Insurers Fail to Uphold Their End on Billing Agreements

BY ALICIA AULT
Associate Editor, Practice Trends

LAS VEGAS — Large insurers will return to inappropriate billing practices as class action suit agreements expire, according to a compliance expert.

In fact, many companies have been accused of violating the terms already, said Edward R. Gaines III, vice president and chief compliance officer for Healthcare Business Resources in Durham, N.C., who spoke at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

Mr. Gaines said that noncompliance among all the plans that have settled has continued to be an issue, which is being dealt with in the courts and administratively. But, "the problem is, once the settlement agreement expires, I can't go back into federal court through an easy process to make my complaint heard," he said.

The settlements were struck in response to Multidistrict Litigation 1334, which was certified as a class action in U.S. District Court for the Southern District of Florida in 2002 and named Aetna Inc., Anthem Insurance Cos. Inc., Cigna, Coventry Health Care Inc., Health Net Inc., Humana Inc., PacifiCare Health Systems Inc., Prudential Insurance Co. of America, United Health Care, and WellPoint Health Networks Inc. as defendants. The suits alleged that the insurers violated the federal Racketeer Influenced and Corrupt Organizations Act by engaging in fraud and extortion in a common scheme to wrongfully deny payment to physicians.

Several state and county medical societies filed the suits on behalf of virtually every physician in the nation—about 900,000 doctors.

United Health Care and Coventry both were summarily released from the litigation. Their release has been upheld on appeal.

Aetna and Cigna struck agreements that entailed an immediate payout in response to claims filed by physicians, some changes in billing behavior, and an agreement to provide prospective relief—$300 million from Aetna and $400 million from Cigna.

Cigna's 4-year agreement has now expired, and Aetna's 4-year agreement expired in June 2007; but Aetna's agreement was extended through June 2008 because of compliance disputes. After an investigation, the New Jersey insurance department fined Aetna $9.5 million in June 2007 for failing to properly pay for out-of-network providers. The insurer is paying nonparticipating physicians only 125% of Medicare rates and informing patients that they are not responsible for the difference.

Mr. Gaines urged physicians to hold the health plans that settled accountable to their agreements. Information on settlement terms and how to dispute claims can be found at www.hmosettlements.com. ■

States Look Inward as Health Tabs Grow; Tax Revenues Fall

BY ALICIA AULT
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WASHINGTON — With health care expenses accounting for the single largest expense in their budget, states are increasingly looking for solutions from within, not from the federal government, according to an annual accounting of state legislative trends compiled by the Blue Cross and Blue Shield Association.

"Health care spending represented nearly one-third of total state expenditures last fiscal year," said Susan Laudicina, BCBSA director for state research and policy at a briefing for reporters. As the economy weakens, health care costs will continue to rise, while tax revenues will fall. That will add to the pressure to find creative solutions, she said.

The most significant trend observed in the states: an attempt to expand coverage. About half of the state legislatures debated universal coverage or expansion programs for children in fiscal 2007. State mandates requiring individuals to buy insurance were introduced in 12 states. All of those failed, largely because they are controversial, said Ms. Laudicina.

Connecticut and New York expanded eligibility for SCHIP to 400% of the federal poverty level and seven other states raised eligibility to 300%, but those efforts are threatened by a rule change issued by the Department of Health and Human Services last August that ostensibly caps eligibility at 250% of the federal poverty level. Eight states have sued to challenge that ruling.

Eight states—Connecticut, Indiana, Kansas, Louisiana, Maryland, New York, Texas and Washington—created programs in which public funds are used to subsidize the cost of private employer-sponsored health insurance to Medicaid-eligible workers. Oklahoma expanded its existing subsidy program, making more people eligible.

So-called "transparency" initiatives are gaining ground, also. These are proposals that require hospitals—and in some cases, physicians—to publicly share information on infections and other adverse events, and also other quality data and pricing. Twenty-one states debated proposals that would require transparency on some level. Transparency bills were enacted in 10 states: Arkansas, Delaware, Georgia, Indiana, Minnesota, New Jersey, Oregon, Pennsylvania, Texas, and Washington. Eleven states will take up transparency measures in 2008, she said. ■

Hospitals Grapple With New Joint Commission Safety Goal

BY MARY ELLEN SCHNEIDER
New York Bureau

The Joint Commission on Accreditation of Healthcare Organizations' new 2008 patient safety goal of requiring a process to respond quickly to a deteriorating patient is being mistakenly interpreted at some hospitals as a mandate for rapid response teams or medical emergency teams, while other organizations that already have rapid response teams are concerned they will need to redo their established systems.

But Dr. Peter Angood, vice president and chief patient safety officer for the Joint Commission, said such presumptions are incorrect—hospitals are simply being asked to select a "suitable method" that allows staff to request assistance from a specially trained individual or team when a patient's condition seems to be worsening.

The key is to focus on early recognition of a deteriorating patient and the mobilization of resources and to document the success or failure of the system that is in place, he said. "This is not a goal that states there needs to be a rapid response team."

Many institutions have implemented rapid response teams, and the data on their efficiency is generally good, but not every study has been positive, Dr. Angood said. As a result, officials at the Joint Commission wanted to move forward with a more basic approach to avoid variation in response from day to day and between shifts. (See box.)

Hospitalists are likely to play a significant role in accomplishing this goal, said Dr. Franklin Michota, director of academic affairs for the department of hospital medicine at the Cleveland Clinic.

Those with hospitalist programs in place are leaning toward using rapid response teams or medical emergency teams, because hospitalists can function as team members. Some hospitals that do not have enough staff to have a 24-hour team in place are considering starting hospitalist programs. Yet another strategy is to form teams that do not include physicians, he said.

But the requirement will not be without cost, Dr. Michota said, especially for organizations that have to add staff.

When hospitalists aren't a part of a response team, they are likely to be central to developing the response plan, said Dr. Robert Wachter, chief of the division of hospital medicine at the University of California, San Francisco. Perhaps the biggest role for the hospitalist is in providing the around-the-clock coverage that could negate the need to call the formal response team as often, he said.

Brock Slabach, senior vice president for member services at the National Rural Health Association, argued that smaller organizations might be able to meet the commission requirements more easily than large, urban facilities can, because they are more flexible and can work faster because there is less bureaucracy.

A number of hospitals have already made a commitment to establish some type of rapid response teams, which is one of the strategies advocated as part of the Institute for Healthcare Improvement's 5 Million Lives Campaign, a national patient safety campaign for reducing harm in hospitals.

Of the 3,800 hospitals enrolled in the 5 Million Lives Campaign as of January, about 2,700 have committed to using rapid response teams, according to the IHI.

The cost of implementing these types of teams varies, said Kathy Duncan, R.N., faculty for the 5 Million Lives Campaign. About 75% of hospitals in the campaign have done this without an increase in their full-time employees, because for most staff, it just entailed an additional task. But investment is required for training team members, which can be costly, she said.

Ms. Duncan said hospitals should start by assessing their available resources, then before implementation, they should test the process. "Start small with a pilot process," she advised. ■

Implementing the Response Plan

Because of the complexity of implementing a process to respond quickly to a deteriorating patient, officials at the Joint Commission are giving hospitals a year to develop and phase in their program.

By April 1, the first deadline, hospital leaders were required to assign responsibility for the oversight, coordination, and development of the goals and requirements. By July 1, there needs to be an implementation work plan in place that identifies the resources needed. By Oct. 1, pilot testing in one clinical area should be underway.

The Joint Commission is serious about organizations meeting these implementation milestones, Dr. Angood said. Hospitals that don't meet the quarterly deadlines will be docked points on their evaluation.

For 2009, hospitals will need to comply with the following six "implementation expectations" set out by the Joint Commission:

- ► Select an early recognition and response method suitable to the hospital's needs and resources.
- ► Develop criteria for how and when to request additional assistance to respond to a change in a patient's condition.
- ► Empower staff, patients, and/or families to request additional assistance if they have a concern.
- ► Provide formal education about response policies and practices for both those who might respond and those who might request assistance.
- ► Measure the utility and effectiveness of the interventions.
- ► Measure cardiopulmonary arrest rates, respiratory arrest rates, and mortality rates before and after implementation of the program.