors held a joint meeting last month in New Orleans to hammer out a joint strategy on how to respond to HCFA's Request for Application.

"We're in a wait and see posture until something concrete develops," said Mark Hobratschk, HIDA's associate director of government affairs.

*Herbert P. Weiss is a Pawtucket, Rhode Island-based writer covering aging and healthcare issues.*



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INSIDE MPS



# Surviving CB: Know Thy Costs

## Cost-Based Accounting is Key in Competitive Bidding Era

*by Herbert P. Weiss*

Calculating the true costs of durable medical equipment (DME) and diversifying customer base away from Medicare are key strategies for dealers to financially survive the era of competitive bidding. So instructed industry experts at a gathering of more than 100 DME dealers at two July educational seminars hosted by a loose coalition of DME provider groups.

The two one-day events were hosted by the Health Care Financing Administration (HCFA), the Health Industry Distributors Association (HIDA), the National Association of Medical Equipment Services (NAMES), the Homecare Providers Co-op (HPC), VGM, the Medical Equipment Distributors and the Florida Association of Medical Equipment Dealers. The meetings were held July 7 and 14 in Greenleaf, Fla., and New Orleans, respectively.

"We had very good, open, frank discussions that allowed everyone to get their questions answered as to how they should respond to HCFA's impending competitive bidding initiative in Florida," said Sheldon Prial, executive director of HPC.

At the sessions, attorney Donald Farmer of Reed, Smith, Shaw and McClay emphasized the need to develop bids without consultation — or collusion — with other dealers. He said that as government purchasers of health care increasingly rely on managed care contractors, antitrust exposure for vendors increases.

Representatives of NAMES and HIDA provided a historical perspective on the competitive bidding rule and explained how HCFA might create its new reimbursement schedule for DME products. In addition, Wallace Weeks, a Rockledge, Fla.-based healthcare financial consultant, walked the dealers though a detailed seminar on determining the true cost of DME products and services through use of activity-based costing.

### Diversify Your Customer Base

Attendees received sound advice on handling mandated competitive bidding. "Don't put all your eggs in one basket," Prial said. Medicare or Medicaid accounts for up to 85 percent of revenues for some dealers, he said. "You can't do this anymore," warning dealers to expand into other cash sale markets and develop sophisticated retailing to grow their businesses.

"People must enter into a bid as they would a relationship with a

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managed care organization," Prial recommended, noting that it is crucial for DME dealers to learn the nuts and bolts of cost-based accounting to determine the true worth of their products.

Steve Haracznak, NAMES's vice president of communication, agreed: "You can't participate in a competitive bidding project if you don't know what it costs to do business — you won't be able to submit a winning bid."

Haracznak noted that once HCFA releases its Request for Application in early fall, more seminars and information will become available to NAMES members on activity-based cost accounting.

Some dealers expressed fear as to how HCFA might use cost information taken from the agency's Request for Application, especially if their bids are far below the standard prices, Prial said. "It's a legitimate concern," Prial said, and predicted that HCFA may use such confidential information in its push for implementation of its inherent reasonableness pricing rule. "Don't expect HCFA's fixation on fixing computer flaws before the year 2000 to derail the agency's competitive bidding initiative," Prial warned.

Mark Hobratschk, HIDA's associate director of government affairs, agreed with Prial's assessment of HCFA's green light for competitive bidding. "Politically speaking, it would be difficult not to go forward with it at this point and delay because of the anticipated Y2K computer problems," given the regulatory effort expanded thus far.

Remember, Hobratschk said, that HCFA has been working since 1990 to implement the initiative, and a pilot site has already been selected in Polk County, Fla.

*Herbert P. Weiss is a Pawtucket, R.I. - based writer covering healthcare, medical and aging issues.*

## Things to Consider

Here are three options for DME dealers to consider as HCFA prepares to release its Request for Application:

1. Go for the Bid. The DME dealer makes a business decision to submit a bid for one or all of the company's product lines. Using cost-based accounting, the DME dealer can generate detailed information about the true costs of merchandise and services to develop an equitable price schedule.

2. Diversify Your Client Base. With profit margins too small, a dealer chooses not to compete in HCFA's competitive bidding demonstration project. Now it becomes crucial to determine client mix. If your company relies too heavily on Medicare, it's crucial to develop a marketing strategy to create new markets (e.g., diabetic supplies, rehabilitation and industrial sales) and increase cash sales.

3. Speak Your Mind to Lawmakers. Whatever option DME dealers choose, it is crucial to keep their Congressional delegation updated as to the impact of HCFA's competitive bidding demonstration project on constituents.

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INSIDE MPS



# Steep Learning Curve Required for PPS

*by Herbert P. Weiss*

Even as the Health Care Financing Administration continues to review more than 400 comments received after the May 12 publication of 65 pages of the interim final rule on the prospective payment system (PPS), the majority of the nation's skilled nursing facilities came on-line with PPS as of January 1. Providers, fiscal intermediaries and HCFA find themselves on a steep learning curve as they grapple with massive changes as to how Medicare pays for skilled nursing care.

## A Rosy Picture

Even with some fiscal intermediaries unable to properly process PPS claims, HCFA is optimistic about the start up of its new payment system. "Implementation of PPS is going smoothly, especially for such major changes in the payment system," said Laurence Wilson, HCFA's PPS project manager. Meanwhile, to help facilities cope with the complexities of the newly implemented PPS system, HCFA continues to disseminate information on its web site (www.hcfa.gov) and through program memorandums. In addition, each fiscal intermediary has received the responsibility to ensure that providers understand the billing and assessment requirements of the case-mix payment system.

*(See Learning, page 7)*

## *MPS* Snapshot

**Setting the Standard — Key Ratios for Hospital Distributors**

| Ratio | Average | Top 25% |
|---|---|---|
| Average Invoice Size | $471 | $972 |
| Average Line Size | $72 | $104 |
| Sales per Salesperson (000) | $1,314 | $2,523 |
| GM per Salesperson (000) | $427 | $496 |
| Sales per Employee (000) | $441 | $510 |
| GM per Employee (000) | $76 | $82 |
| Selling Cost/GM | 23% | 17% |
| Employee Cost/GM | 54% | 48% |

**"Average" refers to the average of all hospital distributors; "Top 25%" refers to the top quarter of hospital distributors; GM=gross margin. Source: HIDA 1998 Hospital Financial Survey, by Drs. William Cron and Ronald Stephenson.**

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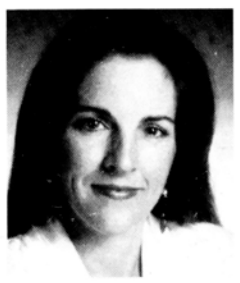

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# A Rocky Road for Implementing PPS

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"The majority of SNFs go onto PPS in January. The real chaos and stress is ahead of us and not behind us for PPS," says Jade Gong, principal of Arlington, Va.-based Health Strategy Associates and a consultant on PPS for the Health Industry Distributors Association. "Up until October 1998, fiscal intermediaries have been using an interim payment system and paying SNFs on the basis of historical interim rates rather than the PPS rates," Gong says. She notes that beginning this October, fiscal intermediaries will begin paying SNFs on the basis of PPS rates. As for those SNFs that went onto PPS in July, Gong says, "many will have to give back money [to HCFA] when the agency begins the job of reconciling the difference between the interim rate and the PPS payment rate."

With PPS incorporating medical supplies as non-therapy ancillary costs, many nursing facilities are now renegotiating their vendor contracts with medical equipment distributors to lower costs, Gong says, noting that many facilities are also standardizing what type of medical supplies are available for use in a facility to restrict use of costly items.

Adds Susan Polniaszek, reimbursement and finance analyst for the American Association of Homes and Services for the Aged (AAHSA), "There are also inconsistencies in the interpretation of PPS among the fiscal intermediaries. For example, one fiscal intermediary does not allow any grace days when submitting the Minimum Data Set while HCFA clearly allows it."

AAHSA is also very concerned about the huge fiscal hits specialty nursing homes take when caring for intensely ill residents. In one facility caring for AIDS patients, drugs alone can cost more than $450 a day. With PPS paying less than that amount, "the facility is losing a ton of money taking care of AIDS patients and they won't be able to financially survive in the new system," warns Polniaszek. AAHSA calls on HCFA to create an appeals process where a specialty nursing home can appeal for increased payments if it can show that its costs are unusually high due to the intensity of care needed.

Before PPS, nursing facilities had little incentive to keep costs down when they negotiated contracts with medical product suppliers and other vendors. "Under PPS nursing facilities are paid a rate based on the RUG category regardless of the cost incurred. Facilities are now developing contracts with vendors to share risks or lower costs," says Polniaszek.

AAHSA has recently published "Understanding and Implementing Consolidated Billing: A Self Study Guide," that explains the Medicare billing changes and provides information on billing and coding procedures, including medical necessity decisions and contracting issues with vendors.

## An Administrator's Perspective

When entering the world of PPS, survival can hinge on practice — "Whatever information system your facility has selected to manage PPS, make it your business to test-run the process for a sufficient period of time. The more confident you become, the better off you will be," states Julie Richard, certified administrator of Health Havens Nursing and Rehabilitation Center, a Vencor facility that entered the PPS system last July. She warns, "If you don't know the intricacies of the RUGs system, you are going to lose money."

*Herbert P. Weiss is a Pawtucket, R.I.-based writer covering aging and healthcare issues.*

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INSIDE MPS



**www.MedicalProductsSales.com**

# Service Is Key to Distributor Success Under PPS

*by Herbert P. Weiss*

Approaching its one-year anniversary, the prospective payment system (PPS) has forced distributors to reposition relationships with their long-term care customers. And while the pressure is on to step up their service, the outcome for savvy suppliers will be improved customer partnerships.

Ten months into PPS, 90 percent of the nation's 16,000 SNFs are now reimbursed on a facility-specific and federal per diem rate that will be phased in over a four-year period, assuming they had Medicare beds in 1995. The facility-specific rate is based on 1995 capital, ancillary and routine costs plus an amount allocated for Part B Services. This rate will be adjusted for inflation. The new federal rate also starts with the average 1995 Medicare costs for free-standing and hospital-based SNFs and is adjusted for inflation and for average facility wage levels and case-mix. Urban and rural facilities will be under a separate rate calculation.

Under PPS, payments are based on 75 percent facility-specific costs combined with a 25 percent federal per diem rate. By the year 2001, SNF payments

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will reflect a 100 percent federal per diem rate. Under the old payment system, facilities were paid retroactively for actual and allocated costs. Under PPS, SNFs will be paid a fixed daily rate based on the acuity of each resident.

Finally, PPS bundles services into a case-mix adjustment federal per diem for Medicare Part A. In addition, beginning Jan. 1, 1999, an annual cap of $1,500 for outpatient occupational therapy and $1,500 for physical therapy and speech-hearing pathology services per Medicare beneficiary under Part B was implemented.

### Keys to Surviving PPS

Business as usual does not describe the new world of PPS, says Gregg Ryberg, director of national accounts for McKesson Redline. As for cash flow, "We're getting slower-paying customers," he says, noting that account receivable terms and days outstanding have been increasing since the beginning of PPS in July 1998. "If facilities do not have their ducks in a row or have everything filled out and filed correctly, their payments are late and in turn they make payments late to us."

PPS has driven SNFs to demand more detailed information. "We are supplying them with more cutting edge technology like bar code tracking systems and providing more efficient ways of doing business through the ordering and charge capture processes," Ryberg said.

Although medical supplies represent 5 to 8 percent of the total operating budget of SNFs, Ryberg sees more administrators price shopping. "They're looking under every rock in an attempt to cut costs."

For Bob Clock, president of Clock Medical Supply, Winfield, Kan., advance preparation has been the key to his success with PPS. Beginning in 1996, two years prior to PPS, Clock positioned his company to meet the changing needs of his long-term care customers. He joined the Affiliated Medical Distributors Service (AMEDS), a group purchasing organization, to increase his company's purchasing power with the goal of lowering his costs of goods. Also, with the Y2K problem looming, Clock improved his company's bar coding scanner systems to ensure their Y2k compliance. "It's taken us a complete year to upgrade all of our coding systems," he said. Clock cites these systems as the key to capturing cost data for labor, products and services to accurately determine the costs of patients in various RUG categories. "They can go to the bank with this data," he says, because it's time- and dollar-qualified.

The fact that PPS forces SNFs to expect more from their distributors is an unexpected benefit, says Clock. "Our relationships with customers are as good or better than we've had in years because of PPS. If we don't understand customers' needs, we won't be a good partner for them," so PPS forces us to step it up, he said.

### Pharmacy, Rehab Harder Hit

PPS hits other ancillary vendors harder than medical product suppliers. So says Elias Coury, president of Pharmed Corp., Cleveland, Ohio. "We have always been scrutinized very closely on price," he says, noting that medical products were historically shopped on price, more so than pharmacy and rehabilitation services.

With PPS forcing facilities to be cost conscious, Coury advises his customers to buy rather than rent high-priced products, such as specialty wound care services. Administrators see the wisdom, he says, when purchasing a $4,500 bed rather than paying $45-$90 a day for 90 days.

### Nursing Facility Views

A growing number of SNFs are effectively creating medical supply formulas to lower costs, says Jade Gong, principal of Arlington, Va.-based Health Strategy Associates and a PPS consultant for the Health Industry Distributors Association. By paring down supplies they offer the facility a way to standardize and gain a handle on what is being used, she notes.

"We're making more capital purchases under PPS to keep our costs at a minimum," says David Ross, executive director of the Jewish Geriatric Home, a 173-bed SNF in Cherry Hill, N.J. By purchasing low air loss overlay mattresses rather than the whole bed, the facility is "getting more bang for our buck" he says, noting that his distributor advises him on products.

"Those vendors that provide the best supplies at the lowest cost will win the contracts," Ross says. "I would advise distributors not to go into facilities with flowery proposals but to provide the very most they can at a base cost. I don't think facilities are going to be as liberal in their approach to evaluating vendors as they were in the past."

PPS forces SNFs to review every purchase, regardless of size, according to Susan Polniaszek, of the American Association of Homes and Services for the Aging. "It's not just the big tickets, but all the paper clips that will drive you out of business," she says.

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*Herbert P. Weiss is a Pawtucket, R.I.-based writer covering aging and healthcare issues.*