

MANAGED MEDICARE *Report*

**NEWS & ANALYSIS ON
MEDICARE+CHOICE,
MEDICARE MANAGED
CARE OPTIONS,
AND SENIOR CARE
MANAGEMENT**

Volume VIII, Number 9

June 24, 2002

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ACRPs

CMS PREPARES 2003 TIMELINE — AGAIN

Congress and the Bush administration have finally agreed to give Medicare+Choice organizations more time to make decisions about staying in the program — just in time for them to prepare for the 2003 contract year.

President **George Bush** on June 12 signed the Public Health Security and Bioterrorism Response Act of 2002 (H.R. 3448), which for the next three years gives M+C plans more time to file their adjusted community rate proposals, a reprieve from lock-in and a delay in the annual election period.

Under the new law, M+COs must submit their ACRPs to the **Centers for Medicare & Medicaid Services** by the second Monday in September — instead of July 1 — through 2004. “As this takes effect immediately upon signing,” notes consultant **John Gorman** of Washington’s **Gorman Health Group** in a June 6 update, “this should give some crucial additional time for this year’s filings and decisions on whether you’re in or out of Medicare+Choice.”

The law pushes the annual election period back to Nov. 15 through Dec. 31 in 2002, 2003 and 2004. It also postpones the Balanced Budget Act of 1997’s lock-in requirements until 2005. “This means that continuous open enrollment will be in place until then,” points out Gorman, “with exception of the Nov. 15 – Dec. 31 coordinated open enrollment period.” He predicts that Congress will repeal lock-in by 2005.

The bill also pushes back CMS’ annual announcement of the following year’s rates from March to May, notes a CMS official. That gives plans less time to compose their ACRPs, as they’ll receive the information four months — instead of six — before the new September filing deadline.

But it will result in CMS numbers that likely will more accurately reflect the marketplace closer to the filing time. Plans won’t know their rates until sometime into the second quarter, the official tells **Eli**, but “it gives our actuaries more time to look at what the rates should be.”

CMS had only recently posted all the documents plans need to prepare their 2003 ACRs and submit their ACRPs and plan benefit packages. CMS even held an industry-wide conference call May 21 to review the agency’s contract year 2003 renewal/nonrenewal instructions, which had been released May 3, for example.

But H.R. 3448 required changes to all those instructions. CMS planned to post the new 2003 ACR instructions by June 21, the official explains.

The new instructions address the non-renewal process, ACRP submissions and clearance of marketing materials. “This updates everything for the plans, based on the new timeline,” he says.

CMS sent the health plan associations a draft of the new 2003 ACRP timeline for comments, says the CMS official. While CMS routinely seeks the associations’ input on M+C regulatory issues, says an official with the **Health Insurance Association of America**, the HIAA couldn’t meet CMS’ quick turnaround on the ACRP draft.

“They sent it out on [June 14] and needed comments back [June 17],” **Marianne Moore**, director of federal regulatory affairs and policy development at HIAA, tells **Eli**. “We just haven’t had time to evaluate it.” The HIAA’s silence on the matter should not be seen as approval, Moore cautions.

The **American Association of Health Plans** did not yet have a reaction to the draft, either. ❖

M+C Reform

REPUBLICANS REVISIT GIVEBACKS

At last, Congress is considering a much-needed pay raise for Medicare+Choice organizations. After months of false starts and speculation, the two committees of jurisdiction began meeting June 18 to mark up a sweeping Medicare reform bill.

The full House Ways and Means and the Energy and Commerce committees June 18 began separate mark-ups of the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954), a bill sponsored jointly by the committees’ Republican leadership, including Ways and Means Chairman **Bill Thomas** (R-CA) and Energy and Commerce Chairman **Billy Tauzin** (R-LA).

Rep. **Nancy Johnson** (R-CT), chair of the Ways and Means Subcommittee on Health, is listed as the sponsor of the legislation, a preliminary copy of which was obtained by **Eli** before it was subject to amendments. The committee passed the legislation June 19 in a 22 to 16 vote along party lines.

According to the draft, the 255-page bill would equalize Medicare+Choice and Medicare fee-for-service payments; revise the blend and the annual minimum increase in rates; abolish “budget neutrality,” a concept that has plagued the Medicare+Choice program since the Balanced Budget Act of 1997; and require the **Medicare Payment Advisory Commission** to produce a re-

port on the AAPCC methodology used to compute risk adjusted payments to M+COs.

Department of Health and Human Services Secretary **Tommy Thompson** would have to determine and announce the 2003 M+C capitation rates within two weeks of the bill's enactment, according to one section. The bill would also amend the freshly signed bioterrorism measure (H.R. 3448) by making permanent its changes to the annual ACRP submission deadline, the annual enrollment period and the annual announcement date of M+C rates. (*See story above.*)

The Medicare reform bill's "voluntary" Medicare prescription drug benefit includes a monthly \$35 premium and a \$250 deductible that will pay 80 percent of spending up to the first \$1,000 and then 50 percent up to \$2,000, according to Tauzin and Energy and Commerce Health Subcommittee Chairman **Michael Bilirakis** (R-FL). Low income seniors will pay less than \$5 per prescription under the preliminary version of the bill.

The bill also provides for an interim discount card program — echoing the Bush administration's unsuccessful stab at instituting a Medicare prescription card program through the **Centers for Medicare & Medicaid Services** last year. But in a nod to the pharmaceutical industry that waylaid CMS' initial drug card efforts, the bill allows the card to be "accepted by local pharmacies, including non-participating pharmacies, through a point-of-service requirement."

One issue the committees are expected to address is whether the drug benefit will be a stand-alone program or will become a required part of the Medicare package that M+COs would therefore be obligated to offer.

"If plans are required to cover it, there needs to be a separate payment prong for the drug benefit," says **American Association of Health Plans** spokesman **Mohit Ghose**. Thus far, M+C plans have been able to provide drug benefits based on "limited means" from the federal government, with no payment to support it, Ghose says. "To the extent payment levels can be corrected, health plans should be able to provide a more robust package, like in 1997," he explains, referring to the days before the Balanced Budget Act.

The bill also includes Medicare+Choice stabilization provisions, according to Tauzin and Bilirakis. It would create "a new competitive structure for M+C plans" that would require them to bid on M+C contracts with CMS. The new bidding system "could allow beneficiaries to realize savings

of 25 percent off their premiums," say the representatives.

The best news for M+COs, though, is that the bill would result in givebacks totaling between \$3 billion and \$4 billion for M+C plans, according to industry sources.

"A giveback package is important to stabilize the market in the areas they're targeting," Ghose says. The AAHP is not supporting any one piece of legislation yet, as the Democrats are expected to bring their own bills to the table. However, AAHP "supports the approach" that the committees are taking, says Ghose.

Democrats are not expected to go along with the M+C pay raise easily, and some Republicans are already protesting the measure's dependence on the private sector. For instance, Majority Leader **Dick Armey** (R-TX) begged Thomas to remove provisions from the bill that "could be construed as tinkering with a popular entitlement by tilting Medicare more toward the private sector," reports the *Washington Post*. ❖

Federal Developments

CMS, PLANS PROMOTE THEIR OWN 'MINORITY REPORT'

The Bush administration is following through on its promises to prop up Medicare+Choice by traveling around the country this summer to drum up support for the program.

The **Centers for Medicare & Medicaid Services** is sending top officials out to selected cities around the United States "to highlight the importance of the M+C program for low-income and minority beneficiaries," according to an agency official. New research indicates these beneficiaries are utilizing the program in larger numbers than was previously thought.

CMS designed the campaign in cooperation with the **American Association of Health Plans** in response to a study released April 25 by **Kenneth Thorpe**, a professor of public health at **Emory University** in Atlanta, a CMS official tells **Eli**. CMS plans to visit San Antonio, San Diego, Denver, Atlanta and Albuquerque, NM in June and July.

Thorpe found that lower-income benes "are disproportionately likely to enroll in Medicare+Choice," according to the report, which was commissioned by the **Blue Cross Blue Shield Association**. "Among beneficiaries earning \$10,000 to \$20,000 a year (without Medicaid or employer insurance), nearly 78 percent in Southern Califor-

nia, 67 percent in Philadelphia, and 51 percent in Florida enroll in Medicare+Choice.”

Beneficiaries in so-called minority groups are also more likely to enroll in M+C. “African-American and Hispanic beneficiaries show a strong preference for Medicare+Choice,” according to Thorpe’s report. “Nationally, 40.3 percent of African-Americans and 51.6 percent of Hispanics are enrolled in Medicare+Choice.”

The first stop on the CMS campaign was the **Texas Diabetes Center** in San Antonio on June 20, where CMS Deputy Administrator **Ruben King-Shaw** and members of **Humana** and **PacifiCare** M+C plans spoke to low-income and minority seniors about the program. Other speakers included Dr. **Francisco Cigarroa**, president of the **University of Texas Health Sciences Center** in San Antonio, and **Jane Delgado**, president of the **National Alliance on Hispanic Health**.

M+C plans involved in the campaign are also taking the opportunity to educate members of Congress who represent districts with large populations of minority and low-income beneficiaries.

The campaign has two purposes, says PacifiCare spokesperson **Tyler Mason**: to increase these populations’ awareness of M+C’s benefits as well as to educate their political representatives about the challenges the program is currently facing. PacifiCare will send members to speak “wherever we are licensed to enroll Secure Horizons members,” Mason reports.

“There are whole communities — voting blocs — and members of Congress that don’t realize how important it is to the people in their communities,” he says. “They may be familiar with M+C, but they probably aren’t as intimately aware of how many members of their constituencies are enrolled in the program. We’re trying to build that awareness.”

Humana participated in the San Antonio event for the same reasons PacifiCare did — “to see additional funding to support the program” so that it will survive as an option for seniors, Humana spokesperson **Mary Sellers** tells **Eli**. Humana, which is working through the AAHP to participate in the event, would consider going to other cities if the AAHP suggests it, Sellers says.

M+COs are still hopeful that Congress will come through with more funding for the program. “We’re still waiting to see what happens with the 6.5 percent increase in the president’s budget,” Mason says. “Folks are starting to pay attention in their home districts to what happens to [the M+C program] if it’s not adequately funded. A lot of

people are asking specific geographical questions.”

While plans can take heart that M+C is still appealing to beneficiaries, they still have to wait on the make-or-break news about funding— a topic that House of Representatives committees are just now beginning to address with actual legislation (*see story above*). “We may not ultimately know until the fall,” laments Mason. ❖

HIPAA

HHS RELENTS ON J CODES

The **Department of Health and Human Services** has finally issued rules that will bring some actual simplification under the so-called Administrative Simplification provisions of the Health Insurance Portability and Accountability Act.

HHS in the May 31 *Federal Register* released notices of proposed rulemaking relating to pharmaceutical transactions and changes to the transactions and code set standards for electronic transactions. Plans, providers and clearinghouses must submit a compliance plan to CMS by this Oct. 16 in order to defer their HIPAA transactions compliance date to Oct. 16, 2003 in accordance with a law passed late last year.

“These are changes that the industry said they needed to make implementation easier,” explains an HHS official, who also mentions the **Centers for Medicare & Medicaid Services’** compliance extension plan, which allows covered entities to request an implementation extension to October 2003. “So, taken together,” the official tells **Eli**, “we are providing, one, easier standards to implement, and, two, more time in which to implement them.”

In the NPRM regarding changes to the code set standards, HHS proposes to adopt 115 of the 231 change requests submitted by plans and providers to Designated Standards Maintenance Organizations. While HHS would normally provide a 60-day comment period in an NPRM, the department says a 30-day period is appropriate because the DSMO changes “already were subjected to the public DSMO process and were discussed and approved by the **National Committee on Vital and Health Statistics** in public sessions.”

HHS says it wants to change from required to situational data elements like provider taxonomy codes and “date last seen by physician” — thus making them optional. It also wants to remove data elements like referral dates and estimated dates of birth. HHS proposes to allow the reporting of some items via external code sets rather than as data ele-

ments in the transactions and to allow entities to cross-reference subscriber IDs and send a patient's primary care number, according to the NPRM.

None of the changes will surprise M+COs. "This is a process of consensus building in those organizations," affirms attorney **Mark Lutes** with **Epstein Becker & Green** in Washington. "There is a modest reduction of burdens, especially if something no longer needs to be collected."

In the pharmacy transactions NPRM, HHS proposes the adoption of various guides and standards for batch transactions, referral classification and authorization transactions, and health care payment and remittance advice transactions. As in the DSMO NPRM, HHS only gives interested parties until July 1 to comment because of the "overwhelming response from the affected industry."

The proposal would also repeal the National Drug Codes as the standard medical data code set for reporting drugs and biologics in all standard transactions, except for retail pharma transactions.

The repeal of the NDCs is a "very welcome change," says **Nancy Schwartz**, a HIPAA official with the **Fallon Community Health Plan** in Worcester, MA. Fallon, like many M+COs, only accepts codes in the Healthcare Common Procedure Coding System, commonly called "J codes" in claims from physicians. MCOs use the NDCs in their outpatient pharmaceutical claims, and that's not a problem, she explains.

But the NDCs were too long for the physicians' claim forms. As the NPRM points out, "The industry has reported that the costs of changing from using HCPCS to NDC for reporting drugs and biologics on institutional claims could exceed an institution's costs for adopting all other combined HIPAA standard transactions."

"This change in the NPRM solves a lot of problems for us," Schwartz says. "We don't have to restructure our system, and physicians don't have to change." And all indications are that the proposed rule will be adopted. "It could be onerous if it's not," Fallon says. ❖

Editor's Note: Go to www.access.gpo.gov/su_docs/fedreg/a020531c.html to see the NPRMs.

Employers

EIN ADOPTION WILL REQUIRE SOME ELBOW GREASE

The **Department of Health and Human Services** has decided on the way M+COs must report data from their employer contracts to CMS.

As HHS originally outlined in a June 16, 1998 proposed rule, the **Centers for Medicare & Medicaid Services** May 31 released a final rule requiring plans, providers and clearinghouses to use **Internal Revenue Service**-issued employer identification numbers for health care transactions under the Health Insurance Portability and Accountability Act. The rule is effective July 30, 2002, and most entities must comply within two years of that date. Small health plans have three years, according to the final rule.

Health plans say the rule will require some extra work to bring their systems up to date but that the change was expected. M+COs currently use a variety of methods to identify the employers they contract with for retiree benefit plans. Plans, clearinghouses and providers often use different identification numbers for different transactions.

"Having multiple identifiers for a single employer slows activities such as health plan enrollment and premium payment," according to HHS. This rule will require all M+COs to use the EINs instead of their own assigned numbers for all transactions submitted to CMS that require an employer to be identified. Enrollment is probably the most important transaction affected by the final rule.

Fallon Community Health Plan, for example, already has the employer tax ID numbers in their system. "We need to do a review of our records," **Nancy Schwartz**, one of Fallon's HIPAA officers, tells **Eli**. "It will probably require some work on our part to make sure we're using it in a standard way and in the right place on transactions."

"But this is one of the more innocuous of the changes" required by HIPAA, adds Schwartz. Plans can still use their own employer identifiers for internal transactions, she points out. ❖

Editor's Note: Go to www.access.gpo.gov/su_docs/fedreg/a020531c.html to see the final rule.

Market Developments

FLORIDA M+CO FINDS SUCCESS FILLING A VACUUM

A Medicare+Choice organization that has persevered in the tough Florida market is ready to take its M+C product to the next level in the Northeast — and its owners are willing to sell the organization to do it.

The owners of **Well Care HMO Inc.** of Tampa, FL announced in mid-May that they would sell the HMO to a New York investor group, **Well Care Acquisitions Co.**, led by **Todd Farha**, a former

executive with **Oxford Health Plans**. Well Care operates commercial, Medicaid and Medicare plans in Florida, Connecticut and New York.

Well Care's founder, chairman and majority owner says he's making the sale in order to forge a partnership with someone who can help him continue to build his company. "When we reached this size," Dr. **Kirin Patel** tells **Eli**, "for me to go to next level, there was a need for capital and an intellectual partner in human resources and finance."

Patel expects nothing to change for the company or its membership, aside from the change in top-level management. While he will not be "operationally involved" in the business, he says he will remain on the board and hopes that the company will expand its M+C presence in New York.

As of April, Well Care's New York M+C enrollment was just under 2,000, according to the latest figures from the **Centers for Medicare & Medicaid Services**. But in Florida, the M+CO covers over 40,000 seniors with its Well Care Choice Health Plan, making it one of the largest M+C providers in the state. In fact, Well Care in May expanded its service area around Pensacola, FL in Escambia and Santa Rosa counties.

Patel is circumspect when it comes to Well Care's future as a Medicare+Choice contractor. The Medicare product needs to be evaluated, and he says he trusts the new management to "make the best decision." Because the deadline for submitting renewals and nonrenewals to CMS has been moved to September, the company will have more time to make the decision, he says.

Well Care was forced to curb its M+C marketing in New York in the past, says Patel. "When I came in, the company was in bad shape," he relates. "We had a Medicare audit recently, which showed we are making good progress." Patel says CMS is slated to return in September, when he hopes they will "confirm that our progress was not a fluke and will continue."

Despite his earlier caution about the M+C side of Well Care's business, Patel says he hopes Well Care will be able to expand its service area in New York, subject to CMS' approval of its progress.

Well Care has already proven that it can succeed in unlikely places. "In Florida, we are doing extremely well," Patel reports. "Many of our Medicare recipients were concerned because I had moved into markets where [other M+COs] were moving out."

Well Care succeeded because it was able to provide services "where there was a vacuum," in

counties such as Hernando and those near Pensacola, he says. Well Care was so successful, in fact, that the M+CO was forced to close enrollment in many of its Florida counties last March because of unexpectedly rapid growth in demand.

Farha's company is awaiting approval from the **Florida Department of Insurance**, which has regulatory authority over the sale. ❖

Markets

HOUSE SUBCOMMITTEE PONDERS RETIREE COSTS

If Medicare+Choice organizations can gain any stability from proposed reforms, they would be wise to market that attribute to two groups — employers and retirees. Both employers and their Medicare-eligible employees have shown great interest in M+C; taking advantage of this is a matter of convincing them you're here to stay.

Many benes without retiree coverage are already in M+C, according to a recent **Blue Cross Blue Shield Association** study conducted by **Kenneth Thorpe**, a professor of public health at Atlanta's **Emory University**. Over 38 percent of beneficiaries without retiree coverage choose M+C plans, says Thorpe. M+C edged out Medigap and fee-for-service Medicare, the study found.

Employer-sponsored health coverage for retirees is waning, but M+COs have not been able to step into the market fully — until now. The **Centers for Medicare & Medicaid Services** recently made it easier for M+COs to design benefit plans for employers (*see MMR, Vol. VIII, No. 7, p. 40*), and President Bush recently signed legislation (H.R. 3448) easing some of M+C's deadlines that have made the program unattractive to new MCOs.

Hearings held recently by the House Committee on Education and the Workforce on why employers are retreating from retiree coverage provide a window to view this possible market.

The committee's first hearing addressed seniors' decreasing access to employer-sponsored retiree health care, noted Rep. **Sam Johnson** (R-TX), chairman of the Employer-Employee Relations Subcommittee at a May 16 hearing on legacy retiree health care costs. "In fact, only 35 percent of employers still offer the benefit."

The problem is health care costs, which M+COs have proven they can handle if their reimbursements are fair. "Firms do not wish to be at risk for rising health care costs and changes to Medicare over the next 50 years," **University of**

Notre Dame business professor **Fred Mittelstaedt** told the subcommittee. “Few firms are establishing new retiree health benefit plans.”

In fact, many employers hoped the M+C program would help alleviate some of the costs of retiree coverage, but the program has given employers nasty surprises over the last few years. The threat of change in Medicare benefits is problematic for those attempting to ensure continued health care protection for retirees, **Louise Novotny**, assistant director of research for the **Communications Workers of America**, and others said at the hearing.

In bargaining with employers, the CWA has tried to strike a balance between holding down employer costs and getting adequate coverage for retirees. “In one of our most labor-intensive and frustrating efforts to modify plan design in order to reap cost savings,” Novotny said, the union negotiated to install retirees of several big telephone companies in M+COs, with the companies picking up some cost-sharing.

The M+C plans offered good benefits and “promised to hold down costs, giving both management and the union some confidence that our negotiated [company spending] caps would hold for many years,” related Novotny. “But no sooner did we begin to implement the program than HMOs began dropping out of Medicare in droves.”

Ford Motor Co. was ready for M+C but hasn’t been able to realize its full benefits, mainly because of low MCO participation. “In certain areas of the country where we have approved Medicare+Choice plans, some of our retirees began to enroll in these plans in 1999, but the penetration into our population has been limited,” Dr. **Vincent Kerr**, Ford’s director of health care management, said at the hearing.

Like many large employers, Ford is faced with increasing costs that managed care is designed to help control. Of the \$2.5 billion that Ford spent on health care costs in 2001, “retiree health accounted for \$1.6 billion, a little over half, although in our population, retirees are slightly less than half of the population,” Kerr testified. “The 2001 cost represented a 25 percent increase over 2000.” ❖

Industry Notes

HOSPITAL COPAYS ANGER PA PROVIDERS

The dominant Medicare+Choice organization in Pennsylvania is doing so well that it can afford to eliminate hospital copayments.

Highmark Blue Cross Blue Shield on June 1 retracted copayments in its SecurityBlue M+C plan for hospital stays and outpatient procedures that it had just instituted in January. The MCO operates SecurityBlue under **Keystone Health Plan West** in western Pennsylvania.

Highmark made the decision based on several factors, spokesperson **Denise Grabner** tells **Eli**. “Both members and hospitals were unhappy,” she explains. The copayment for diagnostic and invasive procedures was \$25, and an inpatient stay carried a \$100 copay, up to an annual \$500 maximum.

“Highmark has done relatively well for the last few years financially, and we wanted to pass some of that back to our members,” Grabner explains. After **Aetna US Healthcare** pulled its M+C product out of western Pennsylvania, she says, Highmark was able to pick up more members. The plan now covers 187,000 M+C benes in 17 counties in that part of the state and enjoys a low 2 percent voluntary disenrollment rate, says Grabner.

Highmark is also caught up in a cutthroat campaign for M+C members with one of the very hospital providers it contracts with. The **University of Pittsburgh Medical Center Health System** entered the M+C market in the fall of 2000 intent to take on Highmark, long the dominant health insurer in the state. (*See MMR Vol. VI, No. 11, p. 65.*)

The **UPMC Health Plan** covers only 3,700 M+C members, according to the latest stats from the **Centers for Medicare & Medicaid Services**. But the M+CO’s membership has been climbing steadily since its launch, and UPMC recently gained over 1,000 members in just one month, from March to April. UPMC also expanded its service area this spring to the Pittsburgh area, where 440,000 eligibles reside.

UPMC, one of the country’s largest integrated systems with 62 hospitals in western Pennsylvania alone, and Highmark also have been locked in a contract battle over reimbursement for a year. “We continue to negotiate with UPMC and are hopeful that we will reach an agreement,” Grabner says.

But Highmark’s backing down on the hospital copayment issue “was not a UPMC-specific decision,” she adds. “The majority of our network hospitals were unhappy with the copayment.”

In Other Medicare News:

- CMS on June 7 released a letter to M+COs directing them to use their Medicare contract number (Hxxxx) as the Medicare Identification number in section A, item 3 of their Electronic Transactions and Code Sets Compliance Extension Plan filings.

“The inclusion of the Medicare contract number will assist CMS in identifying which Medicare MCOs have filed for an extension,” writes **Gary Bailey**, director of the Health Plans Benefits Group at CMS. Go to http://cms.hhs.gov/healthplans/hipaa/ascadelay_letter.zip.

- CMS on May 28 announced its implementation of new marketing and monitoring features in the Health Plan Management System. CMS will now be able to automatically notify an M+CO’s compliance officer when it approves or disapproves marketing materials. M+COs will be able to communicate with CMS about marketing issues online under the new system. Go to http://cms.hhs.gov/healthplans/letters/mcomemonefeatures_1.zip for more information.

- CMS on May 22 held its first quarterly conference call designed to train M+COs on newly released chapters in and updates to the Medicare Managed Care Manual. Chapter authors presented on Chapter 2, Enrollment and Disenrollment; Chapter 3, Marketing; Chapter 5, Quality; Chapter 7, Payments to M+COs; Chapter 10, Compliance with State law and Federal Preemption; and Chapter 11, Contracts with M+COs. CMS expects to hold manual conference calls on the third Wednesday of the second month each quarter “as appropriate,” a CMS official tells **Eli**. The next one is August 21.

- The **National Committee for Quality Assurance** June 10 announced that **American Healthways** is the first organization to earn accreditation under NCQA’s new Disease Management Accreditation program in four categories: diabetes, congestive heart failure, coronary artery disease and chronic obstructive pulmonary disease. NCQA is currently reviewing 21 other DM organizations.

- The **Department of Justice** needs to work harder to justify its expenditures in health fraud prosecutions, according to a recent report by the **General Accounting Office**, “Medicare: Health Care Fraud and Abuse Control Program for Fiscal Years 2000 and 2001” (GAO-02-731). The DOJ also needs to accurately record its collections from settlements with and penalties imposed on health care providers and plans in the Medicare program. Go to www.gao.gov/new.items/d02731.pdf.

- Unclear, incomplete and contradictory information provided by M+COs about their prescription drug coverage makes it hard for beneficiaries to know what’s covered and to compare benefits among plans, according to a new report from the **HHS Office of Inspector General**, “Medicare HMO Prescription Drug Benefits” (03-00-00430).

The OIG insists that M+COs should provide far more detailed drug data to their M+C enrollees, but CMS disagrees. In its response to the report, CMS argues that the OIG’s recommended level of detail would not really help, given the current complexity of the data offered to benes. Go to <http://oig.hhs.gov/oei/reports/oei-03-00-00430.pdf>.

- Buffalo Grove, IL-based **CorSolutions Medical Inc.** announced May 31 that CMS has awarded the disease management giant a project under the agency’s Coordinated Care Demonstration. Over the next four years, CorSolutions’ demo will address the value of integrated chronic care management for fee-for-service benes with heart failure. It began identifying eligible benes and physicians in the Houston area in June.

- CMS on May 23 announced its approval of Cincinnati-based **Anthem Health Plans of Kentucky Inc.’s** expansion into Bullitt County, just south of the Louisville, KY area on June 1. ❖

MANAGED MEDICARE *Report*

The *Managed Medicare Report*, ISSN# 1526-5609, is published 12 times/year by Eli Research, PO Box 90324, Washington, DC, 20090-0324. Subscriptions Cost \$477.

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