

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



2009

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Introduction

The Division of Medical Assistance and Health Services is pleased to present the 2009 NJ Family-Care/Medicaid HMO Performance Report. As of this writing approximately 89 percent of clients receive their health care through a managed care plan. In 2009 five health maintenance organizations (HMO) contracted with the State of New Jersey, Department of Human Services to serve Medicaid and NJ FamilyCare enrollees. These included AmeriChoice of New Jersey (Americhoice), AMERIGROUP New Jersey (Amerigroup), HealthNet Healthy Options (Health Net), Horizon NJ Health (Horizon), and University Health Plans (UHP). A sixth HMO, Healthfirst NJ (Healthfirst) entered the market in August 2009.

HMOs ensure quality and cost-effective care by emphasizing prevention and coordination of care. Their care and case management programs help ensure that clients have continuity of care and receive services that are appropriate for their condition. HMOs 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 medical care.

HMO enrollments were as follows as of December 2009:

HMO	Enrollment
Americhoice	290,000
Amerigroup	116,000
Healthfirst	4,200
Health Net	55,000
Horizon	441,000
UHP	52,000
TOTAL:	958,200

In early 2010 New Jersey's Medicaid managed care market consolidated and two HMOs discontinued operations. On March 1, 2010, the UHP members transitioned to Amerigroup. On May 1, 2010 the Health Net members transitioned to Americhoice.

It is also worth noting that many of the HMOs hold Medicaid managed care contracts in other states and/or represent Medicare and commercial product lines.

This report contains information on how well the HMOs served New Jersey's NJ FamilyCare/Medicaid clients in 2008/2009. It presents information on the quality of HMO performance, both with the care provided to clients and internal operations. In addition, it reports on enrollees' level of satisfaction with their HMO. Also provided is information that some of the HMOs selected as examples of best clinical and administrative practices are currently underway.

1. Healthfirst entered the New Jersey Medicaid managed care program in August 2009 and was unable to report a full year of quality measures. This HMO has been included in the section "HMO Reports on Best Practices."

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 HMO. Each measure and its source are described.

MPRO ASSESSMENT. (Michigan Peer Review Organization)

The Centers for Medicare and Medicaid Services (CMS) requires that an independent, external quality review organization conduct reviews of each of the state's HMOs to assess quality and compliance standards. New Jersey contracts with The Michigan Peer Review Organization (MPRO) to conduct these reviews.

As part of the assessment, MPRO evaluates the HMOs' Quality Assurance Program by providing a rating of how well the HMOs 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 HMOs' 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® 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 71 measures across 8 domains of care. Measures are combined into a set of familiar topics, such as childhood immunizations and maternity care, to score HMOs on providing the right care across a range of sentinel health conditions.

HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis 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®. (The Consumer Assessment of Healthcare Providers and Systems)

Each year New Jersey surveys a sample of HMO 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 subpopulations, 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.

The Assessment of HMO Operations

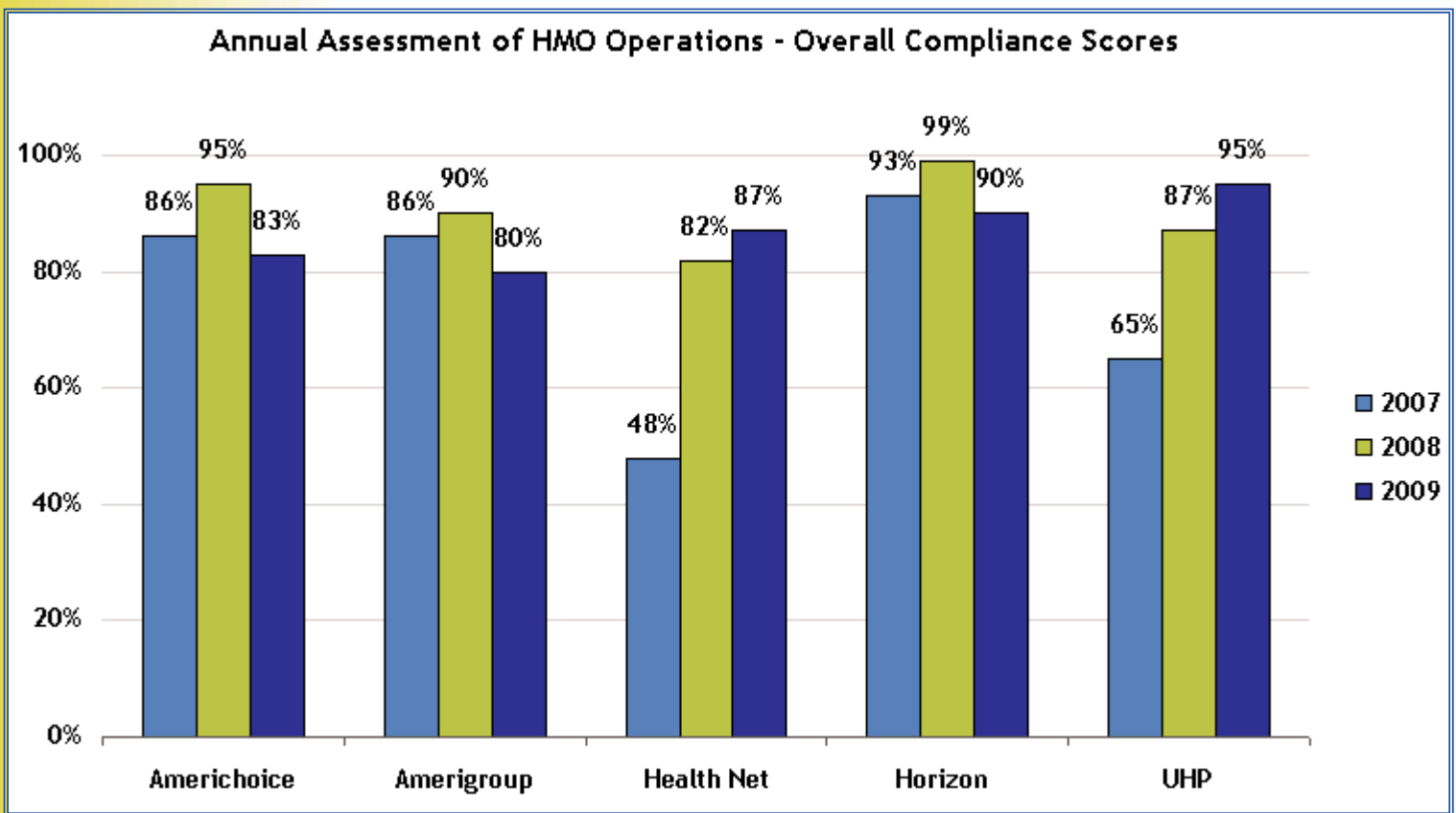
In 2007, 2008, and 2009, The Michigan Peer Review Organization (MPRO) conducted an Assessment of HMO Operations to determine how well each HMO implemented contractual requirements. These reviews provide an evaluation of each HMO's operational systems over a twelve month period. MPRO reviews twelve (12) categories:

1. Quality Assessment and Performance Improvement
2. Health Education and Promotion Services
3. Provider Education and Performance Review
4. Enrollee Rights
5. Provider Contracts
6. Care Management
7. Delegation
8. Credentialing and Recredentialing
9. Utilization Management
10. Administration and Operations
11. Fraud and Abuse
12. Management Information Systems

The Assessment of HMO Operations process allows a one-year break from full review for HMOs that meet a minimum compliance rate of 85%percent. Year 1, which involved a comprehensive review of all requirements for all HMOs (including an onsite visit and file review) is considered the baseline year. HMOs with a compliance score less than 85 percent undergo a comprehensive review of all requirements in the succeeding year. HMOs 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 Partially Met, Not Met, or Not Applicable during the comprehensive review. If an HMO has a partial review, it will have a comprehensive review the following year regardless of the findings of the partial review. HMOs that receive a comprehensive review and subsequently attain a compliance rating of 85 percent or better will have a partial review the following year. HMOs that attain a compliance rating below 85 percent will continue to have comprehensive reviews.

This report contains the overall compliance scores of each HMO reported in 2007, 2008, and 2009, as determined by MPRO. The Medicaid managed care program requests corrective action plans to address inadequate performance.

2007, 2008 and 2009 Overall Compliance Scores by HMO



HMO Overall HEDIS Ratings at a Glance

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

1. Childhood Immunization Status: Combination 2
2. Well-Child Visits in 1st 15 Months of Life
3. Well-Child Visits in the 3rd to 6th Years of Life
4. Adolescent Well-Care Visits
5. Lead Screening in Children
6. Prenatal and Postpartum care: Timeliness of Prenatal Care
7. Prenatal and Postpartum care: Postpartum Care
8. Breast Cancer Screening
9. Cervical Cancer Screening
10. Use of Appropriate Medications for People with Asthma
11. Comprehensive Diabetes Care: HbA1c Testing
12. Comprehensive Diabetes Care: HbA1c Poor Control
13. Comprehensive Diabetes Care: Eye Exams
14. Comprehensive Diabetes Care: LDL-C Screening
15. Comprehensive Diabetes Care: Medical attention for Diabetic Nephropathy.

The charts on the following pages provide a comparison of each HMO's HEDIS performance ratings for these 15 areas.

2. Ratings are based on NCQA's Quality Compass 2009 tool using 2008 HMO data.

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

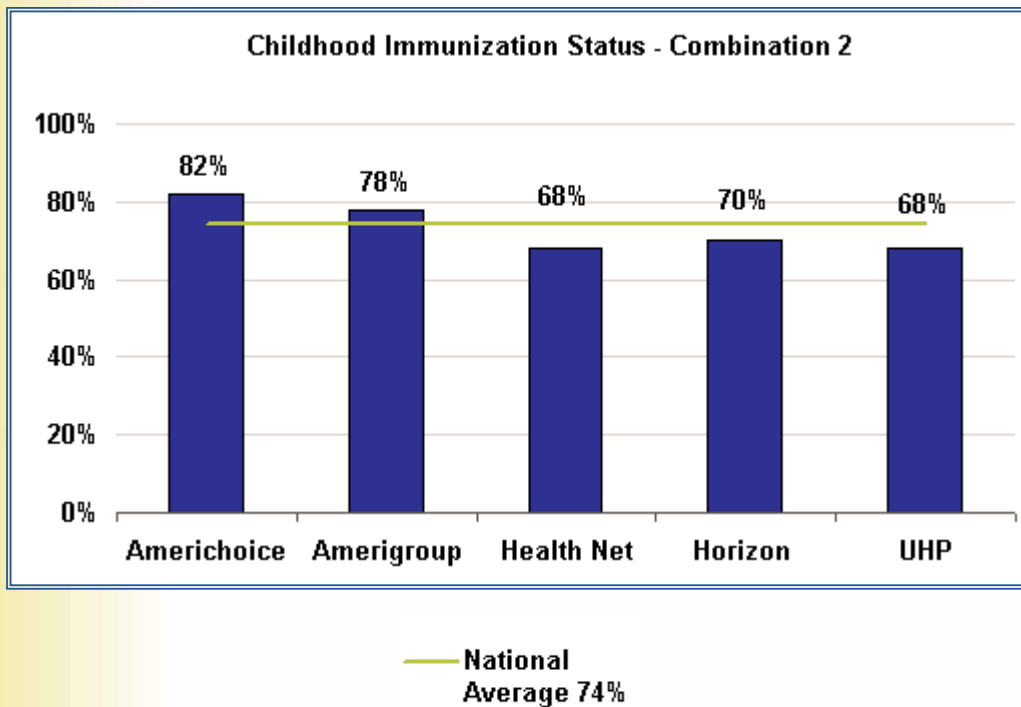


Chart 2. Well Child Visits: Percentage of children who had six or more well-child visits in the first 15 months of life

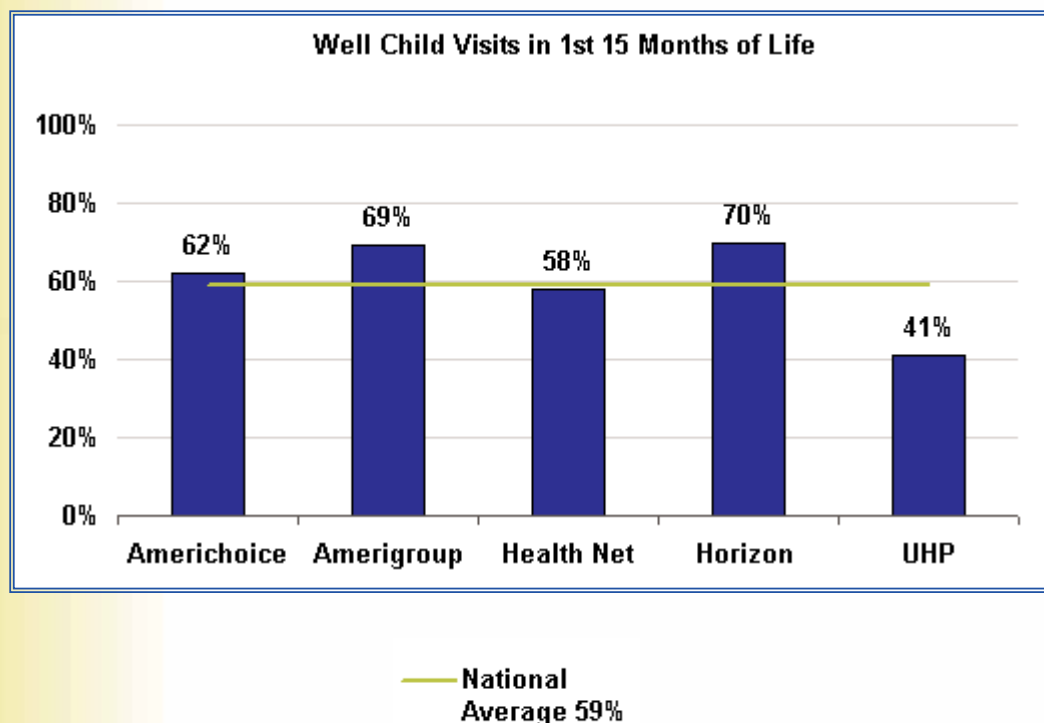


Chart 3. Well Child Visits: Percentage of three – six year olds who had one or more well-child visits during the measurement year.

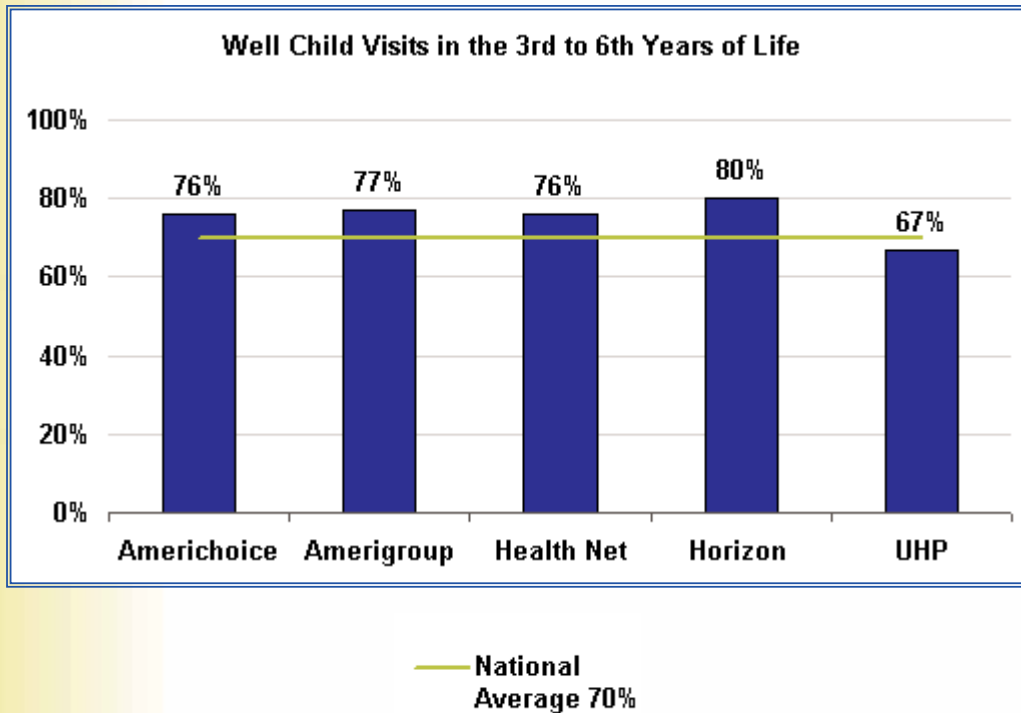


Chart 4. Adolescent Well Child Visits: Percentage of adolescent's 12 - 21years of age that had at least one well-care visit during the measurement year.

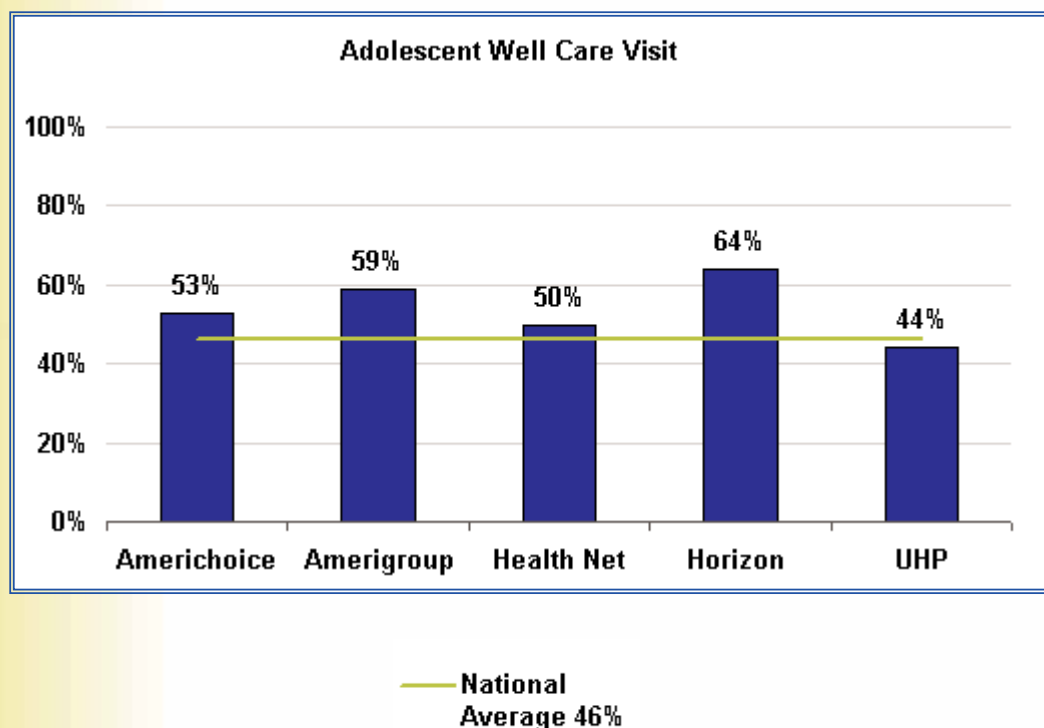


Chart 5. Lead Screening in Children: Percentage of children who received at least one lead screening test on or before their second birthday.

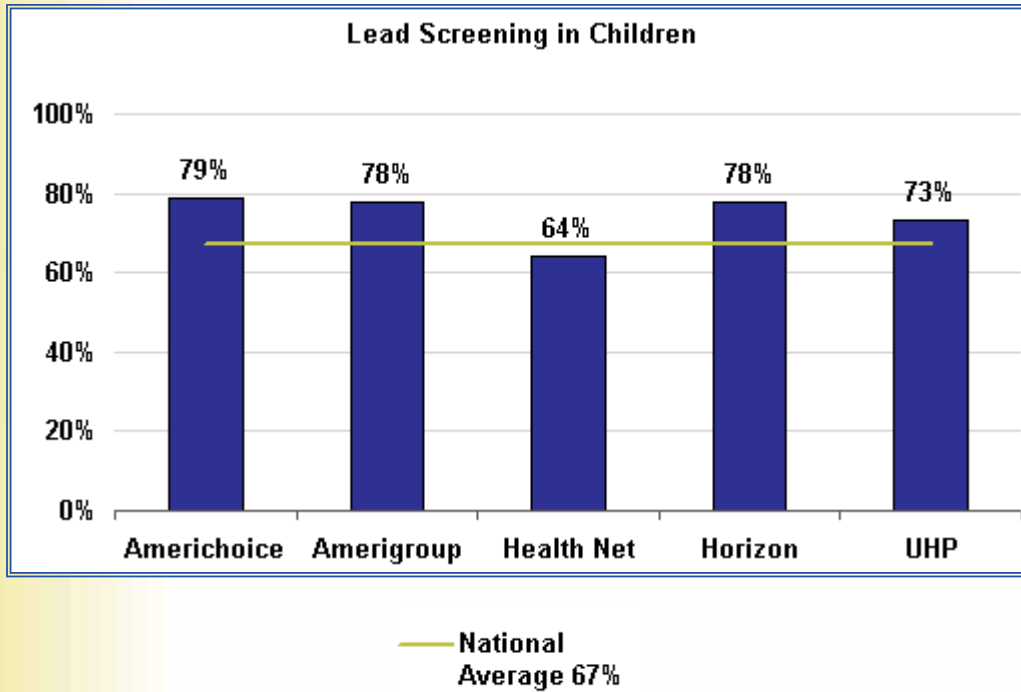


Chart 6. Prenatal Care: Percentage of women who had a prenatal visit within first trimester (or within 42 days of enrollment).

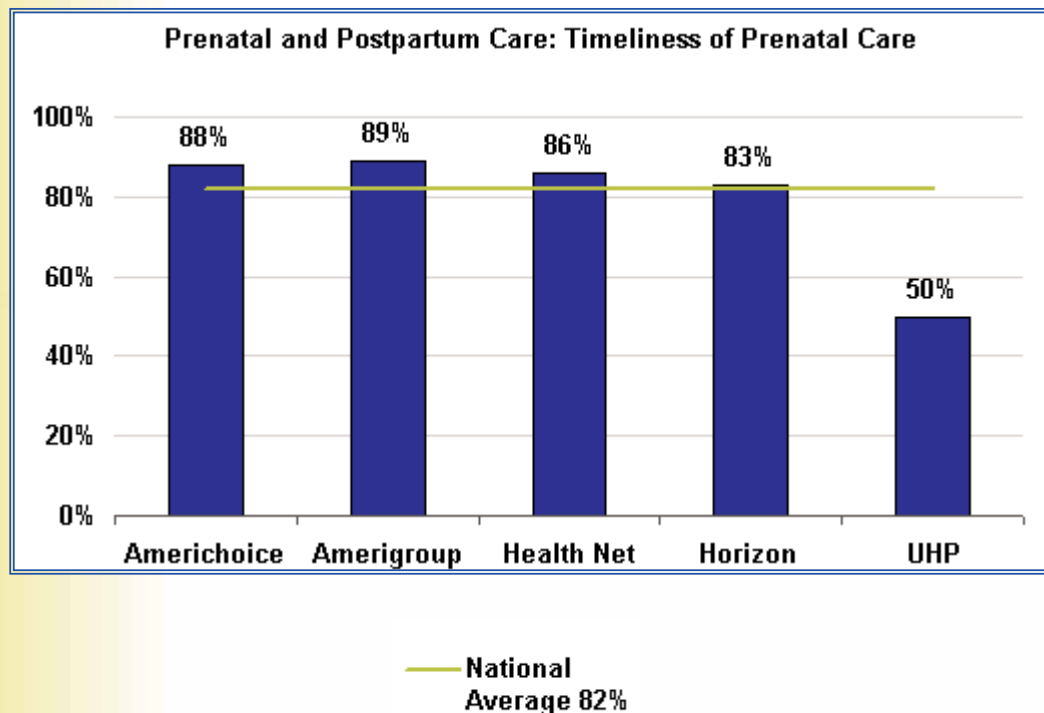
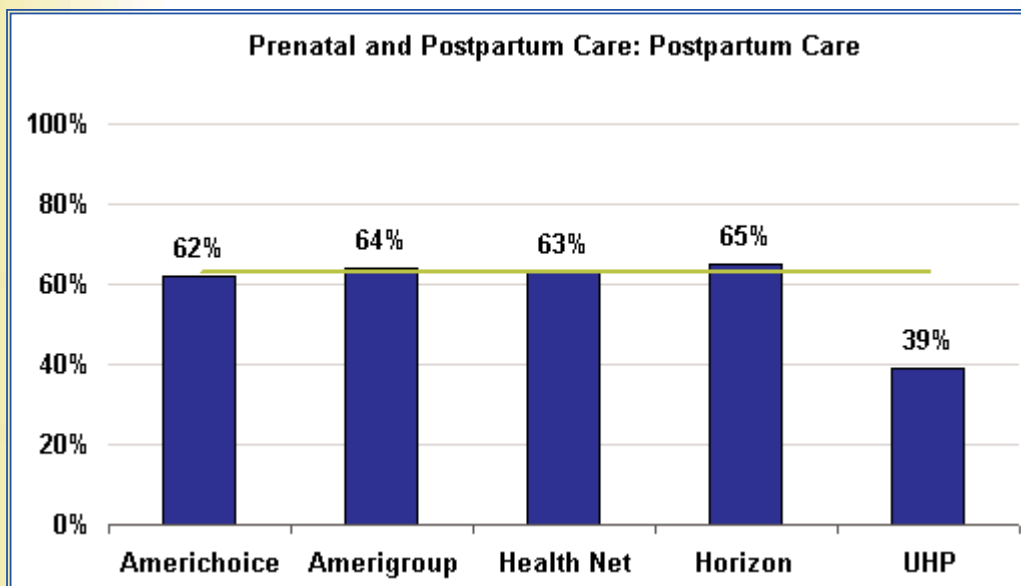
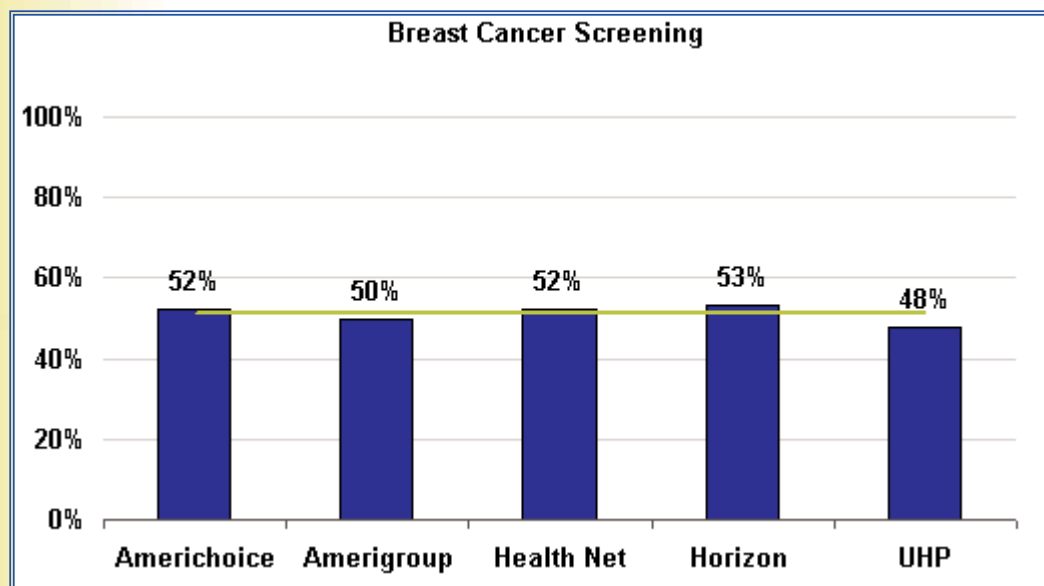


Chart 7. Postpartum Care: Percentage of women who had a postpartum visit between 21 and 56 days after delivery.



— National Average 63%

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



— National Average 51%

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

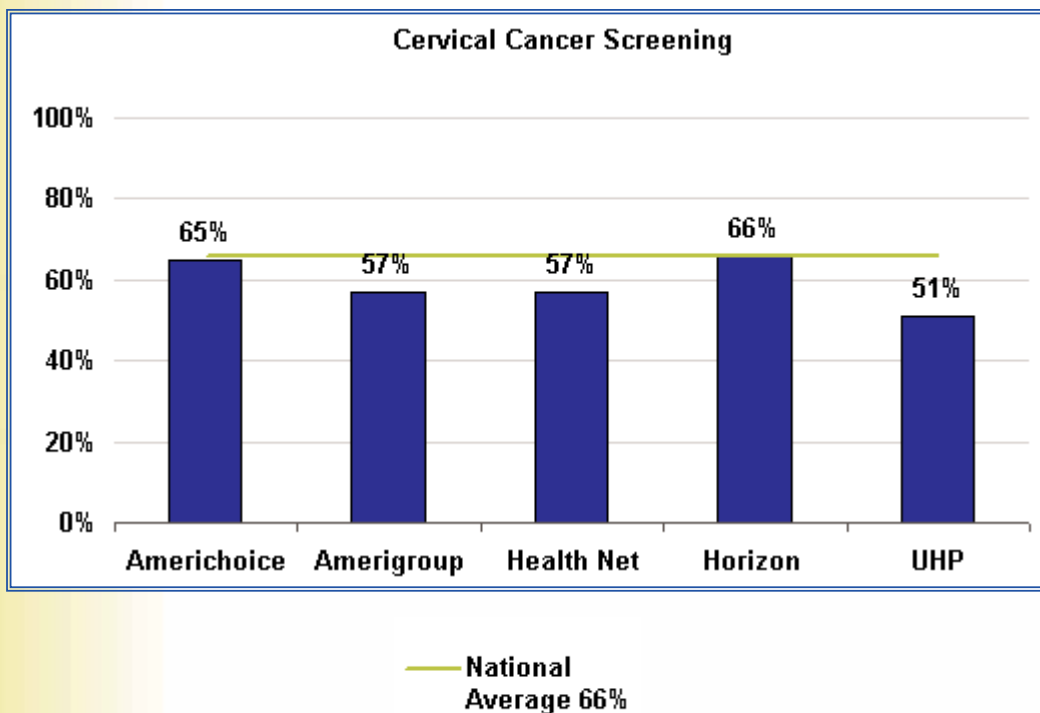


Chart 10. Asthma Care: Percentage of members 5-56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

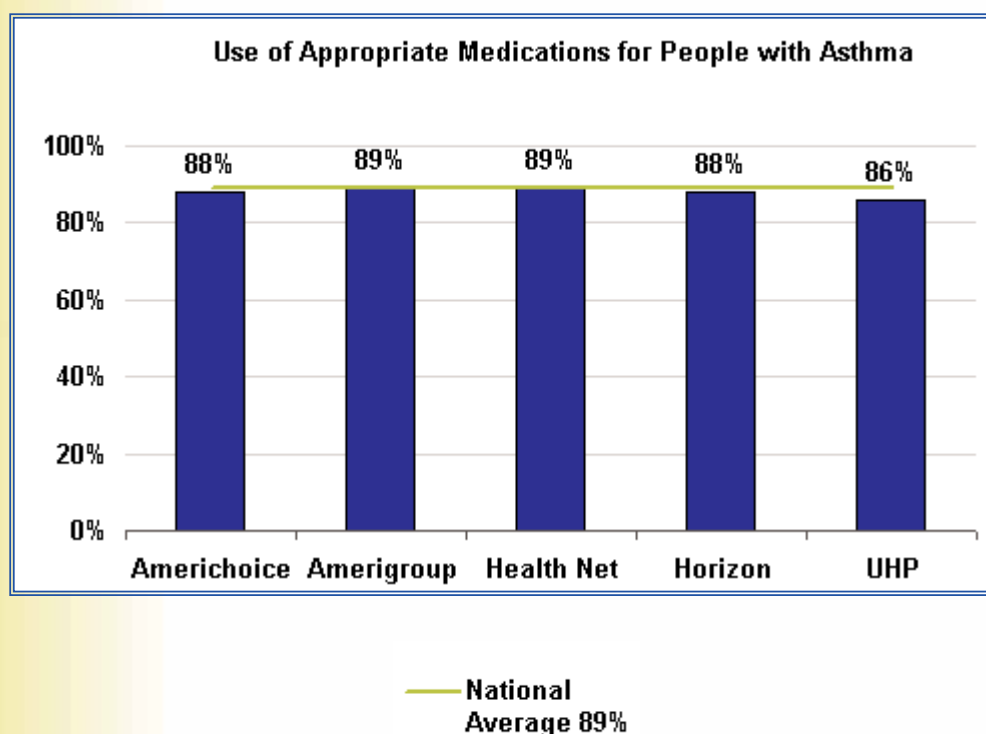


Chart 11. Comprehensive Diabetes Care: Percentage of individuals with diabetes who had yearly HbA1c testing.

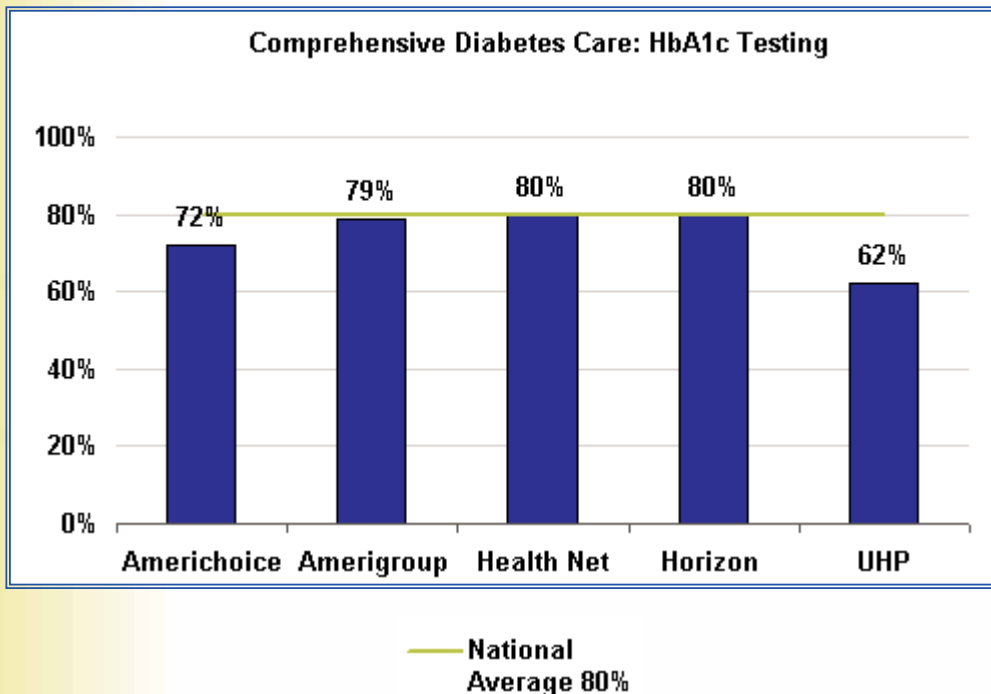


Chart 12. Comprehensive Diabetes Care: Percentage of individuals with diabetes with poor control – HbA1c result >9 (Unlike other HEDIS measures, HbA1c Poor Control is written in a way that a lower rate is ideal).

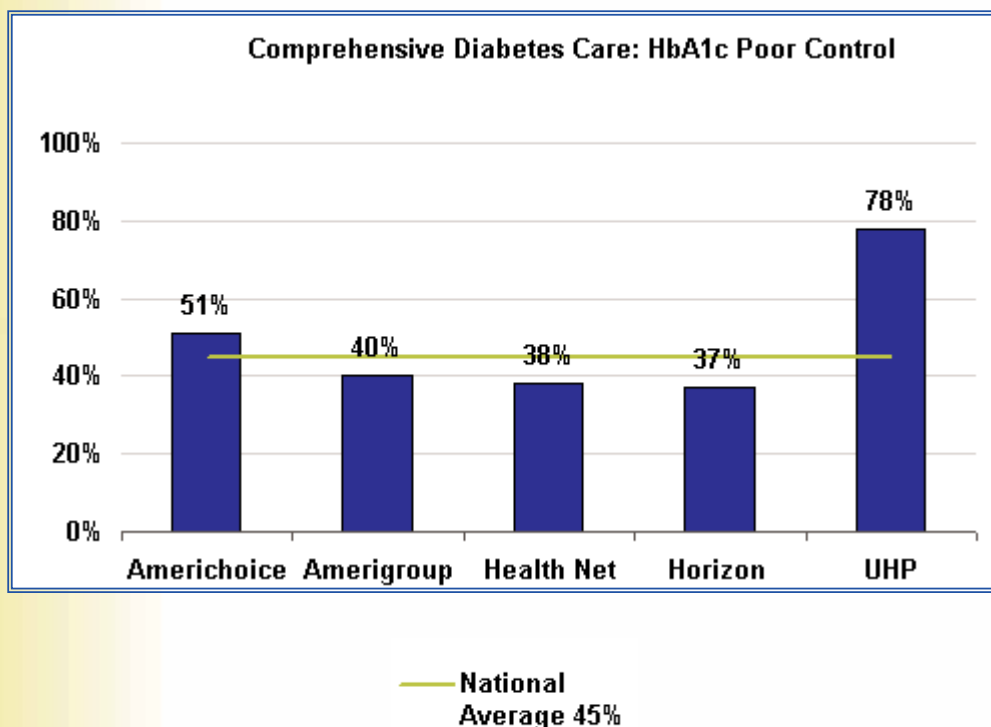


Chart 13. Comprehensive Diabetes Care: Percentage of individuals with diabetes who had a yearly retinal eye exam.

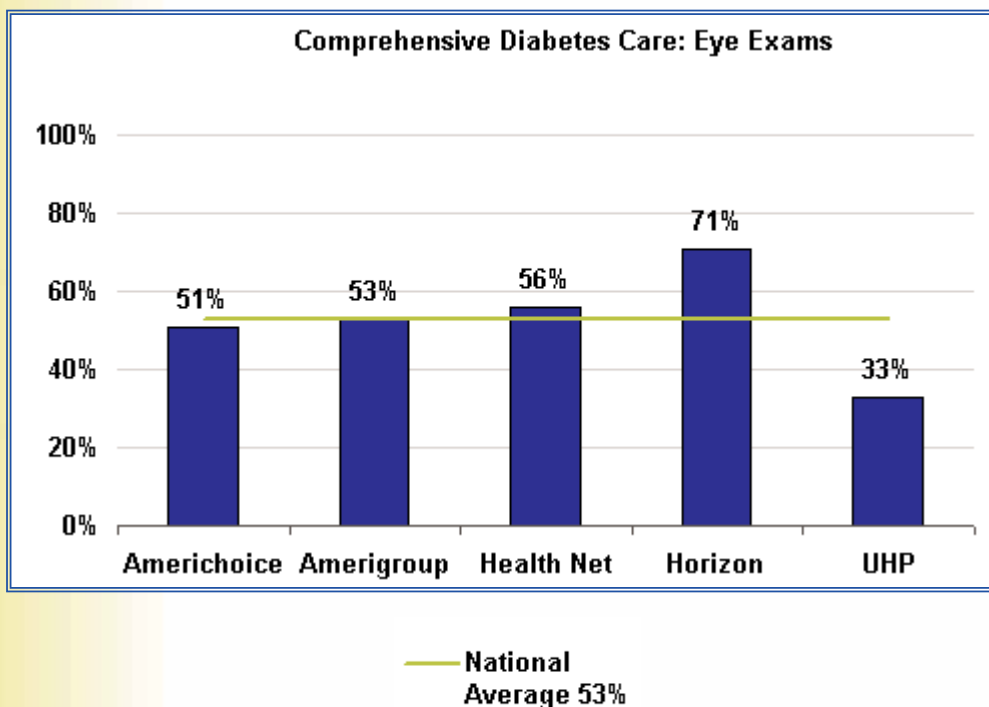


Chart 14. Comprehensive Diabetes Care: Percentage of individuals with diabetes who had a yearly LDL-C screening.

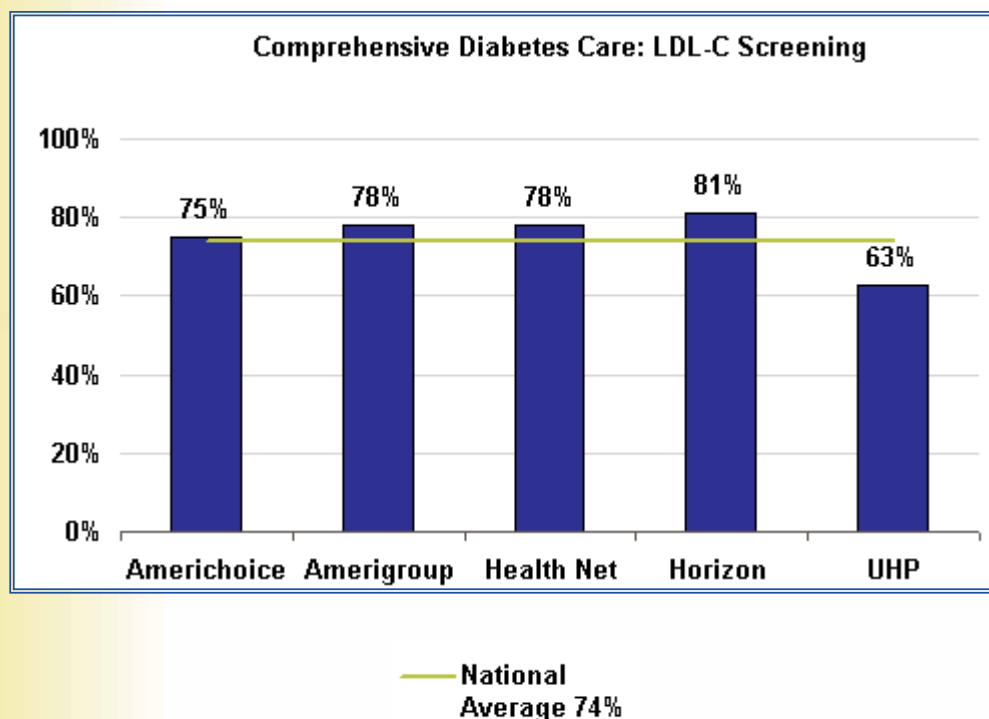
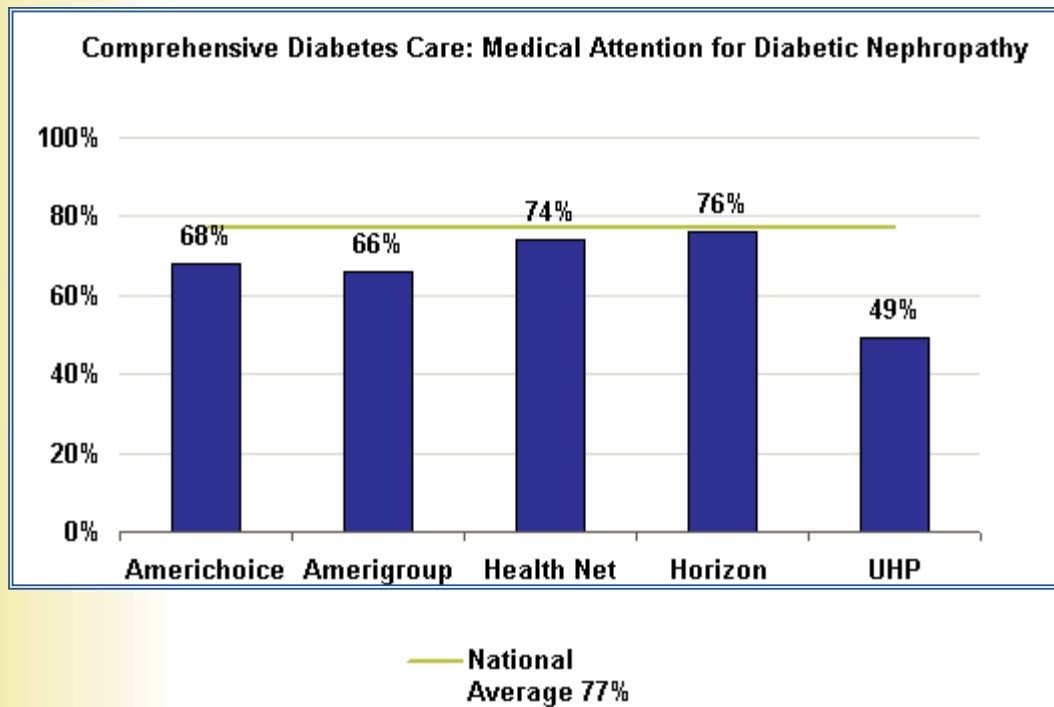


Chart 15. Comprehensive Diabetes Care: Percentage of individuals with diabetes who had a yearly screening or medical attention for nephropathy..



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 2009. They provide members' overall ratings of their own or their children's HMOs, as well as detailed comparison charts for how HMO members rated their care or their child's care in the following areas:

1. Rating of Overall Health Care
2. Getting Needed Care Quickly
3. Getting Needed Care from Specialists
4. Rating of Personal Doctor
5. Rating of Specialists
6. Rating of How Often Customer Service Gave the Information or Help Needed
7. Rating of How Well Doctors Communicate

Please note that the responses on the following charts may not sum to 100 percent due to rounding.

CAHPS - Members Rate their HMOs

Below are the overall ratings that members gave their own health plan and their children's health plan in 2009. The chart illustrates the percentage of 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.

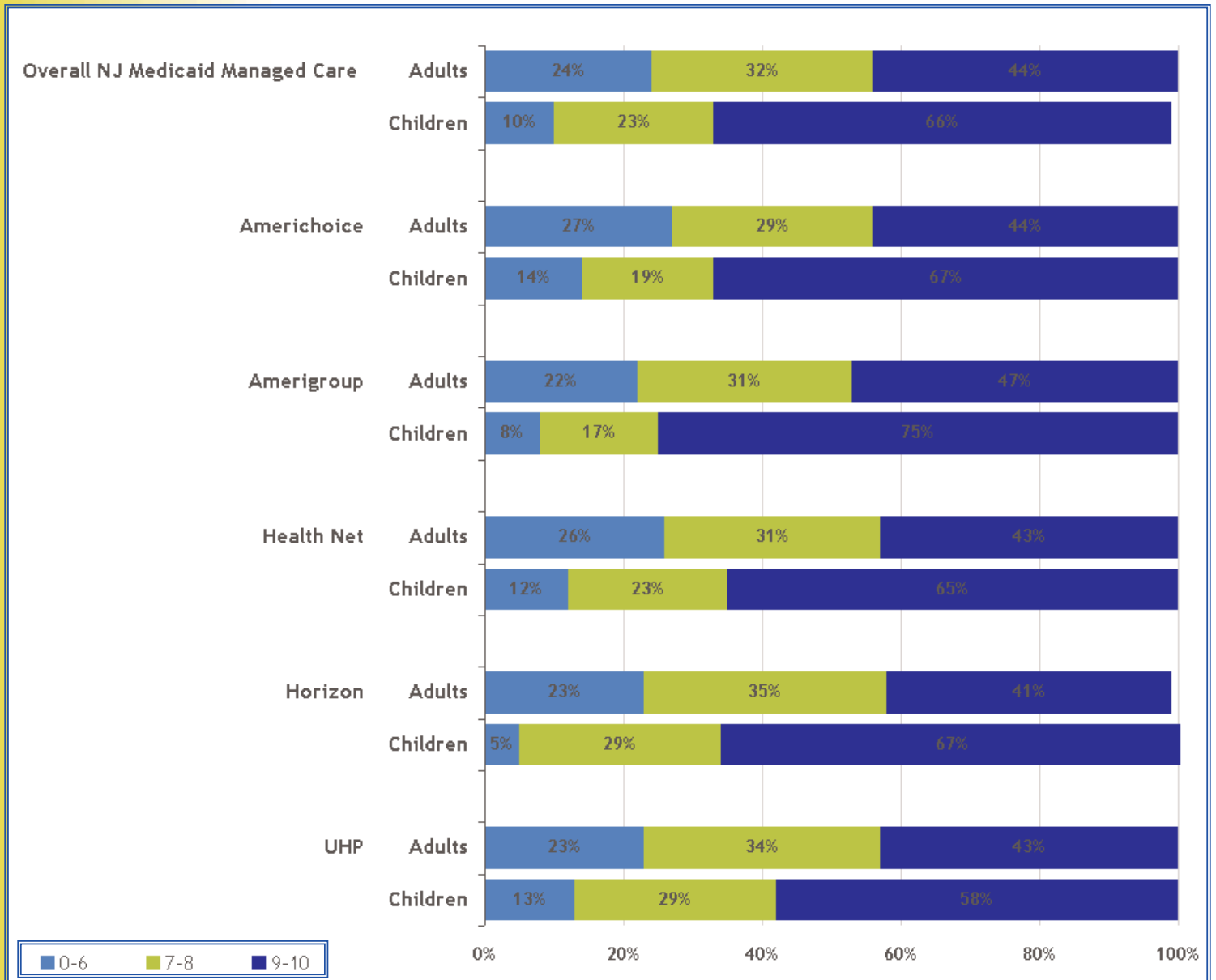
Members' Overall Rating of Their Own HMO

HMO	Satisfied (7-10 Rating)	Overall NJ Medicaid Managed Care Program Satisfaction (7-10 Rating)	Variance
Americhoice	77%	77%	0
Amerigroup	80%	77%	+3%
Health Net	74%	77%	+3%
Horizon	83%	77%	+6%
UHP	69%	77%	-8%

Members' Overall Rating of Their Child's HMO

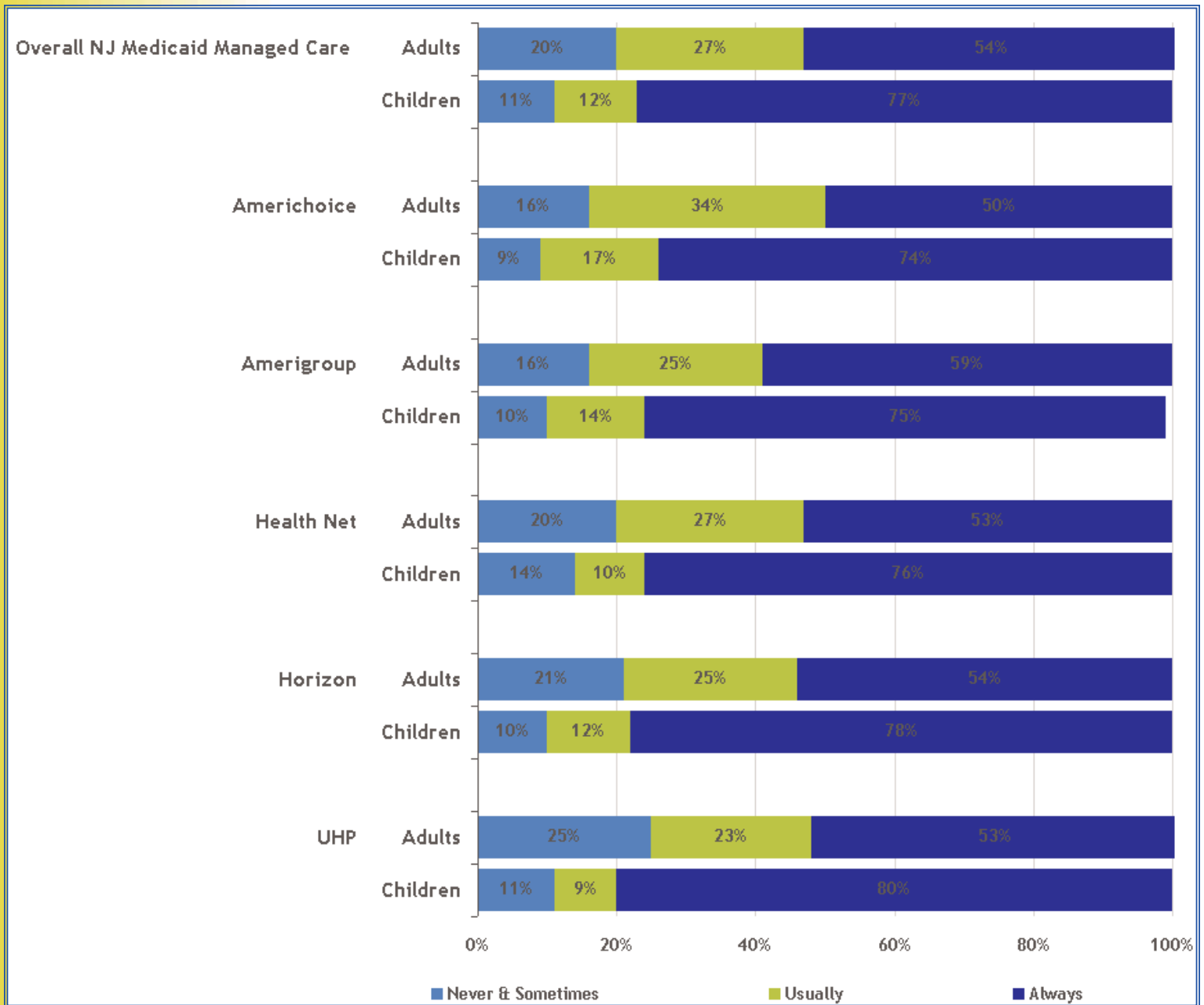
HMO	Satisfied (7-10 Rating)	Overall NJ Medicaid Managed Care Program Satisfaction (7-10 Rating)	Variance
Americhoice	77%	77%	0
Amerigroup	80%	77%	+3%
Health Net	74%	77%	+3%
Horizon	83%	77%	+6%
UHP	69%	77%	-8%

Chart 1: Rating of Overall Health Care



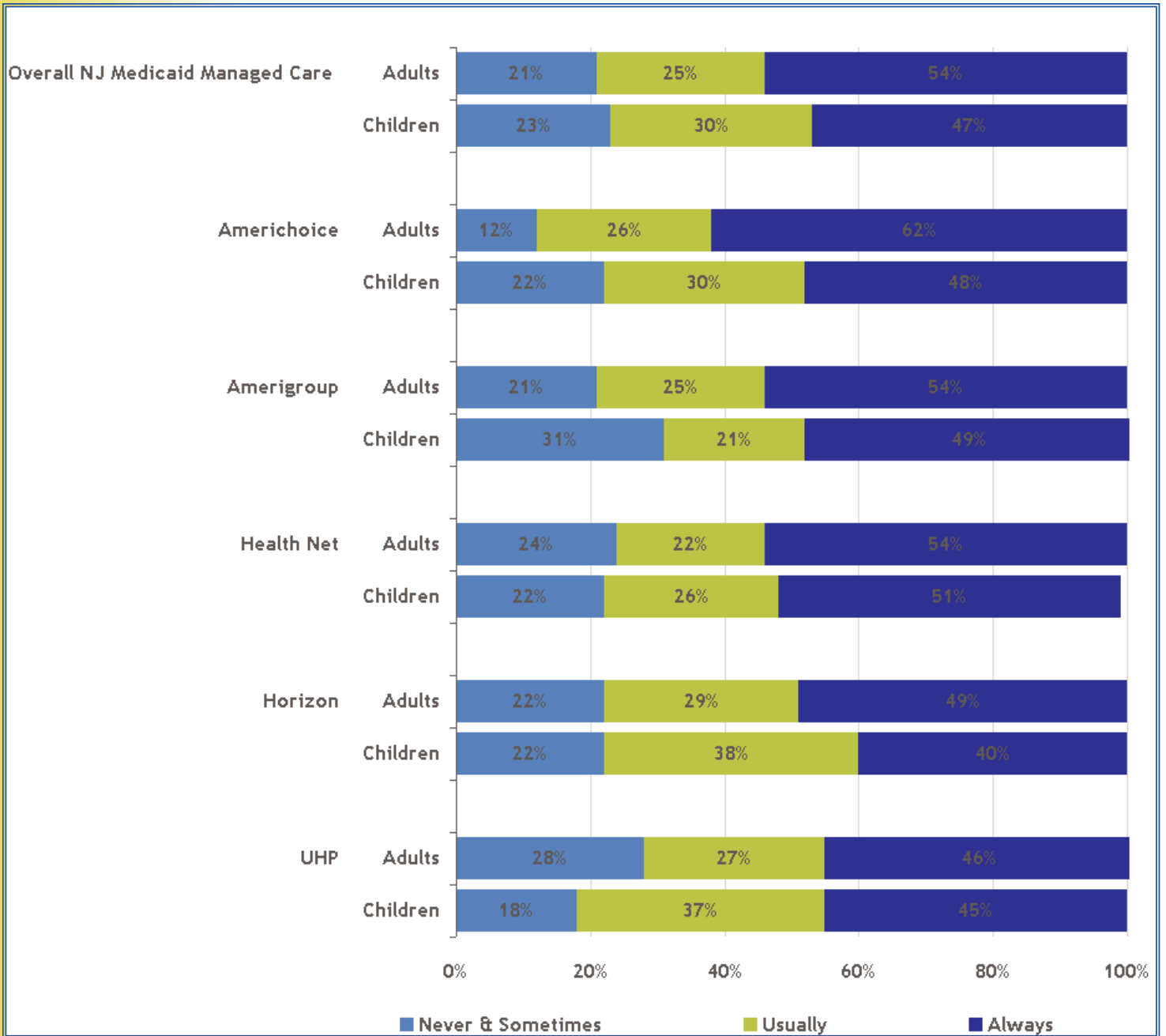
On a scale of 0-10, where 10 is the best, how did respondents rate their overall health care in the last six months?

Chart 2: Getting Needed Care Quickly



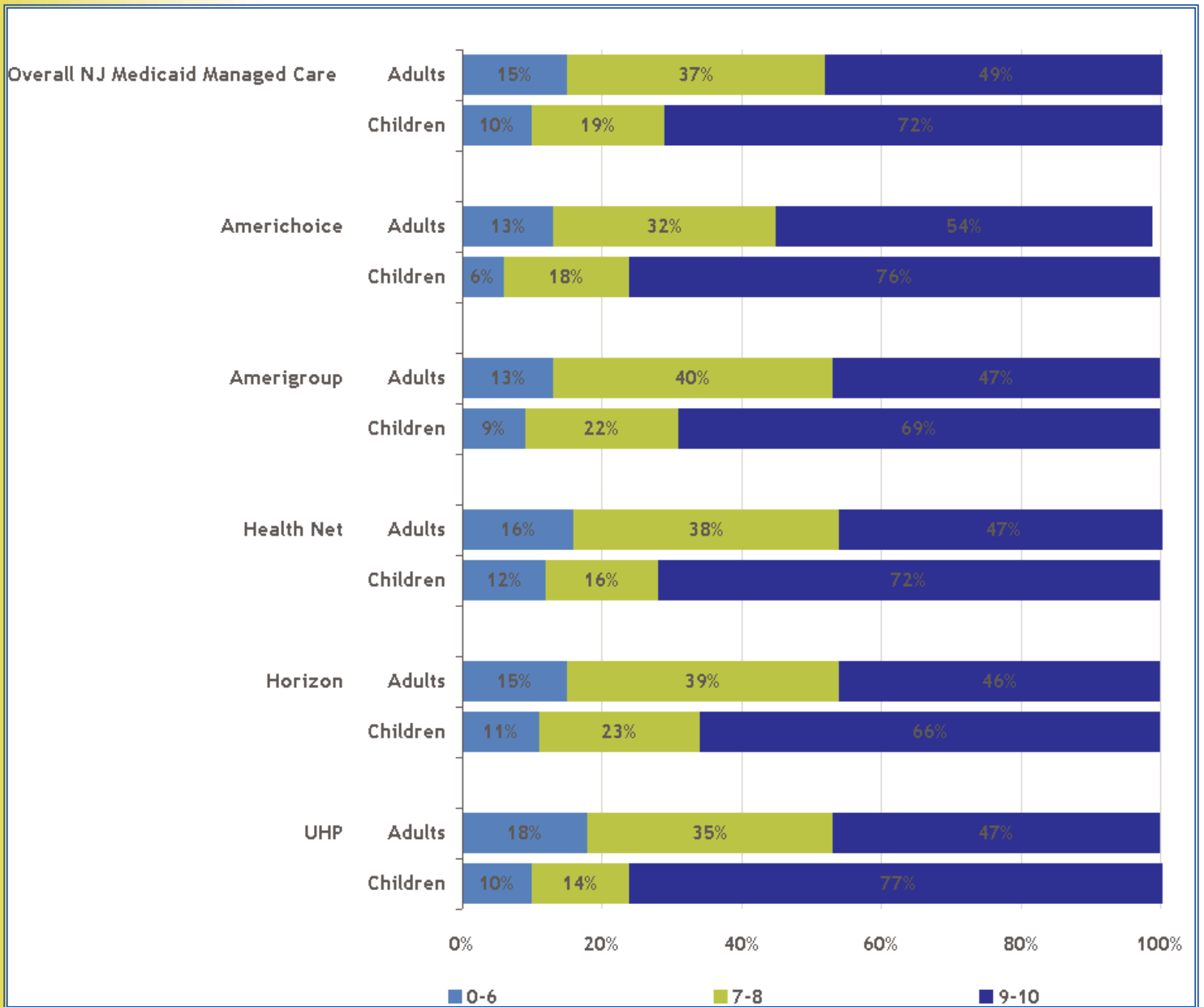
How often did respondents report getting needed care or an appointment quickly in the last six months?

Chart 3: Getting Needed Care from Specialists



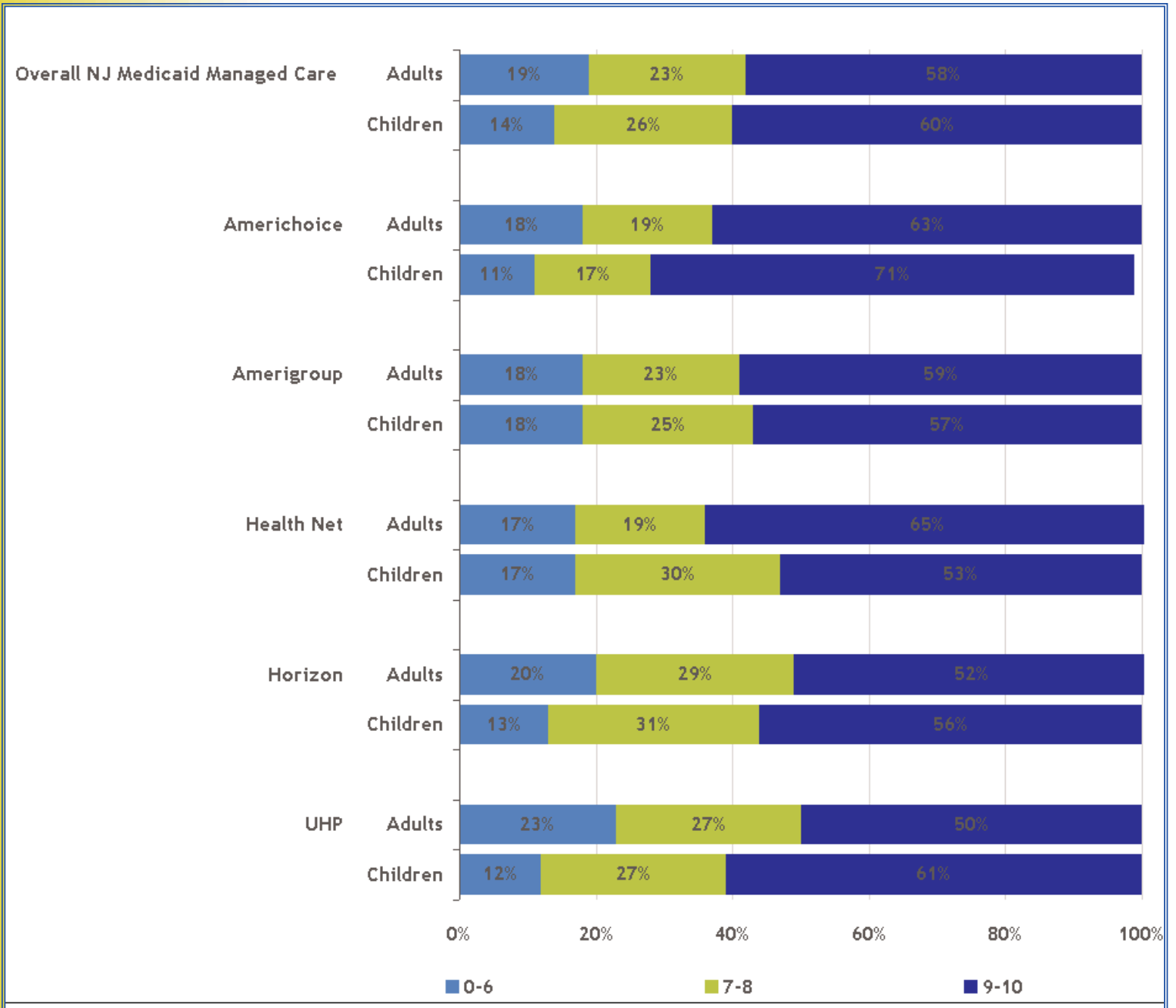
How easy was it for respondents to get needed care from specialists in the last six months?

Chart 4: Rating of Personal Doctor



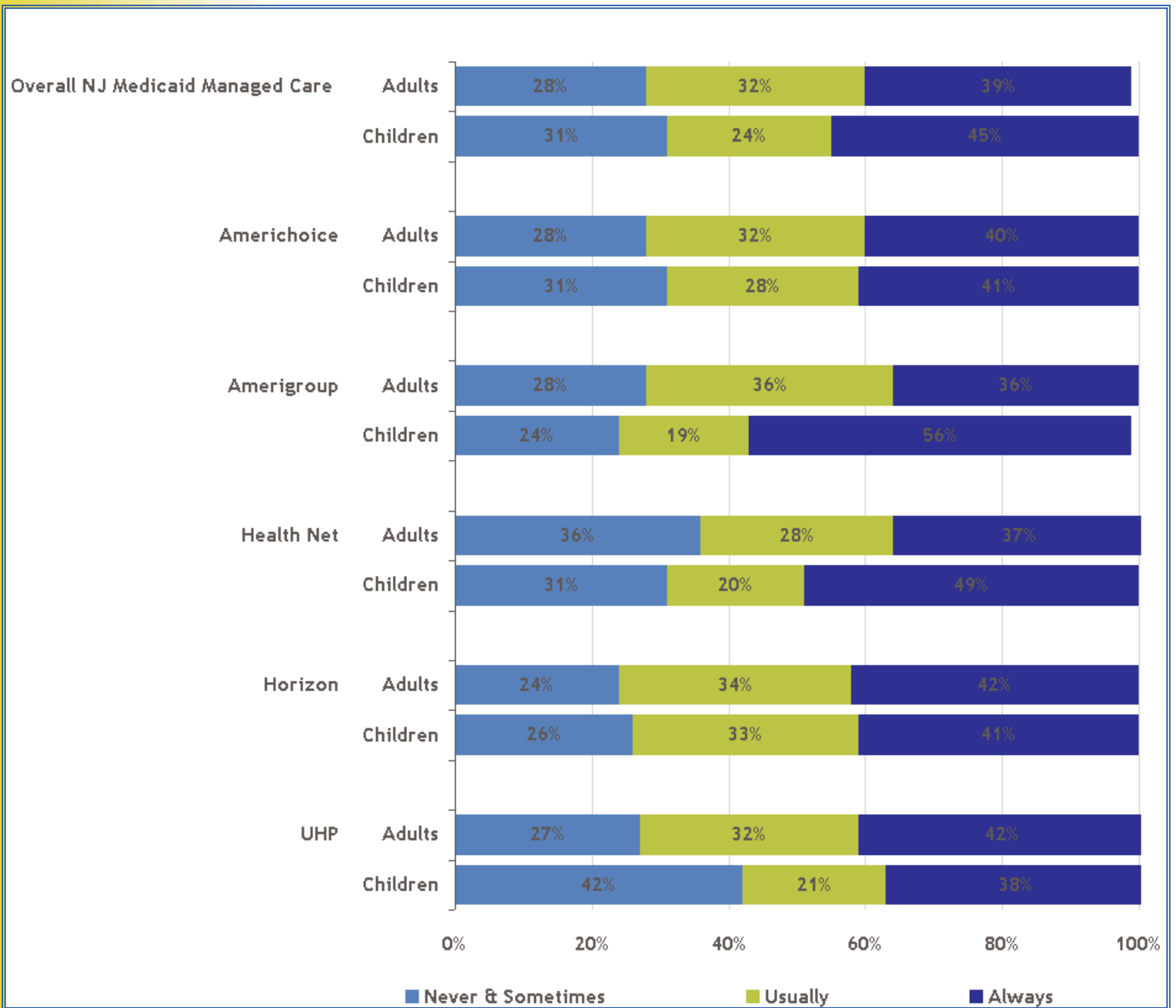
On a scale of 0-10, where 10 is the best, how did respondents who reported having a personal doctor rate that doctor?

Chart 5: Overall Rating of Specialists



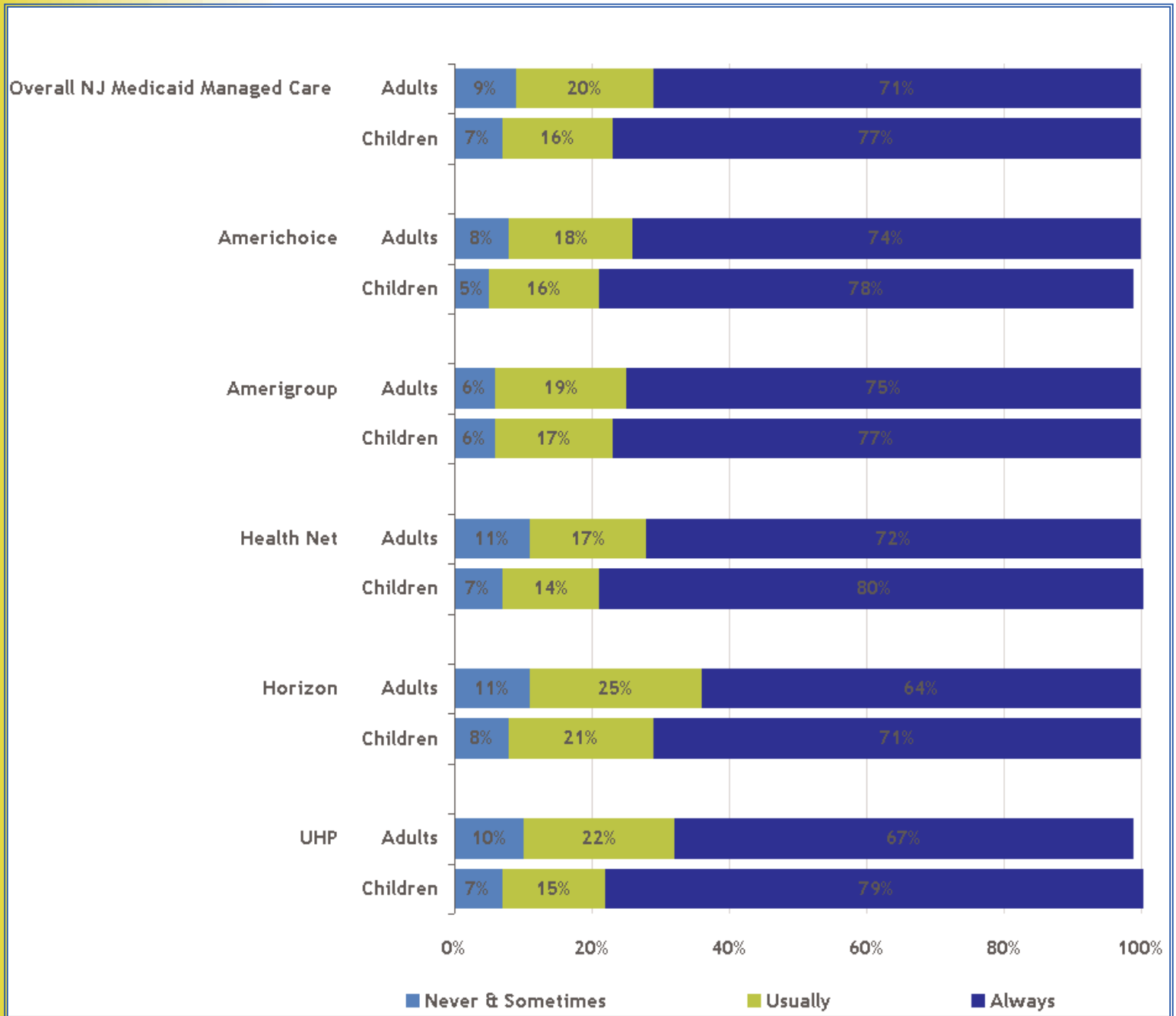
On a scale of 0-10, where 10 is the best, how did respondents who reported seeing a specialist rate that specialist?

Chart 6: Rating of Customer Service Responsiveness



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

Chart 7: Rating of How Well Doctor's Communicate



How often does a doctor or other provider

- Listen carefully to them,
- Explain things in a way that is was easy to understand,
- Show respect for what they had to say, and
- Spend enough time with them?

Reports from the HMOs on Best Practices

The HMOs were asked to provide a description of clinical and/or administrative best practices to showcase in this report. The HMOs reported on practices that give us a window into the variety and complexity of their work in serving the most vulnerable populations.

These include the integration of dental care into pediatric practices, provider performance reviews, disease management initiatives and the development of paperless environments. The HMOs are pleased to share information about these practices for 2009.

AmeriChoice of New Jersey

Best Practice: A Primary Care Physician Fluoride Varnish Program

AmeriChoice has developed an interdisciplinary approach to health care in New Jersey that will result in improving children's dental health care by partnering with the Primary Care Physicians (PCP) and other Health Care Professionals. The program has four goals:

- Increase in HEDIS Scores
- Lower average claim costs
- Reduce operating room utilization
- Enhance integration of dental-medical care.

Overview

Beginning in June 2006 the AmeriChoice Health Home started integrating medical and dental care by establishing a coordinated screening and early referral of members from physicians to dentists and dentists to physicians.

A PCP Fluoride Varnish Web Site was launched to train and award CE credits to network physicians upon course completion. The web site offers an on-line provider directory and claims submission, reference material and member educational handouts.

AmeriChoice HEDIS measures have increased in the last 30 months with the best results achieved for the membership that have been in the Fluoride Varnish Program.

PCPs are reimbursed for the application of Fluoride Varnish and receive additional reimbursement when the child has a dental visit which creates the True Health Home.

Costs savings, reduction in operating room usage and an increase in preventive services have been realized with the creation and establishment of the AmeriChoice Health Home concept.

Results

- Early referrals to dentists by PCPs resulted in lower cost per dental visit of approximately 50 percent per year of initial visit.
- Operating room costs were reduced by 70 percent for children seen by a dentist before age three.
- Improved dental HEDIS rates.

AMERIGROUP New Jersey

Summary

AMERIGROUP members benefit from improved quality and access to dental care through a Primary Care Dentist (PCD) program that ensures each member has a “dental home.” A member’s PCD is their point of contact for all dental care. This concept is similar to the successful Primary Care Provider (PCP) model used in medicine. The PCP model provides a “medical home” where one practitioner is aware of all aspects of a member’s care.

Background

When an AMERIGROUP member enrolls, the system checks to see if they were previously a member and, if so, assigns the PCD the member was seeing in the past. Otherwise, the member is assigned a PCD near their home.

Once a member is assigned to a PCD, they receive a letter advising them of who their dentist is and where that dentist is located, including an office telephone number. The letter also advises them that they can call AMERIGROUP to change their PCD if they are not satisfied with their current one.

Performance Improvement

AMERIGROUP works with Healthplex, its dental vendor, to run monthly utilization reports. These monthly reports identify the percentage of patients under 21 who have been seen by their dental provider. Healthplex uses these utilization reports to work with PCDs with low utilization (those offices with a high percentage of patients not yet seen) to improve their performance. Providers are offered lists of the members assigned to their office who have not yet been seen for dental care that year. The dental office staff is encouraged to perform outreach to these members by mail or phone. Healthplex also rewards PCDs who demonstrate an ability to provide appropriate services to a high proportion of their assigned members. Better performing providers may be rewarded with increased member assignment or increased compensation for services provided.

Healthplex also supports PCDs through member educational mailings as well as monthly outreach calls to members under 21 who have not yet been to the dentist during each calendar year. These calls remind the member of the importance of going to the dentist and give the member the opportunity while they are on the phone to transfer directly to their PCD office to schedule an appointment.

Outcomes

Since AMERIGROUP began its partnership with Healthplex in 2007, dental visit rates for members between the ages of 2-21 (HEDIS specifications) have improved:

- 2007 visits – 42.22%
- 2008 visits – 48.43%
- 2009 visits – 51.46%

Healthfirst New Jersey

Best Practice: Paperless, Integrated Care Management

Healthfirst entered the government programs market in New Jersey on August 1, 2009 with a unique not-for-profit business model that merges the provider and health plan administrative side of managed care into a single integrated team.

Healthfirst is supported through its management contract with Health First Management Services (HFMS), which has seventeen years of experience in the New York City metro area managing Medicaid managed care products and seven years experience managing dual eligible special needs Medicare recipients. Healthfirst has earned a reputation for improving the health of its members by leveraging its relationship with partner hospitals, doctors and other health care professionals.

Through its experience handling the growth of the provider network and membership, HFMS has implemented solutions that are shared by Healthfirst to achieve a paperless environment, which is comprised of much more than the simple scanning of paper into a system. To achieve this we implemented solutions that targeted the source of the problem rather than the resulting effect.

Key areas in which paper seems it must always play a part include provider claims submission, member and provider communication, interoffice memoranda, and medical records. By focusing on the source of the paper, Healthfirst has developed best practices that are repeatable in the State of New Jersey and are already in place within the operations of Healthfirst.

With regards to claims, hospitals tend to have sufficient resources to implement a robust electronic claims submission system, which also can aggregate medical records and provide supporting documentation at the fingertips of billers. On the other hand, many physicians, clinics, and other small providers may not have such resources which can preclude them from implementing electronic billing within their practices.

Healthfirst has partnered with a reputable vendor to offer free electronic billing to New Jersey providers (hospitals excepted), which has cut down on costs for its providers, and has measurably increased the number of electronic claims submissions to Healthfirst. Electronic submission means faster payment and more accurate billing data, in accordance with New Jersey law, so both provider and payer win with this paperless solution.

Other ways in which Healthfirst has successfully implemented a truly paperless environment include Utilization Review/Utilization Management functions, Appeals, Grievances, and Complaints, and communication to providers:

- Authorizations are entered into a Comprehensive Care Management System
- Clinical records are reviewed and decisions are rendered electronically
- From authorization request to approval or denial, determinations can be delivered entirely without use of paper, with communication between employees, clinical peer reviewers, and providers located in multiple locations and different states quickly and efficiently.
- Communication between intra-company departments is handled by an electronic workflow system, with off-site storage and backup of data.

- This provides an efficient means of communication which is trackable and contains a built-in audit trail keeping staff accountable.
- A provider portal containing an electronic Provider Manual allows providers to electronically search the manual, see instant updates, and perform reconsideration requests or appeals electronically, speeding response time and enhancing the reconsideration process.
- Instant communication to contracted and non-contracted providers have been sent using email blasts through the portal.

Through the implementation of these key goals, an added benefit is disaster preparedness. At any instant, if Healthfirst offices were to be compromised, all key employees are able to continue work without interruption from their homes or another offsite location.

As a not-for-profit plan, Healthfirst has a business imperative to operate as efficiently as possible in order to achieve the best possible return, which directly and positively benefits the communities served. This best practice related to the elimination of paper strengthens Healthfirst's position in the market by increasing efficiency and resiliency in all areas of care management.

Health Net NJ

The Health Net launched a Physician Practice Overview Program in 2003. An interactive outreach program, it sought to provide its participating physicians with specific outcome data to identify areas of improvement in their practice. The program was designed to improve care coordination for members by providing member outcomes measures for several key disease states. While this outreach originally focused on low performing physicians, it evolved to include a recognition program for those physicians with superior performance when compared to their peers. Physician outreach included: 1) detailed conversations with targeted physicians, 2) sharing of patient roster information to better understand the disease-specific outcome measures, and 3) discussions about the barriers that still need to be addressed to improve member outcomes and further coordinate their care under the Medicaid program.

Physicians identified a few barriers to good outcomes including: 1) an inability to get members in for services, and 2) the member's lack of understanding the importance of these services. The program has been successfully developed in phases resulting in one-on-one discussions between providers and a Health Net Medical Director to understand and address the barriers to improving care. The Program progressed through four phases:

Phase I, 2003 – 2004.

Annual tracking of provider performance. Reports identified service utilization trends.

Phase II, 2005 - 2006.

Annual tracking of provider performance with mailings to physicians about their service utilization practices compared to their peers for targeted disease states.

Phase III, 2007 – 2008.

Annual tracking of provider performance combined with multi-year trending of low performing physicians. Medical Director outreach to low performing physicians on specific quality measures.

Phase IV, 2009.

Annual tracking of provider performance combined with multi-year trending of low performing physicians. Studied member outcome measures and expanded quality measures. Medical director outreach to low performing physicians on specific quality measures and recognition of high performing physicians.

In sum, the program has had a positive effect on member care and provider performance. Health Net learned the importance of both the health plan and physician to engage members when addressing the common barriers to good health outcomes. A collaborative outreach system by the health plan and the physician community to educate the members on the importance and need for various services may yield the greatest improvements in provider performance and member care.

Horizon NJ Health

Selected Best Practices

Dilated Retinal Eye Outreach Program

The Horizon Dilated Retinal Eye Examination Outreach program is for members with diabetes. This proactive member outreach program works with the health plan's vision vendor, Davis Vision, to encourage members with diabetes to obtain dilated retinal eye examinations for early identification of diabetic retinopathy and prevention of blindness. Added to a member outreach at scheduled intervals, the communication process is enhanced and established between the primary care physician and the vision vendor. The primary care physician (PCP) receives notification by mail of completed dilated retinal eye exams.

- The program has demonstrated significant improvement in the rate of dilated retinal eye exams with increases of 30% in 2007, to 54% in 2008, and to 70.8% in 2009.

Asthma Management Improvement through Drug Utilization Review (DUR)

Horizon has a comprehensive retrospective DUR program that systematically collects and analyzes data on drug utilization. A retrospective review identifies members, including those with asthma who are over-utilizing short-acting beta-agonists (SABAs) and who have not obtained the recommended inhaled corticosteroid (ICS) therapy in accordance with national guidelines for people with persistent asthma. ICSs are the most potent and consistently effective long-term control medication for treating asthma.

Targeted letters are sent to both eligible members with asthma and the member's PCP. Members are targeted if they are over-utilizing SABAs and were not prescribed ICS medication within the previous 6 month period. In July 2009, 6 months after the original mailing, 19% of the targeted members began ICS therapy and 53% of these members were no longer over-utilizing SABA therapy.

A True Community Partner

Preventive health education and screenings are a key component to the Horizon statewide community outreach. The company offers a professional, enthusiastic team of health educators who provide educational and disease management programs. In 2009, Horizon participated in 302 community events, including:

- Community, school and faith-based organizations
- Community fairs and family events
- Clinics and doctor's offices
- Municipal and local health departments
- Health fairs
- Partnerships with community supermarkets and pharmacy chains

Across the state, the two mobile health units, the Horizon Care-A-Vans, bring a wide range of educational topics and health screenings to communities. In 2009, the Horizon Care-A-Vans participated in 72 events and offered more than 1,800 health screenings to individual attendees. Screenings included oral health, blood pressure, blood sugar, cholesterol, and mammography.

Horizon NJ Health is committed to expanding access and enhancing the quality of healthcare for the publicly insured. Horizon NJ Health has Health Plan accreditation by URAC, an independent, nonprofit organization promoting health care quality through their accreditation and certification programs.