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A century of home care: A look at the industry's past and future

Experts share their insights

With the century coming to a close, it just wouldn't be complete without a look at the home health industry and how it has fared over the past 100 years. Because hindsight is 20/20, *Hospital Home Health* asked a few experts in the field to talk not only about what they felt were the most important events or changes to hit home care in the past century, but where they saw the industry headed. Here's what they had to say:

❒ **Jo Burdick, RN, MSN, executive director, MeritCare Home Care, Fargo, ND**

"Cars. Truly, if we're talking about the century and the delivery of home care, without them we wouldn't have the home care we have today. Things like the BBA [Balanced Budget Act of 1997] and IPS [the interim payment system] are dramatically impacting us now, but I don't feel they are any comparisons in terms of overall impact to what happened [at the beginning of this century]. Without the car, if nurses were going to make home visits, they were either walking or taking a horse and buggy, and now with our portable technology it allows for a much greater range of services.

> *"It used to be that Americans would spend 85% of their health care Medicare benefit dollars in the last three months of their life because you went into hospital and stayed in intensive care until you died."*

"As for the future, I think home care will be fine. [The prospective payment system is] a huge bump in the road, but people who know home care know we can't live without it and we will find ways to make the industry work. If you don't think that's the case, then I would say you have larger challenges in your agency as far as reorganization. You need then to look at what you need to do and get out there and do it.

"For years I think too many home care agencies have been living beyond their means, and many have been doing so — well beyond their means. Certainly, there will be challenges, and I hope that we as an industry don't have to decrease access to care.

"A study has shown that a greater number of home care visits doesn't necessarily equate with better outcomes. We have an average of about 30 to 40 visits per beneficiary as opposed to a much higher national average. So while other agencies have been drastically hit, we've had to change very little, and I know that we will be OK."

❒ Elizabeth Hogue, JD, Elizabeth Hogue Chartered, Burtonsville, MD

"I think the biggest development in the last century has to be the development of the Medicare home care benefit. It created a huge momentum for the industry development as well, in many respects, as acting as a stone around the neck of home care providers. When the history of home care is written, it will be very interesting to see how the role of the Medicare home care benefit, especially in view of BBA, will be evaluated. I think it will show that we took a detour from the path that we should have taken.

"With respect to the future, it is absolutely out of sight. I go all over the country saying that to people, and sometimes I'm not sure they believe me. But from my perspective, home care is the answer. Every sign I see points to that conclusion for the future. The entitlement mentality that our parents have doesn't exist in the baby boomer generation.

"They have money, and the thing they are most willing to spend it on is health care. They will demand to remain at home and won't go quietly to nursing homes. I regret a lot of the extreme language that we are still seeing in the home care press talking about devastation and demolition. It's true that a lot of agencies have gone out of business, and I deeply regret that. But, on the other hand, there are some very strong home health agencies that are almost hidden at this point because they don't want to publicly say, 'We're doing great' when others are suffering. I know there is strength in the industry and everything points to a positive future."

❒ Ann Howard, executive director, American Federation of Home Health Agencies, Silver Spring, MD

"I think the most important thing to hit home care in the past century was the enshrinement of home care as part of the health care continuum with the passage of Medicare in 1965. That was the best thing to happen. The worst thing, I would have to say, is the Balanced Budget Act of 1997.

"As for the future, home care has some very severe problems, which need to be addressed legislatively, or its benefits could become shadows of their former selves. I hope Congress will come to its senses and see the imperative to putting resources back into home care. Ultimately, the health care delivery system will move back into the home because it's clinically and economically the most effective and absolutely consumer-preferred. I think there is need for home care, and it will always be here. It's just going to be a rocky road getting to the top."

❒ Larry Leahy, MHA, CHCE, director of program integrity, Beaumont Home Health Service, Victoria, TX

"The most important was the Medicare benefit. Without that program, we would not have had the growth in home care. The second most important thing is the BBA, which cut the Medicare benefits down. So really, Medicare has proven to be a double-edged sword to some extent. When doing residency in early '80s, prior to DRGs being implemented, home care was still very small. The Medicare benefit has been the most important item to help — and sometimes hinder — the industry.

"My opinion is that the home care industry is becoming the locus of health care in the 21st century. I base this on technology advancements and cost. A couple of weeks back, [National Public Radio] had a feature on the differences on end-of-life care and the costs of that care throughout the

COMING IN FUTURE MONTHS

- Corporate compliance
- Assisted living regulations
- Referral revamp
- Errors and omission insurance
- Medication exam

United States. From the statistics, the areas of the country that have lower costs are the ones that are emphasizing home and hospice care. It used to be that Americans would spend 85% of their health care Medicare benefit dollars in the last three months of their life because you went into hospital and stayed in intensive care until you died.

"It's gotten somewhat frustrating in that if Medicare is to survive to 2050, you can't do it through the traditional acute care systems. Home care should be the center. I think it will bounce back but will look different with fewer freestanding agencies and more of a business focus along with the caring focus and a tremendous amount of technology that will be developed to care for patients at home."

❒ Dan Lerman, MHSA, president, Center for Hospital Homecare Management, Memphis, TN

"I would definitely say it is the government's reimbursement of home care services, meaning not everyone needs to pay for it out of pocket. Now this is being expanded with reimbursements from a growing segment of nongovernment insurance programs. As for the future of the industry, I think hospital home care is in the middle of a two- to five-year cycle of contraction but that afterward it will be bouncing back for the long term. I see a tremendous upside to growth."

❒ Susan Schulmerich, RN, MS, MBA, executive director, Montefiore Medical Center Home Health, Bronx, NY

"I'd have to say it was the enactment of Medicare and Medicaid in 1965. The reason we are even dealing with the BBA is because of what happened then. Prior to 1965, there were vast segments of the population who needed home care but had no access to it.

Turning point for home care relief

"I think in the year 2000 the turning point is going to occur for home care relief and from the effects of the BBA, and I suspect that what will happen is another growth spurt in home care utilization. In part because of the baby boomers, but I also think that will be a matter of a certain relaxation or relief from the scrutiny and the dissection of the industry by government and HCFA, in particular. Much as what happened when the Stark lawsuit was settled, agencies will once again not be intimidated into not taking patients that are too costly."

❒ Greg Solecki, vice president, Henry Ford Home Health, Detroit

"My immediate knee-jerk response has to be the involvement of Medicare that came about in the 1960s, for better and for worse. Unfortunately, we are experiencing the 'for worse' right now. When Medicare expanded to the home health benefit and said it no longer required prior hospitalization, it created a niche that allowed home health to be accessible to broader markets.

"As much as I hate to admit it, it has infused certain safeguards for quality and how we make sure providers are doing a quality job. I do think, still on the positive side, it could have a very promising future if [Health and Human Services] and Congress were to finally get the strategic importance of home health care.

"Medicare's involvement has a huge impact on the industry and when we began to see the growth, it became more mainstream and wasn't a cottage industry hidden away; it made the industry more visible.

Overdependent on reimbursement?

"As for the 'for worse' side, our industry has become so dependent on Medicare reimbursement that I'm afraid it's defined itself in Medicare terms. I often hear managers and nurses say they can't visit a patient because there's no skilled care. The fact is that our business is to provide care in the home and if the patient wants us to do it, we should do it. How they pay for it is the patient's issue.

"I don't think as an industry that we can say that since there's no skilled care needed and they're not homebound, we can't provide home care for a patient. The answer we should be giving the patient is that your insurance — in this case, Medicare — may not pay for this. It's a very subtle nuance, but I think we've missed that nuance.

"On the 'for worse' again, unfortunately with Medicare, conditions of participation have increased almost exponentially in terms of the number of standards and things that are looked at. It's also increased the cost considerably as the government continues to add OASIS [Outcome and Assessment Information Set] and 485s and two-week documentation of supervision. These

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are all things that increased administrative costs but the success of reimbursement is contingent upon keeping A&G as low as possible and putting money into discipline-specific reimbursable care. But to keep up with these increasingly stringent conditions of participation, we have increased the cost and we may end up pricing ourselves right out of the market. How long before it's cheaper to send a patient to a nursing home?

"I think the Medicare program has become a behemoth that we don't know how to extricate ourselves from. Our industry has become so inextricably intertwined with our industry's paradigm of what service should be, that it almost has become impossible to separate the two.

"There are some who feel that if home health care weren't provided by a Medicare agency, the patient is being robbed. I contend that patients can get top-notch home health care regardless of whether an agency does an annual program evaluation, especially where there are other checks and balances in place like in a hospital home care agency.

"OASIS is the worst thing that has ever happened to our industry. It will give us data that may bear out in the end for the industry, but it's like killing a mosquito with a blowtorch.

"As for the future, I think that with the advent of Medicare+Choice programs, we're beginning to see a refreshing departure from the obstructed Medicare approach. I think if the new programs are continued to be given a certain degree of freedom it can give us a refreshing departure.

"Those providers that are strong and expert will find ways to provide their value-added care through arenas other than those which are Medicare-certified. I think we'll see an increase in private pay opportunities. We Americans have discretionary income. We see Americans pull $5,000 out of their pockets for liposuction, and those with discretionary spending abilities will spend money on the home health care that Medicare won't provide.

"Initially with managed care programs, we've seen the emergence of home care light, and I think that in the future we may see home care gold, a different and better type of home care that may even be reimbursed by Medicare. From the integrated delivery system perspective I see a lot of promise, despite the naysayers who feel BBA has finally enlightened hospitals as to the foolhardiness of having their own home health care centers.

"We're beginning to see some progress, and BBA was a temporary setback. It's about evolving into a mindset of the right care at the right place at the right time for the right money." ■

Does your agency conduct testing on Medicare?

A pre-hire test worth taking

Mike Ferris with Pasos Houston Home Care receives a lot of requests for his agency's pre-hire tests. **(See test, pp. 137-138.)** He administers them to RNs, he says, during the hiring process "to establish a minimal level of knowledge and establish a baseline of competency."

Ferris points out that there are several questions whose answers can be debated depending on how one interprets their wordings. Ferris says he has "found that the best hires are the ones who question those. It shows knowledge, attention to detail and an interest in the subject matter." ■

Medicare Home Health Services Test

Name _____

Date _____

1. An individual may qualify for Medicare home health services if:
   A. the individual is homebound
   B. the skilled services are medically reasonable and necessary
   C. the attending physician has ordered the therapeutic services
   D. all of the above

2. An initial assessment and evaluation in the patient's residence must occur:
   A. on or before the conduction of the initial therapeutic visit
   B. within twenty-four (24) hours after the agency received the referral
   C. within the allotted time frame identified in the agency's policies and procedures
   D. within forty-eight (48) hours from the initiation of therapeutic services

3. Changes in the plan of care, such as increasing the frequency of therapeutic visits, must be communicated to the patient and documented accordingly in the clinical record.
   A. true B. false

4. The physician must be informed of missed therapeutic visits.
   A. true B. false

5. The duration of a plan of care's certification period:
   A. may be up to 62 days
   B. should never be less than one week
   C. must be at least one month
   D. may be up to 90 days

6. The following actions are generally considered a skilled nursing service EXCEPT:
   A. venipuncture for laboratory analysis
   B. administration of oral medications
   C. health teaching related to a specific condition
   D. assessment and monitoring related to a specific medical condition

7. A patient who leaves his or her residence more than weekly for nonmedical purposes is:
   A. generally considered homebound
   B. only considered homebound if it is a taxable effort to leave the residence
   C. not homebound
   D. homebound if the RN determines the patient requires home health services

8. A licensed vocational nurse may:
   A. conduct an individual's initial assessment and evaluation for Medicare home health services
   B. take a physician's verbal order if allowed by the agency's policies and procedures
   C. conduct a home health aide supervisory visit in the patient's residence
   D. implement changes in the patient's plan of care

9. A skilled therapeutic service (nursing, physical therapy, or speech therapy) is required in order for an individual to qualify for Medicare home health services.
   A. true B. false

10. The plan of care (HCFA 485) must identify the following EXCEPT:
    A. appropriate therapeutic interventions that include frequency and duration
    B. routine medical supplies to be utilized in delivering the appropriate therapeutic services
    C. individualized and measurable goals
    D. the attending physician's signature

11. If nursing home health visits are planned beyond 21 days, the plan of care or clinical record must include an end-in-sight statement(s).
    A. true B. false

12. During the initial certification for home health services, a skilled therapeutic service (nursing, physical therapy, or speech therapy) is required in order for the individual to qualify for home health aide or medical social services.
    A. true B. false

13. Home health aide services must be supervised in the patient's residence:
    A. as determined by the RN
    B. every two weeks by the appropriate professional
    C. only if the patient agrees to the supervisory visits
    D. every month by the appropriate professional

14. Health teaching must be conducted during each therapeutic visit.
    A. true B. false

15. An individual attending an adult day care center for nonmedical purposes is generally considered to be homebound and eligible for Medicare home health services.
    A. true B. false

16. A physician's order is required for all of the following actions except:
    A. increasing the frequency of established therapeutic visits in the plan of care
    B. missed visits
    C. providing treatment
    D. administering a medication

17. The duration of a therapeutic visit must:
    A. be longer than 30 minutes
    B. be conducted only when the caregiver is present
    C. be less than two hours
    D. include all appropriate interventions identified in the plan of care

18. A medical social worker may conduct an individual's initial assessment and evaluation for Medicare home health services.
    A. true B. false

19. Medicare will pay for full-time (beyond eight hours per day) home health nursing services if the physician considers it medically reasonable and necessary.
    A. true B. false

20. The duration of a therapeutic visit must be documented in the clinical note.
    A. true B. false

(For test answers, see box, p. 140.)

LegalEase

Understanding Laws, Rules, Regulations

Courts rule Rehabilitation Act violated in 2 cases

By **John C. Gilliland II**
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Earlier this year, two courts held that home health agencies that discharged patients due to the cost of their care may violate the federal Rehabilitation Act of 1973, a federal law prohibiting disability discrimination in federally assisted programs such as Medicare.

In the first case, a federal district court in Tennessee held that if the home health agency terminated patient services because the severity of a patient's disability and heavy use of home health, the Rehabilitation Act had been violated. [*Winkler v. Interim Services Inc.*, 36 F. Supp. 2d 1,026 (M.D. TN 1999)]

In the second case, a federal district court in Hawaii stated that if a quadriplegic patient was discharged by a home health agency due to his disability and its concomitant loss of profits, the Rehabilitation Act also had been violated. [*Morris v. North Hawaii Community Hospital*, 37 F. Supp. 2d 1,181 (HI 1999)]

Under the interim payment system (IPS), a home health agency's ability to manage its mix of patients in terms of the cost of their treatment can be critical to the agency's survival. IPS is based on the rationale that an agency can balance the cost of caring for any one patient against the cost of caring for all patients. In other words, if the cost of caring for one patient exceeds the per beneficiary limit for that agency, it is offset by the lower costs of caring for another patient. That rationale may or may not be true for very large agencies but, for most, too many high cost patients threaten the agency with economic ruin.

Nor does it appear that the need to manage patient mix will necessary end with the prospective payment system (PPS), which still involves fixed payments irrespective of the amount of service actually provided. There will still be patients whose needs exceed those covered by the PPS payment. Thus, the issue of what have come to be called "economic discharges" will continue after IPS expires.

In dealing with the high-cost patient, most home health agencies have taken comfort in the requirement of the Medicare conditions of participation that patients be accepted ". . . on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency. . ."(42 CFR §484.18) The Health Care Financing Administration (HCFA) has consistently agreed that it is the responsibility of an agency to reject a patient when it does not have the resources, including financial resources, to provide the needed care. Similarly, the understanding has been that if the patient has already been admitted and his or her needs increase, an agency has the responsibility to discharge the patient if it does not have the resources, including financial resources, to provide the increased level of care.

Whether this prevailing view will continue is open to question. In the Health and Human Services' Office of Inspector General's (OIG) work plan for fiscal year 2000, the OIG has stated: "[Our] review will evaluate whether home health agencies are discouraging admission of very ill beneficiaries. The home health interim payment system created by the Balanced Budget Act of 1997 imposed a new per-beneficiary limit based on historical visit rates, and the prospective payment system, to be implemented in the FY 2000, provides a simple payment per episode of care under either it or the interim payment system. As a result, home health agencies now have an incentive to keep visits and associated expenditures down. We will determine whether the agencies are 'dumping' their sicker beneficiaries or are cutting off care before it is medically warranted."

Irrespective of HCFA's and the OIG's position, however, the two court decisions earlier this year show that agencies cannot simply consider Medicare rules as they structure their admission and discharge policies. Other laws can apply as well, especially the Rehabilitation Act of 1973.

In the *Winkler* decision, Medicare patients of the defendant home health agency alleged they were essentially being dumped and abandoned by the agency as a result of changes in Medicare reimbursement, i.e., due to IPS. They contended the agency wanted to discharge them because they were all "heavy service users and economically undesirable patients." The patients argued this violated the Rehabilitation Act as well as various

legal duties of the agency under Tennessee law.

The home health agency moved to dismiss the lawsuit. The court refused to do so. As for the Rehabilitation Act, the court stated what was necessary to state a claim under that law: "The parties agree that to state a claim under Section 504 of the [Rehabilitation] Act, Plaintiffs must show (1) that they are "handicapped persons" under the Act; (2) that they are "otherwise qualified" for participation in the program; (3) that they were excluded from participation in, denied the benefits of, or subjected to discrimination under the program solely by reason of their handicaps; and (4) the program in question received federal financial assistance. . ."

The court did not address each of these requirements specifically. Rather, it considered the home health agency's argument that the Rehabilitation Act does not apply to discrimination based on the severity of a person's disabilities rather than discrimination between disabled and nondisabled persons. The court rejected this argument, noting that many courts have held that discrimination based on severity of disability is the same as discrimination based on the disability itself.

In its preliminary injunction enjoining the agency from discontinuing services to the plaintiffs because of their status as "heavy users" of home care services, the court stated: "The Court finds that the core of this case is Plaintiffs' claim that Defendant decided to terminate Plaintiffs' home health services based upon a change in the reimbursement of Medicare payments, not based upon a change in Plaintiff's [homebound] status. The Court finds that this case is primarily a challenge to the termination of home health care services based on an improper or discriminatory criterion — i.e., heavy utilization of services — not a case about whether Plaintiffs are entitled to benefits."

The *Morris* decision from Hawaii is similar. There the court held that a quadriplegic patient was entitled to a preliminary injunction preventing the termination of home health care benefits. Regarding the Rehabilitation Act, the court stated: "In this case, Plaintiff has alleged, and [the home health agency] does not deny, that his quadriplegia constitutes a disability. Both parties also agree that [the home health agency] is subject to §504 [of the Rehabilitation Act] as the recipient of federal Medicare funds. The parties disagree, however, as to whether Plaintiff is "otherwise qualified" and if so, whether he was denied services due to his disability. . . . Because Plaintiff has adequately alleged both that he is "homebound" within the meaning of Medicare's regulations and that [the home health agency] terminated his services due to his disability and its concomitant loss of profits, the court has jurisdiction to resolve the disputes."

In granting the injunction, the court also balanced the hardship to the patient and to the agency: "The balance of hardships weighs in Plaintiff's favor. The risk to [the home health agency], if any, is financial. [The home health agency] contends that it risks exposure to Medicare fraud if it provides services to Plaintiff for which it knows him to be ineligible. However, Medicare has not declared Plaintiff ineligible. In fact, at no time has Medicare refused to pay for services rendered to Plaintiff. Moreover, the court's determination of Plaintiff's eligibility insulates [the home health agency] from fraud exposure. That is, if Plaintiff is eligible for services, [the home health agency] will not be providing him with services for which he is ineligible. Finally, any financial risk to [the home health agency] is outweighed by the serious health risks to Plaintiff."

Although both the *Winkler* decision and the *Morris* decision were based on the particular facts before each court, they do show how a home health agency's admission and discharge policies must take into account all applicable laws — not just Medicare criteria and regulations.

Nor is this limited to just the Rehabilitation Act. Both cases also involved various state law claims. The *Winkler* case involved allegations of breach of contract, abandonment, outrageous conduct, and violations of the Tennessee Consumer Protection Act. The *Morris* case included allegations of breach of contract and

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Answer Key: Medicare test

1. D	11. A
2. A	12. A
3. A	13. B
4. A	14. B
5. A	15. B
6. B	16. B
7. C	17. D
8. B	18. B
9. A	19. B
10. B	20. A

(For test and more information, see p. 136.)

unfair or deceptive trade practices.

As you structure the admission and discharge policies for your agency, you must take into account all the various laws that can limit your right to admit and discharge patients. This is especially true if you are attempting to achieve a certain mix of patients based on your cost of providing services to them.

Ask your attorney for copies of the *Winkler* and *Morris* decisions and read them. Given the significance of those decisions and the OIG's interest in reviewing agencies admission and discharge practices, you should then have your policies and practices reviewed by your attorney. ■

It's holiday gift-giving time

What's your agency's policy?

With the holiday season upon us, so too is the season of gift giving. Co-workers give to each other, bosses give to their employees, and vice versa. It's the rare company that would ban such expressions of friendship, although some may attempt to put a monetary cap on the office's gift-exchange party. This is a completely different matter, however, when it comes to home health care workers and their clients exchanging presents.

So sensitive is the issue that most home care agencies have banned the practice altogether and instead have a formal policy in place forbidding their employees to either give or receive gifts from their patients. One such agency is Tulare (CA) Home Care. "We don't allow our employees to accept gifts at all nor do we allow them to give gifts to our doctors," explains **Sally Pierson**, BSN, PHN, RN, director of patient services. That's the official policy. As for unofficially, I trust my employees. They know what the policy is, and I trust them to adhere to it."

The specter of impropriety looms large over gift exchanges, and those with suspicious minds may believe that the patient who presents the largest or best gift will receive the best care in return. Then there's the issue of patients who may already have little enough to share with their own families, let alone the nurses and aides who assist them daily. It seems the smartest move then is to simply ban gift exchanges.

Whereas this might make sense on the surface, dig a little deeper and a different picture emerges, says **Greg Solecki**, vice president of Henry Ford Home Health in Detroit, whose agency does have a formal policy forbidding the exchange of gifts between patient and caregiver. "I think that the field staff work so hard and are up against so many mutually exclusive scenarios that to come down heavy on a gift-giving policy would be absurd. Every day, in every city, somewhere along the worst block in the worst neighborhood, there's a woman going into the back bedroom to care for a patient, and if that patient offers a gesture of gratitude, I'm not going to get uptight about it. They deserve that and more."

"However," he continues, "the party line is that our staff are not to accept presents, cash, etc. from patients. But I'm not naive. I know about the bonds established between patients and nurses. If patients insist, because we don't want to seem ungrateful, we encourage them to make a contribution to the Henry Ford system.

Fargo, ND-based MeritCare Home Care also has a policy in place that strongly discourages health care workers from accepting gifts. "When it comes to food and things like that, we're not so strict," says **Jo Burdick**, RN, MSN, executive director, adding that staff are strongly encouraged not to accept gifts of cash or the equivalent. She says there are, of course, exceptions to the gift-giving rule, such as when a patient and caregiver have worked together for a lengthy period of time and it "would be bad not to accept the present."

Tarrant Home Care in Fort Worth, TX, also has a policy forbidding employees to accept

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gifts. There is a caveat, however, explains **Mike Parker**, RN, clinical manager for the facility. "So long as [the gifts are] not valued at more than $25, our employees can accept [them], but were an employee to accept anything of greater value, it would be grounds for dismissal." Within this framework, if a patient insists on giving a gift of greater value, staff would encourage that person to donate to the hospital.

For the most part, the acceptance of gifts is frowned upon, although the consensus seems to be that gift giving isn't a high priority on home care's lengthy list of problems. "This whole thing is really not something we scrutinize closely," says Solecki. "It's a 'don't ask, don't tell' situation, and quite honestly, I don't want to know about it [gift-giving]. It's not one of my priorities when you have to contend with the rest of this absurdity occurring in the industry." ■

Moving on: Appointments, resignations

John Kelly, MD, formerly the director of the American Medical Association's quality division, has been named to head Aetna US Healthcare's new physician relations unit.

Terry Shaw has been named as chief financial officer at Adventist Health System. Most recently he served as senior vice president and CFO at the 1,382-bed Florida Hospital in Orlando. He replaces Calvin Wiese, who will now serve as vice president of strategic development.

Sloan-Kettering Cancer Center in New York City has a new president and CEO: Harold Varmus, MD. A Nobel Prize-winner, he was most recently the director of the National Institutes of Health in Bethesda, MD. He succeeds Paul Marks, MD, who had already announced his retirement.

Matria Healthcare Inc. of Marietta, GA, has hired George Dunaway as its chief financial officer and vice president. He fills the position left by Donald Millard who will stay on as CEO.

Carlsbad, CA-based Sunrise Medical has announced that its chairman, president, and CEO, Richard Chandler, will resign. His successor is Murray Hutchison who has served as a director for the company since 1983. ▼

Organizations announce mergers and acquisitions

Tenet Healthcare has announced the sale of two of its facilities. Palestine, TX-based Trinity Valley Medical Center, a 150-bed facility, and the 101-bed Minden (LA) Medical Center were both sold to Province Healthcare of Brentwood, TN, for $77 million.

Memorial Hermann Healthcare System has been in an acquiring frame of mind, in Texas at least. It recently acquired the 65-bed Fort Bend (TX) Medical Center from Columbia / HCA Healthcare along with the 72-bed Katy (TX) Medical Center. In exchange, Columbia received the 173-bed Memorial Hermann Pasadena (TX) Hospital and an undisclosed sum of cash.

Triad Hospitals, a division of Columbia, meanwhile sold its Beaumont (TX) Regional Medical Center (364-bed facility) and the assets of the closed Silsbee (TX) Hospital for an undisclosed sum.

UPMC Health System in Pittsburgh and Oil City, PA-based Northwest Health System have announced their intent to merge. Under the terms of the agreement, the UPMC would pay $7 million to the latter's medical foundation as well as construct a 110-bed to 150-bed hospital sometime within the next three years and at a cost of $45 million.

NovaCare in King of Prussia, PA, will sell its 623 outpatient physical and occupational therapy clinics in 31 states to Select Medical in Mechanicsburg, PA, for $155 million in cash and the assumption of $45 million in debt. Select runs 120 outpatient rehab clinics and 44 long-term acute care hospitals in the United States and Canada.

Nashville-based Vanguard Health Systems has announced its intention to purchase MacNeal Hospital, a not-for-profit facility in Berwyn, IL, for an undisclosed sum. The sale is expected to be finalized by January 2000. ▼

Premiums could increase 10% or more, says survey

Health care plan premiums are expected to rise an estimated 10.6% next year in response to a probable increase in medical costs of 8.6%, according to a survey of more than 140 health plans by Sherlock Co., a health care consulting firm.

In comparison, this year's premium hike is 8%. This may sound dire; however, the consulting company pointed out that health care plans had, in past years, overestimated the cost increase.

Fee-for-service health insurance plans leave their enrollees with a greater sense of satisfaction than that experienced by enrollees of managed care plans, according to a study conducted by the Employee Benefit Research Institute. The survey found that while 64% of enrollees reported being extremely or very satisfied with their fee-for-service plans, only 49% of those enrolled in preferred provider organizations and 35% of those in HMOs expressed the same sentiments.

Over the three years ending June 30, 1998, about a quarter of acute care facilities in Pennsylvania have lost money. The results were published by the Pennsylvania Health Care Cost Containment Council after examining and auditing 199 such facilities. Although the average Pennsylvania hospital made money, the average total profit margin was 2.7% in FY 98, down from 3.8% the previous year.

About 50% of infusion therapy services provided from 1995 to 1998 to nursing home patients were medically unnecessary, says a Health and Human Services' Inspector General's Office audit. Among the findings: Suppliers charged skilled-nursing facilities up to 10 times the going rate for infusion drugs — a cost that was then passed along to Medicare. Three companies accounted for about 20% of the infusion therapy costs reimbursed on a national basis by Medicare.

Uninsured Americans in 1998 numbered 44.3 million, according to the Census Bureau. This is an increase of 833,000 over 1997 figures, even though in 19 states the number of uninsured residents

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decreased. Meanwhile, the number of uninsured children, says Physicians for a National Health System, rose by 330,300 in 1998. ▼

What's the latest on the legal front?

Class-action lawsuits against HMOs are taking center stage. Aetna US Healthcare was the second HMO within a week to be hit. The suit, filed in U.S. District Court in Philadelphia, alleges that Aetna's enrollees were not provided with adequate information on how the company makes its coverage and treatment decisions. Louisville, KY-based Humana was also slapped with a similar suit in Miami in which it was alleged that the company concealed information on how it decides which claims it will pay.

Two Columbia/HCA Healthcare executives convicted in July of Medicare fraud were granted a brief reprieve when their sentencing was delayed from Oct. 15 to Dec. 3, 1999. Jay Jarrell, president of Columbia's Southwest Florida division, and Robert Whiteside, director of the company's single-markets division, may be "crafting a cooperation agreement" that may result in a reduced sentence. Currently, the two are facing a maximum of 30 years in prison and $1.5 million each in fines.

Mount Sinai School of Medicine in New York City has paid $2.2 million to settle a Medicare fraud case related to the ongoing Physicians at Teaching Hospitals probe, which is looking into charges of questionable physician billing practices. Mount Sinai is the sixth academic medical center to resolve its charges since the investigation began four years ago. ■

CE objectives

After reading this issue of *Hospital Home Health*, CE participants will be able to:

1. demonstrate their knowledge of some of the more significant issues to impact home care in the past century;
2. identify a skilled nursing service;
3. summarize agencies' gift-giving policies;
4. state the number of Americans without health insurance. ■

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