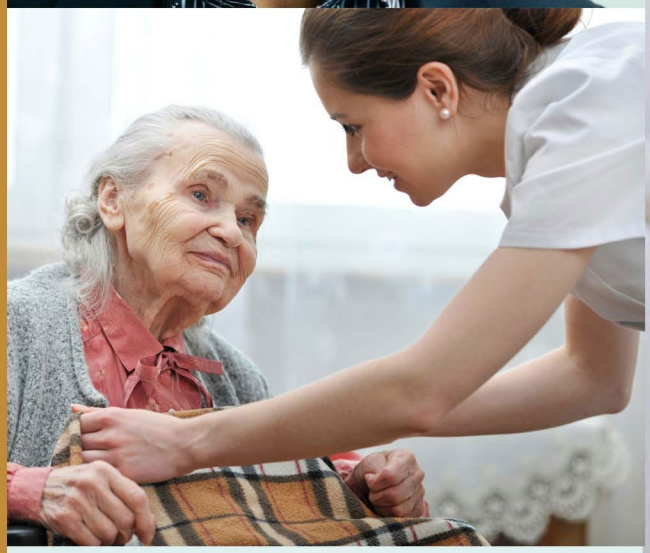
NJFAMILYCARE

Affordable health coverage. Quality care.



2015 Annual Report

Produced by DHS Office of Publications 8/2016

Dear Stakeholder:

It is our pleasure to present the 2015 NJ FamilyCare Annual Report from the New Jersey Department of Human Services' Division of Medical Assistance and Health Services (DMAHS). This Report highlights new initiatives, details ongoing operations and offers a glimpse into future plans for NJ FamilyCare and the 1.7 million beneficiaries it serves.

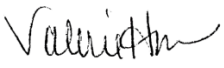
Milestones achieved this year include technological advancements that streamline the application and eligibility determination processes, benefitting individuals and administration alike. We also marked the one year anniversary of the implementation of the Managed Long-Term Services and Supports program, which broadens the care continuum to include home and community-based services so that a nursing home is not the only option for beneficiaries who require long-term care. Innovation is a theme as we launched Accountable Care Organizations and continue to pursue research and learning opportunities with university partners. Additionally, we are proud to partner with the Nicolson Foundation and the Center for Health Care Strategies in the operation of a Medicaid Academy which develops a promising "deep bench" of prepared leaders to guide NJ FamilyCare in the future.

Governor Chris Christie has placed major emphasis on the improvement of the behavioral health landscape for New Jerseyans, hence; initiatives have been implemented throughout many levels of state government. DMAHS is improving the quantity and quality of behavioral health services for NJ FamilyCare beneficiaries. Behavioral Health Homes are operating in four counties and will be expanded to additional counties. Next year, fee-for-service reimbursement rates for most behavioral health services will be increased and substance use disorder services will be added to benefit packages, where currently lacking.

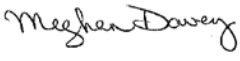
In closing, the Department of Human Services gratefully acknowledges Governor Christie, the legislature, providers, and other key stakeholders for their assistance and support for this vital New Jersey healthcare safety net program.

Sincerely,

Elizabeth Connolly
Acting Commissioner, New Jersey Department of Human Services



Valerie Harr
Deputy Commissioner, Division of Aging Services, New Jersey Department of Human Services



Meghan Davey
Director, Division of Medical Assistance and Health Services

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Executive Summary

NJ FamilyCare is the single program for all public medical assistance in New Jersey, which includes adults and children eligible for services under any state or federal authority. The Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) is the state entity that administers the NJ FamilyCare program. NJ FamilyCare enables access to and delivery of care to 1.7 million beneficiaries and covers a broad range of benefits with limited out-of-pocket costs. For 93 percent of beneficiaries, care is coordinated by one of five managed care organizations contracting with DMAHS, including Aetna Better Health of New Jersey, Amerigroup New Jersey, Horizon NJ Health, UnitedHealthcare Community Plan, and WellCare.

This report highlights new initiatives undertaken by DMAHS throughout 2015, details ongoing operations, and offers a glimpse into future plans. Notably, New Jersey has been a leader in deploying technology in order to improve the applicant experience and reduce administrative burden. New Jersey has pioneered the use of cloud-based technology to automate the eligibility determination process and to upgrade its online application tools. In 2014, New Jersey became the first state in the nation to use "MAGI in the Cloud" web service technology to fully automate eligibility determinations made under standard federal modified adjusted gross income (MAGI) rules. In 2015, New Jersey became the first state in the nation to receive authority to connect to the Federal Data Services Hub using a cloud service. Additionally, a new, streamlined application for most individuals now resides on a cloud platform. Improvements in these application and eligibility determination processes help streamline individuals' application experience and reduce the time needed for a final eligibility determination.

DMAHS is committed to expanding New Jersey's behavioral health landscape in partnership and collaboration with other state agencies. Initiatives undertaken in 2015 and plans into 2016 reflect this strong commitment. In an initial step towards managing behavioral health, an Interim Managing Entity serving adults seeking addiction treatment services, was launched state-wide this year and already has received more than 35,000 calls from New Jerseyans seeking recovery. Other initiatives include the operation of behavioral health homes in select counties, the commitment to expand them to additional counties, and the launch of Accountable Care Organizations, which will help coordinate physical and behavioral health for beneficiaries in Camden, Trenton, and Newark. In 2016, fee-for-service reimbursement rates

for behavioral health services will be significantly increased and substance use disorder services will become available for NJ FamilyCare beneficiaries who currently lack access to these benefits.

Managing the size and scope of the NJ FamilyCare operation entails thoughtful analysis, planning, and execution. The foundation for all programmatic decision-making for DMAHS involves consideration of the four factors referred to as "The Quadrant" by NJ FamilyCare staff: Eligibility, Quality, Infrastructure, and Fiscal. All decision-making begins with the needs of the individuals who are eligible to be enrolled in the program. The nature of the services required and the quality of care delivered is considered, followed by an analysis of the infrastructure required to support and operationalize these services. Once eligibility, quality, and infrastructure are considered, funding capability is assessed. This report communicates important activities in all four quadrants.

Eligibility: January 2015 marked the beginning of the second year of Medicaid expansion eligibility. Overall enrollment continued to grow, however, the pace of the growth slowed. Since the start of expansion in January 2014 through December 2015, NJ FamilyCare added 336,141 newly eligible adult beneficiaries, 101,644 previously eligible, but not enrolled children and parents, and an additional 128,870 adults enrolled in NJ FamilyCare in December 2013 maintained their coverage solely due to the State's decision to expand Medicaid. Outreach initiatives highlighted in this report include training for both presumptive eligibility and Certified Application Assistor programs, and enrolling eligible state and county inmates.

Quality: An external quality review is performed annually on NJ FamilyCare managed care organizations to determine compliance with specific contract elements. Beneficiary satisfaction is measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). Clinical quality is measured by the Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures. For measures and sub-measures with a national average available for comparison, 69 percent of the New Jersey weighted average scores either exceeded the national Medicaid average or fell within three percentage points of the national average, an improvement from 63 percent the prior year.

Infrastructure: An array of systems and services comprise the infrastructure enabling the delivery of care to NJ FamilyCare beneficiaries. Capitation and claim payments, provider servicing, customer service, eligibility and enrollment systems, quality control, the provision of non-emergency transportation, anti-fraud programs, and data analytics are some of the key components required to operate the NJ FamilyCare program. In 2015, New Jersey's contracted Health Benefits Coordinator fielded 1.5 million calls from consumers and assisted the state in performing almost 1 million eligibility determinations. 5.5 million verified paid trips were provided by the state's contracted non-emergency medical transportation broker for transportation to medically necessary appointments. The Medicaid Fraud Division recovered $87.3 million in improperly paid funds and an estimated $771.9 million in other potential expenses were avoided through proactive anti-fraud efforts. Additionally, the DMAHS Office of Legal and Regulatory Affairs generated, or helped to generate, the recovery of over $39.4 million in federal and state funds.

Fiscal: In state fiscal year 2015 (July 2014 – June 2015), NJ FamilyCare expenditures totaled $15 billion in state, federal and other funds, an increase of 13.9 percent over FY2014. During this period, average monthly enrollment grew by 319,722 beneficiaries, an increase of 24 percent. The overall average cost per beneficiary decreased by 7.7 percent, from $9,690 in FY2014 to $8,940 in FY2015. Of the $15 billion in 2015 NJ FamilyCare spending, approximately $4 billion went towards expenditures including disproportionate share hospital (DSH) payments, Medicare premiums for dual eligibles and administrative costs The remaining $11 billion was distributed into major categories of service based on the wide variety of federally mandated and state-optional benefits. Various inpatient and outpatient hospital and institutional services comprise 57% of spending, followed by pharmacy (11%) and physician services (8%).

Looking Ahead to 2016: Building upon 2015 accomplishments, initiatives for the coming year involve a significant focus on behavioral health (a top priority across state government), continued upgrades to infrastructure, and the mobilization of efforts to renew the New Jersey Comprehensive Waiver which is set to expire in June 2017.

2015 Key Initiatives

With the challenges of implementing the expansion of Medicaid in the rear view mirror, initiatives undertaken by DMAHS in 2015 involved embracing opportunities to respond to and anticipate changes in the health care landscape.

2015 Key Initiatives included the following: infrastructure upgrades such as eligibility process improvements, the design and development of a new Medicaid Management Information System (MMIS), continued implementation of the New Jersey Comprehensive Waiver, the launch of Accountable Care Organizations with three key provider groups, the initiative to integrate care and align financing and/or administration for beneficiaries eligible for both Medicare and Medicaid, value-based purchasing involving the health plans and some hospitals, collaboration with university partners for data analysis and policy leadership, and continuation of the electronic health records incentives for qualified providers.

2015 Key Initiatives

Eligibility Process Improvements

With "MAGI in the Cloud" web services to automate Modified Adjusted Gross Income (MAGI) eligibility determinations in 2014, New Jersey continued leadership in the field by becoming the first state to receive authority to connect to the federal data hub using a cloud service in 2015. The ability to connect to the federal data hub enables the receipt of application information from individuals who were determined eligible for NJ FamilyCare by the Federally Facilitated Marketplace (FFM) in real time, which eliminates the prior manual and error-prone transfer process. The use of the federal data hub was expanded by enabling a "Medicaid Eligibility Check", which is a web service hosted by New Jersey that allows the FFM to identify an individual who is already enrolled in the program. By preventing an individual from completing another application on the FFM, more than 55,000 duplicates were avoided in 2015. Preventing duplication yielded time and cost savings, and avoidance of confusing communication to the applicant.

The NJ FamilyCare application process has undergone an upgrade as well. A new, streamlined application for most individuals now resides on a cloud platform, which enables a professional, quality experience for individuals who are applying for benefits. Applicants are able to create an account, save their work, and log in at a later time to add information or check on the status of their application. In addition, capabilities have been advanced for Application Assistors with the creation of an Assistor Portal. After pilot testing, the new cloud worker-portal administration tool was released in December 2015. This tool enables a more efficient application process and eases the administrative burden required to perform annual renewals for beneficiaries, NJ FamilyCare staff, and contractors.

New Jersey Comprehensive Waiver

The New Jersey Comprehensive Waiver enables the design of a New Jersey-specific plan for service provision with a set of innovative strategies. The key components of the Waiver are Managed Long Term Services and Supports (MLTSS), Qualified Income Trusts (QIT), integrated/coordinated behavioral health care services, the Delivery System Reform Incentive Payment (DSRIP) Program and a Supports program for adults with developmental disabilities. The Waiver was approved by CMS in October 2012 and is effective through June 2017.

The MLTSS program marked its one year anniversary on July 1, 2015. Seniors and people with disabilities enrolled in MLTSS have greater access to an array of home and community-based services so that a nursing home is not their only long term care option. Throughout the year,

the NJ FamilyCare team has continued its efforts to ensure that consumers, stakeholders, health plans, providers and other community-based organizations are informed about the program. At the end of 2015, 22,310 beneficiaries were enrolled in MLTSS. Of those, 36.3 percent were receiving home and community-based services (including the Program of All-Inclusive Care for the Elderly known as PACE).

The Supports Program is administered by the Division of Developmental Disabilities (DDD) and provides assistance to NJ FamilyCare adults with intellectual and developmental disabilities so they may continue to live in their own homes or with their families. Examples of supports include, but are not limited to: assistive technologies, employment and day services, various therapies, home and vehicle modifications, transportation, and training. An initial group of about 100 beneficiaries was enrolled in July and August. In preparation for the launch, live webinars were conducted and continue to be available for providers and beneficiaries and their families on an ongoing basis, and a rich supply of information about the Program is provided on the DDD website. Along with service provision to beneficiaries, a key component of this program is a shift from a multitude of varied provider payment methodologies to a single set fee schedule. Providers and trade organizations have been engaged in ongoing communication and training to assist in preparation for this shift.

Another key component of the Waiver is integrated/coordinated care for behavioral health services. Both physical and behavioral health services are provided to NJ FamilyCare beneficiaries; however, because most behavioral health services are not included in the scope of benefits delivered by the health plans, there is a missed opportunity to coordinate care. As an initial step to reform the behavioral health system, an interim managing entity (IME), operated by Rutgers' University Behavioral Health Care, for adults seeking addiction treatment services was launched on July 1, 2015. By moving away from a fragmented network of treatment services, this newly-funded entity has improved access to services for Medicaid eligible people with substance use disorders. The IME is available 24 hours a day, seven days a week and provides the following: a coordinated point of entry, care coordinators who work with beneficiaries to remove barriers to treatment, and support until individuals are fully engaged in services. In 2015, the IME received more than 35,000 calls from New Jerseyans seeking to improve their lives through treatment and recovery.

Beginning in December 2014, DMAHS implemented a financial eligibility policy included in the Waiver that enables individuals whose monthly income exceeds 300 percent of the Supplemental Security Income Federal Benefit Rate ($2,199 in 2015), are otherwise eligible for NJ FamilyCare, and meet long term level of care, to qualify for MLTSS. An individual is required to set up a Qualified Income Trust with a separate bank account in which income above the income threshold is deposited each month. The funds are used for post-eligibility and cost

share expenses. All conditions must be met and are subject to the approval of, and monitoring by the agency determining NJ FamilyCare eligibility for the individual. At the time of death, the funds remaining must be paid to the State up to the cost of Medicaid benefits provided. By the end of 2015, almost 900 beneficiaries were able to take advantage of this new eligibility option.

The performance-based incentive program segment of the Waiver is known as The Delivery System Reform Incentive Payment (DSRIP). Participating New Jersey hospitals must undertake reforms, meet milestones and performance metrics set by the State and CMS to access funding. More information on DSRIP is included in the Value-Based Purchasing section below.

Accountable Care Organizations

The NJ FamilyCare Medicaid Accountable Care Organization (ACO) demonstration provides an opportunity to explore innovative system re-design including testing the ACO as an alternative to managed care, rethinking how care management and care coordination should be delivered to high risk, high cost utilizers, stretching the role of Medicaid beyond just medical services by integrating social services as well, and finally, testing payment reform via pay-for-performance metrics and incentives.

ACO Applicants were required to be a nonprofit organization serving a minimum of 5,000 beneficiaries within a designated region. In addition, the ACO was required to contract with 100 percent of the hospitals, 75 percent of the primary care providers, and at least four mental health providers within the region.

After an extensive process, three ACOs were certified in June 2015: Camden Coalition of Healthcare Providers, Trenton Health Team, and Healthy Greater Newark ACO. Work is currently underway.

Medicare-Medicaid Integration

Individuals who are dually eligible ("Duals") for Medicare and Medicaid are among the most complex and chronically-ill beneficiaries in NJ FamilyCare. Special health plans designed to promote the integration and coordination of benefits for these eligible beneficiaries by a single managed care organization are known as Dual-Eligible Special Needs Plans (D-SNPs). The enrollment of dually eligible NJ FamilyCare beneficiaries into D-SNPs continues to grow as evidenced by an enrollment increase of more than 45 percent during calendar year 2015. In an effort to better serve these individuals going forward, the DMAHS Dual Integration Unit held a

series of in-depth discussions with the health plans, and external subject matter experts around contract modifications needed to comply with the anticipated fully integrated dual eligible (FIDE) SNP designation in 2016. These discussions centered on fully integrating the managed long-term services and supports benefit into the D-SNP program and streamlining an integrated appeals process.

DMAHS also engaged the Center for Health Care Strategies (CHCS) to kick-off discussions informing a roadmap for dual integration in New Jersey. This roadmap will lay out the DMAHS "vision and goals" for dual integration in the State and will incorporate input from each of the D-SNP plans. DMAHS continues to engage with CHCS and has scheduled one-on-one monthly meetings with each D-SNP plan to seek their continued input into the Dual Integration Roadmap.

Value-Based Purchasing

DMAHS is committed to the expansion of value based purchasing strategies that link financial incentives to providers' performance on a set of defined measures. These efforts are expected to achieve better value by driving improvements in quality and slowing the growth in health care spending. In 2015, NJ FamilyCare operated two value-based purchasing initiatives: the Delivery System Reform Incentive Payment (DSRIP) Program (in partnership with the New Jersey Department of Health) and Performance-Based Contracting (PBC).

The Delivery System Reform Incentive Payment (DSRIP) Program is a demonstration program designed for hospitals to achieve three objectives: better care for individuals, better health of the population, and lower health care service costs. This is achieved by transitioning hospital funding to a model in which payment is contingent on achieving health improvement goals. Hospitals may qualify for incentive payments by implementing quality initiatives within their community and achieving measurable, incremental clinical outcomes which demonstrate the initiatives' impact on improving the New Jersey health care system. As of December 2015, 49 eligible New Jersey hospitals were approved to participate in the DSRIP Program. Focus areas for their projects include diabetes, cardiac care, behavioral health, chemical addiction/substance abuse, asthma, obesity, and pneumonia. The DSRIP program supports the Healthy New Jersey 2020 vision: "For New Jersey to be a state in which all people live long, healthy lives."

The Performance-Based Contracting Program is designed to motivate innovation by NJ Family Care's contract managed care organizations in an effort to initiate and sustain improvement in

clinical quality priority areas important to DMAHS and its beneficiaries enrolled in managed care. Each eligible participating health plan has a chance to earn incentive payments. The program is outlined in the New Jersey Medicaid managed care contract available on the DMAHS website. The clinical quality priority areas included in this program are birth outcomes (i.e. pre-term births, pre-natal care, and post-partum care), heart disease (including diabetes care), and obesity. Nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS®) measure definitions are used to ensure a uniform comparison of performance results between the plans. Additional clinical performance payment measures will be implemented in the MLTSS program. In order to receive payments related to attaining HEDIS® measure goals, plans must be accredited by the National Committee for Quality Assurance (NCQA) as "excellent" or "commendable". In future years, plans will be penalized for failing to meet this accreditation standard.

Medicaid Management Information System

Molina Medicaid Solutions was awarded a contract to develop a new NJ FamilyCare Medicaid Management Information System (MMIS). The MMIS replacement will provide a system infrastructure that takes into account the challenges of health care reform, the newest benefits in health information technology, and a health information exchange (HIE). In 2015, the NJ FamilyCare Implementation Team Office conducted stakeholder meetings and is progressively moving through a phased-in system development approach. With the planning phase complete, the Implementation Team will turn its focus to the Requirements Analysis and Design phase in 2016.

The new MMIS will include a modern Business Data Warehouse (BDW), which will vastly improve DMAHS' ability to monitor, oversee, and measure the overall performance of NJ FamilyCare and allow for more timely, data driven decision making on the future direction of the program.

Collaboration with University Partners

In 2015, DMAHS continued its existing partnership initiatives and projects with the Rutgers University Center for State Health Policy (CSHP).

High Utilizer Initiative – Historically, 5 percent of beneficiaries account for more than half of NJ FamilyCare's total medical costs. In his fiscal year 2015 budget address, Governor Christie challenged Rutgers CSHP to examine this population of "high utilizers" and to develop a

comprehensive set of recommendations to improve the quality of care provided to this population while simultaneously reducing costs. As part of this effort, Rutgers CSHP held several sessions with a wide range of health care stakeholders from across the state, examined best practices from other state Medicaid programs and commercial insurers in caring for this population, and began an examination of the medical claims data for this population.

State & University Partnership Learning Network (SUPLN) – This initiative brings together state Medicaid agencies and university research centers to support evidence-based state health policy and practice with a focus on transforming Medicaid-based healthcare, including improving the patient experience with care, improving the health of populations, and reducing the per capita cost of healthcare. As a result of participating in this network, a coordinated effort is underway to enhance DMAHS' capacity to conduct high-quality policy and data analysis by incorporating Rutgers CSHP staff into the DMAHS internal research office.

State Innovation Model (SIM) – In December 2014, Rutgers CSHP was awarded a $3 million SIM design grant by the Centers for Medicare and Medicaid Services (CMS) to engage a diverse group of stakeholders including NJ FamilyCare, along with public and commercial health care payers, providers and consumers, to develop a State Health Care Innovation Plan. DMAHS is supporting Rutgers CSHP's effort to improve healthcare through innovation by providing data for the following activities included in the SIM award: smoking cessation, improved birth outcomes, accountable care organizations, quantification of savings and quality measures for behavioral health homes, and better integration of care for Medicare-Medicaid dual eligibles.

Evaluation of the New Jersey Comprehensive Waiver – CMS approval of the New Jersey Comprehensive Waiver included a requirement to conduct an evaluation of all waiver components. DMAHS entered into a memorandum of understanding with Rutgers CSHP to perform this evaluation. The study, using a combination of quantitative and qualitative analyses, will evaluate the effectiveness of the following waiver components: integrating adult behavioral health with physical health services through a statewide care management entity; expanding Medicaid managed care to include community long-term services and supports to improve institutionalization rates, patient care experiences, and total cost of care; expediting Medicaid eligibility to ease the burden of obtaining community benefits and institutional placement; and transitioning the current Hospital Relief Subsidy Fund to a performance-based Delivery System Reform Incentive Payment program to improve care for individuals, population health, and total costs**.** A Draft Interim Evaluation Report is due with the Waiver Renewal Application and the Draft Final Evaluation Report is due in July 2017.

Electronic Health Records Incentives

The New Jersey Medicaid Electronic Health Records (EHR) Incentive Payment program provides incentive payments to eligible professionals and hospitals who demonstrate they have adopted, implemented, upgraded, and are meaningfully using certified EHR technology. The program is primarily funded by the federal Centers for Medicare and Medicaid Services (CMS) and administered by the states.

Meaningful use of EHR systems is expected to enhance care coordination and patient safety, reduce provider paperwork, facilitate information sharing across stakeholders and state borders, and increase patient engagement in their care. Upon the establishment of a New Jersey Health Information Network (NJHIN) that will connect regional Health Information Organizations (HIO) and State health data sources, EHR utilization is expected to enable communication of health information between authorized users throughout the State. The NJHIN will be the primary vehicle for New Jersey to eventually exchange health information nationally with the eHealth Exchange.

Providers eligible for the program include physicians, dentists, certified nurse midwives, nurse practitioners and optometrists who have at least 30 percent Medicaid patient volume; pediatricians who have at least 20 percent Medicaid patient volume; and hospitals that have at least 10 percent Medicaid patient volume. The first payments were distributed in December of 2011 and the program has supplied over $175 million in support to more than 2,500 providers throughout the State.

EHR Incentive Program Payments through 12/31/2015

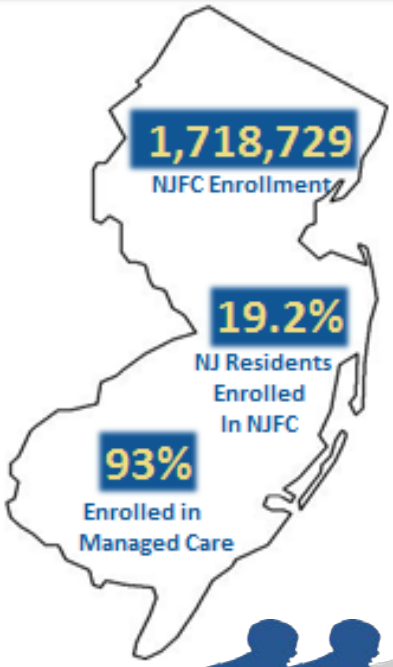
	Providers	Payments	Average Per Provider
Eligible Professionals	2,632	$65,758,890	$24,984
Eligible Hospitals	56	$110,174,431	$1,967,401
Total, All Provider Types: $175,933,321			

2015

NJ FamilyCare Snapshot

2.7 Million
MAGI-in-the-Cloud determinations

10,900
Average determinations per day



Almost **900** Beneficiaries used a ***Qualified Income Trust*** to gain eligibility for long term care services

Rides to medically necessary appointments

2 in 5 New Jersey births were covered by NJ FamilyCare

$65.8 Million
Incentive payments made to **2,632** NJ Providers for Electronic Health Records

(Through 12/31/2015)

69% of the New Jersey weighted average scores either exceeded or fell within 3 percentage points of the national Medicaid average.

HEDIS

NJ FamilyCare Health Plans

- aetna — AETNA BETTER HEALTH® OF NEW JERSEY
- Amerigroup RealSolutions in healthcare
- Horizon — Horizon NJ Health
- UnitedHealthcare Community Plan
- WellCare

Best Practices

DMAHS identified a clinical and/or administrative "Best Practice" to highlight in this Report which includes the initiative's goal, an overview, and the results achieved. These initiatives provide insight into the needs of the covered populations and the requirements to serve them. Below are the descriptions of these Best Practices as submitted by each NJ FamilyCare health plan:

aetna®

AETNA BETTER HEALTH® OF NEW JERSEY

Best Practice: Motivational Interviewing Training for all Care Managers

Goal:
To increase member engagement and participation in their care plan and to empower members to self-manage their conditions, in order to improve health outcomes and quality of life.

Overview:
Aetna Better Health of New Jersey's Integrative Care Management (ICM) Program includes complex care management and condition (disease) management, coordinated through the development of collaborative relationships between care managers and members. Our members face a variety of challenges (medical, social, behavioral and other) that affect their willingness to change behaviors impacting their overall health. Using established interviewing and engagement techniques, care managers can encourage positive member behavior change by increasing the likelihood of a collaborative relationship with members. Member goals are more likely to be achieved when care management staff uses this member-centered approach.

Aetna Better Health of New Jersey has implemented training such that that all care management staff complete a mandatory certification class in Motivational Interviewing. Motivational Interviewing is a specific technique of collaborative conversation that seeks to strengthen a person's own motivation and commitment to change. A key component of Motivational Interviewing is shaping the member's self-care decisions through coaching toward those that are more beneficial to the member's health.

Motivational Interviewing is a core tool in obtaining member engagement and participation with care management, such that members accept care management and aspire to reach their optimal level of health and functioning.

Specific components of Motivational Interviewing include the following:

- Reflecting versus asking questions
- Exploring the meaning of change versus arguing for change
- Evoking member's wisdom versus imparting clinician's expertise
- Collaborating versus Confronting
- Being Member-Centered versus Agenda-Centered
- Guiding versus Directing
- Strategic delivery of information versus standardized delivery of information

Using these techniques, care managers are able to do the following:

- Assess a member's readiness for behavioral change
- Promote member-centered goals
- Improve member health behavior/ outcomes
- Strengthen members' motivation and commitment to change
- Provide a non-judgmental, coaching approach
- Redirect members to focus on solutions they find acceptable
- Improve member satisfaction

In keeping with a corporate Aetna Medicaid initiative across all plans, Aetna Better Health of New Jersey requires Motivational Interviewing certification for all staff involved in case management activities. Periodic refresher courses add to the initial two-day training and provide continuing education in additional techniques. An example of such a refresher is the recent course, "Excellence in Customer Service", that provided training on tools for active listening, questioning techniques to enhance member feedback, methods to recognize and positively deal with members' emotional response and teach-back techniques to confirm member's understanding of information provided.

Results:

Motivational Interviewing has enhanced Aetna's Better Health of New Jersey's member-centered approach to care management and has achieved improved program engagement with Care Management. National level data indicate the following results when staff are trained in and use Motivational Interviewing:

- Member acceptance of entry into Care Management is enhanced, from 55.9 percent acceptance to 88.6 percent acceptance
- Member engagement (members staying in Care Management) improved by 67 percent over baseline

Best Practice: Program Integrity

Goal

Augment program integrity efforts and increase collaboration with state and federal law enforcement agencies through the implementation of a claims payment system enhancement to detect potential fraud, waste and abuse in the home health arena.

Background

According to the U.S. Department of Health and Human Services Office of the Inspector General's fiscal year 2014 report, approximately 30 percent of Medicaid fraud criminal convictions the federal government obtained stemmed from home health aides. Most commonly, those aides were convicted of fraud related to submitting claims for services that were not rendered.

Program Integrity Initiative Overview

To continue to be a prudent steward of state and federal funds, Amerigroup sought to pilot a fraud, waste and abuse detection program for certified home health aide (CHHA) services through the implementation of a processing edit in our claims payment system. Amerigroup requires CHHAs to include a license number on claims submitted in order to receive payment. By also improving our claims payment system to store this data, Amerigroup's Special Investigations Unit (SIU) is able to mine that data for outlier and other suspicious aide activity.

Specifically Amerigroup has the capability to review CHHAs who service more than one member on a specific date of service or date span to validate whether services rendered were appropriate. First, Amerigroup generates a monthly report for all MLTSS CHHA claims submitted by the home health agencies. The SIU then conducts manual reviews relative to claims, dates of service, and units billed per day to substantiate whether any suspicious activity occurred. Amerigroup reviews prospective utilization management notes to identify any discrepancies between authorized and rendered services, and compares that information to other pre-authorized services, such as adult day care and inpatient stays, to ensure the member was not in an alternate care setting when CHHA services were provided. Finally, Amerigroup generates a report by member and CHHA identifier to verify that a member received services only during authorized hours.

Amerigroup also reviews supplemental materials such as member day care sign-in sheets and CHHA employment timesheets to confirm whether the hours worked are implausible due to conflicts with other authorized services, or whether a CHHA was in a member's home versus another place of employment. In the case of the latter, Amerigroup collaborates with law enforcement who can potentially run wage reports to verify additional employment. Timesheets are compared to ensure an aide was not serving more than one member for the time/date billed.

While quantifiable results are not available at this early stage, this robust process has enabled Amerigroup to validate information obtained from investigations and referrals. It better enables us to monitor cases in partnership with the State of New Jersey's Medicaid Fraud Division, and local and federal law enforcement.

Best Practice: Managed Long Term Services & Supports Technology-based Platforms

Overview

Horizon NJ Health created a platform of technology-based support systems to better implement New Jersey's Managed Long Term Services and Supports (MLTSS) program. In 2015, Horizon NJ Health was selected as one of the nation's top business technology innovators in the annual *InformationWeek* Elite 100 and was named a 2015 *Digital Edge* 25 honoree for their innovative use of technology in their MLTSS program.

Goals

- Identify and create a process to better communicate the implementation progress of the MLTSS program
- Create a highly secure and more sustainable mobile technology to aide and support Horizon's 200+ MLTSS workforce while in the field
- Develop a highly customized management system exclusive to New Jersey's MLTSS program that captures data and digitizes assessments while minimizing administrative efforts

Description

Horizon NJ Health has developed a series of technology-based management programs designed to mainstream the implementation of New Jersey's MLTSS program.

Horizon View - MLTSS Operations Process Dashboard: The MLTSS program was designed to provide a significantly higher level of care coordination and services provided by traditional medical benefits. The program required significant collaboration between the health plan and the State, including the introduction of numerous process mandates. Due to the substantial

number of deliverables, tasks and interactions mandated by the State, Horizon NJ Health needed to identify a more effective way to communicate the implementation progress of the MLTSS Program.

Horizon View is a quick-glance dashboard report that allows MLTSS care managers, supervisors and the management team to provide up-to-date status reports regarding current membership, progress and quality-of-care coordination. The dashboard effectively identifies any process issues so members can continue to receive care in a timely manner.

Horizon Clinical Connect - Medical Management System for MLTSS: New Jersey's MLTSS program requires a significant amount of data collection to develop and maintain a plan of care. The plan of care supports the needs of the member in maintaining a quality of life in either the community or a facility.

To support the complexity of assessing and maintaining the needs of MLTSS members, Horizon NJ Health enhanced its systems to digitize the necessary information needed to support the predictive analytics for the plan of care and the prescriptive analytics for reporting features. This helped staff process Service Level Agreements (SLAs) with less administrative effort**.** Horizon NJ Health implemented the Horizon Clinical Connect - Medical Management System for MLTSS. This involved customizing Horizon NJ Health's current Medical Management System to capture critical structured data and digitize assessments that would be specific to Horizon NJ Health's MLTSS population. The customized system maximizes data for analytics while minimizing administrative effort for the Horizon NJ Health Care Management staff.

Managed Long Term Services & Supports Program Mobile Technology Solutions: The launch of the MLTSS program in July 2014 presented challenges for Horizon NJ Health's Information Technology (IT) department's ability to adequately support the technology needed for the 200+ newly hired MLTSS care managers/coordinators. In addition to its need to support a new "mobile" workforce, another challenge was mobile connectivity for the team. Throughout the state, connectivity varies, which caused staff members to experience problems receiving calls while connected to the Horizon network via the "Hot Spot" technology that was provided. This required a quick resolution, and change in technology to securely support connectivity anywhere.

The right technology required an unprecedented approach for integrating traditional medical services with behavioral health and social services to serve Horizon's MLTSS population. To meet this challenge, Horizon NJ Health developed new mobile technological solutions to satisfy its business needs and the highly-customized requirements of the State. Horizon NJ Health's IT department developed a mobile technology solution by adapting and enhancing key technology applications to transform our business to better support Horizon NJ Health's MLTSS field staff.

Best Practice: Healthify App

Healthify is a web-based social services tool developed for field based staff at UnitedHealthcare (UHC) to connect members to community resources and help address the social determinates to health. With several combined years of social service experience, and working collaboratively with UHC leaders, the Healthify team has identified the information, demographics, and resources that best suit our members and their needs.

Using Healthify, staff is able to quickly find local community services that address member needs with food, housing, clothing, transportation, parenting, and other social needs outside of standard health care coverage. By partnering with Healthify to assist members and address their social needs, UHC is able to help remove barriers that prevent healthy behaviors and focus on supporting the members to lead healthy, happy lives.

UHC has more than 140 staff actively using the Healthify App. They have completed over 2,500 searches, and have accessed information on over 12,000 community resources available to NJ residents.

Best Practice: Field Outreach Care Management

Some members require an alternative approach to telephonic outreach as it is not effective, such as those members who have been unable to contact by a Case Manager and/or who are high utilizers of Emergency Departments or those frequently admitted to the hospital. The goal of the Field Outreach Program is to identify, locate, and engage members in order to drive appropriate healthcare utilization and improve health outcomes.

1. WellCare Health Plans utilizes several referral sources to identify members appropriate for the Field Outreach Program. These include:

    a. Members who have met the criteria for Case Management but who have been unable to be contacted by the Care Manager

b. Those members who have not developed a relationship with a Primary Care Practitioner (PCP) to manage their acute and chronic healthcare

c. And an algorithm created using members meeting the following criteria: >3 ED visits within 6 months, >2 inpatient admissions within 6 months for chronic disease diagnoses (CHF, COPD, Diabetes, HIV, Coronary Artery Disease, Hypertension, Behavioral Health/Substance Abuse), members with polypharmacy (>10 current medications or 2 or more psychotropic medications in children) that may require pharmacy intervention and medication reconciliation, members who are potentially vulnerable secondary to living alone with diagnoses of Alzheimer's or other dementias, history of falls, lack of social resources, and/or history of abuse or neglect, and members who are identified as being in the top 10 percent of WellCare's health care cost and utilization.

2. The members meeting the criteria in 1 b & c are attempted to be outreached by the assigned Care Manager. If multiple telephonic attempts are unsuccessful, those members transition into the 1a classification and the member is referred to the Field Outreach Coordinator (FOC). The FOC reviews the contact attempts that have already been made, as well as all of the available contact information in the member's chart.

3. The Field Outreach Coordinator makes phone calls to any provider and/or pharmacy the member has seen within the last 3 months in order to obtain the member's updated contact information.

4. If all telephonic attempts have failed to locate and engage the member, the FOC begins a field based search. He/She goes in person to any EDs the member uses or any community based services the member may use, such as shelters, food pantries, soup kitchens, etc.…

5. When the FOC does locate and engage the member, he/she provides education on Case Management services and encourages the member to participate.

6. If the member agrees, the FOC then refers the member back to the Case Management team.

7. The Care Manager (CM) then takes on this member as a "field-based" case, whereby visits are made to the member's home with member agreement; the CM may accompany the member to provider visits; and or meet the member in a public place that is mutually agreeable. This allows a greater rapport to be developed that may assist with longer term engagement for Care Management compliance.

8. Another component of the Field Outreach process is a Hospital Based Care Manager (HBCM) who will identify admitted WellCare members by making frequent patient rounds,

reviewing current hospital admissions and the ED patient census, and responding to consults from both ED physicians and nursing staff. The HBCM will meet with the patient and the family at the bedside if the member is currently hospitalized. Before seeing each patient, a review of the hospital medical record provides essential clinical information to begin formulating a care plan for the level of care and transition to the field-based care manager. The HBCM interacts with patients and families as part of the discharge planning process, appropriately transferring patients to rehabilitation hospitals, skilled nursing facilities (SNF), or home with services.

9. The HBCM will determine if the member is currently being case managed and notify the assigned CM of the admission. If the member is not being case managed the HBCM will notify a Care Coordinator, who will send an e-mail to the field-based care manager notifying the person of the new case. A copy of the discharge instructions will be sent to the field-based care manager via fax and attached in WellCare's electronic medical management documentation system. The HBCM will ensure that the member and family have the field-based CM contact information before discharge. Within 48 hours of hospital discharge, the field-based care manager will send the patients' discharge instructions to their primary care physicians and contact the member via face to face meeting.

Successes

The Field Outreach Care Management Program began in April 2015. From that time through December 31, 2015, the FOC received a total of 177 referrals and was able to locate 125 of those members, giving him a success rate of 70.6 percent. Of the 125 members he located, 42 (34 percent) accepted Case Management services. HIV and Diabetes are the most common primary diagnoses for members referred. MLTSS members, on average, are located in under a week, as the FOC has been instructed to make MLTSS referrals priority. HIV members have been the most difficult to locate because this population tends to be the most transient of WellCare's membership. The most common methods of finding members are phone calls and home visits.

Eligibility & Enrollment

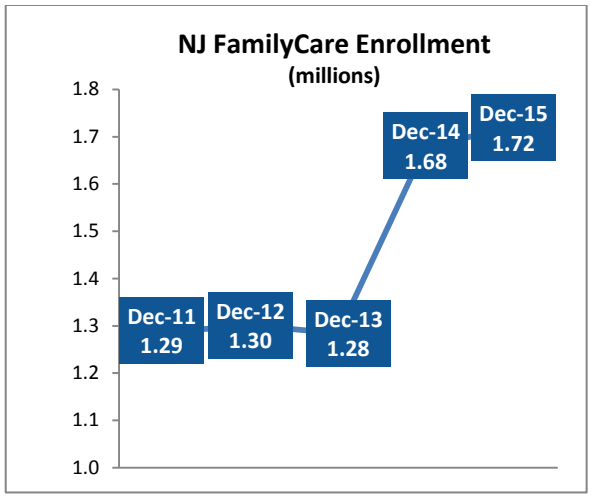
January 2015 marked the beginning of the second year of the expansion of Medicaid eligibility. Overall enrollment continued to grow, however, the pace of the growth slowed. Monthly growth averaged 0.2 percent in 2015 versus 2.3 percent in 2014. There are two key reasons for this slowdown: first, the initial influx of newly eligible individuals joining NJ FamilyCare in 2014 was a one-time phenomenon and second, NJ FamilyCare resumed annual eligibility redeterminations in 2015 after the redetermination waiver expired at the end of 2014.

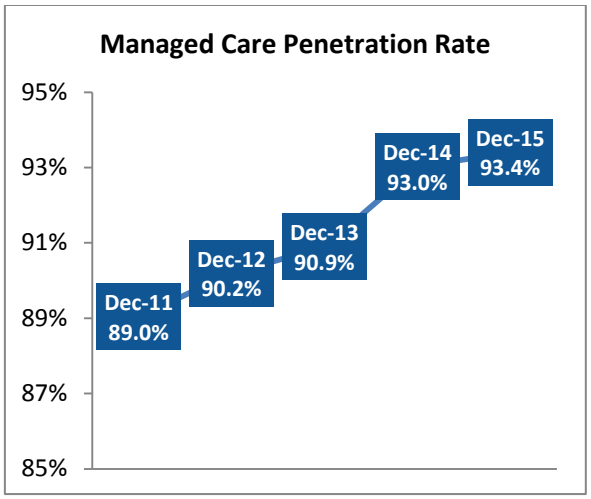
Between the start of expansion in January 2014 through December 2015, NJ FamilyCare added 336,141 newly eligible adult beneficiaries and 101,644 previously eligible but not enrolled children and parents. Finally, 128,870 adults enrolled in December 2013 maintained their NJ FamilyCare eligibility solely due the state's decision to expand. See Appendix A for eligibility categories effective in 2015 and Appendix B for a list of covered benefits.

2015 Enrollment Highlights (since 1/1/14 Expansion)

Newly Eligible Adults	336,141
Previously Eligible Children & Parents	101,644
Enrolled Adults Maintaining Eligibility Due to Decision to Expand	128,870

The managed care penetration rate remains high at 93 percent of NJ FamilyCare beneficiaries receiving their medical service through one of five managed care organizations. The major groups of beneficiaries who are not enrolled in managed care include those who are new to NJ FamilyCare and as yet unassigned to a plan, those who are presumed eligible temporarily until a full eligibility determination can be made, and nursing facility residents grandfathered in the MLTSS program. See charts for enrollment and managed care penetration trend on the next page.





While continuing previous outreach and enrollment efforts, two new key outreach strategies were undertaken by January 2015: training for both the Presumptive Eligibility (PE) and NJ FamilyCare Certified Application Assistor Programs, and enrolling eligible State and County inmates into NJ FamilyCare. PE provides temporary, fee-for-service benefits by participating providers until full NJ Family Care eligibility can be determined. Individuals are screened by State-certified presumptive eligibility staff, usually at Federally Qualified Health Centers and hospitals. Online applications are completed and sent to a dedicated PE unit at DMAHS for expedited establishment of temporary eligibility while their full eligibility is determined by the State health benefits coordinator. As a prerequisite to becoming a PE provider, a standardized, mandated training curriculum was developed and implemented. NJ FamilyCare Outreach trained more than 2,000 PE staff at provider agencies and provided oversight to more than 330 certified PE provider agencies. Second, NJ FamilyCare trains staff at community helping agencies to become Certified Application Assistors. After successfully completing 14 hours of online and classroom study, the Certified Application Assistors are granted access to a special online portal to help consumers apply for NJ FamilyCare. Fifteen classes were held and 225 people were trained.

A successful, multi-agency presumptive eligibility and NJ FamilyCare enrollment process was implemented, which enables federal matching funds for eligible inpatient hospital services to be covered through NJ FamilyCare during an incarceration. This ongoing savings initiative involving State and County inmates consisted of policy changes, collaboration across state and county governments, and information systems updates. More than $15 million in recovered capitation payments, recovery in appropriately paid funds, and cost avoidance has been realized since implementation. In an effort to address recidivism, DMAHS continues to work collaboratively with the New Jersey Department of Corrections to make eligibility determinations on their inmates 30 days prior to release so those eligible for NJ FamilyCare can be released with benefits.

Quality

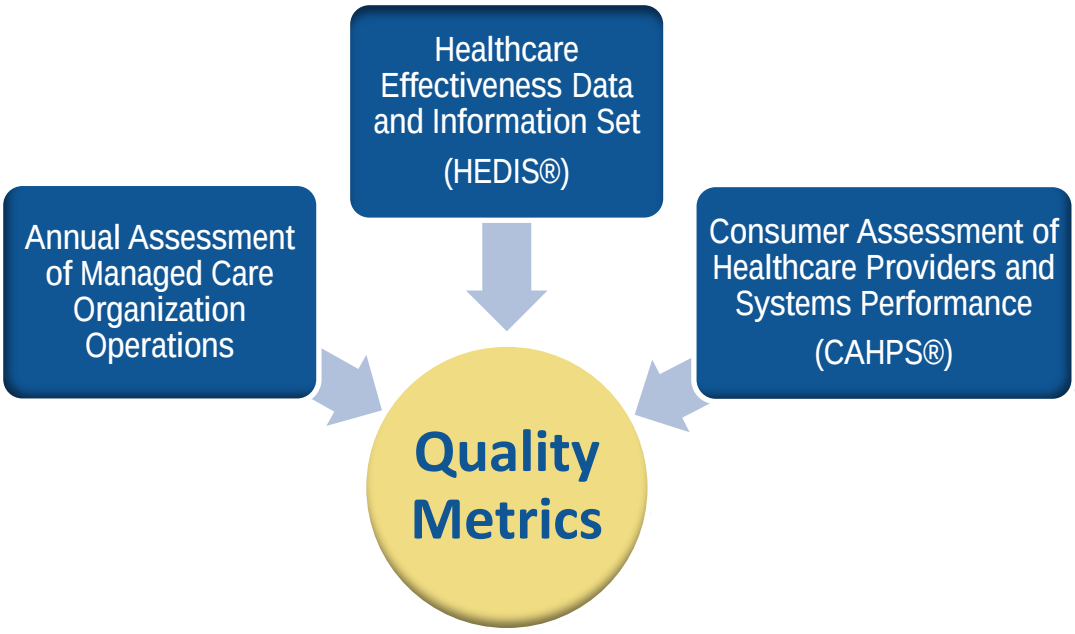
Beginning in the 1980's, DMAHS beneficiaries began transitioning from enrollment in a traditional fee-for-service health insurance program where healthcare providers bill DMAHS directly, into a managed care program in which most benefits are provided in exchange for a monthly, capitated payment. The managed care organizations (MCO) operating in New Jersey coordinate care delivery and provide services to 93 percent of NJ FamilyCare beneficiaries.

DMAHS ensures that members receive appropriate, timely and quality healthcare by monitoring MCO operations, using nationally recognized performance measures to evaluate the utilization, effectiveness, access and availability of healthcare, and measuring beneficiary satisfaction with MCOs and the services they provide. Wherever possible, monitoring methods are standardized, allowing beneficiaries and administrators alike to examine various results and compare each MCO's performance with other New Jersey MCOs as well as with national averages.

Clinical data regarding annual assessments is evaluated by an External Quality Review Organization. Performance measures are collected by the MCOs and evaluated by independent auditors. Member satisfaction data is collected and analyzed by a third party vendor.

Health Plan Scorecards

Following the three Quality Measurement Initiatives sections are the Health Plan Scorecards which were developed by DMAHS to enable plan-to-plan comparisons at-a-glance.



Annual Assessment of MCO Operations

An external quality review organization (EQRO) conducts a review of each NJ FamilyCare plan to assess quality and compliance standards. The Annual Assessment of Managed Care Organization Operations determines compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations.

While the Centers for Medicare and Medicaid Services require state Medicaid plans to have an EQRO perform an Annual Assessment of MCO Operations at least every three years, New Jersey requires a full Annual Assessment of MCO Operations to be conducted at least every two years. Annually, each MCO undergoes either a comprehensive or partial assessment. If an MCO receives a compliance rate of less than 85 percent on a comprehensive assessment, another comprehensive assessment will occur in the following year. If an MCO achieves a compliance rate at or above 85 percent on a comprehensive assessment, the plan will receive a partial assessment in the following year, which includes only those elements scored as "Not Met" or "Not Applicable". Regardless of compliance rate, MCOs must receive a comprehensive assessment at minimum every two years.

The EQRO evaluates the health plans' quality assurance program by rating their performance in implementing contractual requirements in areas such as Provider Education, Health Education and Promotion, Care Management, Utilization Management, Operations, and Credentialing.

This assessment, covering the period from 7/1/13- 6/30/14 is the most recent available and consisted of a partial review. (WellCare began operations in December 2013.) Below is a summary of the findings, however, additional detail and context for each plan may be found in Appendix C.

2014 Assessment of Managed Care Organization Operations

Health Plan	Elements Reviewed Prior Year	Elements Met Prior Year	Subject to Review	Met	% Met	Deficiency Status	
						Prior	Resolved
Amerigroup	175	164	12	4	95%	7	4
Horizon	175	161	15	8	96%	6	8
United	175	165	11	6	97%	5	5
Wellcare	175	93	74	N/A	56%	N/A	N/A

HEDIS®

HEDIS® Healthcare Effectiveness Data and Information Set Performance Measures

HEDIS® is a tool used by more than 90 percent of all health plans to measure performance on important dimensions of care and service. It was developed and is maintained by the National Committee for Quality Assurance (NCQA). The measures and sub-measures are first audited then submitted to DMAHS. Because so many health plans collect HEDIS® data, it is possible to compare the performance of health plans using standard metrics. The data for the 2014 HEDIS® report is based on services provided between January 1 and December 31, 2014.

For measures and sub-measures with a national average available for comparison, 69 percent of the New Jersey weighted average scores either exceeded the national Medicaid average or fell within 3 percentage points of the average, an improvement from 63 percent the prior year. The New Jersey weighted average scored above the national Medicaid average for the following measures and sub-measures:

Frequency of Ongoing Pre-natal Care: 81% of Expected Prenatal Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Well-Child Visits Birth to 15mos: 6 or more visits; Well Child Visits ages 3-6
Appropriate Testing for Children with Pharyngitis	Adolescent Immunizations: Tdap/Td	Adolescent Immunizations: Meningococcal
Adolescent Well-Care Visits	Lead Screening in Children	Cervical Cancer Screening
Children and Adolescents' Access to Primary Care: - 12-24mos, - 25mos -6yrs, - 7-11 yrs, and - 12-19 yrs	- HbA1c Control (<7.0%) for a Selected Population, - HbA1c Control (<8.0%), and - HbA1c Poor control	Asthma Med. Management: 75% Compliance for 51-64 yrs
Controlling High Blood Pressure	Adolescent Immunizations: Combination 1	Eye Exam for Diabetics

In a comparison of the New Jersey weighted average from the 2014 to 2015 reports, some of the largest improvements are seen in Follow-Up after Hospitalization for Mental Illness and BMI Assessment for Children/Adolescents, whereas, an area that showed a decline is Asthma Medication Management. The following charts I-IV show HEDIS® measures or sub-measures where most health plans exceeded the national Medicaid average over a five year period. The complete set of 2015 HEDIS® results can be found in Appendix E.

Chart I Lead Screening in Children*

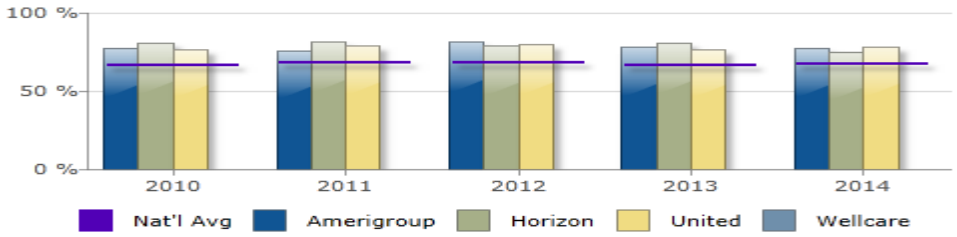


Chart II Well Child Visits Ages 0-15 Months: 6 or More Visits*

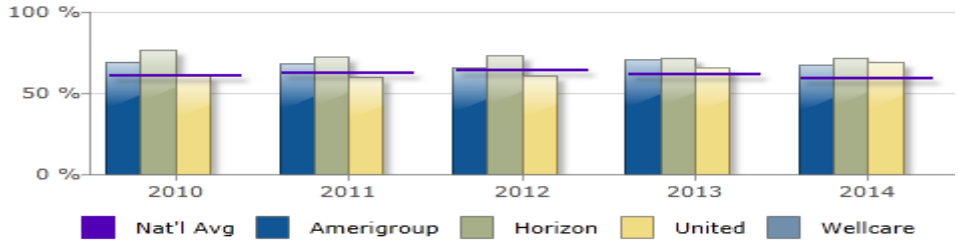


Chart III Immunizations for Adolescents: Combination 1*

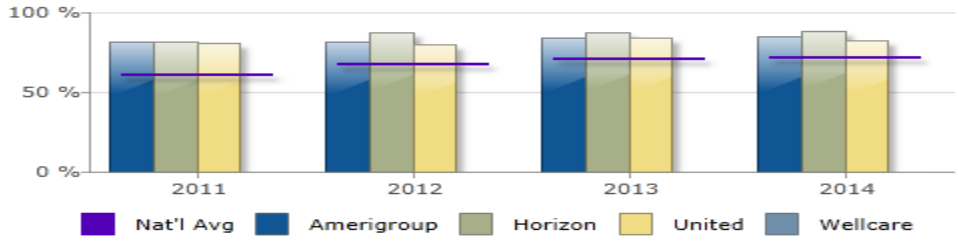
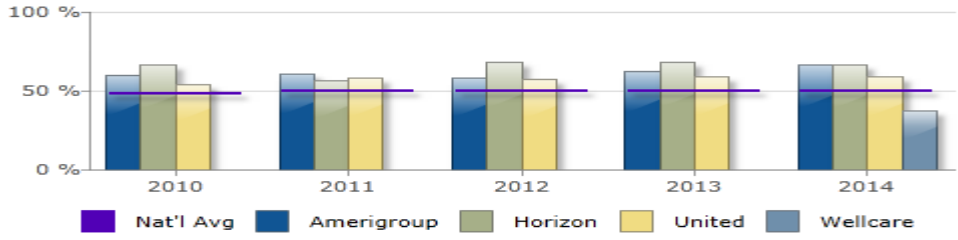


Chart IV Adolescent Well Care Visits: At Least One Comprehensive Visit*



*The year in the chart refers to the measurement year in which services were provided, not the report date year, e.g. measurement year 2014 is the data for the 2015 report. Data source for NJ plans is IPRO, NJ's External Quality Review Organization. Wellcare began operations in New Jersey in 2014. HealthFirst NJ is no longer an active NJ FamilyCare plan and is not shown. The data source for the national Medicaid average is from the State of Health Care Quality, 2010 -2015.

CAHPS®

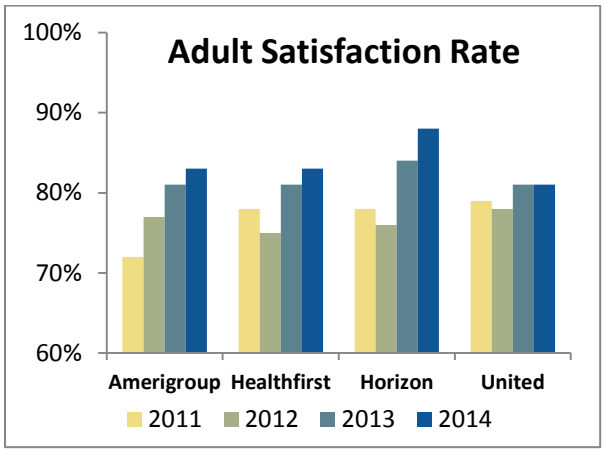
Consumer Assessment of Healthcare Providers and Systems Performance Measures (CAHPS®)

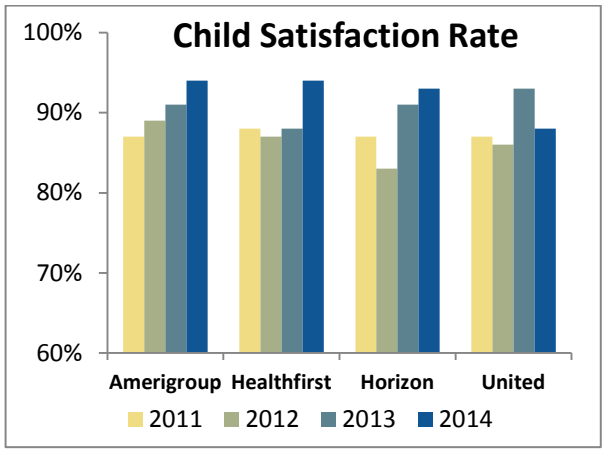
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a public-private initiative which utilizes standardized surveys in order to assess the experiences of patients in various settings. Each year a sample of beneficiaries from each NJ FamilyCare managed care organization is surveyed by mail or telephone to complete CAHPS®. The survey questions ask beneficiaries to report on and evaluate various aspects of their own or their children's experiences of care and service. The CAHPS® survey for state Medicaid plans are overseen by CMS and administered by Xerox, New Jersey's health benefits coordinator.

The data reported was collected in calendar year 2014. (The CAHPS® survey from 2015 is not yet available.) Results indicate that beneficiaries were generally satisfied as illustrated by the NJ Medicaid Plan Averages. The "Overall Rating of Health Care" is at a six year high in both the Adult and Child surveys, with 84% of adults and 92% of children (as answered primarily by parents) indicating satisfaction. Also at a six year high is "Health Plan" rating by adults, at 83% satisfaction. The "Child Health Plan" rating is 88%, down slightly from 89% in 2013. Respondents continue to be very satisfied with their personal doctors with scores of 91% and 94% for adults and children, respectively. Results in each of the four major CAHPS® areas by plan, are shown in the charts below.

Dual Eligible Special Needs Plan (D-SNP) recipients were added to the survey in 2013 as a separate sub-group. D-SNP is a coordinated care plan for New Jersey residents eligible for both Medicaid and Medicare (Parts A, B and D). Results of the CAHPS® survey for D-SNP recipients and detail for the other main survey categories may be found in Appendix D.

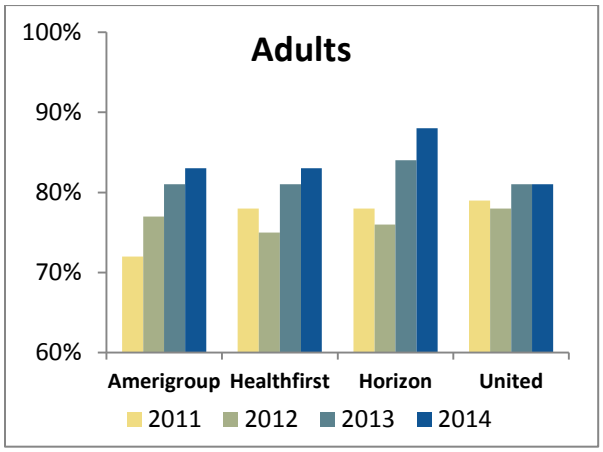
Chart I - Overall Rating of Health Care





Note: Satisfaction is defined as a score of 7-10. Response rate was 15.8% for adults, 15.9% for children and 17.1% for D-SNP

Chart II - Overall Health Plan Satisfaction



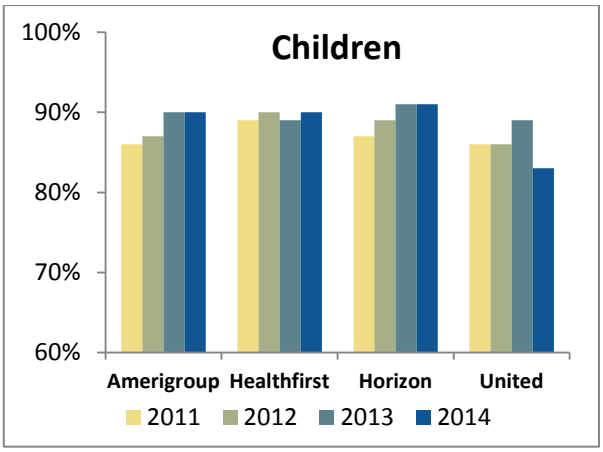
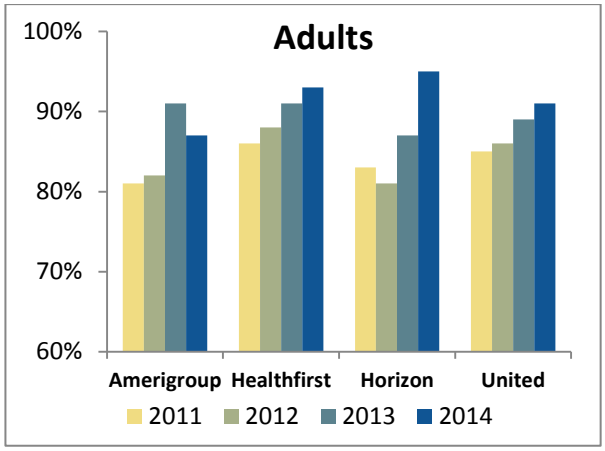


Chart III - Personal Doctor Satisfaction



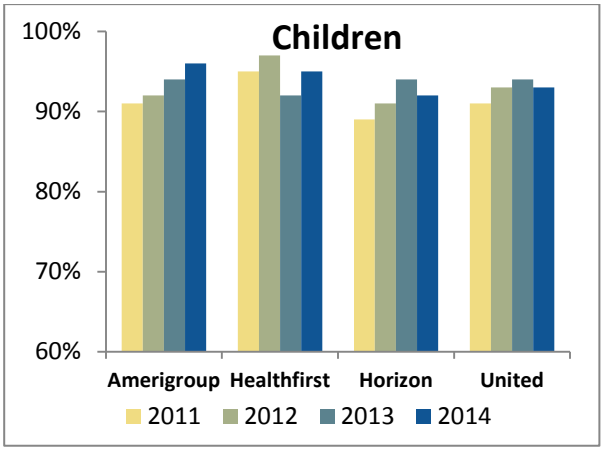
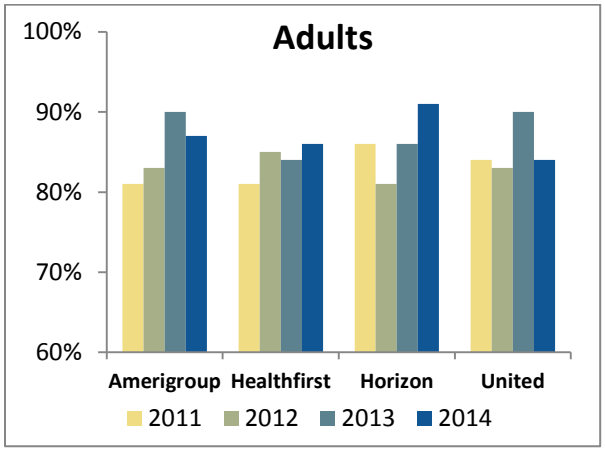
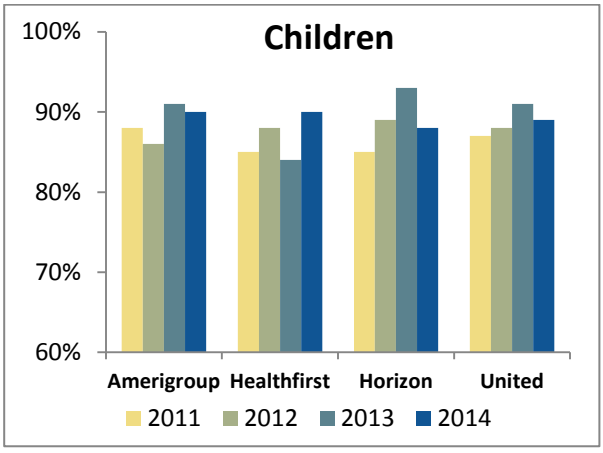


Chart IV - Specialist Doctor Satisfaction





aetna®

AETNA BETTER HEALTH® OF NEW JERSEY

(Aetna began operations in 12/2014, therefore, most performance data is not available)

Select Clinical Quality (HEDIS® -Darkened cells exceed national Medicaid HMO average)				
Reporting Category	***2012***	***2013***	***2014***	***2015***
Timeliness of Prenatal Care				
Post Partum Care (21 -56 Days)				
Diabetes: HbA1C <8%				
BMI Documentation (Age 3-17)				
Well Child Visits 0-15 Months				
Child Immunizations (Combination 2)				
Breast Cancer Screening				

Customer Satisfaction (CAHPS® Survey, Satisfaction defined as a score of 7-10 of 10)				
Measure	***2012***	***2013***	***2014***	***2015***
Adults Satisfied with Health Plan				
Adults Satisfied with Personal Doctor				
Adults Satisfied with Specialist				
Children Satisfied with Health Plan				
Children Satisfied with Personal Doctor				
Children Satisfied with Specialists				

Member Enrollment (As of December 31)				
Category	***2012***	***2013***	***2014***	***2015***
Overall Enrollees				18,646
Adult (age 19+) Enrollees				13,409
Child (age 0-18) Enrollees				5,237

National Performance Indicators (from the National Committee for Quality Assurance)			
	2013	***2014***	***2015***
NCQA Accreditation Status			
NCQA National Medicaid HMO Ranking			
NCQA Ranking Overall Score			

Amerigroup RealSolutions in healthcare

Select Clinical Quality (HEDIS®- Darkened cells exceed national Medicaid HMO average)

Reporting Category	2012	2013	2014	2015
Timeliness of Prenatal Care	*89.1%*	*87.7%*	*82.4%*	81.7%
Post Partum Care (21 -56 Days)	60.2%	52.7%	58.9%	52.0%
Diabetes: HbA1C <8%	*52.7%*	*48.7%*	*47.4%*	*50.5%*
BMI Documentation (Age 3-17)	N/A	35.7%	52.8%	*73.8%*
Well Child Visits 0-15 Months	*68.0%*	*65.5%*	*70.1%*	*67.1%*
Child Immunizations (Combination 2)	*75.7%*	74.3%	73.8%	74.5%
Breast Cancer Screening	*53.3%*	49.3%	52.0%	49.2%

Customer Satisfaction (CAHPS® Survey, Satisfaction defined as a score of 7-10 of 10)

Measure	2012	2013	2014	2015*
Adults Satisfied with Health Plan	76%	80%	79%	
Adults Satisfied with Personal Doctor	82%	91%	87%	
Adults Satisfied with Specialist	83%	90%	87%	
Children Satisfied with Health Plan	87%	90%	90%	
Children Satisfied with Personal Doctor	92%	94%	96%	
Children Satisfied with Specialists	86%	91%	90%	

Member Enrollment (As of December 31)

Category	2012	2013	2014	2015
Overall Enrollees	149,420	150,595	214,768	206,307
Adult (age 19+) Enrollees	62,053	62,891	116,503	115,908
Child (age 0-18) Enrollees	87,367	87,704	98,265	90,399

National Performance Indicators* (from the National Committee for Quality Assurance)

	2013	2014	2015
NCQA Accreditation Status	Commendable (4 of 5)	Commendable(4 of 5)	Accredited
NCQA National Medicaid HMO Ranking	67th of 131	48th of 136	
NCQA Ranking Overall Score	79.6/100	80.2/100	3.5 of 5*

*2015 CAHPS data not available at time of publication

*NCQA ranking methodology changed and no longer provides national rankings

Horizon Blue Cross Blue Shield of New Jersey

Horizon NJ Health

Select Clinical Quality (HEDIS® -Darkened cells exceed national Medicaid HMO average)

Reporting Category	2012	2013	2014	2015
Timeliness of Prenatal Care	*83.9%*	85.6%	77.2%	*87.4%*
Post Partum Care (21 -56 Days)	60.8%	*64.1%*	54.7%	56.8%
Diabetes: HbA1C <8%	47.7%	*50.7%*	*51.6%*	*54.0%*
BMI Documentation (Age 3-17)	*69.8%*	*59.9%*	52.0%	61.0%
Well Child Visits 0-15 Months	*72.3%*	*72.8%*	*71.0%*	*71.4%*
Child Immunizations (Combination 2)	71.8%	72.8%	73.2%	72.0%
Breast Cancer Screening	*52.1%*	*53.0%*	57.1%	55.2%

Customer Satisfaction (CAHPS® Survey, Satisfaction defined as a score of 7-10 of 10)

Measure	2012	2013	2014	2015*
Adults Satisfied with Health Plan	81%	84%	87%	
Adults Satisfied with Personal Doctor	81%	87%	95%	
Adults Satisfied with Specialist	81%	86%	91%	
Children Satisfied with Health Plan	89%	91%	91%	
Children Satisfied with Personal Doctor	91%	94%	92%	
Children Satisfied with Specialists	89%	93%	88%	

Member Enrollment (As of December 31)

Category	2012	2013	2014	2015
Overall Enrollees	565,782	587,922	780,438	840,732
Adult (age 19+) Enrollees	215,670	227,668	376,737	431,628
Child (age 0-18) Enrollees	350,112	360,254	403,701	409,104

National Performance Indicators* (from the National Committee for Quality Assurance)

	2013	2014	2015
NCQA Accreditation Status	Commendable (4 of 5)	Accredited (3 of 5)	Accredited
NCQA National Medicaid HMO Ranking	35th of 131	87th of 136	
NCQA Ranking Overall Score	81.6/100	78.4/100	3.5 of 5*

*2015 CAHPS data not available at time of publication

*NCQA ranking methodology changed and no longer provides national rankings

UnitedHealthcare Community Plan

Select Clinical Quality (HEDIS®- Darkened cells exceed national Medicaid HMO average)

Reporting Category	*2012*	*2013*	*2014*	*2015*
Timeliness of Prenatal Care	81.5%	81.2%	81.0%	84.2%
Post Partum Care (21 -56 Days)	55.5%	61.7%	61.8%	61.1%
Diabetes: HbA1C <8%	43.0%	39.3%	40.3%	46.9%
BMI Documentation (Age 3-17)	28.5%	43.1%	47.5%	51.1%
Well Child Visits 0-15 Months	59.8%	60.1%	*65.8%*	*68.6%*
Child Immunizations (Combination 2)	67.4%	67.4%	65.5%	67.9%
Breast Cancer Screening	*53.7%*	*53.5%*	57.5%	56.1%

Customer Satisfaction (CAHPS® Survey, Satisfaction defined as a score of 7-10 of 10)

Measure	*2012*	*2013*	*2014*	*2015**
Adults Satisfied with Health Plan	77%	79%	87%	
Adults Satisfied with Personal Doctor	86%	89%	95%	
Adults Satisfied with Specialist	83%	90%	91%	
Children Satisfied with Health Plan	86%	88%	91%	
Children Satisfied with Personal Doctor	93%	94%	92%	
Children Satisfied with Specialists	88%	91%	88%	

Member Enrollment (As of December 31)

Category	*2012*	*2013*	*2014*	*2015*
Overall Enrollees	415,524	380,888	487,365	482,158
Adult (age 19+) Enrollees	162,906	148,977	242,482	245,962
Child (age 0-18) Enrollees	252,618	231,911	244,883	236,196

National Performance Indicators* (from the National Committee for Quality Assurance)

	2013	*2014*	*2015*
NCQA Accreditation Status	None	Accredited (3 of 5)	Accredited
NCQA National Medicaid HMO Ranking	No data reported	69th of 136	
NCQA Ranking Overall Score	No data reported	79.2/100	3.5 of 5*

*2015 CAHPS data not available at time of publication

*NCQA ranking methodology changed and no longer provides national rankings

WellCare / healthfirst℠ | New Jersey

(WellCare acquired the assets of Healthfirst New Jersey, July 2014)

Select Clinical Quality (HEDIS®- Darkened cells exceed national Medicaid HMO average)

Reporting Category	2012	2013	2014	2015
Timeliness of Prenatal Care	82.7%	76.9%	79.1%	***87.2%***
Post Partum Care (21 -56 Days)	55.7%	54.6%	51.0%	45.1%
Diabetes: HbA1C <8%	***50.9%***	37.3%	32.5%	NA
BMI Documentation (Age 3-17)	***56.9%***	43.8%	49.2%	57.8%
Well Child Visits 0-15 Months	***73.2%***	64.6%	56.5%	NA
Child Immunizations (Combination 2)	74.2%	64.0%	53.7%	NA
Breast Cancer Screening	***56.3%***	***53.4%***	27.9%	NA

NA = Insufficient data

Customer Satisfaction (CAHPS® Survey, Satisfaction defined as a score of 7-10 of 10)

Measure	2012	2013	2014	2015*
Adults Satisfied with Health Plan	75%	84%	85%	
Adults Satisfied with Personal Doctor	88%	91%	93%	
Adults Satisfied with Specialist	85%	84%	86%	
Children Satisfied with Health Plan	90%	89%	90%	
Children Satisfied with Personal Doctor	97%	92%	95%	
Children Satisfied with Specialists	88%	84%	90%	

Member Enrollment (As of December 31)

Category	2012	2013	2014	2015
Overall Enrollees	42,382	47,378	61,201	55,884
Adult (age 19+) Enrollees	23,311	25,862	20,733	36,917
Child (age 0-18) Enrollees	19,071	21,516	40,468	18,967

National Performance Indicators (from the National Committee for Quality Assurance)

	2013	2014	2015
NCQA Accreditation Status	None	None	Insufficient data
NCQA National Medicaid HMO Ranking	No data reported	No data reported	
NCQA Ranking Overall Score	No data reported	No data reported	

* 2015 CAHPS data not available at time of publication

Infrastructure

An array of systems and services comprise the infrastructure which ultimately enables the delivery of care to NJ FamilyCare beneficiaries. These critical functions are managed internally by DMAHS in addition to external vendors.

Fiscal Agent

Molina Medicaid Solutions functions as the NJ FamilyCare fiscal agent. The fiscal agent performs vital financial transactions and delivers support services to the provider community. Molina operates a provider call center, manages correspondence, administers mandated second opinions, and performs health benefits identification services, training and Fair Hearing functions. In addition to these functions, federal law requires the re-enrollment of providers every five years. Providers initially enrolled after January 2013 are not required to complete the re-enrollment process.

Data Analytics

OptumInsight maintains the New Jersey Shared Data Warehouse which stores more than ten years of NJ FamilyCare claims, eligibility and other data. Information retrieval services and reporting tools for advanced analytics are provided that support research, planning, monitoring, evaluation of program operations and performance, and policy and program development.

In 2015, the Division created a new Office of Business Intelligence responsible for research, performance evaluation and presentations, monitoring of HMO encounter data, and initiatives related to the federal Health Information Technology for Economic and Clinical Health (HITECH) act. This team is leveraging the shared data warehouse to develop interactive tools that allow DMAHS and DHS senior management to access and drill into program data swiftly and with ease.

Customer Service

Xerox, New Jersey's Health Benefits Coordinator, performs functions which include fielding consumer inquires, enrolling beneficiaries in NJ FamilyCare programs, and determining eligibility for certain beneficiaries. These tasks are performed at both remote call centers and physical locations. In 2015, Xerox received 1.5 million calls from consumers and assisted the state in performing almost 1 million individual eligibility determinations and redeterminations. In order to improve efficiency, a six month pilot study is being conducted in which Xerox is assisting the state in performing all modified adjusted gross income (MAGI) eligibility determinations for applications and redeterminations in Morris County. The pilot study, which began November 2015, initially electronically shifted more than 21,000 cases to Xerox. The

County retained all of their Aged, Blind and Disabled (ABD) cases in need of an eligibility determination. During the pilot period, all subsequent MAGI determinations will be rerouted electronically to Xerox. At the conclusion of the study, the efficiency and quality of Medicaid eligibility determinations conducted by a county governmental entity as compared to an automated State approved system operated by a Health Benefits Coordinator will be measured.

Xerox also operates outreach regional offices which were visited by more than 13,000 consumers in 2015 for application assistance, HMO enrollment and resolution of other questions about the NJ FamilyCare program or their specific case. In addition, NJ FamilyCare directly operates five Medical Assistance Consumer Centers (MACC) located throughout the state. The MACCs assist NJ FamilyCare beneficiaries in obtaining needed services and in answering questions regarding their benefit packages

Xerox's contract was extended to June 2016. A request for proposal was released in December 2015 and responses are due by March 1, 2016.

Quality Control

The Bureau of Quality Control (BQC) performs federally mandated case reviews of eligibility and termination decisions. The intent of this process, known as a Medicaid Eligibility Quality Control (MEQC) review, is to ensure that these entities follow the prescribed requirements and processes necessary to make accurate decisions regarding NJ FamilyCare eligibility. Feedback is communicated to the respective organization that performed the initial eligibility determination and the Office of Eligibility Policy addresses trends and corrective action plans resulting from these reviews.

Non-Emergency Medical Transportation

Logisticare is the DMAHS medical transportation broker that provides rides for NJ FamilyCare beneficiaries to their medically necessary appointments. Verified paid trips numbered 5.5 million in 2015. A request for proposal for transportation services was released in December in anticipation of the contract expiration in June 2016.

Medicaid Fraud Division

The Medicaid Fraud Division (MFD), within the New Jersey Office of the State Comptroller, serves as the State's independent NJ FamilyCare watchdog for the NJ FamilyCare program and works to ensure that the program's dollars are being spent effectively and efficiently. The MFD's three units (Fiscal Integrity, Investigations, and Regulatory) recover improperly expended NJ FamilyCare funds, review the quality of care provided to NJ FamilyCare beneficiaries, and pursue civil and administrative enforcement actions against providers that engage in fraud, waste, or abuse within the NJ FamilyCare program. MFD also excludes or terminates ineligible health care providers from the NJ FamilyCare program where necessary and conducts educational programs for NJ FamilyCare providers and contractors. In state fiscal year 2015, MFD recovered $87.26 million in improperly paid NJ FamilyCare funds, which were returned to state and federal budgets, an increase of 12 percent from the previous year. In addition, an estimated $771.9 million in other potential NJ FamilyCare expenses were avoided through MFD's proactive anti-fraud efforts. MFD also excluded 86 ineligible providers from participating in the NJ FamilyCare program.

In addition to MFD's efforts, the DMAHS Office of Legal and Regulatory Affairs (OLRA) was involved in the recovery of Medicaid funds from estates and special needs trusts, and the recovery of NJ FamilyCare funds in other cases, such as those involving tort settlements, casualty insurance, and incorrectly paid benefits. In calendar year 2015 OLRA generated, or helped to generate, the recovery of over $39.4 million in federal and state funds.

Fiscal Summary

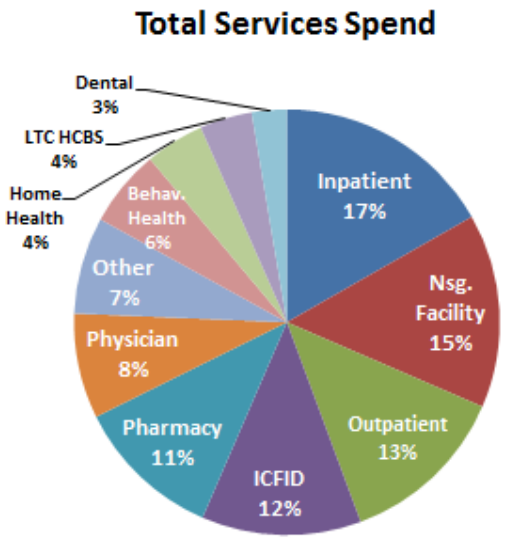
State Fiscal Year 2015 (FY2015)

In state fiscal year 2015 (July 2014 – June 2015), NJ FamilyCare expenditures totaled $15 billion in state, federal and other funds, an increase of 13.9 percent over FY2014. During this period, average monthly enrollment grew by 319,722 beneficiaries, an increase of 24 percent. The overall average cost per beneficiary decreased by 7.7 percent, from $9,690 in FY2014 to $8,940 in FY2015. For comparison, national healthcare inflation (based on the national healthcare consumer price index) was 2.7 percent. In addition, New Jersey was able to decrease the state share of its overall expenditures to 39 percent in 2015 down from 45 percent in 2014 due to enhanced federal matching rates on the Medicaid expansion adult and higher income child populations.

During SFY15, although average monthly NJ FamilyCare enrollment increased 24%, overall spending increased 14%.

Category of Services

Of the $15 billion in 2015 NJ FamilyCare spending, approximately $4 billion went towards expenditures including disproportionate share hospital (DSH) payments, Medicare premiums for dual eligibles and administrative costs The remaining $11 billion can be distributed into major categories of service based on the wide variety of federally mandated and state-optional benefits. Various inpatient and outpatient hospital and institutional services comprise 57% of spending, followed by pharmacy (11%) and physician services (8%).



ICFID= Intermediate Care Facilities for Individuals with Intellectual Disability

NJ FamilyCare serves five primary beneficiary populations, each with their own service needs and per capita cost experience. All of the breakouts described below are based on the $11 billion in direct service spending discussed above.

Medicaid: Aged, Blind and individuals with Disabilities (ABD) includes beneficiaries who are either 65 years of age or over, blind, or are living with a disability. Beneficiaries within the ABD group account for 15 percent of the population and the largest share of expenditures at $4.1 billion, or 37 percent of total direct service expenditures. More than half of this population is eligible for both Medicaid and Medicare coverage. The average per capita cost is $6,908 for beneficiaries with dual coverage and $17,991 for those with Medicaid only coverage. Over 70 percent of services are for the following five services: intermediate care facilities for individuals with intellectual disabilities (26%), inpatient hospital (16%), pharmacy (12%), home health (10%), and outpatient services (9%). Of all the beneficiary populations, people in the ABD category consume the most inpatient services and the second highest amount of behavioral health services.

Medicaid Expansion includes beneficiaries between the ages of 19 and 64 with income up to and including 138 percent federal poverty level (FPL). Expansion beneficiaries account for 30 percent of total enrollment and 19 percent of total direct service expenditures, totaling $2.1 billion. The average per capita cost is $7,487 for childless adult beneficiaries and $3,770 for adults with children. Approximately 70 percent of services consumed for this population are comprised by three categories: outpatient hospital (26%), inpatient hospital (25%), and pharmacy (20%). Of all the beneficiary populations, people in the Medicaid Expansion category consume the most outpatient services.

Medicaid: Long Term Care (Nursing facility, Home and Community Based) includes beneficiaries in need of these services and receiving them in either a nursing facility or a home and community-based setting. While most of these services are provided through NJ FamilyCare's managed care organizations (through the Managed Long Term Services and Supports [MLTSS] program), about half of the beneficiaries receiving these services remained in the fee-for-service program when MLTSS was established in 2014. In FY2015, this population represented 2% of overall enrollment and 21% of total direct services expenditures, or $2.3 billion. The average annual per capita cost is $62,088 for nursing facility residents in this population and $39,210 for individuals receiving home and community-based services. Most nursing facility beneficiaries resided in a nursing facility for the entire year, accounting for 72 percent of total expenditures for this population. The second highest category of spending was for Intermediate Care Facilities for Individuals with Intellectual Disabilities (12%) followed by home and community based services (5%).

Medicaid: All Other is comprised of individuals and families with low incomes and resources who fall below 138 percent of the Federal poverty level (FPL) but do not fit within the ABD, Medicaid Expansion, or Long Term Services and Supports populations. This population accounts for 42 percent of total enrollment and 21 percent of total direct services expenditures, or $2.3 billion. In FY2015, the average annual per capita cost was $8,232 for adults in this population and $2,575 for children. Four services accounted for approximately 70% of spending for this group: inpatient hospital (24%), outpatient (19%), physician (16%), and behavioral health (15%). Of all the beneficiary populations, people in the Medicaid Other category consume the most behavioral health services and the second most inpatient and outpatient services.

CHIP is a program for low-income children—generally those in families with income below 350 percent of the Federal Poverty Level who do not qualify for Medicaid and would otherwise be uninsured. CHIP beneficiaries account for 11 percent of total enrollment and 3 percent of total direct services expenditures, or $339 million in 2015. CHIP beneficiaries are below the age of 22. The average per capita cost is $1,965. Close to 70 percent of services consumed by this population are comprised of four services: physician (21%), outpatient (19%), pharmacy (15%), and behavioral health (12%).

Looking Ahead to 2016

Building on 2015 accomplishments, initiatives for the coming year involve a significant focus on behavioral health, continued upgrades to infrastructure and mobilizing efforts to renew the NJ Comprehensive Waiver which is set to expire June 2017. Below is a snapshot of plans going forward.

Spotlight on Behavioral Health

A major focus of Governor Christie's 2015 State of the State and Budget Addresses and 2016 State of the State Address was the treatment of behavioral health, including mental illness and substance use disorder. A Rutgers Center for State Health Policy study commissioned by the Governor found that within the top 1 percent of the most costly NJ FamilyCare beneficiaries, more than 86 percent have a mental illness, substance abuse issue, or both. In order to address these issues, the objective will be to deliver more effective treatment in order to improve health and lower the long-term cost to the state.

DMAHS is employing a multifaceted approach by improving both the quantity and quality of behavioral health services available to NJ FamilyCare's 1.7 million beneficiaries. Fee-for-service reimbursement rates for many behavioral health services will be increased starting in July 2016 and benefit packages that currently lack substance use disorder services will include these services starting in July 2016. Other behavioral health initiatives include the following:

Interim Managing Entity

The Interim Managing Entity (IME) was established in 2015 and is operated by Rutgers University Behavioral Health Care to assist individuals who need assistance with substance use disorders. In 2016, the IME will operate in an expanded capacity which will include clinical review and prior authorizations for substance use disorder treatment services.

Behavioral Health Homes

Unlike many Patient Centered Medical Home programs that enroll a mix of relatively healthier patients with individuals who have higher needs, New Jersey has conceptualized a Behavioral Health Home program to serve beneficiaries with high intensity needs. This program is a set of services added to the existing behavioral health continuum of care and is directed to children and adults who are high utilizers or at risk for high utilization with serious mental illness or serious emotional disturbances, and those who are at risk of becoming high utilizers. It is not designed to replace any of the existing behavioral health services in the current continuum. Behavioral Health Home programs began operating in two counties in 2014 and will be expanded to three additional counties beginning in early 2016.

Community Supports Services

Community Support Services (CSS) is a program designed for individuals with a serious mental illness. The goal of the CSS program is to assist these individuals in reaching their recovery goals and maintaining their housing and other community supports. The Division of Mental Health and Addiction Services has been leading the implementation of this program and working with DMAHS to establish payment through Medicaid. It is expected that the CSS program will begin in the first half of 2016, once regulations are promulgated for both DMHAS and DMAHS. The CSS program includes a team of multi-level professionals who work from an Individualized Recovery Plan to assist the CSS member in meeting their goals and maintaining their housing. The team consists of doctors, nurses, psychologists, social workers, licensed counselors, bachelor level professionals, and peer wellness coaches. Services included in this program are therapeutic rehabilitative skills; illness management and recovery training; coordination and managing of services; and crisis intervention.

Presumptive Eligibility Training for Behavioral Health Providers

Already operational in physical health, the process of presumptive eligibility (PE) is being extended to Medicaid-enrolled mental health and substance use disorder providers who are licensed as independent clinics. PE provides temporary, fee-for-service benefits for services provided by participating providers until full NJ Family Care eligibility can be determined. PE certification is required by staff at these agencies. DMAHS is working with the Division of Mental Health and Addiction Services to schedule trainings to begin in 2016.

Prospective Payment System for Certified Community Behavioral Health Clinics

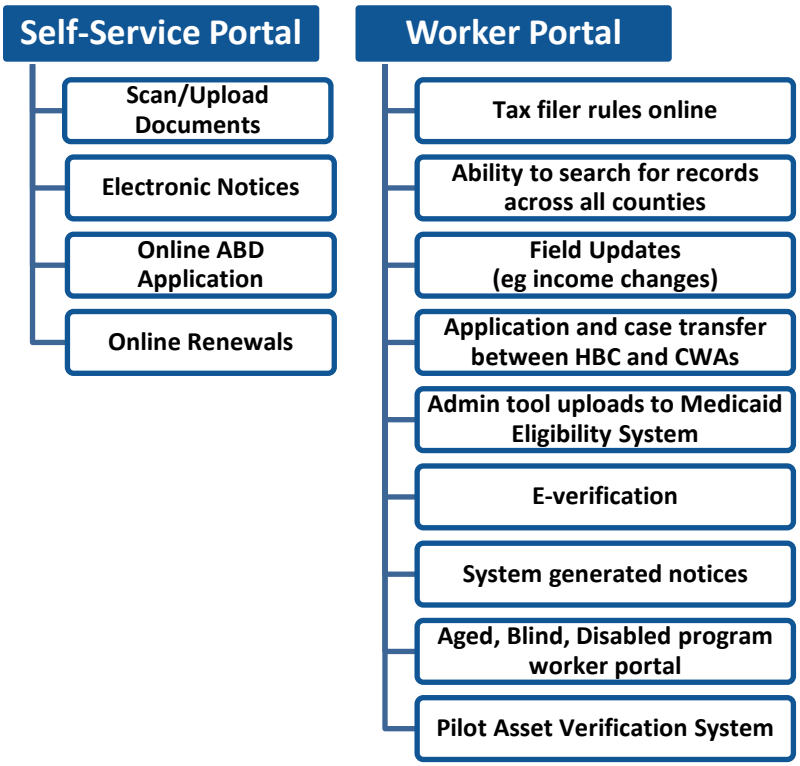
NJ FamilyCare has received a planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services to participate in a time-limited demonstration program to identify Certified Community Behavioral Health Clinics (CCBHC) and a prospective payment system for the CCBHCs. The purpose of this grant is to support states to certify clinics as certified community behavioral health clinics, establish prospective payment systems for Medicaid reimbursable services, and prepare an application to participate in a two year demonstration program. Populations to be served are adults and children with mental health and substance use disorders including veterans and the uninsured. As an outcome of this grant, New Jersey anticipates establishing a prospective payment system for the CCBHC service and applying for the year two of the demonstration grant.

Statewide Opioid Overdose

DMAHS is participating in statewide efforts coordinated by the Department of Health to combat the opioid epidemic as many who require services are eligible or enrolled in NJ FamilyCare.

Automating and Integrating Eligibility Systems

In order to build on advances achieved in the application and eligibility determination processes from prior years, more upgrades are planned for 2016. New Jersey anticipates the following advancements to the self-service and worker portals available through NJFamilyCare.org:



More areas of opportunity exist to coordinate programs across departments that provide social services to New Jersey residents. DMAHS and the Division of Family Development retained KPMG to conduct an analysis of the systems used in the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), Temporary Assistance to Needy Families (TANF) program as well as Medicaid and CHIP. In response, an Integrated Eligibility Oversight Committee was convened which consists of senior staff from all involved state agencies as well as the Governor's Office. A request for information was released in 2015 and 12 vendors presented their systems

Physician Fee Increase

Governor Christie's state fiscal year 2016 budget invested an additional $15 million in state funds to increase NJ FamilyCare provider reimbursement rates starting on January 1, 2016. This state investment is expected to generate $30 million in federal matching fund, with the $45 million total investment benefitting both the fee-for-service and managed care delivery systems. The goals of this investment are to increase rates for certain primary and specialty care services, encourage new and continued provider participation, ensure

beneficiaries have adequate access to physician services, ease strain and limitation of beneficiary access to services with a history of insufficiency, and ultimately promote routine and preventive care practices. Primary care, preventive care and screening, and postpartum services are the areas targeted for the fee-for-service rate increase; each of the managed care plans will submit proposals for their portion of these funds. Additionally, a floor for fee-for-service rates, based on a percentage of Medicare, will be set for all services.

Provider Credentialing

A provider credentialing task force that included representation from several state agencies, NJ FamilyCare's managed care organizations, various health provider groups, and private credentialing vendors recommended that a third party vendor centralize provider data collection, perform primary source verification, and coordinate the credentialing and re-credentialing process for NJ FamilyCare providers. Molina Medicaid Solutions selected Aperture, an organization that focuses solely on credentialing, to implement a single, program-wide credentialing system as part of the new Medicaid Management Information System project. Work on developing this system has begun and it is currently anticipated that the system will be operational for physicians, dentists and behavioral health providers in the first half of 2017. A single credentialing system will reduce the administrative burden on providers by using a common application and more efficient systems processes in managing the credentialing needs of the NJ FamilyCare program and its managed care partners.

National Core Indicators – Aging and Disabilities (NCI-AD)

The NCI-AD is an initiative designed to support states' interest in assessing the performance of their programs and delivery systems and improving services for older adults, individuals with physical disabilities, and caregivers. New Jersey is participating in this initiative to examine the funded long-term services and supports (LTSS) programs regardless of funding source (NJ FamilyCare/Medicaid; PACE; or Older Americans Act). The NCI-AD is an in-person survey that focuses on the performance of New Jersey's LTSS systems instead of specific services and to compare NJ's LTSS recipients on a national level.

New Jersey began planning for the NCI-AD project in October 2014, a few months after launching the Managed Long-Term Services and Supports (MLTSS) Program within the Comprehensive Medicaid 1115 Waiver. New Jersey is anticipating using the information received through the NCI-AD project as one of many tools used to assess the performance of the examined programs and how these services affect the quality of life and clinical outcomes of recipients in these programs.

The expected benefits to the State from participating in the NCI-AD program include the following:

- Focus on performance of New Jersey's LTSS systems instead of specific services
- Provide data on LTSS across various state programs (NJ FamilyCare, PACE, Older Americans Act).
- Compare New Jersey's LTSS recipients on a National level
- Focus on how individuals experience services and how they impact their quality of life (to go beyond services satisfaction).

- Potential to use data to evaluate MCO and quality of services in managed LTSS and for cross agency comparison.
- Assist New Jersey in complying with federal Home and Community-Based Services regulations.
- Identify issues that may require deeper analysis.

Each state's NCI-AD survey data will be analyzed by an outside entity that will produce reports to support state efforts to strengthen their LTSS policy, inform quality assurance activities, and compare performance between states. The draft report for New Jersey's 2015 survey is expected to be available in early 2016.

New Jersey Comprehensive Waiver Renewal

In preparation for the sunsetting of the New Jersey 1115 Comprehensive Waiver in 2017, DMAHS held more than twenty-five internal stakeholder meetings that included staff from the Division of Mental Health and Addiction Services (DMHAS), Department of Children and Families (DCF), Division of Developmental Disabilities (DDD), the Department of Health (DOH) and the Medicaid Fraud Division (MFD). The purpose of these internal stakeholder meetings was to solicit ideas from subject matter experts in preparation of applying for renewal of the Waiver. More than two hundred suggestions were proposed in the key domains of: promoting integrated delivery systems; access to care; modifying Medicaid benefits and reimbursement rates; performance measurement and benchmarking; streamlining Medicaid oversight and infrastructure; and enhancing monitoring through data analytics. The Waiver renewal will be put out for 30-day public comment and is expected to be submitted to CMS in 2016.

Appendix A: 2015 NJ FamilyCare Eligibility Categories

Population	Program	Description	Income Limit
Medicaid Children	AFDC-Related Children	Children up to the age of 18 (or 19 if a full time student)	MAGI Modified AFDC Income Limit
	Psychiatric Hospital	Children already eligible for AFDC-related coverage who are residing in a Title XIX state or county psychiatric hospital.	Already Medicaid Eligible
		Children under age 21 residing in a Title XIX state or county psychiatric hospital. Must be placed from home and the stay must be less than 30 days.	142% FPL*
	Household of One	Children enrolled through the Department of Children's System of Care who are under age 21 and have been admitted to an out-of-home treatment center, with less than 16 beds for more than 30 days.	142% FPL*
	Medicaid Special	Single Adults age 19 through the end of the month that they turn 21.	MAGI Modified Medicaid Special Income Limit
	Children	Children Age 1-18	MAGI Modified AFDC Income Limit> Income ≤ 142% FPL*
	New Born Program	Children under age 1	MAGI Modified AFDC Income Limit> Income ≤ 194% FPL*
CHIP Children	CHIP Plan B	Children under the age 19 without other insurance	142% FPL> Income ≤ 150% FPL
	CHIP Plan C	Children under the age 19 without other insurance	150% FPL> Income ≤ 200% FPL
	CHIP Plan D	Children under the age 19 without other insurance	200% FPL> Income ≤ 350% FPL*
Pregnant Women	Pregnant Women	Must be a Pregnant Woman	194% FPL*
	CHIP Pregnant Woman	Must be a Pregnant Woman without TPL	194% FPL> Income ≤ 200% FPL*
Parents and Caretaker Relatives	Parents and Caretaker Relatives	AFDC Related Parents	MAGI Modified AFDC Income Limit
		Parents	MAGI Modified AFDC Income Limit > Income ≤ 133% FPL*
Adults	Single Adults	Single Adults and Couples without Children	133% FPL*
Medicaid Only	Aged	Community- Must be age 65 or older and living in the community	Income rules are dependent on living arrangement. Resources less than $2000/individual, $3000/couple.
		Long Term Care- Must be 65 or older and determined clinically eligible for LTC	Total countable income less than Medicaid cap. Subject to Resources look back and spousal impoverishment rules.
		Must be age 65 or older and residing in a state or county Title XIX psychiatric hospital or ICF/MR development center.	

* Indicates that 5% disregard applies to this income limit

Appendix A: 2015 NJ FamilyCare Eligibility Categories

Population	Program	Description	Income Limit
Medicaid Only	Disabled	Community- Must be living in the community and determined disabled by SSA or by DMAHS Medical Review Team	Income rules are dependent on living arrangement. Resources less than $2000/individual, $3000/couple.
		LTC- Must be in need of institutional level of care and be determined disabled by SSA or by DMAHS Medical Review Team	Total countable income less than Medicaid cap. Subject to Resources look-back and spousal impoverishment rules.
		ISS Institutional- Must be determined disabled by SSA or DMAHS MRT and meet institutional level of care and reside in an ICF/MR developmental center	
	Blind	Community-Must be determined to be blind by SSA or the DMAHS Medical Review Team and living in the community.	Income rules are dependent on living arrangement. Resources less than $2000/individual, $3000/couple.
		LTC- Must be determined to be blind by SSA or the DMAHS Medical Review Team and determined clinically eligible for LTC.	Total countable income less than Medicaid cap. Subject to Resources look-back and spousal impoverishment rules.
		ISS Institutional - Must be determined to be blind by SSA or the DMAHS Medical Review Team and residing in a state or county Title XIX psychiatric hospital or ICF/MR development center	
	Psychiatric Hospital	Psychiatric Hospital- Children under age 21 residing in a title XIX state or county psychiatric hospital and determined to be disabled by SSA or MRT.	Total countable income less than the Medicaid cap. Subject to resource test and look back.
	Disabled Adult Child	Individuals determined to be a disabled adult child by SSA. Must have been a disabled SSI beneficiary who lost SSI eligibility due to receipt of survivors benefits which exceed the SSI income standards	Income rules are dependent on living arrangement. Resources less than $2000/individual, $3000/couple.
	Disabled Widow	Must be determined a disabled widow by SSA. Must not be Medicare eligible.	
	Disabled	Pickle People -Must be determined disabled by SSA and determined to be a Pickle Person by SSA due to loss of SSI eligibility.	
	Aged	Pickle People -Must be age 65 or older and determined to be a Pickle Person by SSA due to loss of SSI eligibility.	
SSI	Aged	Community - Must be age 65 or older and receiving SSI payments. Person must not need institutional level of care.	Financial eligibility determined by SSI
		Long Term Care- Must be 65 or older and receiving SSI payments. Person must need institutional level of care.	SSI income is the only source of income
		Institutional- Must be 65 or older and receiving SSI payments. Must reside in a state or country Title XIX psychiatric hospital or IFC/MR developmental center.	Financial eligibility determined by SSI
		SSI Essential Person- Must be determined by SSA to be an essential person to an aged person receiving SSI - Community Medicaid	No financial requirements

Appendix A: 2015 NJ FamilyCare Eligibility Categories

Population	Program	Description	Income Limit
SSI	Disabled	Community - Must be determined disabled by SSA and receiving SSI payments. Person must not need institutional level of care.	Financial eligibility determined by SSI
		Long Term Care- Must be determined disabled by and receiving SSI payments. Person must need institutional level of care.	SSI income is the only source of income
		Institutional- Must be determined disabled by SSA and receiving SSI payments. Must reside in a state or county Title XIX psychiatric hospital or IFC/MR developmental center.	Financial eligibility determined by SSI
		SSI Essential Person - Must be determined by SSA to be an essential person to a disabled person receiving SSI-Community Medicaid	No financial requirements
	Blind	Community - Must be determined blind by SSA and receiving SSI payments. Person must not need institutional level of care.	Financial eligibility determined by SSI
		Long Term Care- Must be determined blind by and receiving SSI payments. Person must need institutional level of care.	SSI income is the only source of income
		Institutional- Must be determined blind by SSA and receiving SSI payments. Must reside in a state or county Title XIX psychiatric hospital or IFC/MR developmental center.	Financial eligibility determined by SSI
		SSI Essential Person - Must be determined by SSA to be an essential person to a blind person receiving SSI-Community Medicaid	No financial requirements
	Psychiatric Hospital	Child under age 21 residing in a Title XIX state or county psychiatric hospital.	Financial eligibility determined by SSI
Medically Needy	Aged	Must be 65 or over and living in the community	Must meet set Medically Needy dollar limit with or without spend down
		LTC-Must be ≥ 65 and clinically eligible for LTC	
	Disabled	Must be determined to be disabled by SSA and living in the community	
		LTC- Must be determined to be disabled by SSA or MRT and clinically eligible for LTC	
	Blind	Must be determined to be blind by SSA and living in the community	
		LTC- Must be determined to be blind by SSA or MRT and clinically eligible for Long Term Care	
	Children	Community- < 21 living in the community	
		Community- under the age of 21 and clinically eligible for LTC	
	Pregnant Women	Must be a pregnant woman	
DCP&P	DCP&P Children	DCP&P Custody	Eligibility Determined by DCP&P
		Subsidized Adoptions	
		Kinship Legal Guardianship	
		Chaffee Kids	
		5 Yr. bar exception - State Funds Only	
		Income Exception - State Funds Only	
		DCP&P Services - State Funds Only	

Appendix B: NJ FamilyCare Covered Benefits*

Behavioral Health Home
Case Management for chronic illness
Chiropractic Care
Community health services, including Federally Qualified Health Centers (FQHC)
Dental services
Durable medical equipment
Early intervention services
Emergency services
EPSDT services
Family planning (excluding infertility services)
Health Start
Hearing Aids
Home health care and rehabilitation
Hospice care
Hospital Care- inpatient, outpatient and rehabilitation
Intermediate Care Facility for Persons with Intellectual Disabilities
Laboratory and Radiology services
Maternity and Midwifery services
Medical day care – adult and pediatric

*Not all benefits covered by all NJ FamilyCare Plans

Appendix B: NJ FamilyCare Covered Benefits*

Medical supplies, including diabetic
Mental health- inpatient, outpatient, methadone, substance abuse, rehabilitation
Nursing facilities
Ophthalmology, Optometry, and Optical appliances
Organ transplants (experimental excluded)
Orthotics and Prosthetics
Personal care assistant
Pharmacy
Physician, Certified Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse Midwife , Podiatry services
Private Duty Nursing *when authorized; up to 21 years of age
Rehabilitation services – outpatient physical, speech and occupational therapy
Residential Treatment Center services
School based services
Skilled Nursing Facility
Temporomandibular joint disorder treatment
Thermogram and thermography
Transportation- emergent and non-emergent
Vaccines

*Not all benefits covered by all NJ FamilyCare Plans

Appendix C Annual Assesment of Health Plan Operations

Amerigroup New Jersey, Inc.

Review Category	Total Elements	Met Prior Year	Subject to Review	Met	N/A	% Met	Deficiency Status	
							Prior	Resolved
Access	7	5	2	0	0	71%	2	0
Quality Assessment and Performance Improvement	9	9	0	0	0	100%	0	0
Quality Management	15	12	4*	0	0	73%*	3	0
Committee Structure	7	6	1	1	0	100%	0	1
Programs for the Elderly and Disabled	42	42	0	0	0	100%	0	0
Provider Training and Performance	9	9	0	0	0	100%	0	0
Satisfaction	3	3	0	0	0	100%	0	0
Enrollee Rights and Responsibilities	5	5	0	0	0	100%	0	0
Care Management and Continuity of Care	27	25	2	1	0	96%	1	1
Credentialing and Recredentialing	8	8	0	0	0	100%	0	0
Utilization Management	20	17	3	2	0	95%	1	2
Administration and Operations	11	11	0	0	0	100%	0	0
Management Information Systems	12	12	0	0	0	100%	0	0
TOTAL	**175**	**164**	**12**	**4**	**0**	**95%***	**7**	**4**

* There were four elements that were prior deficiencies and were deficient in the current review cycle. In addition to these, the Quality Management element QM11, which was *Met* in the prior year review, but was reviewed again in the current cycle, was deficient. Three elements for Efforts to Reduce Healthcare Disparities were deficient in the previous year and were included in the Quality Management section in this year's review; all three remained deficient in this review cycle. Thus, the final score is based on 167 *Met* elements out of 175 elements reviewed.

Appendix C Annual Assesment of Health Plan Operations

Horizon NJ Health

Review Category	Total Elements	Met Prior Year	Subject to Review	Met	N/A	% Met	Deficiency Status	
							Prior	Resolved
Access	7	5	2	2	0	100%	0	2
Quality Assessment and Performance Improvement	9	7	2	2	0	100%	0	2
Quality Management	15	12	4*	1	0	80%*	2	1
Committee Structure	7	7	0	0	0	100%	0	0
Programs for the Elderly and Disabled	42	40	2	1	0	98%	1	1
Provider Training and Performance	9	9	0	0	0	100%	0	0
Satisfaction	3	3	0	0	0	100%	0	0
Enrollee Rights and Responsibilities	5	5	0	0	0	100%	0	0
Care Management and Continuity of Care	27	24	3	0	0	89%	3	0
Credentialing and Recredentialing	8	8	0	0	0	100%	0	0
Utilization Management	20	18	2	2	0	100%	0	2
Administration and Operations	11	11	0	0	0	100%	0	0
Management Information Systems	12	12	0	0	0	100%	0	0
TOTAL	**175**	**161**	**15**	**8**	**0**	**96%***	**6**	**8**

* There were four elements that were prior deficiencies and were deficient in the current review cycle. In addition to these, the Quality Management element QM11, which was *Met* in the prior year review, but was reviewed again in the current cycle, was found to be deficient. Three elements for Efforts to Reduce Healthcare Disparities were deficient in the previous year and were included in the Quality Management section in this year's review; two of these remained deficient, while one was resolved. Thus, the final score is based on 168 *Met* elements out of 175 elements reviewed.

Appendix C Annual Assesment of Health Plan Operations

UnitedHealthcare Community Plan of New Jersey

Review Category	Total Elements	Met Prior Year	Subject to Review	Met	N/A	% Met	Deficiency Status	
							Prior	Resolved
Access	7	5	2	0	0	71%	2	0
Quality Assessment and Performance Improvement	9	9	0	0	0	100%	0	0
Quality Management	15	12	4*	2	0	87%*	2	1
Committee Structure	7	7	0	0	0	100%	0	0
Programs for the Elderly and Disabled	42	42	0	0	0	100%	0	0
Provider Training and Performance	9	9	0	0	0	100%	0	0
Satisfaction	3	3	0	0	0	100%	0	0
Enrollee Rights and Responsibilities	5	5	0	0	0	100%	0	0
Care Management and Continuity of Care	27	25	2	2	0	100%	0	2
Credentialing and Recredentialing	8	7	1	1	0	100%	0	1
Utilization Management	20	18	2	1	0	95%	1	1
Administration and Operations	11	11	0	0	0	100%	0	0
Management Information Systems	12	12	0	0	0	100%	0	0
TOTAL	**175**	**165**	**11**	**6**	**0**	**97%***	**5**	**5**

* There were five elements that were prior deficiencies and were deficient in the current review cycle. The Quality Management element QM11, which was *Met* in the prior year review, but was reviewed again in the current cycle, received a *Met* score. Three elements for Efforts to Reduce Healthcare Disparities were deficient in the previous year and were included in the Quality Management section in this year's review; two of these remained deficient, while one was resolved. Thus, the final score is based on 170 *Met* elements out of 175 elements reviewed.

Appendix C Annual Assesment of Health Plan Operations

WellCare HealthPlans of New Jersey, Inc.

Review Category	Total Elements	Met	Not Met	N/A	% Met
Access	7	6	1	0	86%
Quality Assessment and Performance Improvement	9	5	3	1	63%
Quality Management	15	4	10	1	29%
Committee Structure	7	3	4	0	43%
Programs for the Elderly and Disabled	42	13	29	0	31%
Provider Training and Performance	9	3	6	0	33%
Satisfaction	3	0	0	3	N/A
Enrollee Rights and Responsibilities	5	3	2	0	60%
Care Management and Continuity of Care	27	15	9	3	63%
Credentialing and Recredentialing	8	6	2	0	75%
Utilization Management	20	12	8	0	60%
Administration and Operations	11	11	0	0	100%
Management Information Systems	12	12	0	0	100%
TOTAL	**175**	**93**	**74**	**8**	**56%**

Conclusion

The overall score for the plan was 56%. The plan began operations in December 2013. Enrollment in January 2014 was 11, with increasing monthly enrollment through June 2014 for a June enrollment of 8,520. While the plan could not produce reports that required more enrollment for much of the review period, some areas were considered to be *Not Met* because the plan had not yet developed templates or processes during the review period that could be implemented once the enrollment increased.

Appendix D 2014 CAHPS® Health Plan Survey

Measure	Horizon	United	Amerigroup	Healthfirst	New Jersey Medicaid Average	National Medicaid Average
Overall Rating of Health Care						
Adults	88%	81%	83%	83%	84%	92%
Children	93%	88%	94%	94%	92%	92%
D-SNP [1,2]					78%	n/a[3]
Overall Health Plan Satisfaction						
Adults	87%	80%	79%	85%	83%	84%
Children	91%	83%	90%	90%	88%	90%
D-SNP[1,2]					85%	n/a[3]
Overall Personal Doctor Satisfaction						
Adults	95%	91%	87%	93%	91%	87%
Children	92%	93%	96%	95%	94%	93%
D-SNP[1,2]					90%	n/a[3]
Overall Specialist Doctor Satisfaction						
Adults	91%	84%	87%	86%	87%	87%
Children	88%	89%	90%	90%	89%	91%
D-SNP[1,2]					87%	n/a[3]
Overall Rating of Dental Care						
Adults	80%	74%	73%	77%	76%	n/a[3]
Children	87%	87%	81%	89%	86%	n/a[3]
D-SNP[1,2]						n/a[3]

[1] D-SNP is a coordinated care plan for New Jersey residents eligible for both Medicaid and Medicare (Parts A, B and D).
[2] Breakdown by plan are not available for D-SNP measures
[3] National averages are not available for the D-SNP and dental measures

Source: 2014 NJ CAHPS® Survey 5.0 Analysis & Health Plan Comparison Report provided by Xerox, last updated 10/2014.

Appendix E: 2015 HEDIS Performance Measures

Measure	Amerigroup	Horizon	United	Wellcare	New Jersey Medicaid Average [1]	National Medicaid Average
Childhood Immunization: Combination 2	74.5%	72.0%	67.9%	NA	70.9%	73.8%
Childhood Immunization: Combination 3	67.3%	66.9%	61.6%	NA	65.2%	70.4%
Lead Screening in Children (LSC)	76.8%	74.4%	78.1%	NA	76.0%	66.8%
Well-Child Visits in the First 15 Months of Life: 6 or More Visits (W15)	67.1%	71.4%	68.6%	NA	70.0%	58.9%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	79.2%	77.7%	78.4%	NA	78.1%	71.9%
Adolescent Well-Care Visits (AWC)	66.4%	66.1%	58.8%	36.7%	63.7%	50.0%
Breast Cancer Screening (BCS)	49.2%	55.2%	56.1%	NA	54.7%	58.8%
Cervical Cancer Screening (CCS)	61.5%	60.6%	65.0%	22.9%	62.2%	60.2%
Use of Appropriate Medications for People With Asthma (ASM)						
5-11 Years	80.9%	84.7%	86.9%	NA	85.0%	n/a
12-18 Years	78.2%	80.2%	85.6%	NA	81.7%	n/a
19-50 Years	68.8%	77.8%	73.4%	NA	75.7%	n/a
51-64 Years	70.5%	77.2%	72.9%	NA	75.2%	n/a
Overall Rate	75.8%	80.8%	81.7%	NA	80.5%	n/a
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	81.7%	82.3%	84.7%	NA	83.0%	86.3%
HbA1c Poor Control (>9.0%) [2]	41.4%	37.2%	42.6%	NA	39.4%	43.6%
HbA1c Control (<8.0%)	50.5%	54.0%	46.9%	NA	51.4%	46.5%
HbA1c Control (<7.0%) for a Selected Population	38.0%	37.7%	37.0%	NA	37.5%	34.1%
Eye Exam	50.3%	64.1%	54.0%	NA	59.2%	54.4%
Medical Attention for Nephropathy	76.7%	77.4%	79.2%	NA	77.8%	80.9%
Blood Pressure Controlled <140/90 mm Hg	62.5%	62.2%	57.4%	NA	60.8%	61.9%
Controlling High Blood Pressure (CBP)	58.7%	64.6%	46.7%	38.2%	58.3%	57.1%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	81.7%	87.4%	84.2%	87.2%	85.4%	82.4%
Postpartum Care	52.0%	56.8%	61.1%	45.1%	57.6%	61.8%
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	62.5%	65.0%	55.5%	58.7%	61.2%	55.2%
Immunizations For Adolescents (IMA)						
Meningococcal	86.9%	88.3%	82.9%	NA	86.3%	73.4%
Tdap/Td	91.7%	95.9%	91.3%	NA	93.8%	83.7%
Combination 1	84.5%	88.3%	82.1%	NA	85.7%	71.4%
Appropriate testing for children with pharyngitis (CWP)	74.4%	68.8%	76.3%	NA	72.4%	69.5%
Chlamydia Screening (CHL)						
age 16-20	56.7%	40.4%	53.2%	NA	46.7%	51.2%
age 21-24	67.3%	50.6%	59.2%	NA	55.7%	60.1%
Total	61.0%	44.5%	55.7%	NA	50.4%	54.6%
BMI assessment for children/adolescents (WCC)						
age 3 - 11	75.1%	60.1%	54.3%	65.2%	59.8%	n/a
age 12 - 17	71.8%	63.1%	45.1%	NA	58.4%	n/a
Total	73.8%	61.0%	51.1%	57.8%	59.2%	64.0%
Follow up care for children prescribed ADHD medication (ADD)						
Initiation Phase	35.5%	29.2%	37.1%	NA	32.5%	40.1%
Continuation and Maintenance Phase	41.9%	33.8%	42.3%	NA	37.3%	47.5%
Follow-up after hosp. for mental illness [3]						
30 Day Followup	35.1%	16.8%	65.1%	NA	40.1%	63.0%
7 Day Followup	16.2%	8.9%	51.4%	NA	28.2%	43.9%
Adult BMI Assessment (ABA)	86.5%	81.6%	65.8%	NA	76.6%	79.9%

Appendix E: 2015 HEDIS Performance Measures

Measure	Amerigroup	Horizon	United	Wellcare	New Jersey Medicaid Average [1]	National Medicaid Average
Annual Monitoring for Patients on Persistent Medications (MPM)						
ACE Inhibitors or ARBs	88.6%	83.4%	89.1%	NA	85.8%	87.2%
Digoxin [4]	47.1%	52.3%	38.2%	NA	46.4%	54.0%
Diuretics	86.9%	82.8%	88.1%	NA	84.9%	86.9%
Total	87.6%	82.9%	88.2%	NA	85.1%	86.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP)						
12-24 months	95.6%	97.2%	95.9%	NA	96.6%	95.5%
25 months - 6 years	91.2%	93.2%	92.2%	72.7%	92.6%	87.8%
7-11 years	91.1%	95.4%	94.4%	NA	94.6%	91.0%
12-19 years	88.2%	93.0%	92.3%	NA	92.2%	89.3%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	18.5%	22.1%	20.7%	NA	21.2%	22.2%
Med. Mgmnt for People With Asthma						
5-11 Years - 50% Compliance	45.2%	48.7%	52.3%	NA	49.5%	n/a
5-11 Years - 75% Compliance	23.6%	22.6%	25.2%	NA	23.5%	26.6%
12-18 Years - 50% Compliance	44.7%	45.2%	47.5%	NA	45.9%	n/a
12-18 Years - 75% Compliance	22.3%	23.0%	24.1%	NA	23.3%	24.3%
19-50 Years - 50% Compliance	59.3%	58.1%	60.6%	NA	58.9%	n/a
19-50 Years - 75% Compliance	36.4%	34.5%	35.3%	NA	34.9%	35.6%
51-64 Years - 50% Compliance	66.4%	77.9%	77.7%	NA	76.5%	n/a
51-64 Years - 75% Compliance	46.4%	53.8%	54.5%	NA	53.1%	48.2%
Total - 50% Compliance	50.7%	53.0%	54.8%	NA	53.4%	n/a
Total - 75% Compliance	28.7%	28.9%	29.6%	NA	29.1%	30.5%
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)[5]						
Total - <1 Years	714.69	1137.73	775.23	563.26	966.67	
Total - 1-9 Years	340.29	446.26	369.33	301.60	404.28	
Total - 10-19 Years	250.12	314.60	265.97	223.02	288.13	
Total - 20-44 Years	292.99	422.88	355.39	299.95	375.91	
Total - 45-64 Years	509.96	680.85	590.90	612.44	620.44	
Total - 65-74 Years	797.90	729.42	570.75	1068.83	782.65	
Total - 75-84 Years	718.80	657.00	478.68	1251.94	771.51	
Total - 85+ Years	665.64	601.33	229.65	1214.83	636.67	
Total - Unknown Years	0	0	0	0	0	
Total - Total Years	354.25	460.08	378.01	460.81	417.46	
< 1 Year - Dual-Eligibles	0	1066.67	0.0	0	1034.22	
1-9 Years - Dual-Eligibles	0	431.82	444.44	0	433.96	
10-19 Years - Dual-Eligibles	0	0	0	0	0	
20-44 Years - Dual-Eligibles	491.51	381.71	66.54	596.98	504.43	
45-64 Years - Dual-Eligibles	822.17	555.83	120.41	1010.22	811.75	
65-74 Years - Dual-Eligibles	885.65	428.57	46.99	1103.94	902.31	
75-84 Years - Dual-Eligibles	874.32	295.77	36.98	1292.42	948.93	
85+ Years - Dual-Eligibles	829.81	166.67	25.28	1213.70	636.62	
Unknown - Dual-Eligibles	0	0	0	0	0	
Total - Dual-Eligibles	822.52	524.60	49.03	1107.60	822.32	
< 1 Year - Disabled	898.40	1167.20	975.9	146.79	1143.33	
1-9 Years - Disabled	449.65	509.85	504.68	359.79	504.00	
10-19 Years - Disabled	259.17	342.07	292.61	216.71	318.67	
20-44 Years - Disabled	290.22	533.94	365.90	392.84	436.09	
45-64 Years - Disabled	681.26	907.73	823.55	909.07	849.12	
65-74 Years - Disabled	625.56	727.13	665.48	771.90	690.75	

Appendix E: 2015 HEDIS Performance Measures

Measure	Amerigroup	Horizon	United	Wellcare	New Jersey Medicaid Average [1]	National Medicaid Average
75-84 Years - Disabled	527.23	644.31	627.23	777.15	623.13	
85+ Years - Disabled	438.20	586.63	547.14	806.82	558.24	
Unknown - Disabled	0	0	0	0	0.0	
Total - Disabled	467.19	624.34	547.60	640.97	582.65	
< 1 Year - Other Low Income	713.14	1134.73	771.94	570.00	955.48	
1-9 Years - Other Low Income	337.52	441.21	365.22	300.12	398.86	
10-19 Years - Other Low Income	249.56	311.92	264.31	223.36	285.68	
20-44 Years - Other Low Income	291.34	411.19	354.51	279.32	369.34	
45-64 Years - Other Low Income	449.54	603.05	530.94	486.22	548.68	
65-74 Years - Other Low Income	417.53	768.66	545.93	1411.12	884.08	
75-84 Years - Other Low Income	755.10	862.44	594.20	1534.72	1179.11	
85+ Years - Other Low Income	850.00	807.16	142.86	1458.06	1253.50	
Unknown - Other Low Income	0	0	0	0	0	
Total - Other Low Income	330.80	439.09	363.92	333.03	395.51	
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)[5]						
Total - <1 Years	97.71	109.88	84.70	88.60	101.16	
Total - 1-9 Years	50.10	56.40	43.05	47.30	50.93	
Total - 10-19 Years	36.14	43.15	35.27	31.08	39.39	
Total - 20-44 Years	83.36	100.09	73.58	69.71	87.62	
Total - 45-64 Years	69.26	77.36	65.68	59.74	71.62	
Total - 65-74 Years	48.74	33.48	31.66	41.93	39.45	
Total - 75-84 Years	43.13	29.16	32.77	40.66	36.20	
Total - 85+ Years	44.08	30.14	28.40	50.77	37.39	
Total - Unknown Years	0	0	0	0	0	
Total - Total Years	60.33	67.80	52.81	53.82	61.42	
Dual Eligibles - <1 Years	0	0.00	0	0	95.06	
Dual Eligibles - 1-9 Years	0	136.36	0	0	113.20	
Dual Eligibles - 10-19 Years	0	111.11	0	0	71.43	
Dual Eligibles - 20-44 Years	99.00	139.02	43.73	100.70	100.02	
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)[5]						
Dual Eligibles - 45-64 Years	101.26	97.09	62.85	77.40	88.31	
Dual Eligibles - 65-74 Years	57.87	71.43	46.05	42.69	50.76	
Dual Eligibles - 75-84 Years	57.36	14.08	36.30	38.26	44.29	
Dual Eligibles - 85+ Years	60.19	166.67	24.51	45.78	39.39	
Dual Eligibles - Unknown Years	0	0	0	0	0	
Dual Eligibles - Total Years	73.84	114.40	38.18	53.70	60.77	
Disabled - <1 Years	151.52	114.12	106.63	110.09	114.45	
Disabled - 1-9 Years	68.34	71.25	73.04	53.88	71.28	
Disabled - 10-19 Years	48.97	60.76	55.32	50.25	57.93	
Disabled - 20-44 Years	103.31	145.48	103.30	100.13	123.89	
Disabled - 45-64 Years	108.43	131.01	113.58	104.94	121.90	
Disabled - 65-74 Years	30.78	33.01	28.79	28.96	30.99	
Disabled - 75-84 Years	25.38	28.06	31.67	31.02	28.88	
Disabled - 85+ Years	22.96	29.35	34.67	47.08	31.07	
Disabled - Unknown Years	0	0	0	0	0	
Disabled - Total Years	86.37	100.80	88.17	80.71	95.00	
Other Low Income - <1 Years	97.26	109.45	84.34	88.38	100.36	
Other Low Income - 1-9 Years	49.64	55.22	42.14	47.13	49.83	
Other Low Income - 10-19 Years	35.34	41.43	34.02	30.08	37.90	
Other Low Income - 20-44 Years	81.05	95.28	70.71	66.00	83.87	

Appendix E: 2015 HEDIS Performance Measures

Measure	Amerigroup	Horizon	United	Wellcare	New Jersey Medicaid Average [1]	National Medicaid Average
Other Low Income - 45-64 Years	57.46	58.93	52.78	47.93	56.27	
Other Low Income - 65-74 Years	10.31	37.85	44.62	71.34	45.46	
Other Low Income - 75-84 Years	81.63	46.13	14.49	82.20	63.44	
Other Low Income - 85+ Years	0	38.57	0	81.06	66.71	
Other Low Income - Unknown Years	0	0	0	0	0	
Other Low Income - Total Years	57.40	63.57	49.66	51.21	57.72	

[1]Weighted average, uses all MCO data.

[2] HBA1c Poor control is an inverted measure.

[3] Follow-up After Hospitalization is only applicable for the DDD population

[4] AGNJ, HNJH, and UHC reported significant decreases in the rate for the measure Annual Monitoring for Patients on Persistent Medications – Digoxin. The NCQA specification was changed to no longer allow a blood urea nitrogen therapeutic monitoring test to count as evidence of annual monitoring of kidney function. The HEDIS percentiles had similar decreases for this measure.

[5] The eligible population for the AMB measure is the reported member months. AGNJ, Horizon, and WellCare reported unaudited rates for the subpopulation results

Designation NA: Plan had less than 30 members in the denominator.

Designation n/a: National Medicaid Average not avaialble

Sources: NJ plan and Medicaid average from IPRO, NJ's External Quality Review Organization

National Medicaid Average from NCQA State of Healthcare Quality

New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NJ FAMILYCARE
Affordable health coverage. Quality care.