HEALTH CARE INDUSTRY MARKET UPDATE

Home Health

September 22, 2003

Dear Friends of CMS:

As the regulators of over $500 billion per year of Medicare, Medicaid, and S-CHIP funds, we believe it is incumbent on us to better understand the finances of our contractors, health providers, and other related businesses that provide services to the more than 70 million beneficiaries these programs serve. Health plans, hospitals, nursing homes, home health agencies, medical device manufacturers, and pharmaceutical companies are just some of those whose finances depend heavily on these public programs.

I have always been surprised at how little Wall Street and Washington interact—and how companies often paint different financial pictures for each audience. I am a strong believer in adequate funding for our major partners in these programs, but I do not think they should be saying one thing to investors and another to regulators (as it is occasionally in their interest to do). If health plans or providers are struggling to serve our beneficiaries, we should have a thorough understanding of their real financial status to assess the true level of need. Many investment banking firms conduct detailed analyses of major health providers, both for the equity investors in for-profit companies, and for the debt holders of for-profit and not-for-profit entities. Health systems typically provide these investors with clear financial data. These data can be used by regulators and legislators to assess funding adequacy or the need for regulatory reforms.

CMS' Office of Research, Development & Information (ORDI) has gathered research reports from the major investment firms, summarized their analyses, and condensed them into a short, and hopefully, understandable format. Our goal is to provide objective summary information that can be quickly used by CMS, HHS, Congress, and their staffs that oversee these programs. The primary person at CMS assigned to this task is Lambert van der Walde. Lambert previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and research review. Joining the team is Laurel Lindstrom who previously worked in the private equity operations of Swiss Reinsurance in New York.

This Market Update focuses on the home health agency and home respiratory and infusion therapy industry sectors, updating our first report published June 28, 2002. In coming months, we will continue to review the major provider and supplier sectors. Though I am proud of this effort, and believe it will add to understanding of the programs, we welcome comments on the content and format of this report. We want to make this as consumer friendly as possible for everyone who reads it. Please provide comments to Lambert van der Walde at Lvanderwalde@cms.hhs.gov or Laurel Lindstrom at Llindstrom@cms.hhs.gov.

Sincerely,

Tom Scully

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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Perspectives of Home Health Care

Performance varies across the fragmented home health industry.

- **Small, local, and regional providers comprise the majority of the home care market.**
- **After years of dramatic growth in Medicare home health expenditures, followed by three years of significant declines enacted by the Balanced Budget Act of 1997, the number of Medicare home health agencies has stabilized.**
- **Large publicly traded respiratory therapy companies continue to perform well and are profitable.**
- **Respiratory and infusion therapy companies have better access to capital than home health agencies.**
- **Wall Street analysts expect larger home health agencies and respiratory therapy companies to use cash balances for acquisitions and share repurchases.**

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EXECUTIVE SUMMARY

Home Health Care is a $45 billion industry.

American home health spending totaled approximately $45 billion in 2001. Of this, the freestanding home health agency sector (HHA) accounts for roughly $33 billion, while respiratory and infusion therapy services account for approximately $9 billion. This report examines each of these two sectors independently.

Home Health Agencies

The HHA sector does not receive broad analyst coverage as a result of the small sector size and few publicly traded companies. The industry is highly fragmented and currently comprised of more than 7,000 HHAs, which are mostly small, local or regional providers. Gentiva Health Services dominates the sector and is viewed as the only HHA with provider networks of scale. Analysts have a positive outlook on the growth prospects of the industry, and, in particular, for larger companies due to their greater ability to capitalize on favorable industry developments.

Medicare spending on HHAs skyrocketed in the 1990s.

The industry has stabilized under the Medicare PPS.

From fiscal years 1990 to 1997, the provision of home health agency services was one of the fastest growing expenditures in Medicare. During this period, expenditures rose from $3.3 billion to $18.0 billion. Home health was impacted by Medicare payment reductions imposed by the Balanced Budget Act of 1997, and by 2000, more than 3,000 agencies closed or merged. The introduction of the Medicare Home Health Prospective Payment System (PPS) in October 2000 stabilized the industry, and it is now expected to grow at an annual rate of 5% to 10% due to demographic trends, relative cost advantages, and efficiencies under the PPS. The sector's stock price performance has mirrored this trend. Since 2002, the HHA sector has outperformed the S&P 500.

Despite growth prospects, investors view the HHA sector as risky.

Profitability within the HHA industry varies and profit margins are difficult to gauge. The median operating margin for publicly traded HHAs has been positive since 1999 and reached 2.3% in 2002. Significant variability exists among the publicly traded HHAs and there have been many bankruptcies in the sector. Analysts note that smaller HHAs have shifted patient mix to favor Medicare patients as Medicare payments under the PPS offer the highest margins. Because many HHAs do not have a proven track record of success and are subject to regulatory reimbursement risk, both equity and debt investors perceive the sector as risky, which ultimately leads to limited access to capital.

Respiratory and Infusion Therapy Service

Respiratory therapy is a highly profitable sector.

Wall Street analysts view home respiratory companies more positively than home health agencies given their greater margin potential. The industry is expected to grow between 4% and 7% annually due to an aging population, increased diagnosis of respiratory diseases, and improving utilization of home health services. Given the profitability of the sector, available cash assets, and the fragmented nature of the industry, analysts believe significant consolidation opportunities exist in the respiratory therapy market.

Profitability varies and is difficult to gauge because half of the industry is composed of small, local operators. Respiratory therapy is a significantly higher margin business than infusion therapy, and in either sector, margins at larger companies are much higher than those at smaller companies due to economies of scale. Both debt and equity investors are attracted to the profitable respiratory therapy companies, but the larger companies generate sufficient cash and have not sought to access the capital markets.

HOME HEALTH CARE INDUSTRY

The home health care industry includes home health agencies and respiratory and infusion therapy services. American home health care spending totaled approximately $45 billion in 2001. Of this, the home health agency (HHA) segment accounts for roughly $33 billion. Home health agencies employ a variety of different professionals in a patient's home, including skilled nurses, nursing aides, rehabilitation specialists (physical, speech, and occupational therapists), and medical social workers. The remaining annual expenditures can be further subdivided into home respiratory therapy ($4.5 billion), home infusion therapy ($4.7 billion), and durable medical equipment ($2.9 billion).

Figure 1: Home Health Care Industry Expenditures – 2001

($ in billions)

	Market Size	Percent of Market
Home Health Agencies	$ 33.2	73.3 %
Respiratory therapy	4.5	9.9
Infusion therapy	4.7	10.4
Durable medical equipment (DME)	2.9	6.4
Total Home Health Care Market	$ 45.3	100.0 %

Source: Deutsche Bank and CMS

Industry Fragmentation

The home health care industry is highly fragmented. Several large for-profit companies exist, but very few have dominant market presence. The bulk of the industry is made up of thousands of relatively small, local or regional providers, most of which are not highly capitalized. Due to their small size and independence, most home health care providers do not file public financial data. It is important to note that this report focuses on data that is readily and publicly available and therefore examines only a portion of the industry.

Home Health Agencies

There are approximately 7,000 Medicare certified HHA locations nationally, which range from facility-based agencies to small, publicly traded and privately held companies to visiting nurse associations and nurse registries. Of these, 68% are freestanding agencies and about half are for-profit. Despite being the largest publicly traded company in this business, Gentiva Health Services represents only 2% to 3% of the market with 200 locations nationwide.

The largest publicly traded HHA represents only 2% to 3% of the market.

Home Respiratory and Infusion Therapy Services

Although there are a few national providers, including Lincare Holdings and Apria Healthcare Group, small publicly traded and privately held operators control half of these markets. The home respiratory therapy market, which includes home oxygen equipment and respiratory therapy services is very fragmented—with more than 2,000 local providers comprising the majority of the market. Combined, Lincare and Apria generate 33% of the revenue in the home respiratory therapy industry; Rotech generates an additional 10%. While many providers, such as Lincare, focus on the respiratory therapy market, others, such as Apria, target infusion therapy as well. The home infusion industry is also highly fragmented, There are approximately 4,500 infusion therapy sites in the United States, including local and national organizations, hospital affiliated organizations, and national home infusion organizations.

HOME HEALTH AGENCIES

Wall Street's View

Limited analyst coverage exists for the HHA sector.

The HHA sector does not receive broad analyst coverage as a result of the small sector size and few publicly traded companies. Gentiva Health Services (NASDAQ: GTIV) dominates the sector and is viewed as the only HHA with provider networks of significant scale. Overall, analysts are positive on the growth prospects for the industry, and in particular, for Gentiva with its greater ability to capitalize on favorable industry developments. As Matt Ripperger of JPMorgan notes, "Gentiva has positioned itself…as a 'single source' home health solution for managed care companies, which is unique in the industry." Beyond its position as a "single source" provider, he believes Gentiva also stands to benefit from its investments in technology through efficiency gains, which are rewarded under the Medicare PPS.

Larger HHAs have leverage to negotiate managed care contracts.

Despite its ability to extract efficiencies through the Medicare PPS, Gentiva generates a lower proportion of its revenue from Medicare than many other HHA providers, allowing greater exposure to commercial payors. According to Lawrence Marsh of Lehman Brothers, Gentiva has stated that some of its smaller competitors are shifting patient mix towards Medicare due to the higher margin potential. The company noted, however, that it disagrees with such strategies given the uncertainty of proposed Medicare legislation. Further, the company believes commercial payors are becoming more attractive as they are "exhibit[ing] an increased interest in the home health solution as an alternative to costly hospital stays."

Nursing shortage continues to impact HHAs.

Analysts also note that the nursing shortage continues to affect growth prospects for HHAs. Marsh, however, reported that Gentiva management believes "the shortage also creates incentives [for acute care providers] to look for home health companies that can service their patients and get them out of acute settings, where Gentiva believes [it has] an advantage in scale."

Industry Overview: Home Health Agencies

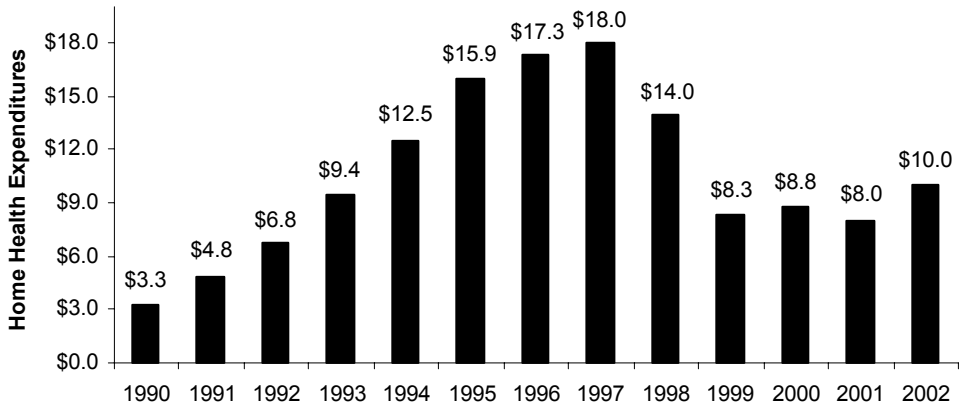
Home care encompasses a wide range of health and social services. These services are delivered at home to recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essential activities of daily living. Generally, home care is appropriate whenever a person is able to stay at home but needs ongoing care that cannot easily or effectively be provided solely by family and friends. In addition, Medicare requires that the beneficiary be homebound[1] as a condition of receiving the benefit. Services may include skilled and home health aide nursing; physical, occupational, and speech therapy; and medical social work services. There are approximately 7,000 Medicare-certified HHA locations nationally which range from facility-based agencies to small, publicly traded and privately held companies to visiting nurse associations and nurse registries. Of these, 68% are freestanding agencies and about half are for-profit.

HHAs that remain in business after the rocky Medicare reimbursement of the late 1990s are better positioned for changes going forward.

During the 1990s, the provision of home health agency services was one of the fastest growing expenditures in Medicare. According to the Medicare Payment Advisory Commission[2] (MedPAC), from 1990 to 1997, Medicare home health spending grew nearly 450%, peaking at $18 billion. Escalating costs and the growing use of home health services provided a catalyst for legislative action. The Balanced Budget Act of 1997 (BBA) significantly reduced Medicare reimbursement to HHAs. In October 1997, as an interim step to establishing a prospective payment system (PPS), caps were applied to the existing system which reimbursed based on cost. This interim payment system (IPS) remained until October 2000 when PPS was implemented. Many agencies, especially new entrants, struggled during the IPS, resulting in the closure or merger of over 3,000 agencies between 1998 and 2000 (as illustrated in Figure 3).

Figure 2: Historical Medicare Home Health Spending: FY1990-FY2002

($ in billions)



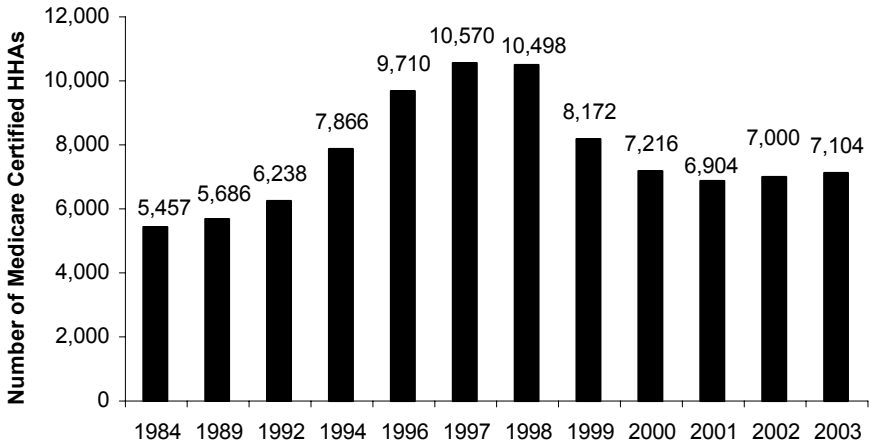
Source: CMS, Office of the Actuary

[1] Medicare defines a beneficiary as homebound if that beneficiary is normally unable to leave home unassisted and that leaving home requires a major effort. When a homebound beneficiary does leave home, it must be to receive medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care.

[2] MedPAC is an independent federal body that advises the U.S. Congress on issues affecting the Medicare program.

Figure 3: Medicare Providers: Number of Home Health Agencies

HHA numbers have stabilized, and are beginning to grow.



Source: CMS; 2003 figure as of August 1, 2003.

The PPS, which pays based on 60-day episodes of care, encourages efficient delivery of care. CMS developed and mandated use of a standardized assessment known as the Outcome and Assessment Information Set (OASIS) to monitor the quality of home health care. OASIS was designed to both ensure appropriate payment and maintain quality of care under the PPS.[3] According to the MedPAC March 2003 report to Congress, available data suggests that despite decreased volume of visits and costs per visit, quality has not declined. What many viewed as overutilization of home health services decreased rapidly following the BBA as a result of changes in eligibility requirements and other structure and incentives of the IPS. The rate of decline in utilization, however, has slowed and the use of home health services is expected to grow due to the effects of the PPS. According to MedPAC, "the PPS creates an environment that allows providers to care for costlier, more complex patients with less financial risk than under the IPS." Further, given the relative cost advantages of home health care, JPMorgan projects the industry to grow at an annual rate of 5% to 10%.

Notwithstanding the impact of the BBA on the HHA sector, the outlook for HHAs is positive. JPMorgan states:

> We are positive on the growth outlook for the home healthcare industry, driven by demographic trends, new clinical protocols that have increased the range of home care services (rehab in particular), and the lower costs of home care versus other institutional settings.

Medicare spending under the Home Health PPS is projected to increase 12.0% in 2003 to $14.9 billion despite a reduction to each episodic payment of 4.9% in 2002 and the sunset of rural add-on payments in April 2003. The 4.9% reduction is comprised of a Congressionally-mandated 7.0% reduction and a 2.1% annual increase for the cost of services that became effective October 1, 2002.

[3] OASIS requirements were reduced and refined by CMS in December 2002 in order to reduce the burden on providers.

Medicare and Medicaid resources account for more than half of total HHA funding.

Revenue Sources

HHAs generate revenue from Medicare, Medicaid, commercial insurers, and individual patients. Total US HHA expenditures in 2001 were $33.2 billion. Medicare and Medicaid accounted for 51.2% of total HHA expenditures in 2001, up from 46.3% in 2000. According to a 2002 GAO report, some agencies have been more likely to accept Medicare rather than private or commercial-pay patients. The GAO attributes this to increased profitability under the Medicare PPS because of fewer visits per episode of treatment, and a higher proportion of users categorized into higher payment groups. Not all HHAs are shifting patient mix toward Medicare. Gentiva, the largest company in the sector, has historically received approximately 20% of its revenue from Medicare, and has not increased its patient-mix as it instead leverages its size to negotiate managed care contracts. As Figure 5 demonstrates, significant variation exists in the payor mix among the for-profit, publicly traded companies.

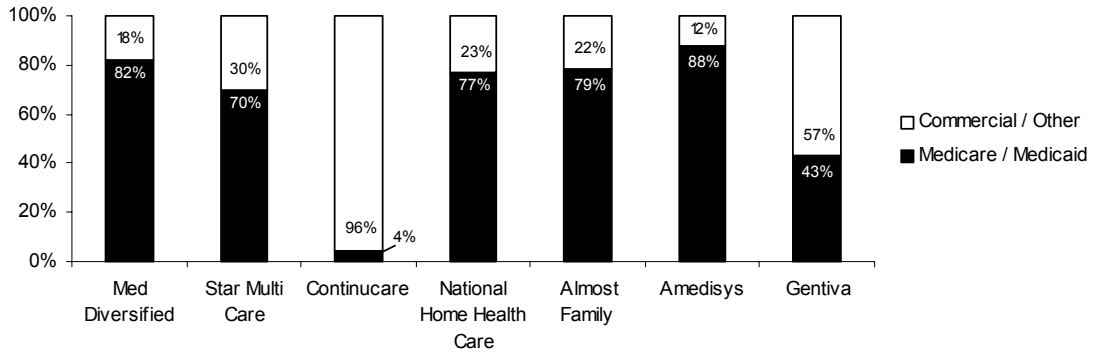
Figure 4: Payor Segmentation – HHA Industry 2001

($ in billions)	Funds Expended	Percent of Total
Private Health Insurance	$ 7.0	21.1 %
Out-of-Pocket and Other Private	7.5	22.5
Total Private Funds	$ 14.4	43.6 %
Medicare (Federal)	$ 9.9	29.7 %
Medicaid (Federal and State)	7.1	21.5
Other Public	1.7	5.3
Total Public Funds	$ 18.7	56.4 %
Total Public & Private Funds	**$ 33.2**	**100.0 %**

Source: CMS, Office of the Actuary, National Health Statistics Group
Note: Freestanding facilities only. Numbers may not add due to rounding.

Significant variation exists in the payor mix of public HHAs.

Figure 5: Payor Segmentation – Publicly traded HHA Companies



Source: Company filings.

Since the establishment of the PPS, Medicare reimbursement rates have stabilized. For fiscal year 2003, the base payment for a 60-day episode of care is $2,160. As announced in the July 2, 2003 Federal Register, the home health reimbursement base rate will increase to $2,230 in FY2004, which represents a total of $340 million in additional Medicare spending.

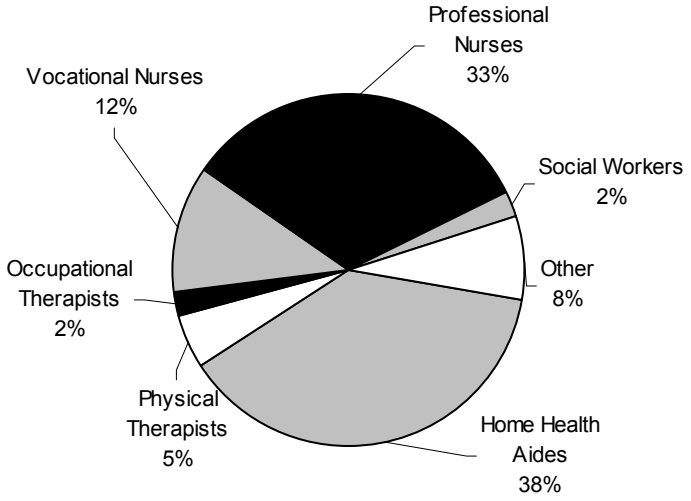
Because a proposed home health co-payment would alter revenue mix, analysts are monitoring developments in Congress on the proposed Medicare prescription drug legislation. Some worry that the introduction of a co-payment, as proposed in the House bill, could discourage the utilization growth of home health services.

Costs

Nursing shortage remains "a major concern" for providers.

Home health care is considered by many to be a cost-effective alternative to extended hospitalizations, lengthy rehabilitation, or nursing facility stays. Because the service is rendered in the patient's home, some of the large capital costs associated with facility-based care are avoided. As a result, HHA costs are substantially labor-oriented. This dependence on labor is pressured by the current shortage of skilled caregivers, which Gentiva noted to Lehman Brothers' Lawrence Marsh is "a major concern."

Figure 6: Personnel Mix – 2003



Source: SMG Marketing, as of May 2003.

Industry sources estimate the home health industry is 3-5 years behind other healthcare industry segments in its use of IT.

Regulatory changes necessitate greater use of technology.

In addition to personnel costs, technology expenditures have been increasing over the last few years as a result of the efficiency incentives under the PPS and other regulatory actions. The home health industry has only recently begun to view technology as a strategic asset, and, as a result, is several years behind other industry groups. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The act also addresses the security and privacy of individually identifiable health information. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care. Electronic processing of transactions is expected to significantly reduce labor and error-related costs. While ultimately a benefit, the initial investment in information technology may be a significant cost to many HHAs.

Industry Performance: Home Health Agencies

One measure of industry performance is the EBITDA margin. EBITDA, earnings before interest, taxes, depreciation, and amortization, tells investors how much cash the business is generating from operations and is available to pay financing costs (such as interest expense). Profitability within the HHA industry varies and profit margins are difficult to gauge. Unlike publicly traded companies, the majority of this market is composed of small, local operators, which are not required to report financial data.

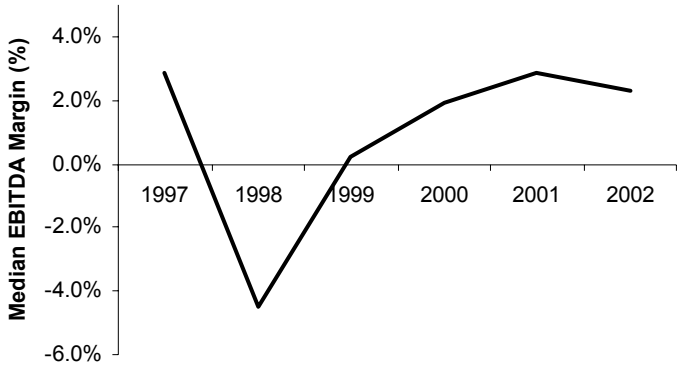
Medicare payments under the PPS offer the highest margins.

Following the BBA-induced closures or mergers of poorly performing HHAs through 1999, operating profitability of publicly traded HHAs has stabilized since the introduction of the PPS (Figure 7). The median EBITDA margin for the small number of publicly traded HHAs is 2.3%. According to Lawrence Marsh of Lehman Brothers, "Medicare has become a better payor over the past few years and offers the highest margins. However, it has the highest cost of participation." In a May 2002 report to Congress, the GAO found that "the Medicare Program is paying HHAs on average considerably more than the estimated cost of care…." Amedisys (NASDAQ: AMED), which generated 88% of its revenues from Medicare in 2002, illustrates this point. In 2002, the company achieved a 10.2% EBITDA margin, much higher than the industry average.

It is important to note that there have been many bankruptcies in this sector, and that the combined market capitalization of the publicly traded HHAs is only $574 million. Gentiva dominates its publicly traded peers, representing 49% of the combined value of the sector. By way of comparison, the single largest publicly held hospital chain has a market capitalization of $17.7 billion.

The median EBITDA margin for publicly traded HHAs was 2.3% in 2002.

Figure 7: Median EBITDA Margin for Publicly Traded HHAs

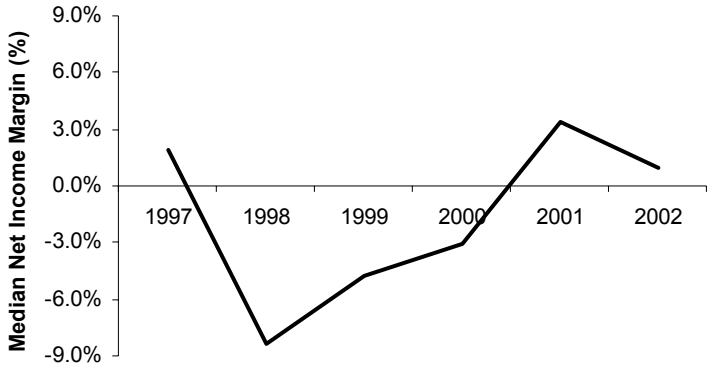


Source: Company filings, Bloomberg, and analyst reports.
Notes: Excludes one-time and extraordinary items where publicly-available. Companies included in index: Almost Family, Amedisys, Continucare, Gentiva, National Home Health Care, New York Home Health Inc., Star Multi Care. Excludes Med Diversified due to the acquisition of Tender Loving Care Services and both entities' current bankruptcy.

Net income is another important measure of industry profitability. This amount is the revenue that remains after accounting for all operating and non-operating expenses (such as interest, taxes, depreciation, and amortization). It is also the total profit or "bottom line," and is the amount that the business can reinvest in itself, or, in the case of a for-profit company, may distribute to shareholders. Figure 8 suggests that net income margins have improved since the BBA for this sample of publicly traded HHA providers. Within this sample, there is significant variability between the net income margins of individual companies. While the median net income margin is 1%, the mean net income margin is (0.3%).

Figure 8: Median Net Income Margin for Publicly Traded HHAs

Net income margins have improved since the introduction of the PPS.



Source: Company filings, Bloomberg, and analyst reports.
Notes: Excludes one-time and extraordinary items where publicly-available. Companies included in index: Almost Family, Amedisys, Continucare, Gentiva, National Home Health Care, New York Home Health Inc., Star Multi Care. Excludes Med Diversified due to the acquisition of Tender Loving Care Services and both entities' current bankruptcy.

Gentiva, the largest company in the home health sector by market capitalization, has focused on internal operations during the last few years and paid off all of its long-term debt. The company is also now a pure play home health company following the sale of its specialty pharmaceutical business in 2002 for approximately $470 million to Accredo Health (NASDAQ: ACDO). These actions have allowed the company to amass significant cash reserves which analysts expect the company to use for selective acquisitions, share repurchases, and special dividends.

Access to Capital: Home Health Agencies

Access to capital is a key indication of industry performance. Without access to external sources of funds, a business is limited to only the net income it generates to fund its operations and invest in new equipment, facilities, or technology. Access to capital is critical for a company to increase its market share and remain financially viable.

Investors view HHAs as risky investments.

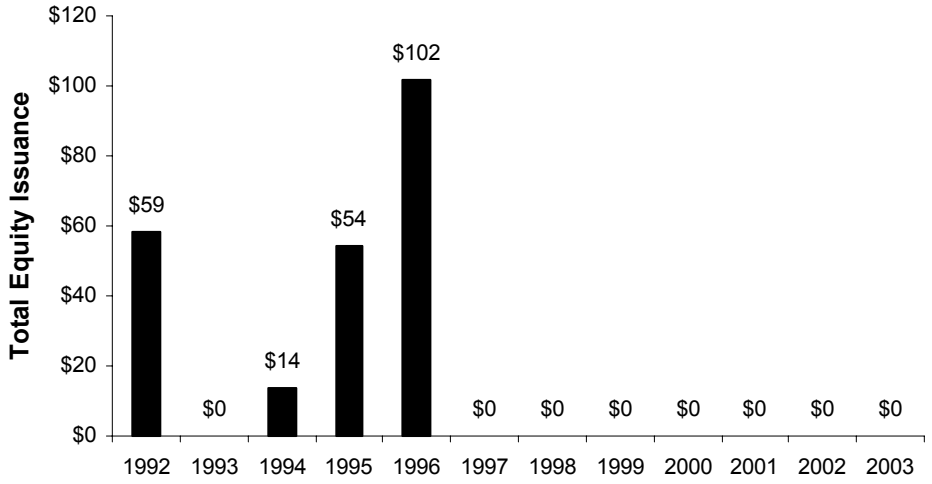
Most equity and debt investors perceive the home health sector as risky because it does not have a proven track record of success and is subject to regulatory reimbursement risk. Given the number of historical bankruptcies and limited profitability to date, Wall Street gives HHA companies relatively low market valuations.

Historically, the industry has had limited access to the equity capital markets. Through the 1990s, the industry was able to raise only $229 million from equity investors. Notably, this financing was all prior to 1997, with no new public equity issuances since that time.

No new public equity has been issued since 1996.

Figure 9: Annual HHA Public Equity Issuance

($ in millions)



Source: Jefferies & Company, Thompson Financial, and JPMorgan.
Notes: 2003 data through August 1, 2003.

HHA companies are also typically too small to access the public debt markets. In order to create investor demand, a bond offering would generally need to be at least $100 million. Borrowing at this level would over-leverage a small company: the debt level would exceed a company's ability to generate sufficient cash to make principal and interest payments.

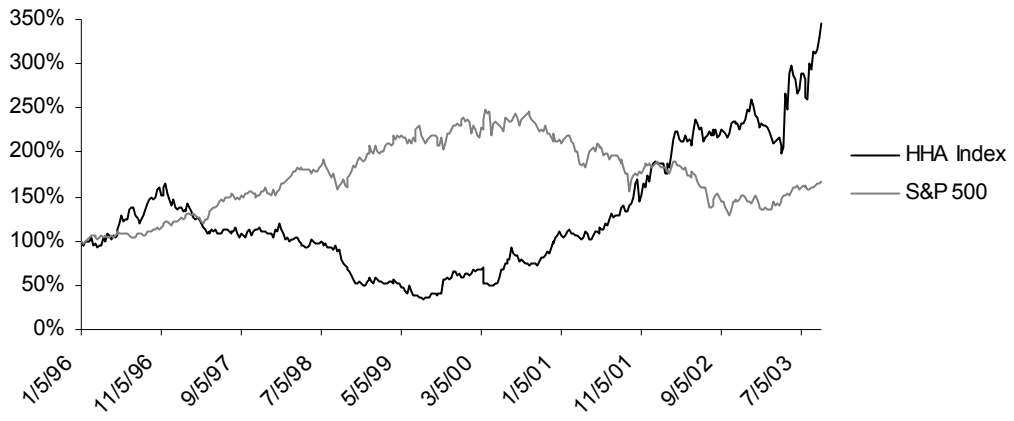
HHAs have historically relied upon bank loans and lines of credit to finance operations. Some small HHA companies have been able to sell their equity shares privately at a 10% to 15% discount to the public market prices (Amedisys did this in 2002). Still others rely on receivables funding secured by Medicare accounts receivable assets. It is likely that until these small HHA companies have a proven track record and achieve critical mass, their ability to access more attractive financing options will continue to be limited.

Stock Market Performance: Home Health Agencies

Home health agency stock price performance was significantly below that of the S&P 500 following the implementation of the BBA in 1997. In the last few years, however, the sector has rebounded and outperformed the S&P, indicating an improvement in investor sentiment. It should be noted that this market-weighted index is significantly influenced by the larger companies, mostly Gentiva, which became publicly traded in early 2000. In May 2003, Gentiva announced that its board of directors had authorized the company to repurchase up to one million shares. Gentiva exhausted the buyback in July 2003. Share repurchases are generally considered a positive indicator of management's confidence in the future performance of the stock. Repurchases also serve to pass value back to shareholders when management feels there may be limited alternative uses for the excess cash.

HHA stock index performance has improved.

Figure 10: Historical Stock Price Relative Performance: 1996 – 2003YTD



Source: Bloomberg through September 19, 2003.
Market-Weighted index includes: Almost Family, Amedisys, Continucare, Gentiva, National Home Health Care, New York Health Care, and Star Multi Care Services. Excludes Med Diversified due to the acquisition of Tender Loving Care Services and the combined entity's current bankruptcy.

Figure 11: HHA Index Components Market Capitalization

($ in millions)	Market Capitalization	% of Index
Almost Family	$ 18.9	3.3 %
Amedisys	87.9	15.3
Continucare	30.9	5.4
Gentiva	283.3	49.4
National Home Health Care	46.7	8.1
New York Health Care	105.0	18.3
Star Multi Care	1.3	0.2
	$ 574.0	100.0 %

Source: Bloomberg as of September 19, 2003.

HOME RESPIRATORY AND INFUSION THERAPY SERVICES

Wall Street's View

Analysts view home respiratory companies more positively than home health agencies given their greater margin potential. According to Eric Percher of Thomas Weisel Partners, "Respiratory = High Margin." For example, Lincare (NASDAQ: LNCR), which derives 90% of its revenues from respiratory services, achieved an EBITDA margin of 39.8% in 2002. Apria (NYSE: AHG), which derives 67% of its revenues from respiratory services, achieved a 23.8% margin.

Industry growth is linked with the prevalence of COPD.

Analysts expect the market to increase between 4% and 7% annually. Industry growth in the respiratory sector is linked with conditions relating to chronic obstructive pulmonary disease (COPD), which is most prevalent in the 65 and older age group. Studies suggest that COPD may be underdiagnosed.[4] Additional diagnosis as a result of patient and physician education may further fuel industry growth, as will increased treatment duration as less severe cases are identified earlier. While the benefits of home health services are recognized, utilization remains relatively low. Analysts expect that increased utilization of home health solutions will continue to drive industry growth.

Significant acquisition opportunities exist in the sector.

Analysts believe significant consolidation opportunities exist in the respiratory therapy market. With nearly 2,000 small local and regional providers, there are ample opportunities for the larger companies to leverage fixed cost bases through acquired revenue streams. For example, Lincare has been highly successful in its acquisition strategy, developing a structured due diligence and systems integration process, leading Percher to state, "We challenge investors to find a more effective 'roll-up' strategy in Healthcare Services." However, the larger companies appear to perceive few available, strategic acquisition targets that are attractively-priced as evidenced by managements' decisions to pursue share repurchase programs. Apria, Lincare, and Option Care (NASDAQ: OPTN) each have repurchase programs currently in place.

Congressional proposals have tempered near-term industry stock market performance.

Long-term growth projections are tempered by near-term uncertainty regarding pending Congressional actions. Legislation pending in Congress creates uncertainty regarding current price performance given potential changes relating to reductions in payment for drugs and the prospect of competitive bidding for oxygen services. Analysts note that a cut of up to 15% in drug payment rates may already be priced into shares given prior studies which state Medicare may over-pay by 13% to 17%. Percher calculates that a 15% cut in drug payment rates in 2004 equates to a reduction in revenue only of 3% for Lincare and .75% to 1.50% for Apria. Further, although competitive bidding may lead to oligopolies in the long-term, the system currently under discussion by Congress may not be operational until 2010.

Percher states that despite the lower margin potential, at least a minimal investment in infusion services and durable medical equipment by respiratory providers is necessary. Balaji Gandhi of Deutsche Bank further notes that this investment is complimentary to provider's home respiratory business. As a result, infusion therapy providers could benefit

[4] For further descriptions of COPD, refer to page 16 of the June 28, 2002 Health Care Industry Market Update on Home Health.

from the implementation of proposed Medicare legislation that establishes a home infusion therapy benefit. David MacDonald of Leerink Swann & Company notes, however, that infusion therapy provider Option Care has historically benefited from an exclusive focus on infusion therapy, which insulates the company from Medicare payment risk, as Medicare does not cover most home infusion therapies.

Despite the uncertainty surrounding potential legislative changes, analysts favor the larger respiratory market players and anticipate acquisition opportunities: larger providers will be able to capture market share from smaller competitors due to their broader geographic reach and breadth of services. Balaji Gandhi of Deutsche Bank states:

> …Any potential reduction in Medicare reimbursement for home respiratory drugs or equipment would encourage smaller independent operators to exit the industry. Accordingly, we believe the leading national providers could partially offset any potential Medicare reductions by accelerating their acquisition pace of these smaller providers.

Industry Overview: Home Respiratory & Infusion Therapy

Home Respiratory Therapy

Home respiratory therapy is the delivery of oxygen therapy, respiratory medications, and sleep disorder products to patients with conditions such as chronic obstructive pulmonary disease (COPD), asthma, lung cancer, and sleep apnea. Usually caused by smoking, COPD, which includes both emphysema and chronic bronchitis, is characterized by obstructed air flow. Emphysema is a chronic disease that causes irreversible lung damage because the walls between the air sacs within the lungs lose their ability to stretch and recoil. Chronic bronchitis is the inflammation and eventual scarring of the lining of the bronchial tubes. Sleep apnea is the temporary suspension of breathing occurring repeatedly during sleep that often affects obese people or those with an obstruction in the breathing tract, an abnormally small throat opening, or a neurological disorder.

Home respiratory therapy services typically include the provision of:

(1) Oxygen systems that consist of oxygen concentrators, liquid oxygen systems, and high pressure oxygen cylinders. Oxygen concentrators are stationary units that extract oxygen from ordinary air. Liquid oxygen systems are portable, thermally insulated containers of liquid oxygen.
(2) Home ventilators that sustain a patient's respiratory function mechanically when a patient can no longer breathe normally.
(3) Sleep apnea equipment used for continuous positive airway pressure therapy that forces air through a patient's respiratory passageways during sleep.
(4) Nebulizers that deliver aerosol medication to patients to treat asthma, COPD, cystic fibrosis, and neurologically related respiratory problems.
(5) Respiratory medications (such as bronchodilators like albuterol sulfate and ipratropium bromide), and related services.

Home Infusion Therapy

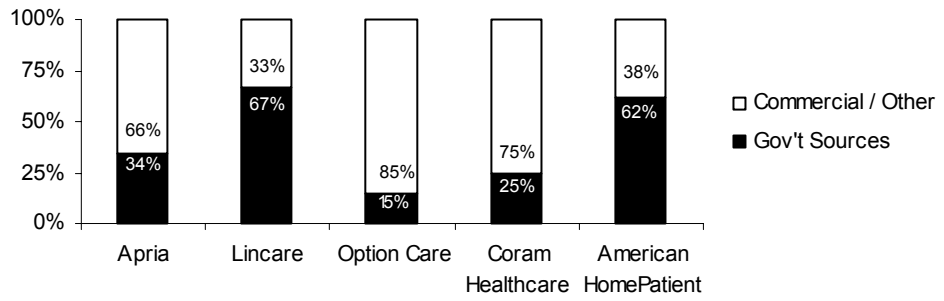
It is often the case that standard, orally-ingested medication does not effectively treat conditions such as cancer, gastrointestinal (GI) diseases, congestive heart failure and immune disorders. Physicians prescribe infusion therapy for these ailments. Home infusion therapies include the intravenous administration of life-sustaining nutrients, chemotherapy, which is the intravenous administration of medications to patients with various types of cancer, and the infusion of antibiotics directly into the patient's bloodstream. The therapy includes pharmacist services and related medical equipment and supplies and involves the administration to patients in the home setting.

Revenue Sources

Payor mix varies among publicly traded respiratory and infusion therapy companies.

Payor mix varies among the publicly traded companies in the respiratory and infusion therapy business. Lincare and American HomePatient (OTC: AHOM) derive the largest percentage of their revenue from government payors (67% and 62%, respectively, in 2002), and Option Care derives the lowest percentage (15% in 2002). Lincare and American HomePatient have increased the percentage of their revenue from government payors (from 62% and 59%, respectively, in 2001). Balaji Gandhi of Deutsche Bank notes that infusion therapy providers such as Option Care and Coram Healthcare (OTC: CRHEQ) derive most of their revenue from commercial payors as, "Medicare only reimburses pharmaceuticals that require administration through medical equipment or infusion devices, and therefore commercial payors are the primary source of revenue in the industry."

Figure 12: Payor Segmentation – Respiratory and Infusion Therapy Services Industry



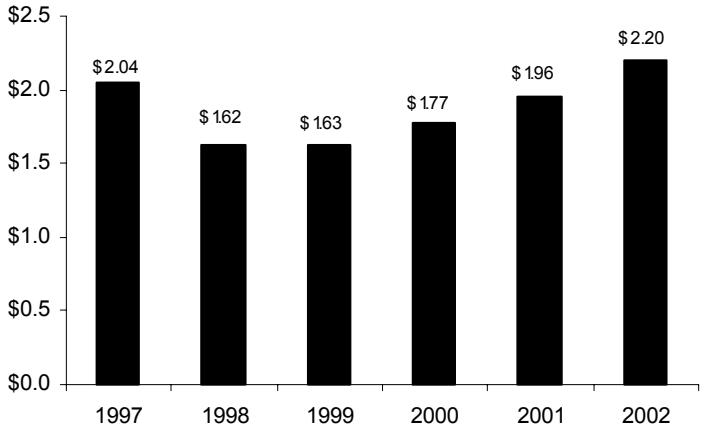
Source: Company filings; 2002 data.

Despite cuts in Medicare oxygen payment, the sector has rebounded and Medicare spending has stabilized.

The Balanced Budget Act of 1997 (BBA) reduced the fee schedule for home oxygen by 25% effective January 1, 1998 and by an additional 5% effective January 1, 1999. In addition, the BBA froze the fee schedule updates for home oxygen for five years, from 1998 through 2002. The Balanced Budget Refinement Act of 1999 (BBRA) later provided for temporary (one time) updates of 0.3% in 2001 and 0.6% in 2002. These updates do not carry over into future years. Despite these payment reductions, and the resulting revenue shortfalls by home respiratory providers, the sector quickly rebounded as Medicare oxygen spending rose**.**

Figure 13: Medicare Spending on Oxygen

($ in billions)



Source: CMS, Center for Medicare Management

Medicare's payment allowance for drugs provided as a part of respiratory or infusion therapy is based on 95% of its average wholesale price (AWP). Of this, the Medicare payment is 80% and the beneficiary co-payment is 20%. Providers often purchase these drugs from the manufacturer or wholesaler at prices significantly below the current Medicare rate. Changes in AWP payment methodology are currently being considered by both Congress and CMS. Further discussion of AWP can be found on page 19.

Average Wholesale Price (AWP)

Average wholesale price (AWP) is a manufacturer-supplied price, not currently defined by any federal law or regulation, and is presently compiled by compendia such as the *Red Book*. Numerous studies have suggested that AWPs, as currently calculated, are higher than the prices drug manufacturers and wholesalers actually charge to physicians and other providers. Medicare beneficiaries are directly impacted by the AWP price of these drugs (except for flu and pneumonia vaccines) because they affect Part B premiums, the $100 Part B annual deductible, and the 20% co-insurance payment for drugs.

Under Medicare, drugs not paid under a prospective payment system are paid based on the lower of the billed charge or 95% of the drugs' AWP, a CMS-determined price identifier. These drugs include drugs administered incident to a physician's service, immunosuppressive drugs furnished by pharmacies, drugs furnished by pharmacies for use with durable medical equipment (*e.g.*, nebulizer drugs), covered oral anti-cancer drugs, and drugs other than erythropoetin that are not included under the end-stage-renal-disease (ESRD) composite rate payment.

A recent General Accounting Office (GAO) report states that Medicare payment rates in 2001 for Part B covered drugs were much higher than the actual acquisition costs for physicians and pharmacy providers. The report indicated discounts of 13% to 34% off AWP were common for many physician-administered drugs and were as high as 65% to 86% for two specific drugs.

The current AWP structure causes several problems for the current Medicare payment system. Because payments are currently tied to published AWP, Medicare cannot obtain the discounts for which private payors can negotiate. AWPs that overstate actual acquisition costs for drugs also result in higher outpatient PPS transitional pass-through payments for many drugs, potentially leaving less money available for other items eligible for pass-through payments under the limit. In addition, manufacturers can arbitrarily increase published AWP and, in turn, offer physicians or providers deeper discounts. This can create an economic incentive to choose particular treatments for Medicare patients because the payment exceeds the cost, creating a profit margin for the provider.

The GAO report discussed above was produced at the direction of Congress (BIPA Section 429) which also directed the Secretary of Health & Human Services to revise the payment methodology based on the GAO findings.

On August 15, 2003, CMS released a proposed rule that would revise, based on one of four approaches, the current payment methodology for Part B covered drugs and biologicals. The four proposed approaches are:

1. Comparability provision: Medicare would pay the same amounts for covered drugs that private insurers pay;
2. Average AWP discount: Medicare would apply a discount of 10% to 20% from the inflated average wholesale price in 2004 and then establish more reasonable payment updates in future years;
3. Market monitoring: Medicare would use existing sources of market-based prices and would develop additional sources to monitor market changes over time, such as drug price catalogs; and
4. Competitive Bidding and Average Sales Prices: Medicare would establish a competitive bidding process for drugs and would also require drug companies to report their average sales prices.

Additionally, CMS is proposing to significantly increase payments under the Medicare physician fee schedule for administering cancer drugs.

CMS is currently receiving comments on the proposed rule and methodologies until October 14, and expects to publish a final rule thereafter for January 1, 2004 implementation.

Costs

Respiratory Therapy

Within the respiratory therapy business, the largest operating cost is labor. Labor costs include the cost of respiratory therapists and pharmacists as well as staff for customer service, selling, and distribution. Lincare and Apria estimate that these labor costs, which are directly variable with revenue growth patterns, account for 60% to 70% of operating costs. Since these companies lease respiratory equipment to patients, they also have acquisition costs associated with the respiratory equipment. Capital expenditures include the purchase of liquid oxygen equipment, portable oxygen tanks, and oxygen concentrators.

In addition to oxygen therapy, a respiratory therapy company provides respiratory medications used with equipment such as a nebulizer. Generally, one-half of the patients who are receiving oxygen treatment also receive respiratory medications.

Infusion Therapy

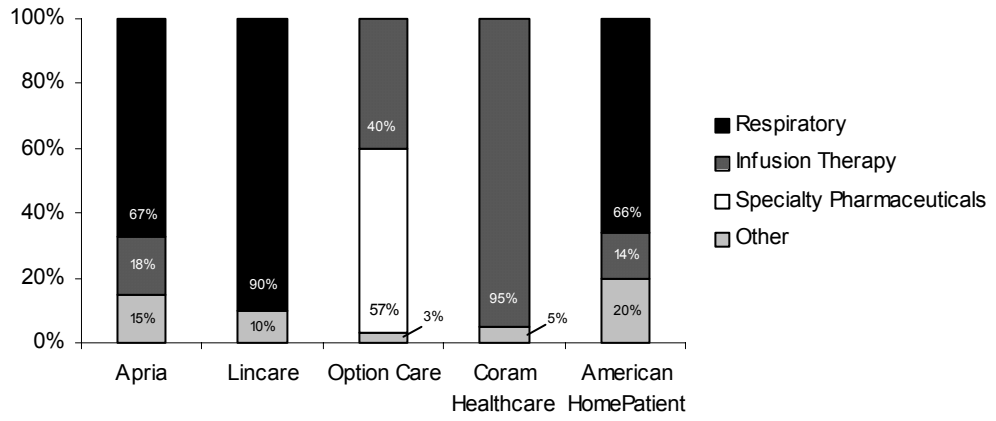
The home infusion therapy business, which involves the administration of chemotherapy and other intravenous and injectable medications to patients in the home, is a lower margin business than the respiratory business. For the infusion therapy business, the cost of the products or drugs is the largest operating expense at roughly 40% to 42% of revenue. Studies have demonstrated that respiratory and infusion therapy providers can derive significant margins on distributed drugs due to the spread available between their acquisition cost and the price paid by Medicare. The second largest operating cost is the labor, which includes the pharmacist, the nurse who administers the home infusion therapy treatment, and the delivery person. Home infusion therapy is a significantly smaller percentage of Medicare spending than home respiratory therapy. In addition, the home infusion therapy business is significantly less profitable than the home respiratory business (as shown in Figure 15).

Industry Performance: Home Respiratory & Infusion Therapy

Profitability varies and is difficult to gauge because half of the industry is composed of small, local operators. The respiratory therapy industry is very fragmented—more than 2,000 local providers make up half of the market. Lincare and Apria each capture approximately 17% of the revenue in the home respiratory therapy industry, and American HomePatient brings in an additional 5%. Rotech Healthcare (NASDAQ: ROHI), which captures approximately 10% of the market share, became a stand-alone entity after emerging from bankruptcy and spinning-off from its parent company, Integrated Health Services, in 2002. Like the home respiratory industry, home infusion therapy is a highly fragmented business, with nearly 4,500 sites of service. Providers include local, national, and hospital-affiliated organizations.

Figure 14: Business Mix of Publicly Traded Respiratory & Infusion Therapy Providers

Revenue mix varies significantly among publicly traded respiratory and infusion therapy providers.



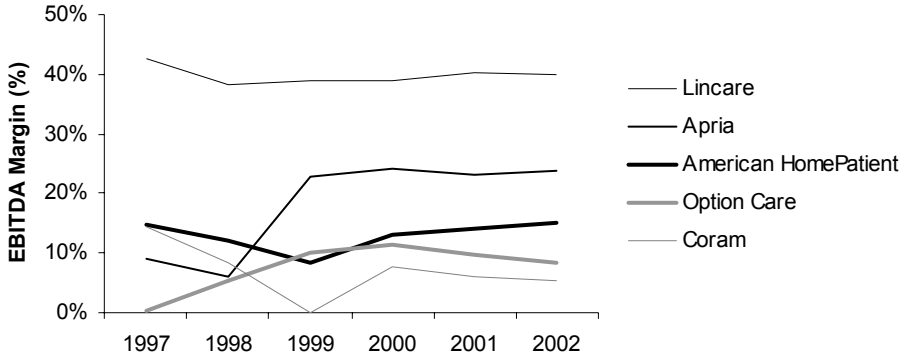
Source: Company filings, 2002.
Note: Other includes home medical equipment and other non-core operations.

Larger companies can extract wider margins by leveraging their scale to spread fixed costs.

Figure 15 illustrates the median EBITDA margin (earnings before interest, taxes, and depreciation divided by revenue) for the publicly traded companies in this sector: Lincare, Apria, American HomePatient, Coram Healthcare, and Option Care. The graph demonstrates that results vary significantly within the industry. The median operating profitability was approximately 15% in 2002 for the publicly traded respiratory and infusion therapy services companies (the *average* EBITDA margin is 19%). The graph further illustrates the significantly higher margin potential in the respiratory business (Lincare). As noted by Eric Percher of Thomas Weisel Partners, however, "…margins at smaller regional competitors are typically substantially lower than those of Lincare or Apria, as both national providers benefit from the efficiency of national reimbursement and accounts receivable management systems."

Figure 15: EBITDA Margins of Publicly Traded Respiratory & Infusion Therapy Providers

Lincare enjoys substantial margins due to a revenue concentration in respiratory therapy.



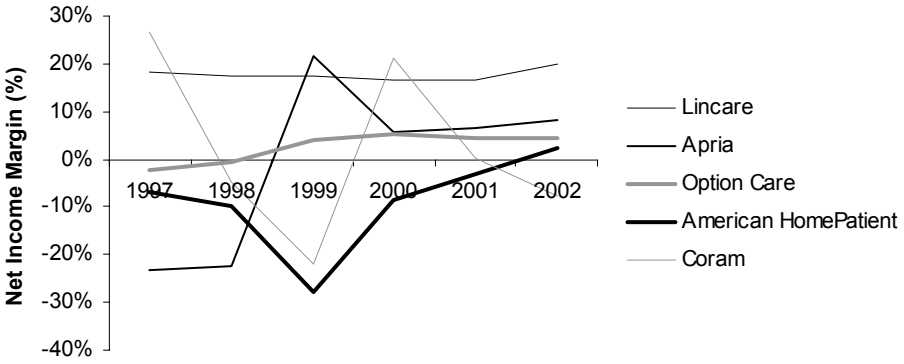
Source: Bloomberg, Company filings, and Wall Street Research.
Note: Reflects continuing operations and excludes one time charges when publicly disclosed.

The publicly traded companies have a wide range of profitability, however. Lincare and Apria consistently post solid profitability figures. It should be noted that American HomePatient and Coram Healthcare are both currently in bankruptcy, and Rotech Healthcare became a stand-alone entity after emerging from bankruptcy and spinning-off from its parent company, Integrated Health Services, in 2002.

Analysis of the median net income margin for the publicly traded respiratory and infusion therapy companies is 4%. This value can only be viewed as a directional indicator due to the disparate results of individual companies performance, as illustrated in Figure 16.

Figure 16: Net Income Margin of Publicly Traded Respiratory & Infusion Therapy Providers

Profitability of individual companies varies substantially.



Source: Bloomberg, Company filings, and Wall Street Research.
Note: Reflects continuing operations and excludes one time charges where publicly available.

Access to Capital: Home Respiratory & Infusion Therapy

Large, publicly traded respiratory therapy companies can largely self fund operations.

Wall Street analysts believe that the large respiratory therapy companies generate enough cash from operations to fund their growth and capital needs. This is largely due to the relatively low capital intensity of this sector as well as the strong operating performance of these companies. As such, most large respiratory therapy companies do not have a great need to access the capital markets.

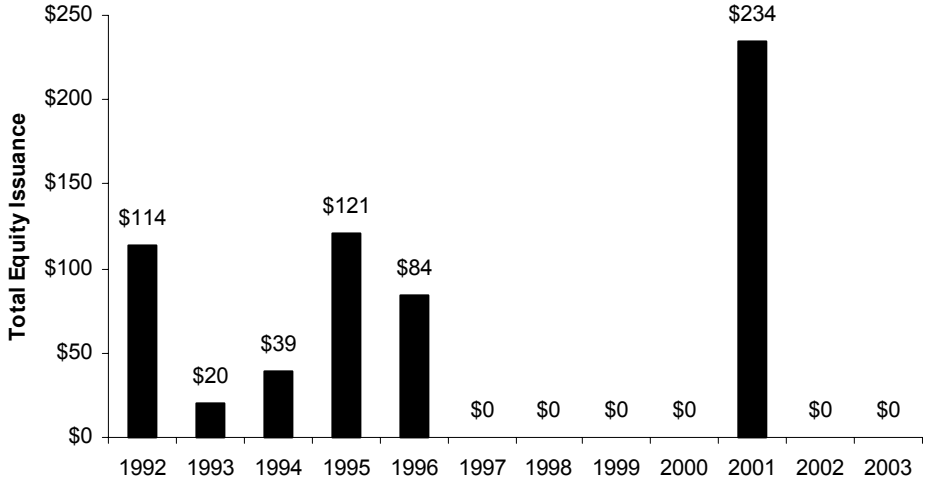
Debt markets are open to larger respiratory therapy companies.

Analysts also believe that if a large respiratory therapy company were to seek access to the public capital markets, it would be able to do so. For example, Rotech Healthcare was able to raise $300 million in capital through a public debt offering in 2002 concurrent with its emergence from bankruptcy. The larger respiratory therapy companies enjoy flexibility in their growth strategies as a result of their ability to access both debt and equity capital markets, or to self-fund operations through internally generated cash flow. In June 2003, Lincare successfully completed a debt offering of $275 million to institutional investors and in August 2003, Apria announced a $200 million bond offering with a concurrent share repurchase of $100 million.

Only $612 million of equity capital has been raised since 1992.

The respiratory and infusion therapy services sector has better access to equity capital than the HHA component of the industry. The respiratory and infusion therapy services sector has raised $612 million over the past decade in the public equity markets, which is three times the issuance of the HHA industry. The graph below details the yearly distribution of the sector's equity issuance. Although equity issuance clearly surged in 2001 with public offerings by Apria and Option Care, home respiratory and infusion therapy services companies did not access the equity capital markets between 1997 and 2000. In 2003, several companies focused on share repurchases to distribute earnings to shareholders and increase share prices.

Figure 16: Home Respiratory and Infusion Therapy Annual Public Equity Issuance



Source: Jefferies & Company, Thompson Financial, JPMorgan, and Company filings.

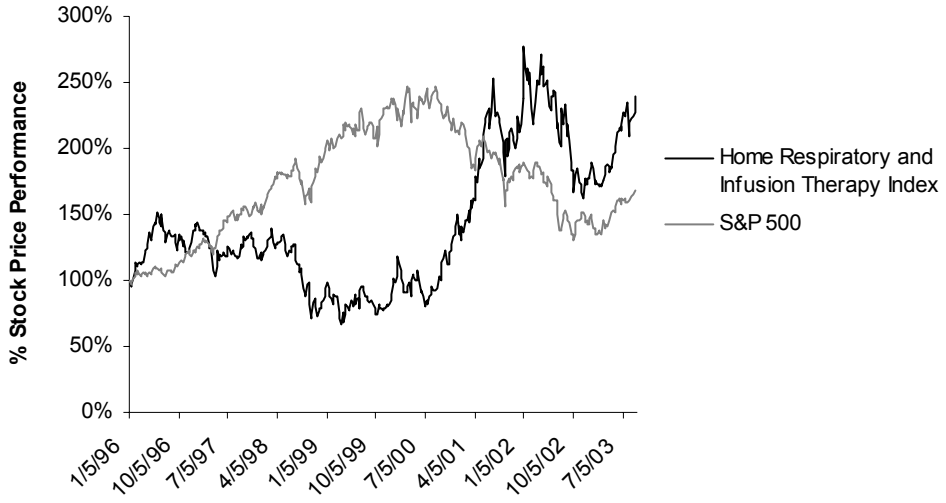
Stock Market Performance: Respiratory & Infusion Therapy

The improvement in stock market performance among respiratory and infusion therapy services companies reflects investors' favorable expectations of future cash flows and justifies Wall Street analysts' strong earnings expectations for the sector.

Recently, companies in the sector have used excess cash for share repurchases.

Additionally, several companies in the sector have been pursuing share repurchase programs over the last few years. When companies repurchase their own shares, it is a signal of management's confidence in future results, as well as a way to pass value on to shareholders. Repurchase programs are intended to increase the company's stock price. Apria, Lincare, and Option Care have all pursued share repurchase programs. Since 1999, Lincare has repurchased approximately $265 million worth of its shares, and an additional repurchase was authorized in February 2003.

Figure 18: Historical Stock Price Relative Performance: 1996 – 2003YTD



Source: Bloomberg as of September 19, 2003.
Market Weight Index Includes: American HomePatient, Apria, Corum, Lincare, and Option Care.

SUMMARY

- Home health agency industry growth and overutilization was curtailed by the Balanced Budget Act and the interim payment system. The number of Medicare home health agencies has since stabilized under the new prospective payment system, which appears to have encouraged providers to streamline operations and efficiently deliver services.

- As noted in last year's report, HHA companies continue to have difficulty raising capital primarily due to their small size. Wall Street analysts suggest that investors will be more inclined to provide capital once government payment policy provides more stability and predictability.

- Large respiratory and infusion therapy services companies demonstrate strong operational and financial performance and are able to attract investors' capital. Where strategic and attractively priced targets are available, these companies are actively consolidating the industry and are likely to continue acquiring smaller providers.

- Overall, large home health providers benefit from the efficiencies achieved from their economies of scale and information technology improvements. Smaller companies struggle in the market.

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