NJ FAMILY CARE

Affordable health coverage. Quality care.

2013 Annual Report

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Dear Stakeholder:

It is with pleasure that we present to you the Department of Human Services, Division of Medical Assistance and Health Services' 2013 NJ FamilyCare Annual Report. This Report provides insight into New Jersey's Medicaid program and its accomplishments to transform and modernize one of the nation's largest health care coverage programs. With annual expenditures of over $12 billion and over 1.3 million lives touched, NJ FamilyCare plays a key role in the direction of the health care delivery system in New Jersey, and thus, has a unique opportunity to improve care for those who would not otherwise have access.

Beneficiaries of NJ FamilyCare are New Jersey residents determined financially and categorically eligible for medical assistance including low-income individuals, pregnant women, and certain dependent children, low-income aged, disabled or blind persons, children in foster care programs, and certain classes of immigrants.

At the cornerstone of NJ FamilyCare is our mission to provide New Jersey citizens access to affordable health coverage, through both traditional and innovative delivery system models, in a manner that is quality performance driven and fiscally sustainable.

This year, we are striving to ensure citizens have a streamlined enrollment experience, access to a broad network of qualified providers, and improved quality of care. While we have undergone positive transformations, we have also experienced the challenges brought forth by new federal health care rules in 2014. NJ FamilyCare has answered this challenge with the ongoing development of new technologies to enhance operations and improve the beneficiary and provider experience.

The Department of Human Services gratefully acknowledges Governor Chris Christie, the New Jersey Legislature, beneficiaries, providers and other key stakeholders for their assistance in making health care services affordable and robust in this state. We hope you find this Report informative and useful as we work together to continue providing quality health care services to New Jersey's most vulnerable residents.

Sincerely,

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

Valerie Harr
Director
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Executive Summary

Effective October 1, 2013, NJ FamilyCare became the single program for all public medical assistance in New Jersey, including all 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) administers the NJ FamilyCare program for approximately 1.3 million low- to moderate-income adults and children. The majority of beneficiaries are enrolled in managed care plans that provide most health care benefits in exchange for a per member, per month payment. In 2013, these plans were administered by four managed care organizations (listed in order of enrollment): Horizon NJ Health, UnitedHealthcare Community Plan, Amerigroup New Jersey and Healthfirst Health Plan of NJ, whose assets were acquired by WellCare Health Plans of New Jersey, Inc. in December of 2013. Program costs are shared between the state and federal governments at varied rates depending on beneficiary income or the service provided.

In February 2013, after considerable discussion and research, Governor Chris Christie announced that New Jersey would participate in the Medicaid expansion included in federal law. Accordingly, 2013 marked a transition period for NJ FamilyCare. Much of the year entailed preparation for the implementation of federal law as well as the pursuit of payment and delivery systems reforms. For many of the initiatives undertaken throughout the year, NJ FamilyCare staff partnered with The Center for Health Care Strategies (CHCS), a nationally recognized nonprofit health policy resource center, and the Rutgers Center for State Health Policy for initiatives such as the Medicaid expansion, movement to Managed Long Term Services and Supports, implementation of Behavioral Health Homes, and Managed Behavioral Health and Delivery System Reform Incentive Payments.

As DMAHS looks toward 2014, the agenda is robust and includes the following: operationalizing federal law provisions, continuing to build and execute payment and care delivery system innovations such as accountable care organizations, pursuing initiatives targeting the needs of high utilizers of medical services, providing telepsychiatry services, and streamlining credentialing for providers. Additionally, two new managed care plans are seeking regulatory approval to enter the NJ FamilyCare market.

Managing the size and scope of the NJ FamilyCare operation requires thoughtful analysis, planning and execution. The foundation for all programmatic decision making for DMAHS involves consideration of 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 our program(s). The nature of the services

required and the quality of care delivered is considered, followed by an analysis of the capacity and ability to support and operationalize the service within our infrastructure. Once eligibility, quality and infrastructure are considered, the funding capability is assessed. This Report communicates important activities in all four quadrants.

Eligibility: Overall enrollment remained steady throughout the year. On October 1, 2013 NJ FamilyCare implemented the Modified Adjusted Gross Income (MAGI) method to determine eligibility, as required by federal law and defined in subsequent federal regulations.

Quality: An external quality review study shows that all plans demonstrated strong compliance and improvement from the prior year. Clinical quality measures improved overall, while some underperforming measures were identified and targeted for improvement through a new performance-based contracting program. Overall consumer healthcare satisfaction increased for all plans in both the Adult and Children categories. A new, consumer friendly HMO scorecard has been developed, which allows for an HMO plan comparison at-a-glance.

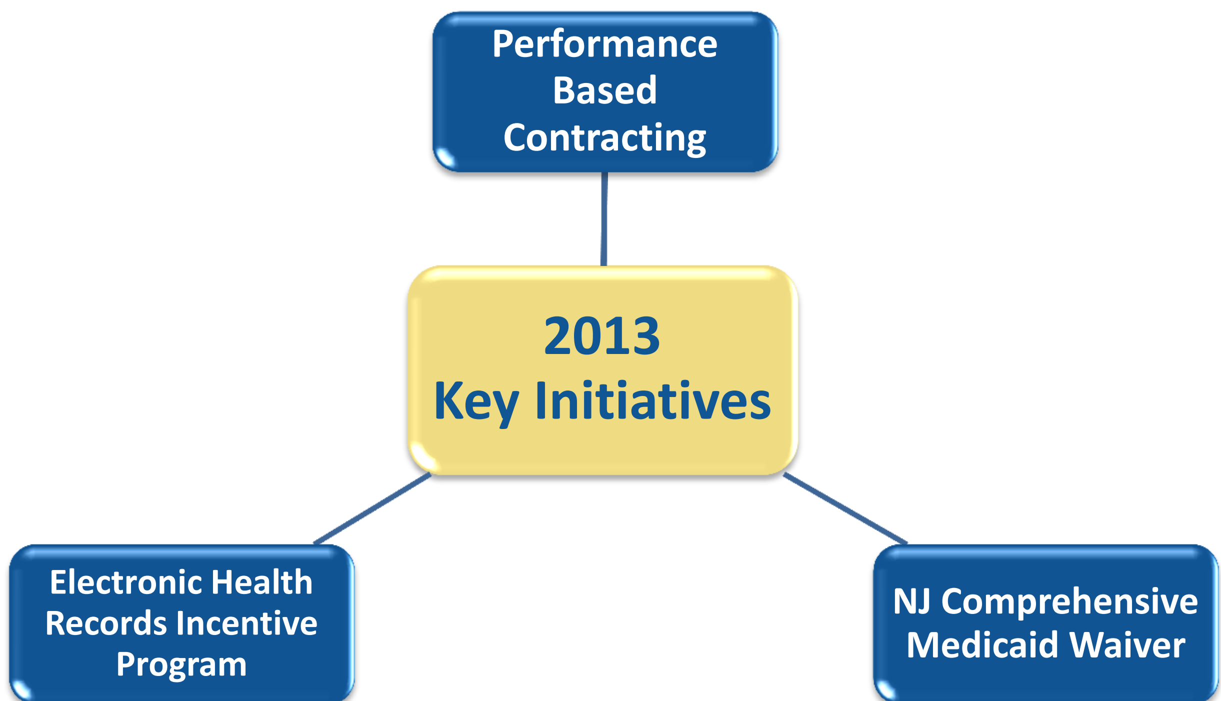
Infrastructure: The framework of the NJ FamilyCare operation includes enrollment and eligibility systems, capitation and claims payment, audit functions, customer service, data analytics and the provision of transportation to beneficiaries for covered services. Business intelligence tools including dashboards have been developed enabling senior management to have a vast amount of data available to support analysis, decision making and reporting.

Fiscal: New Jersey continues to be a national leader in managing spending growth. NJ FamilyCare spending grew well below the national trend between federal fiscal year 2006 and 2012 (the last year national numbers are available; the federal fiscal year is October - September), while New Jersey's cumulative spending growth in this period was less than half of the national Medicaid/CHIP growth rate. One of the primary ways New Jersey has been able to achieve this lower level of overall spending is through the continual migration of physical health medical services to managed care. Over the last three federal fiscal years, spending on managed care capitation payments increased 15% while non-hospital, non-institutional fee-for-service spending has decreased 10%.

2013 Key Initiatives

Key initiatives undertaken by NJ FamilyCare in 2013 reflect a dynamic and complex health care environment influenced by state and federal legislation and rulemaking. Provider payment and care delivery system reforms designed to improve quality and manage costs for recipients with complex needs represent a central theme. Innovative programs such as Performance Based Contracting will provide incentive-based compensation to the health plans for achieving specific, measurable outcomes which are in alignment with Healthy New Jersey 2020, New Jersey's ten-year health promotion and disease prevention plan. Additionally, the NJ Comprehensive Medicaid Waiver is a collection of reform initiatives designed to enable a greater degree of budget predictability, reduce reliance on institutional care, expand home and community-based services and improve health outcomes. Finally, eligible providers participated in an infrastructure upgrade by adopting and using electronic health records (EHR). Approximately 2,000 New Jersey providers and hospitals have received incentive payments for converting to EHR technology.

2013 Key Initiatives Highlighted in this Report



Performance Based Contracting

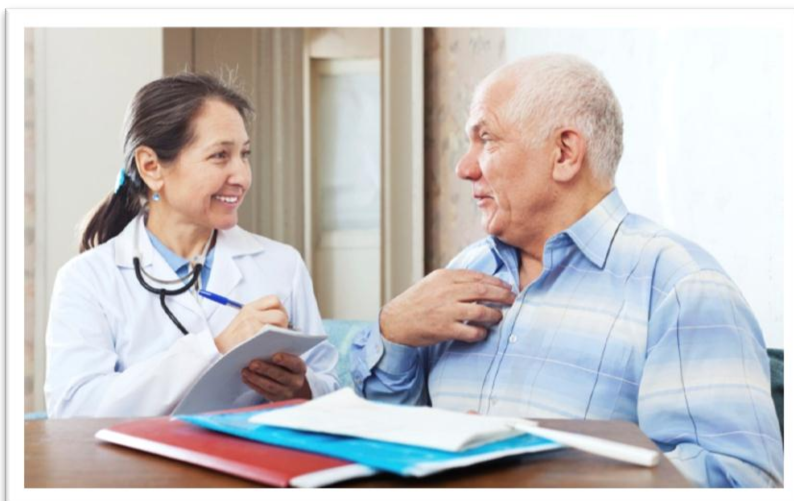
In an effort to expand New Jersey's current value-based purchasing strategy, DMAHS is implementing a performance-based contracting (PBC) incentive program. The PBC incentive program is designed to motivate innovation in an effort to initiate and sustain improvement in clinical quality priority areas important to DMAHS and its NJ FamilyCare beneficiaries. The program is funded by setting aside a portion of the capitation rate paid by DMAHS to its health plans. Contractors will have the opportunity to earn back set aside amounts based on improved results in five specific clinical areas and achieving accreditation by the National Committee on Quality Assurance (NCQA). These indicators are in alignment with Statewide Healthy New Jersey 2020 "Leading Health Indicators" established by the New Jersey Department of Health and available at www.nj.gov/health. DMAHS anticipates including additional indicators in this program in the future.

PBC Indicator Alignment with Healthy New Jersey Priorities	
NJ Public Health Priority	**Measure**
Birth Outcomes	**Timeliness of Prenatal Care** The percent of deliveries that received a prenatal care visit as a member of the managed care organization in the first trimester OR within 42 days of enrollment in the managed care organization **Postpartum Care** The percent of deliveries that had a postpartum visit on or between 21 and 56 days after delivery **Preterm Birth Rate** The percent of all live births that are preterm (<37 weeks gestation)
Childhood Immunizations	**Vaccination Rates** The percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV)
Heart Disease	**HbA1C<8** The percentage of diabetic members , aged 18 to 75 years, who have a hemoglobin A1C <8%
Obesity	**BMI Percentile Documentation** The percentage of members, aged 3 to 17 years, who had evidence of BMI percentile documentation

NJ Comprehensive Medicaid Waiver

The NJ Comprehensive Medicaid Waiver is a statewide health reform effort that will expand existing managed care for certain populations. The Waiver establishes Managed Long Term Services and Supports (MLTSS) and Managed Behavioral Health Organization (MBHO) programs, expands home and community-based services and will simplify administration of New Jersey's medical assistance programs. The Waiver was approved by CMS in October 2012. DMAHS is collaborating with numerous intragovernmental state agencies and is proceeding with input from stakeholders for the design and implementation of these initiatives.

Long-term services and supports are essential to helping NJ FamilyCare beneficiaries who require assistance with mobility or cognitive functioning in order to live as independently as possible. The transition of Long Term Services and Supports (LTSS) from fee-for-service reimbursement into managed care is a complex initiative. The goals are to achieve a cost-effective and financially sustainable system while providing quality care in the most appropriate setting for each individual. The MLTSS governance structure includes an implementation committee comprised of upper-level policy decision makers, an operations committee consisting of front line staff and a project management team who oversees the process. State and managed care organization readiness reviews were conducted and, overall, New Jersey is positioned well. The readiness reviews along with other required elements will be submitted to CMS for review. The needs of this particular provider community, which typically has not interacted with a Medicaid or a managed care program for payment, and beneficiaries are considered as well. Transitional training and communications support tools have been developed in preparation for anticipated implementation in 2014.



The transformation of behavioral health services from an unmanaged, cost-based contracting system to a managed system is a challenging step towards creating an environment where beneficiaries receive appropriate care and supports in a manner that is efficient, accountable, and financially sustainable. The Waiver includes the planned transition to a coordinated and managed behavioral health system through the procurement of an administrative services organization (ASO). The function of the

ASO is to serve as a vehicle to promote improved access and quality of care, greater value, and sustainability for New Jersey's behavioral health system. Initially the ASO will be established as a non-risk entity and will become a risk bearing entity after DMAHS has thoroughly evaluated the behavioral health system's readiness to make this transition. As of December 31, 2013, a request for proposal for the ASO was being developed and will be published after final approval is obtained from all necessary State entities. Additionally, a rate-setting analysis to modify the behavioral health services rates is being conducted for the first time in several years.

Electronic Health Records Incentives

The New Jersey Medicaid Electronic Health Records (EHR) Incentive Payment program provides incentive payments to eligible professionals and hospitals that demonstrate they have adopted, implemented, upgraded, and are meaningfully using certified EHR technology.

Use of EHR systems is expected to enhance care coordination and patient safety, reduce provider paperwork, facilitate information sharing across providers, payers, and state borders, and eventually enable communication of health information to authorized users through state Health Information Organizations (HIOs), the New Jersey Health Information Network (NJHIN) and the Nationwide Health Information Network (NwHIN). The program is primarily funded by the Centers for Medicare and Medicaid Services and administered by the states.

Providers eligible for the program include physicians, dentists, certified nurse midwives, and nurse practitioners who have at least 30% Medicaid patient volume, pediatricians who have at least 20% Medicaid patient volume, and hospitals that have at least 10% Medicaid patient volume.

EHR Incentive Program Payments through 12/31/2013

	Providers	Payments	Average Per Provider
Eligible Professionals	1882	$42,590,696	$22,630.55
Eligible Hospitals	51	$90,902,307	$1,782,398.18
Total, All Provider Types: $133,493,033			

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. The initiatives provide insight into the variety and complexity of their accomplishments in serving the most vulnerable populations. The Best Practices ranged from outreach and member engagement, to targeted disease management with improved outcomes, facilitation of patient centered medical homes and increasing awareness to assist in meeting health goals.

Horizon NJ Health

Best Practice: Member Outreach and Engagement

Overview

Horizon NJ Health engages with members and the community to create and deliver initiatives and programs that help to address health care issues and expand access to care.

Goals

- Improve population-based health outcomes
- Provide culturally and linguistically competent health care
- Enhance collaboration with community groups

Description

Horizon NJ Health has developed programs and established community partnerships to foster member outreach for health education and access to care.

School-Based Programs Horizon NJ Health has been able to reach out to younger members of the community by partnering with schools throughout the state. Programs targeted to this group include an anti-bullying program, an obesity program, and a nutrition program. Horizon NJ Health conducted almost 60 nutrition and obesity programs in 2013. Horizon NJ Health has partnered with the Joetta Clark Diggs Sports Foundation in presenting a fitness challenge to four NJ schools. This program is designed to challenge the students' fitness and academic skills. Looking beyond direct education of students at the schools, Horizon NJ Health offers continuing education through professional development and provides health education and in-service programs to school nurses through our school nurse program. In 2013, Horizon NJ Health

participated in six large-school nurse conferences and six continuing professional development programs.

Member Advisory Council As an outgrowth of the Community Health Advisory Committee (CHAC), which focuses on coordination with community health advocates and community leaders, in 2013 Horizon NJ Health established the Member Advisory Council and the Hispanic Member Advisory Council to directly address member concerns in individual neighborhoods. Both sets of Council meetings are conducted throughout the state four times a year and focus on direct contact and collaboration with groups of 10 to 20 members at each session. As a result of these meetings, members have been able to have their concerns directly addressed and Horizon NJ Health is provided with valuable feedback.

Crisis Community Outreach It was a result of Horizon NJ Health's strong community relationships that immediately after Hurricane Sandy struck New Jersey it was able to launch a large-scale statewide relief effort to aid people whose lives were shattered by the storm. Internal and mobile relief teams were tasked with locating areas that needed help the most and finding ways to assist in the relief efforts. The team worked with community-based organizations and the American Red Cross to determine exactly what types of supplies were needed and where they needed to be delivered. Utilizing community partners and working with the State of New Jersey, Horizon NJ Health identified the most high-volume shelters and sent a team of medical professionals and social workers/case management personnel to help.

During the first two weeks after Hurricane Sandy, Horizon NJ Health made 31 different visits to areas of greatest need. This included 21 visits to shelters and the shelter distribution center (15 different shelters, with several being visited more than once). Ten community-based organizations in need were visited. Donations were made at 23 of 31 visits.

Community Events Horizon NJ Health is able to present a strong presence statewide by participating in more than 800 health fairs and community events annually. Partnering with national and local community organizations, as well as with faith-based organizations, the health fairs offer health screenings and interactive activities such as dancing and games that promote healthy living, mental health, nutrition and physical fitness.

Care-A-Van Program Horizon NJ Health's Care-A-Vans travel directly into New Jersey communities to provide greater access to health care. These mobile health units (one 40-foot Care-A-Van and three 26-foot Care-A-Vans) have been used as outreach vehicles at community health fairs and retail locations to promote health education and enroll New Jersey's uninsured into NJ FamilyCare. Of the more than 800 events Horizon NJ Health participates in every year, more than 400 are Care-A-Van events. The Care-A-Van program helps increase health literacy

through health education and provides preventative screenings at no cost that include, but are not limited to, blood pressure, glucose, cholesterol, dental and seasonal flu vaccine for adult members. In 2013, Care-A-Van event participants received close to 15,000 screenings in conjunction with disease-related health education.

Best Practice: Case Management for Sickle Cell Disease and Asthma in Latino Children

Sickle Cell Disease

UnitedHealthcare Community Plan of New Jersey (UHCCPNJ) has been working cooperatively with Dr. Alice Cohen, a leading hematology/oncology specialist who was identified as using best practices in the field of Sickle Cell (SC) management at Newark Beth Israel (NBI). UHCCPNJ in collaboration with Newark Beth Israel decided to pilot a Sickle Cell Management Program which allows UHCCPNJ members visiting NBI with the sickle cell disease to be given a mandatory hematology/oncology and pain management consultation upon entry to the emergency room with a diagnosis of SC. UHCCPNJ would also perform interactive rounds with case management/pharmacy to track compliance with Hydroxyuria, a medication that when used appropriately, may reduce the episode of sickle cell crisis thereby reducing pain, hospitalizations and increasing the member's quality of life. Outcomes were tracked and trended and appear to result in lower ER utilization/hospitalization.

UHCCPNJ and NBI will initiate discussions in the near future with Patient Centered Medical Homes (PCMH) to determine methods of increasing the rate of PCMH enrollment for members with SC.

Respira: Case Management Collaborative Between UHC and UMDNJ/Rutgers

According to New Jersey Department of Health, Latino children are more than 1½ times more likely than non-Latino children to be hospitalized for asthma. UnitedHealthcare has completed its initial phase of the case management collaborative by working with Evelyn Montalvo Stanton, M.D. and Rutgers New Jersey Medical School to produce an extremely high touch point case management model for Latino children with asthma. The aim of this program is to decrease emergency room visits and hospitalizations, improve quality of life for parent and child, and decrease school absenteeism. This is done through what the program refers to as the three E's: Education, Empowerment, and Enhancement. This program proved to be effective almost immediately, resulting in a decrease in ER visits, increased compliance with

medications resulting in asthma control, and lower spending and medication costs. United Healthcare will lead discussions in the near future to discuss continuation of the program and next phase initiatives.

Best Practice: Facilitating the NCQA Survey Process for Patient Centered Medical Home

Goal To improve health care quality and support a more efficient and effective delivery system by increasing the number of patient centered medical homes (PCMH) in Medicaid Managed Care through the Amerigroup network.

Program Overview

Amerigroup provides support and resources for its contracted medical practices interested in obtaining recognition by the National Committee for Quality Assurance (NCQA) as a Patient Centered Medical Home. Practices are selected for PCMH engagement based on their expressed interest and current Amerigroup membership (500 or more members). Additionally, they must be in good standing and continue to accept new patients. The practice must agree to commit both time and personnel to perform the work needed to complete an NCQA PCMH survey.

Once a provider is selected for engagement, Amerigroup provides the services of a Medical Practice Consultant (MPC) to facilitate the NCQA survey process. The MPC is an Amerigroup employee whose consulting services are provided to each practice at no cost to them. The MPC has received training on the NCQA PCMH standards and will serve as a subject matter expert for the practice.

Engagement with the practices begins with an initial meeting with the clinical leadership and the proposed PCMH leadership team which usually includes a physician lead, nurses, health educators and any other essential practice staff. The MPC performs a gap (opportunity) analysis during this meeting to assess the practice’s current strengths, identify any opportunities for improvement and gain an understanding of the practice’s current operations.

Ongoing meetings are held usually on a bi-weekly basis; the MPC provides a practice-specific Excel worksheet to track their progress and serve as a transformation plan. During each meeting the practice presents any work they have completed or are in the process of completing for the PCMH survey; the MPC reviews this evidence to determine if the documents will satisfy the requirements of the survey. The completed documents and any ongoing or outstanding work are tracked using the practice PCMH worksheet.

Practices are also provided with PCMH reports that vary in frequency and topic, such as a daily inpatient census, weekly ER and monthly reports such as Potential Missed Care Opportunity (gaps in care) and new member report. These reports help the practices track their progress in patient care, such as providing essential preventive care and ongoing chronic care and managing utilization such as hospital admissions and ER visits. Accurate, timely reporting provides data the practice can use to make informed decisions about each aspect of their delivery of patient care.

The PCMH leadership team is strongly encouraged to provide frequent updates to the entire practice staff as to the work being done for PCMH. This ensures all staff are aware of any potential changes in practice policy or workflow and encourages an open exchange with staff including providing feedback on the PCMH process.

Results

- Amerigroup has assisted six practice sites in achieving Level 3 NCQA PCMH recognition.
- Amerigroup's MPC has engaged with a total of 60 providers serving 6,310 Amerigroup members in 16 practice sites.
- Amerigroup averaged 80 consulting hours per month across all engaged practices.

One participating practice noted, "We would like to share with you what a pleasure it has been to have had the benefit of your Medical Practice Consultant… Throughout this transformational process for our practice, [Amerigroup's Medical Practice Consultant] has been a guiding force that helped our team and organizations achieve level 3 NCQA PCMH recognition…"

For data integrity purposes, Amerigroup measures improvements in quality, utilization and health care costs beginning 18-24 months post engagement. Amerigroup's New Jersey PCMH practices are nearing the 18 month mark, when that analysis and data sharing can begin. Our work with the PCMHs will continue.

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Best Practice: Increasing Awareness and Patient Prevention with the Member Passport Initiative

Goal

To focus on helping members of a certain qualifying age track health prevention goals through performing regular screenings, and also assist members living with chronic conditions to successfully manage their disease. This is accomplished through medication reminders and tracking as well as through checklists that are provided to ensure our doctors are addressing their particular needs at each visit.

Overview

Healthfirst developed a tool tailored to both the general population as well as members living with chronic conditions to help them achieve consistency in meeting health goals. The *Wellness Guide* is a member "passport" that serves as a single-point reference to educate, remind and help track medications that are prescribed long-term, as well as regular tests that are needed as associated with specific health goals or conditions. The tool also serves as an engaging and fun way to keep track of prescription medication needs, routine tests and exams that members over certain ages and members living with chronic conditions may require.

Individuals who are chronically ill or who consider themselves healthy but perhaps have concerns as they age sometimes focus on their problems or have unanswered questions that they're afraid to ask. The member passport, or *Wellness Guide*, allows Healthfirst members to work together with their doctor and better understand their health status. Physicians can use the booklet as guide to help our members – their patients – answer questions, address concerns and help to check off any completed testing that may be required during a visit.

Results

Subsequent to implementing this personalized, customizable "passport" approach as a pilot, we have noticed an increase in member engagement with their primary care physicians and completion of health goals within target populations. Our CAHPS scores pertaining to physician communication and satisfaction with care have increased for the populations in which we piloted this approach. Combined with related health goal incentive programs, the *Wellness Guide* is a collaborative tool that brings together physician and patient. Healthfirst has been able to more effectively manage the care of our aging and chronically ill populations with the help of this tool.

Looking Ahead to 2014

While 2013 was a year of planning and laying the foundation for the implementation of Medicaid expansion and the NJ Comprehensive Medicaid Waiver, 2014 will mark the year for operationalizing these changes to NJ FamilyCare programs. In addition, DMAHS is moving forward with a robust agenda which includes the continuation of payment and care delivery system innovations and infrastructure upgrades pursued in 2013 along with new initiatives planned for 2014. DMAHS also anticipates more health plan choices to be made available to its beneficiaries.

NJ FamilyCare Changes

On January 1, 2014 all New Jersey residents earning less than 133% of the Federal Poverty Level ($31,322 for a family of four in 2013) became eligible for NJ FamilyCare benefits. In addition, federal law requires changes to the method of determining eligibility for most NJ FamilyCare beneficiaries under age 65. Eligibility is determined using a method known as modified adjusted gross income, or MAGI, which has been defined by the federal government. An individual's assets are not considered in the MAGI method.

High Utilizers Initiative

In 2013, 5 percent of beneficiaries accounted for 50 percent of NJ FamilyCare's costs and more than 16,000 recipients visited emergency rooms on six or more days. These high cost individuals also face the most complex medical situations. In 2014, DMAHS will partner with Rutgers University to explore innovative ways of providing the best health care services to those who rely on NJ FamilyCare the most while also managing health care costs. For example, high utilizers of preventable hospital-based services could be redirected to care settings that are more appropriate and less costly.

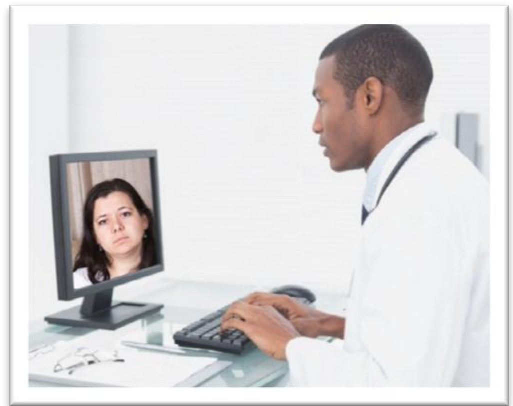
Accountable Care Organizations

Accountable care organizations (ACO) are groups of doctors, hospitals and other health care providers who come together to give coordinated, high quality care to their patients. DMAHS will continue to pursue an accountable care organization demonstration program to evaluate how care management and coordination can help lower costs for this population while improving care. Goals of the ACO are to increase access to primary and behavioral health care, dental care and pharmaceuticals, improve health outcomes, quality and patient experience and reduce unnecessary and inefficient care. The ACO demonstration seeks to achieve these goals through community-based innovation and shared savings.

NJ FamilyCare Managed Care Plan Market

New Jersey is anticipating increased participation in its managed care market in 2014. WellCare received approval to operate a Medicaid HMO in New Jersey then, in late 2013, it announced the acquisition of certain Healthfirst NJ assets and it is expected to complete this transaction during the first quarter of 2014, pending regulatory approvals. Upon approval, Healthfirst NJ's member and physician rosters will be acquired by WellCare, and Healthfirst NJ will wind down its operations. Currently, two other managed care plans are seeking regulatory approval to operate in New Jersey.

Telepsychiatry Initiative



A new telepsychiatry initiative will be implemented in 2014 whose objective is to improve clinical access for members in need of psychiatric services. Independent mental health clinics and hospitals will be able to provide confidential services to their clients from a remote location with secure, two-way, interactive, audiovisual equipment. The Centers for Medicare and Medicaid Services (CMS) has determined that the provision of these telemedicine services meets the definition of face-to-face services and are allowed as billable, provided certain criteria are met.

Streamlined Credentialing for Providers

A task force has been formed with the objective of streamlining the credentialing process for providers. Participants include DMAHS, all NJ FamilyCare managed care organizations, the New Jersey Department of Banking and Insurance and the Medicaid Fraud Division within the New Jersey Office of the State Comptroller. The task force has been compiling and reviewing provider feedback regarding existing credentialing challenges, discussing the feasibility of modifying the New Jersey Universal Physician Application for use by non-medical providers, reviewing strategies employed by other states and issuing a formal recommendation upon completion of its work.

Eligibility & Enrollment

After considerable discussion and research, in February 2013, Governor Christie announced that New Jersey would expand Medicaid to include additional adult populations. Federal funding covers 100% of the cost of services to the expansion population through December 31, 2016 then slowly tapers to 90% starting in 2020. The expansion initiative went into effect on January 1, 2014 and broadens eligibility for NJ FamilyCare benefits to all residents earning less than 133% of the Federal Poverty level ($31,322 for a family of four in 2013).

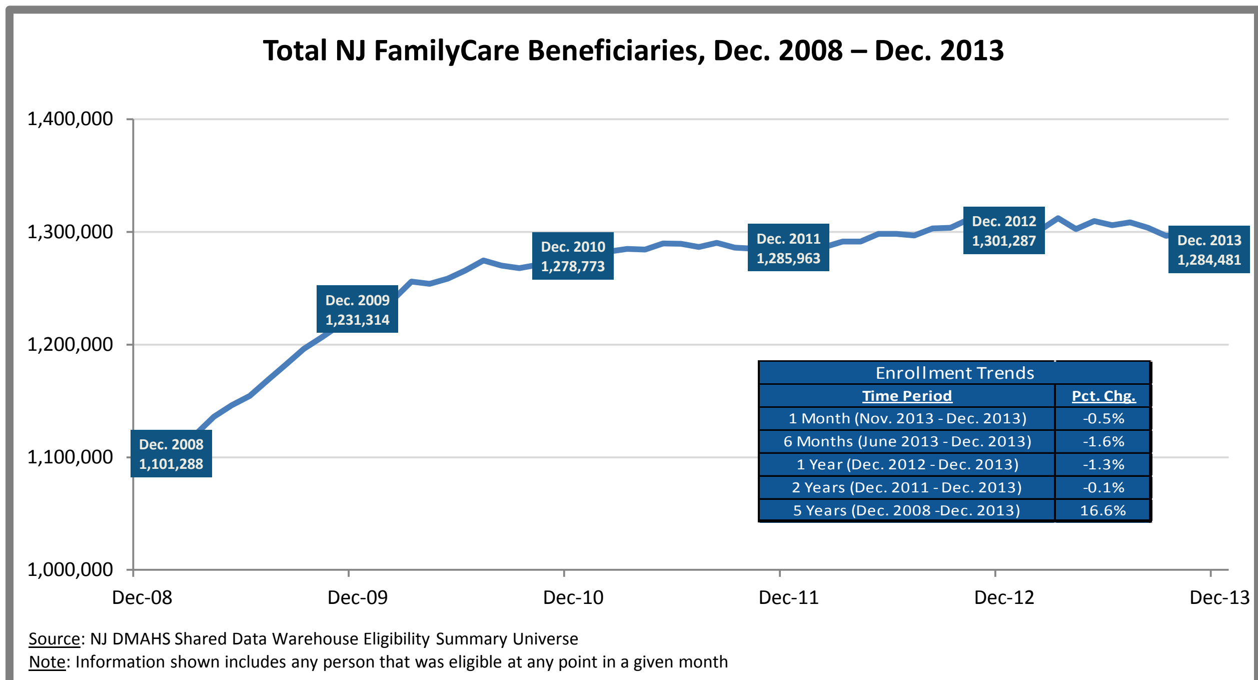
Throughout 2013, DMAHS planned and implemented changes that simplify and streamline the eligibility and enrollment processes. Beginning on October 1, NJ FamilyCare implemented the modified adjusted gross income (MAGI) method to determine eligibility for individuals under age 65, as required by federal law. MAGI is a uniform eligibility standard that establishes a new definition of income for most applicants. An individual's assets are not considered in the MAGI method. Please see Appendix A for a detailed description of eligibility categories effective in 2013 and Appendix B for a list of covered benefits.

Enrollment outreach strategies have been employed throughout the year with various community stakeholders and in coordination with other state government agencies. Strategies implemented in clinics, hospitals and schools have proven to be the most successful in reaching low-income, uninsured children. The Insure Kids Now hotline (1-800-KIDS-NOW) continues to be available nationwide to connect interested families to NJ FamilyCare information. Utilizing

federal funding, the Office of NJ FamilyCare Outreach developed a curriculum on NJ FamilyCare and the new changes included in federal law. As a result, training will be available to statewide agencies via sessions held at local county colleges. The training also includes instruction on applying online, Health Insurance Portability and Accountability Act compliance, cultural diversity and customer service and is the first step to becoming a certified Application Assistor.

Throughout 2013, overall enrollment in NJ FamilyCare remained steady at approximately 1.3 million beneficiaries, continuing a three year trend of limited growth in overall program enrollment.

The Rutgers Center for State Health Policy projects NJ FamilyCare will add 234,000 new individuals by December 2016, including those newly eligible as part of Medicaid expansion and those previously eligible but never enrolled. An additional 175,000 current NJ FamilyCare participants will have a larger share of their health care costs reimbursed by the federal government.

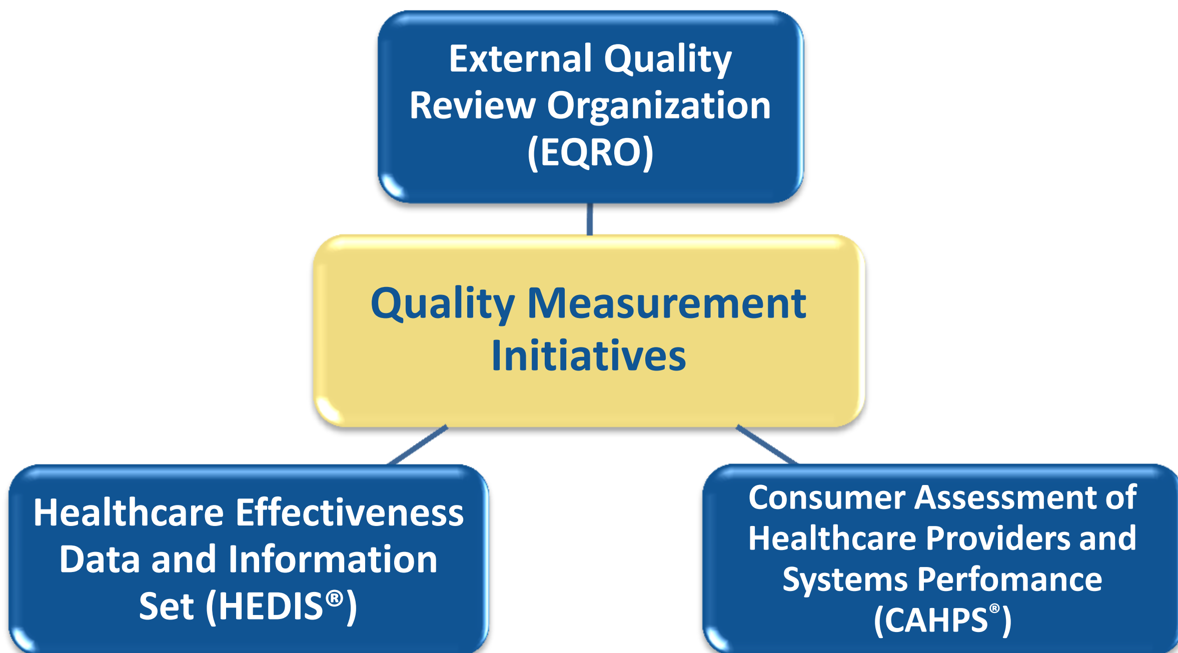


Quality

Beginning in the early 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 four health plans operating in New Jersey coordinate care delivery and provide services to 90% of the NJ FamilyCare population.

In order to monitor the quality of care delivered, measurement initiatives are undertaken to evaluate important indicators in three areas: Health Plan Operations, Health Plan and Health Services Satisfaction, and Clinical Health and Wellness measures. The methods are standardized so that beneficiaries and administrators alike may examine various aspects of plan performance and perform comparisons between all New Jersey plans as well as against national averages. Plan performance and customer satisfaction data is collected and analyzed by third parties for DMAHS while clinical data is collected by the plans and verified by independent auditors.

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.



EQRO

External Quality Review Organization: Assessment of Health Plan Operations

An independent, external quality review organization (EQRO) conducts an evaluation of each NJ FamilyCare plan to assess quality and compliance standards. The evaluation consists of a two-year process. The first year is considered a baseline year in which a comprehensive review of all requirements is performed. In the second year, a partial review of those elements that were Not Met or Not Applicable is conducted only if the plan scored an 85% compliance rate after the full review. New Jersey requires its health plans to conduct a full review at least every two years which exceeds the three-year process required by the Centers for Medicare & Medicaid Services. Island Peer Review Organization conducted the assessment for this report.

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. Additionally, certified auditors validate the health plans' reported Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures, using a process designed by the National Committee for Quality Assurance (NCQA).

Data were collected in State fiscal year 2011 (July 2010 – June 2011) for the full review and State fiscal year 2012 (July 2011 – June 2012) for the partial review. The chart below reflects scores from both years in addition to a final overall compliance score. Each NJ FamilyCare health plan demonstrates strong compliance with the requirements.

Assessment of Health Plan Operations

Health Plan	Elements Reviewed	Elements Met Year 1	Elements Met Year 2	Elements Unmet Year 2	% Elements Met After Year 2
Horizon	171	164	6	1	99.4%
United	171	160	8	3	98.2%
Amerigroup	171	157	11	3	98.2%
Healthfirst*	169	151	11	7	95.9%

*Two standards were considered not applicable for Healthfirst in the partial review as the plan had not yet received results of a contractor survey.

CAHPS®

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

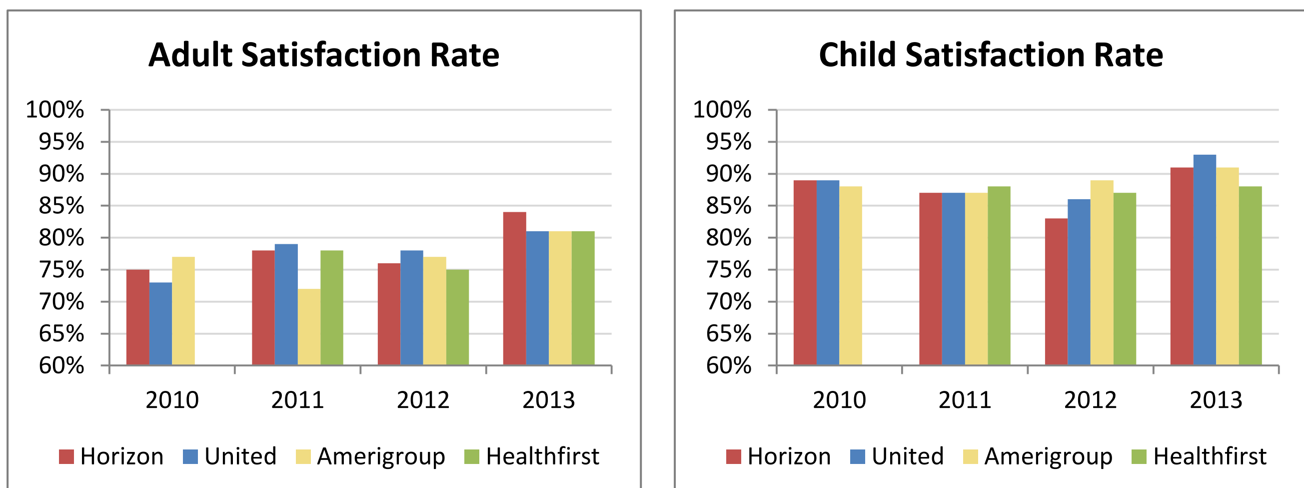
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a public-private initiative that utilizes standardized surveys in order to assess the experiences of patients in various settings. Each year a sample of beneficiaries from each NJ FamilyCare care health plan is surveyed by mail or 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 is overseen by CMS and administered by Xerox, New Jersey's health benefits coordinator.

The data for the 2013 survey were collected from March to June 2013. The results indicate that beneficiaries were generally satisfied with their health plan and that improvement was seen when compared to responses from the 2012 survey. Results in each of the four major CAHPS® areas are shown in the charts below.

Responses were generally comparable with National and Northeast regional averages. The results for "Overall Healthcare Satisfaction" improved for both the adults and children across all NJ FamilyCare plans. The average respondent score increased for 3 of the 4 health plans in all of the other major categories: Overall Health Plan Satisfaction, Personal Doctor Satisfaction and Specialist Doctor Satisfaction.

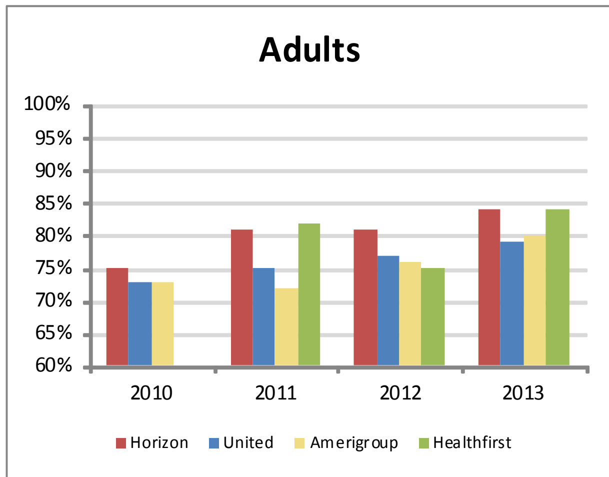
Dual Eligible Special Needs Plan (D-SNP) recipients were added to the survey this year as a separate sub-group. D-SNP is a coordinated care plan for New Jersey residents eligible for both Medicaid and Medicare (Parts A, B and D). Results of the CAHPS® survey may be found in Appendix D.

Chart I Overall Rating of Health Care



Note: Satisfaction is defined as a score of 7-10. Response rate was 13.7% for adults and 14.5% for children

Chart II Overall Health Plan Satisfaction



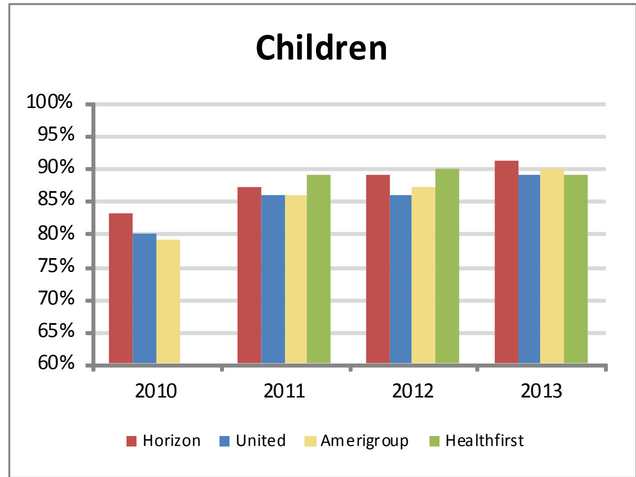
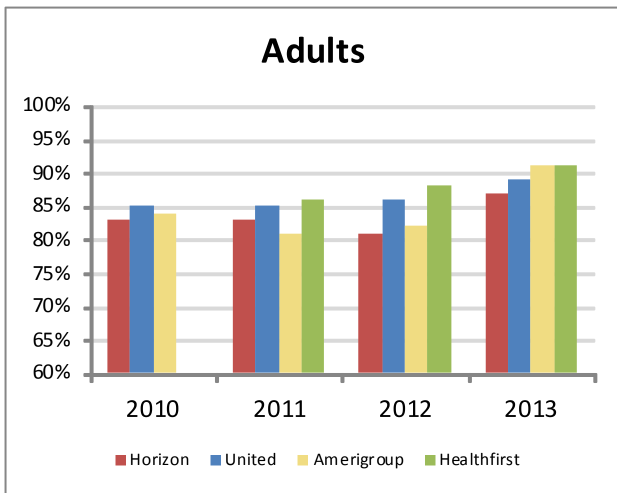


Chart III Personal Doctor Satisfaction



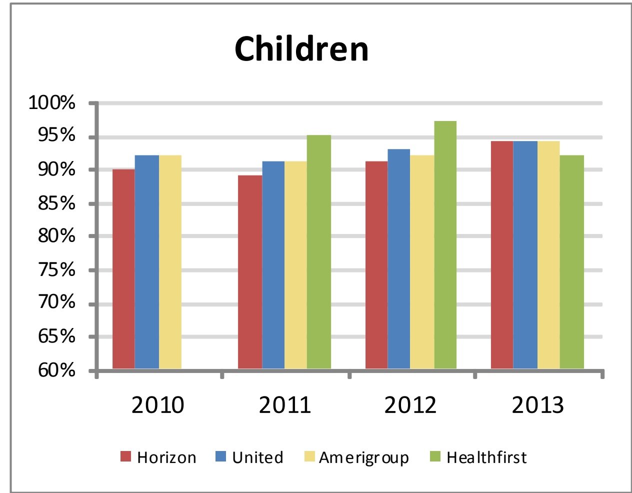
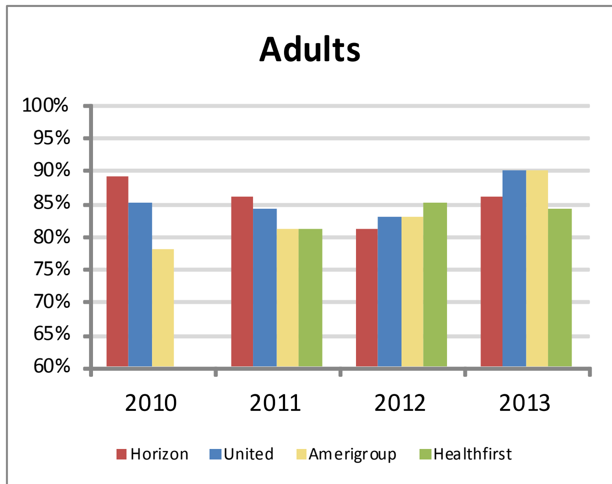
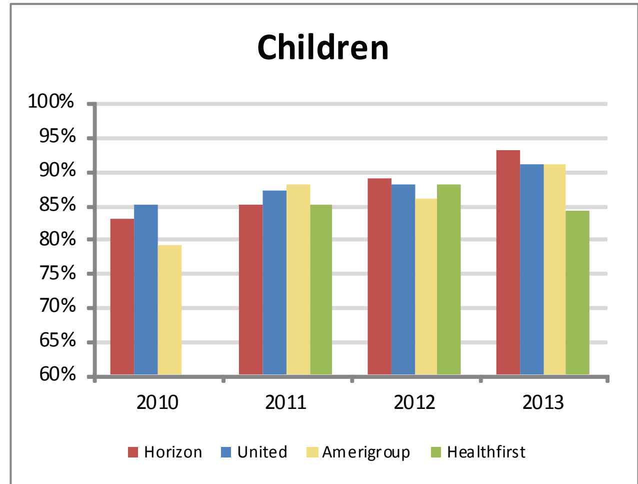


Chart IV Specialist Doctor Satisfaction





Note: Satisfaction is defined as a score of 7-10. Response rate was 13.7% for adults and 14.5% for children

HEDIS®

HEDIS® Healthcare Effectiveness Data and Information Set Performance Measures

HEDIS® is a tool used by more than 90% 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) and consists of 75 measures, across 8 domains of care, of which New Jersey requires its plans to submit 50. 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. 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 2013 HEDIS® report is based on services provided between January 1 and December 31, 2012.

In 2013, 68% of the measure scores exceeded the national Medicaid average or fell within 3% of the average compared to 62% of measures for 2012. New Jersey plans scored above the national Medicaid average in the following areas:

- Well Visits
- Lead Screening in Children
- Breast Cancer Screening
- Prenatal Care
- Immunizations for Adolescents
- Access to Primary Care Physicians
- Adult Asthma Medication Management
- Select Diabetes Care measures

Measures that met or fell within 3% of the national Medicaid average include Monitoring for Patients on Persistent Medication, Adult and Child BMI Assessment, Postpartum Care, Cervical Cancer Screening and several Comprehensive Diabetes Care indicators. Some measures that fell below the national Medicaid average are included in the New Jersey Department of Health's Healthy New Jersey 2020 initiative, and are a part of the new DMAHS Health Plan Performance Based Contracting program. These measures include Adolescent BMI Percentile Documentation and Childhood Immunizations. The following charts I - IV show adult and child HEDIS® measures where most health plans exceeded the national Medicaid average over a four year period. The complete set of 2013 HEDIS® results can be found in Appendix E.

Chart I One or More Well Child Visits (Ages 3-6 Years)

Chart II Lead Screening in Children

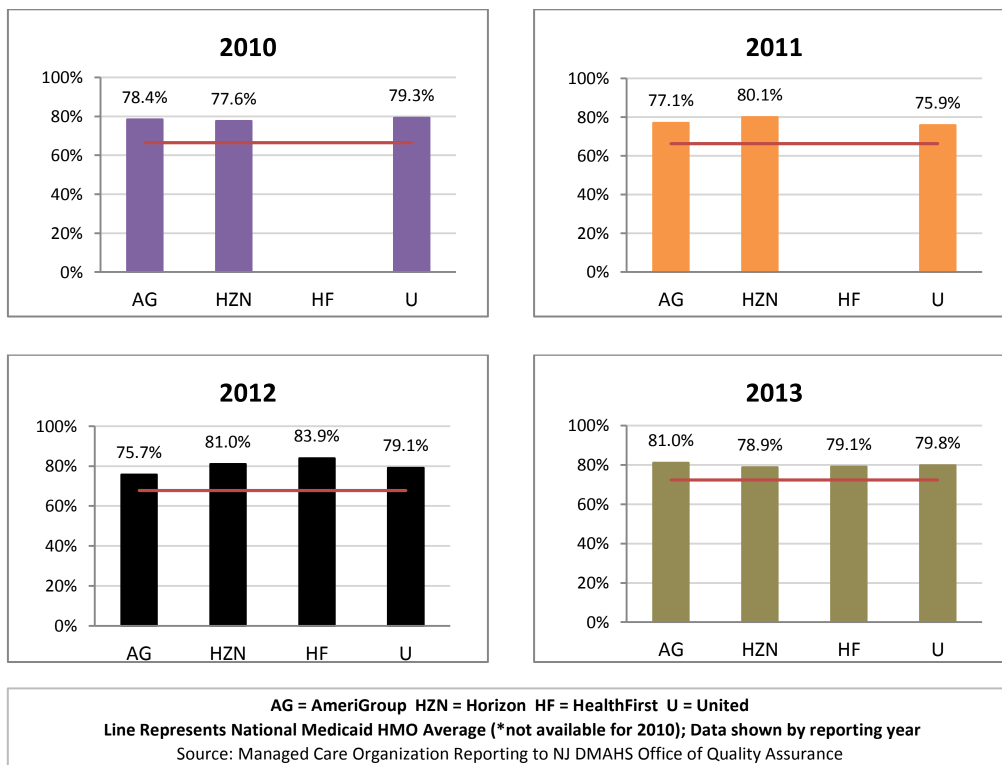


Chart III At Least One Comprehensive Well-Care Visit

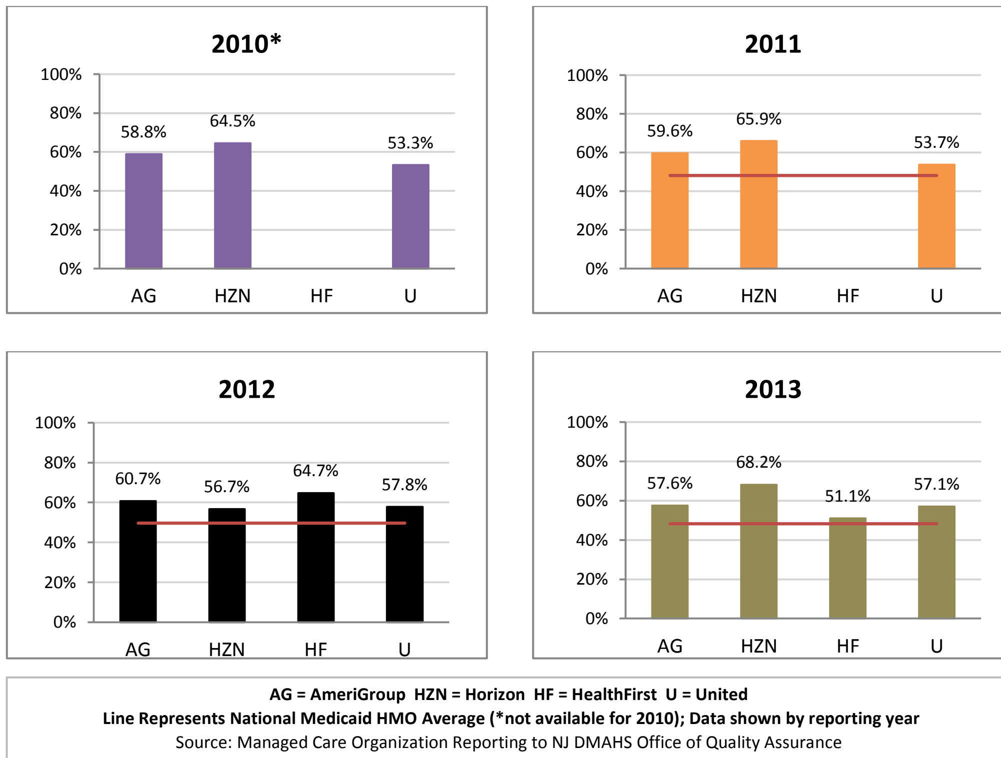
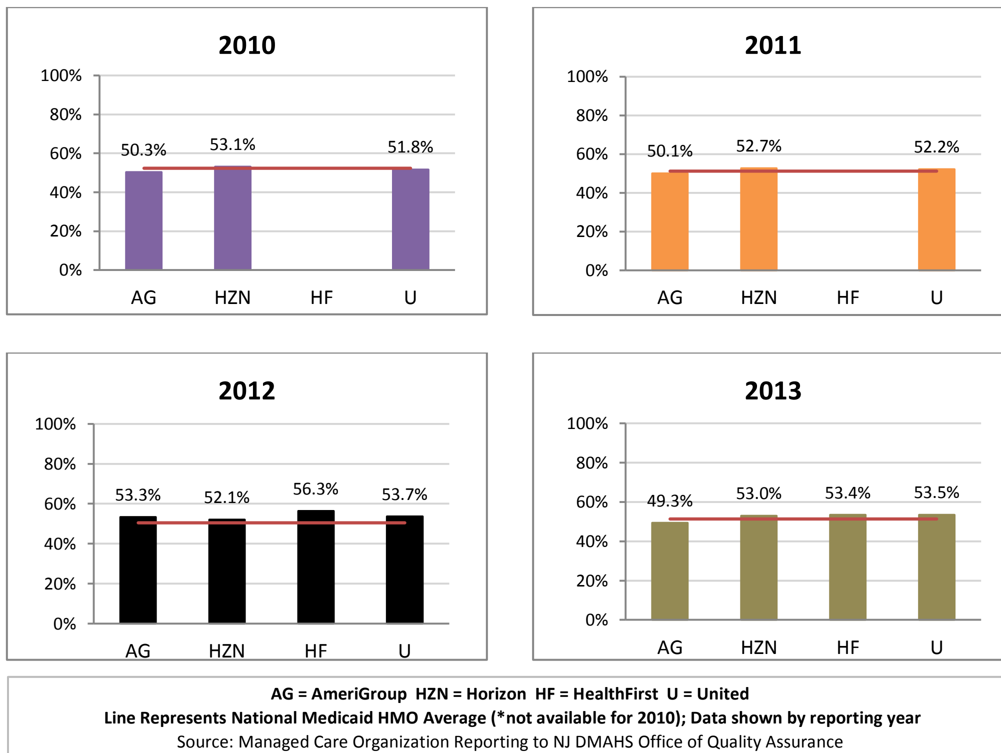


Chart IV Breast Cancer Screening



Health Plan Scorecards

DMAHS has developed scorecards in order to allow comparisons between NJ FamilyCare health plans in a clear, concise format. National rankings, plan enrollment data as well as key clinical and consumer satisfaction quality indicators over a four year period are included for each plan. The scorecards are divided into four sections: Overall Performance Indicators, Enrollment, Clinical Quality and Customer Satisfaction.

The Overall Performance Indicators section is comprised of assessments and rankings developed by the National Committee for Quality Assurance (NCQA). Health plans seeking NCQA accreditation submit to a rigorous on-site and off-site review of their structure and operations against NCQA's national standards for quality measurement and continuous quality improvement. The review addresses patient safety, communication with members, and clinical performance measures such as HEDIS® scores. Plans are assigned individual scores for consumer satisfaction, prevention and treatment, as well as an overall score, and then ranked nationally according to that overall score.

The Enrollment section is a snapshot of the number of members enrolled in each plan as of December 2013 and sub-categorized by age. The next section is Clinical Quality and contains select HEDIS® measures defined as follows:

- *Timeliness of Prenatal care*: Percentage of women who had a prenatal visit within the first trimester or within 42 days of enrollment
- *Postpartum Care*: Percentage of women who had a postpartum visit between 21 and 56 days after delivery
- *Diabetes HbA1C<8%:* Percentage of adults aged 18-75 with diabetes HbA1c < 8.0 % indicating good control
- *BMI Documentation*: The percentage of members 3-17 years of age who had an outpatient visit and whose body mass index (BMI) was documented
- *Well Child Visits 0-15 Months:* Percentage of children who had six or more well-child visits in the first 15 months of life.
- *Child Immunizations:* Percentage of children who by the time they turned two had the recommended number of vaccines - Combination 2
- *Breast Cancer Screening:* Percentage of women who had a mammogram in the measurement year or the prior year.

The final section is Customer Satisfaction as measured by the CAHPS® survey. The percentages refer to the number of survey respondents who indicate that they are satisfied.

Horizon

Horizon Blue Cross Blue Shield of New Jersey

Horizon NJ Health

Overall Performance Indicators

	2012	2013
NCQA Accreditation	none	Commendable (4 of 5)
NCQA National Medicaid HMO Ranking	105th of 115	35th of 131
NCQA Ranking Overall Score (out of 100)	66.1	81.6

Member Enrollment (As of December 31)

Category	2010	2011	2012	2013
Overall Enrollees	472,418	537,012	565,782	587,922
Adult (age 19+) Enrollees	158,576	205,578	215,670	227,668
Child (age 0-18) Enrollees	313,842	331,434	350,112	360,254

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

Measure	2010	2011	2012	2013
Timeliness of Prenatal Care	83.2%	78.4%	***83.9%***	85.6%
Post Partum Care (21 -56 Days)	***65.2%***	58.4%	60.8%	***64.1%***
Diabetes: HbA1C <8%	***54.6%***	***52.7%***	47.7%	***50.7%***
BMI Documentation (Age 3-17)	N/A	N/A	***69.8%***	***59.9%***
Well Child Visits 0-15 Months	70.1%	***75.9%***	***72.3%***	***72.8%***
Child Immunizations (Combination 2)	70.3%	***77.6%***	71.8%	72.8%
Breast Cancer Screening	***53.1%***	***52.7%***	***52.1%***	***53.0%***

Customer Satisfaction (CAHPS® Survey)

Measure	2010	2011	2012	2013
Adults Satisfied with Health Plan	75%	81%	81%	84%
Adults Satisfied with Personal Doctor	83%	83%	81%	87%
Adults Satisfied with Specialist	89%	86%	81%	86%
Children Satisfied with Health Plan	83%	87%	89%	91%
Children Satisfied with Personal Doctor	90%	89%	91%	94%
Children Satisfied with Specialists	83%	85%	89%	93%

UnitedHealthcare
Community Plan

Overall Performance Indicators

	2012	2013
NCQA Accreditation Level	None	None
NCQA National Medicaid HMO Ranking	No data reported	No data reported
NCQA Ranking Overall Score	No data reported	No data reported

Member Enrollment (As of December 31)

Category	2010	2011	2012	2013
Overall Enrollees	356,014	408,663	415,524	380,888
Adult (age 19+) Enrollees	120,926	161,401	162,906	148,977
Child (age 0-18) Enrollees	235,088	247,262	252,618	231,911

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

Measure	2010	2011	2012	2013
Timeliness of Prenatal Care	***87.6%***	82.0%	81.5%	81.2%
Post Partum Care (21 -56 Days)	61.8%	58.2%	55.5%	61.7%
Diabetes: HbA1C <8%	39.7%	45.7%	43.0%	39.3%
BMI Documentation (Age 3-17)	N/A	N/A	28.5%	43.1%
Well Child Visits 0-15 Months	62.3%	60.1%	59.8%	60.1%
Child Immunizations (Combination 2)	***82.2%***	***76.6%***	67.4%	67.4%
Breast Cancer Screening	51.8%	***52.2%***	***53.7%***	***53.5%***

Customer Satisfaction (CAHPS® Survey)

Measure	2010	2011	2012	2013
Adults Satisfied with Health Plan	73%	75%	77%	79%
Adults Satisfied with Personal Doctor	85%	85%	86%	89%
Adults Satisfied with Specialist	85%	84%	83%	90%
Children Satisfied with Health Plan	80%	86%	86%	88%
Children Satisfied with Personal Doctor	92%	91%	93%	94%
Children Satisfied with Specialists	85%	87%	88%	91%

Amerigroup RealSolutions in healthcare

Overall Performance Indicators

	2012	2013
NCQA Accreditation Level	none	Commendable (4 of 5)
NCQA National Medicaid HMO Ranking	No data reported	67th of 131
NCQA Ranking Overall Score (out of 100)	No data reported	79.6

Member Enrollment (As of December 31)

Category	2010	2011	2012	2013
Overall Enrollees	131,311	152,663	149,420	150,595
Adult (age 19+) Enrollees	46,227	65,200	62,053	62,891
Child (age 0-18) Enrollees	85,084	87,463	87,367	87,704

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

Measure	2010	2011	2012	2013
Timeliness of Prenatal Care	***89.4%***	***90.2%***	***89.1%***	***87.7%***
Post Partum Care (21 -56 Days)	64.1%	60.6%	60.2%	52.7%
Diabetes: HbA1C <8%	40.2%	***47.6%***	***52.7%***	***48.7%***
BMI Documentation (Age 3-17)	N/A	N/A	N/A	35.7%
Well Child Visits 0-15 Months	69.4%	***68.8%***	***68.0%***	***65.5%***
Child Immunizations (Combination 2)	***78.4%***	***76.4%***	***75.7%***	74.3%
Breast Cancer Screening	50.3%	50.1%	***53.3%***	49.3%

Customer Satisfaction (CAHPS® Survey)

Measure	2010	2011	2012	2013
Adults Satisfied with Health Plan	73%	72%	76%	80%
Adults Satisfied with Personal Doctor	84%	81%	82%	91%
Adults Satisfied with Specialist	78%	81%	83%	90%
Children Satisfied with Health Plan	79%	86%	87%	90%
Children Satisfied with Personal Doctor	92%	91%	92%	94%
Children Satisfied with Specialists	79%	88%	86%	91%

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Overall Performance Indicators

	2012	2013
NCQA Accreditation Level	None	None
NCQA National Medicaid HMO Ranking	No data reported	No data reported
NCQA Ranking Overall Score	No data reported	No data reported

Member Enrollment (As of December 31)

Category	2010	2011	2012	2013
Overall Enrollees	23,000	46,212	42,382	47,378
Adult (age 19+) Enrollees	6,817	23.215	23,311	25,862
Child (age 0-18) Enrollees	16,183	22,997	19,071	21,516

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

Measure	2010	2011	2012	2013
Timeliness of Prenatal Care	N/A	N/A	82.7%	76.9%
Post Partum Care (21 -56 Days)	N/A	N/A	55.7%	54.6%
Diabetes: HbA1C <8%	N/A	N/A	***50.9%***	37.3%
BMI Documentation (Age 3-17)	N/A	N/A	***56.9%***	43.8%
Well Child Visits 0-15 Months	N/A	N/A	***73.2%***	64.6%
Child Immunizations (Combination 2)	N/A	N/A	74.2%	64.0%
Breast Cancer Screening	N/A	N/A	***56.3%***	***53.4%***

Customer Satisfaction (CAHPS® Survey)

Measure	2010	2011	2012	2013
Adults Satisfied with Health Plan	N/A	82%	75%	84%
Adults Satisfied with Personal Doctor	N/A	86%	88%	91%
Adults Satisfied with Specialist	N/A	81%	85%	84%
Children Satisfied with Health Plan	N/A	89%	90%	89%
Children Satisfied with Personal Doctor	N/A	95%	97%	92%
Children Satisfied with Specialists	N/A	85%	88%	84%

Infrastructure

Some of the major functions that comprise the fundamental framework for the operation of NJ FamilyCare programs include enrollment and eligibility systems, capitation and claims payment, audit functions, customer service, data analytics and the provision of transportation to beneficiaries for covered services. DMAHS has assembled an internal team, as well as external vendors, with the expertise to manage these critical functions for NJ FamilyCare.

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. In addition to processing more than 178 million transactions in 2013, Molina operates a provider call center, manages correspondence, administers mandated second opinions, and performs health benefits identification services, training and Fair Hearing functions.

Data Analytics

OptumInsight maintains the New Jersey Shared Data Warehouse which stores twelve years of NJ FamilyCare 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. Business intelligence tools, including interactive dashboards, were developed using information from the Shared Data Warehouse. These dashboards supply senior management with rapid, nimble access to vital data.

Customer Service

Xerox, New Jersey's Health Benefits Coordinator, performs functions that 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 2013, Xerox received 796,899 calls from consumers and performed 279,941 eligibility determinations. Outreach campaigns served 47,968 individuals in the cities of Camden, New Brunswick, Newark and Paterson, with 11,264 applications processed. NJ FamilyCare directly operates five Medical Assistance Consumer Centers (MACC) with locations throughout the state. The MACCs assist NJ FamilyCare beneficiaries in obtaining needed services and in answering questions regarding their benefit packages.

Quality Control

The Bureau of Quality Control (BQC) performs federally mandated case reviews of eligibility and termination decisions made by the county welfare agencies and Xerox. The purpose of this function, 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 Medicaid/CHIP 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 Transportation

LogistiCare became the DMAHS medical transportation broker in July 2009 and is currently responsible for arranging non-emergency mobility assistance vehicles, ambulance and livery service for NJ FamilyCare beneficiaries in all counties. On July 1, 2011, the broker agreed to assume responsibility for all non-emergency managed care transportation, carving it out of the contracts from the health plans. In 2013, LogistiCare provided more than 4 million verified paid trips to and from medically necessary appointments for NJ FamilyCare beneficiaries.

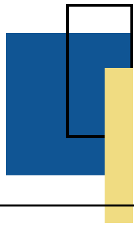
Medicaid Fraud Division

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.

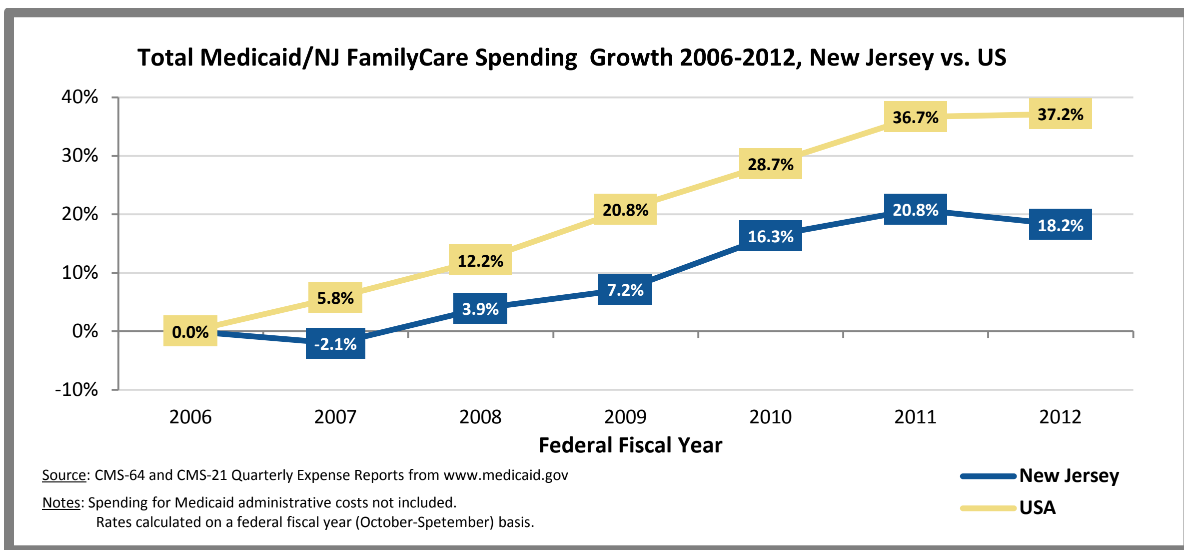
In State fiscal year 2013, MFD recovered a state record $122.9 million in improperly paid NJ FamilyCare funds, which were returned to both the state and federal budgets. In addition, an estimated $392 million in other potential NJ FamilyCare expenses were avoided through MFD's proactive anti-fraud efforts. MFD also excluded 60 ineligible providers from participating in the NJ FamilyCare program.

In addition to MFD's efforts, the DMAHS Office of Legal and Regulatory Affairs was involved in the recovery of Medicaid funds from estates and special needs trusts, and the recovery of NJ FamilyCare funds in cases involving tort settlements, casualty insurance and incorrectly paid benefits due to ineligibility. In calendar year 2013, this Office generated or helped to generate the recovery of $33.9 million in federal and state funds.

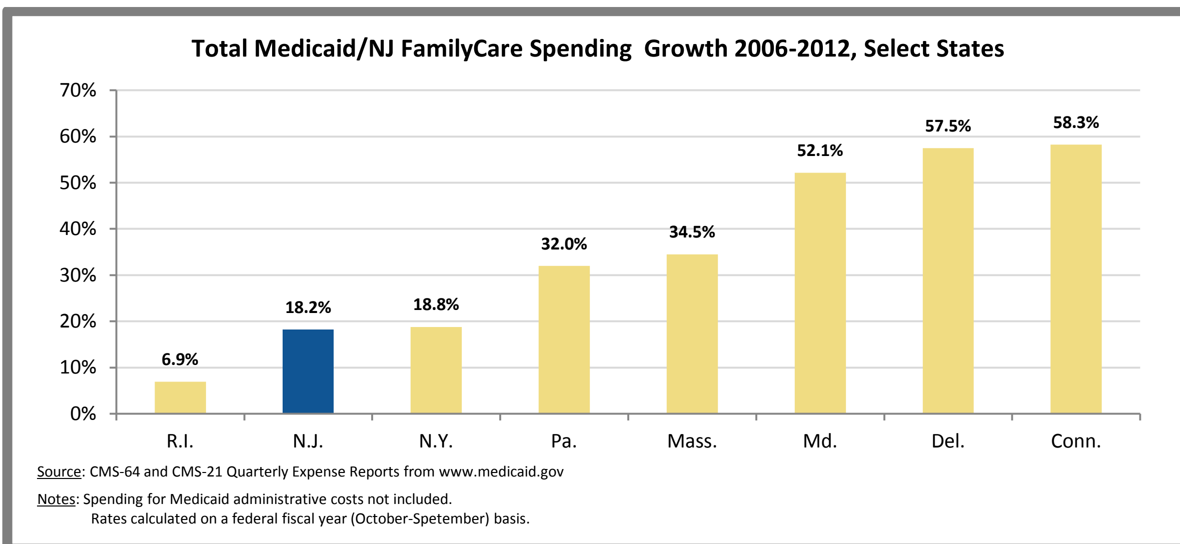


Fiscal Summary

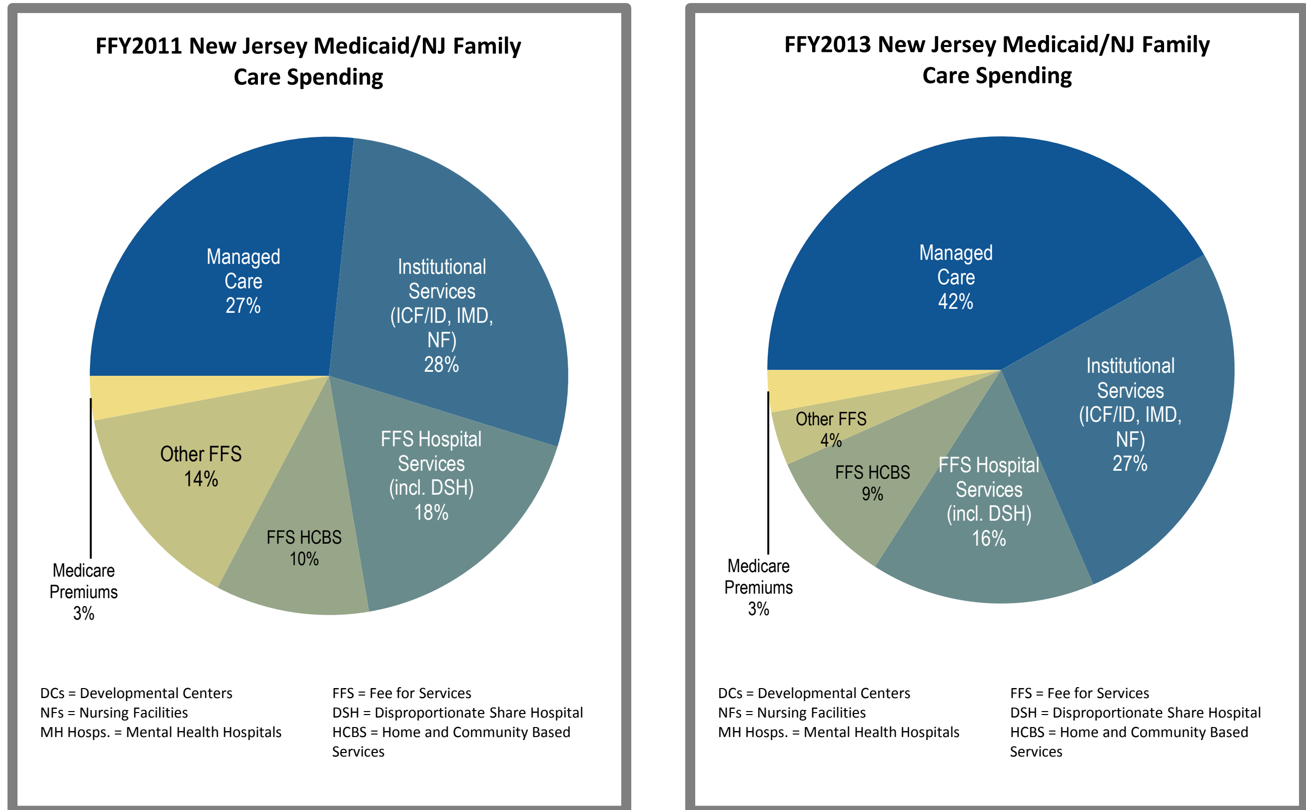
New Jersey continues to be a national leader in managing spending growth. While overall net spending reductions are difficult to achieve in the current medical inflationary environment, NJ FamilyCare spending grew well below the national trend between federal fiscal year 2006 and 2012 (the last year national numbers are available; the federal fiscal year is October - September); New Jersey's cumulative spending growth in this period was less than half of the national Medicaid/CHIP growth rate.



New Jersey's spending growth has been the second lowest in the region over the same period as well.



One of the primary ways New Jersey has been able to achieve lower levels of overall spending is through the continual migration of physical health medical services to managed care. Over the last three federal fiscal years, spending on managed care capitation payments has increased 15% while non-hospital, non-institutional fee-for-service spending, shown as "Other FFS" in the charts below, has decreased 10%.



Source: CMS-64 and CMS-21 Quarterly Expense Reports from www.medicaid.gov
Notes: Spending for Medicaid administrative costs not included.
Rates calculated on a federal fiscal year (October-September) basis.

As the trend towards moving services into managed care continues, oversight of the capitation rates established for NJ FamilyCare's health plans remains crucial to ensuring New Jersey maintains its low rate of spending growth. NJ FamilyCare is utilizing all available tools to ensure that capitation rates continue to grow at a reasonable rate, while incorporating assumed efficiencies from moving additional services to managed care, and improving integration of physical and behavioral health services given the economic reality of continued medical inflation.

Appendices

Appendix A:
2013 NJ FamilyCare Eligibility Categories

Appendix B:
2013 NJ FamilyCare Covered Benefits

Appendix C:
2012 Assessment of Health Plan Operations

Appendix D:
2013 CAHPS Health Plan Survey

Appendix E:
2013 HEDIS Performance Measures

Appendix A: 2013 NJ FamilyCare Eligibility Categories (Before federal law changes)

Population	Program	Description	Income Limit
Medicaid Children	AFDC-Related Children	Children up to the age of 18 (or 19 if a full time student)	1996 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	133% FPL
	Household of One	Children enrolled through the Department of Children's Behavioral Health 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.	Income cannot exceed monthly standard of $185. Child support $50 disregard allowed. All earned income is disregarded if a full-time student; $90 if not. No resource standard.
	Medicaid Special	Single Adults age 19 through the end of the month that they turn 21.	The difference between the 1996 AFDC income standard and 133%FPL is disregarded from the remaining earned income (this disregard is used instead of the normal AFDC earned income disregard). Countable unearned income must be ≤ the 1996 AFDC income standard. Countable income after all disregards income must be ≤ the 1996 AFDC standard. No resource limit.
	Children	Children Age 1-18	1996 AFDC standard> Income ≤ 133% FPL
CHIP Children	New Born Program	Children under age 1	133% FPL> Income ≤ 185% FPL
	CHIP Plan B	Children under the age 19 without other insurance	133% 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	185% FPL
	CHIP Pregnant Woman	Must be a Pregnant Woman without TPL	185% FPL> Income ≤ 200% FPL

Appendix A: 2013 NJ FamilyCare Eligibility Categories (Before federal law changes)

Population	Program	Description	Income Limit
Parents and Caretaker Relatives	Parents and Caretaker Relatives	AFDC Related Parents	1996 AFDC Income Limit
		Parents	1996 AFDC standard> Income ≤ 133% FPL - the difference between the 1996 AFDC income standard is disregarded from the remaining earned income)
	CHIP Parents and Caretaker Relatives	Parents of a child enrolled in CHIP*	133% FPL > Income ≤ 200% FPL
	Former Health Access	Parents*	150% FPL > Income ≤ 250% FPL
Single Adults and Couples Without Children		Single Adults and Couples without Children*	150% FPL > Income ≤ 250% FPL
	CHIP Adults	Single Adults and Couples without Children*	100% 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.	
	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	

Appendix A: 2013 NJ FamilyCare Eligibility Categories (Before federal law changes)

Population	Program	Description	Income Limit
Medicaid Only	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.	

Appendix A: 2013 NJ FamilyCare Eligibility Categories (Before federal law changes)

Population	Program	Description	Income Limit
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
	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

Appendix A: 2013 NJ FamilyCare Eligibility Categories (Before federal law changes)

Population	Program	Description	Income Limit
SSI	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 or over and clinically eligible for Long Term Care	
	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 Long Term Care	
	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- under the age of 21 living in the community	
		Community- under the age of 21 and clinically eligible for LTC	
	Pregnant Women	Must be a pregnant woman	

Appendix A: 2013 NJ FamilyCare Eligibility Categories (Before federal law changes)

Population	Program	Description	Income Limit
DCP&P	DCP&P Children	DCP&P Custody	Eligibility Determined by DCP&P
		Subsidized Adoptions	
		Kinship Legal Guardianship	
		Chaffee Kids	
		5 year bar exception - State Funds Only	
		Income exception - State Funds Only	
		DCP&P Services - State Funds Only	
* Indicates the Program is no longer accepting new applicants			

Appendix B: NJ FamilyCare Covered Benefits*

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
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)
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: 2012 Assessment of Health Plan Operations

Horizon NJ Health							Deficiency Status	
Review Category	**Total Elements**	**Met Prior Year**	**Subject to Review**	**Met**	**N/A**	**% Met**	**Prior**	**Resolved**
Access	7	6	1	1	0	100	0	1
Quality Assessment and Performance Improvement	9	9	0	0	0	100	0	0
Quality Management	12	12	0	0	0	100	0	0
Committee Structure	7	7	0	0	0	100	0	0
Programs for the Elderly and Disabled	42	38	4	4	0	100	0	4
Provider Training and Performance	9	7	2	1	0	89	1	1
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	26	26	0	0	0	100	0	0
Credentialing and Recredentialing	8	8	0	0	0	100	0	0
Utilization Management	20	20	0	0	0	100	0	0
Administration and Operations	11	11	0	0	0	100	0	0
Management Information Systems	12	12	0	0	0	100	0	0
Total	171	164	7	6	0	99	1	6

Source: IPRO: 2012 Annual Assessment of HMO Operations – Last Revised 2/27/2013

Appendix C: 2012 Assessment of Health Plan Operations

UnitedHealthCare Community Plan							Deficiency Status	
Review Category	Total Elements	Met Prior Year	Subject to Review	Met	N/A	% Met	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	12	12	0	0	0	100	0	0
Committee Structure	7	7	0	0	0	100	0	0
Programs for the Elderly and Disabled	42	37	5	5	0	100	0	5
Provider Training and Performance	9	7	2	1	0	89	1	1
Satisfaction	3	3	0	0	0	100	0	0
Enrollee Rights and Responsibilities	5	4	1	1	0	100	0	1
Care Management and Continuity of Care	26	26	0	0	0	100	0	0
Credentialing and Recredentialing	8	8	0	0	0	100	0	0
Utilization Management	20	19	1	1	0	100	0	1
Administration and Operations	11	11	0	0	0	100	0	0
Management Information Systems	12	12	0	0	0	100	0	0
Total	171	160	11	8	0	98	3	8

Source: IPRO: 2012 Annual Assessment of HMO Operations – Last Revised 2/27/2013

Appendix C: 2012 Assessment of Health Plan Operations

Amerigroup New Jersey, Inc.							Deficiency Status	
Review Category	**Total Elements**	**Met Prior Year**	**Subject to Review**	**Met**	**N/A**	**% Met**	**Prior**	**Resolved**
Access	7	5	2	1	0	86	1	1
Quality Assessment and Performance Improvement	9	8	1	1	0	100	0	1
Quality Management	12	11	1	1	0	100	0	1
Committee Structure	7	7	0	0	0	100	-	-
Programs for the Elderly and Disabled	42	35	7	7	0	100	0	7
Provider Training and Performance	9	9	0	0	0	100	-	-
Satisfaction	3	3	0	0	0	100	-	-
Enrollee Rights and Responsibilities	5	5	0	0	0	100	-	-
Care Management and Continuity of Care	26	26	0	0	0	100	-	-
Credentialing and Recredentialing	8	6	2	1	0	88	1	1
Utilization Management	20	19	1	0	0	95	1	0
Administration and Operations	11	11	0	0	0	100	-	-
Management Information Systems	12	12	0	0	0	100	-	-
Total	171	157	14	11	0	98	3	11

Source: IPRO: 2012 Annual Assessment of HMO Operations – Last Revised 2/27/2013

Appendix C: 2012 Assessment of Health Plan Operations

Healthfirst Health Plan of New Jersey, Inc.							Deficiency Status	
Review Category	**Total Elements**	**Met Prior Year**	**Subject to Review**	**Met**	**N/A**	**% Met**	**Prior**	**Resolved**
Access	7	6	1	0	0	86	1	0
Quality Assessment and Performance Improvement	9	9	0	0	0	100	0	0
Quality Management	12	11	1	0	0	92	1	0
Committee Structure	7	5	2	1	0	86	1	1
Programs for the Elderly and Disabled	42	36	6	5	0	98	1	5
Provider Training and Performance	9	6	3	1	0	78	2	1
Satisfaction	3	0	3	1	2	100	0	0
Enrollee Rights and Responsibilities	5	3	2	2	0	100	0	2
Care Management and Continuity of Care	26	25	1	1	0	100	0	1
Credentialing and Recredentialing	8	8	0	0	0	100	0	0
Utilization Management	20	20	0	0	0	100	0	0
Administration and Operations	11	10	1	0	0	91	1	0
Management Information Systems	12	12	0	0	0	100	0	0
Total	171	151	20	11	2	96	7	10

Note: In the prior year all three elements for Satisfaction were determined to be not applicable (NA) for HFNJ. In the current review two continued to be NA and one was determined to be Met. The element determined to be Met is not reflected in the resolved column as it was not a deficiency in the last review.

Source: IPRO: 2012 Annual Assessment of HMO Operations – Last Revised 2/27/2013

Appendix D: 2013 CAHPS Health Plan Survey

Measure	Horizon	United	Amerigroup	Healthfirst	New Jersey Medicaid Average	National Medicaid Average
Overall Rating of Health Care						
Adults	84%	81%	81%	81%	81%	82%
Children	91%	93%	91%	88%	91%	90%
D-SNP [1]	79%	76%	79%	75%	77%	n/a[2]
Overall Health Plan Satisfaction						
Adults	84%	79%	80%	84%	81%	84%
Children	91%	89%	90%	89%	89%	90%
D-SNP[1]	85%	76%	84%	83%	82%	n/a[2]
Overall Personal Doctor Satisfaction						
Adults	87%	89%	91%	91%	90%	87%
Children	94%	94%	94%	92%	93%	92%
D-SNP[1]	90%	90%	95%	91%	91%	n/a[2]
Overall Specialist Doctor Satisfaction						
Adults	86%	90%	90%	84%	88%	87%
Children	93%	91%	91%	84%	91%	91%
D-SNP[1]	92%	85%	89%	87%	88%	n/a[2]
Overall Rating of Dental Care						
Adults	76%	79%	75%	77%	77%	n/a[3]
Children	87%	87%	81%	89%	86%	n/a[3]
D-SNP[1]	73%	74%	70%	61%	70%	n/a[2,3]

[1] D-SNP is a coordinated care plan for New Jersey residents eligible for both Medicaid and Medicare (Parts A, B and D).

[2] National averages are not available for D-SNP measures

[3] National averages are not available for dental measures

Appendix E: 2013 HEDIS Perfomance Measures

Measure	Amerigroup	Healthfirst	Horizon	United	New Jersey Medicaid Average	Medicaid National Average
Childhood Immunization (CIS)						
Combination 2	74.31%	63.99%	72.75%	67.40%	70.49%	75.70%
Combination 3	68.75%	58.39%	66.67%	62.53%	64.97%	72.10%
Lead Screening in Children (LSC)	81.04%	79.08%	78.85%	79.81%	79.48%	67.50%
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	65.51%	64.63%	72.84%	60.05%	66.74%	63.60%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	75.35%	73.97%	81.72%	75.68%	78.48%	72.00%
Adolescent Well-Care Visits (AWC)	57.59%	51.06%	68.15%	57.07%	62.33%	49.70%
Breast Cancer Screening (BCS)	49.32%	53.38%	53.00%	53.53%	52.73%	51.90%
Cervical Cancer Screening (CCS)	62.76%	37.90%	65.72%	65.03%	64.23%	64.50%
Use of Appropriate Medications for People With Asthma (ASM)						
5-11 Years	83.59%	84.62%	82.07%	85.53%	83.50%	89.60%
12-18 Years	78.88%	72.97%	76.85%	81.70%	78.64%	85.60%
19-50 Years	78.43%	NA	75.13%	71.33%	74.25%	73.90%
51-64 Years	81.95%	NA	76.23%	77.71%	77.43%	71.40%
Total	81.10%	79.17%	78.77%	81.14%	79.84%	83.90%
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	79.33%	59.56%	80.47%	78.26%	78.12%	83.00%
HbA1c Poor Control (>9.0%)	43.03%	56.83%	40.33%	51.04%	45.68%	44.70%
HbA1c Control (<8.0%)	48.70%	37.34%	50.73%	39.32%	45.41%	46.50%
HbA1c Control (<7.0%) for a Selected Population	37.11%	30.43%	39.90%	30.80%	35.54%	34.00%
Eye Exam	50.69%	35.88%	64.05%	46.35%	54.09%	53.20%
LDL-C Screening	82.24%	60.84%	77.92%	81.25%	78.50%	75.50%
LDL-C Level <100 mg/dL	37.37%	28.23%	36.13%	29.43%	33.29%	33.90%
Medical Attention for Nephropathy	73.35%	69.76%	74.64%	75.65%	74.53%	78.40%
Blood Pressure Controlled <140/80 mm Hg	30.17%	27.69%	43.61%	32.81%	36.99%	37.80%
Blood Pressure Controlled <140/90 mm Hg	51.00%	42.99%	67.34%	54.30%	58.99%	58.90%
Controlling High Blood Pressure (CBP)	52.09%	44.04%	58.56%	45.26%	51.70%	56.30%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	87.70%	76.90%	85.57%	81.22%	83.95%	82.90%
Postpartum Care	52.67%	54.55%	64.05%	61.71%	61.16%	63.00%
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)[2]	30.91%	58.23%	65.32%	59.02%	62.20%	60.40%
Immunizations For Adolescents (IMA)						
Meningococcal	83.52%	77.39%	89.62%	82.96%	86.16%	69.40%
Tdap/Td	86.45%	84.04%	91.15%	85.93%	88.50%	81.30%
Combination 1	80.95%	75.80%	87.31%	79.26%	83.33%	67.20%
Appropriate testing for children with pharyngitis (CWP)	63.81%	67.69%	52.16%	62.42%	58.57%	68.00%
Chlamydia Screening (CHL)						
16-20	50.70%	45.23%	44.62%	50.28%	47.38%	53.50%
21-24	62.13%	52.85%	53.19%	56.75%	55.61%	63.60%
Total	55.15%	48.29%	48.01%	53.09%	50.75%	57.10%

Source: IPRO New Jersey's External Quality Review Organization -Last Revised 9/26/13

Appendix E: 2013 HEDIS Perfomance Measures

Measure	Amerigroup	Healthfirst	Horizon	United	New Jersey Medicaid Average	Medicaid National Average
BMI assessment for children/adolescents (WCC)						
3 - 11	36.64%	43.22%	61.67%	43.75%	51.60%	52.88%
12 - 17	33.81%	44.93%	56.14%	41.46%	47.80%	53.66%
Total	35.73%	43.80%	59.89%	43.07%	50.40%	52.31%
Follow up care for children prescribed ADHD medication (ADD)						
Initiation Phase	37.38%	47.90%	32.34%	30.12%	32.27%	39.00%
Continuation and Maintenance Phase	38.73%	N/A	40.22%	30.20%	34.61%	45.30%
Follow-up after hospitalization for mental illness (FUH) [3]						
30 Day Followup	32.50%	NA	75.68%	38.46%	43.47%	63.60%
7 Day Followup	10.00%	NA	41.89%	21.33%	22.80%	43.70%
Adult BMI Assessment (ABA)	59.63%	58.15%	72.24%	59.12%	65.41%	67.50%
Annual Monitoring for Patients on Persistent Medications (MPM)						
ACE Inhibitors or ARBs	89.17%	86.18%	82.78%	88.80%	86.03%	86.30%
Digoxin	91.03%	NA	86.85%	92.56%	90.13%	90.20%
Diuretics	89.11%	84.62%	82.41%	88.61%	85.72%	86.00%
Anti- convulsants	64.42%	NA	61.30%	65.20%	63.41%	65.80%
Total	86.27%	85.39%	80.68%	86.27%	83.68%	84.50%
Children and Adolescents' Access to Primary Care Practitioners (CAP)						
12-24 months	96.25%	94.16%	98.10%	97.17%	97.42%	96.00%
25 months - 6 years	87.90%	87.12%	92.07%	91.33%	91.20%	88.30%
7-11 years	89.04%	91.80%	94.27%	93.32%	93.24%	89.90%
12-19 years	88.40%	89.14%	92.16%	91.91%	91.55%	88.40%

[1] Weighted average, uses all MCO data.
[2] Amerigroup's rates are excluded from the weighted and unweighted averages. Amerigroup used Adminstrative Methodology to report this measure.
[3] Follow-up After Hospitalization is only applicible for the DDD population
Designation NA: Plan had less than 30 members in the denominator.
Designation NR: Not Reportable. The plan chose not to report this measure.

Source: IPRO New Jersey's External Quality Review Organization -Last Revised 9/26/13

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