

MANAGED MEDICARE & MEDICAID

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Most M+C Plans Will Get Initial Incentive Payments for CHF Care, Sources Say

Sources tell *MMM* that CMS officially will announce soon that 66% of M+C plans, or 98 MCOs in all, are getting in 2002 first-ever incentive payments in recognition of their success in 2001 in improving outpatient care for congestive heart failure (CHF) patients. The incentive payment to each plan that meets CHF quality thresholds will be doubled in 2003, the sources note.

Medicare HMOs may qualify for extra payments if at least 75% of certain CHF patients received a left ventricular ejection fraction test any time in the past, and if at least 80% of patients were appropriately prescribed an ACE inhibitor within the past year.

Some plans, such as Fallon Community Health Plan in Massachusetts, are ahead of the curve. Not only does Fallon surpass both quality indicators, plan officials say, but the HMO also reports better patient status, high satisfaction for patients and physicians, and significant savings from reduced inpatient utilization after several years of effort in CHF management.

Indeed, a consultant tells *MMM* that managed care companies such as Fallon, began focusing on CHF in 1995 well before it became the M+C program's mandatory national quality initiative for 2001, are reaping financial rewards that could multiply in the near future.

The federal payments, which vary in size based on AAPCC reimbursement, likely "won't make a huge difference" to health plans' bottom lines, says Andrea Seebaum, a

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Medicaid HMO in R.I. Adopts Strategy To Combat Effects of Cost Sharing

Seeking a way to handle recent state budget cuts that are forcing ever-higher cost sharing on some Medicaid beneficiaries, the largest Medicaid HMO in Rhode Island has adopted a two-pronged strategy focusing on beneficiary retention and product diversification.

Effective this summer, the state of Rhode Island will increase premium cost sharing to 5% of annual income — which translates into \$60 to \$90 a month — for Medicaid families with incomes above 150% of the federal poverty level. This follows a 3% cost sharing implemented Dec. 1, 2001, that cost these households \$43 to \$58 monthly — a policy that, according to officials at Neighborhood Health Plan of Rhode Island, Inc., contributed to a 34% attrition rate from October 2001 to March 2002 among its members subject to the cost sharing. That compared with 8% attrition for the HMO's non-cost-sharing beneficiaries over the same period (*see chart, p. 3*). Prior to Dec. 1 there basically was no premium cost sharing for beneficiaries enrolled in one of the state's three Medicaid managed care plans.

Eric Cahow, Neighborhood's director of consumer research and planning, tells *MMM* the Medicaid managed care plan worries that 5% cost sharing could result in a loss of even more beneficiaries, and correspondingly lead to slashed revenues as well as higher expenses because sicker beneficiaries would stay, causing adverse selection.

continued

"We have not in fact found significant evidence of adverse selection at this stage, which is counterintuitive," notes Cahow, who spoke about the attrition at the annual Medicaid Managed Care Congress, sponsored by the Institute for International Research, in Bethesda, Md. June 20. Although average expenses per beneficiary per month (PMPM) have not increased in recent months, he says, pregnant women who joined the plan and had healthy babies are leaving the plan, while women who had sicker babies are sticking with coverage. And plan officials worry that this pattern could prove more expensive to the HMO in the long term than the up-front costs associated with giving birth.

Interventions to Retain Beneficiaries

Every month Neighborhood loses 5% of its beneficiaries, Cahow says, and roughly half, or 2.6%, come back within 90 days, resulting in a net loss of 2.4%. Historically, he says, this loss has been offset by new members coming in, but that influx has been curtailed by the state's new premium cost-sharing requirement.

In surveys and studies, Neighborhood repeatedly has found that beneficiaries do not understand the annual re-certification process, which Cahow says may help explain the fact that while 50% of disenrollees come back to



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the plan within 90 days and 15% leave with other health insurance, the remaining 35% is uninsured and likely falling through the cracks because of incomplete paperwork. "So kids are getting lost," he says. Two-thirds of the HMO's 68,000 Medicaid beneficiaries (out of Rhode Island's 117,000 in managed care statewide) are under age 19.

"Here's the fundamental challenge a Medicaid managed care plan has: They're not our members, they're beneficiaries of a state program," Cahow says. "We want to know 60 days before someone's re-certification so we can intervene" by notifying the beneficiary's physician, sending out reminder post cards or making telephone calls to beneficiaries from the plan's member services staff.

But Cahow says the state is reluctant to share such data because of concerns about patient confidentiality, and because of various complexities involving eligibility. For example, he says, beneficiary termination can occur at any time in the year for AFDC families whose income goes up or location becomes unknown. He also says there is no indication that Rhode Island will follow other states' lead and simplify the re-certification process.

To combat this general lack of understanding about re-certification, Cahow says Neighborhood is using several approaches. It encourages participating providers to check a beneficiary's eligibility through the state's computerized system, and it encourages its Medicaid members to check their mail for state notices.

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Over the past year, however, Cahow says, the plan also has started targeting members dropping coverage. The plan is notified by the state within 10 days of a beneficiary's termination, at which time the plan sends what Cahow describes as a "user friendly" postcard to the beneficiary. The HMO also sends a state-mandated letter about re-certification, but, he says, "I don't think anyone reads it." And Neighborhood sends what Cahow calls a "rescue postcard" 60 days after a beneficiary's termination if the beneficiary has not returned by then.

"It is cost effective to send the postcards," Cahow says. "But it's not a silver bullet." Of all the terminated beneficiaries who are sent a 60-day postcard, he says, perhaps 20% come back to the plan. This compares with 13% who return without the postcard.

Cahow says Neighborhood found that trying to make telephone calls to beneficiaries terminated from coverage became unworkable: "We found an average of 48% of our members do not have telephones, so it's hard to be cost effective." He says the telephone intervention became difficult to justify because the plan could contact about half of the remaining 52% with telephones, which means it reached about 26% — and the postcard intervention already was getting 20% of terminated members back.

HMO Seeks Commercial Beneficiaries

Cahow describes two "bread and butter" business lines for Neighborhood: its participation in RItE Care, the state of Rhode Island's managed Medicaid program, and its support of community health centers. Incorporated in 1993, Neighborhood offers coverage through 13 community health centers. Officials have told *MMM* that the plan was started by community health centers "as a way for them to fulfill their mission to serve the underserved population." (*MMM* 1/21/02, p. 4).

In addition to its core business, Cahow says Neighborhood is "reinvigorating" its commercial business line by actively seeking out large groups that will sign multi-year contracts because it is a small plan with limited reserves to handle small groups. He says the problem is that the market is defined by small groups that go price shopping every year.

Cahow says commercial challenges are significant and twofold: understanding underwriting and pricing, and understanding marketing channels and distribution.

At this point, he says, the HMO has 5,000 commercial beneficiaries from one large group contract that began in third-quarter 2001. Even though the state's premium cost sharing began in December 2001, Cahow explains that Neighborhood officials had "seen the writing on the wall" and started seeking commercial business before that date. "We plan two to three years down the road," he says.

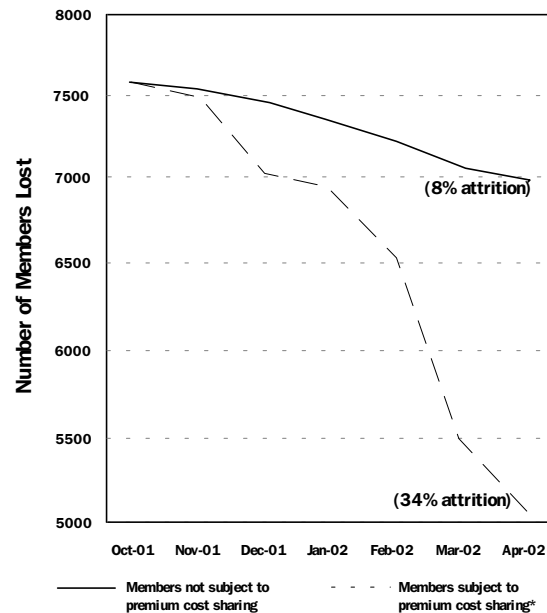
Neighborhood also is turning its attention to special populations, including children in "substitute care" (foster homes or group homes), and children with special health needs, such as disabilities. Cahow says the challenge in seeking to work with special populations lies in working with a sometimes slow-moving state bureaucracy.

Also, Cahow says the plan has identified 300 to 500 "medically needy" adults ages 21 to 64, among the "sickest individuals in the state" (with chronic illnesses that include chronic obstructive pulmonary disease, congestive heart failure, and diabetes), who average eight hospital admissions and 25 emergency visits annually. "We'd like to bring them into some form of management," he explains.

Toward this end, the plan has created a care model for medically needy adults that includes a physician, pharmacist, and nurse case manager. "We're making a major investment, so we need a minimum number of members to break even," he says. Yet he says the state has no waiver to mandate such a program, so the program is voluntary and the HMO is not allowed to market it.

"At this point we are enrolling people slowly," Cahow says. "We have made the investment in software. We

Comparison of NHPRI Attrition Rates By Participation in Cost Sharing



*Households with incomes above 150% of the federal poverty level pay 3% of annual income.

SOURCE: Eric Cahow, Neighborhood Health Plan of Rhode Island, June 2002

have a nurse case manager. . . . We consider it a long-term investment because this is a major growth area [and cost-conscious] states want more people under case management. We are telling the state the advantages of making it a mandatory program.”

Contact Neighborhood’s Cahow at (401) 459-6048 or ecahow@brandeis.edu. ✧

Centene Embraces United’s Planned Expansion in Medicaid

Reacting to UnitedHealth Group’s recently announced plans to pay \$560 million for AmeriChoice, a Medicaid HMO with 375,000 members in New York, New Jersey, and Pennsylvania, some analysts insist that managed Medicaid “seems like a curious choice for an acquisition,” particularly in light of the major shortfall in recent state budgets.

But Centene Corp. President and CEO Michael Neidorff tells *MMM* that he considers Medicaid managed care a “predictable” line of business and regards the questioning assessment by Credit Suisse/First Boston analysts as curious. “Every business has risks associated with it. There are no rewards without risk,” he says. “We know how to manage that risk. . . . There are no bullet-proof businesses.”

Neidorff says UnitedHealth’s acquisition of AmeriChoice, which was announced June 18, endorses the worth of the \$180 billion Medicaid managed care market. “Of course I worked with UnitedHealth Group for a lot of years. I started their St. Louis plan,” he says. “I’m thrilled to have them in this business. It validates the model. It validates what we’re doing.”

It is helpful, he says, to have a company as skilled as UnitedHealth Group is in government regulatory affairs working in the managed Medicaid field. “You want people who know how to work in a responsible way with the government,” says Neidorff, in order to achieve the best health outcomes for Medicaid recipients and to save money for the states. “They are consolidating their skill set into one organization, which probably makes a lot of sense,” he adds.

Analyst Joseph D. France of Credit Suisse/First Boston speculates in his report on the planned acquisition that UnitedHealth’s attraction to AmeriChoice likely stems from AmeriChoice’s strong management team and infrastructure dedicated to Medicaid.

According to France’s report, UnitedHealth already has 655,000 Medicaid members in about 15 states, and the business generates about \$1 billion in revenues annually. That puts the company second only to Health Net, Inc., in terms of Medicaid enrollment. With the planned

AmeriChoice acquisition, France says, UnitedHealth will operate Medicaid plans in two additional states and expects to generate at least \$2 billion in revenues annually. Officials have announced plans to combine the companies’ Medicaid services into a dedicated business unit that will continue operations under the name AmeriChoice and that will be led by AmeriChoice CEO Anthony Welters.

UnitedHealth stated June 18 that creating the business unit is consistent with its strategy of “aligning assets and capabilities to form dedicated businesses focused on specific market opportunities and needs.”

France reports that AmeriChoice, whose enrollment rose by nearly 160,000 lives last year — mainly from two acquisitions completed in 2001 — projects revenues of \$900 million this year. UnitedHealth anticipates that the purchase, which is expected to close in fourth-quarter 2002, will add to its earnings immediately at an annual rate of five cents per share.

Health Net Uncertain of Impact

Officials at Health Net, Inc. of Woodland Hills, Calif., which has the largest managed Medicaid enrollment at 815,000, tell *MMM* that they remain uncertain of the implications of UnitedHealth’s acquisition of AmeriChoice. “We’ve been scratching our heads. . . on what it might mean. Honestly, we haven’t been able to glean any insights,” spokesman David Olson says.

Olson says he can only reiterate Health Net’s own strategy: “We’ll stay where it makes sense, and if the underlying economics don’t work, we’re going to leave. We’re only in three states: California, New Jersey, and Connecticut. We believe the long-term future of the California model is sound. We’re going year by year on our plans in the Northeast.”

Centene Expects Continued Growth

Meanwhile, Centene’s Neidorff says that UnitedHealth’s planned acquisition of AmeriChoice will have “no material impact” on St. Louis-based Centene, except to enlarge the role of “another responsible player in the [Medicaid managed care] program.” He says it will be “business as usual” for Centene, which has confined its business to Wisconsin, Texas, and Indiana as part of its stated “organic” growth strategy that seeks expansion within existing Centene markets.

In keeping with its plans to expand in existing markets, the company announced June 20 that one of its subsidiaries has signed an agreement with Texas Universities Health Plan Inc. to purchase the State Children’s Health Insurance Program (SCHIP) contract for the region of San Antonio, El Paso, Amarillo, and Lubbock, Texas. If

Centene gains regulatory approval, the company says, this would add 26,000 children to its coverage.

Neidorff has stated that Centene's interest is limited to acquisitions that will add to earnings in the first year (*MMM* 5/06/02, p. 5). He says the new Texas SCHIP line of business fits the criterion: It is expected to add five cents per share to earnings in 2003.

But Centene is poised to move beyond Texas, Wisconsin, and Indiana. Neidorff says that Centene is "completing due diligence" on entry into a fourth state that he didn't identify. "We have three states. We've been in Wisconsin for 18 years. We are very pleased with the relationships we have there and the growth we've experienced with our largest plan.... We are in states that demonstrate a commitment to managed Medicaid, and we're very comfortable with the states we have."

"When we get to four [states], we won't stop there. We'll keep moving," Neidorff adds.

Contact Centene's Neidorff at (314) 725-4477. ✦

Matrix Program in Long-Term Care Wins Raves From DM Consortium

The head of a disease management (DM) purchasing consortium in Massachusetts asserts that he has found a vendor with a promising program that could significantly trim managed Medicare and Medicaid costs — by reducing beneficiaries' stays in skilled nursing facilities and their subsequent "bounce backs" to acute care hospitals.

Al Lewis, executive director of the Disease Management Purchasing Consortium (Wellesley, Mass.) whose members include 61 health plans and four state Medicaid programs, says Brooklyn, N.Y.-based Matrix Management Services' "guarantees of a 25% reduction in total SNF costs to the HMO and a 25% reduction in total hospital Part A costs to the state Medicaid agency are easily supported by the evidence. And if I'm wrong, if the vendor's wrong, if the contract's wrong, the payer doesn't pay at the end of it."

Lewis explains that he evaluates vendors' programs and helps payers decide what to buy. "I've yet to see a program which hits on more of the right purchasing criteria than Matrix does," he tells *MMM*. "If you're a health plan with Medicare, you can literally be guaranteed to save \$10 per Medicare life per month — not per SNF resident, but PMPM through a reduction in length of stay and 'bounce backs' to acute care."

Matrix, which started up in January 2001, supports physician practices treating patients in the long-term care setting. It works with three professional corporations in New York, New Jersey, and Connecticut that have hired about 22 primary care physicians and two nurse practitioners on a full-time basis to treat patients where they reside

— in nursing homes, assisted living facilities, adult day care, or at home — and not in physician offices.

Currently, Matrix physicians work in about 30 SNFs and five assisted living facilities in the three-state region.

Matrix Physicians Stay in SNFs

Similar to physician "hospitalists" working in an acute care setting, officials explain that Matrix physicians spend the day in the long-term care setting in an effort to improve patient outcomes, reduce unnecessary readmissions to the hospital, improve family involvement and relationships with nurses and administrators, and coordinate care.

"Basically, our doctors spending more time in facilities provides a higher level of care for patients, reducing length of stay, reducing readmissions to the hospital," says Marcia Naveh, M.D. She is medical director of Matrix Medical Network, which runs the three physician practices, and chief medical officer for the management company.

"The bottom line is when a Matrix physician is in a facility, that physician is more a part of the care team in that facility... and that translates into improvements in outcomes, satisfaction, and coordination of care," Naveh says. She says patients "move more quickly through their care plans... and doctors work closely with the formulary. We think it's probably a reduction in inappropriate costs of somewhere around 20%."

Matrix customers, she adds, can expect tangible savings without additional cost from using the program: "It's easy for a facility or a payer to benefit from what Matrix has to offer. We bill as any other physician would bill for the services provided... and success is easily measured in reductions in length of stay, [hospital] readmissions, and pharmacy costs."

Matrix Develops Track Record

Lewis says he heard of Matrix when the company began but waited until the company had developed a solid track record. "I feel like their track record, plus their guarantee[d savings], plus the fact they don't get paid until they achieve the guarantee is enough. It's an absolute home run for M+C," he contends.

If a health plan has 10,000 over-65 members in a single market, Lewis says that would be the rule of thumb for considering the Matrix program.

Lewis says states' managed Medicaid programs also could benefit from Matrix's program. "Every state is facing large deficits; all are looking at cutting services. Here's a way to close the deficit with honey instead of vinegar." For states' managed Medicaid programs, he says, there now is no solution for the over-65 population. Medicaid pays 20% for each hospitalization for Medicare/Medicaid du-

ally eligible beneficiaries, a figure that Matrix could help trim along with the costs of inappropriate medication use, according to Lewis.

If the state can get a waiver from CMS for the hospital costs for its dually eligible population — and if the federal agency gives the state a check for close to the entire amount that CMS would have spent, Lewis says the state could wind up with substantial savings by working with Matrix. “You could literally save 2% of your entire Medicaid budget with a waiver and this [Matrix] program,” he asserts.

Lewis explains that payment reconciliation in DM can be both time-consuming and adversarial. With Matrix, he says, the reconciliation process is straightforward: length of stay in skilled nursing facilities and the number of days in hospital readmissions are measured.

Also, Lewis says, “You tend to have provider relationship issues in disease management; providers may not cooperate. But this [Matrix system] is totally voluntary with providers....If Matrix guarantees 25% savings, it’s up to Matrix to convince facilities they’re better off with Matrix physicians, and convince the [primary care] physicians that they’re better off sticking to their own practices, not getting into Matrix territory.”

Currently, Lewis says, he has two health plans and a state Medicaid organization negotiating directly with Matrix. “Of the [health plan] payers I have with a significant over-65 population, literally 20% are already negotiating with Matrix,” he says. “This is the most excitement I’ve ever seen a new vendor generate in the seven years I’ve been doing this — times two. It’s not even close.”

Contact Lewis at (781) 237-7208 and Matrix’s Naveh at (347) 328-0303. ♦

M+C Plans Gain in CHF Care

continued from p. 1

principal with MMC 20/20, a managed Medicare consulting firm based in Duluth, Ga. But Seebaum says there is no longer any doubt that plans should be involved in CHF management in order to improve patient outcomes and decrease costs.

Moreover, Seebaum notes that CMS’ extra CHF payments could have a greater financial impact on M+C plans by 2005 because of the agency’s impending changes to its risk adjuster payment method implemented Jan. 1, 2000. She explains that the payment reconciliation system is expected over the next few years to attribute less weight to geography and more weight to the risk adjuster portion of the methodology that would include CHF patients.

As Fallon’s oldest disease management program, CHF “shows what works for disease management for

everyone involved,” says Walter Mlynaryk, Fallon’s assistant director of disease management. He says physicians are pleased because the two nurses dedicated to the plan’s CHF program are focusing on clinical practice guidelines and are helping to ensure proper use of medications and to monitor patients’ health status. Administrators are glad of the savings achieved from lower inpatient utilization, he says, and patients are content because the nurses are giving them extra security beyond that provided by primary care physicians (PCPs).

“We’ve also seen improvement in our patients’ functional status,” Mlynaryk says. “If we can provide the best of care, we know dollar savings will result.”

Fallon Gets High ROI

Mlynaryk points out that Worcester, Mass.-based Fallon, which “is always interested in the return on investment,” has seen a sufficient drop in hospital days to cover CHF program costs. He says Fallon last calculated the CHF program’s return on investment (ROI) in 2000, five years after the program’s launch. That year program costs were around \$143,000, and the reduction in acute care hospital days alone saved \$648,000 for an ROI of about 4.5.

Inpatient days totaled 99.6 days per 1,000 CHF members at Fallon in 1995 baseline data, he notes. This figure fell to 67.5 hospital days for CHF patients in 1997 and dropped further to 54.5 days in 2000, according to the latest available data. Mlynaryk expects the figure eventually to plateau. “As long as we’re below baseline, we’re happy,” he says, adding that Fallon achieved cumulative savings of more than \$9 million from 1995 to 2000 attributable to the decrease in CHF members’ acute care hospital days alone.

Mlynaryk says Fallon expects extra payment from CMS for meeting CHF criteria in the M+C program’s national quality initiative. Fully 99% of Fallon’s patients have documented their “ejection fraction,” well above the required 75%, he says, while about 96% of Fallon’s patients with a low ejection fraction are using ACE inhibitors, comfortably above the required 80%.

Yet he contends that the federal system of incentive payments, initiated last year, has a flawed methodology. “The calculation is messy and almost counter-intuitive,” he says, noting that payments are based on CHF hospital admissions even as MCOs are trying to lower inpatient utilization rates.

Eileen Morgen, Lake Oswego, Ore.-based director of healthcare quality for PacificCare of Washington and Oregon, says both regions for which she is responsible also have met criteria for extra CHF payments from CMS, which could mean an additional \$50 to \$75 per member per month (PMPM).

Morgen says PacifiCare has found that the top three diagnoses leading to hospitalization for members of Secure Horizons, its M+C product, are CHF, hip replacements, and pneumonia. Like Fallon, PacifiCare chose CHF as its quality initiative early — in 1999 — before CHF care was mandated for M+C's national quality initiative two years later.

Both the Fallon and PacifiCare CHF programs are highlighted in a recent report from the American Association of Health Plans, "Innovations in Medicare+Choice Managed Care." The report looks at MCO innovations in several key areas, including preventive services and health promotion, disease management, outreach, and coordination of care.

In a way similar to Fallon's approach, PacifiCare's program targets physicians and CHF patients. PCPs and cardiologists are sent evidence-based guidelines on CHF and are given aggregate figures on their CHF patients' ACE inhibitor use. Physicians also are sent a list of their patients who have been identified as having CHF but show no evidence of taking ACE inhibitors. PacifiCare provides targeted interventions, such as smoking cessation, to CHF members based on their responses to a health

questionnaire. Higher-risk patients receive additional education through a program called Take Charge of Your Heart Health®.

PacifiCare reports ACE inhibitor use in its population increased significantly over a two-year period, with 90% of eligible members taking these medications in 2001. Morgen says PacifiCare conducts an annual member survey on CHF that has found 63% of CHF patients got advice on weight monitoring, close to half monitor their weight on a daily basis, and 85% received counseling from PCPs on restricting sodium intake. She says PacifiCare also works with its pharmacy benefits management firm, Prescription Solutions, which runs pharmacy data that is shared with PCPs whose CHF patients are not taking ACE inhibitors. The health plan then requests responses from the physicians on the matter.

Contact Fallon's Mlynaryk at (508) 368-9384 or mlywa01@fchp.org and PacifiCare's Morgen at (503) 603-7103 or Eileen.Morgen@phs.com. For AAHP's report, go to www.aaahp.org/Content/NavigationMenu/AAHP_Store/Reports_Directory/Reports_Directory.htm. ♦

Fallon Program Uses Interventions Tailored to Patients' Risk Levels

Fallon Community Health Plan officials say that its congestive heart failure program has three objectives: to reduce utilization of inpatient services, to improve CHF patients' clinical and functional status, and to increase participants' satisfaction.

Once CHF patients are identified through claims analysis or referrals, explains Walter Mlynaryk, Fallon's assistant director of disease management, the first step the HMO takes is to go back to that patient's PCP for approval to enroll the patient in the program, which is designed to augment PCP care.

Fallon's penetration rate for the program for members with CHF is about 50% to 60%, which Mlynaryk says is a solid figure that allows the HMO "to grab the majority of our patients with CHF, and our physicians have seen utilization decreasing and patients doing better."

Currently, about 470 patients are enrolled in Fallon's CHF program, and the bulk are covered by Medicare. Since 1995 the program has grown from one nurse with about 200 patients to two nurses who expect to handle a total of 500 patients next year. Typi-

cally, he says, referred patients are at higher risk and need some intervention.

Fallon's approach uses a series of targeted interventions tailored to the individual's level of risk, as determined by the New York Heart Association's functional classification survey. Mlynaryk estimates that 15% of the Fallon CHF population would be considered high risk.

All patients in Fallon's CHF program get educational materials on how to manage heart failure. And upon enrollment in the program, they are invited to a one-time group session — typically lasting about three hours — with a nurse, pharmacist, nutritionist, and social worker — to discuss use of appropriate medications, disease pathology, and other issues.

Fallon also provides telephone outreach to all CHF patients through the two nurses dedicated to the program in order to discuss patient-specific issues and compliance. High-risk patients are called at least once every two weeks, and lower-risk patients at least every three months. Calls are set up as an adjunct to scheduled physician office visits.

NEWS BRIEFS

◆ **Fallon Community Health Plan, based in Worcester, Mass., allegedly received Medicare overpayments totaling \$18,842 for 44 beneficiaries incorrectly classified as institutionalized from Jan. 1, 1998 through Dec. 31, 2000**, according to an HHS Office of Inspector General audit. The report, *Review of Medicare Payments for Beneficiaries with Institutional Status* asserts that the beneficiaries actually were residents of domiciliary type facilities that do not qualify a beneficiary for institutional status. CMS in 1998 changed the definition of an institutionalized facility to include only Medicare or Medicaid certified facilities, excluding domiciliary facilities. OIG says the majority of the overpayments occurred because Fallon staff did not fully implement CMS' new guidance concerning institutional facilities until February 1998. OIG recommends that Fallon refund the overpayments, but the agency does not make any recommendations related to internal controls because it says Fallon's current procedures are adequate to verify each of its beneficiaries' residency. For the report, visit <http://oig.hhs.gov/oas/reports/region5/50100100.pdf>.

◆ **Humana, Inc. has signed two three-year contracts with Puerto Rico's Medicaid program.** The contracts, which extend Humana's five-year partnership with Medicaid in the commonwealth, are expected to generate about \$41 million in revenue for the company. The contracts are effective July 1. The

agreements enable Humana to provide health benefits coverage to an estimated 430,000 Medicaid recipients in two of Puerto Rico's eight Medicaid regions. Visit www.humana.com.

◆ **A report from the National Governors Assn. finds that many states are now using the Internet and other new technologies to facilitate SCHIP and Medicaid enrollment.** The report notes that many states, as part of their online application systems for SCHIP, are eliminating asset tests and face-to-face interviews. The report profiles states now using online application systems either on a statewide basis or through regional pilot tests. Visit www.nga.org for information on the report.

◆ **An issue brief from Mathematica suggests that continuous coverage in Medicaid or SCHIP could be a key part of a state's strategy to increase coverage for children.** Such coverage would allow children to maintain eligibility for either program for a specific period, no matter what income or family structure changes may occur, according to the issue brief. Mathematica says that those greatest at risk include adolescents aged 15 to 19, Hispanics, children qualifying for Medicaid under the poverty-related eligibility provisions, and children who spend part of the year in a state's medically needy program. For information, visit www.mathematica-mpr.org.

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