PAYERS & PROVIDERS

CALIFORNIA EDITION

Calendar

March 8-10

Stepping Up To Leadership Conference. Island Marriott Resort, Coronado. Training program for physician leaders in order to increase their management effectiveness. $575-$995.

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March 13

California Self Insurers Annual Meeting. Disneyland Hotel. A closer look at claims fraud and other relevant issues. $250-$350.

Click Here for More Information

March 29

National Pay For Performance Summit. Century Plaza Hotel, Los Angeles. Sponsored by the Integrated Healthcare Association. $1,495-$1,795.

Click Here for More Information

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.

Language Possible Enrollment Barrier

110,000 Could Pass on Health Coverage Subsidies

Language barriers may keep more than 100,000 Californians eligible for insurance subsidies from purchasing coverage after the bulk of healthcare reform is implemented in 2014, according to a new study.

Researchers at the **UCLA Center for Health Policy Development**, **UC Berkeley** and the **California Pan-Ethnic Health Network** have concluded there are more than 1 million adult Californians with limited English proficiency (not their native language and are uncomfortable speaking it) eligible for tax subsidies toward the purchase of coverage on the state's health insurance exchange.

That's only about one-seventh of Californians who are not proficient with English statewide, but they represent about 40% of all residents expected to be eligible for the subsidies. The vast majority are Spanish speakers, but there are large subgroups who speak Chinese, Vietnamese and Korean.

The subsidies, part of the Affordable Care Act, provide individuals with potentially thousands of dollars in tax credits a year to provide an incentive to purchase healthcare coverage if it isn't already offered by their employer.

A use of simulation software by the researchers to predict enrollment trends concluded only 42% of those eligible enrollees with limited English proficiency will likely purchase coverage, or about 420,000 in total.

"The evidence suggests that Californians who do not speak English very well are at a disadvantage in terms of accessing healthcare reform programs," said **Daphna Gans**, a research scientist at the UCLA Center for Health Policy Research and the lead author of the study.

Observers say Californians who struggle with English would face issues enrolling in the state's Health Benefits Exchange.

"If you go to the website to enroll and it's in a language you don't understand, you basically will close it immediately," said **Ellen Wu**, executive director of the Pan Ethnic Health Network.

If language barriers are lifted, researchers predict enrollment among those with limited English proficiency will rise by more than a quarter and reach 53%, or about 530,000.

Simply translating marketing and applications materials is not expected to suffice. "There needs to be a multidisciplinary outreach to this community," Gans said. An example would be proactive communications by *promotores*, advocates who work in Latino

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In Brief

Scripps Study Links Sleeping Pills To Higher Rates of Cancer, Death

Researchers at the **Scripps Clinic** in San Diego have linked a reliance on commonly prescribed sleeping pills to an elevated risk of cancer and death.

Death rates among patients 18 years and older were elevated 3.6 times even when they were prescribed as few as one sleeping pill per year.

Among those who were prescribed 132 or more sleeping pills per year the risk of cancer was elevated by about 35%.

The study focused on the eight most commonly prescribed hypnotic drugs, including Ambien and Restoril.

"We tried every practical strategy to make these associations go away, thinking that they could be due to use by people with more health problems, but no matter what we did the associations with higher mortality held," said **Robert D. Langer**, M.D., of the **Jackson Hole Center for Preventive Medicine** in Jackson, Wyoming.

Langer co-authored the research with Scripps physicians. It was recently published in the journal ***BMJ Open***.

Kaiser Plans To Reduce Greenhouse Emissions By Nearly A Third

Kaiser Permanente has announced a bold new plan to reduce its carbon emissions by nearly a third by 2020.

Kaiser said it would achieve the reduction by investing in clean and renewable energy sources while also focusing on conservation. It is using cogeneration technology at its

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Barriers (Continued from Page One)

neighborhoods and promote various healthcare options and services – in Spanish.

Both Gans and Wu indicated that officials with the nascent Health Benefits Exchange are committed to aggressively marketing its services in linguistically and culturally sensitive manner.

"The exchange board seems to be very committed to target these populations, and try and make the transition process from current to future programs smoother," Gans said.

Peter V. Lee, the exchange's executive director, was out of town on Wednesday and not immediately available for comment.

DMHC Admits Consumer Breach

Victims' Medical Data Was Posted On Agency Site

For years, the **Department of Managed Health Care** has posted copies of enforcement actions against health plans, medical groups and unscrupulous insurance agents on its website. More than 1,400 are available, with a dozen or so new actions routinely added every month.

That routine abruptly halted in mid-October. DMHC spokespeople gave vague explanations as to why. One mentioned a website redesign; another of "errors" involving some of its enforcement actions.

It turns out in its zeal to be transparent, the regulator had indeed erred.

According to documents obtained by ***Payers & Providers*** as part of a Public Records Act Request, the DMHC had posted the confidential medical information of seven people enrolled in Medicare Advantage plans who had provided information to the agency as part of its investigations into unscrupulous business practices. Another individual had filed a grievance against **Anthem Blue Cross of California**.

DMHC spokesperson **Marta Bortner** confirmed earlier this week that a breach had occurred. She said the documents were normally posted for the public but had been "insufficiently redacted." They were taken down immediately after the error was discovered last October, she added.

The seven Medicare Advantage enrollees had been victims of agents who had enrolled them in new plans using deceptive marketing practices and sometimes without their consent. In many instances the change left them without access to their regular physicians and thousands of dollars of medical bills they would not have had with their original coverage.

One agent, **Stuart Chesler** of Marina Del Rey, had been the subject of a cease and desist issued order by the agency in March 2010. Another agent, **Brenda Ridley** of Bakersfield, had been the subject of a similar order in March 2011. Agents **Dinah Salcido**, **Victor Chervin** and **Sandy Rosales** had received orders in September 2011.

The DMHC had disclosed to the individuals that in posting the documentation of the orders, their normally confidential medical information had been revealed, including the names of their physicians, their medical conditions and the medications they were taking. In the case of the Anthem enrollee, a medical procedure they had received was disclosed.

None of the enrollees had their full medical records posted.

Along with the enrollee disclosures, the DMHC had also disclosed the Social Security number, birthdate and previous address of an insurance agent it had ordered to stop selling policies last fall due to his agency's deceptive marketing practices and his failure to disclose state and federal criminal convictions.

The name of the agent was redacted in the correspondence released by the DMHC, but other information available confirmed it was **Hussein Osman Ali** of Fresno.

The DMHC had played up the orders against Chesler and Ali in press releases, and had recently held an extensive press conference on the subject of deceptive practices among brokers of Medicare Advantage plans. In recent years it had taken

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In Brief

hospitals and installing more energy efficient lighting and window films, among other efforts.

According to data released by the Oakland-based hospital operator, it released 837,000 metric tons of greenhouse gas emissions in 2010, versus 819,000 tons in 2008. It projects it will reduce its emissions by 264,000 metric tons a year by 2020.

"It is our responsibility to reduce our impact on the environment so that we can better protect people's health," said **Raymond J. Baxter**, Kaiser's senior vice president for community benefit. "Our efforts to minimize our impact on the climate reflect a commitment to the total health of our members and our communities."

CDC Says Many Americans Are Struggling With Medical Debt

New data released by the **Centers for Disease Control and Prevention** conclude that one in five families during the first half of 2011 was experiencing financial burdens due to paying medical bills. About 10% of total families could not pay their medical bills at all.

People in lower income brackets were three times more likely to have trouble paying their medical bills over the past year than other income brackets surveyed.

It was the first time the CDC has queried Americans over medical debt. Its numbers are similar to those arrived at in recent years by the Washington-based **Center for Studying Health System Change**.

"As the number of uninsured increased, and there was higher unemployment, you'd expect that more people would report having problems paying medical bills," said the CSHSC's **Peter Cunningham**.

DMHC (Continued from Page Two)

disciplinary actions against more than 20 brokers after documenting illegal sales tactics. The agency is also investigating numerous data breaches disclosed by insurers.

In the DMHC's case, the sensitive information remained publicly available on its website for as long as seven months, although in most instances it was posted for about a month beginning in mid-September, according to documentation.

In November, the DMHC sent disclosure letters containing expressions of regrets or apologies to the enrollees and an apology to Ali. It recommended that the victims monitor their explanations of benefits for any unauthorized charges. In Ali's case, it recommended ongoing credit monitoring, although it did not offer to pay for the service.

Attempts at telephonic contact to the individuals were also made, Bortner said.

At least one of the victims has filed a lawsuit against the DMHC. Bortner could not provide any details about the litihation.

As a result of the error, the DMHC has stopped posting ongoing enforcement actions. It has created new internal policies for redacting documents prior to posting.

Bortner said the postings of new enforcement actions may not resume until this springtime at the earliest.

Health Net Revamps Low-Cost Plan

Adds Enrollees, Access to Complementary Care

Health Net has revamped one of its low-cost health health maintenance organization products, adding wellness incentives for enrollees and opening up access to chiropractors and acupuncturists.

The insurer's Bronze HMO has been renamed SmartCare. The Bronze HMO is a "narrow network" health plan, wherein the provider panel is considerably smaller than a traditional health plan in order to cut costs.

As part of the retooling, enrollees will receive financial incentives to engage in what a statement called "healthy habits."

Health Net spokesman **Brad Kieffer** said the plan is to provide enrollees with a $50 retailer gift card if they visit their primary care physician and fill out a health risk questionnaire. Such a document allows providers to obtain a fuller profile of a patient's personal habits and make recommendations to improve their overall health.

"The idea is to increase the level of engagement with the providers," Kieffer said, noting that many enrollees do not often visit their physician.

In addition to the gift card incentive, enrollees will have access to as many as 10 chiropractic or acupuncturist visits per year with a $15 co-payment.

The SmartCare plan will be used in conjunction with 40 medical groups in Los Angeles, San Bernardino and San Diego counties.

They share our vision of creating strategic provider partnerships that, in many cases, will result in effective accountable care organizations delivering care that is personal, simple and local," said Steve Sell, president of Health Net's western region.

SmartCare will be available to small and large employer groups. It is expected to cost in some instances to cost as much as 25% less than other Health Net HMO products.

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All advertising, subscriber and editorial inquiries:

(877) 248-2360
info@payersandproviders.com

Mailing address:

818 N. Hollywood Way, Suite B
Burbank, CA 91505

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Having The HENS Rule The Henhouse

Hospital Engagement Networks Can Cut Errors, Deaths

The Medicare program is betting on a new course of action to curb what one medical journal has dubbed an "epidemic" of uncontrolled patient harm.

The effort is pegged to the success of a little-known entity called a "hospital engagement network" (HEN). In December, the government selected 26 HENs and charged them with preventing more than 60,000 deaths and 1.8 million injuries from so-called "hospital-acquired conditions" over the next three years. That would be the equivalent of eliminating all deaths from HIV/AIDS or homicide over the same period.

By Michael Millenson

Despite those big numbers, and an initial price tag of $218 million, it's unclear whether the HENs are adequately ambitious or still only pecking away at the patient safety problem. While this is by far the most comprehensive public or private patient safety effort ever attempted in this country, it still aims to eliminate less than half the documented, preventable patient harm.

In December, the government chose a mix of national and local groups -- primarily health systems and hospital organizations -- to run individual HENs. Each HEN is charged with spreading safety-improvement innovations that have been proven to work in leading hospitals to others through intensive training programs and technical assistance. Although the program lasts three years, initial HEN contracts are for two years, with an "option year" dependent upon performance.

This bottom-line accountability is what sets the HENs apart from past voluntary efforts. Program co-directors Paul McGann, M.D. and Dennis Wagner give weekly briefings to Health and Human Services Secretary Kathleen Sebelius. "This is a full-court press unlike anything I've seen in my 10 years in government," McGann said.

Although the HENs' total cost is slated to rise to $500 million by its third year, that's still chicken feed compared to what the government says will be savings of up to $35 billion from safer care, including up to $10 billion in savings for Medicare. In addition to preventing injuries and deaths, the program plans to eliminate 1.6 million preventable hospital readmissions.

Still, there remains the question of whether the program's goals should be even more sweeping. And one might wonder why the chance to not harm patients is not reason enough for hospitals to change without being paid by the government.

For context, it helps to understand that the most widely quoted estimate of preventable patient harm – 44,000 to 98,000 deaths and one million injuries annually – was probably low. That estimate caused an uproar in a 1999 Institute of Medicine report. Today, it seems conservative. The IOM total was based on studies conducted in hospitals in the mid-1980s. Recent research by the HHS Office of the Inspector General and others has found a much higher rate of harm. A Medicare patient today has a one-in-seven chance of suffering harm in the hospital.

Moreover, nearly 9 out of 10 incidents are never reported, the OIG concluded, even including incidents that led to patient deaths. That lack of progress testifies to very modest pressure to show results.

Enter the HENs, prodded by a stick.

In 2008, Medicare began denying payments to hospitals for eight complications of treatment, the program's first major use of negative incentives. The number of conditions has since increased, along with efforts to pressure hospitals through public quality report cards. Meanwhile, the 2010 health reform law includes financial penalties that go into effect later this year to discourage preventable readmissions.

Put differently, hospitals now have a significant financial as well as ethical incentive to participate in a hospital engagement network.

Michael Millenson is president of Health Quality Advisors LLC in Highland Park, Ill. He is a member of the Payers & Providers Midwest editorial board. A version of this op-ed first appeared in Kaiser Health News (www.khn.org).

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

scan HEALTH PLAN®

SENIOR HEALTHCARE ANALYST

JOB SUMMARY: This position will support the HCC and Encounter Team in Health Care Informatics by collecting and analyzing healthcare related data by performing data management, quality improvement studies and by conducting statistical analysis and generating reports for the organization's decision makers.

ESSENTIAL JOB RESULTS: Support operational needs by performing complex analyses on a wide range of organizational data - investigate and uncover root causes, identify trends, etc. and propose solutions. Achieve results by effectively leveraging expertise in healthcare/managed care data including, but not limited to, membership, provider, claims, authorizations, pharmacy, and financial information. Commitment to customer service achieved through timely, accurate, and supportable deliverables. Support customer needs for what-if scenario analysis by developing analytical tools/models. Ensures understanding of customer needs by proactively clarifying scope and requirements and keeps customers apprised of project status through effective communication. Achieves high-quality deliverables by assuring accuracy and thoroughness in executing projects. Manages multiple (department) projects by effectively prioritizing work and communicating workload issues to management. Develops and maintains up-to-date knowledge of the Data Warehouse and other organizational data sources. Maintains professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies. Contributes to team effort by accomplishing related results as needed.

QUALIFICATIONS: Bachelor's Degree, or equivalent experience required. 4+ years of proven analysis experience highly preferred, or 2+ years of proven analysis experience in a Healthcare/Managed Care environment highly preferred. Ability to effectively interact with, and present findings to customers at all levels of the organization including operational managers, medical directors and executives required. Proficiency with MS SQL (queries) highly preferred. Clinical code knowledge related to claims/utilization highly preferred. Experience with managed care contract terms/analysis a plus. Experience in a Medicare Advantage environment a plus. Experience with MS BI products a plus. Expert skills in MS Office productivity software, especially MS Excel. Excellent technical, interpersonal, written and oral communication skills required. Superior analytical skills required.

FT position, M-F 8 AM to 5 PM, with extended work hours and possible travel, as needed. Apply to www.scanhealthplan.com – Job Opportunities – Req. #11-540

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ESSENTIAL JOB RESULTS: Coordinate and execute complex tasks related to network and membership growth via market expansion, in order to ensure the successful completion of ongoing cycles of work. Utilize detailed work lists to manage the timely completion of tasks for each phase of a particular market expansion process and provide necessary updates to management, escalating risks as appropriate. Develop and maintain positive relationships with internal departments and external entities, creating partnerships to achieve program objectives. Effectively communicate and assign deliverables and timelines. Monitor and manage the assigned tasks to achieve timely completion. Monitor quality of tasks performed, develop and recommend process improvements for implementation. Assure a quality market expansion process outcome by making sure that each finished task meets the required level of quality. As needed, troubleshoot issues and provide innovative solutions, focused on continuous quality improvement. Maintain professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies. Contribute to team effort by accomplishing related results as needed.

QUALIFICATIONS: Bachelor's Degree required. Preferred area of study: Business or Health Administration, Management or Process Engineering. Experience within Healthcare/Managed Care, preferred. Demonstrated interpersonal skills with the ability to compromise, persuade, and negotiate, be well-rounded and have excellent communications skills. Solid leadership skills, excellent written and verbal communications skills and ability to establish effective working relationships with many different people, ranging from managers, supervisors, and professionals, to administrative and support staff personnel. Analytical, detail-oriented, flexible, and decisive. Ability to coordinate several activities at once, quickly analyze and resolve specific problems, and manage deadlines. Ability to work with minimal supervision, so need to be self-motivated and disciplined. Expert skills in MS Office productivity software and strong computer skills are essential.

FT position, M-F 8 AM to 5 PM, with extended work hours and possible travel, as needed. Must maintain valid driver's license, automobile insurance and reliable transportation. Apply to www.scanhealthplan.com - Job Opportunities – Req. #12-612

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MDS Consulting is seeking a consulting leader that is highly experienced in medical group, medical foundation, and physician practice development and operations. The successful candidate will have depth of knowledge regarding compensation plans, information technology, organizational structure and finance related to medical groups, IPAs, and ACOs. Development skills in client relations, team management, communications, and report writing a necessity. Position located in Southern California and requires a Masters degree in related field and at least 10 years of related experience.

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