

HOME CARE WEEK™

News & Analysis On Reimbursement, Regulations, Finance, Operations, & Compliance

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Compliance

4 Strategies To Protect Yourself From Whistleblower Suits

Arkansas hospice slapped with qui tam suit filed by competitor.

You may think you've got all the bases covered in heading off whistleblower lawsuits, but you shouldn't overlook the opposing team.

Little Rock, Ark.-based for-profit **Hospice Home Care Inc.** (HHC) is learning that lesson the hard way, thanks to a *qui tam* suit filed by non-profit competitor **Arkansas Hospice Inc.**, also of Little Rock. Arkansas Hospice filed the *qui tam* complaint in 2004, but the suit was just joined by the government and unsealed in federal court last month.

In the original *qui tam* filing obtained by **Eli**, Arkansas Hospice alleges that HHC billed for patients who resided in nursing homes at the general inpatient (GIP) level when they really only qualified for — and HHC only furnished — routine hospice care. HHC used the GIP billing to tell patients and referral sources that the patients wouldn't have to pay for their nursing home costs, because room and board would be covered under the GIP payment.

Background: In 2004, Medicare paid about \$500 a day for GIP while routine hospice care was reimbursed at about \$125 per day, Arkansas U.S. Attorney **Jane Duke** notes in a release.

So far, government prosecutors have reviewed records for 34 patients and found 257 allegedly false claims totaling \$1.4 million in overpayments for unnecessary and unprovided GIP, Duke says.

After families of HHC patients told Arkansas Hospice about their concerns, the hospice spent about \$25,000 to \$30,000 investigating the matter before filing a lawsuit, CEO **Michael Aureli** told the *Arkansas Business* newspaper. Arkansas Hospice and HHC didn't respond to requests for comment by press time.

The bad press from the lawsuit will probably hurt the Arkansas hospice industry overall, Aureli told the newspaper. But the hospice felt it had an obligation to file the suit.

Competitors aren't the first place home care providers suspect potential whistleblowers to come from. "Many providers focus on employees — especially disgruntled former employees — as the source of *qui tam* suits," notes Washington, D.C.-based health care attorney **Elizabeth Hogue**.

But competitor-driven lawsuits are more common than some providers realize, notes attorney **Joel Hamme** with **Powers Pyles Sutter & Verville** in Washington, D.C. "I would suspect that competitors are the second- or third-biggest source of *qui tam* actions after employees and perhaps consumers," Hamme tells **Eli**. "After all, employees, competitors, and consumers are the ones most likely to know of and have familiarity with a provider's services and practices."

The reason there aren't more competitor-filed *qui tam* suits is probably because providers don't like the idea of getting their hands dirty in a prolonged whistleblower case, says attorney **Robert Markette Jr.** with **Gilliland & Markette** in Indianapolis. Many providers prefer to report their concerns to authorities such as a state Medicare fraud unit or the **HHS Office of Inspector General** and move on, he notes.

Competitors also usually want the prohibited practice to stop hurting their own business, but they aren't as interested in gaining financially from a lawsuit as individual relators are, Markette believes. And they often hope for a quicker resolution from enforcement versus litigious means, since whistleblower suits can drag on for years.

Try this: Often the quickest route to resolution can be contacting the offending party directly, Hogue advises clients. Letting them know that you're aware of their behavior and explaining why it is wrong can sometimes stop it in its tracks.

Competitors also usually lack the specific claims knowledge that former employees use to file *qui tam* suits. Instead, they hear about the provider's relationships with referral sources and have grounds for anti-kickback statute charges, Markette adds.

Ward Off Qui Tam Actions With These Steps

To protect yourself against whistleblower lawsuits originating with your competitors, follow this expert advice:

- 1. Perform a self-evaluation for compliance.** Competitor whistleblower suits generally get filed because a provider is performing some improper action that is hurting the competitor's business, Hamme points out. Thus, smart providers will "examine any and all areas that give them a real or potential competitive or financial advantage over others in the same market area," he recommends.

Then they should “ascertain that any such advantage is legitimate and reasonable.”

Bonus: This can help you assess your marketing efforts as well, he adds.

To determine legitimacy, ask yourself questions like whether higher levels of care are necessary and whether that necessity is documented, he says.

2. Take competitor reports seriously. If you receive a call from a competitor calling you out on a certain practice, your first impulse may be to tell them off. But you should take the call seriously and respond appropriately to head off fraud reports to authorities or whistleblower suits like this one, Hogue cautions.

You should promise to investigate the alleged impropriety and get back to the caller with the truth, Hogue advises. Or, if you know the practice to be lawful, you can explain why it is so.

Hogue encourages clients to avoid bad press and take their concerns directly to the affected parties. “When providers engage in fraud, it hurts everyone in the industry,” Hogue tells **Eli**. Especially in this environment of health care reform and looming funding cuts, “Congress and regulators are looking for any excuse to slash funding.”

3. Stand up to improper practices. In today’s competitive environment, providers are tempted to follow another provider’s example when a referral source such as a physician or nursing home tells them “everyone’s doing it.”

“You should be strong enough to say ‘no,’” Markette exhorts.

For example, just because another hospice is paying a nursing home more than fair market value for room and board doesn’t mean it’s OK for you to do it, too.

The short-term gains aren’t worth the long-term consequences, Markette warns. “You’re going to get caught.” Upset competitors will turn to the authorities or the courts for justice. Under the False Claims Act, you could wind up paying \$1 million for \$100,000 worth of claims due to restitution, penalties assessed per claim, and treble damage levels.

“A conspiracy only works when everyone’s happy,” Markette stresses. When you have a competitive advantage over another provider due to questionable practices, that entity isn’t happy.

4. Don’t forget your compliance plan. You should codify your whistleblower-prevention prac-

tices in your compliance plan, Markette advises. Also include how you will respond when you learn of other providers’ improper practices. ❖

*Note: To sign up for Robert Markette Jr.’s July 22 **Eli**-sponsored audioconference “Handle Fraud, Whistleblowers, and Qui Tam Actions before the Federal False Claims Act Does,” go to www.audioeducator.com/industry_conference.php?id=1507 or call 1-800-508-2582.*

Hospice

Inpatient Care Tops Reviewers’ Hospice Hit List

Whistleblower suit shows why your non-routine hospice claims must be squeaky clean.

Are your records ready to withstand the increased scrutiny of one of the newest hospice hot spots — general inpatient care?

At the heart of a recently unsealed whistleblower lawsuit lie allegations that an Arkansas hospice’s GIP claims were unnecessary and the care level not provided (*see story, p. 178*). That’s just one example of the critical eye this area is now under, industry experts say.

Why: Medicare currently pays \$622.66 per day for GIP care compared to \$140.14 for routine home care, the **Centers for Medicare & Medicaid Services** says in a Sept. 10, 2008 memo. That big pay increase leads intermediaries and other authorities to want to make sure the difference is legitimate.

The interest is compounded by the fact that GIP utilization has increased in recent years, notes **Samira Beckwith** with **Hope Hospice and Community Services** in Ft. Myers, Fla. But that increase is more because GIP was not utilized enough before, not because there is inappropriate use of the care level now, Beckwith maintains. “Just because there’s an increase doesn’t mean there’s something wrong,” she insists.

Kickback complication: GIP reimbursement gets even more dicey when the nursing home part of the equation is considered, experts say. Artificially inflating GIP care is “an illegal way to pay nursing homes a lot more money,” Beckwith notes.

In the whistleblower lawsuit, relator **Arkansas Hospice Inc.** of Little Rock accuses competitor **Hospice Home Care Inc.** of paying nursing homes more than fair market value for room and board for GIP patients. And HHC claimed to referral sources and patients that the nursing home stay was “free” to

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Budget

Home Care Gears Up To Fight Further Cuts

Latest proposals take biggest bite yet out of home care funding.

As public concern about the cost of health care reform rises, lawmakers are turning to funding sources to fuel their reform ideas — and home care looks likely to suffer the consequences.

President Obama recently called for \$313 billion in additional Medicare and Medicaid cuts, including so-called “productivity adjustments” that would decrease home health agency payments, notes the **National Association for Home Care & Hospice**.

And House Democrats released a draft of their health care reform bill that’s even more punishing. “The House committees have included every possible recommendation by the **Medicare Payment Advisory Commission** in an effort to generate the maximum possible funding for health care reform,” NAHC laments. “This includes a freeze in the 2010 market basket update, rebasing home health payment rates in 2011, and accelerating case-mix ‘creep’ adjustments in the Medicare home health prospective payment system.” The draft bill also floats a “productivity adjustment” beginning in 2010.

Take action: NAHC calls on providers to reach out to their elected representatives about the legislative proposal. If HHAs “react vociferously to these proposed cuts, it will persuade members of Congress to vote instead for taxing health care benefits and other taxes to help cover the costs of the program,” the trade group believes.

Home medical equipment suppliers are under the budget hammer as well. The House bill contains cuts for wheelchairs via elimination of the first-month purchase option, notes the **American Association for Homecare**. And although not stated in the draft, AAHomecare and the **National Association for Independent Medical Equipment Suppliers** expect lawmakers to raise oxygen cuts as a health care reform funding source as well.

The trade groups urge HME suppliers to contact their reps, too. “Now is the time to make your voice heard,” NAIMES says. ❖

patients due to the GIP level of billing, the *qui tam* lawsuit alleges.

Hospices can’t provide GIP care for any old reason. The Medicare hospice benefit allows for short spells of GIP care only when it’s not feasible to provide the needed services in any other setting, explains consultant **Judy Adams** with **Adams Home Care Consulting** in Chapel Hill, N.C.

“Reasons for general inpatient stay include pain control, management of acute or chronic symptoms, medication adjustment, or treatment stabilization that have not responded in the home or other settings or are [to] such a degree that it requires the higher level of staffing available in the inpatient setting,” Adams relates.

“The criteria for admission to a higher level of care in hospice is actually pretty clear,” believes consultant **Beth Carpenter** with **Beth Carpenter & Associates** in Barrington, Ill. “It is specifically for a period of crisis.” ❖

Note: For tips on polishing your GIP documentation skills, see next week’s issue of Eli’s Home Care Week.

Human Resources

Use These 5 Tips To Become A Better Boss

Know when to use praise — and when not to.

Trying to figure out how to spur your home care employees on to new heights? You may only have to look as far as your own supervisory skills. You can ensure that you are a great supervisor by following these five tenets of excellent leadership:

1. Be accessible. While you may value your privacy and quiet time, an open-door policy is crucial if you want your employees to feel that they can come to you with any problem. Leaving your door open will also ensure that you know about problems as soon as they arise.

Strategy: Don’t just wait for your employees to come to you, get out of your office and interact with them. This will help them feel more connected to you and allow you to be a quick resource for them. This is an extra-big challenge, and extra-crucial, in the home care work environment.

2. Take interest in your employees. The best bosses go out of their way to make sure every employee feels valued and interesting.

Try this: Find out who your employees are. What makes them interesting? What hidden skills or talents do they possess? What makes them special? This personal relationship with your employees will build their loyalty to you and to your company.

The conversation doesn't always have to be about you, say leadership experts **Mark Sekula** and **Jeffrey Neidorfler** of **Kahler Slater Inc.** "Occasionally disclose personal information. It will help people understand you better," they say.

3. Personalize your approach. No two employees are the same, so you can't expect to treat everyone the same and get great results.

Think of it this way: "Some of your subordinates need a short leash, some a long leash. Some need lots of freedom to perform best, some prefer structure," says **Michael Feiner**, author of *The Feiner Points Of Leadership*.

And you don't have to worry that your new approach will seem "unfair" or "unequal." "Equity comes from giving each subordinate what he needs to perform, even though these needs may be different," Feiner explains.

4. Recognize accomplishments and praise regularly. More often than not, your employees don't think they are praised often enough for all the hard work they perform.

Best approach: You can't over-praise or over-recognize your hard workers. Use multiple methods and every opportunity to show them how much you appreciate their efforts.

Caution: What you can't do is praise mediocre work or recognize every small accomplishment. Keep your bar set high so that your employees perform to the best of their abilities to reach it.

5. Lead by example. Your actions speak way louder than your words. As the person in charge, your employees are watching you every minute to determine what's acceptable and what's not.

Consider this: When you choose to break the rules that you've set for everyone else, you're teaching your employees that your standards don't mean anything — and that they don't really need to practice what you preach. ❖

Policy

Obama Administration Prioritizes Olmstead Compliance

Will new initiative be mere lip service or bring real change?

Despite the **U.S. Supreme Court's** landmark *Olmstead* decision 10 years ago, wait lists for state-funded home care programs remain long in many places. Now the Obama administration is trying to address that problem.

The *Olmstead* decision requires the government to serve beneficiaries in their least restrictive environment — at home. But many states have not followed through by offering home care as an equal alternative for institutional care, particularly for the disabled.

President Obama has designated 2009 as "The Year of Community Living" and instructed the **Department of Health and Human Services** and other government agencies to collaborate on making

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community-based care for the disabled and elderly a priority, HHS Secretary **Kathleen Sebelius** notes in a release.

For example: In the June 22 *Federal Register*, the **Centers for Medicare & Medicaid Services** gives advance notice that it will publish a proposed rule focusing on how state waiver programs can be based on need rather than condition or diagnosis. “Unnecessary institutionalization may constitute discrimination under the [Americans with Disabilities Act],” CMS points out in the notice.

HHS and its partners will also offer more housing vouchers for beneficiaries transitioning to the home, make grant funds available to states to strengthen and expand HHS’s Aging and Disability Resource Center Programs, and will hold listening

sessions on “overcoming barriers to community-based living for people with disabilities and the elderly,” the release notes. “ADRCs provide ‘one-stop shop’ sources of information, one-on-one counseling, and streamlined access to programs and services that can enable people to remain in their own homes and communities,” CMS explains in a separate release.

HHS also will step up enforcement of *Olmstead* and ADA requirements, it says.

“Since *Olmstead*, progress has been made,” the **National Association for Home Care & Hospice** says. “But waiting lists for community services have grown considerably and many individuals who would like to receive community services are not able to obtain them.” ❖

Industry Notes

OIG Touts Billions In Fraud Recoveries

Feds go after billing company employees.

If you’re wondering how much incentive regulators have to monitor your compliance, look no further than the **HHS Office of Inspector General’s** latest semiannual report to Congress.

In the first half of fiscal year 2009, the OIG generated \$2.4 billion in recoveries from providers engaged in fraud and abuse, the watchdog agency says. “These recoveries reflect our dedicated efforts to reduce fraud, waste, and abuse in HHS programs,” Inspector General **Daniel Levinson** says in a release.

And providers should expect the scrutiny to only get worse under the **Obama** administration. “We will continue to employ all of our audit, evaluation, investigation, and legal tools ... to accomplish this vital and expanding mission,” Levinson adds.

In addition to home health agency and hospice cases (see *Eli’s HCW, Vol. XVIII, No. 22, p. 174*), the OIG semiannual report profiles the scheme of two Florida durable medical equipment billing company owners who ended up in prison.

All Med Billing Corp. and owners **Abner** and **Mabel Diaz** submitted claims to Medicare on behalf of suppliers for equipment that had not been ordered by physicians or delivered to the beneficiaries as claimed, the OIG says. “All Med facilitated the fraudulent billings by assisting in the concealment of the true owners of the DME companies, forging prescriptions, forging certificates of medical



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necessity, improperly acquiring the identities of Medicare beneficiaries, and directing the DME companies to use certain billing codes.”

The Diazes were each sentenced to 14 years in prison and ordered to repay \$126 million. Another All Med employee, **Suleidy Cano**, was sentenced to 11 years in prison for identify theft and fraud.

The full report is online at www.oig.hhs.gov/publications/docs/semiannual/2009/semiannual_spring2009.pdf.

• **Watch out — your employee liability may extend further** than you think. A Texas state court has awarded former **AmeriCare Home Health Services** employee **Andrea Davila** \$1.7 million for injuries she suffered in a 2005 accident while driving to a patient's home, reports **Action 4 News** in Harlingen, Texas. “Davila's attorneys argued that she was forced to travel in unsafe areas to ensure a timely delivery of health care to certain patients,” the news station says.

An attorney procedural error contributed to the loss, AmeriCare Nursing Administrator **Mario Garza** says in a statement released to Action 4 News. The San Juan, PR agency will appeal the ruling.

• **Hospices served by regional home health intermediary Cahaba GBA** will finally start seeing their money from the wage index restoration signed into law in February in the stimulus bill (see *Eli's HCW, Vol. XVIII, No. 8, p. 58*).

On April 6, the Medicare claims system started paying hospices without the budget neutrality adjustment factor (BNAF) phase-out originally set for 2009. But the law required the delay of the BNAF phase-out for all of the fiscal year.

On June 17, Cahaba began adjusting claims with dates of service after Oct. 1, 2008 but paid at the lower rate before April 6. “Claims being adjusted as a result of this instruction can be identified by the type of bill ‘8XI’ and ‘CR6418’ in the ‘Remarks’ field on Page 04,” Cahaba explains in an e-mail to providers.

The **Centers for Medicare & Medicaid Services** gave contractors six months from the April system update to reprocess the affected claims, Cahaba notes in its June newsletter for providers.

• **If you're looking for a little help**, you may want to check out the newest resource from new HH MAC NHIC.

Home Health Medicare Administrative Contractor **National Health Insurance Corp.**, which took over from **National Government Services**, is making available new “job aids” on a variety of topics ranging from counting episodes to ADRs to hospice physician billing, it says in an e-mail to providers.

The aids are at www.medicarenhic.com/RHHI/RHHI_publications.shtml.

• **When CMS announced that providers could get bonuses** for demonstrating “meaningful use” of certified electronic health records, a firestorm erupted regarding what that term meant.

CMS aims to quell any confusion following a recent meeting where the Health Information Technology (HIT) committee discussed several potential definitions of the term.

CMS intends to issue a proposed rule regarding its “meaningful use” definition later this year. In the meantime, you can submit your comments on the HIT's suggested definitions.

To read the definitions and submit your comments (which are due by June 26), visit CMS's new Web site for HIT at www.cms.hhs.gov/Recovery/11_HealthIT.asp. You can also check out the general HHS HIT site at <http://healthit.hhs.gov>.

• **CMS has issued a new set of marching orders** for medical review of DME, and you'd be wise to make sure your claims will pass muster under them.

In June 12 Transmittal No. 293 (CR 6468), CMS expands and clarifies instructions for reviewing medical necessity, DME accessories, repairs, and maintenance.

For example: When a local coverage decision (LCD) doesn't specify how far back in the patient's record to look for medical necessity documentation, it is up to the reviewer's discretion to set

Newsletter Question or Comment?



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the look-back period, CMS says. “When deciding how far back to look, the reviewer’s primary consideration shall be the likelihood that the beneficiary’s condition or treatment has changed significantly enough to impact the reasonable and necessary assessment for the item,” the transmittal notes.

The 15-page transmittal is at www.cms.hhs.gov/transmittals/downloads/R293PI.pdf.

• **A 72-year-old physician making home visits has been sentenced** to three years in prison for his part in a fraudulent Medicare billing scheme.

Dr. **James Ellegood** in DeSoto, Mo. received the prison term and an order to pay \$983,000 in restitution for submitting claims to Medicare on behalf of another physician in the practice who was excluded from Medicare, the U.S. Attorney for the Eastern District of Missouri says in a release.

Ellegood and his practice, **Missouri Physician Home Services Inc.**, submitted claims falsely representing that he provided home visits when he was actually out of the country in the Bahamas and Mexico, prosecutors say. Coworker Dr. **Rajitha Goli** furnished the services, even though she was excluded from Medicare after a 2002 federal felony conviction for fraud, the release says.

PHS paid Goli by funneling money through two companies owned by relatives of Goli’s and Ellegood’s wife — **Hanford Nuclear Services Inc.** in West Plains, Mo. and medical consulting company **Arogya Inc.** of Durham, N.C. The companies each received three years’ probation and a \$50,000 fine. Ellegood’s wife **Wynsleen** received three years’ probation and fines and restitution of about \$5,500. Goli is awaiting sentencing.

• **The public is taking notice** of the impact an Obama administration regulatory interpretation could have on the elderly.

Department of Labor Secretary Hilda Solis has indicated the administration will reconsider whether to allow the companionship services exemption for personal care service aides in the home (see *Eli’s HCW, Vol. XVIII, No. 22, p. 170*). The exemption means aides don’t have to receive minimum wage and overtime pay under the federal Fair Labor Standards Act.

If the current policy is revised, “health aides may be able to receive overtime for the first time, but seniors who receive the aid of health aides may not be able to afford them,” notes the *El Paso Times* in an article highlighting the issue.

“In the coming years, the need for home health-care services will significantly increase,” Rep. **Silvestre Reyes** (D-Texas) told the paper in a statement. “This is an issue that Secretary Solis will need to weigh carefully in the near term.”

“If this ruling is reversed, the effect of this will be twofold,” says attorney **Peter Panken** with **Epstein, Becker and Green**. “One, it will force a number of people into nursing homes because they can’t afford the services. The second thing ... is it will raise the cost of Medicaid costs to the states,” says Panken, a board member of **Fedcap**, a New York City nonprofit that provides home health aide services.

• **National chain Gentiva Health Services Inc. has purchased Mid-State Home Health** based in Alexandria, La. for undisclosed terms.

Gentiva calls Mid-State “one of central Louisiana’s top-three home healthcare providers” in a release about the acquisition. Gentiva doesn’t currently provide services in Mid-State’s 11-parish operating area, but operates in an adjacent area, the Melville, N.Y.-based company says. ❖

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