NJ FamilyCare / Medicaid

HMO Performance Report

A Report on Utilization, Quality, and Member Satisfaction Delivered Under the New Jersey Medicaid and CHIP Managed Care Program

2011

Prepared by the Department of Human Services • Division of Medical Assistance and Health Services

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Dear Stakeholders:

The Division of Medical Assistance and Health Services (DMAHS) is pleased to present the third annual NJ FamilyCare/Medicaid HMO Performance Report. This Report is designed to provide information to our numerous stakeholders about the performance of Medicaid managed care in New Jersey. This Report includes New Jersey Medicaid managed care health plan performance indicators and best practice narratives. This is not a report on commercial managed health care products or Medicare plan options.

Additional copies of this report are available on the New Jersey Department of Human Services website: http://www.state.nj.us/humanservices/dmahs/news

For additional information on health care plans and services in New Jersey, please review the following resources:

New Jersey Department of Banking and Insurance HMO Report Card:
http://www.state.nj.us/dobi/division_insurance/lhactuar.htm

New Jersey Department of Health and Senior Services Consumer Reports and Resources:
http://www.nj.gov/health/reportcards.shtml

We hope that you find this information useful.

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I. Introduction

The Division of Medical Assistance and Health Services (DMAHS) administers the state and federally funded NJ FamilyCare/Medicaid program for nearly 1.3 million low to moderate income adults and children on a budget of approximately $12 billion.

The program provides health insurance to parents/caretakers and dependent children, pregnant women, and people who are aged, blind or disabled. These programs pay for hospital services, doctor visits, prescriptions, nursing home care and other healthcare needs. While NJ FamilyCare/Medicaid offers a few services through traditional fee-for-service arrangements, the majority of Medicaid benefits are provided through contracts with managed care organizations (MCO).

As of this writing, 98% of enrollable Medicaid beneficiaries are in a managed care plan. A small number of beneficiaries remain in Medicaid fee-for-service, e.g. nursing home residents and children in out-of-state placements. In 2011, four health plans contracted with the State of New Jersey, Department of Human Services to serve Medicaid and NJ FamilyCare enrollees. These included AMERIGROUP New Jersey (Amerigroup), Healthfirst Health Plan of NJ (Healthfirst), Horizon NJ Health (Horizon), and UnitedHealthcare Community Plan (UnitedHealthcare), formerly branded as AmeriChoice prior to January 2011.

Health plans ensure quality and cost-effective care by emphasizing prevention and coordination of care. Their care and case management programs help ensure clients have continuity of care and receive services that are appropriate for their condition. Health plans also provide enabling services such as language translation, community outreach, and health educational programs that facilitate effective communication and access to appropriate and timely care.

Health Plan enrollments were as follows as of December 2011:

Health Plan	Enrollment
Amerigroup	152,694
Healthfirst	46,251
Horizon	536,652
UnitedHealthcare	408,238
TOTAL:	**1,143,835**

New Jersey's Medicaid MCO market remained stable in 2011. There were no entries or exits by managed care plans.

Each of New Jersey's health plans hold Medicaid managed care contracts in other states and/or represent Medicare and commercial product lines. All four health plans have contracted with the Department under a separate Dual Eligible Special Needs Plan (D-SNP) arrangement implemented on January 1, 2012.

This report contains information on how well the health plans served New Jersey's NJ FamilyCare/Medicaid clients in 2010 – 2011. It presents information on the quality of health plan performance, both with the care provided to clients and internal operations. In addition, it reports on enrollees' level of satisfaction with their health plan.

II. Quality Measures Used in This Report

Several quality measures are used to track 1) utilization by members of provider services, 2) health service delivery, and 3) client satisfaction with their health plan. Each measure and its source are described.

EQRO Assessment

The Centers for Medicare & Medicaid Services (CMS) requires that an independent, external quality review organization (EQRO) conduct reviews of each of the state's Medicaid health plans to assess quality and compliance standards. In 2008, 2009, and 2010, New Jersey contracted with The Michigan Peer Review Organization (MPRO) to conduct these reviews. Beginning in 2011 the contracted EQRO was Island Peer Review Organization (IPRO). The reported measures in this Report prior to 2011 were produced by MPRO. The 2011 reported measures were produced by IPRO.

As part of the assessment, the EQRO evaluated the health plans' Quality Assurance Program by providing a rating of how well the health plans do in implementing contractual requirements that involve such areas as Provider Education, Health Education and Promotion, Care Management, Utilization Management, and Credentialing. They also validate the health plans' reported HEDIS® (Healthcare Effectiveness Data and Information Set) performance measures, which are audited by certified auditors using a process designed by the National Committee for Quality Assurance (NCQA) to ensure the validity of the HEDIS® results.

HEDIS® - Healthcare Effectiveness Data and Information Set Performance Measures

HEDIS® is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. It was developed and is maintained by NCQA. Altogether, HEDIS® consists of 75 measures across 8 domains of care. Measures are combined into a set of familiar topics, such as childhood immunizations and breast cancer screening, to score health plans on providing the right care across a range of sentinel health conditions.

HEDIS® makes it possible to compare the performance of health plans using a standard metric because so many health plans collect HEDIS® data, and because the measures are so specifically defined. Health plans also use HEDIS® results to see where they need to focus their improvement efforts. HEDIS® further provides consumers with the information they need to reliably compare the performance of their health plan with that of others.

CAHPS® – Consumer Assessment of Healthcare Providers and Systems Performance Measures

Each year New Jersey surveys a sample of health plan members by mail or telephone to complete CAHPS®, a member satisfaction survey, and asks them to report on and evaluate various aspects of their experiences of care and service. The CAHPS® surveys for state Medicaid plans are overseen by CMS and administered by Xerox, formerly ACS Government Healthcare Solutions, in New Jersey.

The CAHPS® surveys were developed using comprehensive reviews of the existing literature, focus groups with consumers, cognitive testing of survey content and question wording, and field testing of preliminary versions of individual items. A set of core items was developed for all consumers, and certain items were targeted for special sub-populations, such as Medicaid enrollees or Medicare managed care enrollees. The CAHPS® items include evaluations, ratings of care and reports of specific experiences with health plans. This combination of global assessments and reports about different aspects of health plan performance also allows users to link global evaluations with specific information to guide quality improvement efforts.

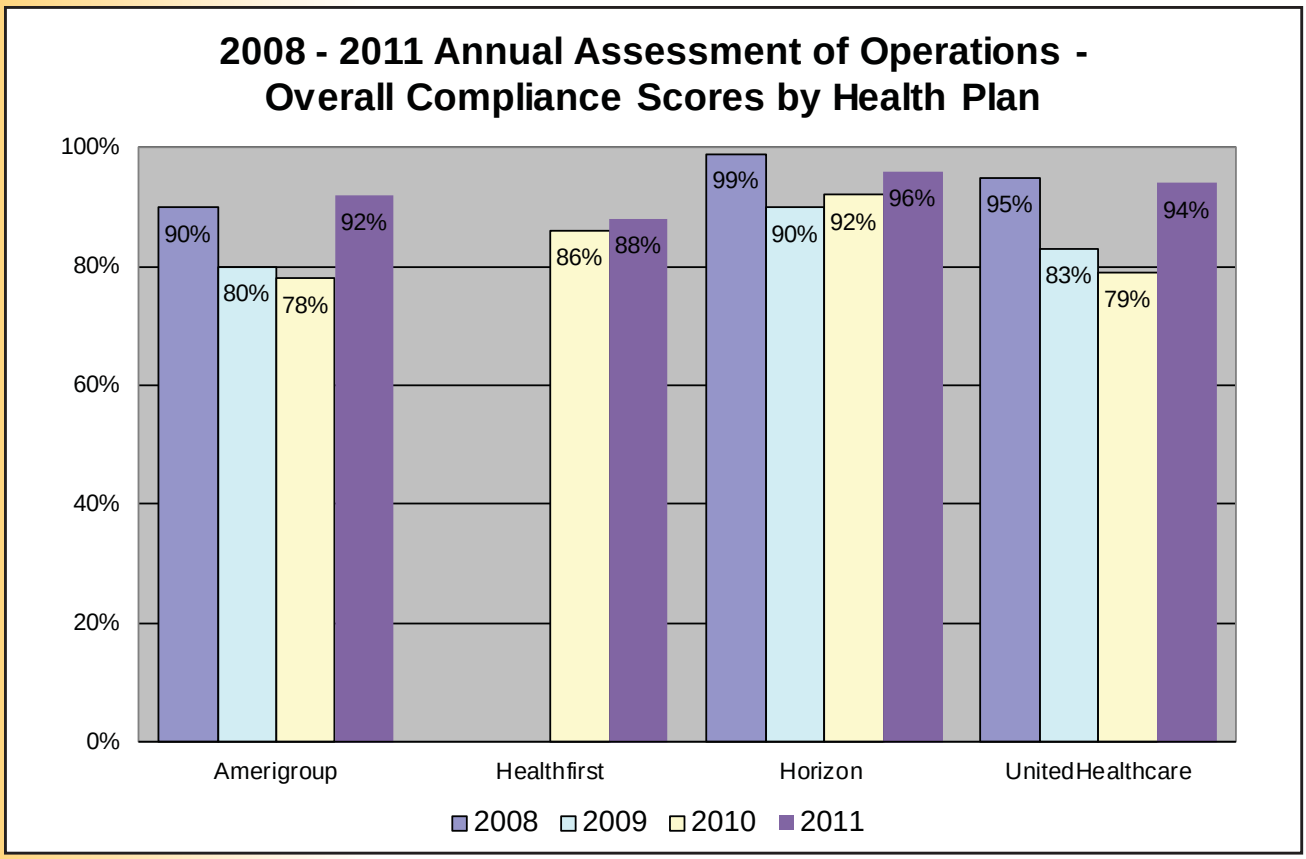
III. The Assessment of Health Plan Operations

Since 2008, the contracted EQRO has conducted an Assessment of Health Plan Operations to determine how well each health plan implemented contractual requirements. These reviews provide an evaluation of each health plan's operational systems over a twelve month period. IPRO reviewed fourteen categories in 2011:

1. Access
2. Quality Assessment and Performance Improvement
3. Quality Management
4. Committee Structure
5. Programs for the Elderly and Disabled
6. Provider Training and Performance
7. Satisfaction
8. Enrollee Rights and Responsibilities
9. Care Management and Continuity of Care
10. Credentialing and Recredentialing
11. Utilization Management
12. Administration and Operations
13. Fraud, Waste, and Abuse
14. Management Information Systems.

The Assessment of Health Plan Operations process allows a one-year break from full review for health plans that meet a minimum compliance rate of 85 percent. Year 1, which involved a comprehensive review of all requirements for all health plans (including an on-site visit and file review) is considered the baseline year. Health plans with a compliance score of less than 85 percent undergo a comprehensive review of all requirements in the succeeding year. Health plans with compliance scores of 85 percent or better are subject to an interim review focusing on areas requiring improvement—specifically those review elements that were Not Met or Not Applicable during the comprehensive review. If a health plan has a partial review, it will have a comprehensive review the following year regardless of the findings of the partial review. Health plans that receive a comprehensive review and subsequently attain a compliance rating of 85 percent or better will have a partial review the following year. Health plans that attain a compliance rating below 85% will continue to have comprehensive reviews. In addition, the Medicaid managed care program requests corrective action plans to address inadequate performance.

This Report contains the overall compliance scores of each health plan reported in 2008, 2009, 2010, and 2011, as determined by the EQRO performing the audit. Overall compliance with Medicaid managed care contract requirements improved in 2011, according to IPRO, reversing a slight three-year downward trend. Provider training and performance was the most frequently noted deficiency with three of the four plans scoring less than 80% compliance.



IPRO evaluated each health plan on the following indicators to determine compliance with performance standards required by contract:

- ✓ **Access**
  The Access review category is designed to ensure the health plan has developed an adequate provider network and established access that meets the needs of its members. The health plan also must promote on-going efforts to maintain and monitor the network of providers with continuing actions to resolve identified deficiencies.

- ✓ **Quality Assessment and Performance Improvement (QAPI)**
  The Quality Assessment and Performance Improvement review category is designed to ensure the health plan's QAPI provides prospective, concurrent, and retrospective assessments of quality assurance (QA) activities, including actions taken as a result of findings about how providers are informed and involved in these activities. The health plan's structure must consist of staff members with appropriate education, experience, or training to carry out these QA activities.

- ✓ **Quality Management**
  The Quality Management review category is designed to ensure the health plan has mechanisms for promoting care according to accepted industry standards, including provisions for adjusting standards based on member needs, monitoring, and follow-up for identified care concerns.

- ✓ **Committee Structure**
  The Committee Structure review category is designed to ensure the health plan has active, operational committees focused on oversight, identification of Quality Improvement (QI) activities, member care issues, and resolution of identified care concerns. The structure also must foster communication of relevant information among committees.

✓ Programs for the Elderly and Disabled

The Programs for the Elderly and Disabled review category includes requirements to ensure that the health plan has provisions in place to identify and address the special needs of elderly members and those with disabilities. These provisions include the development, implementation, and evaluation of specialty programs and initiatives aimed at providing care for these populations.

✓ Provider Training and Performance

The Provider Training and Performance review category assesses whether the contractor has a process in place to produce a Multidimensional Provider Report Card (MPRC), Quarterly Utilization Reports and EPSDT Utilization reports which include State-required elements, that the reports are prepared and distributed to providers, that follow-up is conducted with providers who fail to meet established benchmarks, and that re-evaluation occurs to determine if interventions were successful.

✓ Satisfaction

The Satisfaction review category is designed to evaluate member satisfaction with contractor services, including mechanisms for acting on identified areas of member dissatisfaction, and reassessment to evaluate how effectively the contractor addressed areas in need of improvement.

✓ Enrollee Rights and Responsibilities

The Enrollee Rights and Responsibilities review category evaluates the structures and processes that address the rights of the member as well as the systems in place to ensure those rights are communicated to members both initially and annually in a manner consistent with member literacy and language standards.

✓ Care Management and Continuity of Care

The Care Management and Continuity of Care review category evaluates whether the health plan has an effective care (and case) management service structure and has processes in place to provide services to all enrollees who could benefit from them. The health plan also must have the capacity to offer a higher level of care management, utilizing Comprehensive Needs Assessment protocols and tools, for enrollees identified as having special needs. The Care Management program includes inpatient, outpatient and catastrophic care, coordination of services, links to community support services and agencies, and coordination with State Divisions for individuals with special needs.

✓ Credentialing and Recredentialing

The Credentialing and Recredentialing review category is structured to ensure that the health plan's QAPI Program includes systems that confirm and re-verify that clinical providers are qualified to render services to enrollees.

✓ Utilization Management

The Utilization Management Review evaluates whether the contractor has a comprehensive Utilization Review program that meets State contract requirements which include: a written Program Description with policies and procedures to evaluate medical necessity, use of generally accepted and current criteria and information sources, employment of qualified staff with appropriate credentials, ability to render timely decisions, and upholding the rights of the enrollee in making and communicating its decisions. The contractor must also have systems to detect over or under utilization and to monitor program effectiveness. Also included in the Utilization Management review is an assessment of member and provider complaint and grievance procedures. These programs operate under documented policies and procedures including resolution timeframes, use qualified professionals, and protect member rights.

✓ **Administration and Operations**
The Administration and Operations review category is structured to ensure the health plan has organizational, management, and administrative systems and delegation oversight processes in place to fulfill its contractual requirements. These systems must be designed to ensure necessary staffing by function and qualification; provide staff with appropriate training, education, experience, and orientation; and, define how subcontractors are secured, utilized, and monitored while carrying out the terms of the health plan's contract.

✓ **Fraud, Waste, and Abuse**
The Fraud, Waste, and Abuse review category is designed to ensure the HMO has the structures and processes in place to identify/prevent fraud, waste, and abuse, including mechanisms that encourage appropriate investigation and corrective action when fraud, waste and abuse are identified.

✓ **Management Information Systems**
The Management Information Systems review category is designed to evaluate the health plan's overall information system structure, including reporting mechanisms and capabilities. The system must be able to provide reports related to utilization, claims, enrollee, and provider updates, provider profiling and identification of enrollees with special needs.

IV. Health Plan Overall HEDIS Ratings at a Glance

In this Report, NJ FamilyCare/Medicaid health plan members' quality of care was compared to national standards in the following areas:

- Childhood Immunization Status
- Well-Child Visits
- Adolescent Well-Care Visits
- Lead Screening in Children
- Prenatal and Postpartum Care
- Breast Cancer Screening
- Cervical Cancer Screening
- Use of Appropriate Medications for People with Asthma
- Comprehensive Diabetes Care.

The charts on the following pages provide a comparison of each health plan's HEDIS performance ratings in these areas for 2011.

On most indicators, New Jersey Medicaid health plans meet or outperform the National Committee for Quality Assurance (NCQA) 50th percentile based on the 2011 Quality Compass HEDIS® average for Medicaid HMOs. However, there are differences in performance among the health plans and not all perform equally across all categories. Areas for improvement were identified for each plan evaluated. Across the three HEDIS-evaluated plans, women's reproductive health care revealed a clear need for improvement as it did in the 2010 Report.

Chart 1.

Childhood Immunization Status – Combination 2: Percentage of children who by the time they turned two had the recommended number of vaccines – Combination 2. (Note: Data was not available for Healthfirst.)

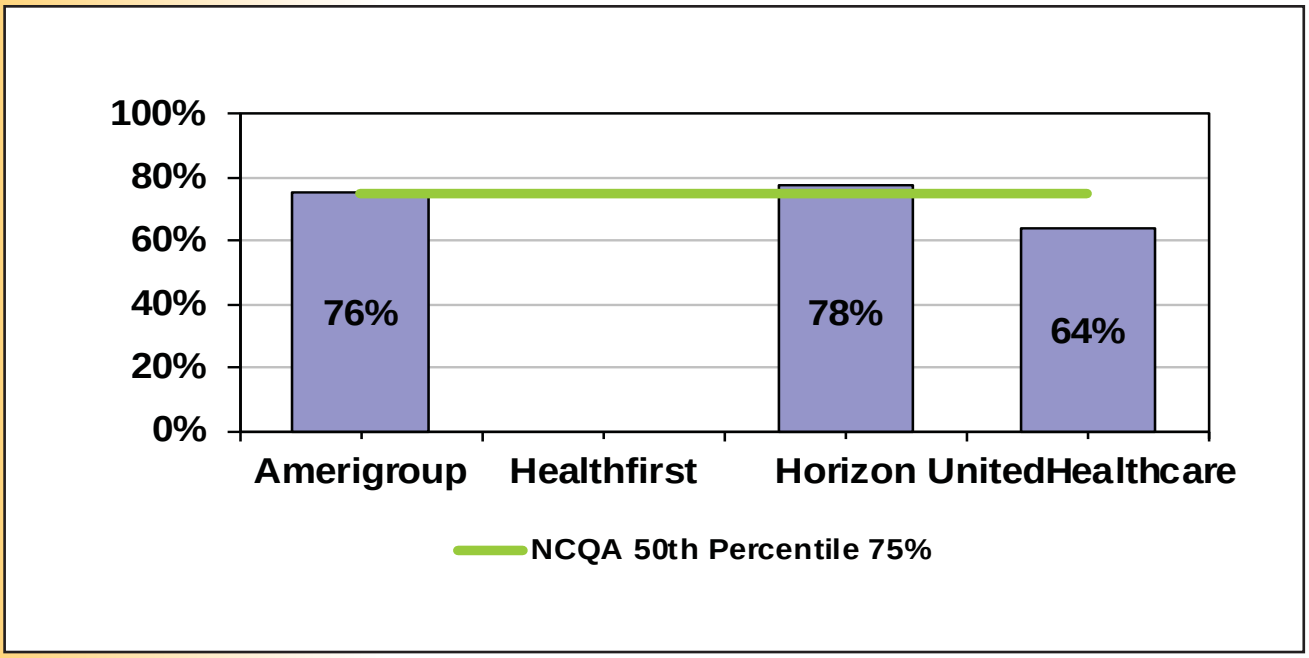


Chart 2.

Well-Child Visits in First 15 Months of Life: Percentage of children who had six or more well-child visits in the first 15 months of life. (Note: Rating for Healthfirst was not reported due to low population.)

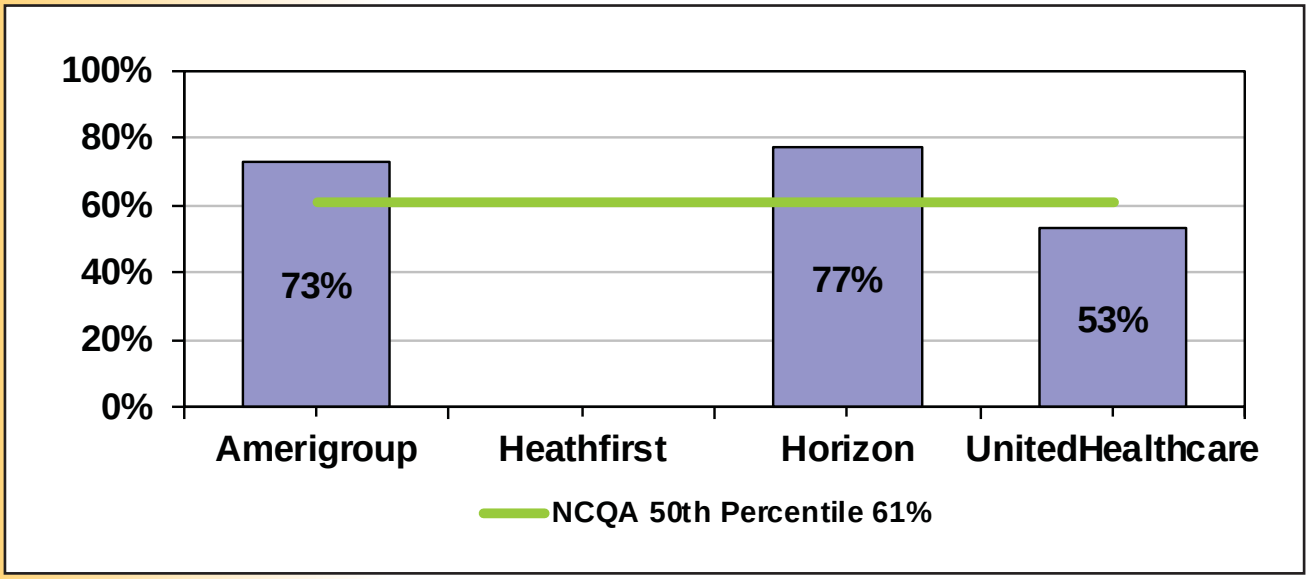


Chart 3.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life: Percentage of three – six-year-olds who had one or more well-child visits during the measurement year.

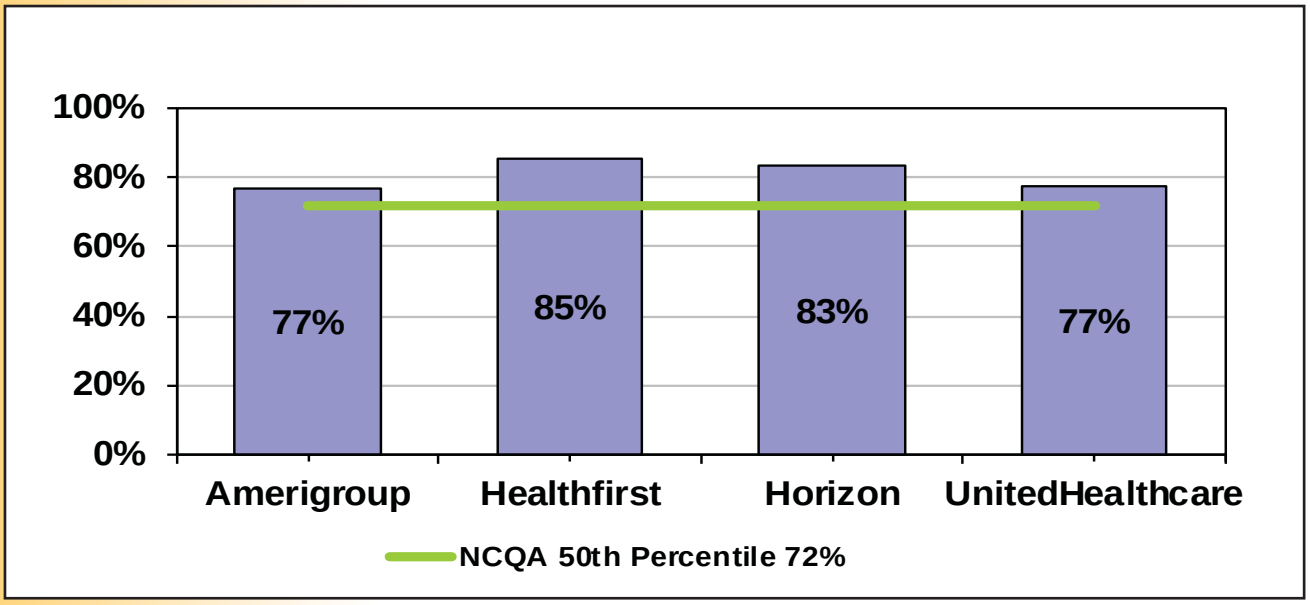


Chart 4.

Adolescent Well-Care Visits: Percentage of adolescents 12-21 years of age that had at least one well-care visit during the measurement year.

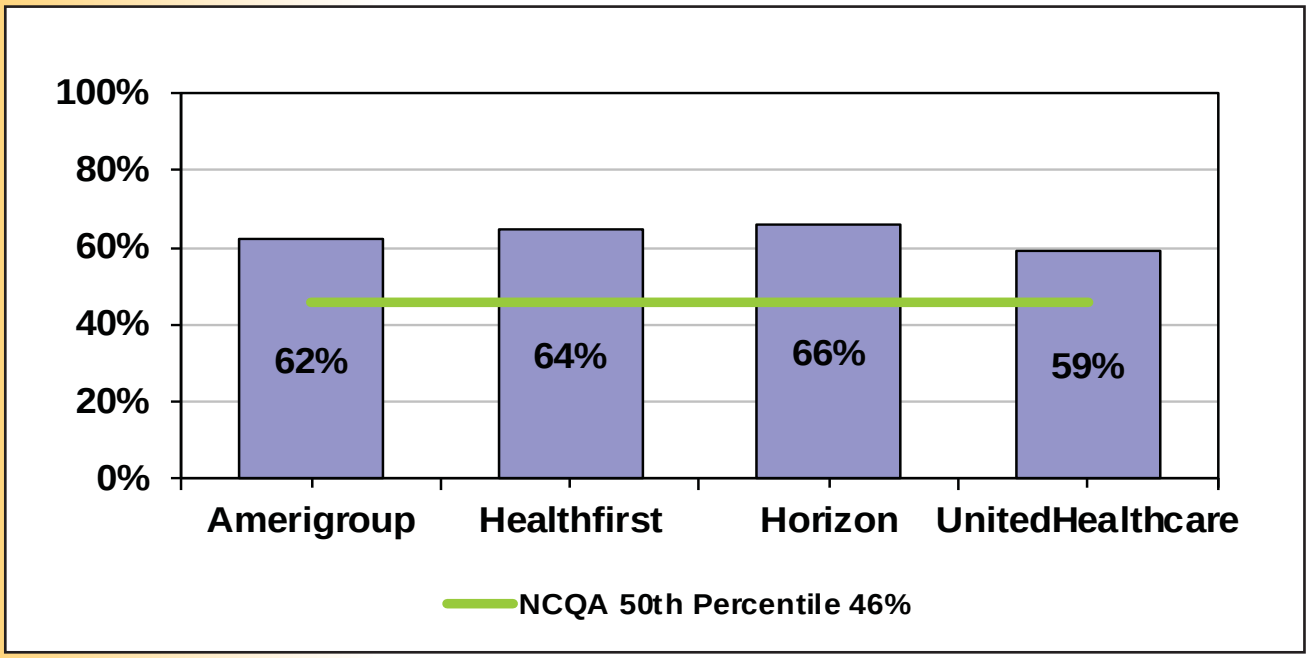


Chart 5.

Lead Screening in Children: Percentage of children who received at least one lead screening test on or before their second birthday.

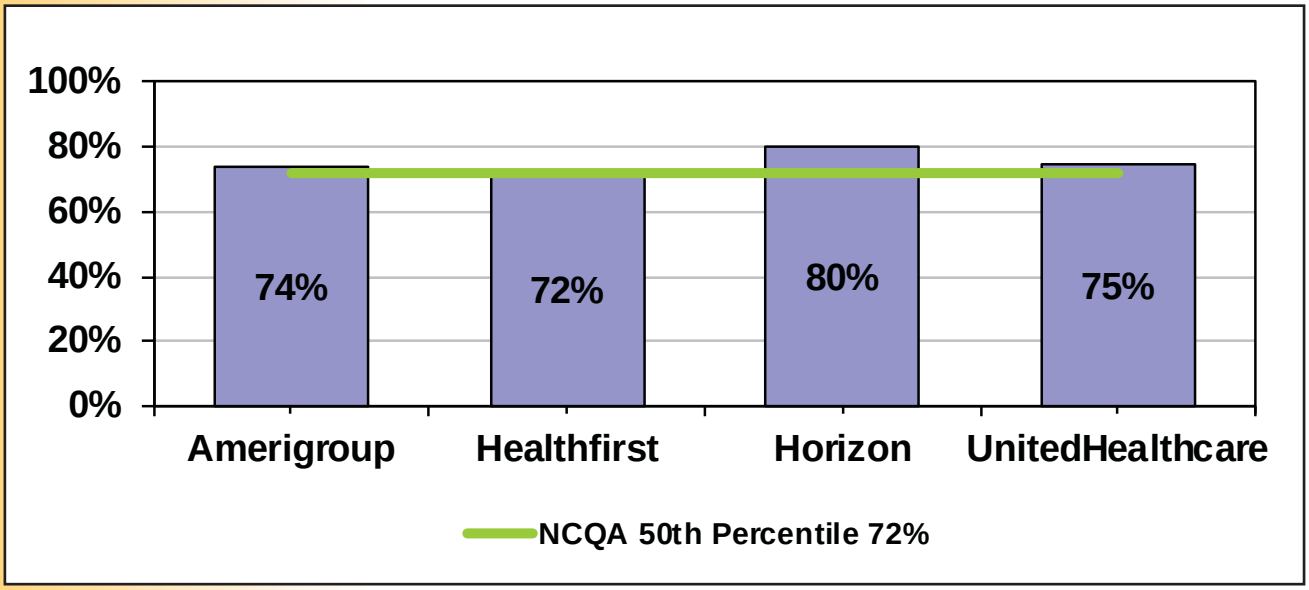


Chart 6.

Prenatal Care – Timeliness of Prenatal Care: Percentage of women who had a prenatal visit within first trimester (or within 42 days of enrollment).

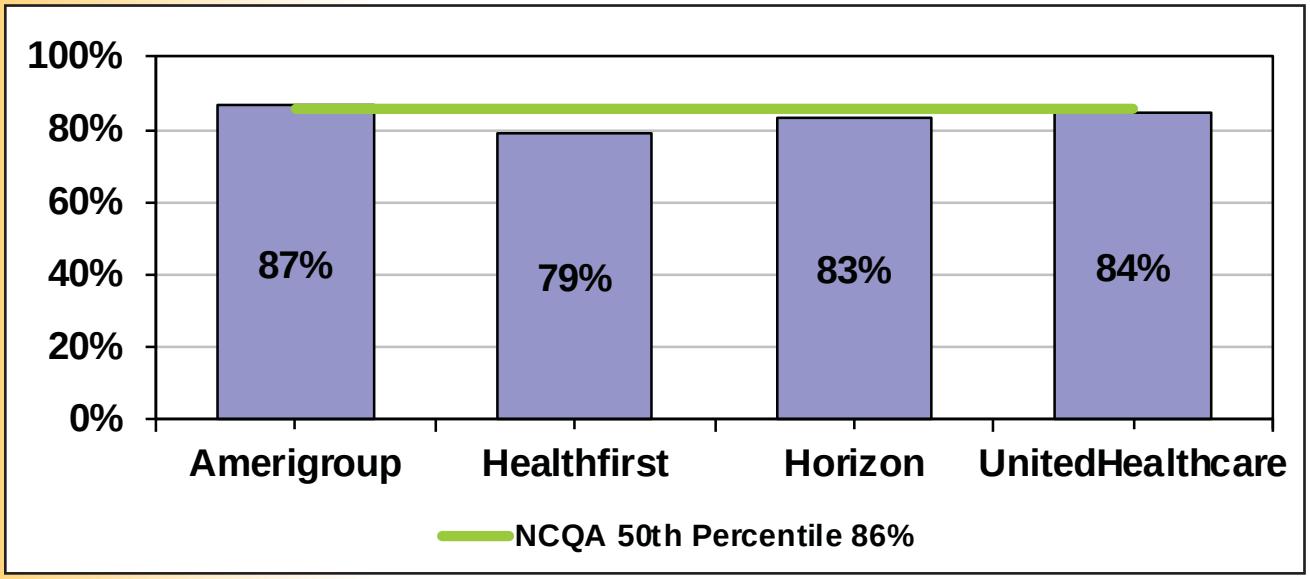


Chart 7.

Postpartum Care: Percentage of women who had a postpartum visit between 21 and 56 days after delivery.

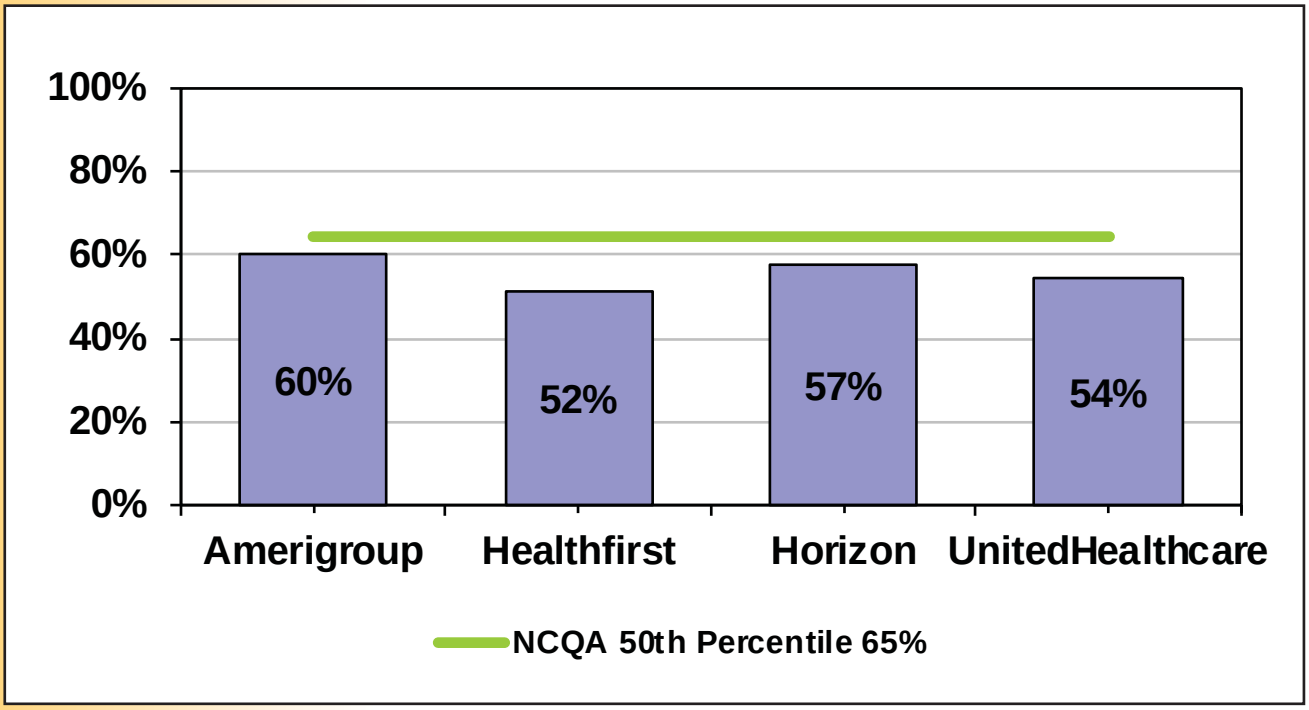


Chart 8.

Breast Cancer Screening: Percentage of women who had a mammogram in the measurement year or the prior year. (Note: Healthfirst did not have sufficient continuous enrollment to produce denominators.)

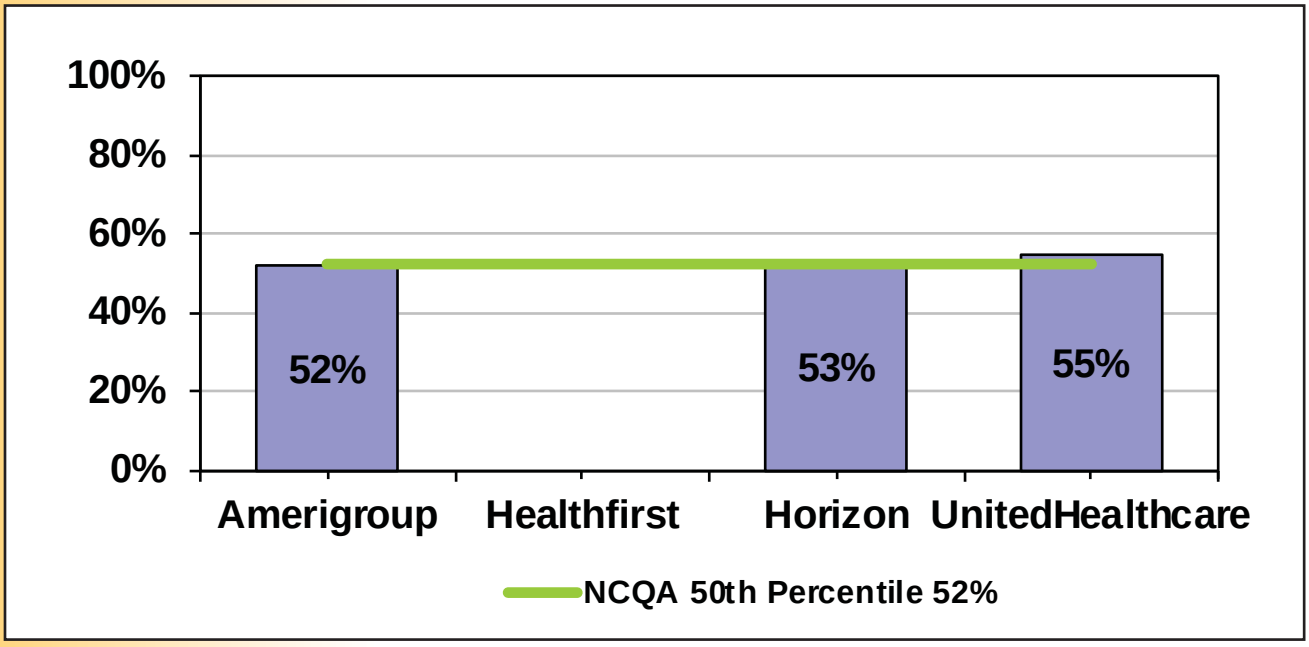


Chart 9.

Cervical Cancer Screening: Percentage of women who had a PAP test within the measurement year or the prior two years.

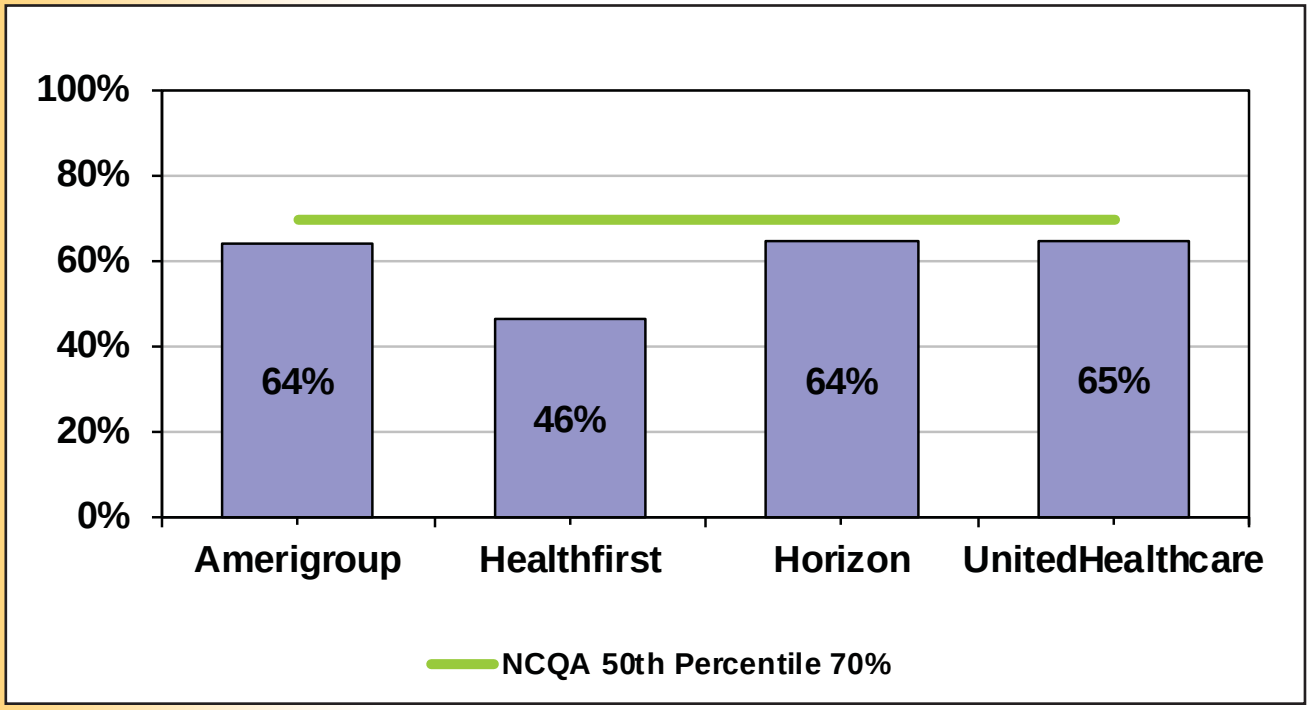


Chart 10.

Use of Appropriate Medications for People with Asthma: Percentage of total members who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year. (Note: Healthfirst did not have sufficient continuous enrollment to produce denominators.)

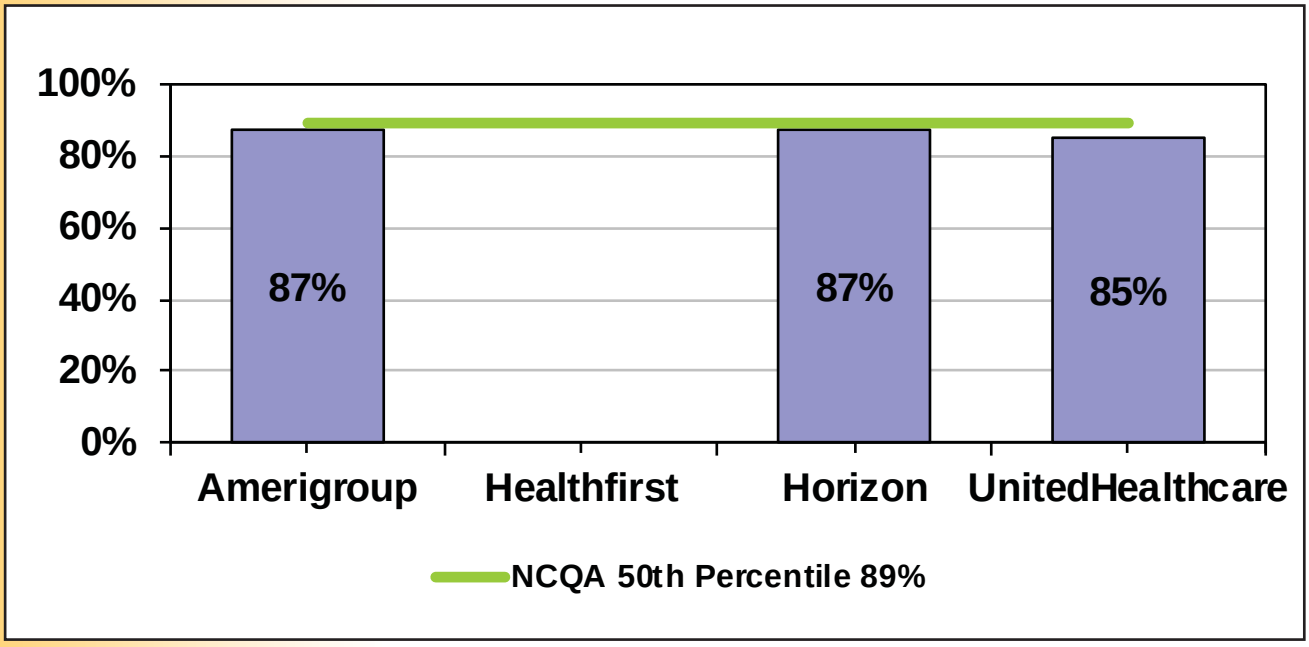


Chart 11.

Comprehensive Diabetes Care – HbA1c Testing: Percentage of individuals with diabetes who had yearly HbA1c testing.

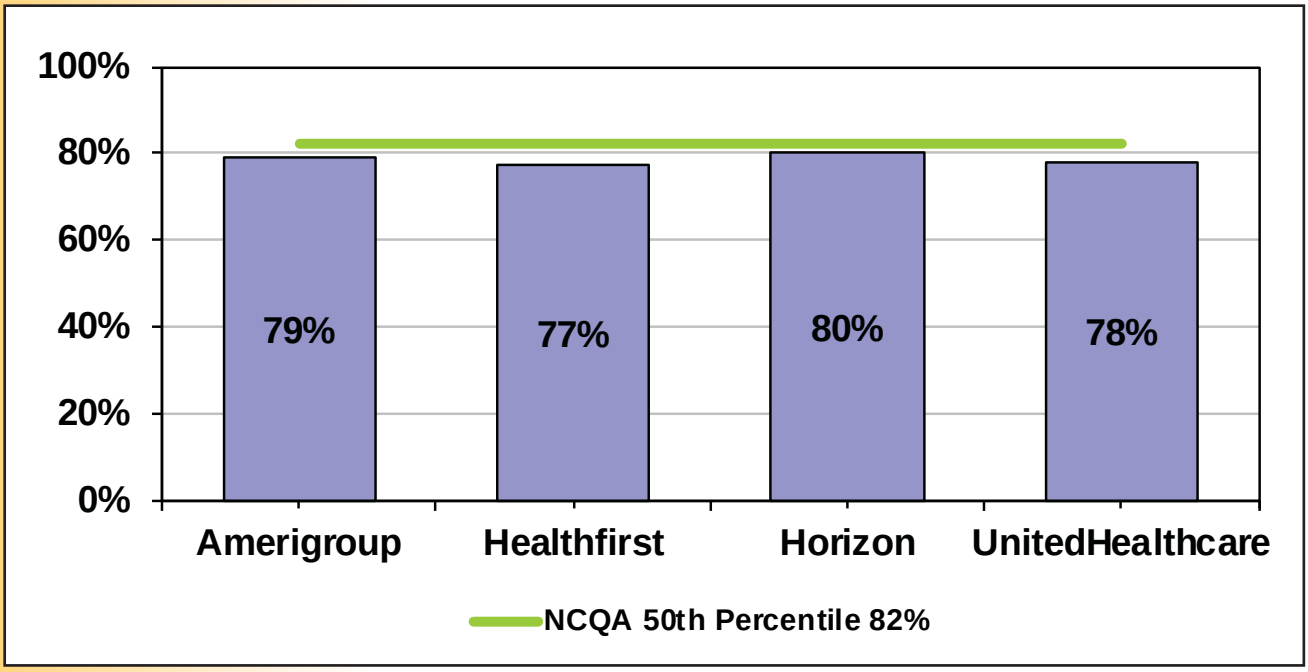


Chart 12.

Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%): Percentage of individuals with diabetes with poor control – HbA1c result > 9 (Unlike other HEDIS measures, HbA1c Poor Control is written in a way that a lower rate is ideal).

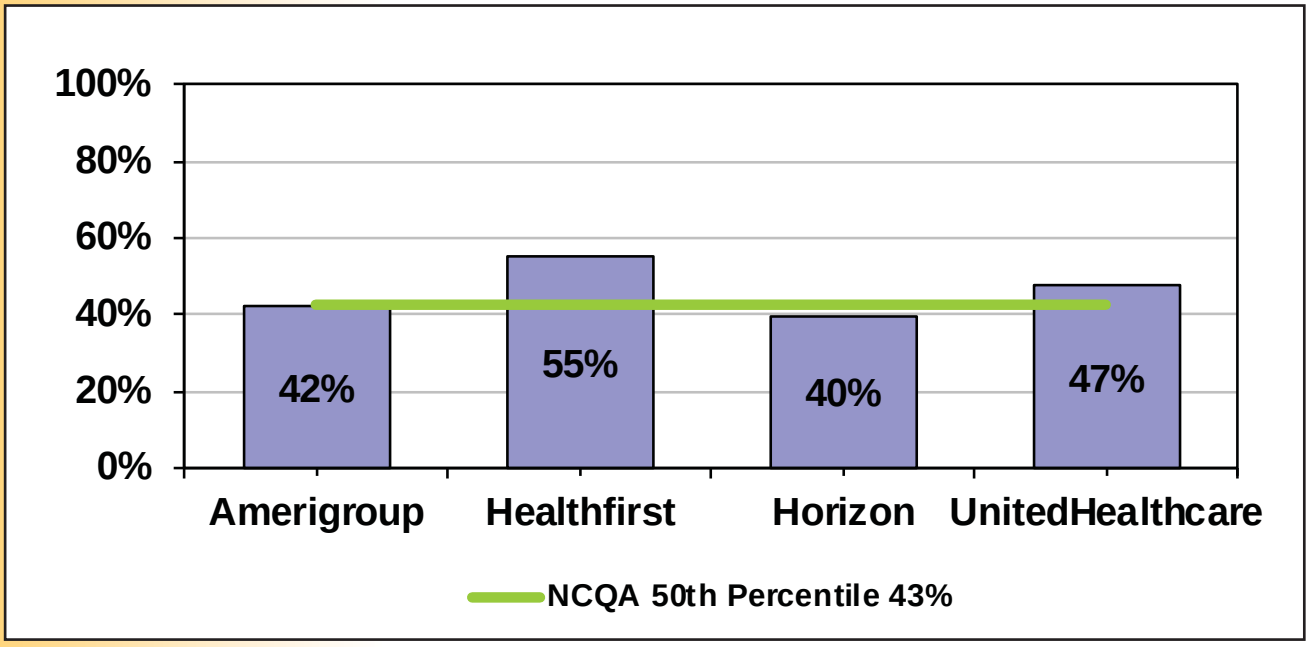


Chart 13.

Comprehensive Diabetes Care – Eye Exams: Percentage of individuals with diabetes who had a yearly retinal eye exam.

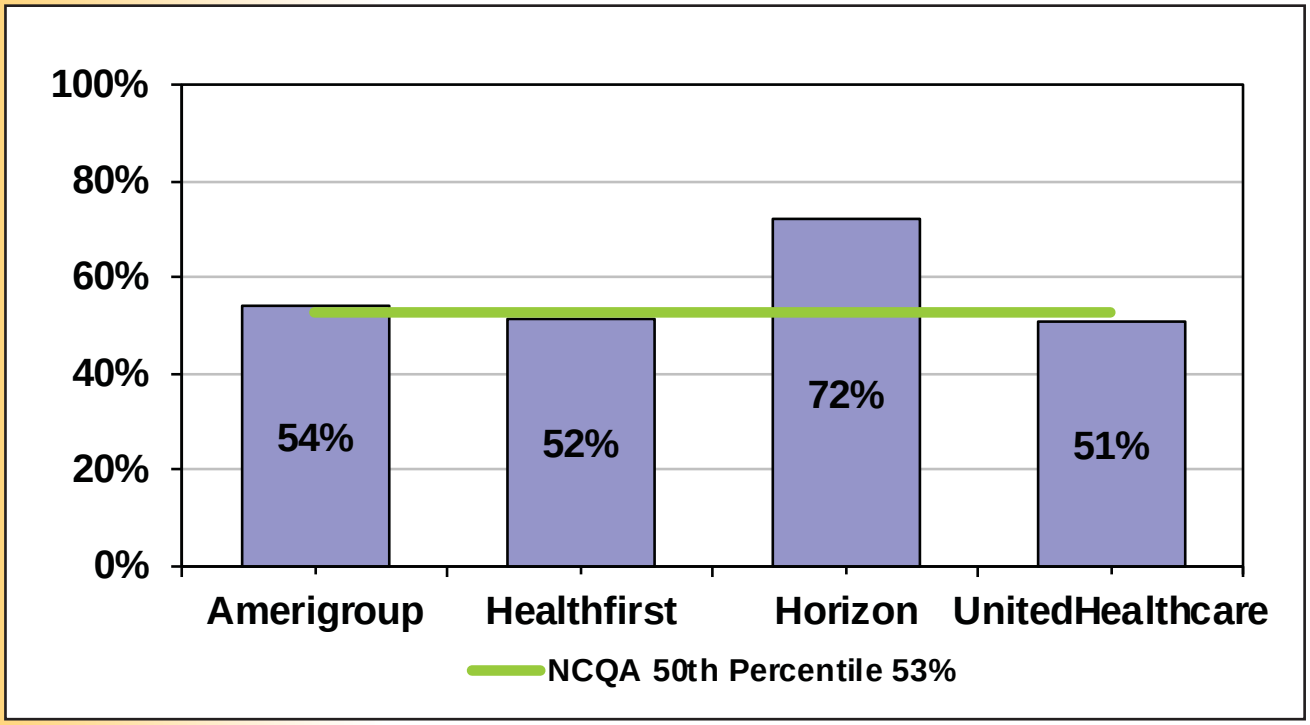


Chart 14.

Comprehensive Diabetes Care – LDL-C Screening: Percentage of individuals with diabetes who had a yearly LDL-C screening.

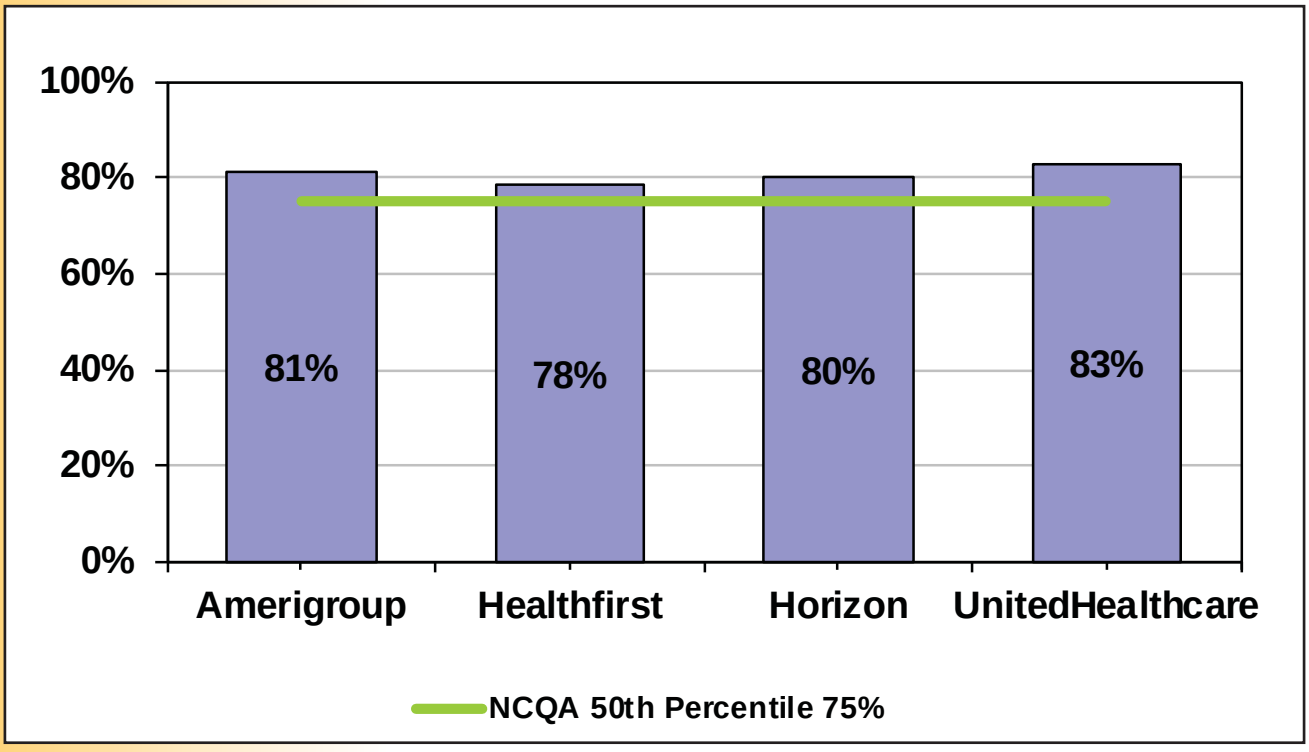
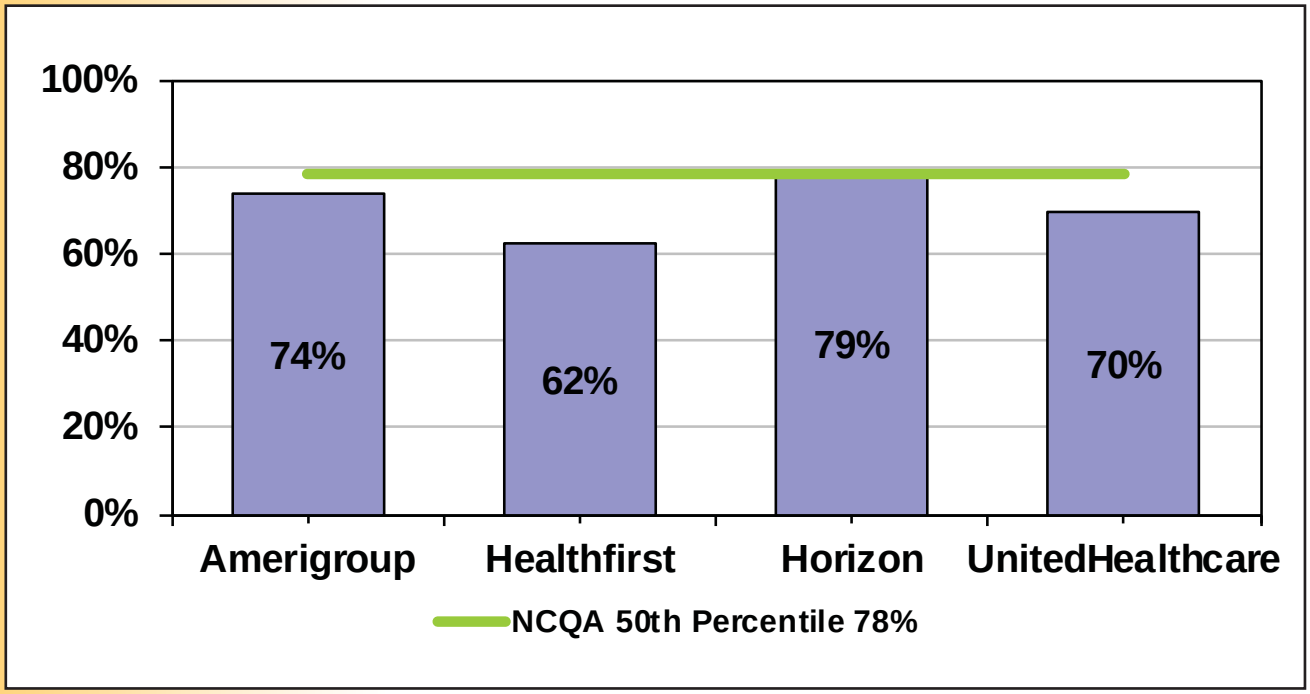


Chart 15.

Comprehensive Diabetes Care – Medical Attention for Diabetic Nephropathy: Percentage of individuals with diabetes who had a yearly screening or medical attention for nephropathy.



V. CAHPS® – Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a public-private initiative to develop standardized surveys to assess the experiences of patients (health care consumers) in various ambulatory settings, including health plans, managed behavioral healthcare organizations, dental plans, medical groups, physician offices, and clinics.

The following pages are a subset of the many areas measured by the CAHPS® survey, conducted with a sample of New Jersey's Medicaid managed care population in 2011. The survey tool provides members' overall ratings of their own or their children's health plans, as well as detailed comparison charts for how health plan members rated their care or their child's care in the following areas:

Specific CAHPS measures used in this Report:

- Overall Rating of Health Care
- Getting Care Quickly
- Overall Rating of Personal Doctor

- Overall Rating of Specialists
- Rating of Customer Service Responsiveness
- Dental Visits in Last 6 Months
- Overall Rating of Dental Care
- Coordination of Care from Other Health Providers
- Number of Emergency Room Visits to Get Health Care

Minor percentage differences observed in the results may represent measurement (sampling) error rather than actual differences in health plan performance. Response distributions presented as whole numbers in bar charts and pie charts may not sum to 100% due to rounding.

Following are the overall ratings that members gave their own health plan and their children's health plan in 2011. The first chart illustrates the percentage of 2,726 adult respondents giving a rating of 7 – 10 on a scale of 0 – 10, where 0 is the worst health plan possible and 10 is the best health plan possible. This represents a 115% increase (or 1,458 respondents) from 2010. The second chart shows the percentage of 3,106 adults rating their child's health plan 7 – 10 (satisfied), an increase of 2,018 representing a 185% increase from 2010.

Enrollees who responded to the survey indicated high overall ratings of their health plans, health status, and health care received from contracted providers. This marks a 4% increase from 2010 in ratings by adults of their own health plan and a 7% improvement in the ratings given by adults for their children's health plan.

Members' Overall Rating of Their Own Health Plan

Health Plan	Satisfied (7-10 Rating)	Overall NJ Medicaid Managed Care Program Satisfaction (7-10 Rating)	Percentage Point Difference
Amerigroup	72%	78%	-6%
Healthfirst	82%	78%	+4%
Horizon	81%	78%	+3%
UnitedHealthcare	75%	78%	-3%

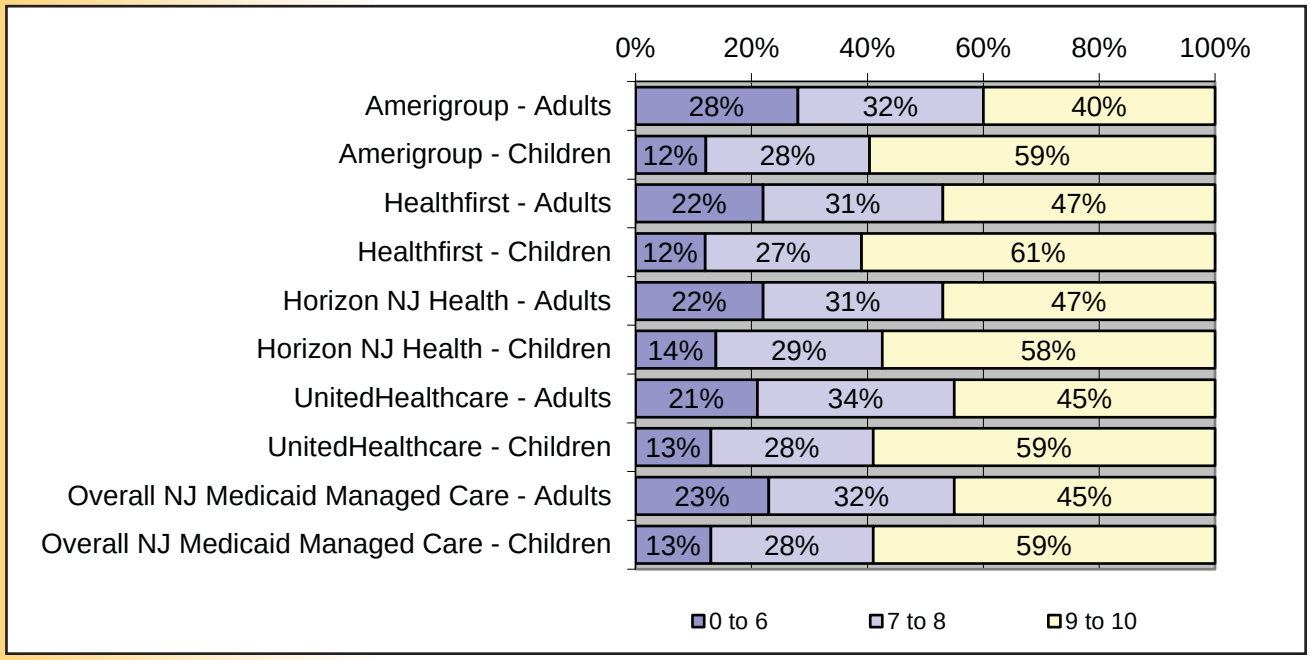
Members' Overall Rating of Their Child's Health Plan

Health Plan	Satisfied (7-10 Rating)	Overall NJ Medicaid Managed Care Program Satisfaction (7-10 Rating)	Percentage Point Difference
Amerigroup	86%	87%	-1%
Healthfirst	89%	87%	+2%
Horizon	87%	87%	0%
UnitedHealthcare	86%	87%	-1%

Additionally, 76% of New Jersey Medicaid adult aged, blind or disabled (ABD) members surveyed were satisfied with their health plans (no change from 2010); among satisfied ABD members, 52% rated their health plans a 9 or 10, indicating the best plan possible. Plans received a greater share of highly satisfied ratings for care delivered to children enrolled in ABD Medicaid; 86% of parents surveyed ranked their child's plan as good or best (up 3% from 2010) where 48% of parents rated their own health plan as the best possible. This is a positive outcome since ABD members with Medicare were mandatorily enrolled into a Medicaid health plan in the measurement year. Previously, ABD members with Medicare were enrolled on a voluntary basis and many fewer of these beneficiaries participated with a health plan.

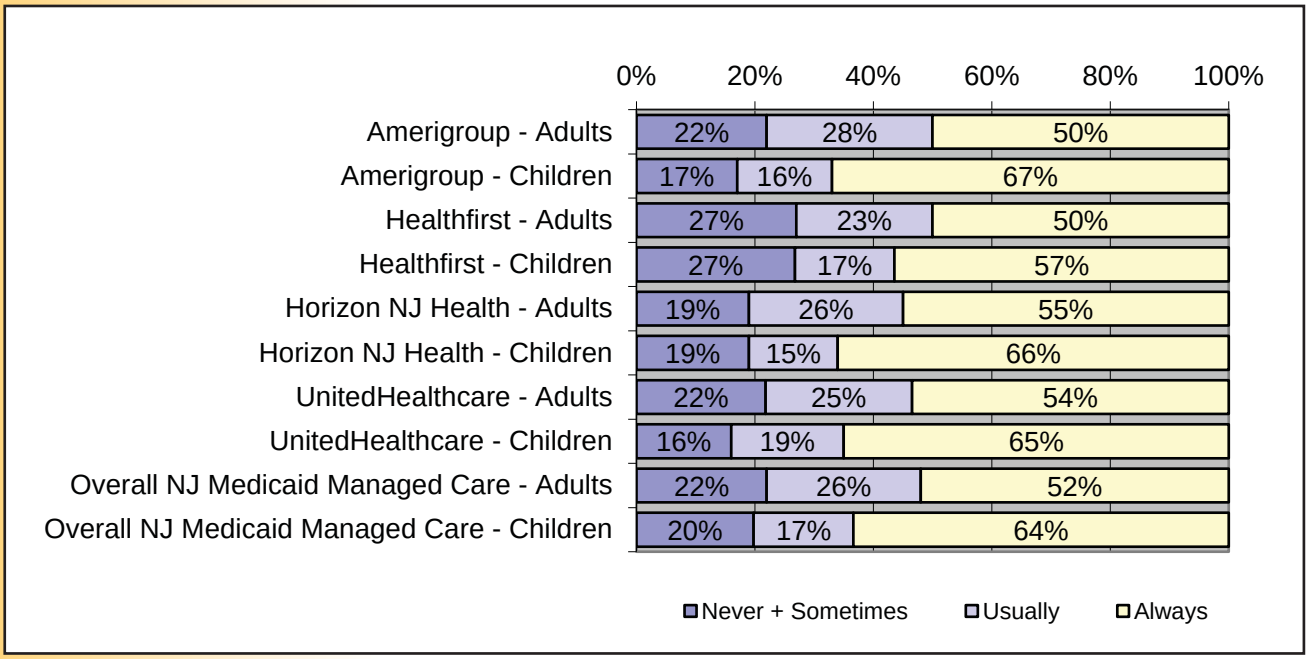
The year 2011 represents the first full year where Healthfirst's ratings were included in the Overall Medicaid Managed Care Program category data.

Chart 1. Rating of Overall Health Care



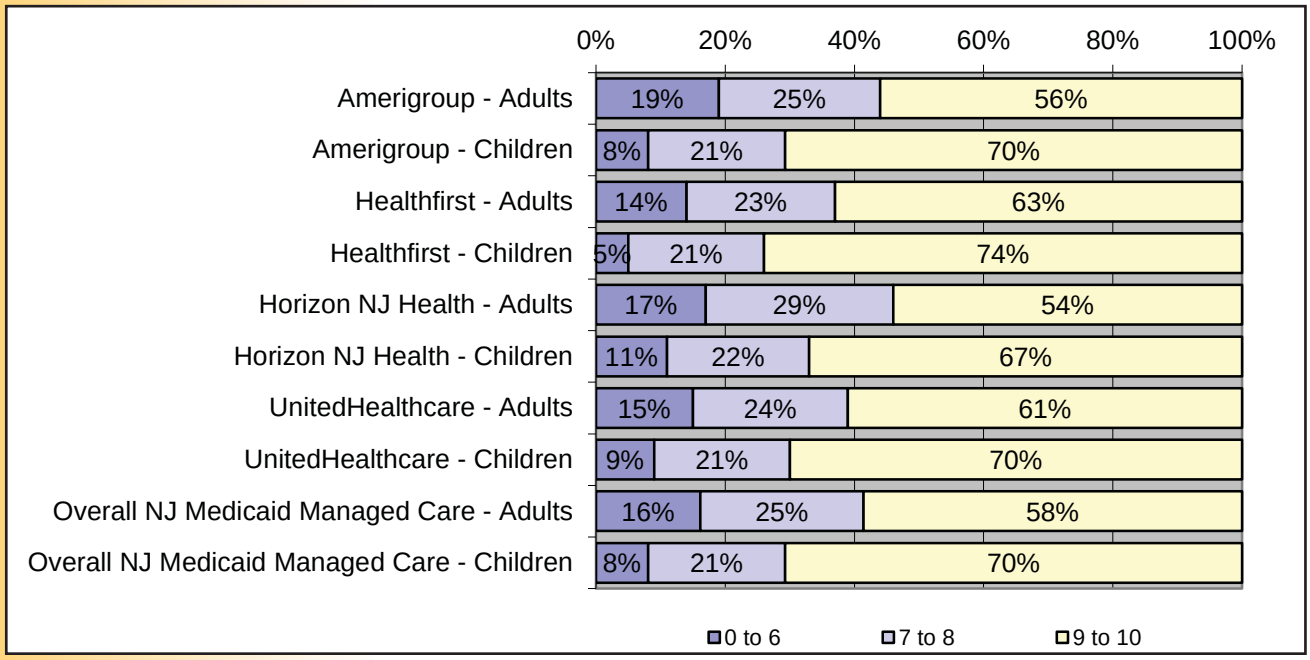
On a scale of 0-10, where 10 is best, how did respondents rate their overall health care in the last six months?

Chart 2. Getting Care Quickly



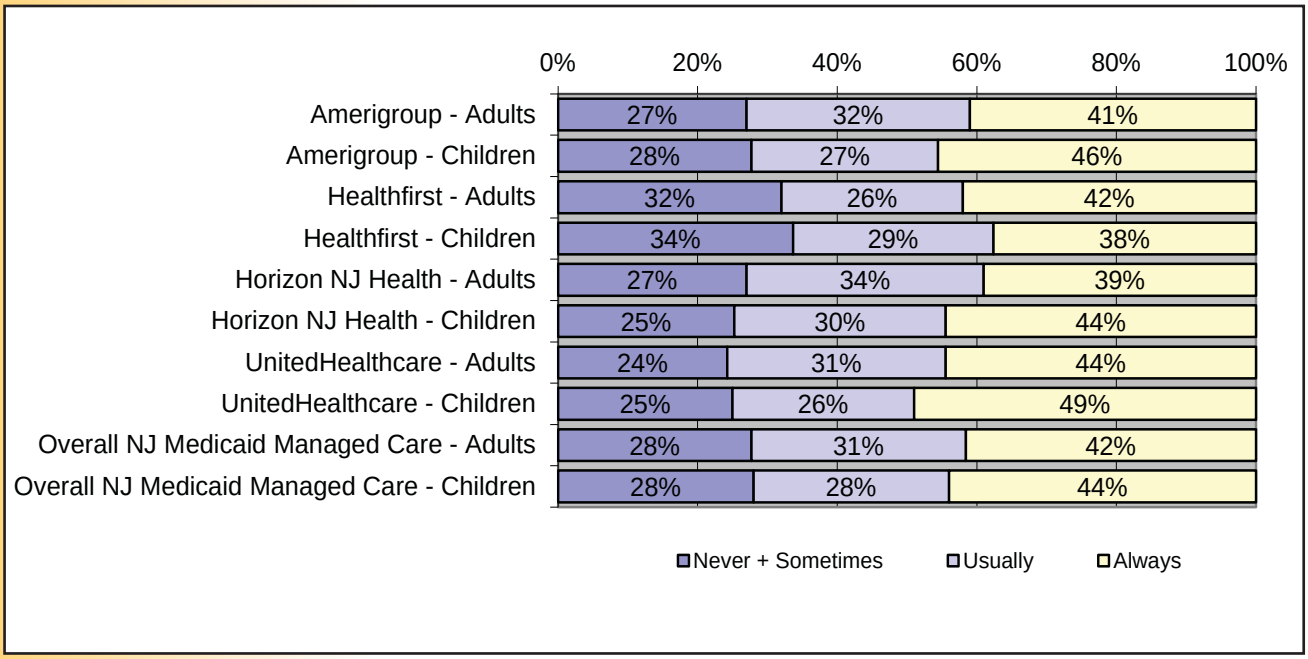
How often did respondents report getting needed care right away, or an appointment as soon as they thought they needed it, in the last six months?

Chart 3. Rating of Personal Doctor



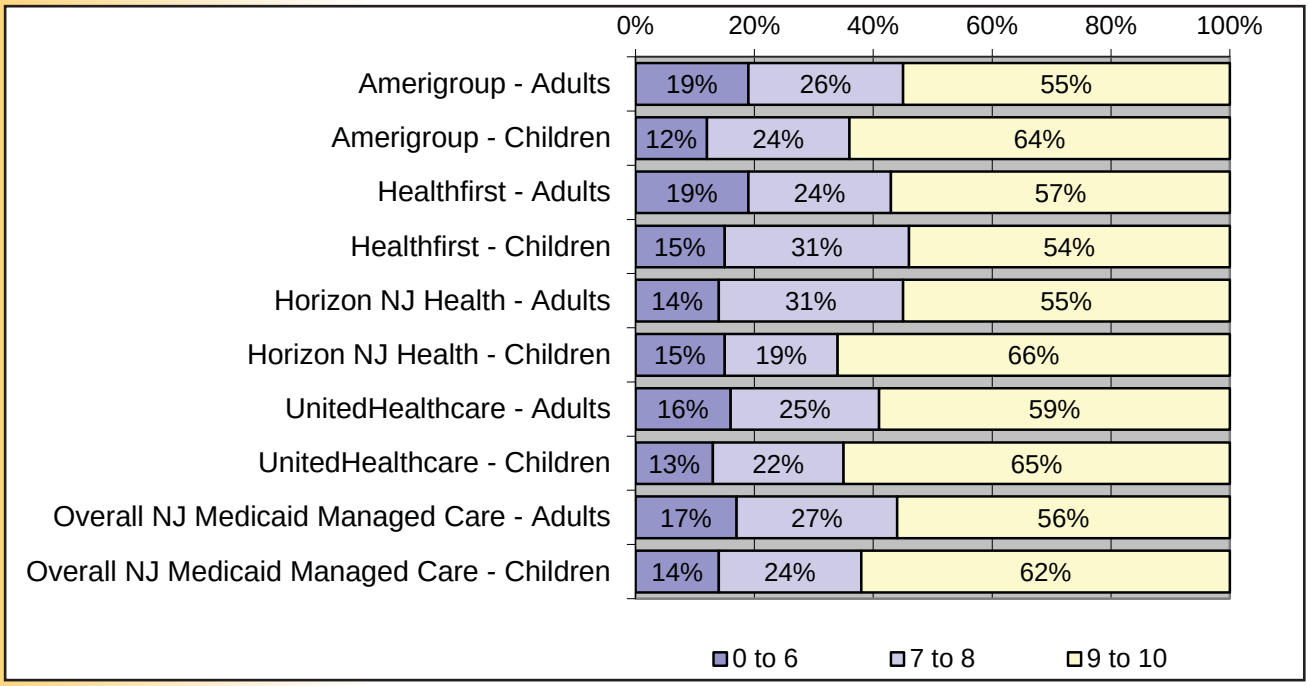
On a scale of 0-10, where 10 is the best, how did respondents who reported having a personal doctor rate that doctor?

Chart 4. Getting Needed Care from Specialists



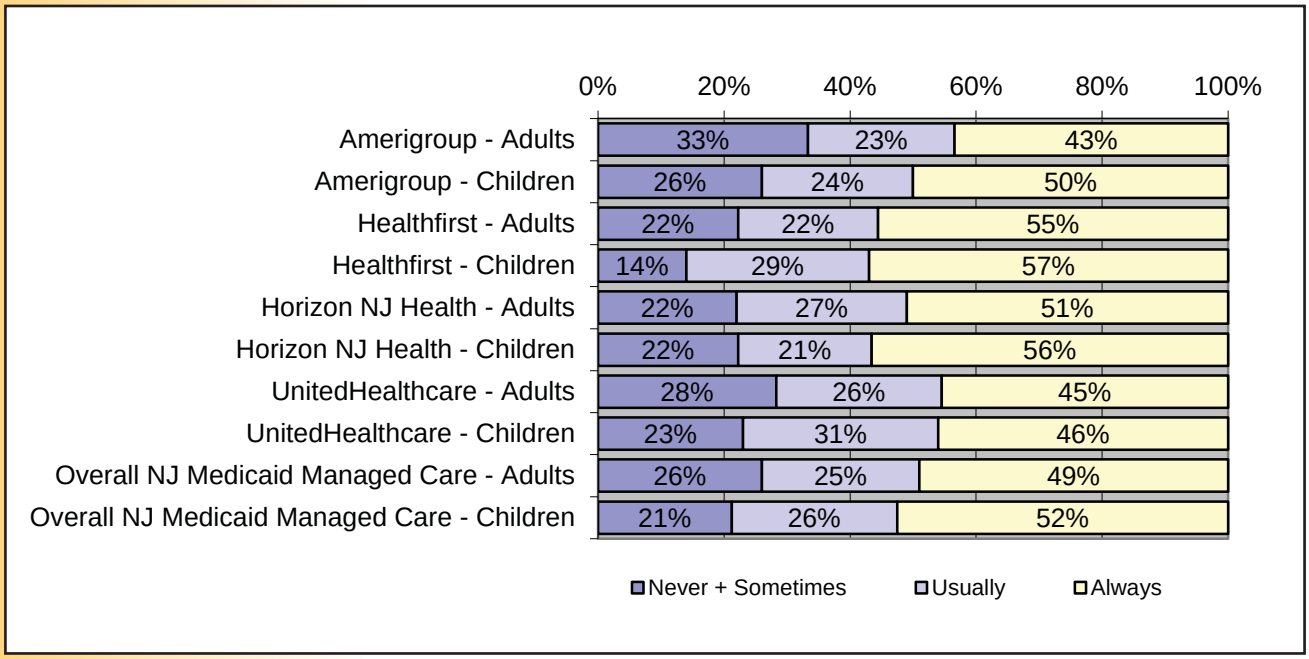
How easy was it for respondents to get needed care from specialists in the last six months?

Chart 5. Overall Rating of Specialists



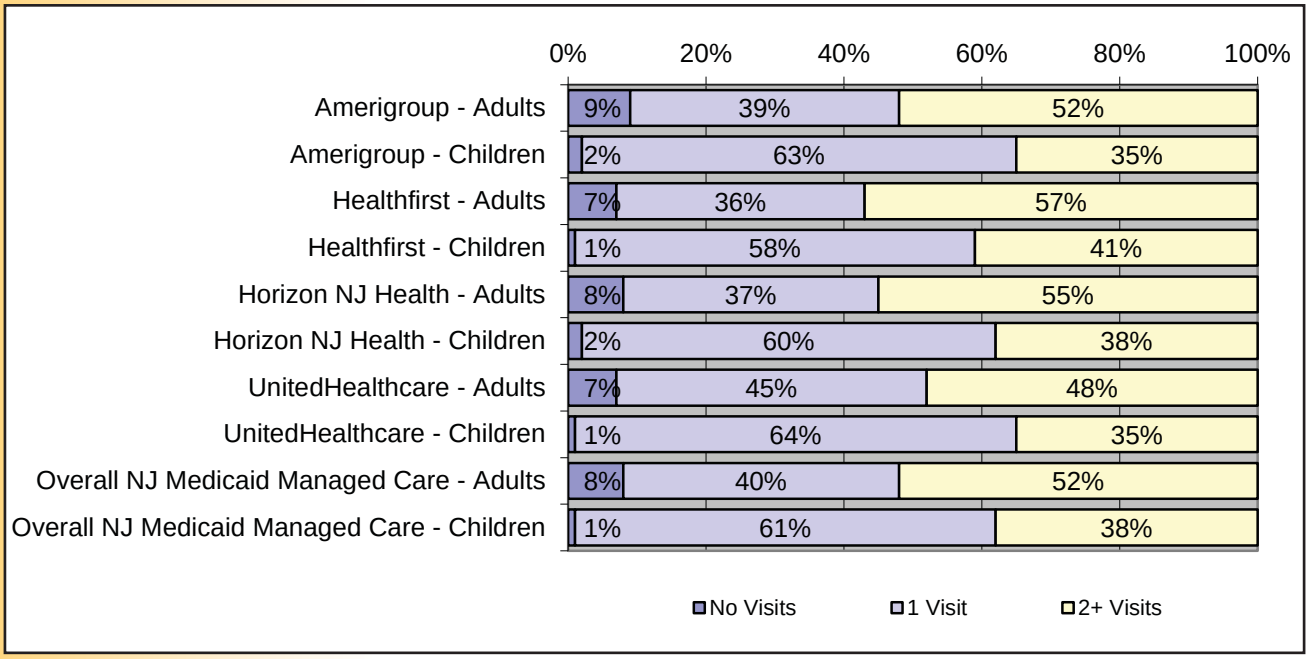
On a scale of 0-10, where 10 is the best, how did respondents who reported seeing a specialist rate that specialist?

Chart 6. Rating of Customer Service Responsiveness



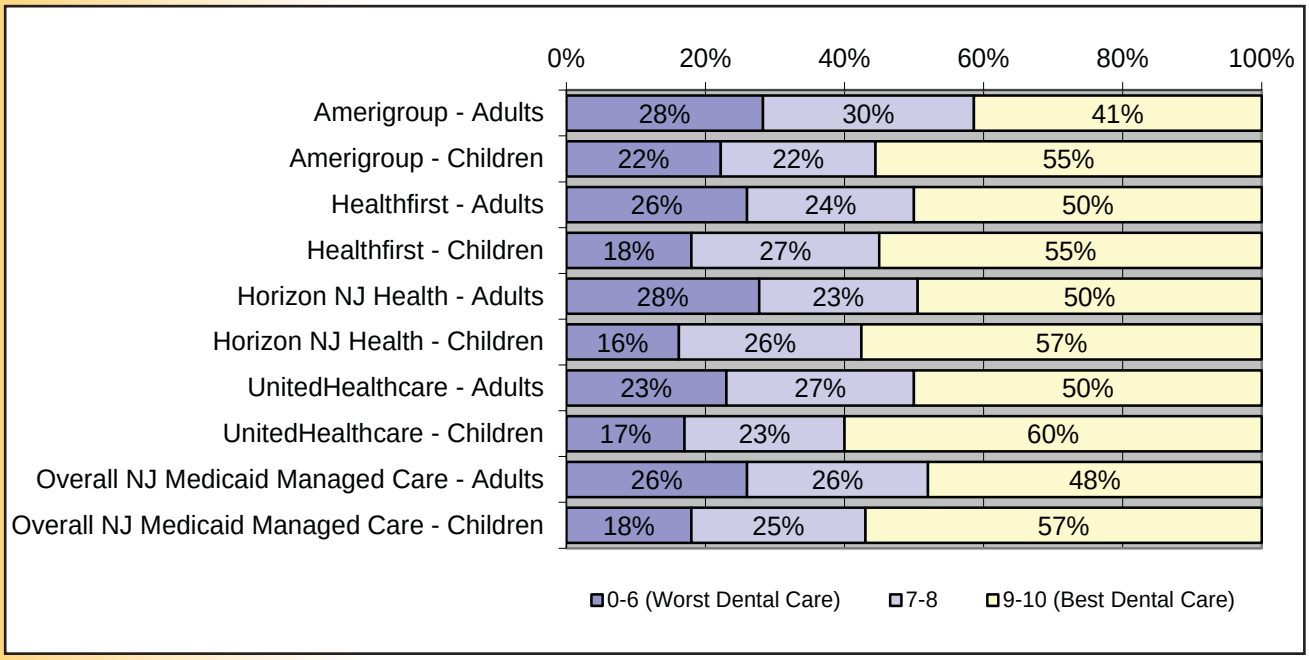
In the last six months, how often did the health plan's customer service staff give good information or help?

Chart 7. Dental Visits in Last 6 Months



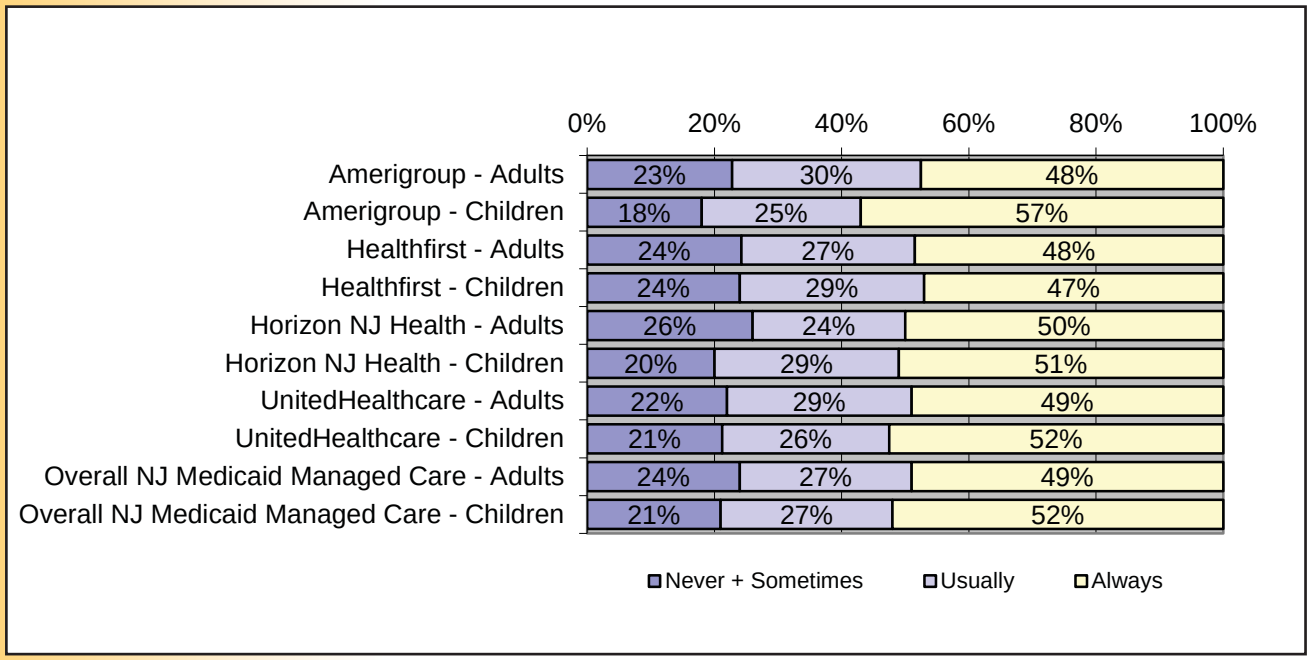
In the last six months, how often did you (your child) visit the dentist?

Chart 8. Overall Rating of Dental Care



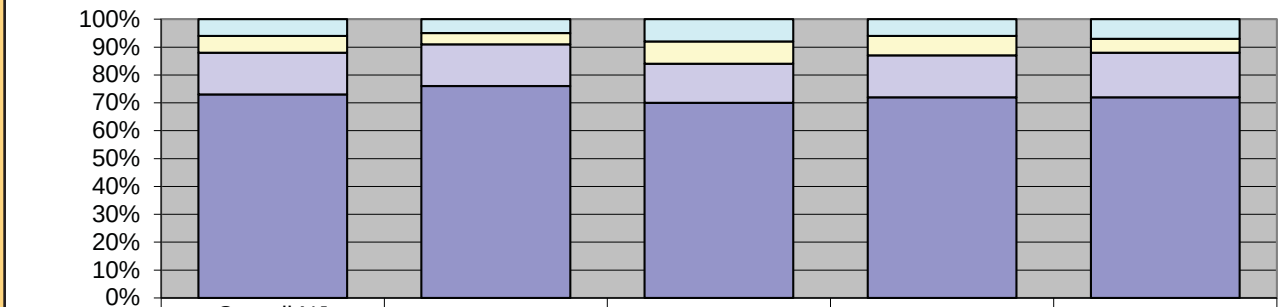
Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all your (your child's) dental care in the last 6 months?

Chart 9. How Often Personal Doctor is Informed of Care Received from Other Health Providers



In the last 6 months, how often did your (your child's) personal doctor seem informed and up-to-date about the care you (your child) got from other doctors or other health providers?

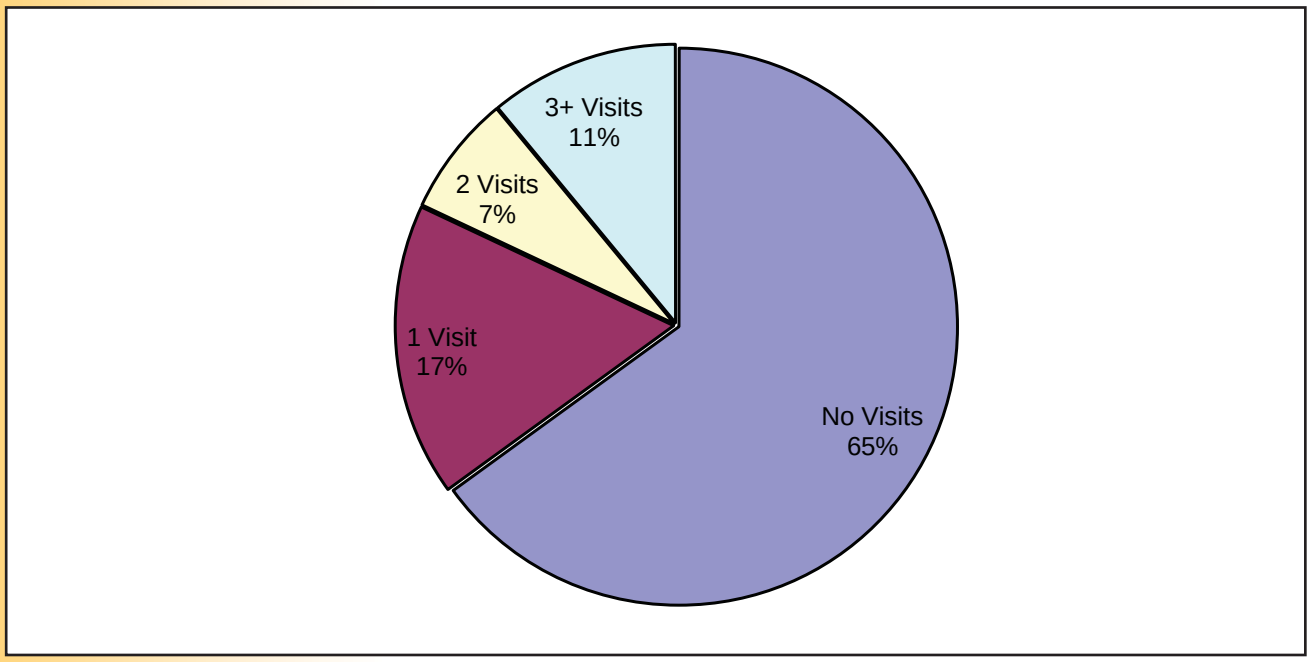
Chart 10. Emergency Room Visit Activity in Last Six Months



	Overall NJ Medicaid Managed Care - Adults	Amerigroup	Healthfirst	Horizon	UnitedHealthcare
3+ Visits	6%	5%	8%	6%	7%
2 Visits	6%	4%	8%	7%	5%
1 Visit	15%	15%	14%	15%	16%
No Visits	73%	76%	70%	72%	72%

Asked of all respondents: "In the last six months, how many times did you go to an emergency room to get health care for yourself?"

Chart 11. Number of Emergency Room Visits to Get Health Care in Last Six Months Among Adult Medicaid ABD Clients



It is worth noting that emergency department (ED) utilization among aged, blind, and disabled Medicaid members was slightly higher than overall ED utilization within the Medicaid program. Also, ED utilization program-wide experienced an increase in each of these categories in the last year.

VI. Reports from the Health Plans on Best Practices

Each of the four HMOs was asked to provide a description of a clinical and/or administrative Best Practice to showcase in this Report including the initiative's goal, an overview and the benefits or results achieved. Each HMO reported on initiatives that provide insight into the variety and complexity of their accomplishments in serving the most vulnerable populations. This year, the HMOs demonstrated expertise in improving four specific modes of care while managing costs in novel ways.

Amerigroup demonstrates how home visits from personal physicians and nurse practitioners providing proactive, personalized care, can dramatically reduce the frequency and expense of trips and return trips to the Emergency Department, and hospital admissions.

Healthfirst has developed innovative communication supporting integrated care management, a new communications channel that helps inform, educate, and influence members to adapt healthy lifestyle choices. ***Healthfirst Healthy Living*** provides members with health-related information, resources, recipes and notices regarding local activities, seminars and events.

Horizon NJ Health details its Pharmacy Case Management Program which uses clinical pharmacists to monitor prescribing among a member's care providers to identify duplicate medications, or dosages higher than recommended. In those cases, Horizon pharmacists conduct outreach with the prescribers to verify dosing and prescribing is appropriate. The result is more accurate pharmaceutical administration to the member and cost savings from the elimination of duplicative or inappropriate dosing.

Finally, UnitedHealthcare has contracted with ***The Camden Coalition*** a unique field-based case management unit deployed into the community to coordinate care for the highest risk members in the City of Camden. The team meets members in their homes to assess medical and ADL needs, and coordinates care with the member's primary care physician, specialists, behavioral health providers and social service providers. The Coalition utilizes Health Information Exchange (HIE) as well as weekly meetings to assess progress.

Each of the health plans is pleased to share highlights of these practices implemented in 2011 on the following pages.

Amerigroup

Best Practice: Physician and Nurse Practitioner Home Visits

A personal physician who comes to a person's home in the middle of the night is not something that can be done for all of us all of the time. It would cost far too much. But it does make sense sometimes, when a person has frequent hospital admissions or re-admissions that are costing the program significantly more than the home visits would. That is when Amerigroup's Home Visit program might be a real solution for an Amerigroup member.

Goal

To improve health outcomes and decrease preventable acute care utilization among high-risk members through in-home visits from personal physicians and nurse practitioners (NP).

Program Overview

Amerigroup's Home Visit program provides in-home visits from personal physicians and NPs for members who have a high risk of hospital admissions, re-admissions and/or ER use. The program provides medical care to the chronically ill in their place of residence 24 hours a day, 7 days a week – through both scheduled and urgent visits. Visiting physicians/NPs are matched with nurse care managers to give Amerigroup members a support team that can address their needs quickly and completely. The program optimizes care by having the patient or family call the team directly for an immediate response with phone call and home visits.

Background

In-home care addresses the important problem that many people have in maintaining close contact with a personal care provider, and many medical practices are not prepared to do intensive outreach to people with complex conditions or disabilities. Even when nurses and social workers do connect with someone, they cannot provide needed medical care themselves. A visiting physician/NP can solve that problem.

Amerigroup's Home Visit program aims to prevent medical crises through proactive preventive care and chronic disease management. Visiting physicians/NPs complete a full clinical assessment, focusing on early recognition and quick intervention for acute medical problems. They provide needed care in the home whenever possible, and help people get the right care at the right time in the right setting, including geriatric care and end-of-life planning.

Amerigroup pays a provider organization a monthly fee to serve specific members who are identified as high-risk through data modeling. The provider organization works with the member to arrange the first home visit, assigns the support team, and manages the member's care from that point forward. If the member has an existing relationship with a primary care provider, that relationship is preserved and supported. Further, if the member does experience a hospitalization, the team will undertake a quality review to look for ways that outcome could have been prevented/improved for that person and others.

Results

- High level of patient engagement – 74% of members identified for the program received a home visit within seven days of a hospital discharge.
- Home care delivered – Amerigroup members participating in the Home Visit program received more than one visit per month on average, plus frequent telephone contact.
- Hospital admissions reduced – Members experienced far fewer hospital admissions during the first year of the program than they had before. And when participating members were compared to a control group with similar baseline data, the participating members experienced 44% fewer hospital admissions than the control group.
- Medical cost reduced – Participating members' medical cost per month was 21% less than the control group.

Note: The outcome data provided here reflects experience in Amerigroup's Tennessee health plan, which is further along and has more complete data for analysis. Amerigroup New Jersey members have recently begun participating in this program.

Healthfirst NJ

Best Practice: Innovative Communication Supporting Integrated Care Management

Healthfirst Health Plan of New Jersey, Inc. (Healthfirst) takes pride in its efforts to anticipate and respond to changes in the health insurance industry. Given the number of recent changes, including implementation of the Affordable Care Act, Medicaid reform, the Managed Long Term Services and Supports (MLTSS) integration and other future changes, it appears the new standard in the industry is "change" itself. Though many of these initiatives are closely tied to the political landscape, Healthfirst's primary commitment is to those they serve.

In order to ensure optimal care for the entire membership, Healthfirst has developed a 2-pronged approach for delivering enhanced member communication and integrated care management. Often, members expect to receive coverage-related information from their insurance company – letters, notices, explanations of benefits. They do not necessarily expect to see a new communication channel that helps inform, educate, and influence them to adopt healthy lifestyle choices.

That is what ***Healthfirst Healthy Living*** is all about. This initiative, developed by the Healthfirst Marketing Department, helps members make healthy lifestyle choices for themselves and their families, such as the foods they eat, their level of exercise and activity and visiting their doctors for annual checkups, health screenings and tests. In addition, ***Healthfirst Healthy Living*** provides members with health-related information, resources, recipes and notices regarding local activities, seminars and events.

As part of this communication initiative, Healthfirst uses the opportunity to provide members with tips to help prevent the risk of falling, education on what it means to fall, and what is at risk, especially for the elderly. This communication has been widely received by Healthfirst members and the health plan looks forward to using this new medium to continue to serve as an influential periodical for membership.

These communications directly support the second prong of Healthfirst's best practice approach: the integrated support of the Care Management Department. Healthfirst Care Managers are trained in all Healthfirst lines of business and products in the state of New Jersey. As a member may join a NJ FamilyCare product at Healthfirst, and later transition to the Dual-Eligible Special Needs Plan product, that individual would retain the same Care Manager throughout the membership. This allows a relationship of trust to be developed, and enhances Healthfirst's ability to manage authorizations, ensuring continuity of care across the organization.

Furthermore, Healthfirst is refining policies, procedures and job aides which continue be used in training Care Managers to handle complex social situations having an impact on member care. We have already seen the positive effect of the actions taken to address the family, housing and community aspects of members' care. In anticipation of the State's plan to implement Managed Long Term Care Services and Supports, the policies will help to ensure a unified approach for handling and escalating issues in a care environment where the psychosocial aspect of the members' medical care is and will continue to be vital.

Horizon NJ Health

Best Practice: Pharmacy Case Management program

The focus on quality at Horizon NJ Health leads to the development of several best practices every year. One example of a Horizon NJ Health best practice is the Pharmacy Case Management program which includes pharmacist-based interventions designed to improve members' quality of care. These interventions focus on members who have been identified as receiving multiple, potentially duplicative, atypical antipsychotics from multiple prescriber practices as well as members who have received doses in excess of medically appropriate limits.

A clinical pharmacist performs ongoing follow-up with prescribing physicians to ensure that care was coordinated among prescribers or prescriber practice groups and reviews all claims that were filled at a dose higher than the medically appropriate limits in place. For members receiving care from multiple prescriber practices or those exceeding dosing limitations based on the medical literature, additional physician outreach was conducted to determine if the members were being managed appropriately and if there was a rational current drug therapy regimen being employed. When necessary, prescribers were advised to reassess current drug regimens based on the dose or, in some cases, lack of coordination and drug duplication resulting from multiple prescribers. In all instances where interventions were necessary, these cases were also referred to Horizon NJ Health nurse care managers to allow for additional member outreach, support and direction to help ensure that optimized drug regimens would be maintained.

Prescriptions for 1.3% of the members identified by Horizon NJ Health as being prescribed multiple medications were deemed potentially inappropriate and likely duplicative, which ultimately led to prescribers reassessing and modifying the existing drug therapy. Doses for all members that were considered higher than current dosing limits were deemed appropriate after additional follow-up with each of the prescribing physicians.

As prescription drug spending continues to escalate, it is more crucial than ever for Horizon NJ Health to reduce waste and contain costs. Abuse of prescription drugs account for an increasing percentage of overall fraud and leads to unnecessary costs and substantial risks. A software package specifically developed to analyze potential patterns of fraud, waste and abuse (FWA) is used to perform a comprehensive scan of all benefits, including pharmacy, dental and medical records for members and providers. Because data analysis is a very valuable tool for detecting, monitoring and mitigating FWA, the expertise of a registered pharmacist with audit experience was an advantage in identifying patterns of FWA. These patterns may not have been immediately apparent under the review of individuals who are not clinically oriented.

Existing queries were refreshed to monitor for developing trends involving commonly abused drug combinations and drugs that are often sold illegally. Daily reviews were refined to concentrate the focus on identifying aberrant dispensing and prescribing patterns across the entire pharmacy network. Targeted therapeutic categories included HIV and other infectious diseases, asthma, behavioral health, and chronic pain.

Results: Compared with 2010, performance results from 2011 yielded the following:

- After the restructuring process was completed, there was a 93% increase in the number of internal prescription FWA referrals compared to the previous year. Various sources of these referrals were Horizon NJ Health internal staff, state liaisons and pharmacy audit vendors.
- Increased awareness through training and presentations to staff has also contributed to an increase in the number of identified cases. The collective effort of all participants made possible a detailed analysis of pharmacy claims, provided new perspectives and allowed the comparison of data with associated prescribers and providers. Specific patterns identified with previously closed cases were used to establish linkages with current providers and ultimately led to the investigation of seven additional cases.
- The documentation of details relating to FWA cases in a central database made it more readily available for internal use. Real-time monitoring of professional sanctions and the use of revised criteria for pharmacy lock-in referrals has reduced the amount of time required for case resolution. These associated pharmacy lock-in referrals contributed to a 27% reduction in pharmacy spending, a 46% reduction in the number of controlled substances dispensed and a 48% reduction in the number of duplicative prescribers. There was also an 80% increase in the number of aberrant claims identified and a 46% increase in pharmacy recoveries. Six new cases investigated in 2011 were the direct result of the valuable pharmacy FWA insight that was gained from regular attendance at state meetings.

UnitedHealthcare Community Plan

Best Practice: Camden Coalition and Coordinating Care for High-Risk Members

The Project Goal: A contract between UnitedHealthcare and the Camden Coalition requires the Camden Coalition to deploy its unique field based case management unit into the community to coordinate care for the highest risk members in the City of Camden.

Overview: In September, 2011, United Healthcare entered into a contract with The Camden Coalition led by Dr. Jeffrey Brenner. Through this program UnitedHealthcare is able to meet members where they live, conduct personal assessments to determine their medical and Activities of Daily Living requirements and develop integrated care plans that fit the needs identified for these high risk members. The Coalition resources dedicated to UnitedHealthcare's members

include a nurse practitioner, social worker and outreach worker. This team engages high risk members and coordinates care with their primary care physician, specialists, behavioral health providers and social service providers. Rounds are held weekly for these members to review their progress. Additionally, UnitedHealthcare exchanges real time information through The Coalition's Health Information Exchange (HIE). This HIE is unique in that it provides real time updates on care received by our members including Emergency Room (ER) visits and inpatient (IP) admissions and discharges.

Results will be achieved by:

- Analyzing clinic capacity and demand, trending same day visits, and identifying opportunities to increase same day access by extending hours, and reducing "no show" rates. Tracking same day appointment trends, actual appointments scheduled and kept on the same day, reflects overall patient demand for same day visits.
- Utilizing Best Practices in supporting Patient Centered Medical Homes (PCMH) through Practice outreach to patients for follow-up with PCP within 7 days of discharge from ER/IP.
- Identifying patients being readmitted, supporting continuous improvement efforts to reduce readmissions, especially for complex care patients.
- Focus and support Practice in using the Registry for pre-visit planning to alert physicians to possible open care opportunities.
- Documentation in Registry for future care planning.
- Best Practices for reducing adverse events for high risk cohorts are achieved using Registry for outreach and tracking last PCP visit.