PAYERS & PROVIDERS

CALIFORNIA EDITION

Calendar

November 10-13

California Association of Health Facilities annual convention and expo. Reniassiance Palm Springs Convention Center. An examination of of trends in long-term care. $179-$839.

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December 9-10

Behavioral Healthcare Symposium. Hilton Waterfront Beach Hotel, Huntington Beach. The exploration of better avenues for behavioral health patients and professionals. $195-$650.

Click Here for More Information

January 15-18

37th Annual Emergency Medicine (Conference) in Yosemite. Yosemite Lodge at The Falls. An examination of the latest trends in emergency medicine and administration. $282-$816.

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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.

Sutter Settles Billing Suit For $46 Million

State Joined Whistleblower Litigation Two Years Ago

Sutter Health has agreed to settle a long-running lawsuit stemming from the way the Sacramento-based hospital operator bills for anesthesiology services.

Under the terms of the settlement, announced earlier this week by the **California Department of Insurance**, Sutter will pay $46 million to settle allegations that first surfaced four years ago that it had been charging patients for anesthesiology services already been baked into its basic operating room charges.

Rockville Recovery Associates, the healthcare auditing firm that filed the original whistleblower suit against Sutter, will split $26 million with its attorneys. Another $20 million will go into California's general fund.

Sutter came under pressure to settle the matter in 2011, when California Insurance Commissioner **Dave Jones** – long a self-styled champion of consumer rights – joined Rockville in the suit.

"This settlement represents a groundbreaking step in opening up hospital billing to public scrutiny," Jones said in a statement.

The matter had been scheduled to go to trial in Sacramento Superior Court later this month. However, a lengthy article by journalist **Steven Brill** that appeared in ***Time*** magazine last March about the often opaque billing practices by hospitals garnered nationwide attention and no doubt made it more challenging for Sutter to seat an unbiased jury. Jones' office went so far as to refer to the article in its statement.

"We made a tough decision—based on the best interests of our charitable assets—that the certainty and closure of a settlement was preferable to the significant human and financial resources associated with a lengthy trial," said Sutter vice president of communications **Bill Gleeson**.

According to Jones' office, Sutter will now have to disclose on its company website every component of its anesthesia billing practices, as well as its costs. And it will have to charge a flat rate for billing purposes, as opposed to the hourly rate it customarily charged.

"Patients, insurers and the public will now be able to compare Sutter's costs to what it charges for anesthesia. They will see any mark-ups. I commend Sutter for agreeing to

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In Brief

93 California Hospitals Get Top Joint Commission Rating

Ninety-three hospitals in California received the top performer designation from the **Joint Commission** for their performance on a variety of quality measures in 2012, up significantly from the prior years.

The Joint Commission surveys hospitals on measures and outcomes for care provided, including heart attacks, heart failure, pneumonia, surgical care, children's asthma care, inpatient psychiatric services, venous thromboembolism (VTE) care, stroke care, and immunizations.

The Joint Commission, a healthcare accrediting agency based in Oakbrook Terrace, Ill., noted that the number of top performer hospitals increased 77% in 2012. The California numbers closely correlate to this increase.

Altogether, 305 hospitals in California submitted data to the Joint Commission, compared to 302 in 2011, when 55 received the top performer designation. In 2010, 278 hospitals submitted data, and 34 were named top performers.

"More than half of Joint Commission-accredited hospitals have reached or have nearly reached top performer distinction, showing that we are approaching a time in which consistent excellence in hospital performance on these important quality measures is the new normal," said **Mark R. Chassin**, M.D., chief executive officer of the Joint Commission. "This means patients are getting better care thanks to the shared commitment by hospitals to using data and proven quality improvement methods to

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Sutter (Continued from Page One)

these reforms and this settlement. This new transparency should lead to lower prices and point the way to similar billing reforms for all types of hospital services," Jones said.

Sutter did not admit any wrongdoing. Indeed, officials with the system, which operates 28 hospitals throughout Northern California, insisted after the settlement was announced that it did nothing wrong.

"We followed the law, as well as hospital industry practice," said Sutter spokesperson **Karen Garner**, who added that about 90% of California's hospitals bill for anesthesiology in the same manner.The settlement also extends to **Marin General Hospital** in Millbrae. It had been under Sutter management until 2010. Two interrelated firms that provide claims processing services on Sutter's behalf, **MultiPlan** and **Private Health Care Systems**, also agreed to pay $925,000 for their alleged role in tamping down objections to anesthesia billing from outside payers.

The **California Hospital Association**, which had filed an amicus brief supporting Sutter in the lawsuit, expressed similar sentiments. It noted Sutter's new billing protocol would be a deviation from the industry standard.

Is Blue Shield Shopping For Regulators?

Jones Claims It Deliberately Moved Business To DMHC

California Insurance Commissioner **Dave Jones** accused **Blue Shield of California** of using regulatory "loopholes" to move virtually its entire book of business for individual policyholders to the **Department of Managed Health Care** in order to save millions of dollars in premium taxes.

Jones made the charges during a press conference Tuesday, where he announced the San Francisco-based insurer had agreed to delay by 90 days the cancellations of 115,000 individual policies as part of its reorganization under the Affordable Care Act.

The Department of Insurance claimed Blue Shield used a loophole to not only cancel the policies, but move individual policies it offers that adheres to ACA guidelines to the DMHC for regulation. Jones said his office had been notified of the shift by Blue Shield in mid-October.

"They've picked up all their marbles and moved to another marble game," he said.

Blue Shield spokesperson **Steve Shivinsky** contended in an email that that characterization was inaccurate. Instead, he said it applied to policies that were not yet being offered in the market but "mirrored" those being offered on the **Covered California** health insurance exchange.

However, Shivinsky did not deny the insurer expects to have most of its book of business in the coming months regulated by the DMHC (the plans offered by an affiliate, **Blue Shield Life & Health Insurance Co.,** are regulated by the DOI). He noted that the DMHC, which focuses on plans that operate under the state's Knox-Keene act and are health maintenance organizations, currently regulates about 80% of its products, and it will grow to 90% by January 2015.

"Consolidating under one company will simplify our operations and significantly lower

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In Brief

always do the right thing and improve quality and safety."

Among those receiving the designations in California included 25 hospitals operated by Oakland-based **Kaiser Permanente** and eight operated by Ontario-based **Prime Healthcare Services**.

Sharp HealthCare, Scripps Health Join San Diego RHIO

San Diego's health information exchange has become an independent entity, renamed itself and added two of the region's most significant providers as participants.

The exchange is now called **San Diego Health Connect**, formerly known as the **San Diego Regional Health Information Exchange**. **Scripps Health** and **Sharp HealthCare**, the region's two biggest hospital operators, have also elected to participate in the exchange and allow their records to be shared with other providers.

"The commitments from Scripps and Sharp...go a long way toward demonstrating that San Diego Health Connect has advanced successfully from a federally-funded, university-based initiative to a self-sustaining, community-funded not-for-profit organization with a greater reach," said **Daniel J. Chavez**, the exchange's executive director.

Current exchange participants incude **Kaiser Permanente San Diego Medical Center**, **UC San Diego Health System**, **Rady Children's Hospital San Diego**, **VA San Diego Healthcare System**, and a variety of community clinics.

The exchange received three years of grants from the U.S. Health and Human Services **Office of the National Coordinator for Health Information Technology**. The funding ended in September, making the exchange an independent entity.

Blue Shield (Continued from Page One)

administrative costs," Shivinsky noted. He added that the company's expanding number of accountable care organizations are also offered under the Blue Shield of California label.

A DMHC spokesperson confimed Blue Shield already has a large majority of its policyholders under its regulation, about 2.3 million in total.

However, shifting large chunks of its business over to the DMHC will permit Blue Shield to avoid the gross premium tax levied by insurance companies that are regulated by the DOI, according to Jones. He estimated that the tax for Blue Shield is approximately $107 million a year, and that it was exercising what he referred to as a loophole to avoid paying it. As a result, Jones suggested that the recent decision by insurers **Aetna** and **Cigna** to exit the individual market in California may have been influenced by this tax advantage Blue Shield enjoyed.

Shivinsky denied Blue Shield was moving their plans over to the DMHC for tax purposes. "There is no 'loophole' – state law allows Blue Cross and Blue Shield plans to offer PPOs under DMHC," he said.

Blue Shield's move to get more of its insurance products under the DMHC's purview is the opposite tack of what consumer advocates said had been a longstanding practice of trying to get policies under the DOI's jurisdiction because the Insurance Commissioner does not have the power to reject premium increases as unreasonable.

"The ACA has leveled the playing field," because of the uniformity of benefits that must be offered by insurers, said **Jamie Court**, president of **Consumer Watchdog**, a Santa Monica-based group that has sponsored a 2014 ballot proposition that would give both the DOI and DMHC the power to regulate rates if approved by voters. As a result, he added, many insurers have gradually been moving their policies over to the DMHC in order to avoid the gross premium tax.

"There's something rotten in California when the health plan can choose their regulator," Court said.

Molina Reports Strong 3Q Earnings

Market Expansion Credited With Numbers Growth

Long Beach-based insurer **Molina Healthcare** more than doubled its earnings for the quarter ending Sept. 30, buoyed by recent market entries in the three states.

Molina, which specializes in managed care plans in the Medicaid market, reported net income in the quarter of $7.6 million on revenue of $1.6 billion. That compares to net income of $3.3 million on revenue of $1.4 billion for the third quarter of 2012.

Premium collection was up 9% for the quarter, buoyed by a 5% increase in overall enrollment, to 1.92 million from 1.82 million, and a 4% increase in monthly revenue per enrollee.

For the first nine months of 2013, Molina reported net income of $62.1 million on revenue of $4.9 billion. That compares to the first nine months of last year, when it reported a loss of $15.8 million on revenue of $4 billion.

Company officials said the gains were attributed to entering the New Mexico, South Carolina and Illinois markets, and stemming losses associated with its business in Texas.

"I am pleased with the third quarter results, particularly because medical margins increased at all but one of our health plans," said **J. Mario Molina**, M.D., Molina Healthcare's chief executive officer. I remain optimistic about our future long-term prospects."

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Paramedics Rescuing Primary Care?

Initiative Planned For Next Year Could Make a Big Difference

The ongoing physician shortage in California is forcing many provider organizations to think outside of the box in terms of how to stretch existing capacity.

There have been mixed results to address this issue legislatively: A watered-down bill to provide a limited scope of practice expansion to pharmacists was recently signed into law. However, similar efforts on behalf of nurses and optometrists have failed due to objections from the California Medical Association and other provider lobbies.

Yet two state agencies – the **Office of Statewide Health Planning and Development** (OSHPD) and the **California Emergency Medical Service Authority** (EMSA) – may succeed where the California Legislature has failed. And paramedics may be placed at the center of reform efforts.

Existing law in California allows OSHPD to test, demonstrate and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes in licensing are made by the Legislature. Using that authority, EMSA is planning to do just that by expanding the role of paramedics in counties electing to participate in a health workforce pilot project next year.

Under this pilot, paramedics would be allowed to transport non-emergent 911 callers to medical sites other than hospital emergency rooms. Paramedics would also be allowed to provide followup care to recently discharged patients who have chronic conditions such as diabetes, asthma and congestive heart failure. And they would also be permitted to partner with primary care providers and community health workers in medically underserved areas (mostly rural and isolated parts of California) to provide preventative healthcare services.

There have been similar scope-of-practice expansion efforts for paramedics in other states. In Colorado, paramedics in one jurisdiction have administered blood tests, conducted visits to newborns and performed some limited medication management. They have been able to save about $1,200 in healthcare costs for each patient treated.

In North Carolina's New Hanover County, paramedics are receiving an additional 300 hours of training on patient assessment and management. Local hospital admissions have dropped significantly as a result, spurring at least a half-dozen other similar programs statewide.

I have to wonder if my physician brother and my emergency room physician friends know this is coming? Aside from the expansion of the scope of practice for EMT-paramedics to be allowed in this pilot, this cuts directly into the income of ER docs (and hospitals) who now get to bill for the care they provide to the many thousands of non-emergency patients brought to hospitals each year by ambulances because that is the current protocol in most jurisdictions for managing 911 calls.

By Jim Lott

At the same time, however, primary care resources will be extended, and it is likely that doctors will feel less overburdened, no doubt allowing them to provide higher quality of care to the patients they do see.

For more reading on this issue, I highly recommend that you read "Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care," a report published last month by the **Institute for Population Health Improvement at UC Davis**.

Jim Lott is the executive vice president of COPE Health Solutions in Los Angeles. He is a member of the Payers & Providers editorial board.

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

