MANAGED CARE OUTLOOK

The Insider's Business Briefing on Managed Healthcare

ASPEN PUBLISHERS

Volume 23, Number 7 • April 1, 2010

At Presstime

HHS Announces Funds for Prevention and Wellness Initiative

The U.S. Department of Health and Human Services (HHS) recently announced a funding opportunity for national public or private nonprofit organizations to apply for $10 million in cooperative agreements to help communities decrease smoking and obesity, increase physical activity, and improve nutrition. The initiative, *Communities Putting Prevention to Work,* will change systems and environments — for example, improving access to healthy foods and opportunities for physical activity — and put into place policies that will promote the health of populations.

Funded by the American Recovery and Reinvestment Act of 2009 (ARRA), the $10 million in available funds will be awarded to national organizations through a competitive agreement process. The HHS Office of Public Health and Science is leading the national organizations component of *Communities Putting Prevention to Work* in partnership with the Centers for Disease Control and Prevention.

To learn more about the *Communities Putting Prevention to Work* program, go to www.hhs.gov/ophs/funding/index.html. ■

Wolters Kluwer
Law & Business

Despite Lingering Barriers to Adoption, Physicians See Value in EHRs, Look for Ways to Adopt

It has been roughly a year since the American Recovery and Reinvestment Act (ARRA) was signed into law by President Obama. Since that time, the push toward greater adoption of electronic health records (EHRs) has continued to gain momentum as physician practices and medical settings across the country have looked for ways to utilize new technologies without breaking the bank.

According to a recent survey[1] conducted by GfK Roper on behalf of Practice Fusion, an online provider of EHR services, a growing number of patients have seen their physicians transition to an electronic system instead of using a paper-based system. The survey also found widespread expansion of the health information technology (IT) sector in general.

(See Despite Lingering Barriers … page 3)

VBID Programs Focus on Improved Health Outcomes for Employees

Value-based insurance design (VBID) is not a new concept in health care, but it is one that continues to evolve and take shape, especially in the midst of health care reform discussions and employers looking for ways to trim (or at least contain) costs while improving the quality of life and health outcomes of their employees.

Last summer, the National Pharmaceutical Council (NPC) partnered with Mark Fendrick, MD, professor of Internal Medicine and Health Management and Policy and co-director of the Center for Value-Based Insurance Design at the University of Michigan, to develop a layman's guide to VBID called "Value-Based

(See VBID Programs … page 6)

Managed Care Outlook (ISSN: 0896-6567) is published twice-monthly by Aspen Publishers, 76 Ninth Avenue, New York, NY 10011. Send editorial correspondence to 2107 Old Mill Road, Cedar Park, Texas 78613. Send address changes to Managed Care Outlook, Aspen Publishers, 7201 McKinney Circle, Frederick, MD 21704.
To subscribe, call 800/638-8437. For customer service, call 800/234-1660. Annual Subscription Rate: $632, plus postage, handling, and appropriate state sales tax. Single issues: $24, plus postage, handling, and appropriate state sales tax. Multiple-copy rates available.

National Briefs

Report Looks at Federal Funding for Public Health: Trust for America's Health and the Robert Wood Johnson Foundation have released a new report, *Shortchanging America's Health: A State-By-State Look at How Public Health Dollars Are Spent*, which finds federal spending for public health has been flat for nearly five years, while states around the country cut nearly $392 million for public health programs in the past year, leaving communities around the country struggling to deliver basic disease prevention and emergency health preparedness services. States in the Midwest receive the least federal funding support for disease prevention in public health, at only $16.50 per person in fiscal year 2009. Northeastern states receive the highest amount, at $19.80 per person. Western states receive $19.22 per person, while Southern states receive $19.75 per person.

JCR Introduces New Consulting Services: Joint Commission Resources (JCR), a not-for-profit affiliate of The Joint Commission, has launched a new consulting service that seeks to provide objective, expert evaluation of technology with a patient safety focus. The service, Safe Adoption of Technology, aims to support the highest level of patient safety as JCR assists both hospitals and technology vendors in safely implementing technology through the integration of patient safety, informatics, and clinical care expertise. An initial focus will be directed toward those technologies that support medication processes.

UnitedHealthcare Launches Registry: UnitedHealthcare recently launched its Oncology Care Analysis (OCA) program, which uses a database that combines clinical and claims data to gauge the quality of cancer patient care based on approved treatment guidelines from the National Comprehensive Cancer Network (NCCN). UnitedHealthcare's cancer registry includes clinical and claims data from more than 2,600 oncologists and 8,600 patients across the country with breast, colon, or lung cancer. The combination of cancer stage data and claims information creates a coordinated electronic medical record of a patient's care and then compares that treatment regimen to existing NCCN guidelines.

CIGNA Simplifies Medical Bill Paying for Millions: CIGNA is rolling out Intuit Inc.'s Quicken Health Expense Tracker℠ online bill payment for its medical and pharmacy plan customers at no additional charge. A year ago, CIGNA made Quicken Health Expense Tracker available to those enrolled in the health service company's Open Access, preferred provider organization (PPO), point of service, and health maintenance organization (HMO) health and pharmacy plans. In addition, Quicken Health Expense Tracker is now also available to customers of CIGNA consumer-driven Choice Fund plans. ■

Despite Lingering Barriers …

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"ARRA's $19 billion for health information technology has effectively created a black swan. During a deep recession, the health IT sector is booming and how we think about health data is being fundamentally redefined," says Ryan Howard, chief executive officer (CEO) of Practice Fusion. "I see the change in the exponential growth of our company. Doctors see it through the availability of innovative new technology. Educators see it through grants and the creation of new health IT courses. Patients see it in their doctor's office."

Of the patients surveyed, 48.4 percent reported that during their last visit to a primary care physician or specialist, the doctor stored their medical records digitally on a computer in the examination room, as opposed to paper charts. The Practice Fusion patient survey on EHR adoption also found the following:

- Of patients who reported that their doctor used a computer during their last visit, 45.2 percent said their doctor made the switch to an electronic system during the previous two years; 14.3 percent said the switch occurred in just the last six months.
- Patients who reported their doctors did not use a computer were split on their doctor adopting the technology. Of these respondents, 38.4 percent wanted their doctor to "go digital" while 32.7 percent did not; 28.9 percent were not sure.
- More women (52.8 percent) than men (43.7 percent) reported EHR use by their doctors.
- Higher income patients saw greater EHR use by their doctors; 52.9 percent for respondents with incomes over $50,000 a year compared to 45.2 percent for those with incomes under $20,000 a year.

Doctors who adopt EHRs can qualify for $44,000 or more in economic stimulus incentives through ARRA. For many, however, a laundry list of barriers may stand in the way of adoption.

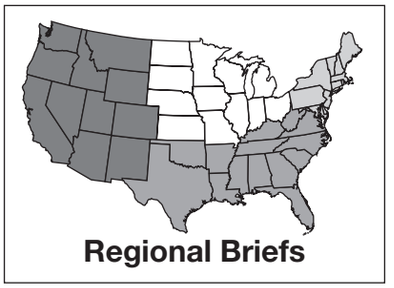
"There are several barriers to implementation of EHRs for small physician offices or primary care practices," explains Robert Rowley, MD, chief medical officer (CMO) of Practice Fusion and a primary care physician with more than 30 years of experience. "There is the issue of cost for many of them. There is also the fear that the EHR will be so difficult to use that it will actually slow them down, resulting in a dip in revenue, which is very critical for people working so close to the margin. There is a common misperception that doctors are all high-margin businesses and can withstand a cutback, but that's just not true. The margins are tight, just like they are for any other business, and many are concerned about encumbering a cost burden for this type of infrastructure."

Companies looking to build a standalone IT infrastructure must take several things into consideration, notes Rowley, including software, servers, networks, security, staff to run the system, backup concerns, Health Insurance Portability and Accountability Act (HIPAA) breaches, et cetera. It is a financial burden that may very well cost more than having a paper-based system and medical record clerks to man the files, he adds.

"It has been our experience that these small practices have been the most difficult segment of the physician market for EHR vendors to penetrate," says Rowley. "They have real concerns about cost and IT infrastructure and in many cases do not take that "next step" as a result. That particular segment of the marketplace, however, has been our sweet spot. We offer a free, Web-based EHR model, with ads, or a model without ads for a small fee; that appeals to a lot of these physician practices who do not want to mess with all the infrastructure issues."

The need to capture data in a quick and easy format that does not slow the physician down is absolutely essential, stresses Rowley. Having all of a patient's information at your fingertips is equally important. Making the transition

(See Despite Lingering Barriers … page 5)



Northeast

Aetna Wins Contract for Pennsylvania Medicaid Program: The State of Pennsylvania has awarded a Medicaid managed care contract to Aetna Better Health,SM Aetna's Medicaid business. Aetna Better Health of Pennsylvania will administer Medicaid benefits for the state of Pennsylvania. Aetna Better Health will begin providing services in Pennsylvania on April 1. The program will offer health care coverage to Medicaid Medical Assistance (MA) members in the five-county Southeast Zone, including Philadelphia, Delaware, Chester, Montgomery, and Bucks counties. The program also is offered in the 10-county Lehigh-Capital Zone, including Northampton, Lehigh, Berks, Lancaster, Lebanon, Dauphin, Perry, Cumberland, York, and Adams counties.

Midwest

UCare Announces Details of 2010 P4P Program: UCare has announced the details of its pay-for-performance (P4P) program for 2010. UCare's P4P program rewards providers for achieving a high-ranking performance or improvements in several health care quality measures for the health plan's Medicaid, Medicare, and special needs plan members throughout Minnesota and western Wisconsin. UCare has made a major investment in provider performance improvement by allocating $2.4 million for distribution in 2011 among provider systems that meet P4P criteria in 2010. The criteria are selected to improve preventive care, identify health issues through screenings for various health risks, and achieve improved outcomes for chronic conditions such as diabetes and cardiovascular disease.

Spectrum Health to Pilot National Payment Reform Program: Spectrum Health is one of four pilot sites selected to participate in a payment reform experiment funded by the Robert Wood Johnson Foundation. Priority Health and Spectrum Health's other business units (Spectrum Health Hospital Group and Spectrum Health Medical Group) will participate in the pilot. The PROMETHEUS Payment® model focuses on transitioning from payment for each care encounter to a single payment for an entire episode of care, often referred to as a bundled payment. Spectrum Health is a not-for-profit health system in West Michigan that offers a full continuum of care.

South

BlueCross Adds New Measures to Physician Quality Tool: BlueCross BlueShield of Tennessee members will now have access to two new measurements in assessing the quality of care they receive from their doctors. On March 3, the company added screenings for childhood immunizations and monitoring of cardiovascular conditions to its existing online suite of eight preventive quality measures. The new measurements are designed to help prevent diseases such as measles, mumps, and rubella and to better manage coronary artery/heart disease. These measures were selected by BlueCross, and reviewed by an advisory panel of physicians, based on their ability to reach crucial segments of the population and positively impact their health status.

West

LiveWell Colorado Releases "Food Policy Blueprint": LiveWell Colorado, a nonprofit organization committed to reducing obesity in Colorado by promoting healthy eating and active living, has released a "Food Policy Blueprint." The Blueprint identifies the most pressing policy needs and opportunities to strengthen access to healthy foods in Colorado. The report was developed

with input from hundreds of stakeholders from across Colorado and offers tools and strategies for improvement in Colorado's food systems. Some tools included in the Blueprint are a searchable healthy foods database; 13 criteria and a scoring system that can be applied to policy recommendations to help prioritize recommendations relating to food access; and eight high-priority policy recommendations that have emerged through surveys and interviews of stakeholders across the state and will direct future policy efforts. For more information, go to www.livewellcolorado.org/resources/policy-blueprints.

Health Net Partners with Stanford to Provide Coverage to Students: Health Net of California, Inc. recently partnered with Stanford University to provide health benefits to the university's undergraduate and graduate students, effective September 1, 2010. Health Net replaces Aetna, Inc. as the administrator of Cardinal Care, Stanford's comprehensive medical and prescription benefits health plan.

Kaiser Permanente Completes EHR Implementation: Every medical facility within Kaiser Permanente's health system is now equipped with Kaiser Permanente HealthConnect®, a private sector electronic health record (EHR). Kaiser Permanente hospitals in Oakland, Richmond, and Vallejo in Northern California are the most recent facilities to complete the final phase of EHR implementation, which includes bedside documentation, clinical decision support, and bar-coding for medication administration. KP HealthConnect securely connects more than 8.6 million people to their physicians, nurses, and pharmacists, personal information, and the latest medical knowledge. ■

Despite Lingering Barriers …

(from p. 3)

to an electronic record, however, isn't always seamless, and there is often a lot of workflow transition that has to happen for the practice to move from a paper-based system to an electronic system.

"The transition can be daunting, which is why we often encourage people to take a step-by-step approach to adoption," explains Rowley. "Maybe you will only use it for scheduling at first, or perhaps chart note capture or electronic prescribing, and little by little, you will add the other pieces and eventually get rid of the paper charts. Some people use an EHR side by side with a paper chart in that transition period that I like to call 'computer-assisted paper chart.' Eventually, the goal is to be paper-free."

Simply going paper-free, however, is not enough, says Rowley. The tool must be intuitive and easy to use. If the physician or other staff members are bogged down with charting, it will cut into the number of patients that can be seen.

"I've seen some that are just like walking through molasses," notes Rowley. "The interface is so cumbersome that the physician spends more time interacting with the EHR than he does interacting with his patients, and that is not a good thing, obviously. That is one of the drivers from a Practice Fusion standpoint. Our goal was to develop something that is so user friendly that you simply look at it and say, 'This is the next logical thing to do.' That's a challenge from a software development standpoint, but there are new Web-based technologies that allow us to adapt and refine the product as we go along. With a Web-based product, users don't have to worry about version upgrades either."

These are only a few of the ways that workflow in private practices can be improved, says Rowley. When data is captured electronically, users can also query that data and have qualitative and quantitative metrics to illustrate how patients are doing.

"It is a real burden for physicians to comply with quality metrics if they don't have electronic records. It would be difficult to say 'sixty-five percent of my diabetic patients have a hemoglobin level of so and so' if you can't query the data electronically. That is extremely important and will change behaviors in the long run."

Practice Fusion recently announced partnerships with 50 certified consultants. The consultants will work with Practice Fusion to provide free, Web-based EHR systems to doctors around the country. Additional information is available at www.practicefusion.com. ■

Endnote:

1. The Practice Fusion survey was conducted from February 5-7, 2010, by GfK Roper Public Affairs & Media, via random digit dialing phone interviews with a nationally representative sample of 1,000 adult interview subjects aged 18 or older nationwide.

VBID Programs …

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Insurance Design Landscape Digest." The Digest highlights three key principles of VBID programs:

- Value equals the clinical benefit achieved for the money spent.
- Health care services differ in the health benefits they produce.
- The value of health care services depends upon the individual who receives them.

"When you talk about 'core principles' of VBID, it all comes down to two or three key points: a) value equals the clinical benefit achieved for the money spent and b) health care services do not produce the same results for everyone," says Fendrick. "If you buy into that philosophy, you likely aren't a big proponent of a health benefit that asks patients to pay the same price for every doctor visit, every diagnostic test, and maybe more importantly, every single drug in a particular tier of a formulary. The challenge is that inertia in the health care sector is extraordinarily hard to overcome. Luckily, however, that inertia seems to be shifting."

Simply stated, VBID programs identify the most clinically valuable interventions and lower or eliminate the financial barriers to purchasing them. According to the Digest, "VBID encourages demand for medically necessary utilization of evidence-based medical services through appropriate cost sharing and reduces barriers to access for these services." In other words, it changes a patient's out-of-pocket costs for health care services based on the clinical benefit achieved — the more clinically beneficial a service is to a patient, the lower the patient's cost share, including copayments.

"Historically, higher patient cost-sharing has been used to reduce utilization of health care services and lower health care spending. And typically, the same level of cost-sharing is broadly applied to categories of medical services or tiers of drugs without consideration of value," explains Dan Leonard, president of NPC. "Value-based programs allow us to get out of that one-size-fits-all, or perhaps one-size-fits-many, approach and adopt an approach that works best for the patient."

It's not just about cost containment, stresses Leonard. It is also about improved quality of care and improved health outcomes.

"One of the points that we make more than a couple of times in the Digest is that the goal of the health care system is to improve health, not to save money," emphasizes Fendrick. "I frequently remind people that I did not go to medical school to learn how to lower health care costs. I went to medical school to learn how to improve the health and quality of life of my patients."

One of the fundamental goals of the collaboration between NPC and the Center for Value-Based Insurance Design is to better quantify the noneconomic benefits of improved health to the employer, notes Fendrick. "There are people who only look at one side of the ledger sheet. They look at health care costs in terms of what they spend on benefits and hospitalizations, but I believe we need to be looking at the full package, including costs incurred in terms of productivity and disability. When we look at areas like pain, depression, migraines, and so on, one of the easiest ways to show benefit from a financial perspective is not how often these people are going to see their doctor or being hospitalized but how often they are missing work due to these problems, which can be markedly improved with the use of pharmaceutical and nonpharmaceutical interventions."

While the tide has certainly turned in terms of the acceptance of VBID programs and the number of employers implementing VBID programs at the behest of their employees and customers, there is still some work to be done in terms of widespread acceptance and implementation of VBID programs, admits Leonard. "The reason progress has been a little slow going is that the focus, for a very long time, has been on the cost side of the equation versus the health outcomes side. Employers trying to bring down or contain costs instinctively have attacked it only from the cost angle, but companies are increasingly looking at VBID programs as a way to improve health outcomes and maximize the benefit from their spending on health care."

The good news is that cost containment and improved health outcomes may not be mutually exclusive, stresses Leonard. "You don't have to compromise on the cost side because you are implementing a VBID program. Research shows that by steering your employees toward the most clinically beneficial treatments, you can potentially avoid costly adverse events and higher aggregate medical care costs. That is very encouraging news for employers."

One of the unfortunate elements of the reform process is that much of the debate has been driven by achieving cost savings, notes Leonard. "A lot of work has been done to find solutions that save money rather than on programs that actually improve health outcomes. At the end of the day, employers want a healthier, more productive workforce." ■

Four Essential Pieces of the Health Care Reform Puzzle: Population Data, Incentives, Provider Reimbursements, and Technology

The debate over health care reform shows no signs of slowing down. With the latest $950 billion proposed bill still fresh on our minds, there is no question that the stakes are high, but even with such a big price tag, is everything being done that needs to be done? One industry expert gives his insight.

"Regardless of what goes on from a health care reform perspective, there are a number of things that we all need to do to reform health care delivery in this country," notes Joe Berardo, Jr, chief executive officer (CEO) and president of MagnaCare. "The bottom line is that we have to control costs, and we will only be able to do that if we find a way to control chronic illnesses and revamp the reimbursement models to providers by incenting behaviors — of both patients and physicians — that lead to better health management. In conjunction with that, we must continue investment in technology, which the legislation currently under consideration certainly aims to do."

Chronic Illness

The need to control costs related to chronic illness is a huge part of the problem, says Berardo. But access to information, he stresses, is not the issue. There is plenty of access to claims data, pharmacy information, and laboratory values. As a result, a robust snapshot of what is going on in any population is only a click away for most systems — as is the ability to identify gaps in care. Armed with this information, providers have the ability to work with members and have an impact on their behaviors and lifestyles.

"Unfortunately, for the most part that isn't happening today," Berardo adds. "The parallel I draw is that if you are a bad driver with lots of points and lots of accidents, you would expect to pay more for your car insurance. If you are in bad health because you are overweight and don't exercise and you smoke, however, it's almost taboo to talk about it, and yet everyone can probably agree that the individual in poor health costs the system more money. It simply doesn't make sense."

Creating incentives for people to get more active in managing their illness is something worthwhile, stresses Berardo. Take for example two patients with diabetes. The first one manages his diabetes well. He gets his hemoglobin A1c levels tested; he exercises; he watches what he eats. As a result, his monthly costs are roughly $147 for the plan. The second diabetic patient is a different story. He does not watch his diet, exercise, or take any other steps to manage his illness. He has admissions to the hospital and other comorbidities as a result. His price tag is closer to $1,800 a month.

"You can have two people with the same disease but different behaviors, and it results in a huge cost differential," Berardo notes. "We as health care administrators have the tools and the resources and the ability to work with the plan sponsors and work with employers to reach out to these individuals. That's where we are going to make a difference."

Provider Reimbursements

The second part of the equation involves provider reimbursement, says Berardo. "In our current health care system, we have created incentives for providers to do more. I'm not trying to cast providers in a bad light, but the simple fact is that we have created a reimbursement system in which a provider gets paid to do more — more surgeries and more visits means more money. What we haven't done is align incentives for providers, particularly in the area of primary care. What if we gave them data related to their patients' chronic illnesses and then paid them more if their patients met certain criteria? Perhaps they could receive incentives if all their diabetic patients received two hemoglobin A1c tests in a given year or all age appropriate people received cancer screenings. If we spent more money on prevention, I believe we would spend a whole lot less on the catastrophic stuff.

"We aren't asking people to do something that isn't good for them. We aren't denying them care. We are asking them to go have these tests done for their own good," continues Berardo.

Technology

The third piece of the puzzle is technology, says Berardo. "You have to have a strong technological infrastructure, or you won't be able to provide information in a digestible manner to plan sponsors. Without useful, actionable information, I'm not sure if you could have the kind of impact we are talking about. The bottom line is that we have to share the information we have to incent behavior change and help members make better choices, from a quality perspective as well as a cost perspective. The paradigm has to shift. There has to be more money spent on the preventive side. Otherwise, we will just be spinning our wheels."

MagnaCare is a New York metropolitan-based health plan services company. For additional information, go to www.MagnaCare.com, facebook.com/magnacare, or twitter.com/magnacare. ■

No Easy Solutions to Medicare Bad Debt

Reimbursement issues concerning Medicare bad debt have created significant challenges for providers, hospitals, and health systems for quite some time. Recent developments, however, may have further complicated the issue.

"Medicare bad debt has been around for a long time without a tremendous amount of change, but even without change, it is a very difficult area within health care," explains Paul Soper, a partner with IMA Consulting. "Medicare bad debt comes from Medicare deductibles and coinsurance that have not been paid. These are often very small dollar amounts — especially on the outpatient side. As a result, bigger hospitals will literally have thousands, maybe tens of thousands, of transactions being processed each year. It can be an overwhelming task."

Medicare beneficiaries receiving hospital services generally are required to pay deductibles and/or coinsurance amounts for those services. In the event these amounts are not paid by Medicare beneficiaries, Medicare will pay providers for these bad debts to avoid a scenario in which the costs of these services potentially could be passed on to non-Medicare patients.

Each year, hospitals file a cost report that includes information about the amount of Medicare bad debt that the hospital has had for the year. This information is submitted to the Centers for Medicare & Medicaid Services (CMS) for reimbursement. Before any unpaid Medicare deductibles and coinsurance can be paid under the Code of Federal Regulations,[1] however, certain criteria must be met. Those criteria include the following:

- The debt must be related to covered services and derived from deductible and coinsurance amounts.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was actually uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery in the future.

(Sections 308 and 310 of the Provider Reimbursement Manual (PRM) also address these criteria.)

If CMS determines that a reimbursement is warranted, it will reduce the amount submitted by 30 percent and pay the hospital 70 percent of the amount on the cost report. At its most basic level, that is how Medicare bad debt works.

The biggest challenge of Medicare bad debt involves patients who do not have a secondary form of payment and are responsible for paying the bad debt themselves but cannot make the payment. That is the first "category" of Medicare bad debt.

Sometimes state Medicaid programs "pick up" coinsurance and deductible amounts that have not been paid. If a state does not pick up the coinsurance or deductible amounts, however, providers are allowed to claim those bad debts. Once again, certain criteria must be met. The hospital must bill the state Medicaid program for those amounts. The state will then supply information indicating whether or not it is responsible for paying those amounts. Once that determination has been made, the hospital can claim bad debt that has not been paid.

"Generally, if Medicare pays more than Medicaid would have paid, then Medicaid is not required to pay the deductible amount," explains Mark Taylor, director at IMA Consulting. "That is a separate category of Medicare bad debt; it is not part of the self-pay bad debt. There is also a third category of bad debt in which a provider will determine if a Medicare beneficiary is indigent or a charity

case; if so, the provider is able to claim that as Medicare bad debt as well."

Each category of Medicare bad debt has its own set of nuances, which further complicates the problem, says Taylor. This causes a fair amount of confusion for providers. "The key is to come up with a good Medicare bad debt listing where, depending on the kind of Medicare bad debt it is, they have met all the requirements needed to claim it."

Reasonable Efforts

The idea of "reasonable collection efforts" has created quite a bit of controversy, notes Taylor. Typically, there is a 120-day waiting period. After 120 days, if the coinsurance or deductible has not been paid, providers may deem the debt as uncollectable. In most cases, providers will send that debt to a collection agency, and the collection agency will attempt to collect it. Traditionally, once a provider sends that bad debt to the collection agency, the provider would claim it on the Medicare cost report.

In 1987, CMS issued something called the moratorium for bad debts. Initially, the moratorium continued to allow hospitals to claim Medicare bad debt sent to agencies if the fiscal intermediary (FI) allowed them to do so prior to the date of the moratorium. More recently, however, CMS challenged the moratorium saying it no longer applies if a provider has changed its intermediary, changed its provider number or ownership, revised bad debt policies, or any other number of changes. Now those providers must wait until their bad debts are returned from the collection agency before they can be claimed.

"You've got providers wondering, 'Am I covered under the moratorium or not? Can I claim these bad debts now when I send them to the collection agency, or do I have to recall them before I can claim them? Those are all significant challenges that providers are struggling with," says Taylor. "The bottom line is that those bad debts, assuming they meet all the criteria, are still going to get paid, but it is now a timing issue."

"There is also the issue of knowing when to recall these Medicare bad debts from the collection agency," stresses Soper. "You can't just bring back Medicare bad debts from a collection agency because you have to treat all payers the same. Therefore, a company may have a total of $400 million at the collection agency for all of its bad debt and only $5 million for Medicare bad debt, but it will have to bring it all back to claim only the Medicare portion of it. That creates some pretty significant challenges for hospitals and providers. As long as a bad debt remains at the collection agency, there is still a chance it will be collected. Once it comes back, that chance no longer exists."

For additional information about IMA Consulting, go to www.ima-consulting.com. ■

Endnote:

1. Code of Federal Regulations at 42 CFR 413.89(e).

Annual Report Focuses on Efforts of Health Plans to Improve Care, Control Costs for Patients with Diabetes

The National Business Coalition on Health (NBCH) recently issued its annual report for employers on how America's health plans are doing to improve care and control costs for diabetes. While insurers are slowly improving their outreach to and management of patients with diabetes, there is still significant room for improvement, according to the report, which is based on health plan survey data from NBCH's eValue8™ program.

The publicly available report, "2009 Health Plan Diabetes Performance," outlines important treatment goals for diabetes and the approaches plans are using to prevent the disease and improve its care. With health care

reform on the horizon and the inexorable movement toward electronic health information systems, coalitions and employers hope to see an acceleration of activities that stem the tide of new diabetes cases and prevent the devastation and increasing costs of improperly managed disease.

Report Findings

The findings of the eValue8™ report indicate that health plans are moving forward on diabetes quality efforts, but there have been no major transformations in approaches or outcomes.

- Overall diabetes quality indicators continue to improve slowly. Health plans report that 80 percent of diabetics have at least an annual hemoglobin A1C test, an important indicator, and an annual cholesterol screening. Still, one-third of patients have uncontrolled blood sugar. eValue8 sets a standard that plans should leverage their information about gaps in care (*e.g.*, informing doctors which of their patients failed to take a necessary test), but more fundamental changes need to take place to motivate physicians and consumers if we want outcomes like lab results to improve.
- Virtually all health plans offer a personal health assessment (PHA) to identify people with or at risk for diabetes, and some proactively search for members with diabetes using claims and other data sources; however, PHA use and uptake is far from universal by health plan members; only 3 percent of members respond to the PHA, and not all employers offer it through their plan. Plans do offer to administer incentives for PHA completion, but the onus is more on the employer to improve completion rates.
- Plans continue to work with physicians to help them overcome shortcomings in physician information management systems and identify gaps in care: 95 percent of health plans indicate they report back to physicians on gaps in care, 70 percent of plans can now show physicians how they compare with their peers, and 35 percent of plans offer financial rewards or incentives to physicians to adopt electronic health systems.
- Plans are also making progress in helping members identify and select the better quality physicians, but this capability is still low. Less than 20 percent offer a lower copayment, deductible, or premium to members who choose a high-quality primary care doctor, and less than half offer any financial rewards to patients for selecting higher-quality specialty physicians, where the health stakes are even higher. For most plans, performance differentiation at the physician practice level demands inter-plan collaboration to reach the level of information necessary to adequately portray all practices in a community.
- Value-based benefit design continues to gain traction as a means to encourage members to use essential medications and treatments for chronic disease. In 2008, 48 percent of plans had the capability to waive copayments for first-time prescriptions and equipment for diabetes. For maintenance medications in 2009, 57 percent of plans could alter the copayment as an incentive. Seventy-three percent of plans have the capability to reward members for using the PHA to identify and control risk factors.

For additional information, visit www.nbch.org. ■

Report Shows America's Middle Class is Shouldering the Brunt of Health Insurance Crisis

The two recessions that Americans have weathered in the first decade of the 21st century have taken a tremendous toll on people's ability to afford health insurance — and employers' capacity to offer it. A new report from the Robert Wood Johnson Foundation (RWJF)

documents that while the situation has been tough for everyone, it's America's middle class that has been hardest hit.

The report, *Barely Hanging On: Middle-Class and Uninsured*, shows that the number of middle-income earners who obtained health insurance from their employers dropped by 3 million people from 2000 to 2008. Just 66 percent of people in families earning roughly $45,000 to $85,000 are now insured through their employer — a drop of seven percentage points from 2000 to 2008.

Employer-sponsored insurance (ESI) has long been the mainstay of health coverage for middle-class families, who typically do not qualify for government insurance programs. Among middle-income Americans, only about half of the decline in employer-sponsored coverage from 2000 to 2008 was offset by government insurance programs. For people who earned less money, declines in ESI were even steeper, but those numbers were mostly offset by increases in coverage through government insurance programs like Medicaid. The result is that America's middle-class became uninsured at a pace faster than those with less or more income. In total, 13 million middle-income earners were uninsured in 2008 — about 2 million more than in 2000.

The report chronicles state-by-state health coverage trends. In the first decade of this century, nearly every state has seen increased numbers of uninsured residents, greater costs for individual and family policies for health insurance, and significant erosion in private coverage. The report was prepared by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota. Researchers averaged data from the U.S. Census Bureau from 1999/2000 and 2007/2008 and data from the U.S. Department of Health and Human Services.

Additional information about the report is available at www.rwjf.org. ■