MANAGED CARE OUTLOOK

The Insider's Business Briefing on Managed Healthcare

Volume 18, Number 2
January 15, 2005

At Presstime:

TennCare Returning to Managed Care

Faced with rapidly-increasing costs, and the prospect of dropping as many as 430,000 people from the state's TennCare program, Tennessee Gov. Phil Bredesen has decided to take steps towards returning to managed care. Under Bredesen's plan, as many as 323,000 adults who are not eligible for Medicaid will lose TennCare coverage. But 24 percent of those enrollees will still be covered under Medicare. Bredesen says his plan preserves full coverage for all 612,000 children in TennCare, and maintains "a reasonable level of benefits" for almost 400,000 adults eligible for Medicaid. The program will return to the managed care model, which was dropped in 2002. "It's time to put MCO accountability back into the program," Bredesen said.

ASPEN PUBLISHERS

Mass. Play-Or-Pay Proponents Think They May Succeed Where Calif. Failed

By Howard Wheat

Will Massachusetts pick up the "play-or-pay" torch that was dropped by California last November when its voters narrowly rejected a state law that would have required employers to provide health care coverage for employees or else pay into a fund that would do it for them?

Even the most ardent supporters of the concept in Massachusetts don't believe it will happen in 2005, even though the Bay State is seen as being ripe for some kind of coverage expansion in the near future for its 500,000 uninsured citizens.

State Sen. Richard Moore and Rep. Deborah Blumer, both Democrats, have filed companion play-or-pay bills for introduction into their respective Massachusetts legislative chambers.

Massachusetts Republican Gov. Mitt Romney and Democratic Senate President Robert Travaglini are both opposed to play-or-pay, although they have both expressed a keen interest in expanding coverage to the state's uninsured.

(See Play-or-Pay... page 5)

Recent URAC Study Finds UM Is Still Important, But Its Nature Is Changing

By Garry Carneal, JD, MA

Pundits have been predicting the demise of utilization management (UM) programs for several years. However, a new URAC publication showcases that UM interventions and regulations are still common place and thriving in most managed care settings. The findings in the 2005 URAC report, though, highlight the fact that the nature of UM is changing along with the focus of regulation.

UM Industry Trends

For over three decades, UM processes have helped determine what care is medically necessary and appropriate. As a result, UM programs have improved medical practice patterns, reduced unnecessary

(See UM... page 7)

Managed Care Outlook (ISSN: 0896-6567) is published twice-monthly by Aspen Publishers, 111 Eighth Avenue, New York, NY 10011. Send editorial correspondence to P.O. Box 2100, Montpelier, VT 05601-2100. 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. To order 100 or more article reprints, contact Journal Reprint Services, toll-free at 866/863-9726 (outside the U.S. at 610/586-9973) or visit their website at www.journalreprint.com.

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National Briefs

Americans rank health priorities: Almost two-thirds of U.S. adults say that lowering the costs of health care and health insurance should be a top priority for President Bush and the new Congress, according to a post-election survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health. Other leading priorities, the survey found, were making Medicare more fiscally sound for the future (58 percent of respondents) and increasing the number of Americans with health insurance (57 percent of respondents). Just over one quarter of survey respondents (26 percent) said that reducing malpractice jury awards ought to be a top priority. Just under one third (31 percent) said allowing prescription drugs to be imported from Canada should be a top priority.

HMO class-action suit allowed: The U.S. Supreme Court has refused to hear an appeal by six managed care companies that sought to challenge the class-action status granted to a racketeering lawsuit filed in federal court. The Supreme Court let stand a ruling by the U.S. Court of Appeals for the 11th Circuit in Atlanta, which allowed the class-action lawsuit to proceed to trial. The six HMOs had argued that the Court of Appeals used too lenient a standard for a class-action claim. The Supreme Court did not comment on its refusal to hear the case. Meanwhile, U.S. District Judge Federico Moreno in Miami has postponed the start of the trial from early March to Sept. 6. Moreno changed the trial date because appeals of earlier rulings had delayed preparation for trial, including taking depositions and providing witness lists.

Quovadx sells off managed care system: Quovadx, Inc., a software company, has sold its Managed Care Transaction Manager system to Royal Health Care Data Center, LLC, a subsidiary of Royal Health Care, LLC, a management services organization serving New York health care organizations. The transaction was valued at $1.9 million. In addition to purchasing the source code for the system, the sale also included hardware in the Albuquerque, N.M., data center, assumption of the facility lease, hiring of 11 Quovadx employees, and the assignment of customer agreements related to the system. The transfer took effect Dec. 31.

TPAs acquired: An investor group has acquired a majority interest in North American Health Plans, Inc., a Buffalo, N.Y. third party administrator, and North American Benefits Network, Inc., a Ohio health plan TPA. The investor group acquired these companies through North American Health Care, Inc., a new company it formed to participate in the consolidation of the TPA sector. The combined company will cover more than 400,000 health plan participants and process in excess of $1 billion of health care claims annually.

Coalitions launch BTE initiative: The National Business Coalition on Health has selected four of its member organizations as Bridges to Excellence program demonstration sites. The four business coalitions selected as demonstration sites are: Employers' Health Coalition, Fort Smith, Ark.; Tri-State Health Care Coalition, Quincy, Ill.; Heartland Healthcare Coalition, Peoria, Ill.; and Colorado Business Group on Health, Denver, Colo.

Kaiser Online Program Gets Consumers Up and Moving

In keeping with its mandate of promoting health and wellness through prevention, Kaiser Permanente has made its 10,000 Steps walking/fitness program available to both members and non-members.

By clicking on the Web site at kp.org/totalhealth, participants can sign up for the online program aimed at increasing their physical activity by adding to their daily steps.

Offered in association with HealthPartners, a Minneapolis managed care organization, the 10,000 Steps program is one of many strategies that Kaiser Permanente is using to put prevention and wellness on par with diagnosis, treatment and cure. Kaiser Permanente recently rolled out its companion Healthy Lifestyle Program, a series of online programs that address weight management and fitness, smoking cessation, stress reduction and nutrition.

For a nominal fee, participants in the 10,000 Steps program can sign up for eight months of access to the Web site and purchase a high-end pedometer at the same time.

Pedometers provide a tangible means to measure performance, Kaiser Permanente says, so that participants can see immediately why they should use the stairs instead of the elevator or park at the far end of the lot, not near the door. Everything participants need to assess their current status and monitor their daily successes can be accessed on the Web site in a secure manner, Kaiser Permanente says. In addition, if losing interest is a concern, participants can sign-up for daily e-mail tips and encouragement.

"We're anticipating great results from 10,000 Steps," said William Caplan, MD, director of clinical development for Kaiser Permanente's Care Management Institute. "We're confident that by walking further, and more frequently, participants will do positive things for their weight, their bodies and their overall health. We're giving them the motivational and measurement tools — all they have to do is provide the energy and determination. Since our emphasis is on helping our members make wiser, more sustainable lifestyle choices, we're excited when we can offer a simple tool that might inspire consumers to get up, get moving, and get healthy. 10,000 Steps does just that."

Recently, Health and Human Services Secretary Tommy Thompson announced that the 10,000 Steps program of HealthPartners was one of 11 winners of the second annual Innovation in Prevention Awards. The awards are presented each year by the U.S. Department of Health and Human Services to highlight businesses and organizations that are leading efforts to promote healthy lifestyles.

10,000 Steps is predicated on research showing that most people don't achieve the level of activity necessary to maintain health, let alone improve it. Sedentary adults, for instance, take between 2,000 and 4,000 steps per day, with moderately active individuals raising the bar to between 5,000 and 7,000. Active men and women, however, regularly walk 10,000 steps daily, burning up the 150 kcal (or more) recommended for improving health.

Taking into account stride length and an individual's weight, 2,000 steps is roughly a mile and burns about 100 calories. Burning an extra 100 calories a day can help prevent a 1-2 pound weight gain over the course of a year. Household chores can be converted to steps; mopping floors translates to 51 steps per minute, dancing to 93 steps a minute, and so on.

When developing 10,000 Steps, HealthPartners based its program on findings like these, and on focus group results revealing how improved health and increased energy can prompt a target audience of 35-to-50-year-olds to be more physically active. This same audience identified walking as a convenient, cheap and relatively easy way to accomplish their goals. They also saw the pedometer as an intriguing means to mark progress. According to a HealthPartners study published in the August 2000 *Journal of the American Dietetic Association*, study participants agreed that the pedometer was helpful in raising their physical activity by motivating them to accumulate and track their steps. ■

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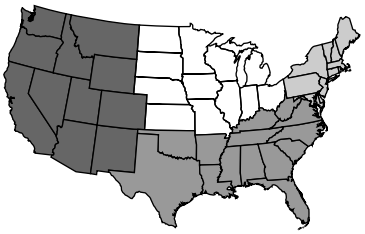

Regional Updates

Northeast

Dismissal of lawsuits upheld: Connecticut's Supreme Court has affirmed a trail court's decision to dismiss lawsuits filed by the Connecticut State Medical Society against Oxford Health Plans and ConnectiCare. The Supreme Court said that the medical society did not have proper standing to bring the cases. The society, on behalf of more than 7,000 physicians, claimed that the insurers had deceptively denied, reduced, and delayed claim payments.

WellChoice to tier: WellChoice, which operates a Blue Cross and Blue Shield plan in New York, says it will start offering tiered health plans. The plans will be offered to large employers as early as January 2006. WellChoice will develop a set of objective criteria to measure hospital quality by July. Hospitals that meet the standards will be placed in the preferred tier, and members will pay less if they use those preferred hospitals.

Acquisition completed: AMERIGROUP says it has completed the acquisition of CarePlus Health Plan, one of the largest Medicaid managed care organizations in New York City. The acquisition was effective Jan. 1. The CarePlus acquisition provides AMERIGROUP with about 115,000 members served by New York's Medicaid, Child Health Plus, and Family Health Plus programs.

South

Georgia looks for bids: Gov. Sonny Perdue of Georgia is planning to move 800,000 of the state's Medicaid beneficiaries and 200,000 in the PeachCare program for children from traditional fee-for-service into private managed care organizations. The state has asked private health insurers to bid on the business. The Department of Community Health says it expects vigorous competition in bidding among insurance companies.

Lawsuit against HMO goes forward: Physicians who claim that Neighborhood Health Partnership of Miami, Fla., routinely delayed or downcoded medical claims have been granted class-action status in their lawsuit against the insurer. A Miami-Dade County Circuit Court judge's ruling means that about 4,500 doctors can join the lawsuit. A spokesman for the HMO said the company is disappointed with the decision. "We strongly believe this is a case without merit," he said.

Midwest

Ohio HMO acquired: Ion Health Holdings, Inc., says it has acquired Community Health Plan of Ohio and will file with the state for permission to operate a Medicaid managed care plan in eight Ohio counties. Ion Health says the purchase was approved by the Ohio Department of Insurance. The company will operate as an HMO under the name Ion Health of Ohio. Ion Health intends to operate in Butler, Clark, Franklin, Hamilton, Lorain, Mahoning, Montgomery, and Trumbull counties. Ion Health said it could provide health care access to more than 445,000 people in the eight counties.

Molina awarded HMO license: Molina Healthcare, Inc., says its wholly owned subsidiary Molina Healthcare of Indiana, Inc., has been awarded a license to operate as an HMO in the state. The license precedes the implementation of a two-year contract to provide Medicaid services within 13 mandatory managed care counties starting Jan. 1.

HMOs renew push: Four HMOs in Illinois plan to launch the Illinois Association of Medicaid Health Plans to lobby state lawmakers to put more Medicaid beneficiaries into managed care plans. The health plans involved in the new association are AMERIGROUP, Harmony Health Systems, Inc., Humana, Inc., and United HealthCare of Illinois, Inc.

West

Colorado clinics to expand: Kaiser Permanente says it plans to expand its network of clinics in the Denver area to keep up with growing demand for care. Kaiser has opened an $11 million primary care clinic in Jefferson County, and plans to open a clinic in Highlands Ranch by midyear. Kaiser officials said the network of clinics will continue to grow. "We are looking at more sites and plan more growth in the suburban areas," said a spokesperson. "We're at capacity" in the current clinics, she said.

Play-or-Pay … (from p. 1)

John McDonough, executive director of Health Care For All, which helped develop the play-or-pay bills, admits that the legislation is a "place-holder" or the "initiation of a conversation (that) has a long way to go."

Play-or-pay supporter Philippe Villers, co-chair of the Massachusetts Business Leaders for Quality and Affordable Health Care, acknowledges that the legislation has a better chance of passage in 2006 than 2005 as more people become educated about the concept and as public pressure builds for state lawmakers and the governor to act.

Ask any of the play-or-pay supporters in Massachusetts about whether their state has any similarities with California and its unsuccessful experience with play-or-pay and they will tell you just how different their state is.

McDonough said California put together its legislation in a big hurry and in such a way that would have left it vulnerable to legal attack had it survived the referendum.

California's law was signed by outgoing Democratic governor Gray Davis and ultimately put to the voters, narrowly failing 51 percent to 49 percent. New Gov. Arnold Schwarzenegger, a Republican, actively campaigned against the law and is credited with being the driving force in its repeal.

Villers, who is president of Grainpro, Inc., a Concord, Mass.-based firm that sells technology to help preserve grains and other commodities, points out that the California law went down with the help of an enormous infusion of advertising dollars that unfairly characterized the issue. "There will be attempts to misrepresent the legislation (in Massachusetts), but I don't think they will work," he said.

McDonough observed that Massachusetts is starting out with a bigger, stronger and broader base of support for play-or-pay than California, and it promises to swell over time. Supporters consist of provider groups, organized labor, patient and consumer grassroots organizations across Massachusetts, as well as some businesses, he added.

"We don't have mainline business, but we have a new and growing coalition of business leaders committed to expanding access," McDonough said, referring to the Massachusetts Business Leaders for Quality and Affordable Health Care that Villers helps lead.

"They will support a mandate on employers," McDonough added. "They're paying a high cost to cover their workers and the workers from firms who don't offer coverage. They understand there's not a solution without some mechanism to have every employer in the game."

Villers believes the fledgling coalition will grow to between 50 and 100 companies and maybe more. "We don't think companies should be forced to subsidize their competitors," he said, adding that a play-or-pay law would essentially level the playing field.

Having a system where everybody pays in some way for the health coverage of their employees and where low-wage workers receive a subsidy from the state to purchase coverage is part of the answer in eliminating spiraling double-digit health insurance costs, Villers asserts.

Representing what McDonough calls mainline business is Eileen McAnneny, vice president of government affairs for Associated Industries of Massachusetts (AIM), which represents more than 7,600 Massachusetts employers from all types of industries. She said the organization does not support a play-or-pay employer mandate.

McAnneny said 99 percent of AIM's members provide health care coverage to their employees, noting that such a mandate on employers is not a good position for the state to adopt from an economic development standpoint. "The senate president and governor don't think an employer mandate will happen," she said. "I think it is pretty much off of the table."

While play-or-pay is not necessarily the only way to expand coverage in Massachusetts, Villers said the unpopular alternative is to finance an expansion out of general tax revenues. He added that a play-or-pay approach is the most natural evolution from where Massachusetts is today with many employers already providing coverage for their workers.

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Individual health plans in Massachusetts are quick to defer to their state association on play-or-pay. Marylou Buyse, who heads the Massachusetts Association of Health Plans, said it has not yet taken a specific position on the legislation because it has yet to see the details.

However, rather than have a strict play-or-pay approach, Buyse said there should be incentives to encourage businesses who do not now offer coverage to their employees to do so.

The basic problem with the lack of access to health insurance in Massachusetts, Buyse said, is the high cost of health care. No purported solution will work unless that issue is addressed, she added.

McDonough said some health plans are waiting for a so-called "Roadmap to Coverage" to be issued by the Blue Cross and Blue Shield of Massachusetts Foundation before they take sides on the play-or-pay issue. "At this point, they are not on board and they're not against us," he added.

While connected to Blue Cross and Blue Shield of Massachusetts, the foundation is run separately from its namesake. Andrew Dreyfus, the foundation's president, said it is engaged in a year-long project to develop a concrete, realistic and practical plan to expand coverage in Massachusetts.

"Our hope is that by the time the bill comes up for a public hearing, the roadmap is out and has gotten significant public acceptance and we are able to redraft our legislation to incorporate it," said McDonough.

McDonough said the roadmap wouldn't be unveiled until late spring, noting that it may or may not include an employer mandate. "At this point, we're talking less about a particular bill or product and more about a process," he said. "We have confidence that in the end it will lead to the next major (piece) of coverage expansion."

Massachusetts is fortunate, according to Dreyfus, in that it has a relatively low percentage of uninsured citizens and a relatively formalized system of caring for the uninsured and paying for that care. "We start out with a distinct advantage over other states," he added.

The first phase in the development of the roadmap — an analysis of the medical care provided to uninsured patients in Massachusetts — is complete. The second phase, according to Dreyfus, involves the development of a series of options to achieve broader coverage such as employer and individual mandates, subsidies to low-wage workers and small business, expansion of Medicaid and market reforms to make coverage more affordable.

"At this point, we're talking less about a particular bill or product and more about a process. We have confidence that in the end it will lead to the next major (piece) of coverage expansion."

Dreyfus said the roadmap could be ready in June, while expressing hope that such a thoughtful plan that spells what it will cost, who will benefit and what changes need to be made in the system will help catalyze debate and help people make decisions.

With a Republican governor proposing major health care reform, legislative leaders expressing support on this issue and dissatisfaction with the state's free care pool, Dreyfus said the status quo is increasingly viewed as unacceptable by a variety of major players.

All of that makes Massachusetts ripe for reform, as difficult as that is to accomplish on a state-by-state basis, Dreyfus adds. "There is a lot of energy pointing to health care reform," he added. "The final structure it will take is open to speculation and debate. The good news is we will have a health care reform debate in Massachusetts." ■

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UM ... (from p. 1)

medical expenses, and reduced long term hospital stays.

Yet despite these advances, many of the initial benefits associated with UM have diminished over time. Recent studies looking at the impact of prospective and concurrent UM have demonstrated a low denial rate for UM interventions (e.g., net savings in total per capital medical expenditures of about 5 percent). As a result, the lower "return on investment" (ROI) in UM systems is a byproduct of the fact that most costs have been squeezed out of the system, and best practice treatment patterns have been identified and implemented for most routine care.

This has led to a re-vamping of the focus of how UM systems operate. For example, clinical staff are pulling back from the application of rigid precertification and concurrent requirements to a more fluid care coordination model. In part, medical directors are able to now design and implement a more flexible approach to medical management as sophisticated health IT systems are implemented and more data becomes available to analyze health utilization trends.

Other notable UM and medical management trends include:

- Due to higher salary costs stemming from the short supply of licensed and experienced nurses, clinical staff are often detailed to higher cost procedures;
- UM enhancements have led to the expansion of more intensive care management services which often concentrate on high dollar medical cases;
- Automated UM pre-screening tools are now common place;
- Due to technological advances, payor-based electronic health records are being actively used by clinical staff at medical management companies to help manage care;
- Clinical guideline usage (e.g., Milliman, InterQual) continues to be standardized and better defined in part by the greater reliance on evidence-based medicine;
- Predictive modeling is becoming wide spread and more sophisticated to help identify, analyze and stratify high cost patients;
- Health outcomes reporting and the supporting ROI methodologies for various medical management interventions are becoming closely scrutinized by plan sponsors;
- Public policy advocates are encouraging the implementation of patient safety protocols within medical management programs;
- Independent and/or external reviews are more common place due to regulation and other stakeholder interest;
- UM functions have become the backbone of care coordination and other enhanced medical management interventions which include CM and DM services;
- Physician profiling of treatment patterns is on the increase as a "counter balance" to the more fluid UM requirements; and
- Some medical management functions are moving off shore (e.g., internationally-operated health call centers serving U.S. citizens).

Regulatory Trends

In a recent URAC survey of state UM regulation, the findings show some noteworthy changes in the UM regulatory landscape during the past five years:

- 50 states and the District of Columbia either through direct or de facto regulation such as patient's rights legislation now require some sort of initial appeals process for UM activities (up 25 percent since URAC completed its last UM survey in 2000);
- 46 states presently regulate either health UM entities and/or UM activities by managed care organizations (up 12 percent since 2000);
- 41 states specifically mandate that only physicians or clinical peers, or a non physician provider whose scope of practice includes a similar treatment or service, may render adverse UM decisions (up 28 percent since 2000).
- 39 states have specific clinical review criteria guidelines for UM or managed care entities (up 11 percent since 2000);
- 39 states and the District of Columbia require an external appeal or independent review process should that individual wish to chal-

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lenge their UM decision to a neutral third party (up 15 percent since 2000);

- 36 states require UM or managed care entities that practice UM make any clinical review criteria used for adverse determinations available upon a participant's request (up 89 percent since 2000);
- 34 states require licensure, registration, certification, or accreditation for health UMOs, or organizations that practice UM (up 13 percent since 2000);
- 24 states impose prohibitions on financial incentives for UM reviewers or UM organizations (up 9 percent since 2000); and
- 19 states now have "same-state licensure" provisions for either reviewers and/or medical directors (up 90 percent since 2000).

The survey findings clearly indicate that states continue to actively supervise how medical necessity review determinations are made to ensure that UM decisions are made in a standardized manner based upon a sound medical basis.

Similar to state regulations, the federal regulatory environment for UM has changed significantly with the implementation of the U.S. Department of Labor's (DOL) claims procedure in 2002. These regulations, issued under the Employee Retirement Income Security Act of 1974 (ERISA), are the federal government's first major entry into the oversight of medical management processes (outside of Medicare and Medicaid).

Self-insured plans — which were exempt from most state oversight requirements — now have to comply with the federal UM requirements. In addition, insured plans must now reconcile federal and state regulations in each state where they operate. The necessity to fully understand and implement these DOL regulations is an essential element for any effective UM compliance program.

The Patient Safety Factor

Since the 1999 release of the Institute of Medicine's (IOM) report, *To Err is Human*, the issue of patient safety has become a major public policy issue. Automated UM systems have the capability of flagging unexpected events that may be indicators of a quality and safety problem, including unexpected readmissions or other medical complications. Findings by URAC generally show that medical management organizations possess untapped resources that may be mobilized to promote patient safety. Such capabilities include:

- Overseeing clinical patient encounters;
- Promoting more direct patient contacts through CM and DM interventions;
- Detailing discharge responsibilities and follow-up;
- Improving data resources and infrastructure;
- Expanding use of clinical staff;
- Implementing guidelines and algorithms that can be used to identify unanticipated events; and

Humana Site Allows Members to Compare Hospital Costs

In addition to quality measures already available through its online Compare Hospital tool, Humana, Inc. is adding out-of-pocket cost data as a consumer-focused enhancement.

Humana says it is now including an estimate of members' out-of-pocket costs for the diagnosis and treatment of covered procedures. The information is available through the member's secured personal home page, MyHumana.com. The Compare Hospital tool will compare costs for up to five different hospitals for the same procedure. The tool is powered by HealthShare Technology and updated annually.

Humana members already can access information about hospital performance for a variety of conditions, diagnoses and treatments ranging from maternity services to chest pain.

"We want health care expenses to be more transparent to consumers and are giving them cost information so they can make informed decisions for themselves as they do in other aspects of their purchasing lives," said Beth Bierbower, vice president of product innovation for Humana.

The cost comparison is an enhancement of the capabilities Humana members have had through the Compare Hospital tool to select a diagnosis, treatment and procedure in order to compare hospitals based on the number of procedures performed, complication rates, lengths-of-stay and mortality rates.

- Expanding use of electronic health record systems.

Existing UM capabilities could be applied to help improve patient safety by:

- Identifying specific safety indicators relevant to medical management processes;
- Staff training;
- Promoting regular and systematic use of flags, triggers and protocols;
- Tracking and trending safety indicators through the provider or facility; and
- Reporting and collaborating with purchasers, providers, and other stakeholders regarding the selected safety indicators.

The Future of UM

A primary example of UM's continued survival is the fact that URAC continues to see at least a dozen new UM accreditation applications annually. While the focus of UM may be changing, it still serves an important function within the health care system. UM and other medical management services continue to undergo constant change as clinical and information advancements are made. UM programs also assume an integral role in advanced care coordination systems that are driven by CM and DM interventions.

These trends make it difficult to predict exactly what UM will look like in the future – in part due the robust flexibility and customization that occurs today.

While the exact future of UM may be difficult to forecast, UM services will continue to support medical decision-making by determining what care is medically necessary and appropriate given the facts of the case, the available resources, and the clinical treatment alternatives. ■

Garry Carneal is president and CEO of URAC, an independent nonprofit organization based in Washington, D.C., that is committed to promoting health care quality through accreditation, certification and other quality improvement activities. For more information on URAC, go to www.urac.org.

Michigan Blues Provides Members With Online Health Survey

To help their two million members identify health risk factors and improve their health, Blue Cross Blue Shield of Michigan and the Blue Care Network are providing free online access to an interactive, personalized health appraisal tool.

The online tool was developed by the Michigan Blues with assistance from a population health management company, HealthAtoZ, and the University of Michigan Health Management Research Center. The feature is an enhancement to the Blues' existing comprehensive health management program called BlueHealth Connection.

"We are excited about the opportunity to give so many individuals in our state an up close and personal appraisal of their health status and risks to begin their new year. This highly confidential appraisal is designed to be the first step in a process that gives consumers greater control over their health," said Karen Maher, Blues vice president of medical management.

Maher said the new tools give members immediate feedback that can be used to develop personal action plans, track and monitor progress online and subscribe to personal health education materials, and other tools that help members stay well or better manage chronic health problems.

Douglas Woll, MD, Blue Care Network's senior vice president and chief medical officer, describes the overall program as "one of the many critical tools in the Blues' mission to better arm members with access to timely, accurate and meaningful information and assistance to improve their health."

Woll said the Blues are also taking steps to raise awareness among physicians of the kind of support that BlueHealthConnection programs can offer to their patients.

Maher said the need to place tools in the hands of consumers that strengthen and support their interactions with health care professionals will only grow as the U.S. population ages and the incidence of chronic disease continues to mount.

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Not only can such tools improve health for individuals, they can also help hold down the costs of health care, the Michigan Blues point out. HealthAtoZ representatives say research consistently proves access to electronic health and medical information and counseling programs leads to lower health care costs by making employees better informed medical consumers. They cite a report that showed test companies achieved a return on investment over time of between $2.30 and $6 for every dollar spent on the programs in the studies.

"These types of tools can help decrease unplanned absenteeism and increase productivity by helping workers achieve optimal health. This is a good investment in the long run," Maher said.

"These types of tools can help decrease unplanned absenteeism and increase productivity by helping workers achieve optimal health. This is a good investment in the long run."

Michigan Blues employees are among those who will be able to use the new tool. "I find the online personal health record feature convenient for keeping track of my most recent exam and lab results. I'm looking forward to watching for improvement, or talking to my doctor about follow-up action, if the indicators show I could be heading for a slip in my health," said Michigan Blues employee Jaime Curto. More than 8,000 Blues employees are being encouraged to complete the survey.

BlueHealthConnection appraisal takers can view their reports and appraisal results as often as they like. The online appraisal can be taken every six months. Members are encouraged to have the following information on hand when they log in for the 15-minute appraisal questionnaire:

- Most recent blood pressure readings
- Cholesterol levels
- Date of last checkup
- Recent vaccination dates
- Recent screening test dates

Blues members whose health plan is underwritten (fully insured) by the Blues automatically qualify for the assessment (unless their group opts out of the program). Members in larger companies that self-insure and contract with the Blues to administer their coverage have the option of whether to add BlueHealthConnection and these new tools to their range of benefits. Approximately 2 million Michigan Blue plan members will have the online service. ■

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AMERIGROUP Combats Diabetes Through Games and Exercise

By Mary Elizabeth Fratini

Type II diabetes is on the rise among children across the country and AMERIGROUP's subsidiary in Texas is fighting back with crab-walking contests and food pyramid puzzles.

The activities are part of an educational program called "Walk the Walk, Talk the Talk, See Your Doc!" It is designed for children ages 6-11 and delivers straight talk about the risks and reality of diabetes through exercise and games.

"We wrote the program to be splashy and appeal to elementary school children because the problems [that lead to diabetes] start very young," said David Escame, marketing and community outreach director for AMERIGROUP in Austin, Texas. According to Escame, 38 percent of first-graders in East Austin are overweight and 20 percent remain overweight by the time they are in middle school.

The hour-long program has three components: exercise (the walk); information about diabetes (the talk); and recommendations for regular check-ups (the doc). "The core idea is encouraging kids to exercise three times a week on their own," Escame said. "Schools only offer physical education once a week now, so by they time they get to us the kids are really ready to get moving."

The physical activities range from pushups to relays to the crab-walking contests. Program staff participate alongside the children. "The kids will monitor each other and start making rules, like five fake push-ups equals one real one," Escame

said. "No matter how ridiculous it looks, we are right there with them."

"We get them with the exercise portion first and then we do the talk, 'what is diabetes?'" Escame explained. The information includes risk factors, early warning signs and complications of diabetes, and also how to prevent it through exercise and healthy eating. "We also ask if they know anyone with diabetes and the answer is always yes, often a family member," Escame said.

AMERIGROUP's diabetes program is designed for children ages 6-11. Above are some of the participants from Austin, Texas. Photo courtesy of AMERIGROUP.

The presentation is blunt, but not graphic, in covering topics like amputation, kidney failure and blindness. "We show them how blood without insulin looks like molasses, but we don't show pictures of complications," Escame said. "It doesn't shake them at all at the time, but I think when they go home it hits them at some level."

The kids also complete handouts of a 'food safari' puzzle where they find healthy foods hidden within a picture. They then have a question and answer session with prizes like water bottles. "You have to tell kids things five times before they remember it, so I will ask the same question in different ways," Escame said. "We want to beat this dead horse until more kids know the answers."

"We wrote the program to be splashy and appeal to elementary school children because the problems [that lead to diabetes] start very young."

The last part of the program, "See Your Doc," covers the importance of regular check-ups and encourages kids to be proactive about their own health. "We send them home with information because, while it's great to have fun with the kids, this needs to get into the hands of parents to really make a difference," Escame said. "I think it has a greater impact for parents to get this directly from their own child."

Walk the Walk was created with the American Diabetes Association (ADA) and is also co-sponsored by the Boys and Girls Clubs and Shoes for Austin. "The ADA had a great diabetes fundraiser walk for schools, but it is hard for kids this age to do a fundraiser," Escame said. "So we use their materials and get the information to a different community."

According to the ADA, African-Americans are 1.6 times more likely to have diabetes than whites, and Hispanics are 1.5 times as likely. The educational program is available in both English and Spanish as part of AMERIGROUP's commitment to bridging this minority health gap.

AMERIGROUP has presented this program 12 times in Austin and the surrounding communities since its launch in November of 2004. The company has offered it in afterschool programs, YMCAs, community centers, and Boys and Girls Clubs throughout Austin. The response from kids has been overwhelmingly positive, said Escame. "At one program a kid refused to leave when his mom came to pick him up. At another, a little girl asked my coworker, 'Where's Diabetes Dave?'" he recalls. "The reaction and feedback has been fanatastic."

Publicity comes largely through word-of-mouth referrals within the community. "We are getting calls to come back a second and third time that we have to postpone for now, and in that sense we are already a great success," Escame said.

After six months, Escame will review the program to quantify the effort, resources and overall its success to determine how long the

(continued on next page)

company will offer it in Austin and whether it should be expanded to other areas of the country that AMERIGROUP serves. “We have offices in seven states that develop their own programs independently; those that succeed then spread to other states,” said Doug Blue, public relations manager for AMERIGROUP. “This was a great program, very creative and I fully expect to see it replicated elsewhere.”

In the meantime, Escame is looking at the possibility of creating programs for even younger children through Head Start or an Americorp program called Healthy Tots that targets children aged 0-5. “We are hoping that having all these different organizations tag-team diabetes, which is really an epidemic for this community, will have a real payoff and impact down the road as these kids get older,” Escame said. ■

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Most CalPERS Members Decide to Switch Doctors

When it came to lowering their health care costs or sticking with their doctor, about three-fourths of the members of the California Public Employees Retirement System opted for lower costs.

CalPERS had decided to exclude from its HMO network 24 high-cost hospitals, including 13 owned by Sutter Health. The move is expected to save CalPERS $45 million.

About 48,000 members had to decide whether to find a new doctor or pay more to see their existing doctor at one of the excluded hospitals. About 77 percent opted to save the money, CalPERS says.

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