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How bright of a future should the home care industry expect?

The right spirit will prevail, editorial board member predicts

By **Elizabeth E. Hogue**, JD

Despite predictions of dire consequences and widespread discussion of devastation in the home care industry wrought by the Balanced Budget Act of 1997, the future of home care is extremely bright. Medicare-certified and private duty home care providers should be mindful of 10 characteristics of the home care industry of the future:

1. The future of home care is assured.

Despite debate and skepticism about the survival of home care, the industry's future is absolutely assured. The primary basis for this optimistic attitude rests on the fact that home care's objectives and services are consistent with those policy objectives that receive widespread endorsements by politicians, health policy experts, and the general U.S. population. Specifically, home care generally allows patients to exercise maximum autonomy and independence by remaining at home in the least restrictive, most cost-effective environment possible while still maintaining quality of care. These values, as reflected in the home health model of care, will ultimately prevail.

2. The home care industry must overcome current predictions of gloom and doom.

There is no doubt that the past two years have been rough. The home care industry has been radically changed by the Balanced Budget Act. In all likelihood, these changes are permanent. By the same token, the sometimes pervasive gloom and doom in the industry has taken on considerable life among some providers to the extent that it paralyzes providers and prevents them from taking positive action to respond to new challenges in the industry. This attitude must be resisted.

3. The home health industry of the future will not be dominated by the Medicare program as it has been in the recent past.

The incentives of Medicare reimbursement prior to the Balanced Budget Act rewarded volume, both in terms of the number of patients admitted and the number of visits provided to each patient. Many providers may now regard the period of time when such a system dominated the home health industry as the "good old days." The reality is that those days are likely gone forever.

Providers should no longer view the Medicare home health benefit as the most viable source of reimbursement for their services. Instead they should look to alternative sources such as baby boomers, who likely will have considerable disposable income and be willing to spend it on health care. Agencies must therefore place less emphasis on Medicare reimbursement and focus more specifically on how to meet the needs of aging boomers.

4. Managed care as it has developed in this decade will not survive.

When the process of health care reform failed in 1992, managed care rushed in to fill the void. Although costs were initially reduced, it now appears that the money was simply moved from the pockets of indemnity insurers into the pockets of managed care organizations (MCOs). The growth of the managed care industry in the 1990s did not involve any process of true health care reform, and not surprisingly, many continue to find an unreformed health delivery system dominated by managed care to be less than satisfactory for a variety of reasons. Stemming from this blanket dissatisfaction, state legislatures, Congress, and the courts have begun the long and difficult task of establishing limitations on the ability of MCOs to operate as they have in the past decade.

5. Home care providers must develop new services related to all types of community-based services.

Home health providers must consider new lines of business that are centered on community-based services regardless of whether they are rendered in patients' homes. Such services may include assisting public schools with meeting their obligations under PL-94-142, the federal statute requiring schools to provide services to disabled students.

Parish nursing services are also a viable niche for home care providers. Ambulatory clinics, which assist patients with treatments for asthma, coronary disease, and diabetes among other diseases, should also be explored and developed by the home health industry.

6. Case management will survive and thrive.

There is general recognition that home care providers are case managers. The role of case mangers as reflected in national standards of care published by the Case Management Society of America (CMSA) will be essential to the future of home care in this country. Case managers, according to standards of CMSA, are generally required to assess, evaluate, plan, advocate, and monitor in order to assure quality and cost-effective outcomes. These skills, already well developed in the home care industry, will be in demand in a variety of settings in the future and, as such, agencies should work to further enhance their skills in this crucial area.

7. Home care providers must take responsibility for the future of the industry.

It does not appear that the Health Care Financing Administration (HCFA) has developed a comprehensive plan for the Medicare home care industry. Furthermore, it is unlikely to do so because of the highly politicized environment in which HCFA must operate. It is likely, though, that HCFA will develop new initiatives that may be of assistance to agencies in the future. One such program is tentatively named "Home Care Plus."

Although still in the early stages of development, the program is intended to establish a direct business partnership between home care agencies and HCFA. Participating agencies' claims still will be processed by intermediaries, but under the plan, HCFA will work together with each agency on an individual basis to develop performance standards that the agency must meet each year. An annual review will assure that these standards are met. Keep in mind that even with the development of such initiatives, the future of home care truly rests with the members of the industry and not government agencies.

8. Continuing education is paramount for a strong home care industry.

It almost sounds cliché at this point, but intense education at all levels is a continuing prerequisite of a strong industry. The pace of clinical, regulatory, and reimbursement change is fierce. Despite the pace of change, there is a tendency to view

continuing education as a luxury and not a necessity. Home health agencies must continue their strong commitment to continuing education in order to succeed in the future.

9. **Home care providers must develop data that support the quality and cost-effectiveness of the care provided.**

In general, the home health industry has been poorly served by the lack of data regarding the quality and cost-effectiveness of the services it provides. This absence has contributed to the political vulnerability of the industry as a whole. Accordingly, this deficit must be remedied so agencies can provide hard numbers to support legitimate concerns about radical changes in regulatory control and reimbursement.

10. **This country may be ready to engage in a process of true health care reform in the near future, and home care providers will play a crucial role in a reformed system.**

A truly reformed health care delivery system is likely to be characterized by these components:

- Emphasis will be placed on preventive care, including intensive patient teaching.
- Primary care, as opposed to specialty care, will greatly expand.
- Community-based care will be paramount.
- Nonphysician practitioners, including nurses, will play key roles, but only if they can focus on quality, cost-effective care as consistent, mutually compatible goals for each patient.

Because the home health model of care already focuses on these aspects, home care has a crucial role to play in truly reformed health care delivery system.

The spirit of home care

In addition, the spirit of home care as embodied in the care provided to patients is essential to a reformed system. The spirit of home care includes a deep commitment to patients and the willingness to go the extra mile over and over again to meet their needs.

A fine example of this spirit comes from an agency in Maine. In the middle of winter in a rural area, a home health aide went to a patient's home for the first time to give the patient a bath, among other services.

When the aide walked into the patient's home she noted that the main room was heated by a wood stove and was warm, but the other rooms, including the only bathroom, were closed off. The temperature in those rooms was icy. When the aide entered the bathroom to prepare the bath, she immediately saw that there was a headless bear in the tub. Since she was from the same area of the state, she realized that the bear was part of the family's food for the winter.

Still, she was puzzled as to how to give the patient a bath in these circumstances. However, she remembered she had a Hoyer lift for the patient, so in short order, she took it into the bathroom, lifted the bear out, put the patient in, and when the bath was completed, reversed the procedure leaving a clean patient and a bear no worse for wear.

There was the true spirit of home care in action, and it's this spirit that will ensure the long-term success and viability of the industry in a reformed health care delivery system.

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HCFA makes revisions to beneficiary notices

How they'll affect you

The Health Care Financing Administration (HCFA) has announced its newest requirements concerning the notification of Medicare patients for whom home health agencies believe care will be reduced or terminated.

Under Medicare rules, if a home health agency believes that Medicare will not cover a medical treatment, the agency must notify the beneficiary of such (and, accordingly, that they are responsible for payment) before reducing or terminating physician-ordered care. According to these conditions of participation, agencies must make the notice both orally and in writing, although the format of the notice is the choice of the individual agency provided it meets specified requirements.

The revised requirements state:

- Agencies may continue to develop their own notices as long as the notice is such that its design and readability are easy for the beneficiary to

understand, i.e., italics and ornate typeface are discouraged.

• No body type or text heading should be less than 12-point type.

• In order for the notice to be considered as "received," the beneficiary must be able to comprehend it.

• The notice must take the patient's special needs into account, meaning that it must be provided in the beneficiary's language be it Spanish or Braille, etc., large print, via an interpreter, etc.

• The document must clearly state that it is the agency and not Medicare that is issuing the notice.

• The notice must clearly state a beneficiary's options for payment, continued care services, or the submission of a demand bill. (A demand bill is the process granting a patient the right to ask that the home health agency submit a claim for an official determination from Medicare, a determination that might not otherwise be submitted because the provider believes the care won't be covered.)

• A home health agency must, according to the National Association for Home Care, "promptly submit a claim to the intermediary and report, on the claims submitted, condition code 20, to indicate that the beneficiary believes the services are covered."

• The agency must provide the beneficiary requesting a demand bill with a copy or the claim or a written statement testifying to the fact that the claim was submitted and on what date.

(These notice requirements do not apply in instances when a physician agrees either that care is not needed or that the beneficiary's care should be reduced or terminated.

In the event that there are changes to a beneficiary's care, however, the requirements still hold, as well as in cases where the home health agency expects there might be a change in Medicare payment for certain care services. As a rule, it's advised that home health agencies provide their beneficiaries with the appropriate notice even in cases where a physician terminates care.) ■

Employee or contractor: What's the difference?

When it comes to your staff, check with an expert

In fields such as home health care, it's not uncommon to hire people on a part-time basis, dependent on the number of days they will work or even the number of patients or cases they will handle.

While your intentions are straightforward enough, the waters can become muddied when it comes time to fill out your employee's withholding forms. At that point, the determination must be made whether or not someone is an independent contractor or an employee, a fact that depends on your intent.

According to **John C. Gilliland II,** JD, an attorney who specializes in home health care issues and founder of Gilliland & Associates in Covington, KY, there is no simple, one-size-fits-all definition.

"The problem of whether someone is an independent contractor or an employee depends on the purpose for which you are trying to determine. For instance, there is a set of qualifications to be met for the IRS, then there is one if you're talking about minimum wage and overtime pay. There's another for workers' compensation as well."

According to Gilliland, the most common set of circumstances is for the IRS. There, he explains, the common-law test applies. **(See related article, p. 17.)**

"This test has been developed by the courts over hundreds of years. If you took all the various purposes, the common-law test has boiled them down into the most common, and hence the name," he explains. While this set of guidelines can certainly prove helpful, Gilliland points out that there "is no single controlling factor."

An employee is under employer's control

Confused? Well, it's not surprising. Still, there are a few general guidelines to follow. The first, says Gilliland, is "an employee is subject to an employer's direction who has control over the manner and means by which the work is performed. In contrast, with an independent contractor, the employer is looking only at the outcome and not how it is achieved.

"In home care, very, very few workers are independent contractors, in part because the IRS made a ruling that held all home health agency workers to be employees because Medicare requires that all home health care workers have

SOURCES

- **John C. Gilliland**, II, JD, Gilliland and Associates, 211 Grandview Drive, Suite 205, Covington, KY 41017. Telephone: (606) 344-8515.

supervision. That said, there are still some safe havens where if certain conditions are met, you don't have to withhold taxes from that person's paycheck."

As a general rule, the only place "you might have a shot at someone being an independent contractor is with therapists in private practice and, in some states, medical social workers. When it comes to home health nurses and aides," says Gilliland, "I would have trouble believing they would be."

Gilliland's recommendation: "Obtain legal advice. If you're treating anyone as an independent contractor and haven't had this reviewed by a knowledgeable advisor, it's dangerous."

He advises seeking out a reputable employment labor attorney; while there are accountants who are very knowledgeable about the IRS common-law test, that's usually where their knowledge stops. "The law isn't a part of their training, and this really boils down to more of a legal than a tax question."

Severe penalties could apply

The consequences of "misdiagnosing" an employee can be severe. If, for example, you fail to withhold taxes, the IRS will hit you with financial penalties plus interest — even if the independent contractors have been paying taxes on their own. Penalties are also levied by OSHA and any one of the other governing bodies dealing with labor and employment.

"Depending on the circumstances," notes Gilliland, "these penalties could put you out of business."

Still, there are some who fail to heed solid advice because they don't want to pay for the "employee's" Social Security or benefits. "That's something you can do if you wish, but calling them independent contractors isn't the way," says Gilliland. "What you call someone is virtually meaningless. Calling them an independent contractor doesn't make them one. In this case, the simple, quick fix will come back to bite them." ■

IRS rules regarding independent contractors

An employer must generally withhold income taxes, withhold and pay Social Security and Medicare taxes, and pay unemployment tax on wages paid to an employee. An employer does not generally have to withhold or pay any taxes on payments to independent contractors.

Common-law rules

To determine whether an individual is an employee or an independent contractor under the common law, the relationship of the worker and the business must be examined. All evidence of control and independence must be considered. In any employee-independent contractor determination, all information that provides evidence of the degree of control and the degree of independence must be considered.

Facts that provide evidence of the degree of control and independence fall into three categories: behavioral control, financial control, and the type of relationship of the parties as shown below.

1. Behavioral control.

Facts that show whether the business has a right to direct and control how the worker does the task for which the worker is hired include the type and degree of:

• Instructions the business gives the worker. An employee is generally subject to the business's instructions about when, where, and how to work. All of the following are examples of types of instructions about how to do work:

— when and where to do the work;

— what tools or equipment to use;

— what workers to hire or to assist with the work;

— where to purchase supplies and services;

— what work must be performed by a specified individual;

— what order or sequence to follow.

The amount of instruction needed varies among different jobs. Even if no instructions are given, sufficient behavioral control may exist if the employer has the right to control how the work results are achieved. A business may lack the knowledge to instruct some highly specialized professionals; in other cases, the task may require little or no instruction.

The key consideration is whether the business has retained the right to control the details of a worker's performance or instead has given up that right.

• An employee may be trained to perform services in a particular manner. Independent contractors ordinarily use their own methods.

2. Financial control.

Facts that show whether the business has a right to control the business aspects of the worker's job include:

• The extent to which the worker has unreimbursed business expenses. Independent contractors are more likely to have unreimbursed expenses than are employees. Fixed ongoing costs that are incurred regardless of whether work is currently being performed are especially important. However, employees may also incur unreimbursed expenses in connection with the services they perform for their business.

• The extent of the worker's investment. An independent contractor often has a significant investment in the facilities he or she uses in performing services for someone else. However, a significant investment is not necessary for independent contractor status.

• The extent to which the worker makes services available to the relevant market. An independent contractor is generally free to seek out business opportunities. Independent contractors often advertise, maintain a visible business location, and are available to work in the relevant market.

• How the business pays the worker. An employee is generally guaranteed a regular wage amount for an hourly, weekly, or other period of time. This usually indicates that a worker is an employee, even when the wage or salary is supplemented by a commission. An independent contractor is usually paid by a flat fee for the job. However, it is common in some professions, such as law, to pay independent contractors hourly.

• The extent to which the worker can realize a profit or loss. An independent contractor can make a profit or loss.

3. Relationship type.

Facts that show the parties' type of relationship include:

• Written contracts describing the relationship the parties intended to create.

• Whether the business provides the worker with employee-type benefits, such as insurance, a pension plan, vacation pay, or sick pay.

• The permanency of the relationship. If you engage a worker with the expectation that the relationship will continue indefinitely, rather than for a specific project or period, this is generally considered evidence that your intent was to create an employer-employee relationship.

• The extent to which services performed by the worker are a key aspect of the regular business of the company. If a worker provides services that are a key aspect of your regular business activity, it is more likely that you will have the right to direct and control his or her activities. For example, if a law firm hires an attorney, it is likely that it will present the attorney's work as its own and would have the right to control or direct that work. This would indicate an employer-employee relationship.

IRS help is available

If you want the IRS to determine whether a worker is an employee, file Form SS-8, Determination of Employee Work Status for Purposes of Federal Employment Taxes and Income Tax Withholding, with the IRS.

Industry examples

The following examples from the IRS may help you properly classify your workers.

1. Computer industry

Example: Steve Smith, a computer programmer, is laid off when Megabyte Inc. downsizes. Megabyte agrees to pay Steve a flat amount to complete a one-time project to create a certain product.

It is not clear how long it will take to complete the project, and Steve is not guaranteed any minimum payment for the hours spent on the program. Megabyte provides Steve with no instructions beyond the specifications for the product itself. Steve and Megabyte have a written contract, which provides that Steve is considered to be an independent contractor, is required to pay federal and state taxes, and receives no benefits from Megabyte.

Megabyte will file a Form 1099-MISC. Steve does the work on a new high-end computer which cost him $7,000. Steve works at home and is not expected or allowed to attend meetings of the software development group. Steve is an independent contractor.

2. Attorney

Example: Donna Yuma is a sole practitioner who rents office space and pays for the following items: telephone, computer, on-line legal research linkup, fax machine, and photocopier. Donna buys office supplies and pays bar dues and membership dues for three other professional organizations. Donna has a part-time receptionist who also does the bookkeeping. She pays the receptionist, withholds and pays federal and state employment taxes, and files a Form W-2 each year.

For the past two years, Donna has had only three clients, corporations with which there have been longstanding relationships. Donna charges the corporations an hourly rate for her services, sending monthly bills detailing the work performed for the prior month. The bills include charges for long distance calls, on-line research time, fax charges, photocopies, postage, and travel, costs for which the corporations have agreed to reimburse her. Donna is an independent contractor.

3. Taxicab driver

Example: Tom Spruce rents a cab from Taft Cab Co. for $150 per day. He pays the costs of maintaining and operating the cab. Tom Spruce keeps all fares he receives from customers. Although he receives the benefit of Taft's two-way radio communication equipment, dispatcher, and advertising, these items benefit both Taft and Tom Spruce. Tom Spruce is an independent contractor.

4. Salesperson

To determine whether salespeople are employees under the usual common-law rules, you must evaluate each individual case. If a salesperson who works for you does not meet the tests for a common-law employee, discussed earlier, you do not have to withhold income tax from his or her pay.

However, even if a salesperson is not an employee under the usual common-law rules, his or her pay may still be subject to social security, Medicare, and FUTA taxes. To determine whether a salesperson is an employee for social security, Medicare, and FUTA tax purposes, the salesperson must meet all eight elements of a statutory employee test. A salesperson is an employee for social security, Medicare, and FUTA tax purposes if he or she:

- works full-time for one person or company except, possibly, for sideline sales activities on behalf of some other person;
- sells on behalf of, and turns his or her orders over to, the person or company for which he or she works;
- sells to wholesalers, retailers, contractors, or operators of hotels, restaurants, or similar establishments;
- sells merchandise for resale, or supplies for use in the customer's business;
- agrees to do substantially all of this work personally;
- has no substantial investment in the facilities used to do the work, other than in facilities for transportation;
- maintains a continuing relationship with the person or company for which he or she works;
- is not an employee under common-law rules.

Source: IInternal Revenue Service. *Employer's Supplemental Tax Guide. IRS Publications 15-A. Washington, DC; January 2000.* ■

List of top 100 hospitals released

The results from "100 Top Hospitals: Benchmarks for Success," a survey conducted by the Baltimore-based health care information company HCIA, are out.

The study, which examined 2,946 acute-care hospitals from across the country and rated them on nine measures of clinical, operational, and financial performance, found that those who consistently perform in the top percentile are those who are operating with a slightly leaner work force than the industry average, but whose employees are paid substantially more.

Prepare for change

Other similar characteristics are that these hospitals have lower mortality and complication rates than the industry average and are spending approximately $1,000 less per discharge than other hospitals. They display twice the capacity to cover debt with available funds and invest 7% more per discharge on capital improvements.

According to HCIA, evidence exists that those hospitals that made the grade anticipated the negative effects of changes in Medicare reimbursement and changed operations accordingly. Not only did small community hospitals fare

well, a positive omen for good management practices under the Medicare crunch, but the South continued to dominate the list bringing 44 hospitals to the group. The list was not ranked within each of the five following categories but are presented here alphabetically:

Hospitals with fewer than 100 beds

American Fork Hospital (UT)
Baptist DeKalb Hospital, Smithville, TN
Buffalo (MN) Hospital
Castleview Hospital, Price, UT
Donalsonville (GA) Hospital
Gerber Memorial Hospital, Fremont, MI
Northfield (MN) Hospital
Otsego Memorial Hospital, Gaylord, MI
Our Lady of the Way Hospital, Martin, KY
Powell (WY) Hospital
Punxsutawney (PA) Area Hospital
Shelby Memorial Hospital, Shelbyville, IL
St. Benedicts Family Medical Center, Jerome, ID
St. Clare Hospital, Lakewood, WA
St. John's Mercy Hospital, Washington, MO
Tri-City Community Hospital, Jourdanton, TX
Valley View Medical Center, Cedar City, UT
Wedowee (AL) Hospital
Wellstar Douglas Hospital, Douglasville, GA
Wilcox Memorial Hospital, Lihue, HI

Hospitals with 100 to 249 beds

Appleton (WI) Medical Center
Bellin Memorial Hospital, Green Bay, WI
Brandon (FL) Regional Hospital
Bulloch Memorial Hospital, Statesboro, GA
Cape Cod Hospital, Barnstable, MA
Cottonwood Hospital Medical Center, Murray, UT
Gulf Coast Medical Center, Panama City, FL
Indian Path Medical Center, Kingsport, TN
Inova Fair Oaks Hospital, Fairfax, VA
Meadowview Regional Medical Center, Maysville, KY
Mease Countryside Hospital, Safety Harbor, FL
Medical Center of Southeastern Oklahoma, Durant
Mercy Hospital Anderson, Cincinnati
Milford-Whitinsville Regional Hospital, Milford, MA
Mills-Peninsula Health Services, Burlingame, CA
North Florida Regional Medical Center, Gainesville
Seven Rivers Community Hospital, Crystal River, FL
St. Francis Hospital, Federal Way, WA
St. Joseph Medical Center, Tacoma, WA
Theda Clark Medical Center, Neenah, WI
William Beaumont Hospital, Troy, MI

Major teaching hospitals with 400+ beds

Albany (NY) Medical Center Hospital
Baystate Medical Center, Springfield, MA
Brigham and Women's Hospital, Boston
Christ Hospital and Medical Center, Oak Lawn, IL
Evanston (IL) Northwestern Healthcare
Hospital of St. Raphael, New Haven, CT
Lutheran General Hospital, Park Ridge, IL
St. Joseph Mercy Health System, Ann Arbor, MI
Sparrow Health System, Lansing, MI
Spectrum health Downtown Campus, Grand Rapids, MI
Univ. of Tennessee Memorial Hospital, Knoxville
Univ. of Virginia Medical Center, Charlottesville
Vanderbilt University Hospital, Nashville
Washington (DC) Hospital Center
William Beaumont Hospital, Royal Oak, MI

Nonteaching hospitals with 250+ beds

Aventura Hospital ad Medical Center, Miami
Baptist Hospital of East Tennessee, Knoxville
Baptist Hospital of Miami
Blake Medical Center, Bradenton, FL
Clear Lake Regional Medical Center, Webster, TX
Good Shepherd Medical Center, Longview, TX
Hemet (CA) Valley Medical Center
Hoffman Estates (IL) Medical Center
Leesburg (FL) Regional Medical Center
Licking Memorial Hospital, Newark, OH
Martin Memorial Health Systems, Stuart, FL
Memorial Hospital of Jacksonville, FL
Middletown (OH) Regional Hospital
Morton Plant Hospital, Clearwater, FL
Munroe Regional Medical Center, Ocala, FL
Regional Medical Center-Bayonet Point, Hudson, FL
Spring Branch Medical Center, Houston
St. Rita's Medical Center, Lima, OH
Trident Regional Medical Center, Charleston, SC
Wellstar Kennestone Hospital, Marietta, GA

Minor teaching hospitals with 250+ beds

Aultman Hospital, Canton, OH
Chippenham and Johnston-Willis Hospitals, Richmond, VA
Exempla St. Joseph Hospital, Denver
Harris Methodist Fort Worth (TX)
Inova Fairfax Hospital, Falls Church, VA
Lancaster (PA) General Hospital
McAllen (TX) Medical Center
Memorial Hospital System, Houston
Meridia Hillcrest Hospital, Mayfield Heights, OH
Munson Medical Center, Traverse City, MI
Palmetto General Hospital, Hialeah, FL
Pamona (CA) Valley Hospital Medical Center
Providence Portland (OR) Medical Center
Providence St. Vincent Medical Center, Portland, OR
Rochester (MN) Methodist Hospital
South Miami (FL) Hospital
Southwest Washington Medical Center, Vancouver
St. Cloud (MN) Hospital
St. John's Mercy Medical Center, St. Louis
St. Mary's Medical Center, Duluth, MN
St. Thomas Health Services, Nashville, TN
St. Vincent Hospitals and Health Services, Indianapolis
SwedishAmerican Health System, Rockford, IL
Wellmont Holston Valley Medical Center, Kingsport, TN
York (PA) Hospital ■

NEWS BRIEFS

What are the latest mergers and acquisitions?

Sacramento, CA-based Sutter Health has completed its purchase of the 420-bed Summit Medical Center in Oakland, CA, following the rejection by a federal judge of an antitrust challenge posed by the California attorney general.

Sutter, which owns 26 hospitals in addition to Summit, plans to merge its latest acquisition with the 555-bed Alta Bates Medical Center in Berkeley, CA. Sutter will spend about $450 million on capital improvements, as well as assume $100 million of Summit's debt.

Sparta Surgical Corp. in Concord, CA, has signed a non-binding letter of intent to purchase all the common stock of HomeTech Medical Services Inc. in Stockton, CA. Sparta is a home medical equipment manufacturer and distributor.

The 30-bed Manhattan Eye, Ear, and Throat Hospital (MEETH) was recently denied permission to sell its campus for $41 million to Memorial Sloan-Kettering Cancer Center in New York City by a state Supreme Court judge. Under New York state law, not-for-profit organizations, such as MEETH, need the approval of the state Supreme Court to sell.

The judge deemed that while MEETH might have been fairly compensated for the value of the real estate, the board of directors, which petitioned the court to sell, did not take into account offers from competing avenues which would have allowed the 130-year old hospital to continue operations.

Under MEETH's proposal, Sloan-Kettering would have used the space to develop a breast cancer center while a real estate developer had plans to construct an apartment building. MEETH, meanwhile, had planned to partner with New York Presbyterian Hospital to open and run outpatient centers in underserved areas of the city. ▼

New association formed

Three of the home care industry's largest associations have announced their intent to merge. The Home Health Services and Staffing Association (HHSSA), the National Association for Home Medical Equipment Services (NAMES), and the home care division of the Health Industry Distributors Association are combining their memberships to form the American Association for Homecare (AAH).

The new association will be based in Alexandria, VA, and have about 1,000 members, representing more than 3,000 home care locations nationwide. NAMES brings to the group some 800 members while the remaining two associations each are bringing about 200 members. AAH's focus will be on issues concerning home health agencies and home medical equipment companies. ▼

HCFA offers service that's above-average

According to the American Customer Satisfaction Index, a study by the University of Michigan Business School, the Health Care Financing Administration (HCFA) ranks as offering above-average customer service. That's better than most government agencies but worse than private-sector businesses.

HCFA earned a score of 71 out of a possible 100 in the study, which looked at 29 "high impact" federal agencies that serve 90% of the American public. The average score for government agencies was 68.6 while the private sector finished with an average score of 73. ▼

Senior's health costs are on the rise

According to a recent study by the American Association of Retired Persons titled "Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections," on the average, elderly Americans are paying more than $2,400 — about 19% of their income — on out-of-pocket health care costs.

A quarter of all Medicare beneficiaries, the study goes on to say, will pay more than $3,000 annually in out-of-pocket medical expenses. More than half of these out-of-pocket payments go toward health care goods and services as opposed to premiums and deductibles, the study reported. Those expenses include such items as Medicare premiums, copays, deductibles, and premiums for supplemental insurance, as well as prescription drugs and eyeglasses. Prescription drugs, the study found, constitute 17% of total out-of-pocket spending and equal what seniors spend on physician care, vision services, and medical supplies combined.

Seniors with Medical supplemental insurance, known as MediGap, will spend $3,250 in out-of-pocket expenses due in part to the cost of the MediGap premium. This is compared to those beneficiaries who participate in Medicare health maintenance organizations and don't generally pay supplemental premiums. They pay $1,630 on average in out-of-pocket costs.

Long-term nursing home care and home health payments were considered as long-term costs and therefore excluded from the study. ▼

Eight files you should keep

The Health and Human Services' Office of the Inspector General (OIG) has urged home medical equipment suppliers and home health agencies to self-disclose any legal or internal regulatory violations they may detect or risk stiffer penalties. To that end, the OIG has issued a checklist of areas for which organizations should audit and retain documentation. They are:

- all internal audit results;
- hotline call logs and their resolutions;
- corrective action plans;
- due diligence efforts;
- employee training records including the number of training hours;
- disciplinary action and modification;
- distribution of policies and procedures and disclosures;
- overpayment refunds to the carrier or intermediary. ▼

PROs enter home health

If the Health Care Financing Administration (HCFA) has its way, home health agencies may be seeing more of peer review organizations (PRO). HCFA is encouraging the PRO program, which it administers, to expand its quality initiatives into the home care arena. PROs at one time were limited to hospitals, but in 1986, Congress

COMING IN FUTURE MONTHS

- Errors and omission insurance
- Patient prescription handout
- Contract negotiations
- Referrals: Should you give them?
- Working with the media

agreed to expand their jurisdiction to include home health agencies and skilled nursing facilities. Up until now very few PROs chose to enter the home health sector, but under HCFA's urging that might be about to change.

The program, which consists of 53 PROs each responsible for ensuring the quality, effectiveness, efficiency, and economy of health care service provided to Medicare beneficiaries in a given state and territory, is currently engaged in what HCFA calls the Sixth Scope of Work.

Under that, HCFA has requested that PROs submit proposals describing their plans involving home health agencies and skilled nursing facilities, as well as for a new quality project based on the use of OASIS data for home health agencies' outcome improvement. ▼

NAHC thanks Congress, recognizes advocates

The National Association for Home Care (NAHC) in Washington, DC, has released its list of top home care advocates for 1999 in the U.S. House of Representative and in the Senate. The top advocates in the Senate are:

• **Sen. William Roth** (R-DE). As the chair of the Senate Finance Committee, Roth formulated a home care provision package for inclusion in the Balanced Budget Amendment Refinement Act and for marshaling the Finance Committee and obtaining full Senate support for the measure.

• **Sen. Tom Daschle** (D-SD). Daschle, as the senate minority leader, introduced S 1678 and rallied support from the Democrats to support meaningful home health relief, thus helping to convince the administration to take action.

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• **Sen. James Jeffords** (R-VT). Jeffords introduced S 1358 and advocated for home and hospice care in critical Senate Finance Committee deliberations on the BBA Refinement Act.

• **Sen. Susan Collins** (R-ME). Collins served as chair of the Governmental Affairs Subcommittee on Investigations and introduced S 1063. She conducted hearings on the need for home health relief and on the regulatory burdens faced by the industry.

• **Sen. Christopher "Kit" Bond** (R-MO). Bond worked as chair of the Senate Small Business Committee to introduce S 1063. He fought for regulatory relief for home health care agencies and frequently spoke on behalf of home care beneficiaries and providers.

• **Sen. John Chafee** (R-RI). The late senator introduced home health relief legislation, played an important role in securing BBA relief during the past Congress and served as a champion of home care throughout his time in office.

In the House, NAHC honors:

• **Rep. Bill Thomas** (R-CA). Thomas, as chair of the House Ways and Means Subcommittee on Health, was a leader among those seeking relief through the BBA Refinement Act and ensured that home health and hospice issues were addressed throughout the year.

• **Rep. Pete Stark** (D-CA). As a ranking member of the House Ways and Means Subcommittee on Health, Stark worked tirelessly to correct the "technical glitch" in the provisions the delays the 15% automatic reduction and to reform home health surety bonds.

• **Rep. J.C. Watts** (R-OK). Watts served as Chair of the Republican Conference and introduced HR 2628, the home health industry's legislative package to reform IPS.

• **Rep. John Peterson** (R-PA). Peterson played an important role in the creation of the Home Health Working Group as part of the House Rural Health Caucus. Under his leadership, the working group was successful in communicating a number of home health and hospice concerns to Health Care Financing Administration. ■

CE objectives

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

1. Discuss the characteristics of a reformed health care delivery system.

2. Recognize Internal Revenue Service examples of work instructions.

3. Identify the characteristics of top-performing hospitals.

4. List those administrative areas for which all documentation should be saved. ■