HEALTHSCRIPT

November 2007

A publication for HNE providers and their staff

HEALTH NEW ENGLAND EARNS TOP-TEN SPOT IN NATIONAL HEALTH PLAN RANKING

We are excited to announce that HNE placed among the top ten health plans in the nation. HNE was ranked 9th among the 250 plans reviewed in the just-released U.S. News & World Report/NCQA America's Best Health Plans 2007 ranking.

Each year U.S. News & World Report magazine works with the National Committee for Quality Assurance (NCQA) to determine the rankings. Health plans are rated on a variety of measures including access to care and service, overall member satisfaction, preventive care and overall quality.

Peter Straley, President and CEO of HNE said this is the highest ranking his company has ever achieved. "This is an example of how a small plan like HNE can have a big impact, even on a national level," Straley said.

U.S. News and World Report released the results today on their website. The full report is featured in the November 5 issue of the magazine.

NEW MEANS OF COLLECTING HEDIS®[1] PATIENT DATA

by Pat Scheer, HNE Quality Operations Manager

Increasingly, the Healthcare Effectiveness Data and Information Set (HEDIS) measures are moving away from merely counting the number of tests performed, but also adding information about the result of the test.

A case in point would be reporting a blood pressure for a diabetic. The measure now requires that information about the BP levels be collected and reported regarding the percent of diabetic members whose BP is <130/80, ≥130/80, <140/90, and ≥140/90.

Until recently, the BP level was available only through medical record review. As a major step toward collecting more information through claims submitted by providers rather than through medical record review, the National Committee for Quality Assurance (NCQA) and the American Medical Association (AMA) have developed a set of procedure codes. The Current Procedural Terminology (CPT) Category II codes are specific to the HEDIS measures, and report such things as LDL-C level, A1c level and even BP level.

Physicians are urged to add a line or two to the claims they submit in order for these items to be measured through claims data rather than having to pull the medical record, copy pertinent pages and submit the medical record information to HNE when requested. Thus, a claim that included the CPT Category II codes shown below would indicate his/her BP was the level indicated all without having the physician office having to go through the extra steps of providing the medical record documentation.

BP Level	Systolic	Diastolic
<130/80	3074F	3078F
≥130/80	3075F, 3077F	3079F, 3080F
<140/90	3074F, 3075F, 3076F	3078F, 3079F
≥140/90	3077F	3080F

[1]HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)

2007 QUALITY PROGRAM EVALUATION AND 2008 QUALITY PROGRAM DESCRIPTION AVAILABLE

HNE annually reviews the scope and effectiveness of its quality improvement program. Based on results of the evaluation, the next year's quality program is developed. If you would like a copy of either document, contact Pat Scheer, HNE Quality Operations Manager at 413-233-3435.

HNE'S HEDIS® 2007 SUMMARY

Quality of care and services provided to members is an important measure of the effectiveness of any health plan. The National Committee for Quality Assurance (NCQA), a not-for-profit organization, measures health plan quality using a standardized series of health plan quality measures called the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Consumer Assessment of Healthcare Providers and Systems

(CAHPS®[1]).

Plans reporting HEDIS and CAHPS data must adhere to stringent specifications on how to collect the data. An independent auditor conducts an audit to ensure data collection specifications are being followed. Plans meeting all audit specifications receive a "Full Audit" designation. Once again, HNE has received this honor for the HEDIS 2007 audit.

NCQA publishes HEDIS and CAHPS results in *Quality Compass*®[2], a national database of results for managed care plans. HNE uses *Quality Compass 2007*® 90th percentile as a benchmark. As reported in the NCQA's "State of Managed Care Quality 2007" report, *Quality Compass* data represents over 241 health plans across the country.

HNE uses HEDIS/CAHPS results to help evaluate our performance and implement improvements as needed. Where our rate falls short of the benchmark, teams analyze data to identify barriers that prevent members from receiving appropriate or timely care, or that preclude providers from rendering appropriate or timely care. Once barriers are identified, the information is used to develop educational or behavioral interventions directed at members and/or providers. These interventions encourage the medically appropriate use of available benefits by members, and give providers tools they need to ensure members receive suitable and timely care as well as age- and sex-appropriate preventive care services.

If you have any questions or comments regarding HEDIS/CAHPS rates, please contact Pat Scheer @ 413-233-3435.

[1] *CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)*
[2] *Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA)*

CAHPS 2007 RESULTS

In spring 2007, the 2007 HEDIS/CAHPS Survey was administered by The Myers Group, an approved vendor of NCQA. 1,100 randomly selected surveys were distributed with a response rate of 47.71%

Measure	HNE	Quality Compass 90th Percentile
Getting Care Quickly Composite	87.74%	90.86%
Definition: The composite score is the overall percentage of members who responded "Always" or "Usually" to the following questions: Q4. In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? Q6. In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?		
Getting Needed Care Composite	85.33%	89.20%
Definition: The composite score is the overall percentage of members who responded "Always" or "Usually" to the following questions: Q23. In the last 12 months, how often was it easy to get appointments with specialists? Q27. In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?		
How Well Doctors Communicate Composite	92.72%	95.21%
Definition: The composite score is the overall percentage of members who responded "Always" or "Usually" to the following questions: Q15. In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand? Q16. In the last 12 months, how often did your personal doctor listen carefully to you? Q17. In the last 12 months, how often did your personal doctors show respect for what you had to say? Q18. In the last 12 months, how often did your personal doctor spend enough time with you?		
Rating of All Health Care	78.64%	80%
Definition: Q12. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months? The result displayed is the percentage of members who answered this question with 8, 9, or 10.		
Rating of Health Plan	69.95%	73.18%
Definition: Q42. Using any number from 0 to 10 where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan? The result displayed is the percentage of members who answered this question with 8, 9, or 10.		
Rating of Personal Doctor	86.35%	86%
Definition: Q21. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? The result displayed is the percentage of members who answered this question with 8, 9, or 10.		
Rating of Specialist Seen Most Often	82.35%	84.86%
Definition: Q25. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist? The result displayed is the percentage of members who answered this question with 8, 9 or 10.		

HEDIS 2007 RESULTS

Access to Care			
Adults	Adults who had ambulatory/preventive care visits in the past three years:	95.90%	95.90%
	• Ages 20 to 44	96.36%	96.92%
	• Ages 45 to 64		
	• Ages 65 and older	98.23%	98.60%
Children	Children who had an ambulatory/preventive care visit in 2006:		
		99.79%	99.07%
	• Ages 12 months to 24 months		
	• Ages 25 months to 6 years	96.58%	94.97%
	Children who had an ambulatory/preventive care visit in the past two years:	97.39%	95.72%
		95.90%	93.71%
	• Ages 7 to 11 years		
	• Ages 12 to 19 years.		
Prevention and Screening			
Childhood Immunizations	Children receiving appropriate immunizations (except Pneumocccocal) by age two: • One MMR by age two • One DTap followed by at least 3 DTap/DTs between ages of 42 days and two • Three IPVs between ages of 42 days and two years • Three HIBs between ages of 42 days and two years • Three Hep Bs by age two • One VZV by age two • Four Pneumoccocal conjugate by age two	82.97%	87.65%
Appropriate Testing for Children with Pharyngitis	Children ages 2 to 18 who were tested for strep, diagnosed with pharyngitis and received a prescription for antibiotics	81.29%	85.96%
Appropriate Treatment for Children with URI	Children ages 3 months to 18 years who were diagnosed with an URI and were not given an antibiotic until at least 3 days after diagnosis	91.12%	91.14%
Adolescent Immunizations	Adolescents who received all the appropriate immunizations by age 13. • Two MMRs by age 13 • Three HepBs by age 13 • One VZV by age 13	88.0%	81.32%
Advising Smokers to Quit	Represents the percentage of smokers ages 18 and older who saw a doctor and were advised to quit smoking.	75.78%	80.20%
Breast Cancer Screening	Women ages 42 to 69 who had a mammogram during the past two years.	78.22%	76.66%
Cervical Cancer Screening	Women ages 24 to 64 who had a PAP test during the past three years.	82.82%	87.10%
Colorectal Cancer Screening	Adults ages 51 to 80 who had an appropriate screening for colorectal cancer.	62.5%	65.1%
Maternity Care			
Prenatal Care	Women who received prenatal care in the first trimester, or within 42 days of enrollment.	94.39%	97.53%
Postpartum Care	Women who had a postpartum visit three to eight weeks after delivery.	92.44%	89.08%
Treatment of Acute and Chronic Illness			
Cardiovascular Conditions			
Beta-Blocker Treatment After a Heart Attack	Adults ages 35 and older who were prescribed a beta-blocker after hospitalization for a heart attack.	100%	100%

Cholesterol Management for Patients with Cardiovascular	Adults ages 18 to 75 who were hospitalized for a cardiovascular event or had a diagnosis of ischemic vascular disease, whose most recent cholesterol screening in 2006 was <100.	66.18%	66.18%
Conditions			
Controlling High Blood Pressure	Adults ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during 2006.	67.40%	68.13%
Diabetes and Asthma			
Eye Exams for Diabetics	Diabetics ages 18 to 75 who had a retinal eye exam in 2005 or 2006	80.05%	71.17%
Cholesterol Screening for Diabetics	Diabetics ages 18 to 75 whose most recent 2006 cholesterol screening with < 100.	49.15%	51.34%
Hemoglobin A1c Testing for Diabetics	Diabetics ages 18 to 75 whose most recent 2006 hemoglobin A1c test was in good control (<7)	Not in QC 2007	55.23%
Hemoglobin A1c Poor Control	Diabetics ages 18 to 75 whose most recent 2006 hemoglobin A1c was out of control (>9.0) or were not screened in 2006. (lower % better)	10.22%	18.98%
Nephropathy Monitoring for Diabetics	Diabetics ages 18 to 75 who had medical attention for nephropathy during 2006.	86.86%	87.26%
Use of Appropriate Medications for People with Asthma	Members ages 5 to 56 who were diagnosed with persistent asthma and were prescribed appropriate medication in 2006.	92.66%	94.84%
Mental Health			
Antidepressant Medication Management	Assessing medication management for depression during different phases of treatment for members ages 18 and older who were diagnosed with depression.		
• **Optimal Phase:**	Members who had three follow up visits with their physician during the 12 week period following diagnosis of depression.	90.81%	31.01%
• **Acute Phase:**	Members who remained on antidepressant medication during the entire 12 week period following diagnosis of depression.	63.97%	69.52%
• **Continuation Phase:**	Members who remained on antidepressant medication for at least six months following diagnosis of depression.	49.87%	53.02%
Follow-Up After Hospitalization for Mental Illness	Members ages 6 and older who had an ambulatory follow-up visit after hospitalization for treatment of mental health disorder.		
	• within 7 days of discharge	73.17%	72.50%
	• within 30 days of discharge	89.02%	87.61%

PROVIDER KUDOS

HNE would like to congratulate Baystate Health. Baystate Medical Center was named to "Leapfrog Top Hospital" list!

BAYSTATE MEDICAL CENTER NAMED ONE OF ONLY 41 HOSPITALS NATIONWIDE NAMED TO "LEAPFROG TOP HOSPITALS" LIST

Significant Gaps in Safety and Quality Practices Among Other Hospitals

Still the Norm according to The Leapfrog Group

Baystate Medical Center has received national recognition for the second year in a row for its high-quality patient care and safety as one of only 41 hospitals in the United States to be named to the Leapfrog Top Hospitals list.

The national list, announced recently by The Leapfrog Group, is based on results from the Leapfrog Hospital Quality and Safety Survey, a national rating system that offers a broad assessment of a hospital's quality and safety.

"Our continuing status as a top Leapfrog hospital is a testimony to the hard work of many individuals who are elevating the standard of care we deliver at Baystate Medical Center to new levels, reaching new heights in clinical and service excellence, and carrying out our charitable mission in compassionate ways," said Mark R. Tolosky, president and CEO of Baystate Health.

"Leapfrog Top Hospitals demonstrate an exceptional level of performance on quality and patient safety measures and serve as a model for other hospitals," said Suzanne Delbanco, CEO, The Leapfrog Group. "However, all of the participating hospitals deserve praise for their willingness to raise the veil on how well they perform on vital quality and safety practices."

The Leapfrog Hospital Quality and Safety Survey is the most complete and current assessment of hospital quality and safety available in the United States and the 2007 Top Hospitals list is based on 1,285 hospitals that responded to the survey.

Data is collected from hospitals on their progress toward implementing practices in four categories in which Baystate Medical Center has met and exceeded Leapfrog requirement, noted Dr. Evan Benjamin, vice president, Healthcare Quality, Baystate Medical Center.

- Computerized Physician Order Entry: Do physicians enter patient prescriptions and other orders into computers linked to error prevention software?
- ICU Physician Staffing: Are intensive care units staff by trained ICU intensivists?
- Evidence-Based Hospital Referral: How well do hospitals perform seven high-risk procedures and care of three high risk neonatal conditions.
- Leapfrog Safety Practices Score: How well are hospitals progressing on the other 27 National Quality Forum Safe Practices?

New in this year's survey results is information about bariatric and aortic valve surgery. In addition, Leapfrog now considers surgeon experience in rating these and the other high-risk surgeries that are part of Evidence-Based Hospital Referral. According to Leapfrog officials, meeting their recommended thresholds for surgeon experience is difficult for most hospitals.

This year, hospitals also reported for the first time on their level of transparency as measured by their participation in other public quality reporting efforts. The survey's Transparency Indicator reveals that an impressive 96% participate in at least one reporting effort in addition to the Leapfrog Survey.

Ellen Stovall, president and CEO, National Coalition for Cancer Survivorship, praised The Leapfrog Group for introducing the Transparency Indicator. "This part of the Leapfrog Survey gives consumers a good idea about how committed a hospital is to being forthright about their quality and safety track record," she said.

If all non-rural hospitals in the United States implemented computer physician order entry, ICU physician staffing and just five of the EBHR conditions (not including bariatric surgery and aortic valve replacement) , over 65,000 lives per year could be saved and over 907,000 serious medication errors prevented (John D. Birkmeyer, MD, University of Michigan, 2004). Moreover, the U.S. health care system could save approximately $41.5 billion annually. (Conrad and Gardner, University of Washington, 2005).

"Our shared vision for the future is to be one of the leading health systems in the nation, and the exemplary work of our staff is getting us there," Tolosky said.

Recently, Baystate Medical Center was named one of "America's Best Hospitals" by *U.S. News and World Report*.

Further recognizing its national efforts in healthcare quality, Baystate Medical Center was recently named a 100 Top Hospital by Thomson in 2006 and has received the Beacon Award for Critical Care Excellence for three consecutive years. Winner of the 2006 Premier Award for Quality, Baystate Medical Center is also the only western New England hospital to receive Magnet status from the American Nurses Credentialing Center.

About The Leapfrog Group

On behalf of the millions of Americans for whom many of the nation's largest corporations and public agencies buy health benefits, The Leapfrog Group aims to use its members' collective leverage to initiate breakthrough improvements in the safety, quality, and affordability of health care for Americans. The Leapfrog Group was founded in November 2000 by the Business Roundtable and is supported by its members, the Robert Wood Johnson Foundation, The Community Fund, the Agency for Healthcare Research and Quality and other sources. For more information, visit **www.leapfroggroup.org**

TWO IMPORTANT CLINICAL GUIDELINES UPDATED!

2007 Massachusetts Guidelines for Adult Diabetes Care Now Available

HNE adopts guidelines relevant to membership needs to promote preventive care and support management of chronic health conditions. Each year, HNE distributes information about Guidelines to physicians.

Guidelines are available at (http://hne.com/HNE_providers/preventive.html) as well as the physician-only secure web site, HNEDirect. If you would like a paper copy of a Guideline, call the HNE Provider Relations Department at 413-787-4000 or 800-842-4464, ext. 5000.

National Asthma Guidelines Updated

From the NHLBI:

The National Asthma Education and Prevention Program (NAEPP) issued the first comprehensive update in a decade of clinical guidelines for the diagnosis and management of asthma. The guidelines emphasize the importance of asthma control and introduce new approaches for monitoring asthma. Updated recommendations for managing asthma include an expanded section on childhood asthma (with an additional age group), new guidance on medications, new recommendations on patient education in settings beyond the physician's office, and new advice for controlling environmental factors that can cause asthma symptoms.

Coordinated by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health, NAEPP convenes an expert panel when there is sufficient science to warrant a rigorous, systematic review of the published medical literature to ensure that the asthma guidelines reflect the latest scientific advances.

"The goal of asthma therapy is to control asthma so that patients can live active, full lives while minimizing their risk of asthma exacerbations and other problems," notes William W. Busse, M.D., chairman of the Expert Panel, and chairman of the University of Wisconsin Department of Medicine.

Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma - Full Report, 2007 provides new guidance for selecting treatment based on a patient's individual needs and level of asthma control. The guidelines emphasize that, while asthma can be controlled, the condition can change over time and differs among individuals and by age groups. Thus, it is important to monitor regularly the patient's level of asthma control so that treatment can be adjusted as needed.

EPR-3 builds upon complete asthma guidelines issued in 1991 and 1997 and an update on selected topics released in 2002. The guidelines focus on four components of asthma care: measures to assess and monitor asthma, patient education, control of environmental factors and other conditions that can worsen asthma, and medications.

Key features and changes to these four components of asthma care include:

- *Assessment and Monitoring:* EPR-3 takes a new approach to assessing and monitoring asthma by using multiple measures of the patient's level of current impairment (frequency and intensity of symptoms, low lung function, and limitations of daily activities) and future risk (risk of exacerbations, progressive loss of lung function, or adverse side effects from medications). The guidelines stress that some patients can still be at high risk for frequent exacerbations even if they have few day-to-day effects of asthma.

- *Patient Education:* EPR-3 confirms the importance of teaching patients skills to self-monitor and manage asthma and to use a written asthma action plan, which should include instructions for daily treatment and ways to recognize and handle worsening asthma. New recommendations encourage expanding educational opportunities to reach patients in a variety of settings, such as pharmacies, schools, community centers, and patients' homes.

A new section addresses the need for clinician education programs to improve communications with patients and to use system-wide approaches for integrating the guidelines into health care practice.

- *Control of environmental factors and other conditions that can affect asthma:* EPR-3 describes new evidence for using multiple approaches to limit exposure to allergens and other substances that can worsen asthma; research shows that single steps are rarely sufficient. EPR-3 also expands the section on other common conditions that asthma patients can have and notes that treating chronic problems, such as rhinitis and sinusitis, gastroesophageal reflux, overweight or obesity, obstructive sleep apnea, stress, and depression may help improve asthma control.

- *Medications:* EPR-3 continues the use of a step-wise approach to control asthma, in which medication doses or types are stepped up as needed and stepped down when possible. Treatment is adjusted based on the level of asthma control.

The step-wise asthma management charts are revised and expanded to specify treatment for three age groups: 0-4 years, 5-11 years, and 12 years and older. The 5-11 age group was added (earlier guidelines combined this group with adults) as a result of new evidence on medications for this age group, and emerging evidence that suggests that children may respond differently than adults to asthma medications.

Recommendations on medications are updated to reflect the latest evidence on effectiveness and safety. EPR-3 reaffirms that patients with persistent asthma (e.g., patients who have symptoms more than twice a week during the day or more than twice a month at night) need both long-term control medications to control asthma and prevent exacerbations, as well as quick relief medications for symptoms as needed. EPR-3 also reaffirms that inhaled corticosteroids are the most effective long-term control medication across all age groups. EPR-3 includes new recommendations on treatment options such as leukotriene receptor antagonists and cromolyn for long term control; long acting beta agonists as adjunct therapy with inhaled corticosteroids; omalizumab for severe asthma; and albuterol, levalbuterol, and corticosteroids for acute exacerbations.

EPR-3 also describes areas of current research to improve asthma management, such as new ways for monitoring asthma control (for example, tests using a patient's sputum and exhaled air), and tailoring treatment based on the particular characteristics of a patient's asthma and the patient's genetic makeup.

NAEPP is developing tools and partnerships to improve adoption of the guidelines, including a Summary Report of EPR-3 to be released October 17. An NAEPP-appointed independent panel of experts and guideline end-users is developing an action plan to improve guidelines implementation.

HEDIS INFORMATION - BEHAVIORAL HEALTH

HNE's Behavioral Health (BH) department utilizes the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS®) measures to evaluate and improve the BH services available to our members. We want to share information about the BH HEDIS measures as well as some of the interventions we're taking to help improve compliance.

1. Follow-up after Hospitalization for Mental Health (the percentage of members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who were seen on an ambulatory basis or were in intermediate treatment with a mental health provider on day of discharge or within 7/30 days). This is important because timely outpatient follow-up care has been shown to reduce readmission rates.

HNE's Interventions:

- To encourage members to attend a first follow-up appointment within 7 days of discharge and a second follow-up appointment within 30 days, HNE implemented a "Voucher Program." Through this program, HNE pays the member's copayment for the first five follow-up appointments. Vouchers have been sent to participating hospitals to give to members prior to discharge. HNE also sends the vouchers to members' homes.
- The HNE BH department staff provide telephone outreach to members on days 2, 4, 10, and 21 post-discharge from a mental health facility. Through this direct outreach to members, HNE BH department staff encourage members to receive follow-up care in an effort to reduce another hospitalization.

2. Antidepressant Medication Management

- **Optimal Practitioner Contacts for Medication Management** (the percentage of members 18 years of age and older who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner coded with a mental health diagnosis during the 84-day [12-week] Acute Treatment Phase. At least one of the three follow-up contacts must be with a prescribing practitioner).

- **Effective Acute Phase Treatment** (the percentage of members 18 years of age and older who were diagnosed with a new episode of depression, were treated with an antidepressant medication, and remained on the antidepressant medication during the entire 84-day [12-week] acute treatment phase).

HNE Interventions:

- The HNE BH department staff encourage and support patients diagnosed with a new episode of depression to fill antidepressant prescriptions for the entire 12-week acute phase of treatment. Through direct outreach to members, HNE BH department staff encourage members to attend follow-up appointments with their psychiatrists or PCPs for antidepressant medication monitoring.

- **Effective Continuation Phase Treatment** (the percentage of members 18 years of age and older who were diagnosed with a new episode of depression and treated with an antidepressant medication, and remained on the antidepressant medication for at least 180 days).

HNE Interventions:

- The HNE BH department provides education to members about depression. A three-part series on depression in "MemberMatters" (HNE's member publication) encourages members to remain on their medication as prescribed. This information is also available in a brochure format. Brochures have been sent to participating providers.

3. Initiation of Alcohol or other Drug Treatment (the percentage of members (18-65) with an alcohol or other drug-related diagnosis who initiate treatment through inpatient **or** outpatient services for AOD and have an additional AOD service within 14 days).

HNE Interventions:

- To encourage members to attend a first follow-up appointment within 7 days of discharge and a second follow-up appointment within 14 days, HNE implemented a "Voucher Program." Through the "Voucher Program," HNE pays the member's copayment for the first five follow-up appointments. Vouchers have been sent to participating hospitals to give to members prior to discharge. HNE also send the vouchers to members' homes.
- The HNE BH department staff provide telephone outreach to members on days 2, 4, 10, and 21 post-discharge from a substance abuse facility. Through this direct outreach to members, HNE BH department staff encourage members to

receive follow-up care in an effort to maintain sobriety and reduce another hospitalization.
- The HNE BH department provides education to members about substance abuse. A three-part series on substance abuse in "MemberMatters" (HNE's member publication) encourages member to continue in treatment and seek out additional support to maintain sobriety. This information is also available in brochure format. Copies of the brochure have been sent to participating providers.

4. Follow-up Care for Children Prescribed ADHD Medication (the percentage of children newly prescribed ADHD medication who have at least 3 follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed).

HNE Interventions:

- The HNE BH department provides education to members about ADHD. A three-part series about ADHD in "MemberMatters" (HNE's member publication) provides information and suggestions to parents/guardians of children with ADHD. This information is also available in brochure format. Copies of the brochure have been sent to participating providers.
- HNE developed additional ADHD Guidelines that recommend a second appointment within 30 days of medication being prescribed and at least two more follow-up appointments within 9-months of the second appointment. Guidelines are available at http://hne.com/HNE_providers/preventive.html.

FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM

While most people are honest, a small minority commit health care fraud and abuse. This costs health plans and government programs – and you – a lot of money every year. Incidents of fraud and abuse are low in Massachusetts when compared to other parts of the country. That doesn't mean we can let out guard down, though. That's why HNE has implemented a fraud, waste, and abuse prevention program.

In this article, we explain what fraud, waste, and abuse are. We provide examples of suspicious activity. We also discuss important laws in the prevention of fraud, including protections for whistleblowers.

Report Suspicious Activity

Please tell us if you see any suspicious activity. You can call our toll-free compliance hotline, email, or send us a letter via fax or mail.

- ***Compliance Hotline:*** (800) 453-3959 (available 24/7; reports can be made anonymously)
- ***Email:*** compliance@hne.com (please use secure messaging at https://hne-mail.com)
- ***Fax:*** (413) 233-2806
- ***HNE mailing address:***

Health New England, Inc.
Attn: Compliance Officer
One Monarch Place
Springfield, MA 01144-1500

HNE cannot retaliate if you report suspicious activity. When making a report, please provide as much detail as possible. Names, dates, and a description of the issues in question are helpful. For example, you may wish to describe why you think an activity is a cause for concern. If possible, please include your name and telephone number. That way, we can contact you if we have any questions during our investigation. If you wish to use email to report a concern, please use secure messaging to protect your confidentiality. For example, you may send and receive secure messages by logging in to the *HNE Secure Mail Message Center*. Go to https://hne-mail.com, create a login, and compose a message. You will be able to log in later to receive our response.

What are Fraud, Waste, and Abuse?

Fraud is the intentional use of false statements to cheat another person or company out of something of value. It includes any act that constitutes fraud under state and federal law.

Waste is any unnecessary cost that results from poor or inefficient practices.

Abuse is an activity that goes against sound business, monetary or medical practices. Abuse may include practices by providers, members, or customers that result in unnecessary costs to the health plan.

Suspicious Activity is any activity that you think is fraudulent, wasteful, or abusive. Here are some examples:

Examples of Suspicious Activity by Providers:

- Altering medical records.
- Billing for non-covered services as if covered.
- Billing for services that weren't provided.
- Falsely certifying that services were medically necessary.
- Kickbacks and bribery.
- Certain billing activity, like "unbundling" or "upcoding."
  - Unbundling is billing for each piece of a service, instead of for the service as a whole.
  - Upcoding is billing for a costlier service than the one provided.
- Use of unlicensed staff.

Examples of Suspicious Activity by Members:

- Adding someone to your plan who is not your dependent.
- Not taking a dependent off a policy when they are no longer eligible.
- Forging or altering bills or receipts to get payment from the health plan.
- Forging or altering a prescription
- Selling your prescription drugs to someone else.
- Getting medical care and benefits with someone else's insurance card
- Letting someone use your insurance card to get medical care and benefits.

Examples of Suspicious Activity by Brokers or Agents:

- Altering documents.
- Accepting or offering kickbacks or bribery.
- Falsifying or misrepresenting information to get better rates. This is called "clean sheeting."
- Failure to disclose information that may affect conditions of coverage.
- Sale of non-existent policies.

Examples of Suspicious Activity by Employer Groups:

- Providing false group information to get coverage.
- Misrepresenting eligibility for coverage.
- Falsifying an employee hire date to modify the date of health care coverage.
- Falsifying an employee termination date to eliminate premium payments.

Overview of Fraud and Abuse Laws:

Federal False Claims Act:
This law makes it illegal to "knowingly" submit false or fraudulent claims for payment or approval to the federal government. Penalties for violations include penalties of $5,500 to $11,000 plus three times the damages for each false claim. Violations could result in criminal prosecution and conviction as well as exclusion from the federal government program or contract.

Massachusetts False Claims Act:
Modeled after the federal False Claims Act, this law makes it illegal to make false claims against the commonwealth or a political subdivision of Massachusetts.

Massachusetts False Health Care Claims Act (also known as the Massachusetts Insurance Fraud law)***:***
This law makes it illegal to submit fraudulent bills to private health insurers and other health care payers. Violators are subject to criminal prosecution. The health insurer or payer is entitled to bring a civil action to recover the amount paid, along with attorneys' fees and the costs of investigation.

Whistleblower and Whistleblower Protections:
Both the federal False Claims Act and the Massachusetts False Claims Act include provisions to encourage private citizens who know about fraud to file suit against those that committed the fraud. The government decides whether or not to join in the suit. If a suit is successful, the "whistleblowers" are awarded a percentage of the amount recovered. These laws also include important protections for whistleblowers. The laws make it illegal to retaliate against those participating in a whistleblower action. If an employer retaliates in any way against an employee, the employee may bring an action against the employer. Settlement may include reinstatement, two times the amount of back pay plus interest, attorney's fees, and damages.