



News

late-breaking news from your medical association

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state

CMA Opposes Senate HCR Bill

In its current form, CMA has taken a position in opposition to the Senate health care reform bill. Although there are provisions it supports, the bill has many shortcomings, including: 1) not repealing the Medicare SGR payment formula; 2) expanding Medi-Cal by more than a half million Californians, while failing to ensure these patients have access to doctors; 3) building health reform on unproven programs; 4) potentially reducing funding for poor, minority, uninsured patients through the "value index"; 5) build off programs that have historically produced inaccurate physician cost and quality information, failing to help physicians improve quality; 6) gives authority to the Independent Medicare Commission to make draconian provider cuts if Medicare spending exceeds the CPI; and 7) fails to allow patients to privately contract with physicians of their choice. Organized medicine will be working to achieve improvements in the current health reform proposals.

U.S. Healthworks Plans Big Expansion

U.S. HealthWorks, which runs 19 occupational health clinics in the Bay Area, has letters of intent to buy 21 more by early 2010. The Valencia-based firm hopes to acquire 75 to 100 Bay Area occupational health centers over the next two to three years as part of a broader industry roll-up that could add more than 250 additional centers to its roster of 151 clinics in 14 states. In Northern California the company has about 400 employer clients, including Pepsi Bottling, AC Transit, Comcast, Caltrans, and the San Francisco Zoo. The CEO, Dan Crowley, earlier in his career, helped build Foundation Health (now part of HealthNet). The company plans to have 100 clinics in the greater Bay Area in the next couple of years.

Fewer Interruptions Result in Fewer Errors by Nurses

A 9-month UCSF program to improve accuracy in administering drugs, with particular emphasis on reducing interruptions that often lead to mistakes, resulted in a nearly 88 percent drop in errors over 36 months at nine Bay Area hospitals. Medication errors make up the largest slice of the medical error pie. Improving these numbers is a huge benefit to patient safety and, secondarily reduces costs, according to UCSF's Integrated Nurse Leadership Program. Errors in administering medication cause about 400,000 preventable injuries in hospitals and about \$3.5 billion in extra medical costs a year, according to the Institute of Medicine. The UCSF program involved UCSF Medical Center, Kaiser hospitals in Hayward and Fremont, San Francisco General Hospital, St. Rose Hospital in Hayward, Contra Costa County Medical Center, Stanford Hospital, San Mateo Medical Center, and Sequoia Hospital. Striving to reduce interruptions that lead to mistakes, teams of nurses at the different hospitals came up with a variety of methods - often surprisingly low tech, though Kaiser facilities have more high-tech methods.

Top Three Insurers in CA Deny 30 Percent of Medical Claims

California is the only state in the union that requires health insurers to report medical claims data. According to a study by the Center for American Progress (CAP), three of the state's six largest health insurance companies each denied 30 percent or more of claims during the first six months of 2009 (United Healthcare/PacifiCare, 39.6%; CIGNA, 32.7%; and HealthNet (30.0%). The six companies examined control two-thirds of California's managed care market, the largest in the country. The report suggests that when it comes to claim denials, insurers may be putting profits ahead of patients' interests. Most major insurance companies have reassigned their medical directors to report to their business managers. Former senior medical personnel have charged that Aetna, CIGNA, and UnitedHealthcare made internal changes in recent years that gave business executives more direct authority over the companies' doctors who evaluate claims. The CNA compiled the company data from the DMHC's website, <http://wps.dmhc.ca.gov/fe/search.#top>.

Federal Waiver Sought to Restructure Medi-Cal Program

The state Department of Health Care Services (DHCS) plans to seek a waiver from the federal government under Section 1115 of the Social Security Act, for a comprehensive demonstration project restructuring the state's Medi-Cal program. The state Legislative Analyst's Office reports that Medi-Cal is one of the fastest-growing General Fund programs, with spending forecast to increase by 8.1 percent annually for fiscal years 2010 through 2014. A major element of the DHCS proposal is reducing fee-for-service expenditures for high-cost beneficiaries with serious chronic medical conditions and to provide better access to coordinated and integrated care for the beneficiaries. While half of the Medi-Cal beneficiaries receive coverage through managed care-based systems, most of the balance is treated on a fee-for-service basis. The majority of Medi-Cal spending is for FFS beneficiaries who have multiple chronic health conditions. Ten percent of Medi-Cal beneficiaries account for 74 percent of the total program costs. Most physicians believe there is a need for primary care physicians to provide a medical home for these beneficiaries.

State Rates PPOs

The state Department of Insurance (DOI) has announced patient quality of care ratings for five of the state's six largest PPOs. PPOs were rated on measures used by HMOs using the HEDIS set from NCQA which focuses on clinical factors, and the federal government's Consumer Assessments of Healthcare Providers and Systems (CAHPS) survey data. The rating criteria included asthma care, checking for cancer, diabetes care, and treatment of children. None of the Five PPOs receive the DOI's highest four-star rating. Aetna, CIGNA, and HealthNet received three stars, and United Healthcare and Anthem Blue Cross received two stars. Blue Shield did not report data due to technical issues, which are to be resolved for next year's assessment.

HealthNet Provides US-Mexico Binational Plan

HealthNet has launched its "Salud HMO y Mas" into San Diego County designed for small to mid-sized employers on either side of the US-Mexico border. It is also available in San Bernardino, Riverside, Orange and Los Angeles counties. It is the only Mexican health plan licensed by the California Department of Managed Health Care and includes 200 plus physicians throughout the Mexican border cities of Tijuana, Mexicali, Tecate, and Rosarito. The network essentially ignores the border's existence by configuring a network with providers and patients interacting on both sides of the international dividing line. The region is characterized by people who live in Mexico and work in the US and vice versa. This product is the only one of its kind that offers patients the binational option.

Legislative Analyst's FY 10/11 Budget Outlook

California's Legislative Analyst has released his 2010//11 budget analysis, projecting a fiscal deficit of \$20.7 billion, which includes a current year deficit of \$6.3 and a 2010/11 deficit of \$14.4 billion.

Kaiser, VA & Defense to Exchange Data

Kaiser Permanente will test the exchange of electronic health records between its clinical information systems and those of the Departments of Defense and Veterans Affairs. By mid-December Kaiser will start an initial pilot with the VA in San Diego, using standards developed for the nationwide health information network. The organizations during November have sent joint letters to veterans in the San Diego region to invite them to participate in the testing. The program will link Kaiser's HealthConnect EHR, primarily from Epic Systems Corp., with the VA's VistaA system. The Department of Defense will join the pilot in early 2010.

Outpatient Spending on Blood Thinners a Huge Cost

According to the Agency for Healthcare Research and Quality (AHRQ), third-party payers and patients in the U.S. spent \$900 million in 2007 on outpatient prescriptions for anticoagulant drugs for adults. The report stated that 4.2 million Americans age 18 and older used a blood thinning drug in 2007.

AMA to Develop Tool to Help Physicians Transition to ICD-10

The AMA has been directed by its House of Delegate to develop systems to help physicians transition to the ICD-10 procedure coding system. The organization already has undertaken several initiatives to smooth that transition including the development of a web-based, look-up tool to assist physicians in identifying the conversion of ICD (International Classification of Diseases) codes latest updates. Physicians need to work with their systems vendors on receiving necessary upgrades to their systems to accommodate the ICD-10 code sets.

The health care industry will switch to ICD-10 on October 1, 2013. Encounters and discharges occurring before October 1, 2013 will use ICD-9, and those occurring on or after that date will use ICD-10. The final rule suggests that compliance activities (gap analysis, design, development, internal testing) should begin in January 2011. The fundamental driver for ICD-10 is financial — the inability for ICD-9 to support the growing number of high-priced medical procedures.

Rapid Growth of Retail Health Clinics Has Slowed Significantly

The retail medical clinic market growth peaked at an astronomical 350 percent in 2007, dropped to 30 percent in 2008 and was halved again in 2009. By year-end it is estimated only 1,250 clinics will be in operation. MinuteClinic and TakeCare dominate the market with 72 percent of market share. Not surprisingly, the economic downturn that began in the latter part of 2007 had a chilling effect on retailers. The CVS-owned Minute Clinic closed 131 clinics in the first half of 2009, citing poor demand. It is anticipated that in the coming years the retail clinics that emerge will be a more refined business model. At current demand levels retail clinics are only marginally profitable. The report was issued by the Deloitte Center for Health Solutions. The vast majority of retail clinics operate in drug stores (82%), followed by supermarkets (12%) AND big-box discount stores (6%).

Quality of Primary Care In U.S. Lags Behind Other Countries

The Commonwealth Fund released a report, "A Survey of Primary Care Physicians in Eleven Countries, 2009" concluding that national policies have played an integral role in the leading countries to achieve 24-hour access to care, achieve health IT implementation, and advance primary care teams. The report highlights the lack of national policies focused on U.S. primary care. Unless primary care practices are part of more integrated care systems, they are on their own facing multiple payers with uncoordinated policies. See Web Exclusives at <http://content.healthaffairs.org/index.dtl>.



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PECOS Enrollment Delayed

Beginning October 5, Medicare began implementing "soft edits" on remittance advice of physicians who listed on their claims the names of other referring or ordering physicians who are not in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) enrollment database (the national database of all Medicare physicians and other providers). Starting January 4, CMS planned to reject claims where the referring/ordering physician was not in PECOS. Fortunately, thanks to the AMA and state, county and local medical organizations who objected to this time line, CMS has agreed to postpone the policy until April 5. The delay was extended in order for CMS to establish a re-validation process with Palmetto that will not disrupt the standard enrollment processes.

PQRI Incentive Payments Increase in 2008

Under Medicare's 2008 Physician Quality Reporting Initiative (PQRI), 85,000 physicians and other eligible professionals successfully reported quality-related data receiving payments of more than \$92 million. This figure is well above the \$36 million paid in 2007. The number of incentive payments increased by one-third from 2007. In 2007 providers only could participate in the program during a six-month reporting period, however, the program was expanded in 2008 to allow reporting for either a six-month or a 12-month period. Over 153,600 providers participated in the 2008 PQRI, resulting in a 56 percent success rate of those participants who met the statutory requirements for satisfactory reporting and received incentive payments. The average incentive amount for individuals was more than \$1,000, with the largest payment to an eligible participant totaling more than \$98,000.

Consumer Group Appeals Denial of Request for Physicians' Claims Data

The nonprofit consumer information organization, Consumers' Checkbook Center, has asked the U.S. Supreme Court to review whether a federal appeals court's decision to deny the release of Medicare claims by physicians under the Freedom of Information Act (FOIA) was proper. The appeals court found that the HHS, in overseeing the Medicare program and promoting quality in Medicare services, do not create a "cognizable public interest" and that the disclosure of the information would constitute a clearly unwarranted invasion of the physicians' personal privacy. The Consumer Checkbook organization states that the requested data would allow the public to evaluate the extent to which CMS is issuing reimbursements for fraudulent claims or unnecessary procedures. See Consumers' Checkbook Center for the Study of Services v. HHS, U.S. No. 09-538.