PAYERS & PROVIDERS

CALIFORNIA EDITION

Calendar

January 27-28

Personalized Medicine World Conference. Computer History Museum, Mountain View. A discussion of the adoption of personalized medicine and the companies driving the effort. $1,200-$1,500.

Click Here for More Information

February 24

Palliiative Care Transitions Conference. Pasadena Hilton. Sponsored by the Hospital Association of Southern California, this conference will focus on best practices and advances in palliative care. $150-$200.

Click Here for More Information

March 24-26

Ninth Annual Pay-for-Performance Summit. Hyatt Regency San Francisco. And examination of how P4P models and payments are evolving. Sponsored by the Integrated Health Association. $795-$1,795.

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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.

Unique Tweak To San Bernardino EMS

Paramedics May Oversee Multiple Patients at Hospitals

Hospitals in San Bernardino County are encountering such capacity issues that ambulance crews are now able to hand off patients to the care of other paramedics waiting at hospital loading bays prior to their admission.

The change in policy, implemented Jan. 13, makes San Bernardino County the only California county that allows paramedics to hand off patients before they're wheeled into the hospital, according to **Tom Lynch**, emergency medical services administrator for the **Inland Counties Emergency Medical Agency**.

According to data compiled by ICEMA, the number of hours patients waited to be handed off to hospital care increased by 50% last year, to more than 15,000. That works out to an average delay of about 25 minutes.

According to Lynch and other ICEMA officials, recent increase in the number of patients with flu-like symptoms and other factors have been putting stress on the county's emergency rooms. Countywide, about 25% of all 911 calls are not answered by paramedic teams within 10 minutes. County regulations prohibit hospitals from diverting ambulances to other ERs when theirs reaches capacity.

Although Lynch said that paramedics have been trained to monitor multiple patients at once, they rarely do so unless there has been a disaster or other incident that creates multiple injuries.

It was also stressed that the policy change is not permanent. It is in place until Feb. 28, at which point ICEMA may rescind the new policy or keep it in place for another fixed period of time.

"This is an interim fix to address the dramatic increase in patient volume currently being experienced in the local emergency rooms. It is not intended as a solution to the overall problem of holdovers," said **Jason Sorrick**, a spokesperson for **American Medical Response**. The Colorado-based AMR operates about 70 ambulances in San Bernardino County under a contract with the county's public health agency.

There are also caveats for the new policy: Ambulance crews may only monitor multiple patients if they're stable and require no new medications or treatments. The crews also have the option of not monitoring multiple patients if they feel it will be a threat to their safety.

Nevertheless, the change has left the provider community unhappy, claiming that it is being done for the benefit of ambulance companies, which get paid for each patient they transport. Freeing up more vehicles in theory would provide them more patient volume.

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In Brief

Health Net Wins Dual-Eligibles Contract

A subsidiary of the Woodland Hills-based insurer **Health Net** has received a contract from the **Centers for Medicare & Medicaid Services** and the **California Department of Health Care Services** to provide services to the dual-eligible populations in Los Angeles and San Diego Counties.

California is moving about 456,000 dual-eligibles – those both enrolled in Medicare and Medi-Cal – into managed care under a program known as Cal MediConnect as part of a demonstration project to confirm whether care for this population can be better coordinated at a lower cost. There are about 1.1 million dual-eligibles in California. Eight counties in the Bay Area and Southern California are participating in the demonstration project.

"We look forward to improving the quality of care and service for those who are most in need of a truly integrated care delivery system," said **Jay Gellert**, Health Net's chief executive officer. "We believe that the rate setting methodology in this contract, which is based on the historical fee-for-service costs of providing care to this population, will provide the necessary resources to improve the delivery of care to these beneficiaries."

Health Net Community Solutions is expected to begin coverage no later than April 1. No enrollment figures or dollar value for the contract were immediately available.

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EMS (Continued from Page One)

"I foresee problems with this," said **Jennifer Bayer**, spokesperson for the **Hospital Association of California**. Bayer noted that this could create new liability issues for providers.

"This policy puts profits for ambulance companies ahead of risk to patients," said **Jim Lott**, executive vice president of external affairs for **Cope Health Solutions**, a Los Angeles firm that focuses on clinical integration for hospitals.

Sorrick suggested that the issue could be addressed by expanding ER capacity at hospitals in the county, a solution hospital officials say is complex and extremely expensive.

"It's definitely a bandaid cure," Bayer said.

Prime Whistleblower Suit Is Unsealed

Former Employee Says Alvarado Hospital Overbilled

The director of performance improvement at **Alvarado Hospital** in San Diego has filed a whistleblower suit against its owner, **Prime Healthcare Services**, claiming the Ontario-based hospital chain systematically overbilled the Medicare program.

The suit claims Prime violated the federal False Claims Act by disregarding guidelines for keeping patients under observation care, admitting them as inpatients and them not discharging them to post-acute care facilities.

Patients kept under observation are a sore point for hospitals, as they get paid significantly less than if they admitted them as inpatients. But if such patients are admitted and kept for less than two full days, their charges to Medicare are far more likely to draw the attention of Medicare billing auditors.

Karin Berntsen filed the suit in 2011, but it was unsealed last week because the statute for keeping such litigation under wraps had expired.

"Karin became concerned after witnessing numerous instances in which patients were admitted and kept in the hospital unnecessarily," said **Elaine Stromgren**, one of Berntsen's attorneys. "This exposed patients to a greater risk of complications, like infections and medical errors." Stromgren added that the suit was filed after hospital management spurned Berntsen's request to change course.

The suit claims Alvarado overbilled Medicare by at least $4 million. If Prime's other hospitals are taken into account, the overbilling may exceed $50 million, according to the lawsuit. Plaintiffs, or relators as they're known in such actions, are entitled to 15% of any amount recovered.

Prime officials dismissed the suit as "speculative nonsense" noting that they would not engage in such conduct given the level of scrutiny the company has received in California.

In 2011, the ***California Watch*** investigative website reported that Prime hospitals in California systematically billed Medicare for rare medical conditions at frequencies far higher than is commonplace for other hospitals in the U.S., prompting a federal investigation. Prime also paid a $95,000 fine for breaching patient privacy when managers of one of its hospitals in

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In Brief

Campbell Claims Charity Care Bill Would Imperil Patient Access

A new study co-authored by former California Finance Director **Tom Campbell** warns that pending legislation could lock out thousands of the state's residents from obtaining healthcare coverage if passed into law.

Of particular concern is Assembly Bill 975, which would exclude the writing off of medical bills as charity care, and require hospitals and multispeciality clinics to conduct community needs assessments under the guidance of the Office of Statewide Health Planning and Development. Such assessments would also have to be updated every two years.

"Lawmakers may not be intentionally seeking to undermine healthcare reform, but new mandates in AB 975 or other similar legislation would result in less hospital capacity, the loss of health care jobs, and a loss of state tax revenues," Campbell said. "Instead of moving forward with greater access to care, cumbersome new regulations would be a giant step backward."

Although the bill may be reconsidered by the Assembly later this year, it is currently in that body's inactive file, and no votes or hearings are currently scheduled, according to a state website that monitors the status of bills.

Campbell's study was performed in conjunction with the **Berkeley Research Group** and was underwritten by the **California Hospital Association**.

"Our non-profit hospitals are preparing to meet the demands of more than 3 million people who will have new access to healthcare as a result of federal reform," said CHA Chief Executive Officer **C. Duane Dauner**. "AB 975 or bills with similar mandates would create unrealistic requirements."

Prime (Continued from Page One)

Northern California shared with the ***Los Angeles Times*** medical records of a patient who complained about her care.

The **U.S. Department of Health and Human Services** has not yet made a decision to join Berntsen's suit.
continuing to investigate the allegations.

Cost Of Birth In State Varies Widely

Study Slams Hospitals' Reliance on Outmoded Pricing

The cost of delivering a child in California's hospitals varies widely, according to a new study conducted by researchers at **UC San Francisco**.

UCSF researchers studied the records of nearly 110,000 births that occurred in California in 2011 – about 20% of the statewide total that year, analyzing data provided by the **Office of Statewide Health Planning and Development**. They examined nearly 77,000 vaginal births and nearly 33,000 Caesarean sections.

Their conclusion: Hospital charges ranged from $3,296 to $37,227 for a vaginal delivery, while charges for a C-section ranged from $8,312 to $70,908.

"Childbirth is the most common reason for hospitalization, and even for an uncomplicated childbirth, we see a staggering difference in what hospitals charge, even for the same, average patient," said **Renee Y. Hsia**, M.D., a UCSF associate professor of emergency medicine and the study's lead author.

Government hospitals were the least expensive, charging 14.6% less on average than non-profit facilities. For-profit hospitals charged 17.2% more than non-profits. Hospitals located in counties with large numbers of uninsured patients tended to charge less than facilities located elsewhere.

Hsia said the huge variation was reflective of the "appalling state of affairs of healthcare in the United States," Hsia noted, and was particularly unfair to patients given the recent trends in cost shifting by insurers.

"These charges affect not only the uninsured, but also the fee-for-service reimbursements by some private insurers, which can translate to out-of-pocket costs for patients," Hsia said.

On average, the discounted price insurers paid amounted to 37% of the hospital's original bill. Discounted prices for vaginal deliveries ranged from $835 to $12,873, while the prices of discounted C-section deliveries ranged from $1,135 to $28,105. One unnamed facility discounted charges by more than $29,000.

Altogether, the hospitals billed $1.3 billion more than they received from insurers. Hsia and the study's other authors said the current healthcare finance structure is outdated, particularly given the trend of cost-shifting to patients. And uninsured patients were most likely to be charged the full price, necessitating charity care or drawn-out payments by the patient and their families was likely.

"At a time when out-of-pocket payments for health care are increasing, and the growing number of 'consumer-directed,' high-deductible health plans put more pressure on patients to make cost-efficient health care decisions, the opacity of health care pricing is increasingly concerning," the study concluded.

The study was funded by the **UCSF-Clinical and Translational Science Institute**, the **Robert Wood Johnson Foundation Physician Faculty Scholars Program**, as well as a grant from the **UCSF Center for Healthcare Value**.

The study was published in the most recent edition of an online version of the ***British Medical Journal***.

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ACA Party Poopers: The Uninsured

Their Recalcitrance in Obtaining Coverage is a Problem

By Robert Laszewski

What if most of the uninsured literally don't buy Obamacare?

"Only 11% of consumers who bought new coverage under the law were previously uninsured," according to a survey of 4,563 consumers eligible for the health insurance exchanges done by McKinsey & Company and reported in the Wall Street Journal.

The Journal reports that "insurers, brokers, and consultants estimate at least two-thirds" of the 2.2 million people who have so far signed up in the new exchanges are coming from those who already had coverage.

This is consistent with anecdotal reports from insurers I have talked to that are seeing very little net growth in their overall individual and small group markets as of Jan. 1.

That's even worse than I thought it would be, even considering the Jan. 1 individual policy cancellations and small group renewals that are driving employers to reconsider offering coverage—and that is saying something.

This also tells us why the first three months of the Obamacare enrollment had a relatively high average age—they came from the same market that tended to skew older that the health plans already covered.

When McKinsey asked why subsidy eligible people weren't buying, 52% cited affordability as the reason. I'm not shocked to hear that given what I have been writing about the high after-tax premiums, net of the subsidies, people are finding, as well as the high deductibles and narrow provider networks the subsidized Silver and lowest cost Bronze exchange plans are offering people.

Another 30% cited "technical challenges" with the website as reasons they have not yet bought. That said, enrollment in the state exchanges that have generally been running well—California, Washington state, New York, Connecticut, Kentucky, and Colorado are also only enrolling a very small number of people relative to the number of policy cancellations in their markets and the size of their uninsured population.

At Michigan's Priority Health about 25% of their new exchange customers came over from employer coverage and 50% from the individual market—leaving only 25% to come from the ranks of the uninsured.

I will suggest that the significant number of the new enrollees coming over from discontinued employer coverage should be troubling to Democratic politicians who support the Affordable Care Act. While low paid workers might fare better in the exchanges, many of those eligible for federal subsidies, particularly in two-income families, will fare far worse compared to the plan their employer offered them. Creating a circumstance that forces people to lose their employer coverage is not going to be a political win.

If this keeps up there won't be a "death spiral." So far the insurers are primarily re-enrolling their old customers at higher rates.

In addition, many of the 2.2 million exchange enrollees have not yet paid their premiums. The carriers I talked to at the end of last week report that anywhere from a low of 70% to a high of 85% of new enrollees have paid so far. Some of the health plans have closed their books on January and some are willing to take premium until the end of the month. It would appear there will be an overall 10% to 20% final attrition rate due to non-payment of premium.

However many finally pay, so far it is clear that the uninsured just aren't buying Obamacare.

The Obama administration will now argue they had lots of computer problems between October and January and there are three months remaining to get people interested in and purchasing health insurance.

They are right.

But when the spin is over, they must be sweating bullets.

Robert Laszewski is the president of Health Policy and Strategy Associates in Alexandria, Va.

Op-ed submissions of up to 600 words are welcomed. Please e-mail proposals to editor@payersandproviders.com

