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Calendar

January 24-28

Leadership Strategies For Information Technology in Health Care. Harvard University School of Public Health, Cambridge, MA. An intensive seminar focusing on governance and IT issues. \$5,495.

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January 25

The Disney Approach to Quality Service in Healthcare. Seminars being held in San Diego, Richmond, VA, Virginia Beach, VA, San Antonio and Nashville. Discussion of the renown Disney strategy for customer services and how to transfer it to the healthcare sector. \$395.

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February 19-20

CHIME/HIMSS CIO Forum. Orange County Convention Center, Orlando, FL. This conference will explore the shifting landscape and how CIOs must address it moving forward. \$350-\$1,150.

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E-Mail info@payersandproviders.com with the details of your event, or call (877) 248-2360, ext. 3. It will be published in the Calendar section, space permitting.

CMS Moves Against Medicare Plans

Suspensions, Terminations Issued For Part D Gaffes

The **Centers for Medicare and Medicaid Services** has sanctioned three Medicare Advantage health plans headquartered in California, citing gross mismanagement or misleading business and marketing practices.

Woodland Hills, CA-based **Health Net**, Oakland, CA-based **Arcadian Management Services** and Houston-based **Universal American Corp.** have been suspended from soliciting new members for their Medicare Advantage and Part D pharmacy plans until corrective actions are taken and they prove to CMS the deficiencies are not likely to occur. Health Net's suspension went into effect on Nov. 19. Arcadian and Universal American's suspension began on Dec. 5. Current enrollees will continue to receive coverage through all three plans.

In the case of Health Net's suspension, CMS officials decided against providing a standard 15-day interim period before its imposition. "The fear was that waiting could lead to health and safety issues," said CMS spokesman **Peter Ashkenaz**.

Ashkenaz noted that the deficiencies in Health Net's management of its formulary for Medicare enrollees were so severe that they have been matched by only one other

company, Arizona-based **Fox Insurance Co.** CMS terminated its Part D contract with Fox in March.

In a particularly cathing letter sent to Health Net's chief government programs officer **Scott Kelly** on Nov. 19, CMS officials outlined a series of failures regarding Health Net's formulary for Medicare enrollees. Among them:

- Enrollees were denied medications that CMS mandated should have uninterrupted access, such as anti-convulsant and AIDs drugs.
- Quantity limits were imposed on drugs where no limitations should have been imposed.
- Prescriptions were denied as not being part of Health Net's formulary when they actually were.
- Health Net failed to respond to redetermination requests (asking to reverse its decisions) in a timely manner.

"Health Net has been wholly unable to satisfactorily address these serious deficiencies and to deliver services in a

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In Brief

Obama Signs Bill Delaying Medicare Cuts To Physicians

President Barack Obama has signed into law legislation that delays the pending sustainable growth rate cut in Medicare pay to doctors for one year.

The 25% cut in physician payments had been scheduled to kick in Jan. 1. Delaying the cut will cost the government an estimated \$19 billion.

The money to pay for delaying SGR will be shifted from the healthcare overhaul law, mostly by tightening rules on tax credits intended to prevent waste. However, Republicans may also try and defund a portion of the bill that promotes healthy lifestyles. That is funded for \$15 billion over the next decade.

Introduced in 1998, the SGR formula is designed to keep Medicare spending in check. But Congress routinely has stepped in to delay payment reductions, including a 3% cut that had been slated to go into effect on Dec. 1. Groups like the American Medical Association have regularly pushed not only to delay the cuts, but to reach a long-term solution.

Recession Caused Ranks Of Uninsured To Swell

A new study in the journal Health Affairs concluded that 5 million Americans lost health insurance coverage between 2007 and 2009, mostly as a result of the Great Recession.

Continued on Page 3

CMS (Continued from Page One)

manner consistent with its obligations to CMS and to the Medicare beneficiaries," the letter said.

Health Net had been issued 36 notices of non-compliance with CMS regulations and three warning letters between January and September of this year, and had been previously restricted from receiving enrollees reassigned from other health plans. It had been briefly suspended from marketing and enrolling new Medicare beneficiaries in 2008 due to similar troubles.

"We are working closely with CMS to resolve these matters as quickly as possible. We hope in the next months we can demonstrate to CMS that we have successfully addressed the issues they have raised," said Health Net Chief Executive Officer **Jay Gellert** in a prepared statement. Health Net officials did not respond to a request for further comment. In Arcadian's case, the plan was accused of allowing its agents to engage in unethical and deceptive behavior to recruit new enrollees. It had been under CMS scrutiny since 2008.

Among the abusive practices cited by the agency was enrolling individuals in Arcadian plans without their consent; claiming Arcadian's products were connected to national healthcare reform; and making direct contact with prospective enrollees at their homes or through cold calling. These violations either came from consumer complaints verified by CMS or as the result of CMS's "secret shoppers" attending Arcadian marketing events.

In October 2009, Arcadian received a formal warning from the agency to reform its marketing practices. However, the volume of consumer complaints CMS received between January and August this year regarding misrepresentations

involving Arcadian was anywhere from double to 3.5 times the national average. In one instance, a cancer patient misled into enrolling missed weeks of chemotherapy. In another case, a disabled minor was enrolled after false assurances were made to her father. The enrollee subsequently had her anti-seizure medication cut off, leading to an 18-day hospitalization that resulted in her developing pressure ulcers.

"This is horrifying," said **Judy Dugan**, research director for **Consumer Watchdog**, a Santa Monica, CA-based consumer advocacy organization that monitors health plans. "They are preying on the poor and disabled for profit. Both plans essentially put lives at risk."

An Arcadian spokeswoman declined to comment directly on the suspension and allegations, but did provide what she termed "approved talking points" via e-mail.

"Our goal is to work closely with CMS to meet or exceed their expectations as well as the expectations of our members," said the fourth and final point.

In Universal American's case, the plan was suspended for deficient training given its broker staff, which led to marketing practices that violated CMS guidelines, such as cold-calling and in-person calls, bait-and-switch tactics and the distribution of unauthorized sales literature. CMS also noted 26 different deficiencies among UA's Medicare plans.

UA has been under CMS scrutiny since late 2007, and the agency had sent nine warning letters to the plan last year.

In a prepared statement, UA CEO **Richard Barasch** observed that "compliance is integral to Universal American's culture and operations and we are working diligently to resolve these issues with CMS as quickly as possible."

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In Brief

The Midwest and South were hit hardest by the loss of coverage, which boosted the number of uninsured nationwide from 45 to 50 million, or about 17% of the population. About 60% of those who lost coverage were white.

Despite the grim increases, the number of children who had healthcare coverage increased by 600,000, partly because their families' loss of income made them eligible for state children's health insurance programs.

Moreover, the study's authors concluded the Patient Protection and Affordable Care Act would not only obtain coverage for those who lost it, but weaken the link between health insurance and employment.

Kaiser Claims 136% Return On Quality Initiatives

Oakland-based **Kaiser Permanente** is claiming that its quality initiatives have saved \$2.36 for every dollar invested. The initiatives include aligning hospitals by region to reduce deaths from sepsis, and other management initiatives.

"We focused on designing a system wide performance improvement approach that cascades from national to regional to facility levels," said **Lisa Schilling**, vice president of Kaiser's care and service quality division. "Our system demonstrates the value of investing in developing capability to improve capacity in operations, supporting its application in the delivery setting and its impact on overall medical center performance. These elements can be adapted to smaller systems and single hospitals."

OIG: Medicaid Overpaid \$724M Payments Made to Unqualified Personal Care Aides

The Medicaid program overpaid \$724 million in personal care attendants, according to a new report by the Office of the Inspector General.

According to a new 30-page OIG report, 18% of personal care Medicaid claims paid between September 2006 and August 2007 "should not have been paid because they lacked documentation of the personal care provider's criminal background checks, minimum age, health status, education or training requirements." Such claims totaled 6.5 million in all, although the OIG sampled only 450 claims at random to reach that figure.

Although the personal care sector is a relatively small portion of Medicaid, it is growing at a quick rate. Claims totaled \$9.9 billion in 2006, up 20% from 2004. Attendants help Medicaid enrollees – often dual-eligible Medicare enrollees – in their

homes rather than a skilled nursing facility.

Qualifications for such attendants differ from state to state, but they usually require that an attendant be a minimum age, have no criminal record, and some level of education and training.

Among the inappropriate claims, 2% did not provide any records of providing services to the recipients at all. More than 40% of the claims indicated that the attendants did not meet any of the qualifications at all.

The OIG recommended to the Centers for Medicare and Medicaid Services that it withhold payments to attendants who do not fully document their qualifications, and that it work with states to recover inappropriate payments. The CMS concurred with those recommendations, according to the report.

Mediation For Malpractice Suits? A Study Suggests The Process Could Cut Costs

A new study of medical malpractice cases that went into mediation suggested that such a process could save money for the defendants and bring settlements to the plaintiffs more quickly.

The study, co-authored by **Carol Liebman** of the **Columbia University School of Law**, focused on 31 cases brought against not-for-profit hospitals in New York City that went to mediation between 2006 and 2007. Of those, 70% settled either during or immediately after mediation for sums ranging from \$35,000 to \$1.7 million.

The study cited the benefits of mediation,

including speedier payments to plaintiffs, not having to hire expensive defense attorneys, or prepare medical staff for the rigors of legal discovery and trial. However, it did note that management at many hospitals are still reluctant to use the process, and that physicians rarely participate – which could hinder an even better outcome.

"Change will require medical leaders, hospital administrators, and malpractice insurers to temper their suspicion of the tort system sufficiently," said the study, which was published in the **Journal of Health, Politics, Policy and Law**.

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DATA SNAPSHOTS from MCOL

By the Num3rs

excerpt from MCOLWeekend's Tidbits

Physician Hospital Alignment

Physician survey data from PwC report: From courtship to marriage: Why health reform is driving physicians and hospitals closer together
PwC Health Research Institute, December 2010

Physician Survey Responses:

- 82%** agree more physicians will become integrated with medical groups.
- 74%** said MDs will become more integrated with hospitals in next 5 years
- 71%** already aligned financially with hospitals via employment, contracts, etc.
- 68%** believe hospitals want MD alignment for contracting clout with payers
- 63%** of cardiology specialists are interested in hospital employment
- 58%** want to move toward an even closer financial relationship with hospitals
- 48%** of primary care physicians are interested in hospital employment
- 30%** believe hospitals want to align so they can prepare to form ACOs
- 24%** already work primarily in hospital practice settings
- 20%** don't trust hospitals

Source: www.pwc.com/us/en/health-industries/health-research-institute

Factoid

Appearing in **MCOL Daily Factoids**, Dec. 7, 2010

12.4% of all physicians relocate their practice on an annual basis, including 11.9% of primary care physicians

Data Source: SK&A, A Cegedim Company, April 2010.
Publication: Pharmaceutical Commerce.com, September/October 2010

LISTS from



Medical Home Obstacles

Survey Data from Medical Home Web Summit /MCOL 2010 e-poll: Most Important Issues to Overcome for Widespread Implementation of Medical Homes

- 1.** Lack of payer commitment to reimburse care coordination (38.2% of respondents)
- 2.** Growing shortage of primary care physicians (25.4% of respondents)
- 3.** Lack of sufficient team culture being taught in medical schools and residency programs (11.0% of respondents)
- 4.** Lack of sufficient incentives to adopt and implement EHRs (10.2%)
- 5.** Other Reasons (15.2% of respondents)

Source: <http://www.healthwebsummit.com/medicalhome.htm>

Notes: Each survey response indicated one item as the single most important issue

BLOGBITS

Data snippets from recent **MCOLBlogs**:

Average Deductibles

MCOLBlog: Let's Move to the Atlantic Seaboard or North Dakota: New Commonwealth Fund Report found that U.S. average deductibles by firm size were:

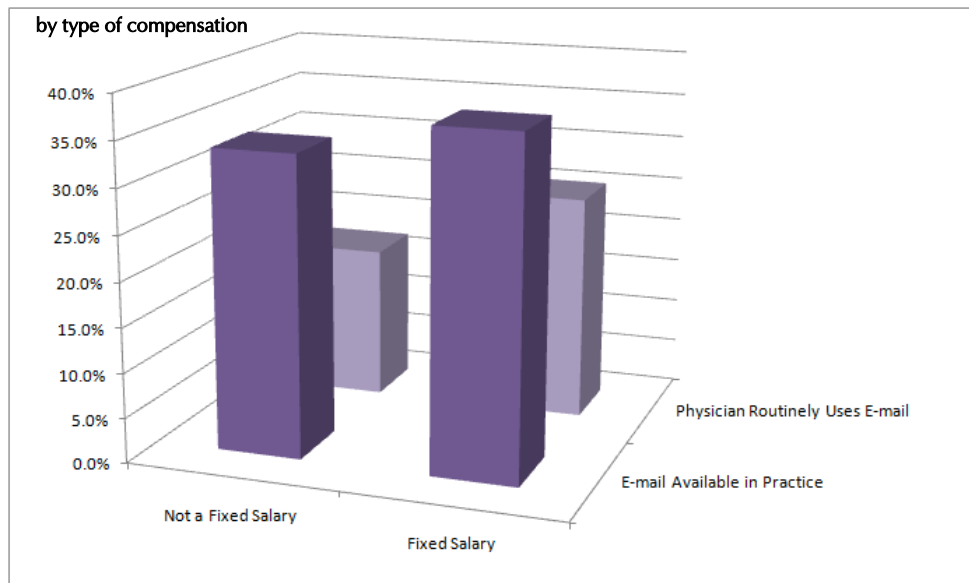
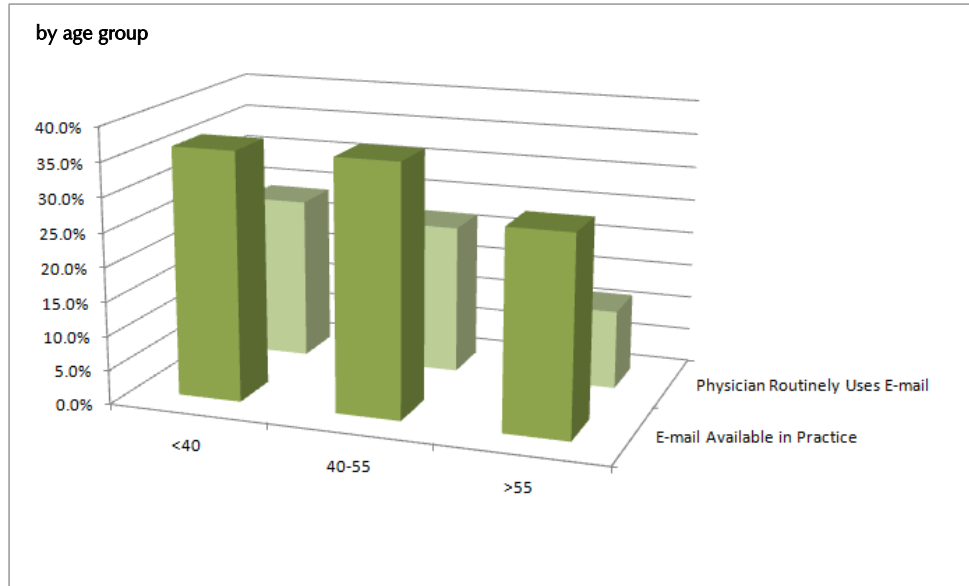
Deductible	2003	2009
Single: Small Firm	\$ 703	\$1,283
Single: Large Firm	\$ 452	\$ 822
Family: Small Firm	\$1,575	\$2,662
Family: Large Firm	\$ 969	\$1,610

Source: www.commonwealthfund.org

DATA SNAPSHOTS from MCOL

Trends appearing in MCOL Paid Member Web Site, December 2010

Physician E-Mail Clinical Communication with Patients



Source: Issue Brief: Findings from HSC, October 2010, Center for Studying Health System Change, Robert Wood Johnson Foundation <http://www.rwjf.org/files/research/70328.pdf>

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Thinking Outside The Inpatient Box

The Future of Hospitals is Found Beyond Its Four Walls

One of few “knowns” in the otherwise unknown world of what health reform will bring is the fact that all hospitals will need to do a better job of truly concerning themselves with the health of their communities beyond the hospital walls.

In the 20th century, our industry focused the majority of its attention on how to better care for people from the time they were admitted into the hospital until they were discharged. But truth be told, it is a fairly infrequent event that people encounter a hospital at all. So here in the 21st century, it is now time to start focusing on where people spend the majority of their lives – not from admission to discharge but from discharge to admission. We as a society, and particularly as responsible healthcare providers, must have a new commitment to maintaining and improving health rather than merely treating episodic illnesses.

The emergence of Accountable Care Organizations will help this shift occur because it forces hospitals to think value, not just volume. As one of the government-prescribed remedies aimed at improving quality of care while reducing overall health care costs, ACOs call upon hospitals to reflect on the community as a whole and morph from a traditional health center concerned with admissions to a new charter dedicated to keeping people healthy and out of the hospital whenever possible.

Toward this end, Huntington Memorial Hospital recently became the first hospital in the country to partner with Healthy Communities Institute (HCI) in offering a one-stop, online source of data about community health. The website, known as Healthy Pasadena (www.healthypasadena.org), is designed to help community members and policy makers learn about health related issues so individuals can make informed, healthy lifestyle choices for themselves and their families.

The new website creates a repository for information and data that assists public health departments, local administrators, hospitals and community. It is designed to

help local residents connect with a wide range of health resources in the community

Healthy Pasadena also provides a calendar of community events, as well as news and statistics regarding the social, educational and economic elements of the community. Visitors can compare the San Gabriel Valley’s health status to that of Los Angeles County and the State of California and learn best practices and protocols for addressing health related issues. They can also identify local resources for health and social services throughout the area.

There is also information about air quality, cancer rates, and crime, plus more than 100 “indicators” that address topics including public safety, transportation, voter turn-out and more.

Healthy Pasadena even provides a page where visitors can take content information from the site and fill in fields to create their own personal report – ideal for school or business.

HCI has developed a network of similar sites throughout the country, but whom better than the local community hospital to be a partner in this effort? After all, it is the hospital that is there for the community 24 hours a day and whose very mission is centered on being the local “expert” in health and healthcare.

Nonprofit hospitals have always recognized that we have a unique obligation to be concerned with our community’s overall health wherever that may take us. But the confluence of healthcare reform, community demand and the power of the internet now make this commitment more possible than ever for all of us. The upshot of healthcare reform may still be cloudy, but I like to think of it as cloudy with a chance of greatness.

Jane Haderlein is senior vice president of external affairs for Huntington Memorial Hospital in Pasadena, Calif.



By
**Jane
Haderlein**

Op-ed submissions of up to 600 words are welcomed. Please e-mail proposals to editor@payersandproviders.com, or call (877) 248-2360, ext. 3.

ROUNDTABLE INTERACTIVE

PAYERS & PROVIDERS

Payers & Providers and MCOL present **Roundtable Interactive**. It debuts March 2011 in the Payers & Providers National edition.

Our readers always want to know what is on the minds of healthcare's c-suite executives. Conferences and trade events often only allow for crucial moments to interact with these thought leaders. With Roundtable Interactive, you'll cut through the preliminaries and immediately know what's on their mind.

Every Roundtable Interactive will feature a Q&A session conducted by Payers & Providers Publisher Ron Shinkman. His decades of experience in journalism and the healthcare industry will promise concise and revealing interviews.

Topics for upcoming Roundtable Interactives include:

- **Integrated Systems vs. Private Practice:** To what degree will physicians not already in larger medical groups or integrated health systems remain in private practice during this decade, and why. What are the advantages, disadvantages and implications in today's environment?
- **Medicaid Plans and Delivery Systems:** How much is their clout growing as Medicaid enrollment is projected to soar as part of reform? Will Medicaid increasingly be used as a vehicle for setting healthcare policy? To what degree will major health plans and systems try to increase share and concentration in this market?
- **Accountable Care Organizations:** Are they overhyped? What type of health care systems should be pursuing ACOs, and what systems should be sitting on the sidelines for now? How tied is the ACO movement to the success or failure of Medicare ACO pilots? Does the definition of ACOs need more specificity, or is it preferable to have a big tent of inclusion?

Do you want to propose or participate in a future Roundtable Interactive? Participation is entirely online, with a commitment of no more than one hour. Call Ron Shinkman at 877-248-2360, ext. 1, or e-mail him at editor@payersandproviders.com.

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