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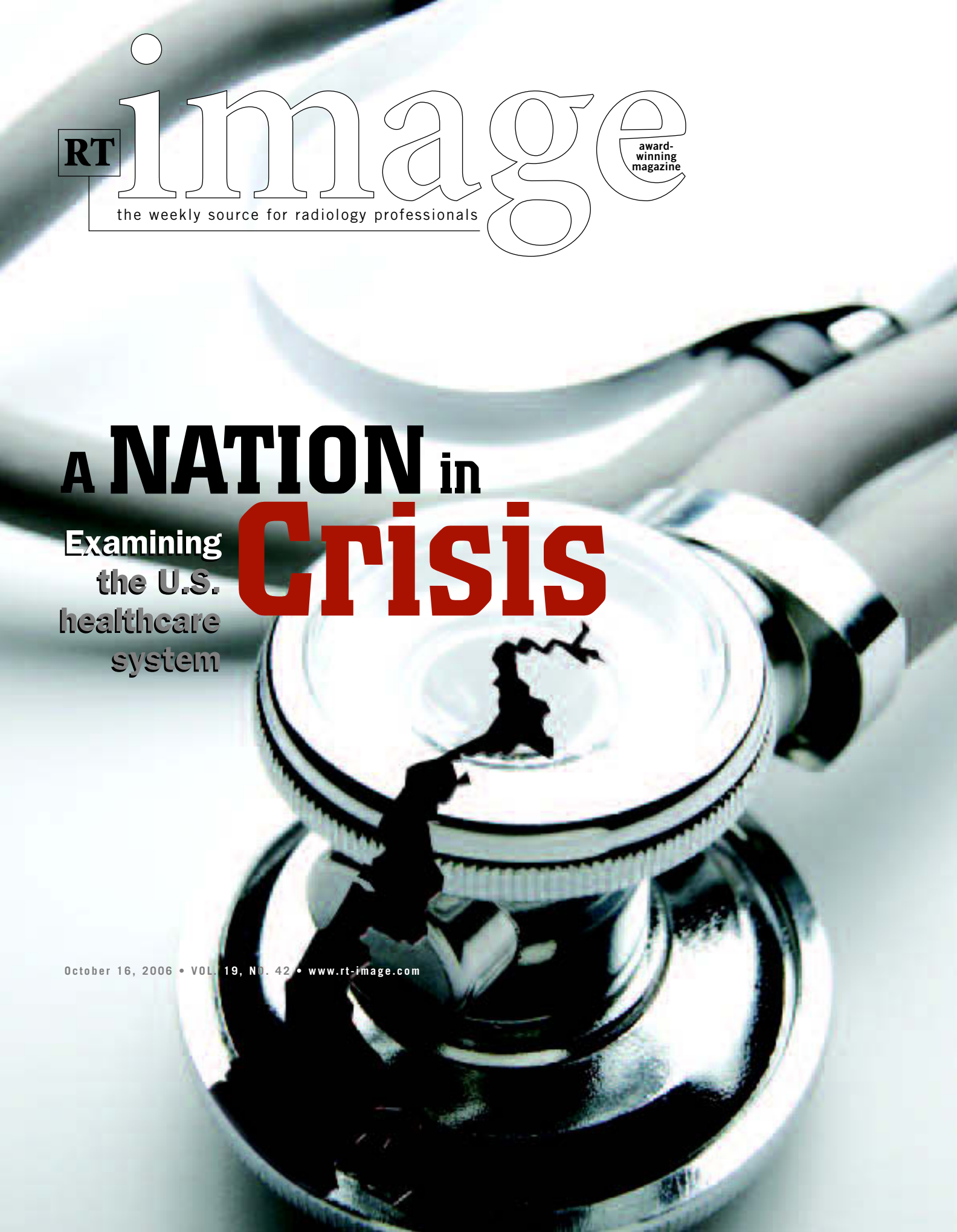

A NATION in Crisis

Examining the U.S. healthcare system

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If we are, in fact, experiencing the dark, global political realities prophesied by the Bible, it is no exaggeration to say that the future of health coverage in the United States is bleak.

A widespread combination of factors, including faulty planning, inadequate resources and loud demand, threatens to crush a healthcare system struggling to bear a burden it was never intended to support. Nearly 46 million Americans – some 16 percent of the population – remain without healthcare, according to the U.S. Census Bureau.

This figure includes neglected demographics such as children younger than 18 (11 percent of the uninsured, or 5 million people), blacks and Hispanics (52 percent of the uninsured, or 24 million people) and non-citizen immigrants (44 percent of the uninsured, or 20 million people).

The increasing discrepancies in healthcare coverage

A Widening Gap

The scope of this crisis has been expanding at an alarming rate in the past few years, as the aging baby boomer generation absorbs a growing amount of Medicare and Medicaid resources. However, numerous other sectors of the population – the unemployed, the homeless, undocumented aliens and even those stranded by natural disasters, such as Hurricane Katrina, also require healthcare, but are more likely to slip through the cracks of the insurance system.

According to 2004 Census figures, the percentage of Americans who can rely upon their employers for health insurance has fallen almost four percentage points in as many years. That decline means that 12 million fewer Americans have job-based health coverage. To some critics, that slide represents the first trickle of uninsured persons that one day could threaten to flood the U.S. healthcare system. To others, it is at least a sign that the days to come are as uncertain for themselves as for their children.

For many medical practitioners, working under conditions in which coverage is scant, rates are explosive and patients are many, it feels like struggling to swim against a strong current.

THE GATHERING STORM

Gregory Kusiak, MBA, is the president of Arcadia-based California Medical Business Services, a medical practice management firm, specializing in billing and collections for hospital-based healthcare systems. From the standpoint of the federal government, he says, confronting the national health coverage problem with statistics has always been the standard procedure.

"We have already seen the history of government responses to financial pressure," says Kusiak. "Even though it's a huge payer, and in some ways a sophisticated payer, the government is not a medical manager. Officials just ratchet down the dollars and let the economic consequences play themselves out as they must.

"The instruments with which government officials manage patient care are entirely budgetary," Kusiak says. "They'll make logistical decisions and budget decisions that are not necessarily compatible, and that classical dilemma has existed for a long time."

If current deficit reduction policies were allowed to stand as is, says Kusiak, the pace of equip-

By Matthew N. Skoufalos

ment upgrades would pretty much grind to a halt. That could mean the beginning of the end for the burgeoning crop of outpatient imaging centers that thrive on customer-oriented competitive advantages.

As the population grows and technology improves, very few outpatient facilities would be able to maintain state-of-the art access. In the longer term, those imaging centers might become outdated, driving their clients into more urban locations or into hospitals which face a different set of demands.

"Cost pressures will affect every provider whether it is a dedicated provider or not," says Kusiak, "but there's an innate ability to influence volume when you're providing these services to your own patients. There is a certain 'open cookie-jar phenomenon' that occurs even in the best facilities, and tries to drive up utilization. My concern is that radiologists who dedicate their entire careers to the diagnostic imaging business are most likely the ones to suffer, and I'm not sure that's a good public policy consequence."

The flip side of this argument, according to Michael Pentecost, MD, is that technological progress sometimes complicates, rather than simplifies, the situation. Pentecost directs the institute for health policy and radiology at the American College of Radiology. Much to the chagrin of economists and policymakers, Pentecost says, new technology is "more additive than substitutive."

"There's long been the hope that new imaging modalities would render diagnoses more quickly, accurately and less expensively, and that [such] progress would justify the expense of this new equipment," says Pentecost. "In reality, that hasn't happened for the most part. The cost of imaging to the system has gone up pretty steadily through the years, and yet I don't see a technological solution to the issues of healthcare inflation and access."

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>
> ▸ Gregory Kusiak, MBA

A PUBLIC OUTCRY

From a policy perspective, the healthcare crisis is a social problem, says Pentecost, involving a vast population of uninsured people. To address this concern requires allocating money and scant resources at an unsustainable rate. Presently, 16 percent of the U.S. gross national product (GDP) is devoted to healthcare costs – and that figure is continually on the rise. It is only a matter of time, he says, before that effect is reconciled, and it can only be addressed with political action.

"Something will have to happen to cause public interest to reach consensus around it," says Pentecost. "I don't know if that something will be a tragedy or just a gradual ebbing of faith in the current system. Middle-class people see their insurance increasingly threatened. What's the world going to be like when you have to pay cash for radiology? When that happens, people will start to drop out of the system. That's the impact that you're going to see now."

"I think that the increasing shift to self-pay is going to grow for two reasons," concurs Kusiak. "More people are going to be uninsured, which makes them self-pay by definition – or no-pay, perhaps. As employers hang onto insurance as a benefit, they will continue to shift more payment responsibility onto their employees. Deductibles will continue to get higher, co-insurance will continue to get higher, some people will fall out of the system altogether and the costs of people paying for things will grow and grow and grow."

One such proposed solution, health savings accounts (HSAs), is unlikely to offer much of a stopgap, says Kusiak. What he terms as the "false choice of shopping around for the most cost-effective policy" is undermined by the relationships among insurance providers and the insured (who are contractually obligated to carry insurance when they enroll in HSAs).

"As a claims processor and provider, I am very skeptical at the impact that high-deductible insurance plans, or health savings accounts, will have on the cost of healthcare," says Kusiak. "The bottom line is that I think those people who have HSAs don't understand them; they have a lot of false expectations, which are going to create a whole adverse-selection insurance market. The people who are going to graduate to the high-deductible HSAs are going to be the young and relatively well-off, meaning that the people who remain in those HMO pools are going to be poorer and sicker."

DIMINISHING RETURNS

In a scenario where throughput is a moral issue and meeting volume thresholds is a bust, radiologists ultimately struggle to receive reimbursement from private payers almost as a matter of doing business with these companies. As the system tightens, radiologists could continue to face resistance when submitting claims for payment from private payers – perhaps more so than they already do.

This scenario is not unfamiliar to Francis Guasp, the billing manager for Miami-based Avisena Inc. and supervisor of its radiology section. Guasp calls the staffers who collect for radiologists in their network: "the hawks."

"Any insurance carrier will try to hold on, to any extent, to be able to withhold payment," Guasp says. "We have a separate billing and collections department just for radiology, and I call them hawks. They'll go to every extent possible to collect for the doctors – and these are just for in-patient readings. These doctors aren't even getting paid the bulk amount."

At the in-patient end, Guasp says the biggest problem comes from hospitals that fail to call in information or verify patients for insurance. Sometimes physicians submit incomplete transcriptions or those that lack supporting diagnoses, which places a premium on educating the physicians within her network on the way to properly create their transcriptions. Once they learn the procedure, Guasp says, the physicians are sometimes able to resubmit claims with the required information included, which makes payment less difficult to obtain.

"If things are not done properly from the first stage, it becomes very hard for us to do our job and do it right," she says. "The hospitals are swamped and the systems that are in place are obviously not working. We see it from hospital to hospital. Sometimes the hospital does not call in the services until three to four days afterward. Sometimes doctors will be burned by the insurance company. But if we can't collect for them, it's like saying that these doctors are doing these services for free."

Most of the radiology billing that Avisena pursues is done for the professional component of services, because hospitals bill for the technical portion directly. Yet with the high volumes these hospital radiologists are required to meet daily, physicians do not take the time to associate a patient scan with an insurance policy.

According to Guasp, these readers don't often associate a name with the film, maybe just an age or a gender. Before determining other procedures, such as surgeries, other hospital physicians often have the opportunity to credit a patient with an insurance carrier. Even if they can't, these surgeries can still be associated with a larger bill for an inpatient stay.

"At least 75 percent of the clients we bill for are inpatient stays," says Guasp, "and we have a good percentage of collecting the money there because the procedure is associated with an inpatient stay. With diagnostic procedures, these are scheduled tests; they make up probably 25 percent of our clients. The hospitals would rather bill these diagnostic tests as an outpatient service because insurance carriers are not giving the clearance for these examinations unless they are determined to be linked with a 'significant condition.'"

In order for a patient to have multiple CT scans done at one time, the insurance carrier must deem sufficient reason to substantiate the need for the additional scans – yet for other specialists, insurance carriers will cover a procedure with far less evidence, according to Guasp.

A normal ultrasound in the morning will require additional documentation before a second test may be run in the afternoon. Whereas a specialist can order several different tests, Avisena receives ultrasounds taken during the same day in a bundle, and sometimes the insurance carrier will refuse to pay for the second reading.

"Sometimes if you have a CT [scan] and an MRI done on the same day, they won't pay for one or the other," says Guasp. "Collection-wise, this is much harder than multi-specialty billing and collection."

Moreover, she says, the billing shift presently being considered by Medicare would further seek to bundle same-site, same-day scans to reduce payment for radiology services.

"I was in shock," says Guasp. "These tests are very expensive, and I can't believe that it would come down to this."

DUMBBELL DISTRIBUTION

Although there may not be a technological solution to the problems of access and mass health coverage, Kusiak believes that in the future a technological solution will be reached to the billing refutation that he and Guasp confront daily.

For starters, according to Kusiak, its likely that in the next few years standardized electronic transaction sets brought about by HIPAA regulations will produce a more streamlined language of claims processing, which will eliminate or reduce historical problems like paper and labor costs. The greater utilization of management tools to constrain the cost of diagnostic imaging creates a "dumbbell distribution," however, that would eliminate all but the bare-bones and high-end providers.

"At the high end will be efficient management companies like NIA (Magellan)," says Kusiak. "On the other hand, you'll have the other people who recognize the disincentive to this kind of seamless claims processing. They'll throw obstacles in your path, doing petty denials, testing to see if you'll follow up and appeal or if you'll just let it drop at the first obstacle. One of the things the transaction sets will do is allow documentation to flow with the claim electronically. That paper trail is very expensive to handle on the claims submission end – and on the claims adjudication end as well."

In addition to responding to the changing technological landscape, Kusiak also believes that the policy shift dictated by dwindling resources will cause providers to cut their rates.

"Let's say you set your fees at five times Medicare rates," he says. "In some parts of the country, your real expectation might be 150 percent to 200 percent of Medicare costs with major insurers. The remainder of your clients is insured with small indemnity plans; some are uninsured or already participate in the federal programs. By leaving that fee schedule really high, those smaller, indemnity-based plans are stuck paying your fees."

In addition, Kusiak says, "The fact that you got a premium out of them helped boost your bottom line a little bit, but it seems to be a very marginal benefit to get your fees jacked way up. I think people are going to give up on trying to get that margin out of those huge companies and they're going to drop their fee schedules to something more along the lines of what they can actually cost. There are some providers who have a conscience."

BEST PRACTICES

As the insurance predicament deepens, physicians face subordinating their financial well-being to the health of their charges. But when making this sacrifice means loss of payment for services rendered or leaving sick people to fend for themselves, physicians are left between a rock and a hard place.

"It hasn't reached the level of an ethical conundrum that physicians can't accept any more," says Pentecost, "but I don't know that a groundswell of ethical resurgence is going to be the solution to this. Medicare came about in fits and starts, and finally there was a tipping point where the legislature, the Congress, and the President passed it in 1965. Physicians, frankly, fought that; that was not an ethical or professional groundswell. Politicians saw a need that they wanted to correct, and even that took a long time. I think Americans are conservative people, and if we learned anything from the Clinton plan in 1994, radical change is not what they like. We have a greater taste for more incremental changes."

"I think it is easier for hospitals," he continues. "As a patient, once you get into the emergency room, you're going to get what you need. You're not going to pay for it, but you're going to get what you need. For someone in the community who is not emergently ill, but who is chronically ill, there's nothing easy about that in medicine. I think it's probably the least tasteful part of life for most physicians."

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Indraprastha Apollo Hospitals

An MRI is performed on a patient at one of the state-of-the-art Indraprastha Apollo Hospitals in New Delhi.

Medical tourism is quickly becoming a major export service for many non-western countries all around the world, generally catering to American, European and Canadian tourists who are seeking more than just the sites. Over the last decade, medical tourism has grown in popularity and quality, bringing comprehensive healthcare into the global marketplace.

Medical Tourism

Why many Americans are electing to travel abroad for healthcare

By Jennifer Pilling, MA

With treatments costing a fraction of the cost in other countries – such as India, Jordan, Malaysia, Thailand and South Africa – than that of the same treatments in the U.S. or Europe, savvy consumers have seized the opportunity to not only improve their health, but also to see the world.

Many Americans have become increasingly frustrated with expensive healthcare plans that lack extensive coverage. Long wait periods for surgery and transplants plague many Western countries (particularly England), and sometimes waiting becomes a matter of life and death. Recognizing a dearth of service and an opportunity to bring in significant revenue, developing countries have begun to fill the gap, building state-of-the-art facilities and populating them with highly qualified physicians trained in Western medicine – and they're reaping the rewards of their keen foresight.

For more than a decade, plastic surgery has been a popular motive for travelers to head abroad for top-notch spa service and a nose job (or liposuction, chin implant, face lift, breast augmentation or any other cosmetic procedure). South Africa has long been a popular destination with several vacation spots that offer a variety of procedures for a fraction of the cost. The price often includes spa treatments, stays in four-star hotel accommodations and even safari tours.

More recently, medical tourism has attracted patients in need of a larger variety of healthcare, including heart surgery, dental work, cancer treatments, joint replacement surgery and more. Medical tourism is no longer for the rich and well-connected. In fact, foreigners without health insurance who are willing to travel greatly benefit from the new offerings, even with the added cost of airfare and hotel stays.

But, the patients aren't the only ones who benefit from this new trend. The countries offering treatments have much to gain. Not only does medical tourism bring well-equipped hospitals and highly trained physicians to areas that previously lacked any standard of care, but it greatly boosts the economy of the entire country, bringing in jobs and money.

THE PRICE IS RIGHT

Milicia Bookman, professor of economics at St. Joseph's University, Philadelphia, has done extensive research on medical tourism, its economical benefits for the providing countries, and its effects

on the countries from which these foreign patients originate. "Medical tourism brings about growth and development to provider countries because it is a source of foreign currency, investment (With increased demand for international medical services, provider countries invest in building hospitals, clinics and more.) and tax revenue," explains Bookman.

"In turn," she says, "that growth and development diffuses throughout the economy and results in economic infrastructure that can support further expansion of medical tourism."

In fact, India is quickly catching up with England in comprehensive stem cell research. Generally, India is becoming the hot spot for medical tourism. India's premiere medical corporation, Apollo Hospitals Group, offers foreigners a vast variety of surgery, treatment and care well below Western medical costs.

With 55,000 heart surgeries performed at a 98.5 percent success rate, treatments such as coronary angiographies, coronary artery bypass graft surgeries, pediatrics cardiac surgery and CT angioplasty range from just $550 to $6,500 – pennies compared to the hundreds of thousands Americans pay for the same procedures.

The facility also offers medical packages for cosmetic surgery procedures, dentistry, spinal surgery, oncology and surgical oncology, orthopedic surgery, opthamology, transplant surgery (a kidney transplant for $14,500 and no waiting time), gynecology, bariatric surgeries and gastrology treatments – all for sometimes only 10 percent of the cost Americans pay for the same treatment.

And, for just $143.50, patients can recover in a large, private room with a refrigerator, wardrobe, a large bathroom, sofa bed, a TV, phone service and air conditioning. Not enough? Pay $276 and add a pantry, lounge, separate bathroom for attendants and the patient, and a special reclining, fully adjustable bed – about the same price travelers might pay to stay in a New York City hotel.

What explains these price differences? "Simply put, it is the difference in cost, specifically the cost of physical capital inputs as well as the cost of highly skilled labor," explains Bookman. "Developing countries that provide medical tourism have managed to keep costs of capital and highly productive labor low relative to the more developed countries."

How can these countries provide state-of-the-art medical care at a fraction of the price charged in the West? "All services in poor countries are generally cheaper than in rich countries," says Bookman. "Moreover, these countries have benefited from cost-reducing advances in medical technology. They are conducting research and development that provides more efficient methods of production and adapts technologies to local contexts. The medical tourism industry relies on local capital and labor inputs, thus keeping costs lower than they would be if these inputs had to be imported."

THE NEXT BIG THING

And so the trend strengthens with no sign of slowing. Certain countries are specifically known for certain treatments or benefits. Thailand seems to be most popular to Americans seeking treatment overseas, and is well-known for emphasizing the vacation aspect of travel.

A hospital in Israel specifically specializes in treating both male and female infertility, in-vitro fertilization and high-risk pregnancies. Dental work has also grown in popularity, where

Indraprastha Apollo Hospitals

Above: The lobby and waiting room of Indraprastha Apollo Hospital in New Delhi. As India's premiere medical corporation, Apollo Hospitals Group offers foreigners a variety of surgery, treatment and care well below Western medical costs.

costs are rarely covered by insurance. India, Thailand and Hungary attract patients seeking a filling, extraction or root canal, as well as a vacation.

Although there are some drawbacks to medical tourism, most are offset by the benefit of reduced cost. For instance, unfortunately, unless patients have an international healthcare policy, most likely, treatment will not be covered under healthcare insurance plans. But because many treatments are expensive even with coverage and deductibles, often the cost overseas is still more economically friendly.

Knee replacement surgery performed in the Philippines by Western-trained surgeons might only cost $6,000, whereas in the U.S., this same treatment costs approximately $50,000. Heart bypass surgery in Asia costs around $10,000, compared to $60,000 on American soil. Gastric bypass surgery, often not covered by insurance, costs $10,000 to $20,000 in the U.S., but can be done for well under $5,000 abroad.

Worried about quality of care? Don't. Many of the physicians performing surgeries offshore are trained in Western medicine, and practice in state-of-the-art facilities, with the same, and sometimes better, technology and equipment than the U.S. offers.

Better equipment than the U.S.? Sometimes. In a recent article, Bookman and co-author Richard J. Bookman compared the U.S. healthcare industry with that of other countries boasting medical tourism. "To frame the problem in purely economic terms, we will increasingly outsource the most profitable procedures to off-shore suppliers." According to the authors, one result of outsourcing on the American healthcare system is "a further weakening of the U.S. primary-

care system, with even fewer resources to implement aggressively the preventive practices needed to reduce the suffering and the downstream medical costs from chronic diseases such as diabetes, heart disease, etc."

Some critics of the American healthcare system blame the medical malpractice suits for much of the high cost Americans pay for insurance premiums and hospital stays. Paper pushing and malpractice costs account for a significant chunk of medical costs in America. This leads to another potential drawback of medical tourism: "U.S. patients are typically required to waive their right to sue, thereby eliminating medical malpractice insurance from local costs of doing business," writes Bookman in her article. But generally speaking, this does not result in a lower quality of care. "While there are some horror stories and quacks, the data are sparse and the evidence does not support any broad-based significant increase in risk."

Furthermore, physicians working in countries that advertise medical tourism rely on their reputation much more heavily than physicians working in Western countries. They need to attract increasingly more travelers to sustain their practices, and word of mouth is what gives them the edge. Physicians working in Western countries currently do not experience any lack of patients – in fact, most are overburdened with them.

HEALTHCARE NORTH OF THE BORDER

Not all benefits of medical tourism require extensive travel. American patients need not travel far at all to get new and effective treatments. Canada has just begun to offer a new and highly effective treatment for prostate cancer patients, and Americans are coming in by the thousands seeking treatment. Ablatherm® high-intensity focused ultrasound (HIFU) is a nonsurgical procedure that uses a precise ultrasound beam to safely and effectively destroy the prostate tissue.

The treatment is usually performed as an outpatient procedure, and is noninvasive. According to John A. Warner, BSc, MD, FRCS(C), University of British Columbia, who has been recommending the treatment since its introduction in Canada, the procedure offers "pinpoint accuracy, no blood loss and success rates at least as good as, if not better than surgery or radiation." And without the added risk that surgery presents, this treatment seems to be the answer to prostate cancer.

"Ninety percent [of patients] are successfully treated with one treatment only. In those rare cases where cancer recurs, it is definitely possible to use this treatment again, which is something none of the other treatments can offer," says Warner. As a result, many patients who were treated with different methods, but had a recurrence of cancer, use Ablatherm HIFU with great results.

With fewer side effects and no need for surgery, why can't Americans seek this treatment in the U.S.? According to Warner, "Ablatherm HIFU is currently under clinical trials by the U.S. FDA. The FDA requires that clinical trials be performed in the U.S., whereas Canada accepted the European clinical trial data." The FDA has only recently taken a closer look at Ablatherm HIFU and begun testing.

With approval still pending, American patients are traveling to Canada and paying the price for treatment. "Approximately 80 percent of our enquiries come from American patients and 40 percent of our patients are American. Americans are not waiting for the procedure and are traveling to Canada and paying out of pocket," explains Warner.

The trend to travel for medical care is certainly on the upswing. Western countries may need to start acknowledging the trend and re-think healthcare. An increased number of services are being outsourced to reduce costs, and consumers will end up cashing in.

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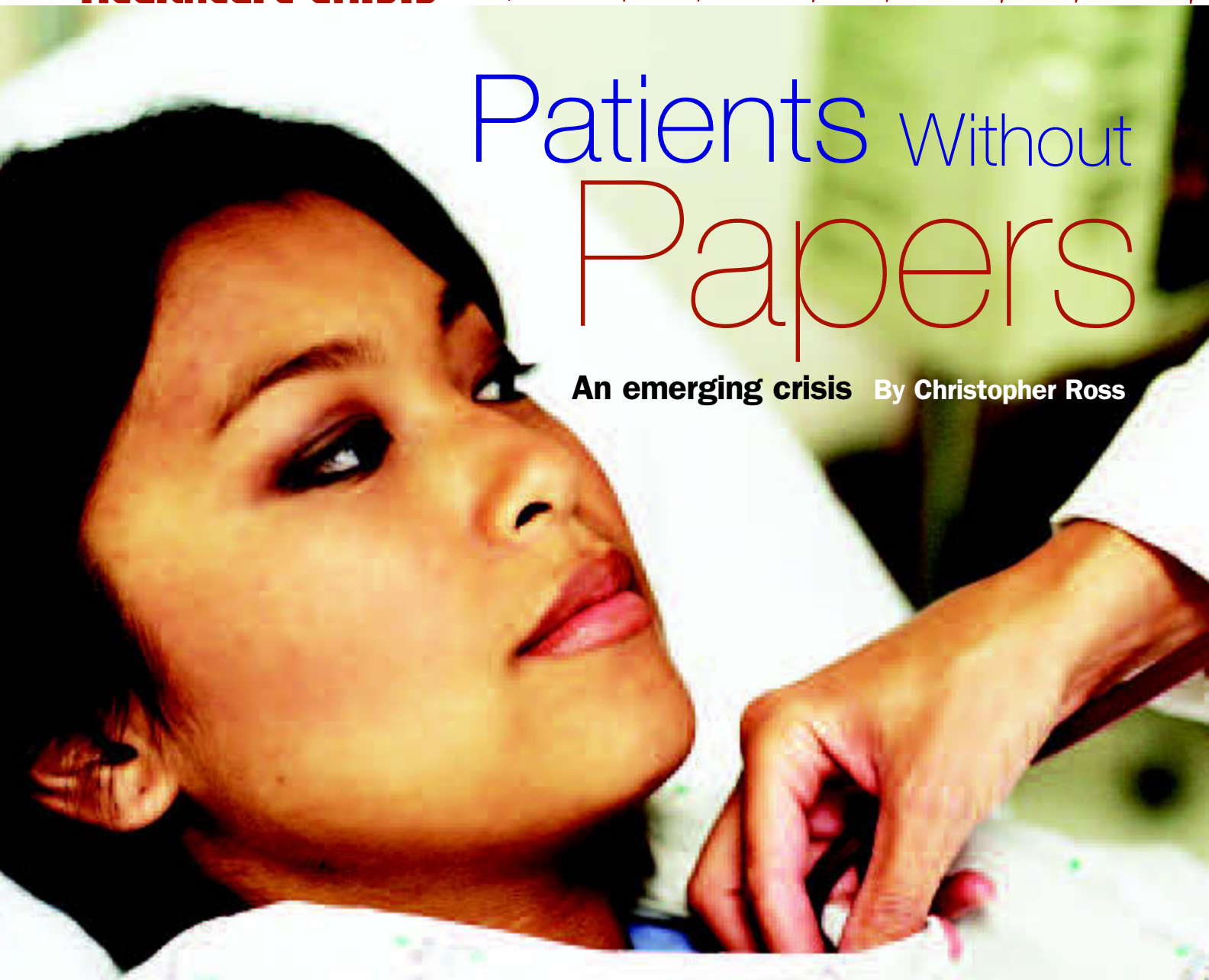
A BRIGHTER FUTURE

While many hospitals consider the reimbursement program to be a huge improvement – though as of yet an insufficient solution – other factors are easing the weight on hospitals' shoulders. Several hospitals in Arizona are working together to assist Mexican hospitals to provide better medical care by donating medical equipment and helping the hospitals maintain it.

While Mexico does have many competent physicians, it lacks the kind of medical technology found in the United States. With some Mexican hospitals able to offer healthcare services equal to those in the U.S., immigrants have less reason to use U.S. hospitals, thus minimizing the costs of unreimbursed spending.

In a May 2006 article, the *Associated Press* reported on Copper Queen Community Hospital of Bisbee, Ariz., which claimed to see rapidly declining numbers of undocumented patients. This allowed the hospital to write off less than $7,000 per month, down from $30,000. Border patrol statistics affirmed the hospital's beliefs – apprehension of illegal immigrants in the hospital's county were half what they had been in the previous year.

Christopher Ross is the editorial intern at RT Image. *Questions and comments can be sent to editorial@rt-image.com.*



Patients Without Papers

An emerging crisis

By Christopher Ross

Citing continued gang violence and drug smuggling associated with the flow of illegal immigrants entering the United States, the governors of New Mexico and Arizona declared states of emergency in August 2005. "I will do anything I have to, to get Washington's attention to this matter," said Janet Napolitano, governor of Arizona. The declaration secured $1.75 million and $1.5 million, respectively, in disaster aid for the two states. Politicians in California urged Governor Arnold Schwarzenegger to follow suit and declare a state of emergency as well.

While some critics cited the purely political advantages of these actions for the governors, the financial burden placed on the border states by undocumented immigrants was very real – and one of the hardest hit industries was the healthcare sector. One year later, hospitals still face staggering costs, but are learning how to cope.

The annual cost for emergency care of undocumented immigrants to hospitals along 24 border counties of Arizona, New Mexico and California alone is $200 million, finds a recent U.S.-Mexico Border Counties Coalition report. Other estimates place the nationwide annual cost of emergency care for illegal immigrants at $1.45 billion. But experts will tell you not to put too much faith in this number because, in reality, no one knows exactly how much money hospitals are losing to emergency care for undocumented immigrants each year.

ASKING THE HARD QUESTIONS

"People who are undocumented rarely stand up and say, 'Hey, I'm undocumented.' You never absolutely know," says John Gates, CFO of Parkland Memorial Hospital in Dallas. No one absolutely knows because it is illegal to directly ask whether a patient is a citizen of the United States, under a section familiar to all hospital administrators: Section 1011 of the 2003 Medicare Modernization Act.

Section 1011 represents the federal government's latest, and according to some medical professionals, very late attempt at assuaging the incredible financial burden hospitals face due to illegal immigration. Section 1011 supplies $250 million per year through 2005 to 2008 in

payments to hospitals that provide emergency health services to undocumented immigrants. While hospitals may ask patients for documents to validate claims for payment, Mark McClellan, administrator of the Centers for Medicare and Medicaid Services (CMS), says hospitals should not directly ask a patient, "if he or she is an undocumented alien."

This leaves hospitals in the unenviable position of trying to identify undocumented immigrant patients in order to collect reimbursement money, while avoiding direct methods of determining this specific information. "The one thing you can't do is ask somebody directly," says Gates. "It reminds you of the military a few years ago – 'don't ask, don't tell.' In essence, what you have to do is ask for information that allows you to ascertain that the person is a citizen of another country: foreign driver's license, foreign passport, foreign birth certificate, the consulate cards – these are ways of determining if the person is not undocumented. The more we've done it, the better we've gotten at it."

Elise Bryant, director of communications at El Centro Medical Center in Calif., describes a set of questions prescribed by the Medicare Modernization Act of 2003. Based on these approved questions – which avoid the issue of residency – the hospital may put a special code on a patient's chart, allowing the hospital to submit charges to the government for reimbursement.

"We are participating in that program, but I can tell you that it has cost us thousands of dollars more to implement the program than we have received in reimbursement," says Bryant. "We've tracked about a 29 percent payment rate on the submitted charges, which is quite low."

MAKING IT WORK

Implementing the hospital reimbursement program nationwide has come with its own birth pains and learning curves. In February 2005, Senators Kay Bailey Hutchinson (R-Texas), Dianne Feinstein (D-Calif.) and Jon Kyl (R-Ariz.) wrote a letter to CMS administrator McClellan, urging him to accelerate the hospital reimbursement program for emergency care to unauthorized aliens. The senators were concerned – the program had yet to begin, although the original start date was set for Sept. 1, 2004.

"The federal government has consistently failed to respond to the needs of the state and local communities struggling to stay afloat on account of the growing costs of illegal immigration. And all too frequently, local communities are forced to shoulder this burden alone," said Feinstein.

The senators' letter cited another prescient fact of this controversy: Under the Emergency Medical Treatment and Labor Act, hospitals are required to provide emergency care, regardless of citizenship status, incurring all costs. While some hospitals, such as the JPS Health Network in Ft. Worth, Texas, require legal immigration documents before they provide non-emergency care, all hospitals must provide emergency health services, without distinction.

Gates describes how Parkland Memorial began billing in June 2005, billing out $1.9 million in charges and receiving $1.1 million. In September, they billed out $2.1 million, but received only $900,000 from the government, since more hospitals were joining the program.

But over the next few quarters, Parkland improved their methods of identifying undocumented immigrant patients and billed about $4 million in charges last June. "We're getting better and better at collecting them, which is why our numbers are going up," says Gates. "I don't believe our volume has changed; we're just better at identifying. But that by no means tells you how big of a problem this is."

Bryant reports less luck with this issue at El Centro. "We obviously know that there are hundreds and hundreds of patients who choose not to answer those questions, so they don't qualify for reporting," says Bryant. "The percentage of patients who qualify for the program we think is actually quite small."

Gates also points out that many hospitals across the nation are not taking advantage of the hospital reimbursement program, due to either difficulty in identifying undocumented immigrants, or perhaps the costs associated with implementation of the program.

"Some of the statistics we're seeing are that at this point, only about 17 percent of the claims, of the dollars, are being utilized," says Gates. "In Texas, we use 100 percent. Something like 20 states, the only one of those 20 I know for sure is New Jersey, have not billed a claim yet."

SATISFACTION NOT GUARANTEED

Indeed, many hospitals have experienced difficulty with simply the implementation process, leading to mixed reviews of the program's efficacy in dealing with this ongoing crisis. "This program has some problems," says Bryant. "There are significant costs for the set up and implementation of the program."

She cites one case in which El Centro responded to a mandate requiring hospitals to submit all bills and medical records electronically. El Centro implemented the computer programs, but they were informed immediately afterward that they would need to make hard paper copies, a task which would incur high costs. "There are a lot of overhead costs associated with the program," says Bryant. "This is a good start, but it is certainly not going to solve the problem."

Gates has similar feelings about his hospital's satisfaction with the program. Gates describes a burn victim with a $450,000 claim. Although they treated the patient before the enactment of the Section 1011 funds, under the program they would have received only a few thousand dollars on the $450,000 bill. "Obviously, we would like to see the program enhanced," says Gates. "That said, it's better than what we had before, so we're certainly not going to complain."

Many hospitals, despite the problems, are appreciative of the program – the crushing burden of costs due to emergency care for undocumented immigrants had been forcing hospitals to close or shut down units.

But while the reimbursement program does offer relief, hospitals are still bending under the costs. In annual uncompensated costs, Texas, California and Arizona hospitals pay $74 million, $79 million and $100 million respectively. According to the Section 1011 formula for 2005, they would've received $47 million, $72 million and $41 million, respectively.

Patients Without Papers *continued on page 27*