NJ FamilyCare / Medicaid

HMO Performance Report

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

2010

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

December 2011

Dear Stakeholders:

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

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

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

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

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

We hope that you find this information useful.

Jennifer Velez, Esq.
Commissioner
New Jersey Department of Human Services

Valerie Harr
Director
Division of Medical Assistance and Health Services
New Jersey Department of Human Services

Table of Contents

Page

I. Introduction 3

II. Quality Measures Used in This Report 4

III. The Assessment of Health Plan Operations 5

IV. Health Plan Overall HEDIS Ratings at a Glance 8

V. CAHPS® – Consumer Assessment of Healthcare Providers and Systems 16

VI. Reports from the Health Plans on Best Practices 24

I. Introduction

The Division of Medical Assistance and Health Services (DMAHS) administers the state- and federally- funded NJ FamilyCare/Medicaid program for approximately 1.3 million low- to moderate- income adults and children on a budget of approximately $11 billion.

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

As of this writing, 98% of Medicaid beneficiaries are enrolled in a managed care plan. A small number of beneficiaries remain in Medicaid fee-for-service, e.g. nursing home residents and children in out-of-state placements. In 2010, four health plans contracted with the State of New Jersey, Department of Human Services to serve Medicaid and NJ FamilyCare enrollees. These included AmeriChoice[1], AMERIGROUP New Jersey (Amerigroup), Healthfirst Health Plan of NJ (Healthfirst), and Horizon NJ Health (Horizon).

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

Health Plan enrollments were as follows as of December 2010:

HMO	Enrollment
AmeriChoice (UHCCP)	355,382
Amerigroup	131,164
Healthfirst	22,991
Horizon	471,775
TOTAL:	981,312

New Jersey's Medicaid managed care organization (MCO) market experienced more stability in 2010 than in 2009. There were no entries or exits by managed care plans.

Most of New Jersey's health plans hold Medicaid managed care contracts in other states and/or represent Medicare and commercial product lines. All of the four health plans intend to contract with the Department under a separate Dual Eligible Special Needs Plan (D-SNP) arrangement to be implemented beginning in January 2012.

This report contains information on how well the health plans served New Jersey's NJ FamilyCare/Medicaid clients in 2009/2010. It presents information on the quality of health plan performance, both with the care provided to clients and internal operations. In addition, it reports on enrollees' level of satisfaction with their health plan.

[1] AmeriChoice assumed the brand name UnitedHealthcare Community Plan (UHCCP) in January 2011.

II. Quality Measures Used in This Report

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

EQRO Assessment

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

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

HEDIS® - Healthcare Effectiveness Data and Information Set Performance Measures

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

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

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

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

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

[2] Healthfirst entered the New Jersey Medicaid managed care program in August 2009 and was unable to report a full year of quality measures. Healthfirst completed its first comprehensive Annual Assessment in 2010. CAHPS and HEDIS measures were not captured for 2010 due to a lag in data collection as the health plan prepared for full operation, but will be part of the 2011 CAHPS and HEDIS surveys for the 2011 HMO Performance Report. Healthfirst is represented in the Best Practices section of this report.

III. The Assessment of Health Plan Operations

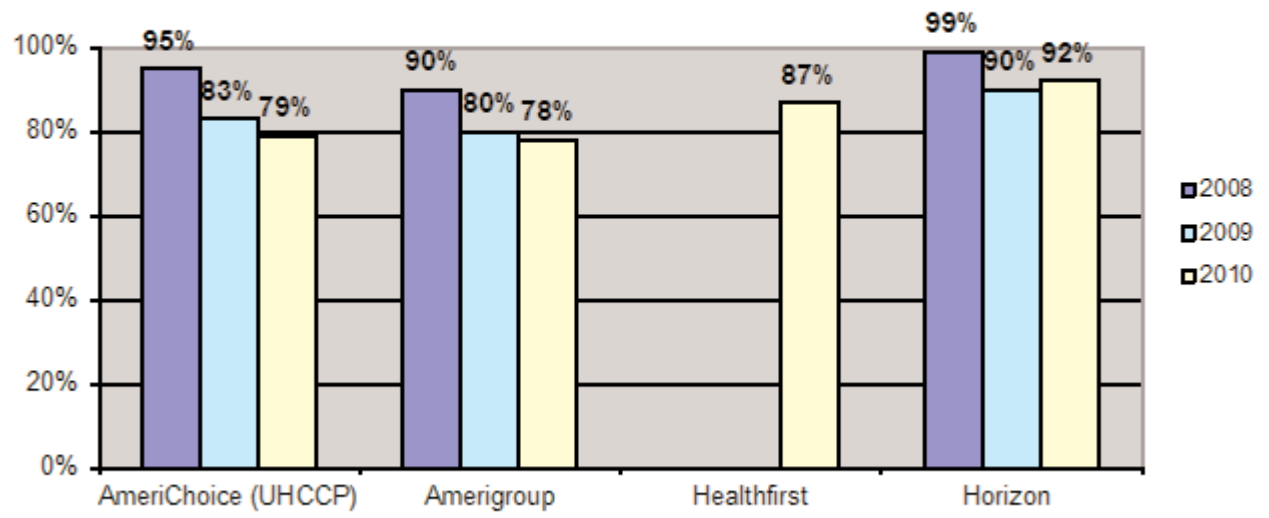
In 2008, 2009, and 2010, MPRO conducted an Assessment of Health Plan Operations to determine how well each health plan implemented contractual requirements. These reviews provide an evaluation of each health plan's operational systems over a twelve month period. MPRO reviewed fourteen categories in 2010:

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

The Assessment of Health Plan Operations process allows a one-year break from full review for health plans that meet a minimum compliance rate of 85 percent. Year 1, which involved a comprehensive review of all requirements for all health plans (including an on-site visit and file review) is considered the baseline year. Health plans with a compliance score of less than 85 percent undergo a comprehensive review of all requirements in the succeeding year. Health plans with compliance scores of 85 percent or better are subject to an interim review focusing on areas requiring improvement—specifically those review elements that were Not Met or Not Applicable during the comprehensive review. Note that the prior year's review included a rating category called "Partially Met" that was discontinued for the 2010 reporting year. The new compliance rating categories include "Met," "Not Met," and "Not Applicable." If a health plan has a partial review, it will have a comprehensive review the following year regardless of the findings of the partial review. Health plans that receive a comprehensive review and subsequently attain a compliance rating of 85 percent or better will have a partial review the following year. Health plans that attain a compliance rating below 85% will continue to have comprehensive reviews. In addition, the Medicaid managed care program requests corrective action plans to address inadequate performance.

This report contains the overall compliance scores of each health plan reported in 2008, 2009, and 2010, as determined by MPRO. While overall compliance with Medicaid managed care contract requirements remains high, compliance rates—as determined by MPRO—continued on a slight three-year downward trend. Substandard performance for all four plans was concentrated in provider credentialing and training processes.

2008 - 2010 Annual Assessment of Operations - Overall Compliance Scores by Health Plan



MPRO evaluated each health plan on the following indicators[3] to determine compliance with performance standards required by contract:

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

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

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

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

[3] MPRO (Michigan Peer Review Organization). 2010.

✔ Programs for the Elderly and Disabled

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

✔ Provider Training and Performance

The Provider Training and Performance review category is designed to ensure providers receive proper training in managed care and the health plan's policies and procedures. The health plan also must have mechanisms to monitor, evaluate, and report provider performance and adherence to specified requirements, including processes for intervening when providers do not meet the standards.

✔ Satisfaction

The Satisfaction review category is designed to evaluate member satisfaction with contractor services, including mechanisms for acting on identified areas of member dissatisfaction.

✔ Enrollee Rights and Responsibilities

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

✔ Care Management and Continuity of Care

The Care Management and Continuity of Care review category evaluates whether the health plan has an effective care (and case) management service structure and has processes in place to provide services to all enrollees who could benefit from them. The health plan also must have the capacity to offer a higher level of care management for enrollees identified as having special needs; further, it must ensure the continuity, collaboration, coordination, and management of an enrollee's health care by participating providers, including development of a treatment plan.

✔ Credentialing and Recredentialing

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

✔ Utilization Management

The Utilization Management review category addresses activities involved in planning, organizing, directing, and controlling health care services by comparing them with established guidelines and criteria.

✔ Administration and Operations

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

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

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

IV. Health Plan Overall HEDIS Ratings at a Glance

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

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

The charts on the following pages provide a comparison of each health plan's HEDIS performance ratings in these areas for 2010.

New Jersey Medicaid health plans outperformed the National Medicaid Average on most indicators. However, there are differences in performance among the health plans and not all perform equally across all categories. Areas for improvement were identified for each plan evaluated. Across the three HEDIS-evaluated plans, women's reproductive health care revealed a clear need for improvement.

Chart 1. **Childhood Immunization Status:** Percentage of children who by the time they turned two had the recommended number of vaccines – Combination 2.

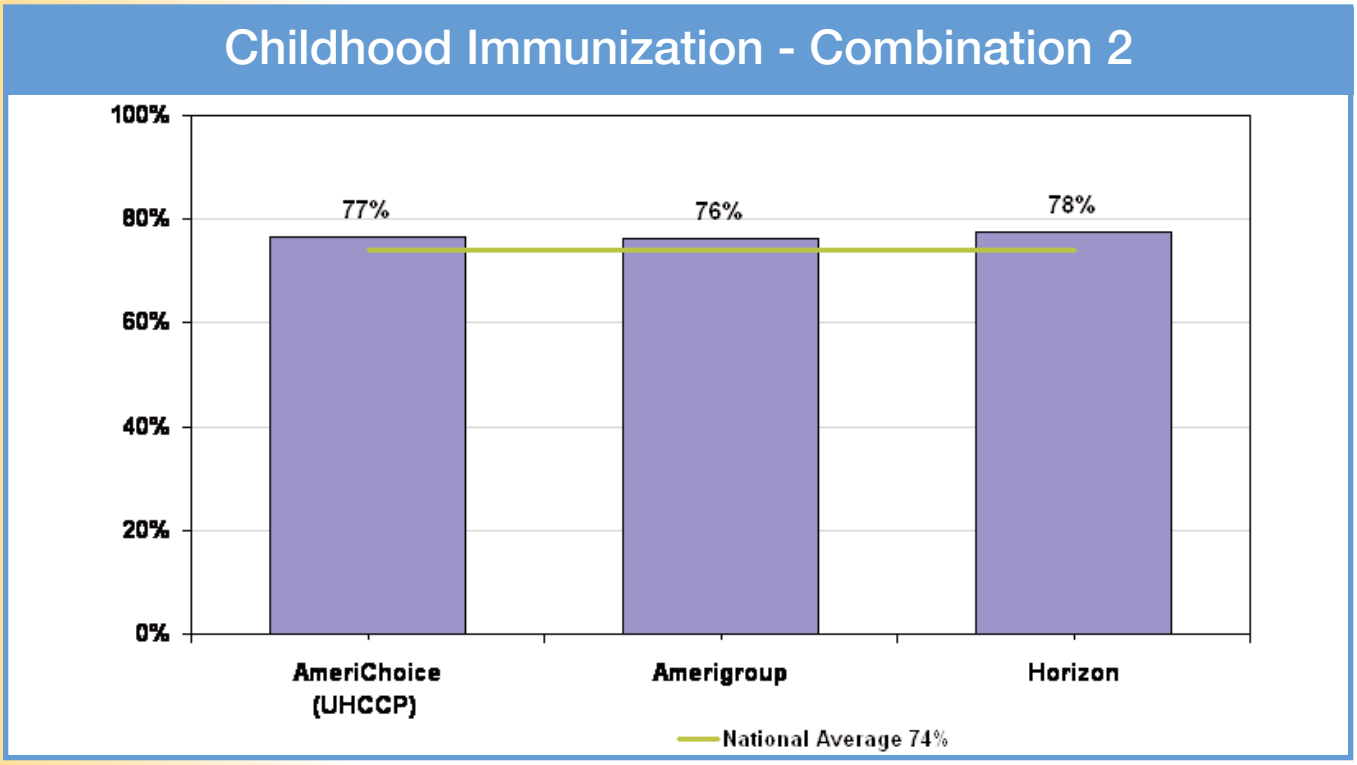


Chart 2. **Well-Child Visits:** Percentage of children who had six or more well-child visits in the first 15 months of life.

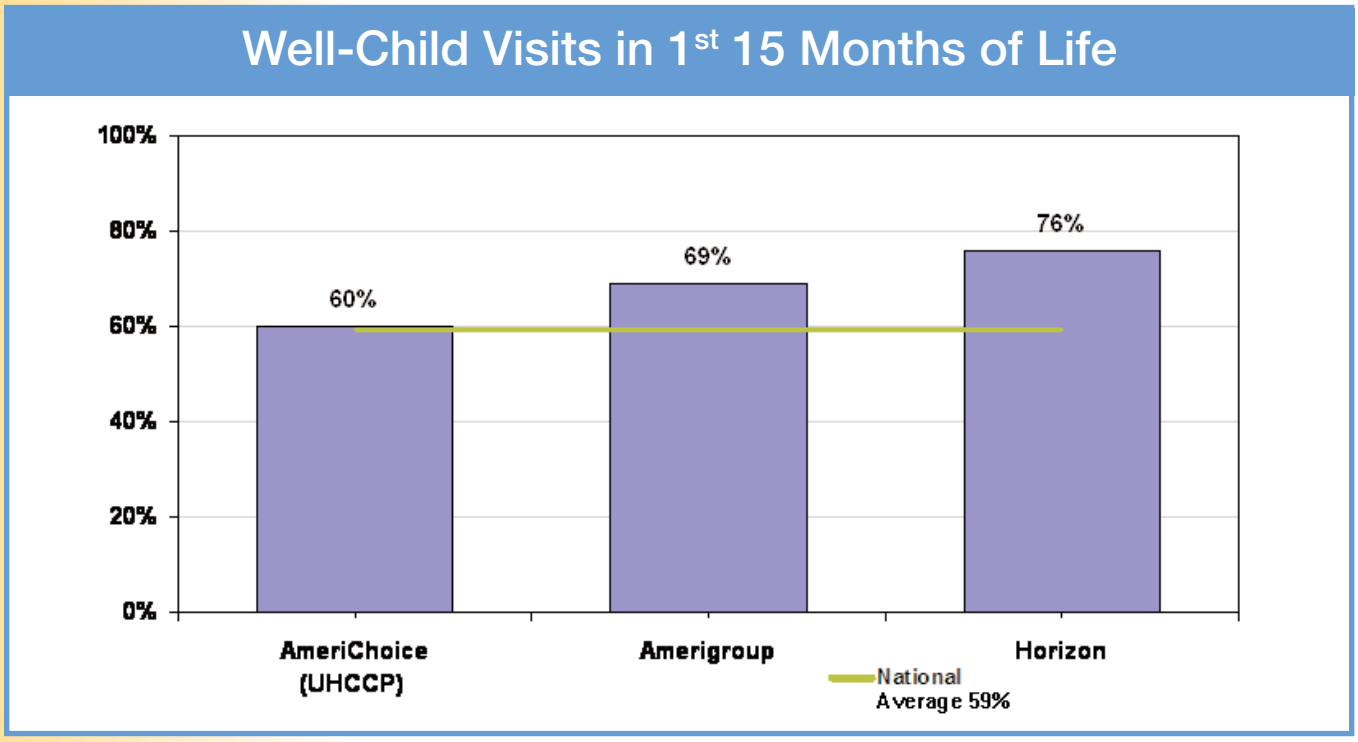


Chart 3. Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life: Percentage of three—six-year-olds who had one or more well-child visits during the measurement year.

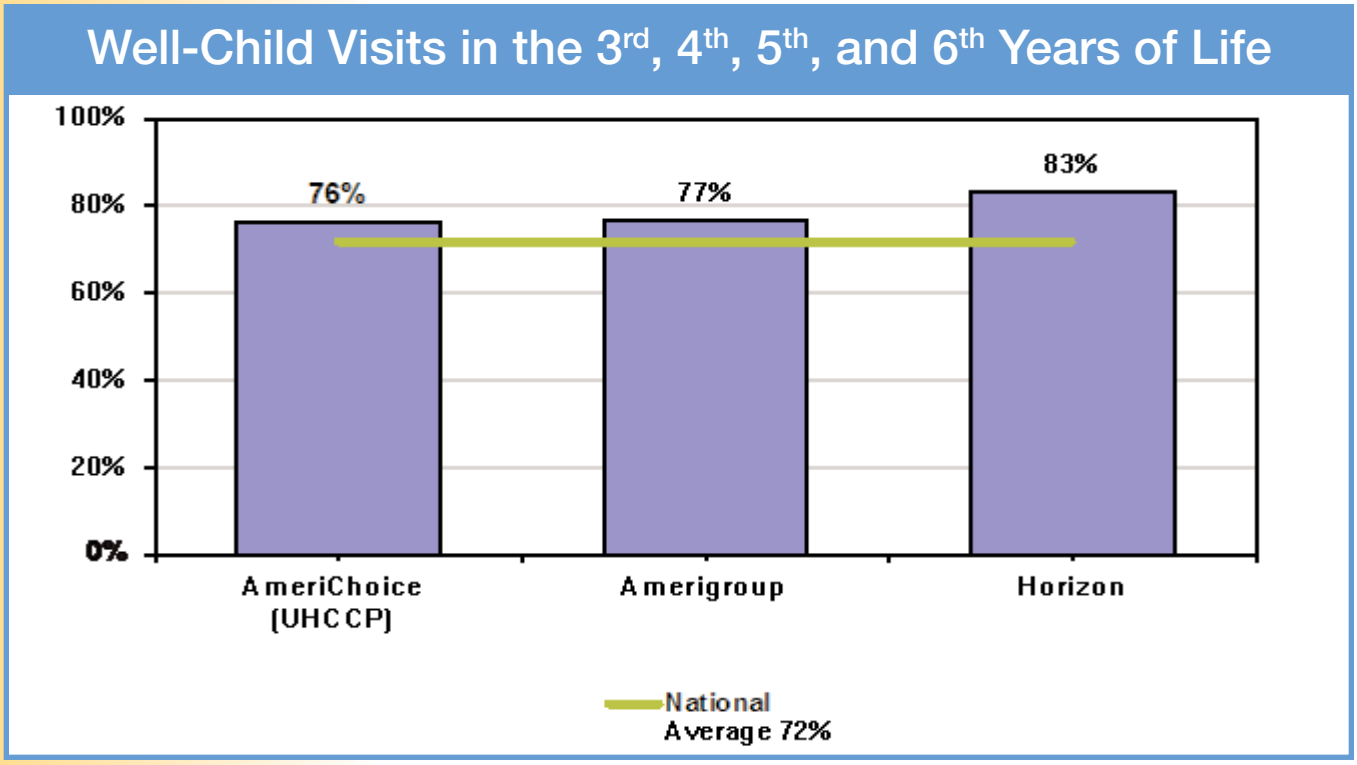


Chart 4. Adolescent Well-Care Visits: Percentage of adolescents 12-21 years of age that had at least one well-care visit during the measurement year.

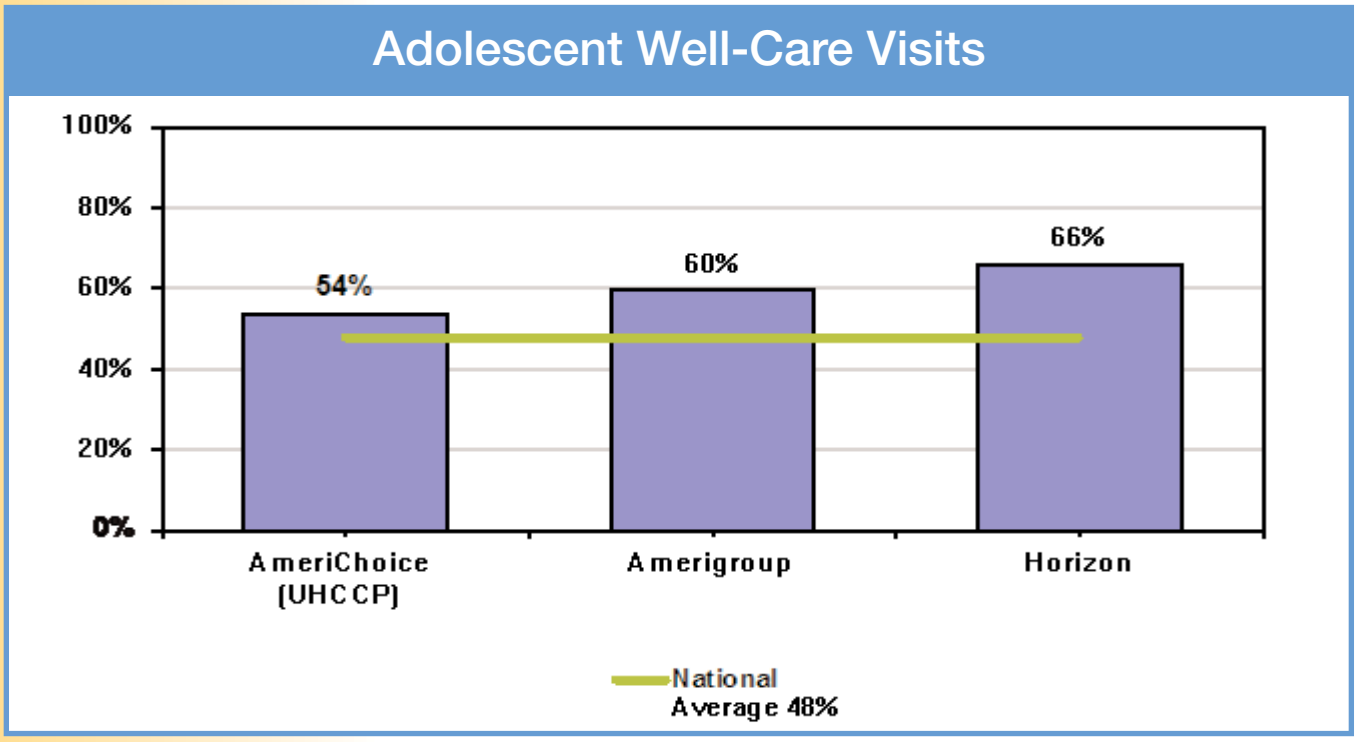


Chart 5. Lead Screening in Children: Percentage of children who received at least one lead screening test on or before their second birthday.

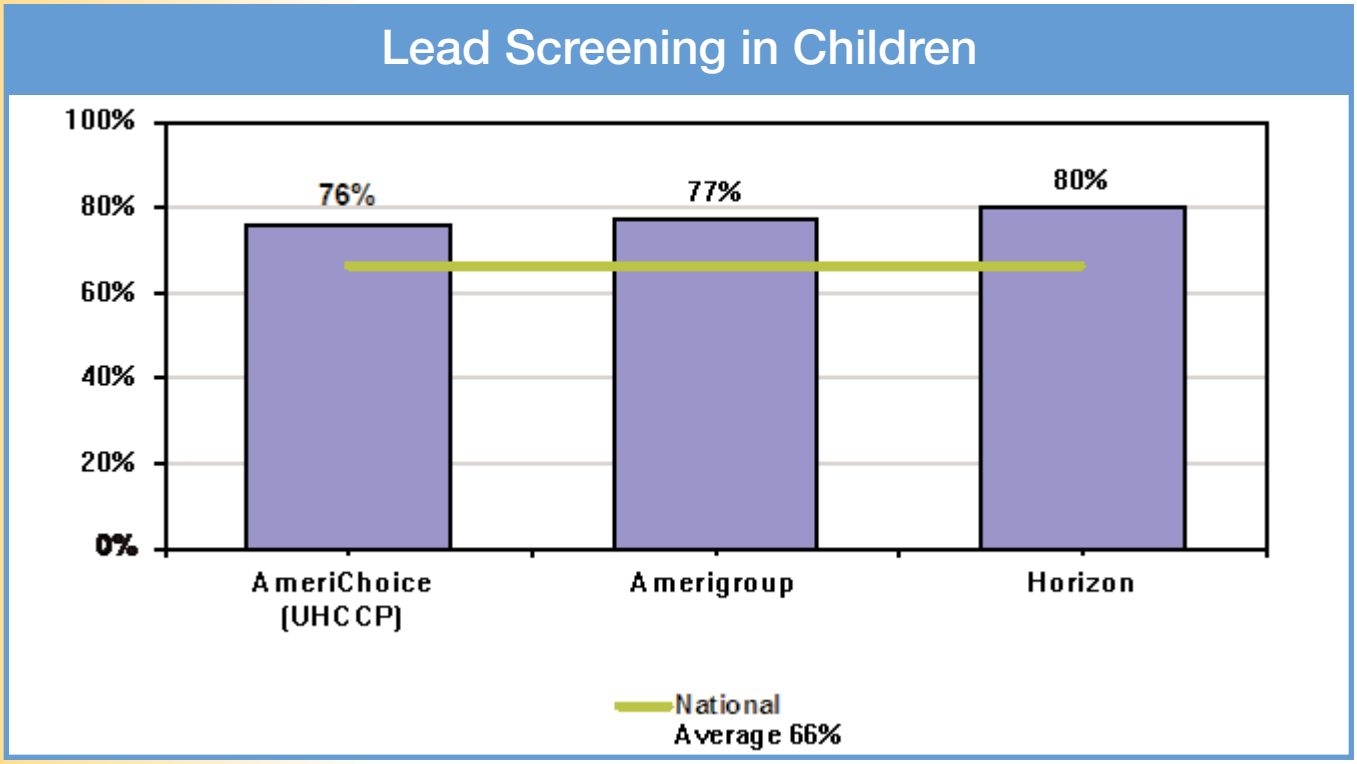


Chart 6. Prenatal Care: Percentage of women who had a prenatal visit within first trimester (or within 42 days of enrollment).

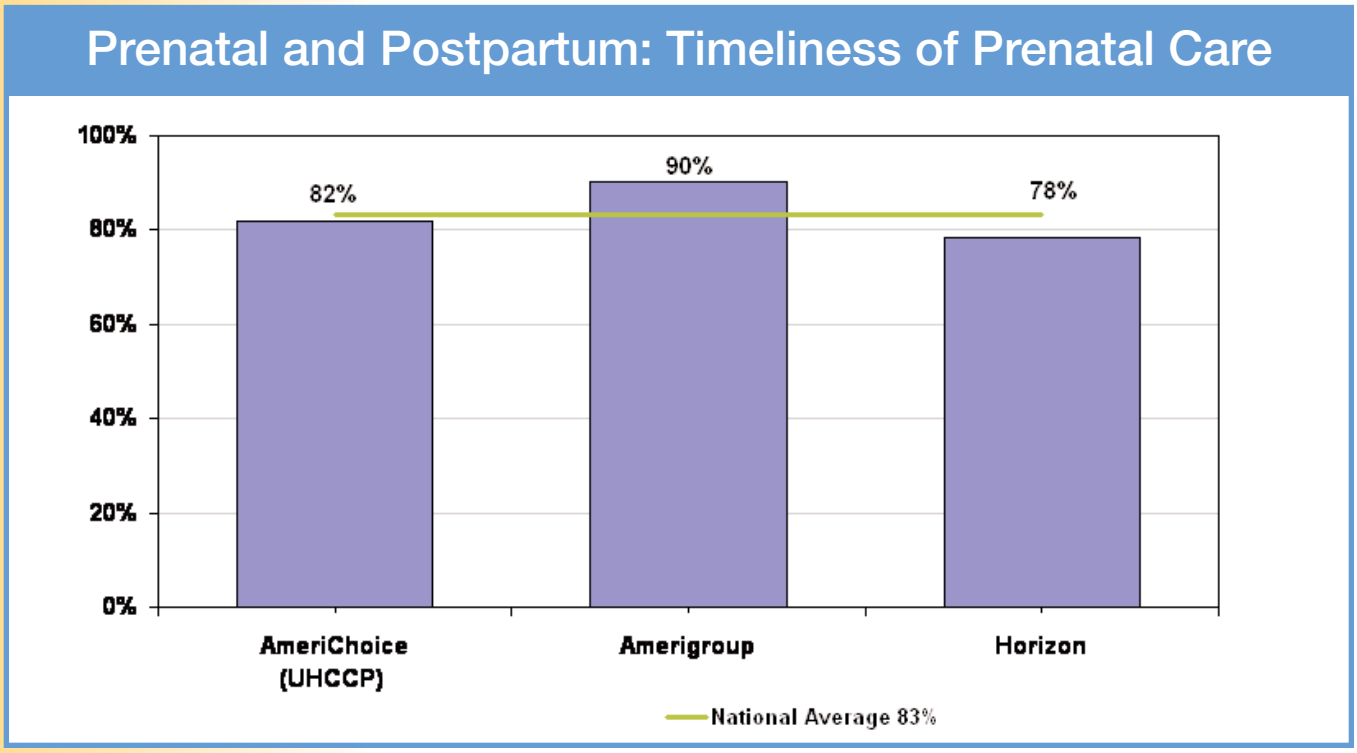


Chart 7. Postpartum Care: Percentage of women who had a postpartum visit between 21 and 56 days after delivery.

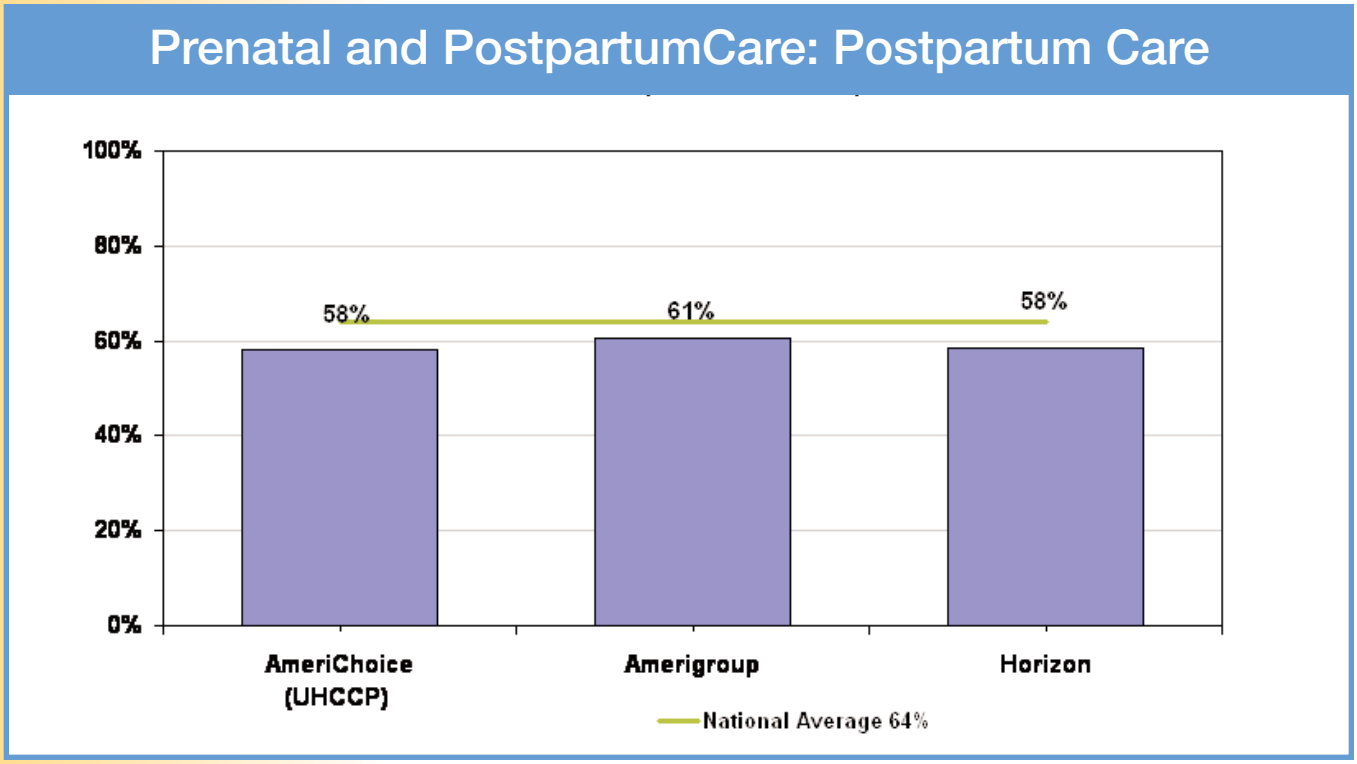


Chart 8. Breast Cancer Screening: Percentage of women who had a mammogram in the measurement year or the prior year.

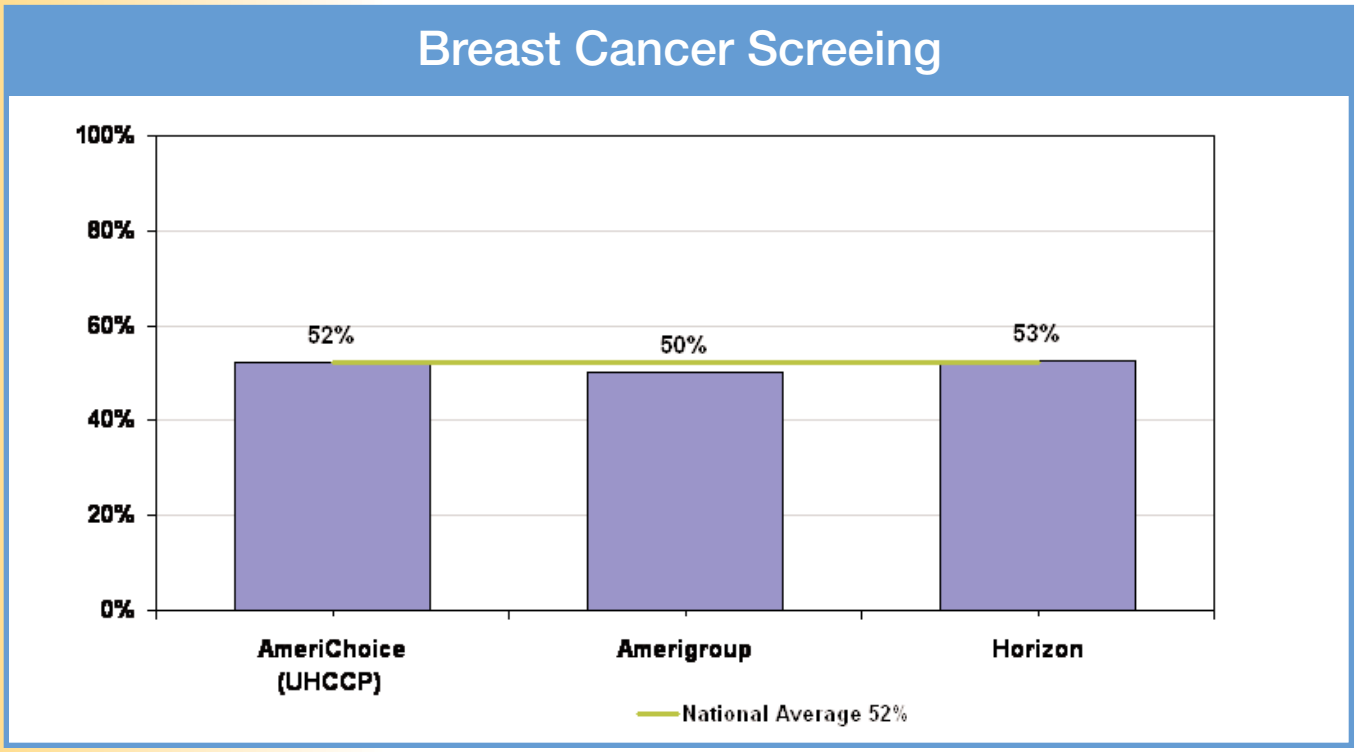


Chart 9. Cervical Cancer Screening: Percentage of women who had a PAP test within the measurement year or the prior two years.

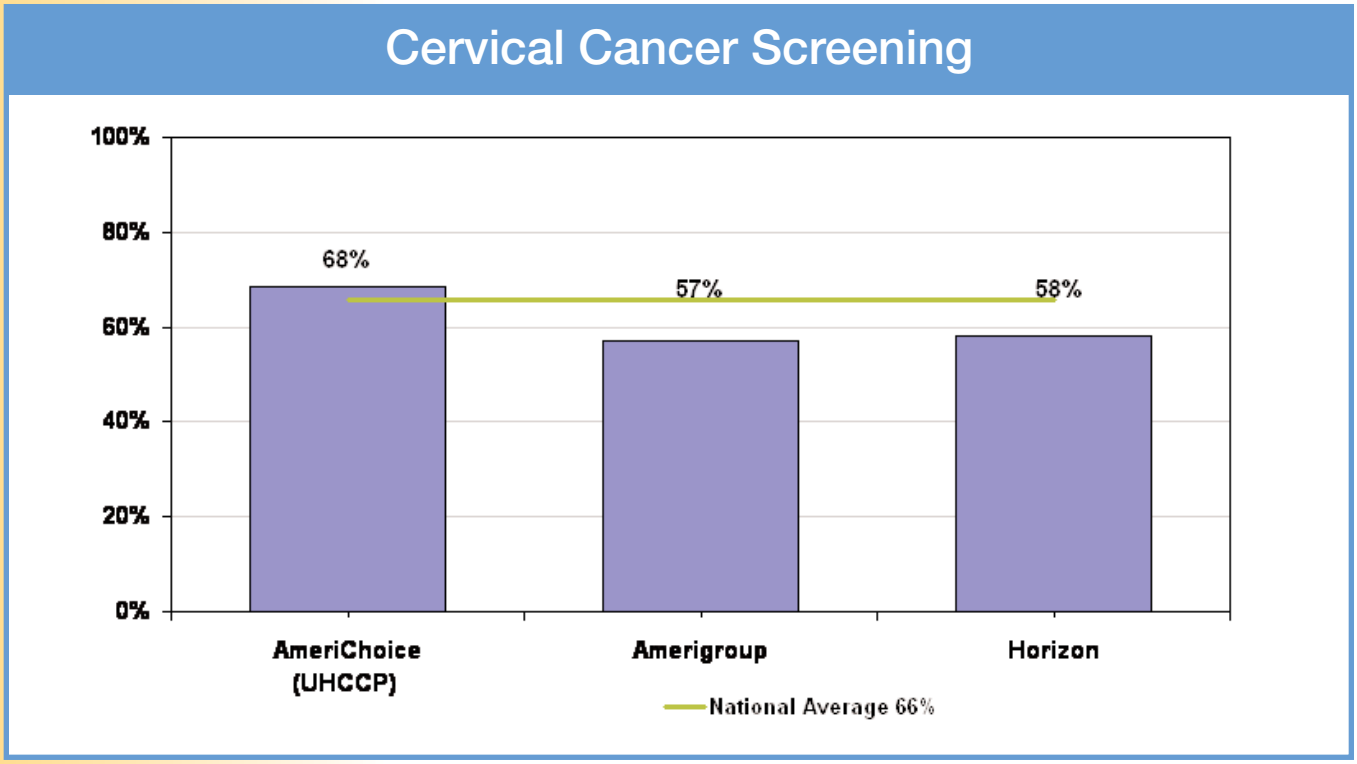


Chart 10. Asthma Care: Percentage of members 5-56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

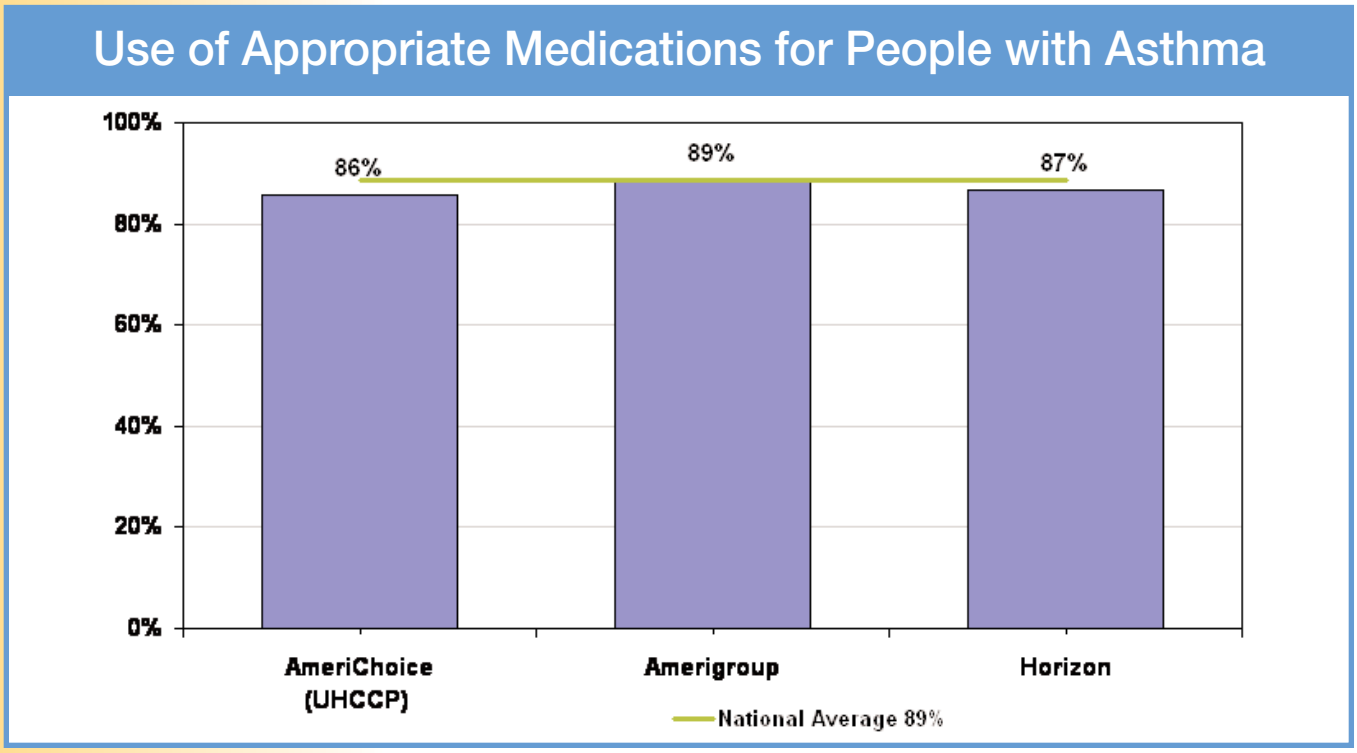


Chart 11. **Comprehensive Diabetes Care:** Percentage of individuals with diabetes who had yearly HbA1c testing.

Comprehensive Diabates Care: HbA1c Testing

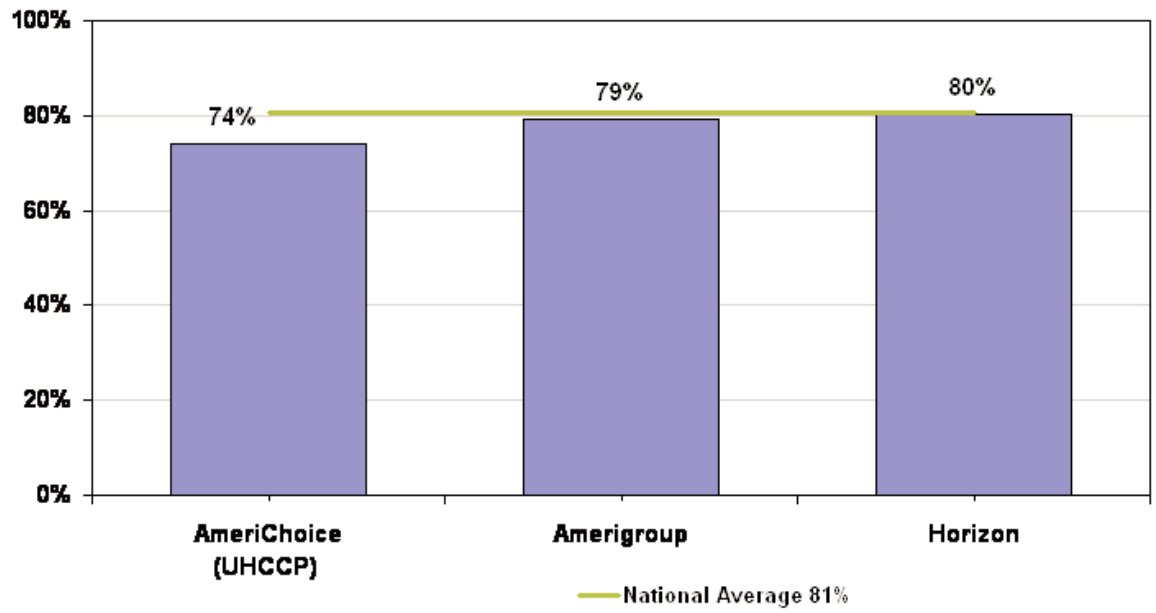


Chart 12. **Comprehensive Diabetes Care:** Percentage of individuals with diabetes with poor control – HbA1c result > 9 (Unlike other HEDIS measures, HbA1c Poor Control is written in a way that a lower rate is ideal).

Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

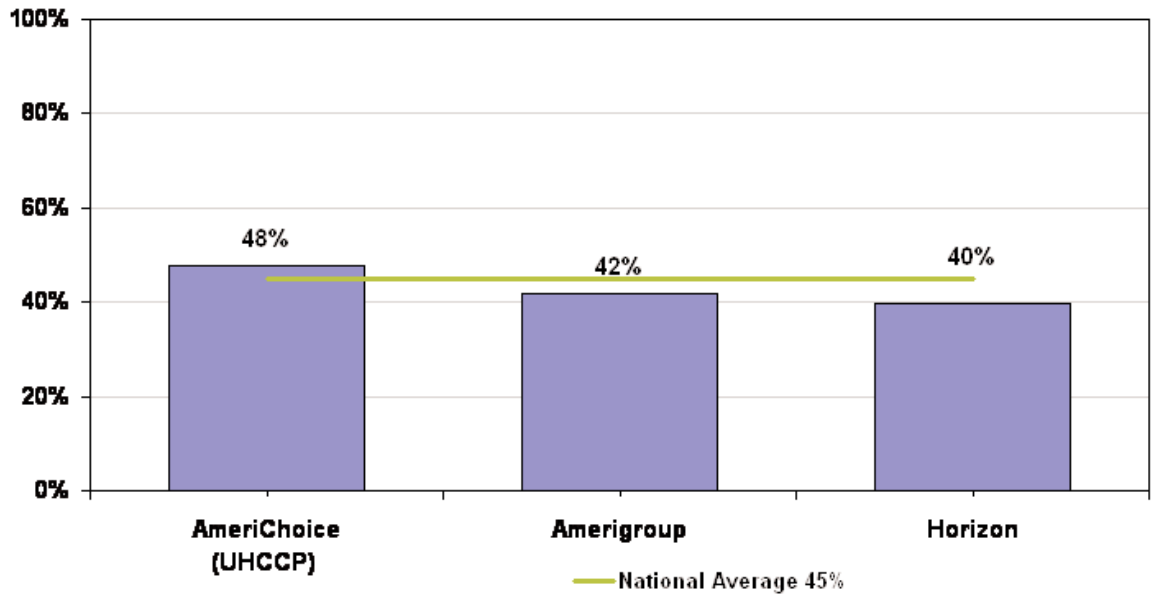


Chart 13. Comprehensive Diabetes Care – Eye Exams: Percentage of individuals with diabetes who had a yearly retinal eye exam.

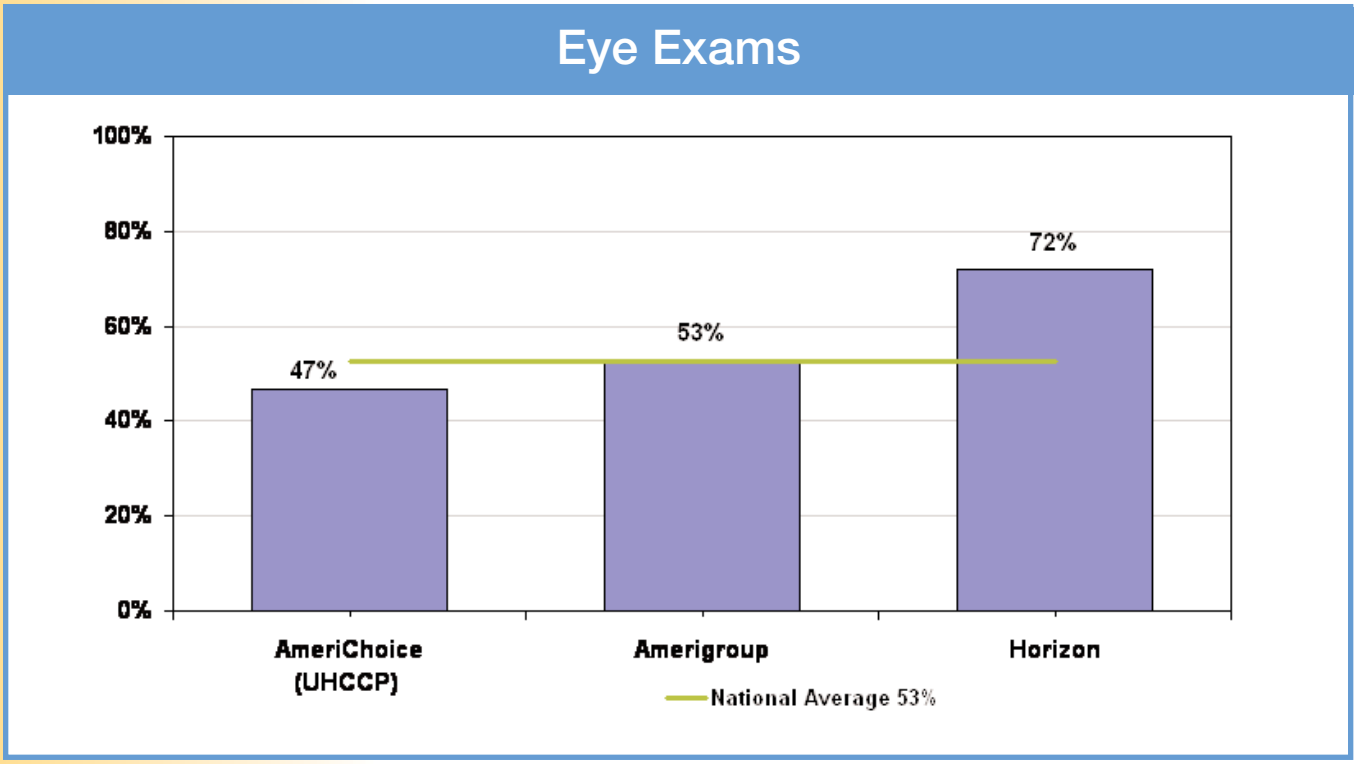


Chart 14. Comprehensive Diabetes Care – LDL-C Screening: Percentage of individuals with diabetes who had a yearly LDL-C screening.

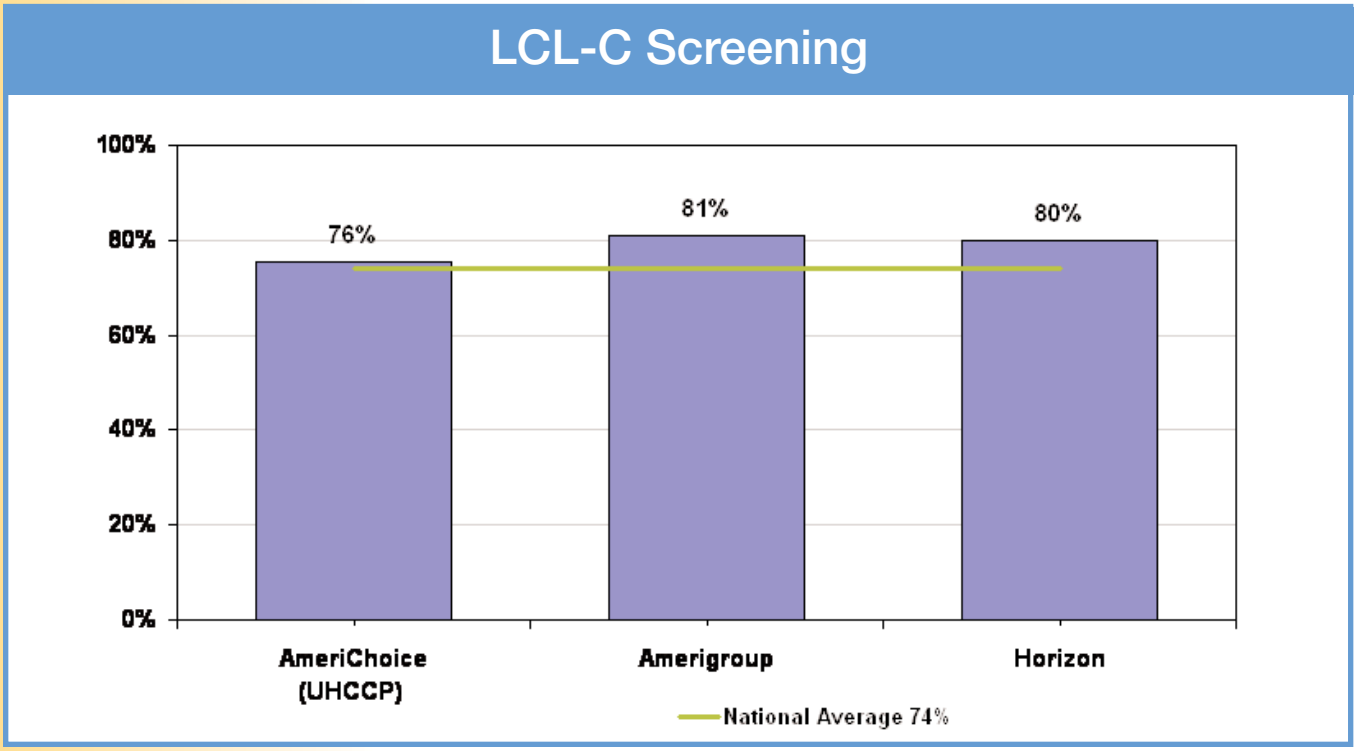
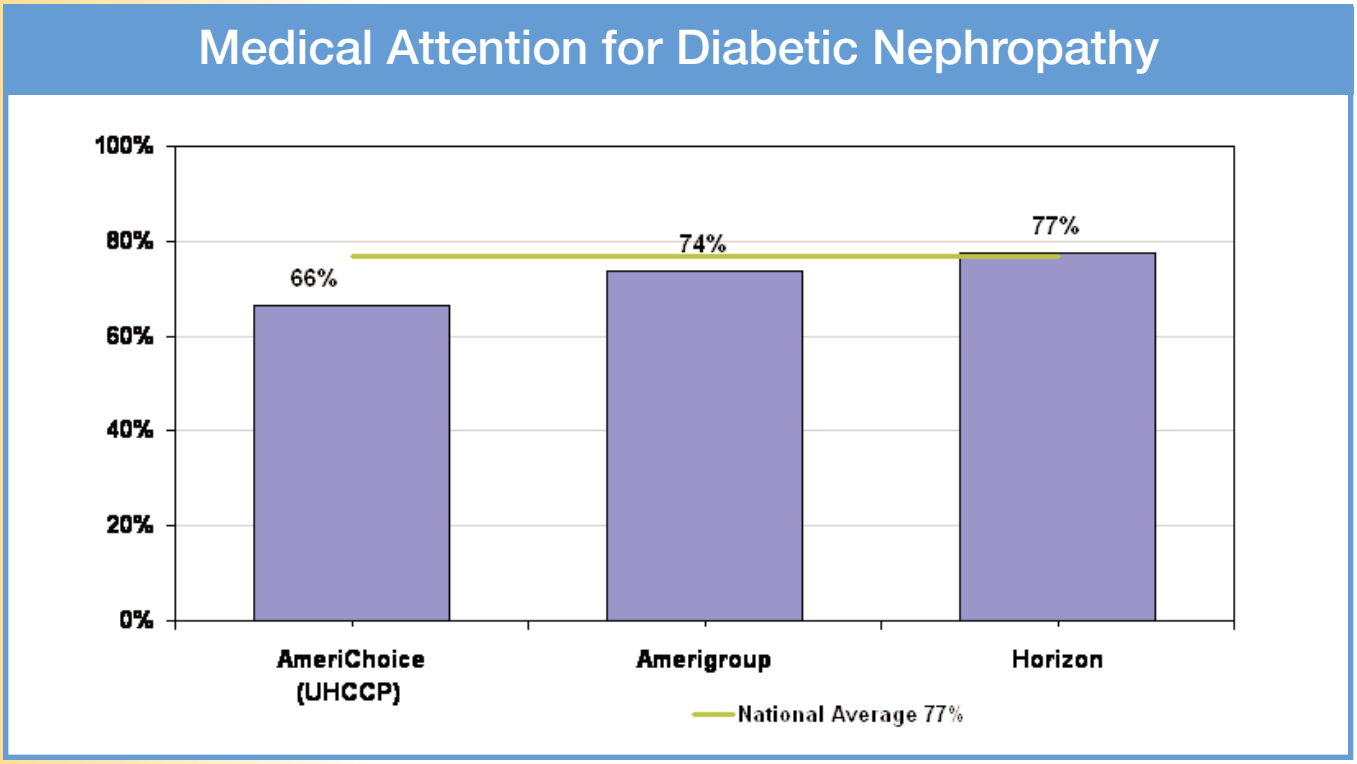


Chart 15. Comprehensive Diabetes Care – Diabetic Nephropathy: Percentage of individuals with diabetes who had a yearly screening or medical attention for nephropathy.



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

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

The following pages are a subset of the many areas measured by the CAHPS® survey, conducted with a sample of New Jersey's Medicaid managed care population in 2010. The survey tool provides members' overall ratings of their own or their children's health plans, as well as detailed comparison charts for how health plan members rated their care or their child's care in the following areas:

Specific CAHPS measures used in this report:

- Overall Rating of Health Care
- Getting Needed Care Quickly
- Overall Rating of Personal Doctor
- Overall Rating of Specialists
- Rating of Customer Service Responsiveness
- Dental Visits in Last 6 Months

- Overall Rating of Dental Care
- Coordination of Care from Other Health Providers
- Ease of Getting Mental Health Treatment or Counseling
- Overall Rating of Mental Health Care
- Number of Emergency Room Visits to Get Health Care.

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

Below are the overall ratings that members gave their own health plan and their children's health plan in 2010. The chart illustrates the percentage of 1,268 respondents giving a rating of 7 – 10 on a scale of 0 -10, where 0 is the worst health plan possible and 10 is the best health plan possible.

Enrollees who responded to the survey indicated high overall ratings of their health plans, health status, and health care received from contracted providers. This marks a slight decline from 2009 and 2010 in ratings by adults of their own health care and an improvement in the ratings given by adults for their children's health care.[4]

Members' Overall Rating of Their Own Health Plan

Health Plan	Satisfied (7-10 Rating)	Overall NJ Medicaid Managed Care Prog. Satisfaction (7-10 Rating)	Percentage Point Difference
AmeriChoice (UHCCP)	73%	74%	-1%
Amerigroup	73%	74%	-1%
Horizon	75%	74%	+1%

[4] ACS Government Healthcare Solutions. 2010. 2010 CAHPS® *Health Plan Survey 4.0 Part 2: Health Plan Comparison Report.* Page 2. Hamilton, NJ: ACS."

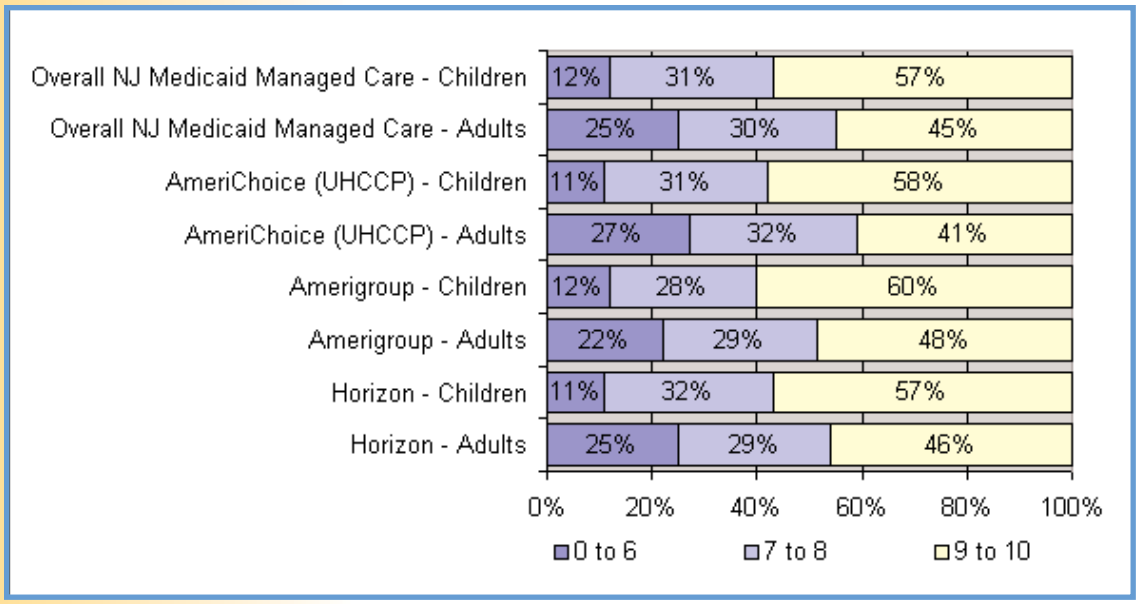
Members' Overall Rating of Their Child's Health Plan

Health Plan	Satisfied (7-10 Rating)	Overall NJ Medicaid Managed Care Prog. Satisfaction (7-10 Rating)	Percentage Point Difference
AmeriChoice (UHCCP)	80%	80%	0%
Amerigroup	79%	80%	-1%
Horizon	83%	80%	+3%

Additionally, 76% of New Jersey Medicaid adult aged, blind or disabled (ABD) members surveyed were satisfied with their health plans; among satisfied ABD members, 54% rated their health plans a 9 or 10, indicating the best plan possible. Plans received a greater share of highly satisfied ratings for care delivered to children enrolled in ABD Medicaid; 83% of parents surveyed ranked their child's plan as good or best where 64% of parents rated their own health plan as the best possible.

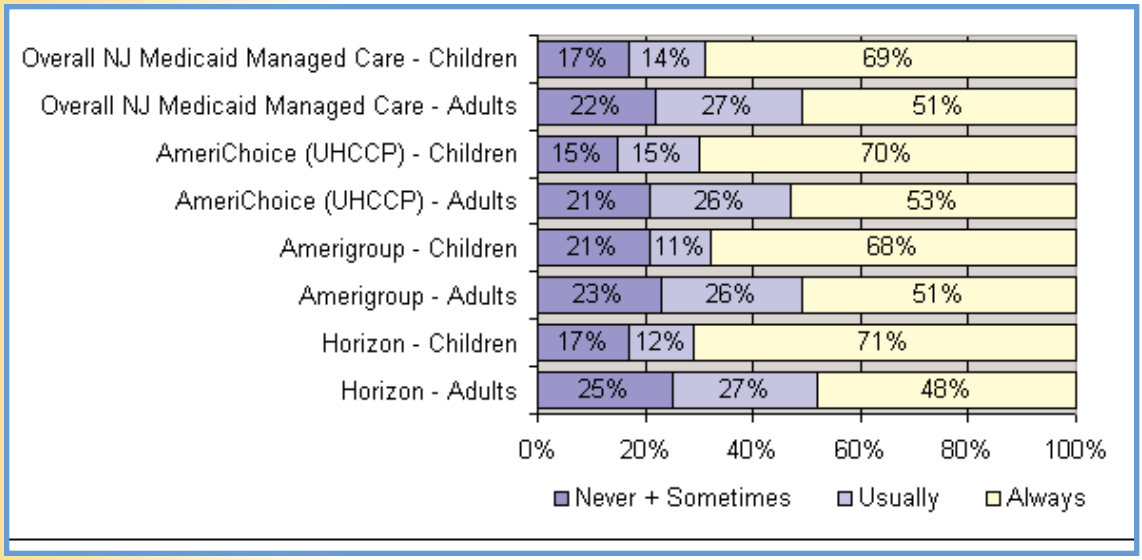
Health Net left the New Jersey NJ FamilyCare/Medicaid market in 2010. CAHPS® Survey data was collected on HealthNet, but is not reported here. Though Health Net's ratings are included in the Overall Medicaid Managed Care Program category data, they are omitted from the individual plan reports. Overall program ratings are slightly different than they would be if calculated from the ratings of AmeriChoice (UHCCP), AMERIGROUP, and Horizon NJ Health alone.

Chart 1. Overall NJ Medicaid Managed Care - Children



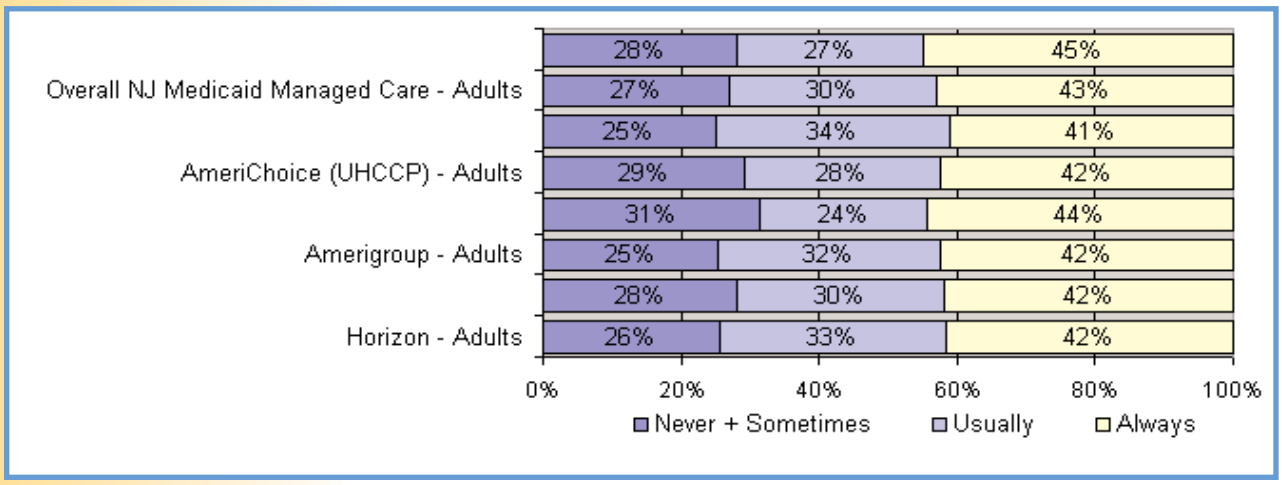
On a scale of 0-10, where 10 is best, how did respondents rate their overall health care in the last six months?

Chart 2. Getting Needed Health Care



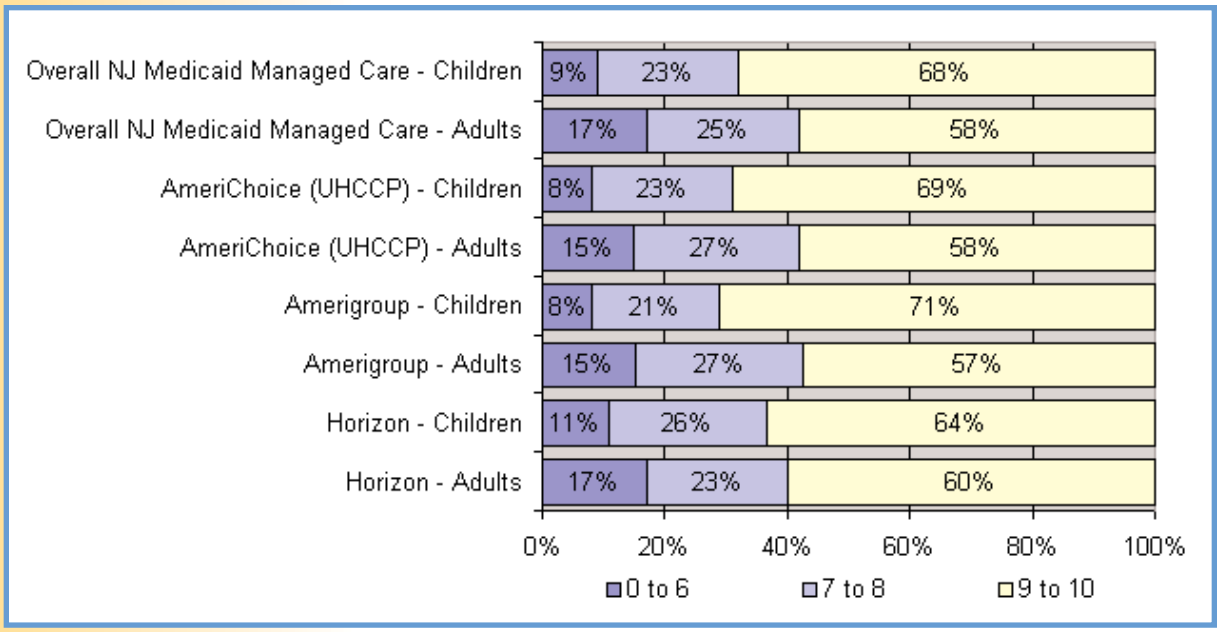
How often did respondents report getting needed care or an appointment quickly in the last six months?

Chart 3. Getting Needed Care from Specialists



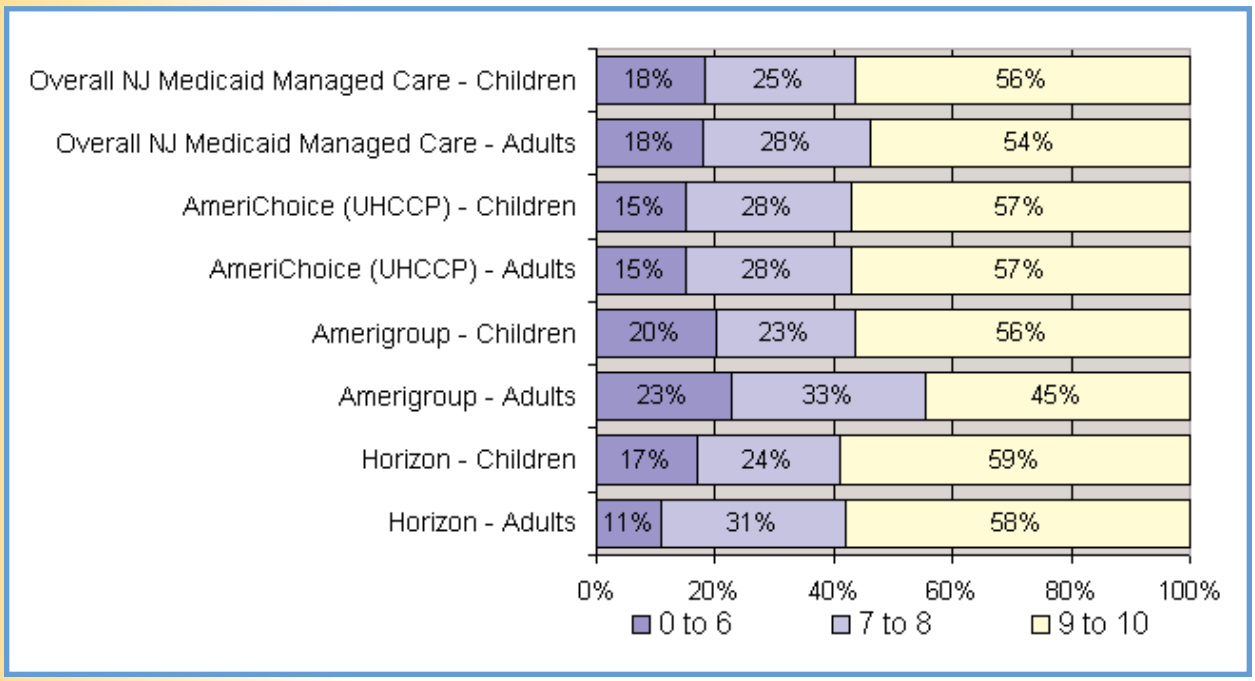
How easy was it for respondents to get needed care from specialists in the last six months?

Chart 4. Rating of Personal Doctor



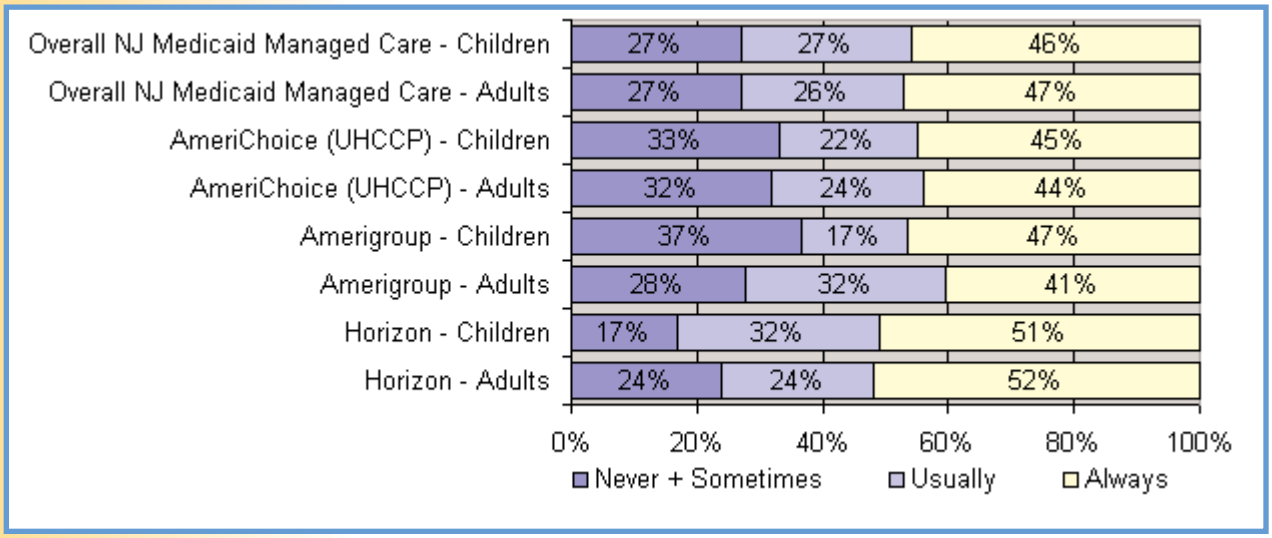
On a scale of 0-10, where 10 is the best, how did respondents who reported having a personal doctor rate that doctor?

Chart 5. Overall Rating of Specialists



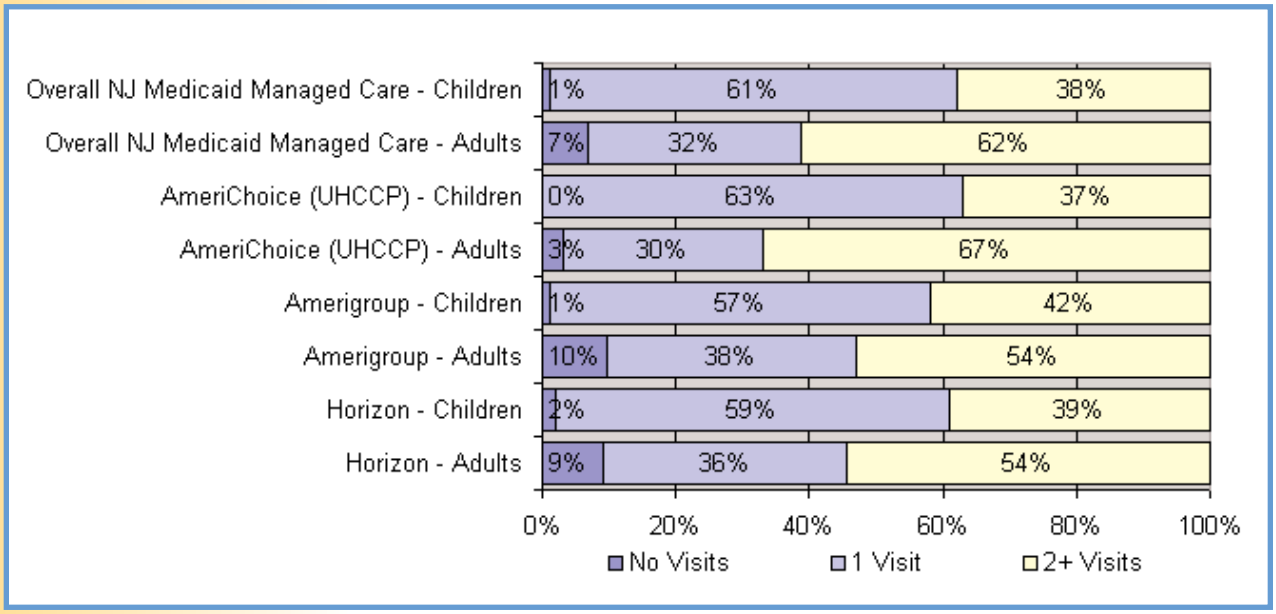
On a scale of 0-10, where 10 is the best, how did respondents who reported seeing a specialist rate that specialist?

Chart 6. Rating of Customer Service Responsiveness



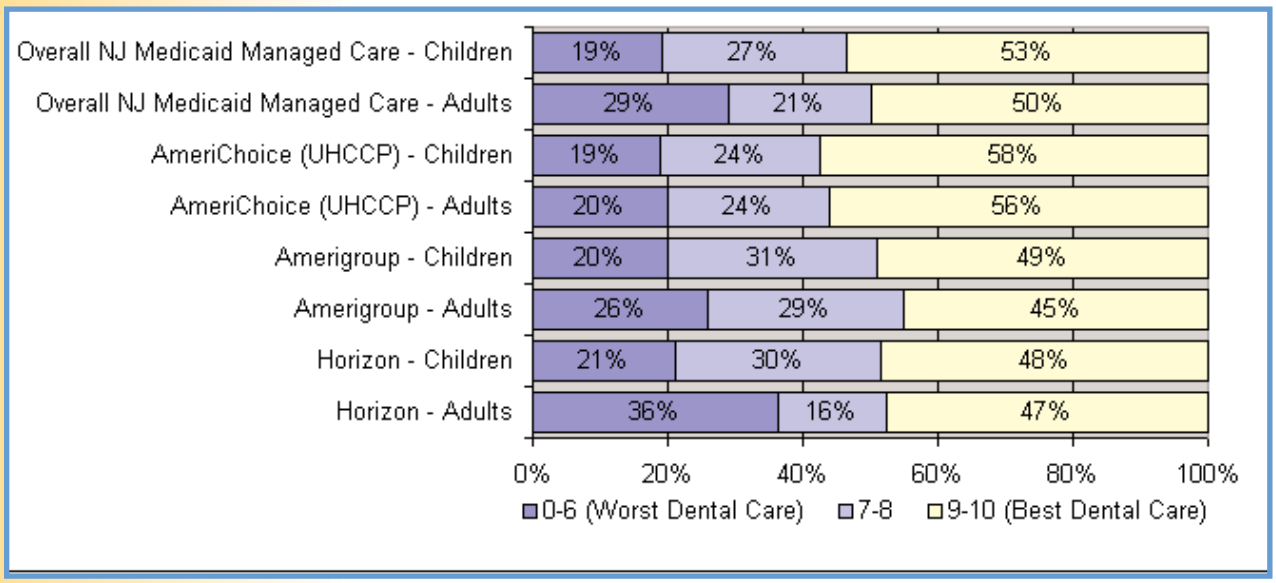
In the past six months, how often did the health plan's customer services staff give good information or help?

Chart 7. Number of Dental Visits in Last 6 Months



In the last 6 months, how often did you (your child) visit the dentist?[5]

Chart 8. Overall Rating of Dental Care

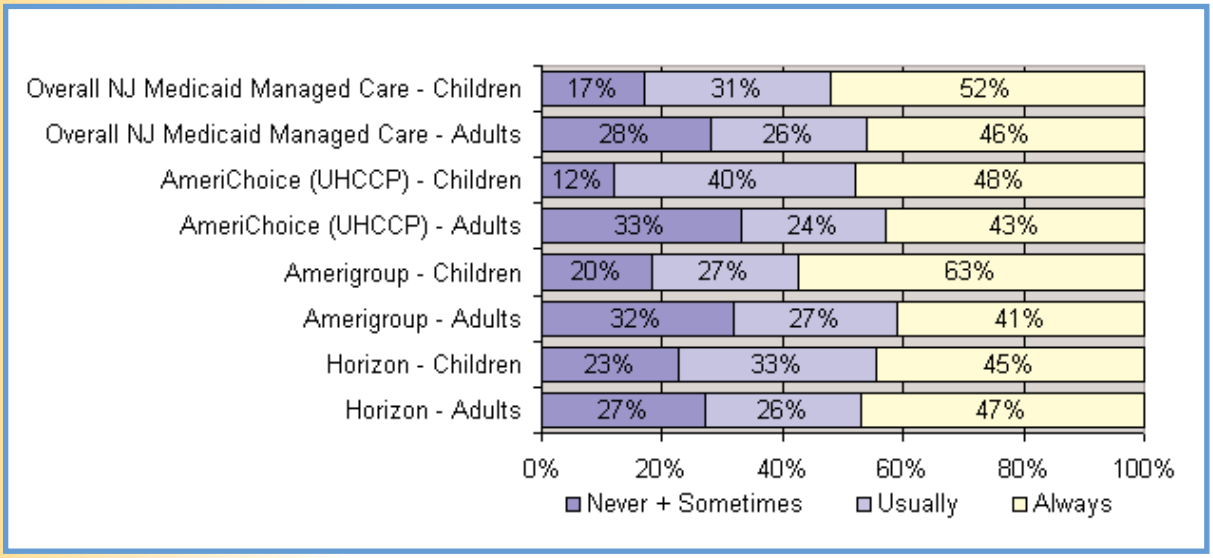


Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all your (your child's) dental care in the last 6 months?[6]

[5] Adult Dental Visits in the Last 6 Months results for Amerigroup, AmeriChoice (UHCCP), and Horizon were based on responses from slightly less than 100 members. The CAHPS grantee team recommends a minimum of 100 responses per survey group to ensure that differences detected in plan performance are both reliable and valid.

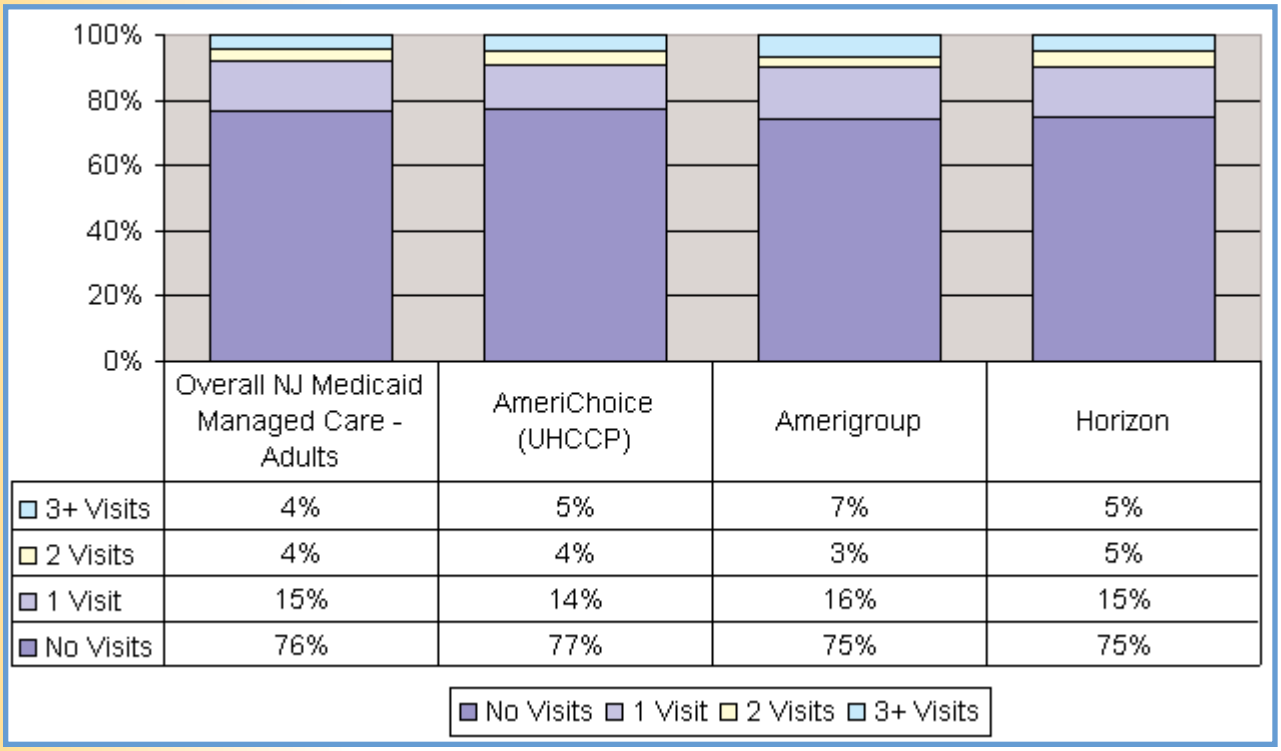
[6] Adult Overall Dental Ratings for Amerigroup, AmeriChoice (UHCCP), and Horizon were based on responses from slightly less than 100 members. The CAHPS grantee team recommends a minimum of 100 responses per survey group to ensure that differences detected in plan performance are both reliable and valid.

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



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

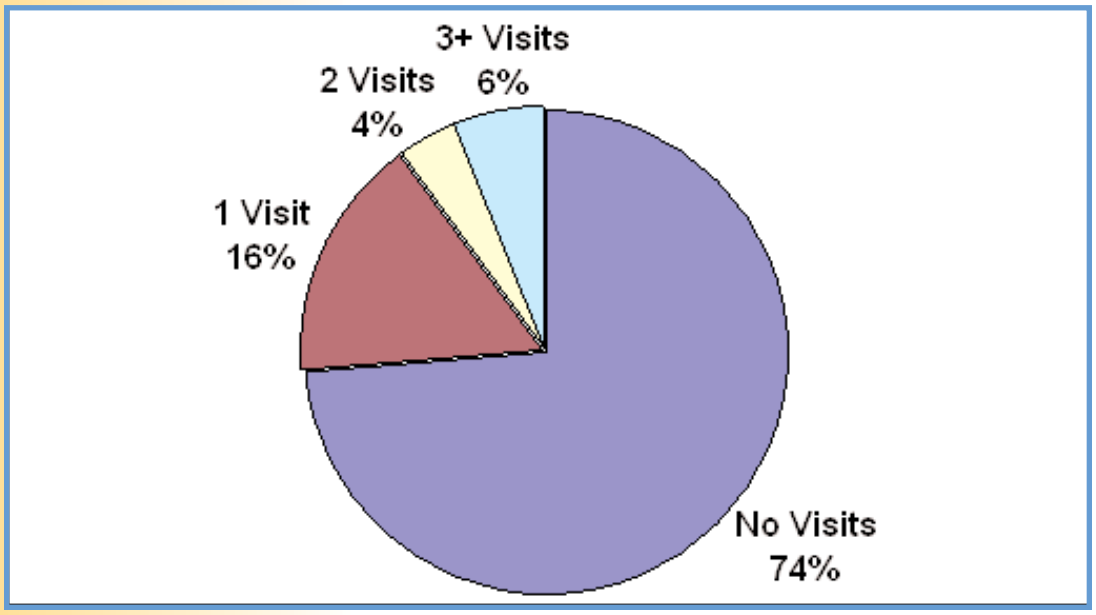
Chart 10. Emergency Room Visits to Get Health Care in Last 6 Months



	Overall NJ Medicaid Managed Care - Adults	AmeriChoice (UHCCP)	Amerigroup	Horizon
3+ Visits	4%	5%	7%	5%
2 Visits	4%	4%	3%	5%
1 Visit	15%	14%	16%	15%
No Visits	76%	77%	75%	75%

Asked of all respondents: "In the last 6 months, how many times did you go to an emergency room to get health care for yourself?"

Chart 11. Number of Emergency Room Visits in Last 6 Months Among Adult Medicaid ABD Clients



It is worth noting that emergency department (ED) utilization among aged, blind, and disabled Medicaid members was similar to overall ED utilization within the Medicaid program.

VI. Reports from the Health Plans on Best Practices

The health plans were asked to provide a description of clinical and/or administrative best practices to showcase in this report. The health plans reported on initiatives that provide insight into the variety and complexity of their accomplishments in serving the most vulnerable populations.

This year, the health plans showcased partnerships:

- with technology in delivering compelling educational programs on the prevention and management of obesity,
- with hospitals to reduce readmissions, reduce dental emergency room visits and narcotic analgesia prescription fills through greater focus on utilization reports, and
- to advance early childhood literacy through focused partnerships and outreach programs.

Each of the health plans is pleased to share highlights of these practices implemented in 2010.

Amerigroup

***Best Practices/Initiatives*:** Reducing Hospital Re-admissions

Amerigroup's Hospital Intervention Program (HIP) is an integrated program to reduce preventable hospital re-admissions.

The project goals are:

- ❑ Deploy multifunctional teams to address the needs of members as their health status changes.
- ❑ Reduce hospital re-admissions.
- ❑ Help members follow their doctor's plan of care.

Overview

Preventable hospital re-admissions cost American taxpayers billions of dollars every year, and those re-admissions are disappointing to patients who want to be healing and returning to family and work life. Re-admissions often occur because patients do not understand their discharge plan, are confused about their prescriptions, or fail to see their doctor for a necessary follow-up visit. Re-admission is common for patients with circulatory, respiratory, and digestive diseases.

The federal Medicare Payment Advisory Commission recently estimated that up to three-quarters of re-admissions are preventable,[7] and the federal Office of Management and Budget has projected an estimated $26 billion in savings over ten years from better prevention.[8]

Amerigroup learns very quickly when a member is admitted to a hospital, rehabilitation or nursing facility. The member appears on a report that notifies our clinical staff which members have been admitted and where they are receiving care. Our clinical team connects with staff at the facility to learn the reason for admission, then begins to focus on what the member may need upon discharge. Examples of these needs include prescription drugs, wound care, delivery of supplies, home care visits, and follow-up appointments with one or more doctors.

When the member is an appropriate candidate for the Hospital Intervention Program (outside of ongoing case management) and ready for discharge, the Amerigroup nurse who has been working on the case with hospital staff will share clinical information and the discharge plan with our health promotion team.

A representative from Amerigroup's health promotion team will make an outreach call to the discharged member within 24 hours. That call starts with simple questions like, "How are you feeling?" and "Were you able to get your prescriptions filled?" Depending on the member's needs, clinical staff might also talk about how to make a follow-up appointment with a Primary Care Provider (PCP) or specialist, how to set up transportation to get to those appointments, and why those visits are important. The member might be interested in changing PCPs or might need help setting up delivery of equipment or supplies. The outreach representative can help make these arrangements for the member, and may bring in a nurse case manager if the member needs additional support. Often, this means connecting the member to support and services available through their Medicaid benefits and beyond.

[7] http://www.medpac.gov/chapters/jun07_ch05.pdf

[8] http://www.whitehouse.gov/omb/blog/09/04/08/NewStudyonHospitalReadmissions/

The goal of the HIP call is to support the member's successful transition to home and connection to follow-up care, ensuring that services the member needs are available and accessible, and that any barriers are identified and addressed.

Results

In every quarter of 2009 and 2010, the re-admission rate for Amerigroup members reached with HIP calls was better than the re-admission rate for members who were not reached. Comparing the two rates, we estimate that HIP outreach prevented more than 100 re-admissions in 2009 and 2010.

The Hospital Intervention Program is just one piece of our model of care. It unites our ongoing care and case management, disease management, broad health promotion, and medical home initiatives. Together, these programs support Amerigroup's focus on the whole person, expanding access and understanding, encouraging preventive care, improving overall wellness, and being a real solution for our members who need a little help.

Healthfirst NJ

Best Practices/Initiatives: Community-based Partnerships

Healthfirst Health Plan of New Jersey, Inc. (Healthfirst NJ) has noted trends that indicate some key national health issues are adversely affecting the health and well-being of our communities. Illiteracy is a common issue among older adults and parents who may not have had an opportunity provided to them to learn to read. As a result, many children do not have the reinforcement at home to enjoy reading and learn to read well. Childhood obesity is also a widespread issue especially in many of the underserved communities in our service area. As a health plan, the primary way Healthfirst NJ strives to combat these problems is through partnering with community organizations. These joint efforts have a positive impact on the lives of members and their neighbors.

The project goal is: Promote the proactive education of the families, friends and neighbors who live in the State of New Jersey to help influence healthier lifestyle choices.

Overview: Healthfirst NJ values the partnerships they have established in the community. They believe that in order for healthcare management to be effective, the philosophy of the plan must go beyond high quality care delivery. The Healthfirst NJ Outreach team and mobile offices keep in touch with the community and provide educational resources that help improve the health and well-being of the families they serve – and reinforce their commitment to their members.

Congruent with this approach, Healthfirst NJ focuses on building strong relationships with local hospitals, providers, community organizations, businesses and elected officials to influence the development and improvement of health care programs and services in their communities. By combining this two-pronged approach to engage their plan with the community at both the leadership and citizenship level, the beneficiaries gain an understanding of healthy living and develop good habits, while important programs continue to improve.

As an example of this best practice philosophy put into action, Healthfirst NJ recognizes the importance of education and literacy to the overall health and well-being of the communities we serve. To that end, we partnered with *Reach Out and Read (ROR) NJ*, a not-for-profit organization with a focus on promoting early childhood literacy. This program provides books at enrolled medical facilities to children under the age of five years old who live in low-income areas. The

ROR literacy program also trains doctors and nurses to advise parents about the importance of reading aloud. This unique partnership brings the ROR program to select physician offices, Federally-Qualified Health Centers (FQHC), and hospitals within New Jersey. Healthfirst NJ's commitment to literacy offers a way for children to gain easy access to books, develop a love and appreciation for reading, and– in the case of English as a Second Language (ESL) households–aid in learning a new language.

The vision and desire for a healthier community is something that Healthfirst NJ is consistently trying to imbue in the communities around us. In addition to the literacy program, Healthfirst NJ recognizes the significant challenges that childhood obesity is creating in communities and has sought to positively influence the lifestyle of those in the community by collaborating with major sports teams. Through partnering with these teams in the community, Healthfirst NJ has supported Youth Clinics that encourage children to exercise, develop leadership and team building skills, and boost positive self-esteem. Joining with the Red Bulls soccer team, Healthfirst NJ has sponsored a free Youth Clinic for 75 children, ages 6-14, to learn about the sport of soccer. Healthfirst NJ worked with community based partner organizations in their service area to invite children to participate at a special personalized instruction clinic from the Red Bulls Academy trainers. The children learned game strategies and rules, aspects of teamwork, and other soccer techniques that encourage pro-social skills to empower them in making more positive life choices.

Darryl Dawkins of the New Jersey Nets, spoke at the Annual Teen Health Fair in Paterson, NJ, sponsored by Healthfirst NJ. The program consisted of educating students about healthcare, social services, education, employment opportunities available in the community, and how to manage difficult teen matters. Darryl spoke about the importance of goal setting and healthy lifestyle choices. There were more than 1,500 high school students from Paterson Public Schools in attendance.

As a final example of the benefits of promoting the health of our communities, Healthfirst NJ partnered with the American Heart Association (AHA), which has helped to exercise the mission to positively impact communities. AHA is training Healthfirst NJ's Community Outreach staff how Life's Simple Seven Health Guidelines provide other tools to help educate our communities on the importance of good heart health.

Healthfirst NJ is also sponsoring Teaching Gardens, at schools in low-income areas, to teach kids the importance of growing and eating healthy foods through hands-on interactive learning. There will be a school curriculum that will be taught in the classrooms to go along with the gardens. Research supports that if children learn how to grow their own fruits and vegetables and become familiar with the process, they will be more inclined to try to eat more fresh produce.

Results: While the time, effort, and funding required to engage in community-based partnerships is often substantial, the positive outcome is most noticeable in the lives of the beneficiaries. Students, parents, adults and children of all ages, backgrounds and cultures have gained a better understanding of how to take care of their own health through lifestyle changes. These tangible improvements are a direct result of the collaboration of Healthfirst NJ with organizations desiring to influence constructive change in the community. By impacting the community in this way, members consider their health plan an asset to help them make healthy decisions, rather than just an insurance company that pays their claims.

Horizon NJ Health

Best Practices/Initiatives: Reduction of Emergency Room (ER) Visits

Improper use of hospital emergency facilities by members enrolled in a managed care plan continues to be an escalating issue throughout the nation. Horizon NJ Health developed and implemented an initiative focused on reducing non-emergency ER visits.

The project goal is: Reduce the number of ER visits by members without dental benefits as well as those seeking narcotic analgesics.

Overview: It was determined, through the use of utilization reports, that members without dental benefits as well as members seeking narcotic analgesics were responsible for many non-emergency ER visits. Members that presented primary dental diagnoses codes tended to have non-life threatening, non-traumatic conditions, and hospital emergency facilities are ill-equipped to properly diagnose and treat such patients.

In order to reduce these visits, Horizon NJ Health placed case managers into four of the highest volume hospitals' ERs to provide post-utilization member education and guidance. Members that visited the ER three or more times during the measurement month and filled prescriptions for a narcotic analgesic within 24 hours of each visit were targeted and referred to Horizon's Pharmacy Department. Once members were referred, Horizon's Pharmacy Department:

- mailed a letter to members' primary care physicians, notifying them of their patients' high utilization of the ER.
- referred members with frequent visits to the Pharmacy Lock-In Committee for a possible lock-in to a single pharmacy for prescription fills.

In addition, dental outreach was provided to members on a monthly basis to help facilitate appointments at proper in-network private practices or Federally Qualified Health Centers' dental facilities. Members were also educated about proper ER utilization.

Horizon NJ Health then included panel members' ER utilization metrics into its Physician Profiling tool, which determines physicians' annual incentive awards.

Results: With the implementation of this initiative, Horizon NJ Health has seen:

- 97% reduction in dental ER visits by members from 701 to 20 visits per month: A change in visits/1000 from 1.57 to 0.04. A 98% reduction in the number of members responsible for the visits from 592 to 13.
- 98% reduction in dental ER visits by members in which a narcotic analgesic prescription was filled within 24 hours of the visits from 372 to 8 visits per month: A change in visits/1000 from 0.84 to 0.02. A 98% reduction in the number of members responsible for the visits from 295 to 5.
- 100% reduction in dental ER visits from 63 to 0 by members with three or more visits in a measurement month: A change in visits/1000 from 0.14 to 0.00. A 100% reduction in the number of members responsible for the visits from 14 to 0.
- 100% reduction in three or more dental ER visits by members from 51 to 0 in the measurement month in which narcotic analgesic prescriptions were filled within 24 hours of the visits: A change in visits/1000 from 0.11 to 0.00. A 100% reduction in the number of members responsible for the visits from 11 to 0.

UnitedHealthcare Community Plan

Best Practices/Initiatives: Interactive programs on obesity prevention and management

Liberty Science Center and UnitedHealthcare Community Plan have collaborated to deliver six obesity-focused *Electronic Field Trip* programs to at-risk Newark youth, grades 4-9. The *Electronic Field Trip* will appear as a permanent menu offering for Liberty Science Center's popular EFT program and will be available to schools across the U.S., giving the project national reach.

The project goals are:

1. Deliver six Obesity Prevention Electronic Field Trips (EFT), reaching 180 Newark students.
2. Educate Newark youth on how the human body works.
3. Explain how lifestyle choices can prevent or manage obesity and associated disease, and lead to improved quality of life.
4. Motivate participants to adopt a balanced diet and daily exercise as personal lifelong habits.

Overview

UnitedHealthcare Community Plan is working with the Liberty Science Center to develop an interactive education program that will help children prevent and overcome obesity. The program, "Keeping Our Bodies Healthy," will be part of the Liberty Science Center's Electronic Field Trips (EFT) series, which provides interactive science-related lessons via live videoconferencing from the center to classrooms throughout the country.

The lesson plan for grades 4 – 6 will allow students to explore how personal and social factors can influence nutritional choices, and will examine the effect of nutrition and balanced diet on growth and development. The lesson plan for grades 7 – 9 aims to give students a greater understanding of how the body breaks down food for use in growth and maintenance. Students will design a nutritional plan for families with different lifestyles, resources, special needs, and cultural backgrounds. Students will also learn to investigate the link between nutrition, health issues and associated risk factors.

Results

Upon completion of the project, the evaluation will include both process and outcomes components. The process component is designed to assess the degree to which key activities in the project have been completed. The outcome component will consist of evaluating key indicators of successful program development and learning on the part of participating youth. Results of the evaluation will be communicated through periodic evaluation memoranda and a final report.