



# Medicaid Health Plans of America's 2010-2011 Best Practices Compendium



A Compilation of Best Practices within the  
Medicaid Health Plan Community



## About MHPA, the Center for Best Practices and this Compendium



Medicaid Health Plans of America (MHPA) is the leading trade association solely focused on representing Medicaid health plans. MHPA is a nonprofit, tax-exempt organization formed in 1993 and incorporated in 1995. The Association provides advocacy, research, analysis and organized forums that support the development of effective policy solutions to promote and enhance the delivery of quality health care.

MHPA's Center for Best Practices compiles, develops and promotes best practices in the clinical and operations areas of Medicaid health plans. The Center specifically conducts data-driven research to address: (1) operations including conducting research on issues of operational value to MHPA members; (2) support of MHPA's advocacy agenda with clinical and operational research; (3) the dissemination of best practices and key research findings about Medicaid health plans and their members to the health care community; and (4) education of those involved in the federal safety net on ways to improve the health outcomes of Medicaid/SCHIP enrollees.

*MHPA's 2010-2011 Best Practices Compendium* is a compilation of the best practices put forward by the Medicaid health plan community. This booklet, published annually, is provided as a valuable reference tool. The Compendium also features Centers for Medicare and Medicaid Services (CMS) statistical data on the state of the managed care industry as well as a listing of the current state Medicaid directors and an MHPA-member/vendor health plan resource directory.

## Introduction

### A Special Message from Thomas L. Johnson, MHPA President & CEO



Welcome to the fourth edition of the Medicaid Health Plans of America's *Best Practices Compendium*. The Compendium continues to highlight how Medicaid health plans around the country combine innovation, expertise and to offer to their members programs and services that improve the health status for Medicaid recipients.

Medicaid health plans continue to make significant contributions in improving health outcomes of health plan members in an era where government resources are increasingly scarce. Our plans have strong private public-private partnerships with the states, and we work together in the best interests of our members.

This year, the Compendium also highlights a new development with MHPA. Medicaid Health Plans of America has created the MHPA Center for Best Practices. Launched in 2010, the Center compiles, develops and promotes best practices in the clinical and operations areas of Medicaid health plans. The Center specifically conducts data-driven research to address: (1) operations including conducting research on issues of operational value to MHPA members; (2) support of MHPA's advocacy agenda with clinical and operational research; (3) the dissemination of best practices and key research findings about Medicaid health plans and their members to the health care community; and (4) education of those involved in the federal safety net on ways to improve the health outcomes of Medicaid/CHIP enrollees.

The long range vision of the Center is to become a preeminent repository of information about the health of the medically underserved. The focus of the Center, which will add breadth and depth to the programs of MHPA, was adopted as part of the 2010-2015 MHPA Strategic Plan. Many organizations, commissions and institutes include the elimination of health disparities as one of their primary goals. MHPA and the Center occupy a unique place for addressing the long-standing problems of improving health outcomes of the medically underserved. With the vast resources, data and experience in providing both theoretical and practical expertise in prevention, research and treatment of the medically underserved in health and healthcare among ethnically diverse populations, the Center is poised to assume a leadership role in this arena.

Also, as we have done previously, we have included examples of the most effective business practices in use today. We have also included statistical data about the industry from the 2009 Centers for Medicare and Medicaid Services (CMS) national Summary of the Medicaid Managed Care Program and Enrollment. We hope you find the information in this report helpful, and we look forward to continuing our mission to improve the health and quality of life of our members.

Sincerely,

A handwritten signature in black ink that reads "Thomas L. Johnson". The signature is fluid and cursive.

President & CEO  
Medicaid Health Plans of America

# Table of Contents

## Part I: Best Practices Compendium

### The 2010 Best Practices (SUBMISSIONS LISTED ALPHABETICALLY BY TITLE)

Acute Case Management ( <i>Horizon NJ Health</i> ) .....	7
Asthma Management Improvement through Drug Utilization Review (DUR) ( <i>Horizon NJ Health</i> ) .....	8
Biggest Winner Nutrition Program ( <i>Health Partners of Philadelphia, Inc</i> ) .....	9
Childhood Obesity: Improving the Monitoring of BMI ( <i>Midwest Health Plan</i> ) .....	11
Clinical Documentation Standard - CHATME ( <i>Missouri Care</i> ) .....	12
Chopper Check Dental Screening for Children ( <i>Health Partners of Philadelphia, Inc</i> ) .....	13
Community Baby Shower Program ( <i>Keystone Mercy</i> ) .....	14
Connections Plus® ( <i>Centene</i> ) .....	15
Cultural Competency Program ( <i>Missouri Care</i> ) .....	16
Dancing for Your Health ( <i>Horizon NJ Health</i> ).....	17
Diabetes Disease Management Program ( <i>Passport Health Plan</i> ) .....	18
Diabetes “One-on-One” Pilot Program ( <i>Horizon NJ Health</i> ) .....	19
Don’t Gamble with Your Numbers: Improving Control of Hypertension and Hyperlipidemia ( <i>Midwest Health Plan</i> ) .....	20
Early Periodic Screening Diagnosis and Treatment (EPSDT) Program ( <i>Passport Health Plan</i> ) .....	22
Embedding a Care Manager in the Physician Office ( <i>Keystone Mercy</i> ) .....	23
ER Diversion Program ( <i>UnitedHealthcare Community &amp; State – Unison Health Plan of the Capital Area</i> ) .....	24
Flouride Varnish Program ( <i>UnitedHealthcare Community &amp; State – New York</i> ) .....	25
Generic Drug Fill Rates ( <i>Centene</i> ) .....	26
Glorious Women Assembly ( <i>Passport Health Plan</i> ) .....	27
Gift for Life: Aggressive Mammography Outreach and Event Scheduling ( <i>Keystone Mercy</i> ) .....	28
Gold Star Program ( <i>UnitedHealthcare Community &amp; State and Unison Plan of Pennsylvania</i> ) .....	29
Health Literacy ( <i>Horizon NJ Health</i> ) .....	30
Healthy Moms and Babies ( <i>Select Health of South Carolina, Inc.</i> ) .....	31
“Healthy You, Healthy Me” Childhood Obesity Program ( <i>AmeriHealth Mercy Health Plan</i> ).....	32
Heart Failure Program ( <i>Health of South Carolina, Inc.</i> ) .....	33
HEDIS Enhanced Capitation Program ( <i>CHOC Health Alliance Schaller Anderson/Aetna</i> ) .....	34
Hospital ER Focused Dental Initiative ( <i>Horizon NJ Health</i> ).....	35
Improving Blood Lead Screening in Two-Year Olds ( <i>UnitedHealthcare Community &amp; State and Great Lakes Health Plan</i> ).....	36
Lose to Win Type II Diabetes and Obesity Education Program ( <i>Keystone Mercy</i> ) .....	38
Mommy & Me Program ( <i>Passport Health Plan</i> ) .....	39
Navigating for Care – Aged, Blind and Disabled ( <i>Midwest Health Plan</i> ) .....	40
Notice of Action Database ( <i>Missouri Care</i> ) .....	41
Nurse Response™ Treatment Adherence Support Program ( <i>Centene</i> ) .....	42
Nurtur® Asthma Program ( <i>Centene</i> ) .....	44
Pediatric Obesity Program ( <i>UnitedHealthcare Community &amp; State – Tennessee</i> ) .....	45
Pharmacy Multi-Lingual Program ( <i>Horizon NJ Health</i> ) .....	46

Physician Summit Awards ( <i>Centene</i> ) .....	47
Reducing the Risk of Recurring Preterm Births with 17-P ( <i>Select Health of South Carolina, Inc.</i> ) .....	48
SECA Program ( <i>UnitedHealthcare Community &amp; State - Pennsylvania</i> ) .....	49
Start Smart for Your Baby® 17P Program Impact on Reducing Premature Birth ( <i>Centene</i> ) .....	50
Start Smart for Your Baby® Notification of Pregnancy Process ( <i>Centene</i> ) .....	51
Synagis® Success ( <i>Centene</i> ) .....	52
Texas Health Passport and Its Impact on Psychotropic Medication Utilization in Texas Foster Care Children ( <i>Centene with Superior HealthPlan Network</i> ).....	53
Text4babies Program ( <i>UnitedHealthcare Community &amp; State - National Medical Management: Healthy First Steps</i> ) .....	54
Thumbs Up Johnnie Health Initiatives for Children ( <i>Centene</i> ) .....	55
Type YOU Campaign ( <i>Select Health of South Carolina, Inc.</i> ) .....	56
Well-Child Outreach Initiatives ( <i>Select Health of South Carolina, Inc.</i> ) .....	57
WI Wrap Around Intensive Case Management Program ( <i>United Healthcare Community &amp; State-Wisconsin</i> ).....	58
Women's Cancer Screening Program ( <i>Passport Health Plan</i> ) .....	60

## Part II: State of the Medicaid Managed Care Industry & Information

---

### CMS Statistical Information (Graphs & Charts)

Managed Care Trends.....	61
Medicaid Managed Care Enrollment.....	62
Dual Eligible Enrollment.....	63
Number of Managed Care Entity Enrollees by State.....	64
National Breakout of Managed Care Entities and Enrollment.....	65
Total Annual Medicaid Population Distribution by Year: Managed Care vs. Other.....	66
Number of Managed Care Entities by State.....	67
Regional Break-out of Medicaid Managed Care Enrollment.....	68
States with Comprehensive Health Care Reform Demonstrations .....	69
Medicaid Managed Care Enrollment.....	70
Managed Care Entity Types.....	71
Number of Prepaid Inpatient Health Plans and Enrollment by State.....	72
Number of Prepaid Ambulatory Health Plans and Enrollment by State.....	73

### State Medicaid Directors

List of State Medicaid Directors.....	74
---------------------------------------	----

### Resources for Medicaid Health Plans

MHPA Vendor and Other Resources.....	80
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### Index

Best Practices Submitted by Health Plan .....	90
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# PART I: Best Practices Compendium

## Horizon NJ Health

### Acute Case Management

**DESCRIPTION:** Horizon NJ Health case manages those members who have acute care needs. The company developed a screening tool to identify and balance member needs, as well as staff workload. The tool is used to successfully case manage these members.

**ACTION TAKEN:** All members referred to Case Management are screened. After reviewing the member's record, the Case Manager validates member history to complete the screening tool measures. The member is placed into Case Management if the member has a score of 25 or more and/or at the discretion of the nurse. Determination is based on care coordination issues or if member needs are not met. A complex needs assessment and care plan are initiated so members can be placed in Acute Case Management. A member scoring less than 25 and no ER/IP (In Patient) in six months would receive telephonic outreach two or three times per year, based on needs. All activities are documented and no Complex Needs Assessment/Care Plan is required.

Screening Tool Components to Identify and Measure Needs of Pediatric and Adult Members:

- Barriers to care; transportation, language needs, etc.
- Care-giver needed
- Co-morbidities
- More than five prescription medications or outpatient (OP) intravenous (IV) medications
- Functional disabilities/ADLs
- Use of Durable Medical Equipment
- Pain
- Documented, unstable mental health
- Three or more hospitalizations, within last 90 days
- Three or more ER visits in the past three months
- Possible impact on quality; ability to improve outcomes and/or impact on cost savings

**OUTCOMES:** Internal and ongoing audits have validated this tool as an effective screening method for gathering and reviewing case management efficiencies for members.

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## Horizon NJ Health

# Asthma Management Improvement through Drug Utilization Review (DUR)

**DESCRIPTION:** Horizon NJ Health has a comprehensive retrospective DUR program that systematically collects and analyzes data on drug utilization. Retrospective review identifies members, including those with asthma, who are seemingly over-utilizing short acting beta<sub>2</sub>-agonists (SABAs) in the absence of compliant inhaled corticosteroid (ICS) controller therapy, in accordance with national guidelines. An increased use of SABAs may indicate inadequate control of asthma and the need to initiate or intensify long-term controller therapy. Inhaled corticosteroids are the preferred therapy for initiating long-term control in adults and children.

**ACTION TAKEN:** Letters were sent to eligible members with asthma and their Primary Care Providers. Members were targeted if they were receiving multiple refill SABAs within the past three months and they were not compliant with ICS therapy within the past six months. Members with a diagnosis or medications consistent with chronic obstructive pulmonary disease (COPD) were excluded from the DUR.

**OUTCOME:** In July 2009 and six months after the original mailing, 19% of the targeted members were subsequently filling ICS therapy and 53% of these members were no longer over-utilizing SABAs.



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## Health Partners of Philadelphia, Inc

### Biggest Winner Nutrition Program

**DESCRIPTION:** Health Partners is a not-for-profit health plan that provides Medical Assistance access to quality care for underserved residents in the Philadelphia region and surrounding suburbs. Now celebrating our 25th year of building healthier communities, Health Partners is one of the few hospital-owned health plans in the country. With over 160,000 members, Health Partners continually strives to improve the health outcomes of its members, while raising awareness in the larger community regarding health issues that disproportionately affect minority populations. There is a direct correlation, for example, between the incidence of diabetes and those living in socioeconomically challenged communities (regionally and nationally).

We know from our ongoing disease management statistics that many of our members suffer from chronic conditions such as diabetes, hypertension, and heart disease. They are less likely to seek care for their chronic conditions due to factors like transportation, lack of child care, and lack of awareness/understanding of the importance of maintaining healthy blood sugar, cholesterol, and blood pressure levels.

This information suggested that we could have a positive impact on our members through participation in an educational program set in a convenient location. Such a program would also help us increase awareness of the importance of nutrition and exercise in the larger community.

**ACTION TAKEN:** Health Partners developed the “Biggest Winner” Nutrition Program, an award-winning eight-week series designed to:

- Educate and screen members who have diabetes and/or hypertension and high cholesterol, especially those who were identified as non-compliant.
- Create a fun learning environment using nutrition instructors from Penn State University’s Nutrition Links Program (teaching in both English and Spanish), and include a tour of the Fresh Grocer Supermarket in Philadelphia.
- Generate community awareness of the program through targeted direct mail to members, press releases, and coverage by Philadelphia news outlets.
- Emphasize the value of making healthy food choices each day instead of dieting to maintain a healthy weight.

The targeted direct mail invited members to join for better health, and upon completion of the program, receive a \$50 gift card to Walmart and a “Biggest Winner” T-shirt. We chose to limit the first program to 16 participants as a pilot of the initiative, which was held in summer 2009.

The series included:

- A1c (blood sugar), blood pressure and blood cholesterol testing.
- Weekly cooking demonstrations.
- Fitness demonstrations and optional Body Mass Index (BMI) screening.
- Health presentations on diabetes and heart disease.
- On-site tour of a Fresh Grocer store and a meet-and-greet with the store manager for an informative Q&A session.
- Classes on how to decipher food labels.
- Healthy refreshments.
- A graduation ceremony featuring Health Partners’ President and CEO William S. George and other key Health Partners staff members, as well as the Penn State Instructors.

In the words of one graduate, “We have been given a valuable tool... information... that has ignited and enriched our lives.” The program was so successful, with all 16 participants graduating, that Health Partners scheduled a second series in the fall of 2009.

We increased the class size for the second series, which was a rousing success, with more than 50 participants. In between, word of mouth had spread among members regarding the “new

look and healthy lifestyle” of those who attended our first series. The following lists the outcomes for the second series, as an example, and outlines follow-up in 2010.



**OUTCOMES:** Thirty-eight women and 16 men completed series two of “Biggest Winner,” with all of the participants lowering their numbers in at least one of the three measures (blood pressure, sugar, and cholesterol). Many reduced their numbers in all three measures and lost weight/reduced their BMIs. Members reported feeling empowered with the knowledge of how to read food labels and understand their chronic disease, as well as the effects their new outlooks had on family members and friends in the community.

The Biggest Winner Nutrition Program garnered extensive media coverage, including Univision Spanish language TV, which reaches over a quarter of a million households in the Philadelphia Metro area. Health Partners also covered the event in its member and provider newsletters.

From an initial program of 16 participants, the program has grown so successfully that we have three series scheduled for 2010 (the first of which was due to conclude in July). We continue to enhance individual components of the program for the benefit of the member.

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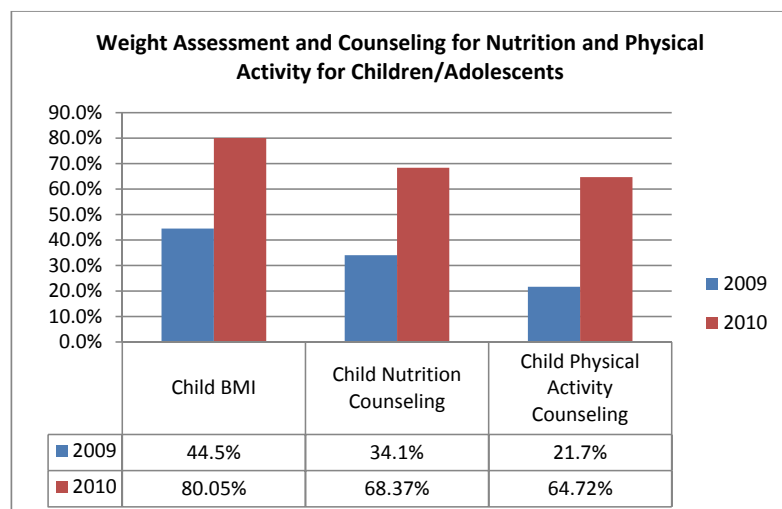
## Midwest Health Plan

### Childhood Obesity - Improving the Monitoring of BMI

**DESCRIPTION:** In the past 30 years, the occurrence of obesity in children has doubled and it is now estimated that one-in-five children in the United States is overweight. Increases in the prevalence of obesity are also being seen in younger children, including preschoolers. Also, while more children are becoming overweight, the heaviest children are getting even heavier. As a result, childhood obesity is regarded as the most common prevalent nutritional disorder of US children and adolescents. Obese children are more likely to be obese as adults, hence they are at increased risk for a number of diseases including stroke, cardiovascular disease, hypertension, diabetes and some cancers.

**ACTION TAKEN:** In order to increase awareness among providers and members of the importance of identifying, treating and preventing childhood obesity, Midwest Health Plan initiated an obesity project in the fall of 2008. The goals of the project were to educate providers on the importance of calculating patient BMI at every office visit; stress the importance that PCPs counsel patients based on their BMI on healthy nutrition and activity; educate members and promote within the community healthy nutrition and physical activity; and measure the percentage of providers who are documenting patient BMI and counseling members according to NCQA HEDIS specifications. Midwest mailed a letter to PCPs informing them of the importance of calculating patients' BMI. A BMI table was included with the mailing. Midwest discussed the topic at provider meetings including handing out Obesity Clinical Guidelines and laminated copies of the BMI chart to post near scales so office staff could easily look up BMI at the time the patient weight and height was recorded. Midwest also signed an agreement with Weight Watchers to offer members and employees discount rates with Weight Watcher programs and publicized the offer in member and provider newsletters. Midwest also sponsored community events such as school sports physical events in Wayne County and "Taking on Childhood Obesity Health Fair" in Dearborn.

**OUTCOME:** Midwest Health Plan saw dramatic improvements in its BMI HEDIS measures and the Plan's 2010 rates all exceeded NCQA's 2009 Medicaid 90th percentile. BMI HEDIS trends are provided below.



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## Missouri Care, an Aetna Company

### Clinical Documentation Standard: CHATME

**DESCRIPTION:** Missouri Care identified the need to promote an enhanced systemic clinical documentation practice to meet state and NCQA denial management standards. Processes involved included steps to:

1. develop a basic, more-focused approach to capture the key elements of a request;
2. address the need to improve the readability of the documentation by establishing a strict abbreviations standard;
3. require clinical staff to strictly adhere to the documentation practice standards;
4. establish performance measures and supporting audit tools for clinical staff and medical director reviewers; and
5. reinforce training and good behavior by including as a standing agenda item in staff meetings “Let’s CHAT” documentation tools and “lessons learned” presentations.

**ACTION TAKEN:** While the early audit results identified the need for continued training and timely reinforcement of the CHATME principles, there is a steady improvement across the board on adhering to the format. The best overall area of improvement is in capturing the medical necessity criteria used for the review and that a medical director review was initiated. The medical director reviewers that perform daily standard reviews for Missouri Care are very conscientious about using the required “MD” format entry. The “MD” format within the CHATME structure clearly demonstrates the medical director’s review decision, which is then easily cut and pasted into appropriate areas within the NOA. The ability to cut and paste the medical director’s online decision directly into the NOA eliminates any prior practices to interpret the medical director’s decision by the staff.

**OUTCOME:** The requirement that Missouri Care medical directors do online review decisions supports their documentation audit process and provides reinforced training to achieve full compliance with the state’s and NCQA’s documentation requirements. Missouri Care is continuing to audit, train and reinforce the CHATME documentation principles and audit performance as the NCQA look back period has begun.

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## Health Partners of Philadelphia, Inc.

### Chopper Check Dental Screening for Children

**DESCRIPTION:** Health Partners is a not-for-profit health plan that provides Medical Assistance access to quality care for underserved residents in the Philadelphia region and surrounding suburbs. Now celebrating our 25th year of building healthier communities, Health Partners is one of the few hospital-owned health plans in the country. With over 160,000 members, Health Partners continually strives to improve the health outcomes of its members, while raising awareness in the larger community regarding health issues that disproportionately affect minority populations.

Approximately half of our members are children ages 21 and under, and we focus many of our community outreach initiatives on children's health. Unfortunately, with regular health concerns and access issues like lack of transportation or awareness, children's dental care, especially, falls to the bottom of the priority list.



**ACTION TAKEN:** Health Partners created “Chopper Check,” a children's dental outreach initiative for Health Partners members. The screenings are held in collaboration with St. Christopher's Foundation for Children. The Foundation's Dental Mobile provides the clinical setting, and parents of member children ages three to eight are invited to bring their youngsters to convenient locations in the community.

Chopper Check also offers parents the opportunity to take advantage of free screenings like blood pressure checks. To enhance the experience and help raise awareness of the importance of early dental checkups, the events provide fun and information, as well as incentives to encourage parents to take their children to the dentist. Follow up appointments are also scheduled to increase the likelihood that parents will continue to take their children to the dentist for regularly scheduled checkups. Included in the day are:

- A full dental examination and treatment plan for children.
- Face painting.
- A visit from Health Partners' mascot, Ms. Roo.
- Two movie tickets for children who receive a dental exam.
- A \$15 Walmart gift card for parents who are Health Partners members and participate in a free blood pressure screening.
- Information on children's health, including the importance of regular dental visits (EPSDT guidelines for child and teen dental health are provided).

**OUTCOME:** In 2009, Health Partners provided dental checkups for 106 member children, and have several Chopper Check events scheduled in 2010. By encouraging parental involvement, we were also able to screen 203 parents for blood pressure, making appropriate recommendations for follow up with the members' PCP and dental health providers.

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## Keystone Mercy Health Plan, a member of the AmeriHealth Mercy Family of Companies Community Baby Shower Program

**DESCRIPTION:** In Philadelphia, premature birth and low-birth weight are significant contributors to infant mortality, often as a result of late or no prenatal care. African American women have the highest rate of inadequate prenatal care, which is attributed to low availability of culturally sensitive providers and a lack of education surrounding the need for early prenatal care. In an effort to reverse this trend, Keystone Mercy Health Plan sponsors “Community Baby Showers” to connect pregnant women with health care providers, care managers from Keystone Mercy’s prenatal care program, and other community organizations providing valuable support for pregnant members.

**ACTION TAKEN:** Philadelphia Medicaid recipients represent approximately 75 percent of Philadelphia’s 22,000 annual births. Sixty-four percent of these births are to Keystone Mercy members (Knauer, 2007). Community Baby Showers are scheduled in neighborhoods with the greatest identified need and Keystone Mercy partners with maternity and community referral organizations, as well as OB/GYN providers, to identify participants. Flyers are mailed to pregnant Keystone Mercy members and the community outreach team makes reminder telephone calls. At the event, guest speakers provide valuable information on a wide range of topics such as the importance of early and regular prenatal care, preparing for a baby and the importance of proper dental hygiene during pregnancy. Dentists are onsite and all members who receive a dental screening are presented with an incentive gift card. Raffles for prizes are held throughout the day and a nutritious lunch is served to all the attendees. In addition to providing education and support, the Community Baby Shower helps to identify high-risk women and connect them with Keystone Mercy care managers.

### OUTCOME:

- Three community baby showers were hosted by Keystone Mercy Health Plan in 2010.
- More than 300 moms received information about the importance of prenatal care and nutrition including:
  - Stages of pregnancy;
  - Risks of smoking and drugs during pregnancy;
  - Signs of preterm labor and prevention;
  - Stress management, exercise and rest;
  - Healthy eating during pregnancy (culturally appropriate); and
  - Early and Periodic Screenings Diagnosis and Treatment (EPSDT).
- Over 200 pregnant moms participated in overall prenatal assessments, depression screenings and dental screenings.
- Twenty advocacy organizations participated in the event and provided referrals.

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## Centene Corporation

### CONNECTIONS Plus®

**DESCRIPTION:** CONNECTIONS Plus® is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable phone. The program puts free, pre-programmed cell phones into the hands of the members. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions, and premature birth. Members are identified through case management activities or through a referral. CONNECTIONS Plus® is available to high-risk members in all Centene health plans.

**ACTION TAKEN:** If the member is eligible, a case manager refers them to CONNECTIONS Plus® to receive a cell phone. The MemberConnections® Representative is notified of the request and places the order, providing all of the member's provider contact information. The phone is pre-programmed to only allow specific numbers that are important to the member's health care and safety. Pre-programmed numbers include the member physician, specialty physician, case manager, NurseWise® (our 24/7 nurse advice line) and any identified



community resources. Phones have texting and preloaded podcast capabilities. The MemberConnections® Representative conducts a home visit, educating the member on phone features and appropriate reasons to contact pre-programmed numbers. To date the program has given phones to 2,500 unique members.

**OUTCOME:** Centene reviewed data from 680 adults with chronic medical conditions who received a phone versus a 200 person adult control group who did not receive a phone. A pre- and post-comparison of 6 months utilization data shows a 38% drop in inpatient admissions, a 29% decrease in average length of hospital stay, and a 20% drop in Emergency Room visits. All measures are statistically significant.

Empowering a patient with tools and education to communicate with their medical home makes a significant impact in better outcomes as measured by decreased inappropriate utilization of services (ER, inpatient, ambulance) and cost.

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## Missouri Care, an Aetna Company Cultural Competency Program

**DESCRIPTION:** Missouri Care programs have always supported diversity as a key component in all health plan activities. However, the focus on health literacy and the requirements under the Culturally and Linguistically Appropriate Services (CLAS) standards required the development of a detailed plan program addressing a broader issue: Cultural Competency.

### **ACTION TAKEN:**

**Internal Staff:** Staff completed a baseline assessment in May. Full training is scheduled for August and re-assessment will be completed in November. ASK Me 3 and Health Literacy training is underway for all staff. ASK Me 3 brochures are included in all new member packets as well in individual mailings completed by the case managers. The Cultural Competency Committee, made up of cross disciplinary staff, meets quarterly to review the program and determine next steps / activities.

**Providers:** ASK Me 3 brochures are distributed to provider offices. System set up is under way to allow Missouri Care providers access to Cultural Competency training via the Aetna Provider training site. Three courses will be available: Physician, Clinical staff and office staff and provide CME credit for the course at no cost to the provider or staff. The training program is slated to be online by mid July.

**Advocacy/Community Resources:** Missouri Care values the role of advocates and community leaders. These resources (currently four community leaders), along with plan staff, form the Community Outreach Advisory Council on Health (COACH). COACH meets quarterly to review and evaluate community needs and outreach activities related to cultural competency and health needs of the communities served. The panel provides a forum for interactions / discussions with the health plan. It encourages advice and recommendations from the community organizations regarding any facet of the health plan/member interactions. The committee is also reviews and evaluates the Cultural Competency plan and work plan annually. COACH reports to the Cultural Competency Committee.

**OUTCOME:** The program has been well received by the community and plan staff. We look forward to the provider training roll out. We will be the first MCO in Missouri with online training available to our provider network.

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## Horizon NJ Health

### Dancing for Your Health

**DESCRIPTION:** Dancing for Your Health (DFYH) is a bi-lingual, health education, community outreach program that emphasizes dancing as an enjoyable exercise or physical activity. Programs with music are presented in schools (using a four-week, interactive teaching program), health fairs, community-based organizations, Federally Qualified Health Centers (FQHC), summer camps and at after-school programs. The targeted audience includes adults of all ages and in schools: children, ages three years old to 12.

In schools, the four-week DFYH classes meet once a week, depending on the organization's request and there are special sessions for 20-minute health education presentations on healthy nutrition. School personnel are encouraged to continue the momentum for the activity as a result of the positive response and information shared.

#### ACTION TAKEN:

- Participation in the program is promoted by outreach, including mailings, phone calls, on site activities and information at community events, school health conference presentations, collaborative faith-based and community partnerships plus coalition meetings.
- Participants receive education and materials about various food groups, choosing healthy and nutritious food and the health benefits of dancing as exercise and fun.
- Participating school children receive a certification of accomplishment.
- Evaluation includes data collection, such as: number of programs per year, number of participants per program and evaluation forms with participants' comments.

#### OUTCOME:

- From 2008 to 2010, Horizon NJ Health conducted the program in schools, summer camps, a FQHC, after-school programs and with various community-based organizations.
- In the program's first two years, the company presented at and attended more than 600 statewide events and sites in the communities, including venues with Dancing for Your Health activities.
- Since January 2008, more than 1,700 adults and children participated in more than 30 school programs.
- Children's comments about the program:
  - "I hope they come back next year. This dance program was so much fun. I really looked forward to every Friday. It was fun learning all the dances."
  - "I liked the fact that this program was high energy. I've never had so much fun 'exercising.' It didn't even feel like a workout, because it was so much fun."
  - "The best part was having fun and you could workout at the same time. You could be yourself and then be active. I wish this program could be all year round."
  - "Dancing makes me feel great about myself."
  - "When I dance, I feel like a dancing machine."

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## Passport Health Plan

### Diabetes Disease Management Program

**DESCRIPTION:** Passport Health Plan recognizes that Kentucky is ranked ninth in the Continental United States in incidence of diabetes. In 2006, the Kentucky Diabetes Fact Sheet reported 9.9% percent of Kentuckians had a diagnosis of diabetes and an estimated 127,200 individuals had undiagnosed diabetes resulting in a total of 445,200 (approximately one in every seven adults) diagnosed and undiagnosed cases of diabetes. In 2002, the cost of diabetes in Kentucky totaled \$2.9 billion. Furthermore, diabetes is the sixth leading cause of death by disease in Kentucky.

**ACTION TAKEN:** The Plan uses medical claims and pharmacy data to identify adult members with diabetes. All newly identified members receive a welcome letter that introduces them to the program and provides information on how to contact a diabetes care manager. On a quarterly basis, all program participants receive educational materials, including dietary recommendations. The Plan sends reminders for eye exams and other diabetes-related testing twice a year. Diabetes care managers contact members who have had an emergency room visit or hospital admission for diabetes and may not be managing their diabetes appropriately. Diabetes care managers assess members' needs and provide information about the disease. The Plan stratifies members based on the severity of their disease and the types of services they have used. Members receive educational materials and services tailored to their specific needs.

**OUTCOME:** In 2009, the Plan achieved continued improvement in the following areas:

- An increase in members who received a Hemoglobin A1c\* to 87.30% from 64.93% in 1999.
- An increase in members who received a screening for kidney disease (nephropathy) to 78.77% from 29.15% in 1999.
- An increase in members who noted good control of diabetes with a Hemoglobin A1c of less than 7.0% to 56.95% from the 2006 baseline measurement year of 37.59%.
- An increase in members who noted LDL-C control of less than 100 to 45.24% from the 2003 baseline measurement year of 28.21%.

In 2003, the National Committee for Quality Assurance (NCQA) chose the Plan's Diabetes Disease Management program for a Best Practices award. The award recognized the Plan's support of effective physician practice patterns and members' use of effective care.

\*Hemoglobin A1c measures the average blood sugar over a three month time period, and is an indication of how well the individual is controlling his or her diabetes.

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## Horizon NJ Health

# Diabetes “One-on-One” Pilot Program

**DESCRIPTION:** Diabetes affects 23.6 million Americans or 7.8 percent and 8 percent of New Jersey’s population. If current trends continue, one-in-three Americans will develop diabetes. As a major cause for deaths nationally (ranking sixth) and statewide (ranking fifth), diabetes is often treatable and lifestyle changes can make a difference. (Centers for Disease Control and Prevention–CDC).

The Disease Management staff designed a “one-on-one” diabetes member education program targeting members with elevated HgbA1C. The Program sought to:

- Improve communication and understanding between members and providers, while expanding members’ ability to manage their disease.
- Help members understand the disease process to prevent/reduce complications.
- Incorporate health literacy concepts for communication.
- Educate on importance of a medical home for scheduling regular visits with their Primary Care Provider (PCP).

### ACTION TAKEN:

- Targeted telephonic outreach to invite members with a high Hgb A1C to participate.
- Each member signed an agreement to participate and to follow up with their diabetes disease management nurses during a one year period.
- Pre- and post-written diabetes test questions were given to each participant.
- Each member received educational literature and community resources.
- Members were educated on standards of care for diabetes.
- After completing the educational program, each member was given grocery store gift certificates, lists of healthy food choices and fresh herb plants in a flower box, given as an encouragement to members so they could incorporate herb flavorings into food for healthy, flavorful meals.

### OUTCOME:

- Empowered members to maintain diabetes standards of care through routine visits with PCP at six months and one year.
- Monitored diabetes ER/IP(in patient) utilization over the next six months to one year.
- Based on individualized health literacy needs, one on one sessions provided an opportunity to educate members.
- Educated members by using targeted words, more pictures and utilized the teach back/repeat techniques.
- Revision of pre/post test to allow questions to be read to members.

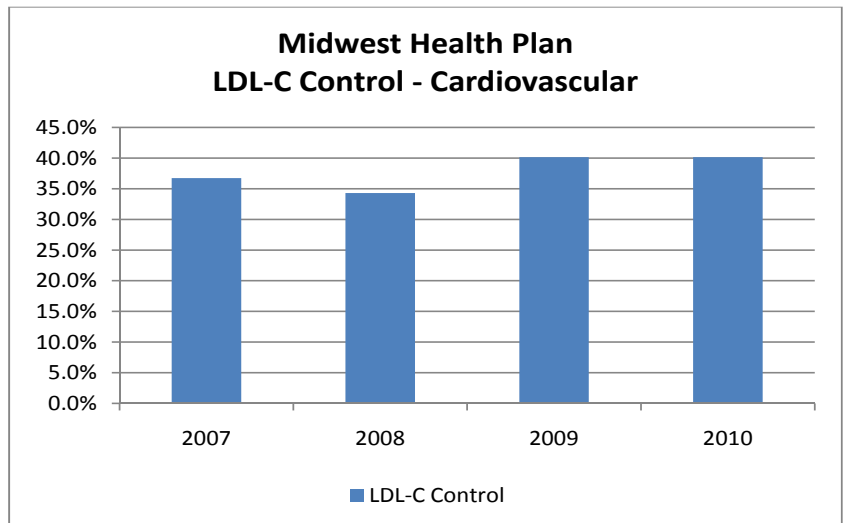
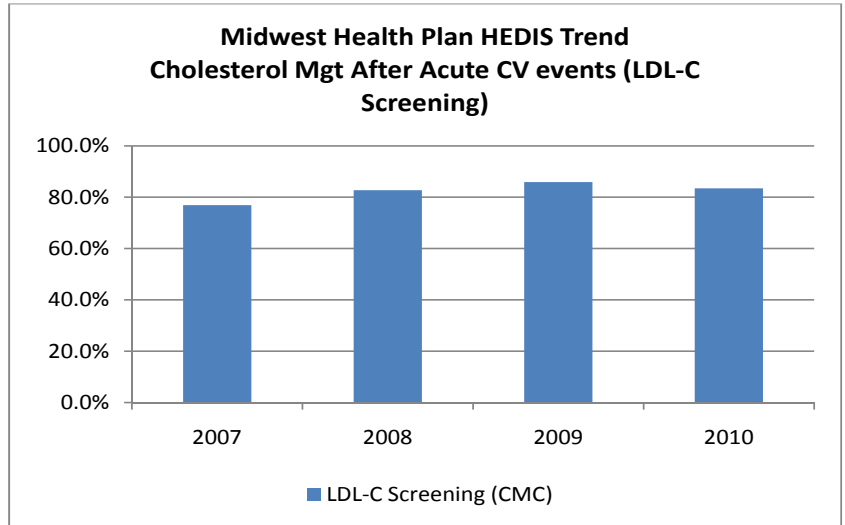
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## Midwest Health Plan

# Don't Gamble with Your Numbers: Improving Control of Hypertension and Hyperlipidemia

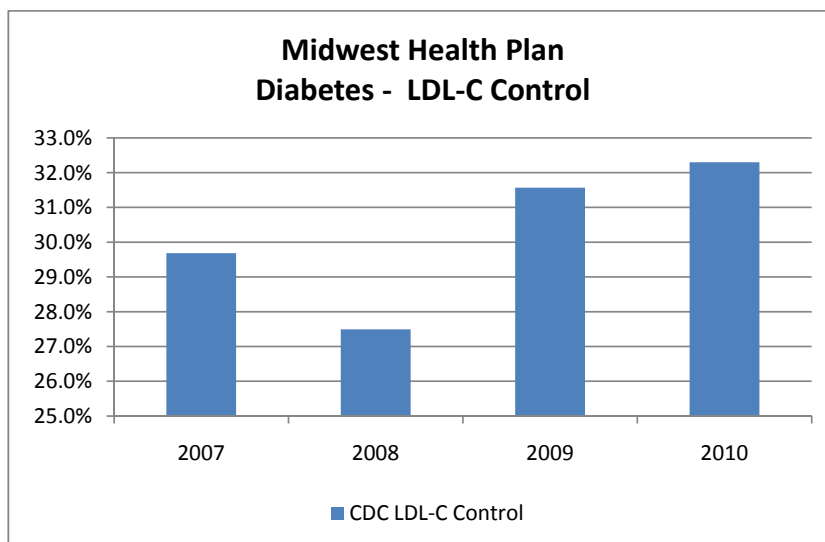
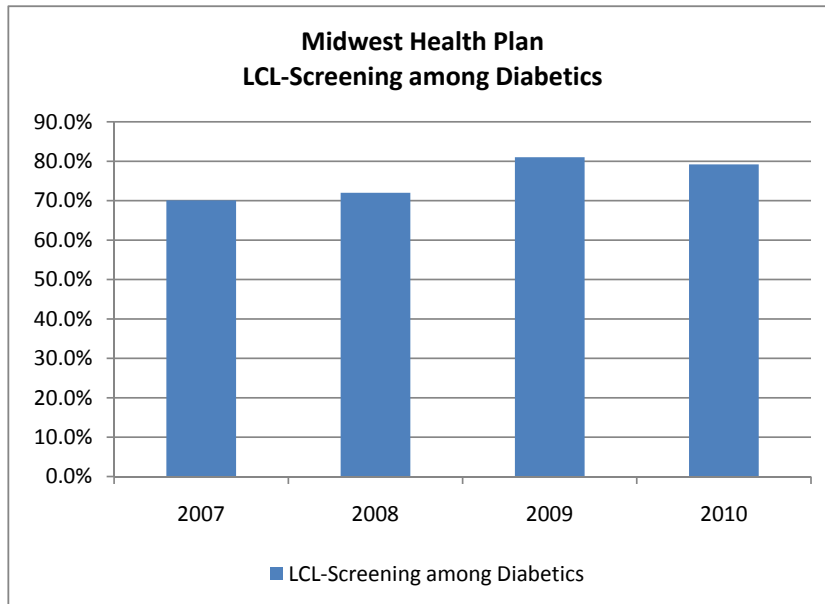
**DESCRIPTION:** One in three American adults has some form of cardiovascular disease, including coronary heart disease, high blood pressure, heart failure and stroke.<sup>1</sup> Coronary heart disease claims over 450,000 lives annually and continues to be the number one killer in the U.S.<sup>2</sup> High cholesterol is a major risk factor for and cause of cardiovascular disease. Screening and managing cholesterol levels in patients with cardiovascular conditions is extremely important and very effective at reducing the harm caused by heart disease and other cardiovascular disease. In 2007, Midwest Health Plan scored below the NCQA 50th percentile in the Cholesterol Management for Patients with Cardiovascular Conditions LDL-C screening sub-measure. Among diabetic patients, Midwest scored second lowest of Michigan Medicaid plans in LDL-C screening (70.1%) and below the national 50th percentile in LDL-C control among diabetics.

**ACTION TAKEN:** Recognizing the need to raise its HEDIS rates, Midwest initiated quality improvement activities around improving hyperlipidemia screening and control among cardiovascular and diabetic patients. Midwest Health Plan also applied for and was awarded a mini-grant from the Michigan Department of Community Health, Cardiovascular Health, Nutrition and Physical Activity Section. By partnering with the State of Michigan, Midwest was able to learn from prior studies, obtain sample letters and materials, and share ideas with other grantees. Midwest believes that this partnership helped to strengthen the quality of materials used for its intervention. Participants targeted for the project were health plan members with diagnosed hypertension and/or hyperlipidemia. Midwest Health Plan (MHP) identified 2,248 members with high blood pressure, 418 members with Cardiovascular Conditions, and 1,802



members with Diabetes. In total, there are 3,311 members that had one or more of the above conditions, and 216 members with all three diagnoses. MHP sent a provider mailing to 110 PCPs with information about the grant project and included the following clinical guidelines, a Diabetes checklist and a listing of

members with hyperlipidemia, heart disease and diabetes along with reported LDL screening dates and LDL levels reported through administrative data. MHP also sent a member mailing encouraging patients to visit their doctor and included information on Diabetes, Cholesterol and Heart Disease. QI nurses made follow-up calls to members to answer questions and provide assistance.



**OUTCOME:** Midwest Health Plan realized statistically significant increases (using chi-squared analysis) in LDL-C screening rates among members with acute cardiovascular events and among diabetic members. LDL screening rates for members with acute cardiovascular events increased from 82.7% in 2008 to 83.5% in 2010. The rate was above the NCQA Medicaid 50th percentile. LDL-C control also increased from 34.3% in 2008 to 40.2% in 2010. LDL screening among diabetics increased from 70% in 2007 to 79.2% in 2010 which is above the NCQA Medicaid 50th percentile. Midwest Health Plan helped promote evidence-based practices for diabetes and hyperlipidemia among 110 providers and provided member listings with administrative data so individual practices could also perform outreach to members.

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## Passport Health Plan

### Early Periodic Screening Diagnosis and Treatment (EPSDT) Program

**DESCRIPTION:** EPSDT preventative health services are available to all members under the age of 21. Approximately 70% of the population is under the age of 21. National Child Advocates successfully lobbied to ensure Medicaid children received preventative health services to prevent childhood illnesses. As a result, each state is required to provide outreach and education to this population. In 1997, the Centers for Medicare & Medicaid Services (CMS) established an 80% EPSDT compliance/participation goal to be met by 2006.

**ACTION TAKEN:** EPSDT staff members make phone calls to families who have not received the recommended EPSDT screening. Members who cannot be reached by phone are provided with a home visit through the Plan's contract with the Department of Health. EPSDT screens are also a part of the Plan's Provider Recognition Program. Providers are encouraged to increase their screening and participation rates. Providers receive monthly "Screens Due" reports for their panel that identifies members due for EPSDT screenings.



**OUTCOME:** In 1997, the statewide EPSDT screening rate was 17% prior to the Plan's inception. Since 1997, the Plan has improved the EPSDT screening rate to a remarkable 95%, an increase of two percentage points from the Federal Fiscal Year (FFY) 2008 rate of 93%. The participation rate for the EPSDT program also noted improvement from the FFY 2008 rate of 71% to the FFY 2009 rate of 74%, which is an increase of three percentage points.

In 2009, the Plan showed improvement in the areas of well-child visits, annual dental visits, and childhood immunizations when compared to 1999:

- The number of annual dental visits for children ages 2 to 21 increased 14.88 percentage points.
- The number of well-child visits for children in the first 15 months increased 38.19 percentage points.
- The number of well-child visits for children 3 to 6 years old increased 22.92 percentage points.
- The number of well-child visits for adolescents increased 28.55 percentage points.

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## Keystone Mercy Health Plan, a member of the AmeriHealth Mercy Family of Companies

### Embedding a Care Manager in the Physician Office

**DESCRIPTION:** Keystone Mercy Health Plan (a Medicaid managed care organization) and Mercy Health System (an urban integrated delivery system) partnered to develop mechanisms to enhance the coordination of care in an integrated delivery system setting. The program goals benefited both organizations: improving the quality of health care delivered to individuals served by both populations, optimizing the efficiency of the integrated delivery system, and increasing the percentage of care delivered by the Mercy Health System providers to individuals in their community. Keystone Mercy chose a clinic practice with a panel of 460 health plan members for the intervention.

**ACTION TAKEN:** The program embedded a health plan Care Manager within a clinic practice. The Care Manager actively engaged health plan members during their office visit. He or she also provided the practice staff with information on members' care gaps — clinically recommended services for which the health plan did not have a record — and served as a liaison with the health plan to address barriers and arrange for additional covered services. Working with the health plan's Rapid Response and Community Outreach Teams, the Case Manager coordinated outreach and appointments for high-risk members who had not seen the physician in the last year.

**OUTCOME:** The program started at the end of 2008. Through the end of 2009, 179 health plan members belonging to the clinic practice were actively engaged in care management by the embedded Care Manager. Sixty-seven percent of the engaged members had predictive risk scores in the high range, compared to 33 percent of the remaining panel.

Initial outcomes show the following:

- Reductions in hospital admissions per 1,000, from 627 admissions pre-program to 523 post-program.
- Reductions in inpatient length of stay, from 4.3 days pre-program to 2.7 post-program.
- Reduction in readmissions within 30 days, from 30 percent pre-program readmissions to 7 percent post-program.
- Increases in the percent of members hospitalized within the health system, from 70 percent pre-program hospitalized to 86 percent post-program.

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## UnitedHealthcare Community & State (Unison Health Plan of the Capital Area) ER Diversion Program

**DESCRIPTION:** Unison Health Plan of the Capital Area became operational in May 2008. The Plan insures the Medicaid population and an uninsured population known as the Alliance Program. Although assigned PCPs, members often seek care from area emergency departments (ED). In 2009, the Emergency Department diversion program was implemented under the direction of the Chief Medical Officer, to reduce inappropriate utilization.

**ACTION TAKEN:** Unison Health Plans' Emergency Diversion Program began in fourth quarter 2009. Nurse case managers receive daily information from hospitals regarding emergency visits for Unison members. The nurses contact these members and ascertain their reason for emergency room usage and make certain they understand the instructions given from the ED physician. Nurses then attempts to engage the member in primary care and assist in obtaining a primary care appointment for members who need assistance. The nurse contacts members to ensure that they keep their appointments. They also leave their contact information in the event that the member needs assistance in seeking further care.

**OUTCOME:** Data analysis was performed in April 2010. Analysis occurred for the period October 2009 through February 2010. The data demonstrated a 37.9% decrease in ED admissions and approximately a 41% decrease in non-medically necessary ED visits. While the plan acknowledges that there are activities that can be done to enhance this clinical outreach program, the preliminary results are encouraging. Health Plan management are satisfied that the program has been an effective use of resources.

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## United Healthcare Community & State (New York) Fluoride Varnish Program

**DESCRIPTION:** This pediatric primary care program will educate and engage Primary Care Physicians/Pediatricians (PCPs), dentists and members in early preventive oral hygiene. It is a collaborative model which seeks to create a true “health home” for children age four and younger, and coordinate medical and dental health in preventive care.

The program provides incentives to primary care physicians to apply fluoride varnish to pediatric patients, and to refer them to dentists.

Physician training is web-based with a full complement of resources. Upon completion of training, physicians are rewarded with CEU credit from the Arizona School of Dental Health. The program includes member education materials in several languages, sample starter kits for PCPs, dental assessment kits, as well as dental homecare kits for children age four and under.

**ACTION TAKEN:** The goal will be to have all children age four and under establish a health home (i.e. integrated medical and dental home) by early referral of physician to dentist at three designated Federally Qualified Health Centers (FQHCs). This will create a solid partnership with United Healthcare Community & State (NY) and allow the Sales and Marketing teams to establish background and develop necessary relationships with program directors.

**OUTCOME:** Short-term success will be measured by analyzing claims data to see the number of applications of fluoride varnish and visits to the dentist by the target population at the targeted FQHCs. Long-term success will be measured by analyzing medical and dental outcomes over time.

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## Centene Corporation

### Generic Drug Fill Rates

**DESCRIPTION:** Centene Health Plans offer a drug benefit that provides appropriate and high-quality drug therapy to members, which also promotes adherence and improved medication outcomes while achieving lowest net drug costs.

**ACTION TAKEN:** Centene uses several utilization and communication tactics to achieve better adherence results in combination with lower net drug costs.

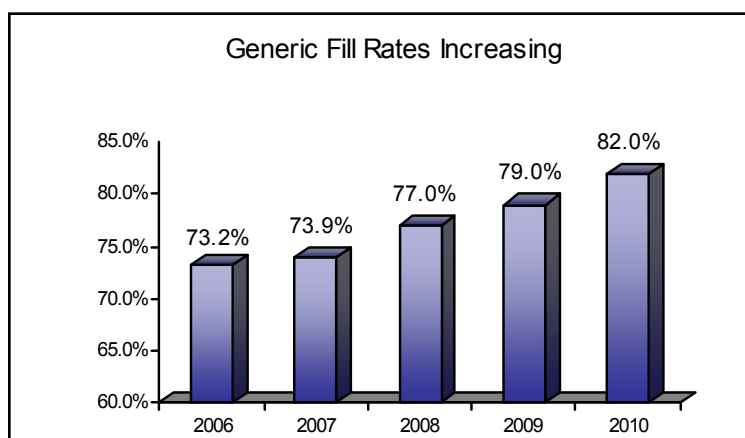
First, Utilization Management tactics are employed that promote the use of generic drugs as first line therapies. Tactics include:

- Mandatory generic benefit set-up at the pharmacy benefit manager.
- Step Therapy edits and Prior Authorization edits requiring usage of generic therapeutic equivalent Preferred Drug List (PDL) product prior to brand-name product].
- Selective use of co-pays (when allowed).
- Over-the-counter benefits.
- Required submission of a MedWatch form when brand drug override is requested.

Secondly, timely communication of the pharmacy benefit to providers, pharmacies and members enables the use of generics versus brand names where applicable. Tools include:

- Retail pharmacy point of sale messaging, which advises the dispensing pharmacy of generic therapeutic equivalent PDL products.
- PDL Quick Reference Guides.
- Timely provider and member communication of PDL changes.
- Web posting of PDL.

**OUTCOME:** Generic Fill Rates (GFR) have steadily increased for more than four years, resulting in better adherence to medications as well as lower costs.



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## Passport Health Plan

### Glorious Women Assembly

**DESCRIPTION:** In most communities in the United States, women tend to care for their families before addressing the needs of their own health and welfare. There is a high prevalence of major health concerns among women of color and those living in poverty. According to the Office of Minority Health: “Poverty disproportionately affects women. Nearly 13 million women live in households with incomes below the Federal poverty level. Poor or near-poor women are more likely than high-income women to report fair or poor overall health and limitations of activity. They are also more likely to report having anxiety or depression, arthritis, asthma, diabetes, hypertension, obesity, and osteoporosis.” However, women still remain as one of the last minorities to recognize and validate their own health concerns. In addition, refugee and immigrant women who access both public and private health care services continue to struggle to assimilate to health care practices and services in the United States, and to those offered within the Plan’s service area. These refugees and immigrants also show poor health outcomes and status.

**ACTION TAKEN:** The Plan created the Glorious Women Assembly (GWA) in 2007 to focus on the health needs of women. The GWA is a special annual event focused on celebrating womanhood by encouraging women to make or renew their commitment to health. The event offers women a day to focus on themselves and receive pertinent health information in a sharing and warm environment. During the GWA, women discuss their health concerns with providers and other women in the community, and service providers are available on location with mobile units to provide information and conduct important screenings such as mammography. Providers are also on-site to offer private consultations and individualized medical advice.

In 2010, the GWA theme was “Accessorize Your Health.” The event was decorated from head-to-toe with shoes, purses and hats. The decorations added a fun component to the event and not only became a talking point, but allowed the participants to discuss their health with more enjoyment. Each of the classes were conducted by an area female physician and the class titles matched the theme. The classes ranged from “Before the Mascara” (Diabetic Eye Care), “If the Shoe Fits” (Arthritis & Osteoporosis), “Applying Foundation” (OB/GYN); to the emotional and spiritual inspirational message “Hats Off.” The Plan uses HEDIS data to determine the subjects covered and information provided to the women. The HEDIS data identifies areas for improvement among women’s health outcomes.

**OUTCOME:** Since the program’s inception, the Plan has seen a drastic improvement in the event’s participation and diversity. The event’s attendance improved from six women in 2007 to 90 in 2010. In 2010, the Plan served the most diverse group of women to date: ages ranged from 20 to 89 years old and languages spoken included English, Spanish and Russian.

Additionally, in 2010:

- 46 women received cholesterol screenings.
- 30 women were given on-site mammograms.
- 20 women were given clinical breast examinations.
- 8 women were referred for Pap smears.
- 6 women were sent home with colon care kits and referred for testing.
- 3 women scheduled eye care appointments.

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## Keystone Mercy Health Plan, a member of the AmeriHealth Mercy Family of Companies

# The Gift for Life: Aggressive Mammography Outreach and Event Scheduling

**DESCRIPTION:** Keystone Mercy Health Plan took an aggressive approach to ensure that eligible members receive recommended mammography screenings for breast cancer. Breast cancer is the second most common cancer among women, and experts report that African-American women have higher mortality rates because the cancer is often detected in later stages of the disease. Early screening and detection of breast cancer remains the most effective way to combat this deadly disease. The Gift for Life program was developed to engage and educate Keystone Mercy members who have not had screenings in the past two years and encourage them to have a mammogram.

**ACTION TAKEN:** The Gift for Life Program provides mammography screenings for Keystone Mercy members in the neighborhoods where they live. Keystone Mercy Health Plan partners with mobile mammography vans and local providers to arrange accessible locations throughout their five-county service area. The Medical Management staff provides scripting and Informatics identifies the names and contact information for members who meet the requirements for a mammogram but have not had a claim within the last two years. Additional screenings are also available at selected events, such as cholesterol, blood pressure, height, weight and BMI and HbA1C. Keystone Mercy contacts plan members to explain the importance of the screening, help them schedule the test and assist with transportation needs. Behind the scenes, Keystone Mercy modified their software systems to flag members in need of a mammogram. Member Service representatives and Care Managers who are speaking with a member for any reason are alerted to the member's need for a mammogram. Prior to the event, outreach team members make reminder calls to maximize participation, and following the mammogram, members receive a gift card incentive for their participation. This collaborative, cross-functional strategy has increased community accessibility to mammograms.

**OUTCOME:** From May through December 2009, Keystone Mercy held 88 separate mammography events, providing a mammography screening to 1,196 members. Keystone Mercy's HEDIS results for breast cancer screening rose from 52.28 in 2008 to 57.9 in 2009.

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## UnitedHealthcare Community & State (Unison Health Plan of Pennsylvania)

### Gold Star Program

**DESCRIPTION:** The Unison Health Plan of Pennsylvania Gold Star pay-for-performance program has completed a third year (2007/2008/2009). The program was developed to meet the plan's internal need to improve quality, grow membership, enroll excellent providers in the plan network and control the cost of health care. The Gold Star program also satisfied a mandate from the Pennsylvania Department of Public Welfare to Pennsylvania Medicaid Managed Care organizations to "develop or enhance a pay-for-performance program." The Gold Star program is also part of a successful strategy that enabled the health plan to capture a substantial bonus (\$5.1 of \$12 million available) for 2009 with the expectation that the bonus earned for 2010 will be greater.

**ACTION TAKEN:** The Health Plan developed metrics which were used to award the Unison Health Plan "Gold Star" designation for providing excellent quality health care to Unison Health Plan members.

The metrics developed for the program are:

- Membership levels and maintaining an open panel
- Medical loss ratio
- Emergency department usage reduction
- Electronic claims and encounter data submission
- Quality measures (all are HEDIS measures and are included in the PA DPW P4P bonus program)
- Member satisfaction

**OUTCOME:** As of February 2010, Gold Star practices have shown a 19% increase in overall membership in their practices.

The primary premise of the Gold Star program is that quality practitioners provide cost-effective care. MLR for 2009 is 8.5% lower for the Gold Star providers than the Non Gold Star providers. Additionally, the cost of service from specialists is 10% lower for members served by Gold Star doctors even though the need for a referral to a specialist from the PCP is removed for Gold Star doctors.

The Unison Gold Star physicians demonstrated a higher level of performance on the HEDIS measures than the non-Gold Star practices. The rates for Childhood Immunizations and Well-Child Visits exceed the plan results. In relation to our pay-for-performance measures, Gold Star providers scored higher in Adolescent Well Care, Breast Cancer Screening, Lead Screening and Timeliness of Prenatal Care, all contributing to the \$780,000 earned by Unison for these four pay-for-performance measures.

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## Horizon NJ Health

### Health Literacy

**DESCRIPTION:** Health literacy is the use of a wide range of skills that improve the ability of people to act on information in order to live healthier lives. These skills include reading, writing, listening, speaking, numeracy and critical analysis, as well as communication and interaction skills.

Low health literacy among the Medicaid population results in members who are less likely to adhere to prescribed treatment and self-care regimens and often fail to seek preventive care. This population often requires additional care resulting in annual health care costs that are four times higher than for those with higher literacy skills.

**ACTION TAKEN:** Horizon NJ Health developed numerous activities to address the challenges generated by low health literacy. Programs were developed for internal and external stakeholders (members, providers, etc.)

- Training all staff on Health Literacy issues to raise awareness about members who may have limited or low health literacy concerns.
- Horizon NJ Health was a sponsor and promoted NJ's First Statewide Health Literacy Summit (April 2009).
- An internal health literacy reference site was established that included health literacy guidelines for written and oral communications with members.
- Educating the provider community involved implementing a provider/office staff health literacy toolkit, promotion of health literacy via newsletter articles and the Horizon NJ Health Website.
- Recognizing that community organizations are a link to members, Horizon NJ Health engaged its Community Health Advisory Committee (CHAC) to promote the issue. Committee members received training on health literacy and actively reviewed the company's member program materials; feedback received on additional ways to improve communications with members.
- As a result of the CHAC input, Horizon NJ Health is an active participant in The NJ Health Literacy Coalition which seeks to bring together organizations and individuals committed to improving the effectiveness of the health care system.

**OUTCOME:** Using established health literacy guidelines:

- Member education and marketing materials edited and redesigned.
- As part of the company's continuous training, nursing staff, with one-on-one member contact, participate in case conferences-presenting examples of how health literacy tools were used in their member interactions. These case reviews are used to reinforce the need to address low health literacy during daily member interactions.

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## Select Health of South Carolina Healthy Moms and Babies

**DESCRIPTION:** Beginning in 2008, Select Health of South Carolina experienced a significant increase in the enrollment of pregnant members as a result of the state's transition to an external enrollment broker program. This change in Medicaid health plan enrollment resulted in a notable increase of pregnant members for Select Health, far outweighing the increase in membership of the plan's general population.

Select Health responded by restructuring the formerly established case management program, Healthy Moms and Babies. The goals of this program are to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention.

**ACTION TAKEN:** This program is a unique integrated model performing maternal and newborn utilization review, risk-based case management and member education. Efforts are focused on early and complete prenatal and postpartum healthcare, a significant key to having a healthy baby. The program offers the following:

- Nurse case managers with OB or NICU experience, some having both. Most come from South Carolina hospitals and are familiar with their local facilities and practitioners.
- Every pregnant member receives a range of prenatal, postpartum and newborn educational information.
- High-risk OB members are contacted by a nurse case manager throughout their pregnancy to ensure they are receiving appropriate healthcare.
- Site visits to high volume OB providers to promote the health benefits and cost savings of the program.
- Promotion of the "text4baby" national program providing maternal health information and topics to members.
- Identifying pregnant members earlier through pharmacy reports and Medicaid Fee-for-Service enrollment history.
- Earlier identification of high-risk OB members by encouraging OB practices to submit Risk Assessment forms for each member.
- Expand educational outreach efforts by engaging the plan's Member Services Department to assist with members identified as low risk.
- Completion of post-delivery outreach calls to every member to assess needs and postpartum/newborn follow-up care.

**OUTCOME:** The program assesses plans, teaches, coordinates, monitors and evaluates options and services required to meet the individual's health needs using communication and available resources to promote quality and outcomes. The design of the program allows for collaboration between the Healthy Moms and Babies case manager, the member and the prenatal care provider for assessment and interventions to support the management of behavioral /social health issues. The plan reported an increase in the 2010 Prenatal HEDIS results listed below.

- Prenatal and Postpartum Care – Timeliness of Prenatal Care from 83.44% to 90.04% in 2010.
- Frequency of Ongoing Prenatal Care (greater than 81%) – from 57.85 to 66.46%.
- Prenatal and Postpartum Care – Postpartum Care from 67.55% to 69.03% in 2010.

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## AmeriHealth Mercy Health Plan “Healthy You, Healthy Me” Childhood Obesity Program

**DESCRIPTION:** Today’s children and youth are the most overweight generation in the history of the United States. According to the National Center for Health Statistics, the prevalence of overweight children and youth has more than tripled over the last 35 years. In addition to the increase in type II diabetes in children, which was formerly only seen in adults, overweight children also have increased the rates of diagnosed hypertension, asthma, and sleep apnea. (NIHCM, 2003) Factors contributing to this epidemic include improper nutrition, physical inactivity, genetics, and lifestyle.

**ACTION TAKEN:** In an effort to combat this epidemic, AmeriHealth Mercy Health Plan partnered with the Neighborhood Center in Harrisburg, Pa. to create our “Healthy You, Healthy Me” Childhood Obesity Program. The program uses the CATCH (Coordinated Approach To Child Health) Kids Curriculum, which was developed with funding from the National Institutes of Health (NIH) to help youth, their parents and caregivers in both home and community settings to meet the overall goal of preventing obesity. This curriculum provides activities and programs that encourage improved nutritional choices and increased physical activity in youth ages 5 to 13. The 10-week program is composed of three 90-minute sessions per week, which include healthy lunches or snacks to reinforce the importance of proper nutrition.



**OUTCOME:** Self-inventories were given to participants to assess how they felt about the importance of nutrition and activity. In addition, pre- and post-event BMI screenings were completed by AmeriHealth Mercy Health Plan’s medical staff. As a result of the program:

- 45 percent of the participants decreased their BMI since the program’s inception in 2006.
- 38 percent of the participants in the July 2010 program decreased their BMI by .45 points.
- 40.6 percent finished the 2010 program at “healthy weight.”

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## Select Health of South Carolina Heart Failure Program

**DESCRIPTION:** According to the American College of Cardiology and the American Heart Association, heart failure is a growing health problem in the United States. About 5.8 million people in the United States are living with heart failure. According to the CDC, of South Carolina adults, 30.4% had hypertension, 39.2% had elevated cholesterol, 9.6% had diabetes, 21.9% were smokers and 65.3% were overweight or obese. All of these conditions are risk factors for heart failure and contribute to the prevalence of heart failure in South Carolina

**ACTION TAKEN:** Select Health implemented the Heart Failure Program in 2009 to improve the health and quality of life for identified members with heart failure. Members enrolled in the program receive direct case management follow-up, focused educational mailings along with education on preventive measures for worsening symptoms of heart failure, medication compliance, lipid level monitoring and smoking cessation. The nurse case manager also monitors any inpatient hospitalizations to assist with care coordination, discharge medications and follow-up physician appointments. To promote self-awareness, self-management and communication between the patient and medical provider, the plan provides home monitoring devices (BP monitors and scales) to all members engaged in the program. Monitoring and tracking weight gain promotes early detection of fluid retention for prompt intervention by the physician. Practitioners are notified when members are enrolled into the program and the case manager works closely with the physician regarding medication compliance and care coordination.

### OUTCOME:

- Increased member knowledge regarding appropriate heart failure treatment and self-management skills.
- Favorable behavior modification with reinforced teachings by case management staff (noted improvement with appointment and medication compliance).
- Availability of blood pressure monitors and scales has improved member participation in self-management behaviors.
- Anecdotal report of increased member compliance with daily weights — a key factor in managing CHF.

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## CHOC Health Alliance Schaller Anderson/Aetna HEDIS Enhanced Capitation Program

**DESCRIPTION:** CHOC Health Alliance (CHA) is a Consortium between CHOC Children's Hospital and CHOC Physician Network. CHA is composed of more than 300 Primary Care Physicians (PCP) and over 400 specialists caring for approximately 104,000 children of Orange County. The CHA Enhanced Capitation Program (ECP) gives the 37 PCPs with the highest membership an opportunity to provide high-quality care and receive additional monthly income to assure that the proper preventative care is provided. The 37 participating providers hold approximately 70% of the total membership.

**ACTION TAKEN:** On a monthly basis providers involved in the ECP receive a list of members with unmet HEDIS interventions based on state regulator's focused HEDIS goals. Lists are disseminated on a monthly basis. A bonus of \$1.00 PMPM (based on panel size) is paid on a monthly basis for providers meeting 90% of their monthly target, set at the beginning of the measurement year. The target is set by determining the necessary number of HEDIS measures that need to be met in a given year for a set HEDIS population. That number is then divided by 11 months, which determines a monthly goal. Providers need to meet 90% of the established measures that have been identified in order to receive the \$1.00 PMPM bonus. Encounter data is used to capture the necessary data electronically. This provides approximately 75% of the data, with the remainder being captured through clinical documentation, PM160, and CMS 1500 submitted by the PCP's offices for manual entry. Monthly feedback is provided to participating providers, which includes the monthly goals met, a check for meeting those goals, list of measures still not met for the year, and a letter stating what new goals have been set after previous submission, along with earned or unearned capitation. Providers also have an opportunity to make up for lost bonus from previous months by submitting extra encounters whether electronic or paper.

**OUTCOME:** Over the past three years, CHA has shown steady improvement in most areas related to HEDIS such as adolescent well care, childhood immunizations and chlamydia. These efforts have resulted in improved annual HEDIS rates and significant additional revenues to the physician group.

CHA has developed and implemented a sophisticated management program which involves groups of representatives from multiple departments (Quality, Medical Management, Provider Relations, Member Services and Finance). This group meets on a regular basis and conducts roundtable discussions regarding the performance of individual PCPs and medical groups in the ECP plans for improvement of future performance, as well as plans ways to improve the management and administration of this program.

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## Horizon NJ Health

### Hospital ER Focused Dental Initiative

**DESCRIPTION:** Some Medicaid managed care members visit hospital ERs for treatment of emergent, urgent and routine issues of dental origin. They use the ER, because ERs offer 24/7 service. Their visits are reimbursed through their medical benefits, which results in no “out-of-pocket” expenses for these members. With the exception of dental trauma treatment, ERs offer little to help patients with tooth-related pain or swelling, aside from prescribing antibiotics and/or analgesics and recommending care at dental facilities. For some members, receiving narcotic analgesics may be the goal for these visits.

**ACTION TAKEN:** Horizon NJ Health has identified, on a monthly basis, those members utilizing ERs with primary diagnoses codes of dental origins as well as for those who were also filling narcotic analgesic prescriptions, within 24 hours of their visits. Each time a visit occurs, a letter is mailed to those identified.

The letter explains that we are aware of our members’ dental-related issues and offers an overview of what constitutes a dental emergency. The letter includes steps members can take if and when they have a dental-related emergency. For those members who have no dental coverage, the letter explains they can call Member Services for referrals to Federally Qualified Health Centers in their area. For those who have dental coverage, this letter describes how they can find an in-network dental home, with the help of Member Services, if necessary.

Members with three or more ER visits within three months are referred to our Pharmacy Department. Several steps are then taken: there may be a need to communicate with the members’ Primary Care Provider (PCP), pharmacy lock-ins can occur or substance abuse counseling can be initiated. Those with the most egregious ER visit patterns are also referred to our Special Investigations Unit as potential abuse cases.

#### OUTCOME:

- Increased awareness of oral health by members and physicians.
- Members are better able to receive appropriate care at appropriate facilities.
- More members in dental homes.
- Future decrease in dental-related ER utilization.
- Reduced burden on ER resources.
- Potential discovery and treatment of substance abuse issues.

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## UnitedHealthcare Community & State (Great Lakes Health Plan) Improving Blood Lead Screening in Two-Year Olds

**DESCRIPTION:** Lead poisoning may affect 20,000 Michigan children under the age of six. If not detected early, the lead that accumulates in a child's body may cause brain damage, mental retardation, developmental delay, learning difficulties, behavior problems, anemia, liver and kidney damage, hearing loss, hyperactivity, and in extreme cases, even coma and death<sup>1</sup>. Lead poisoning is said to be the most common environmental illness of children in the United States.

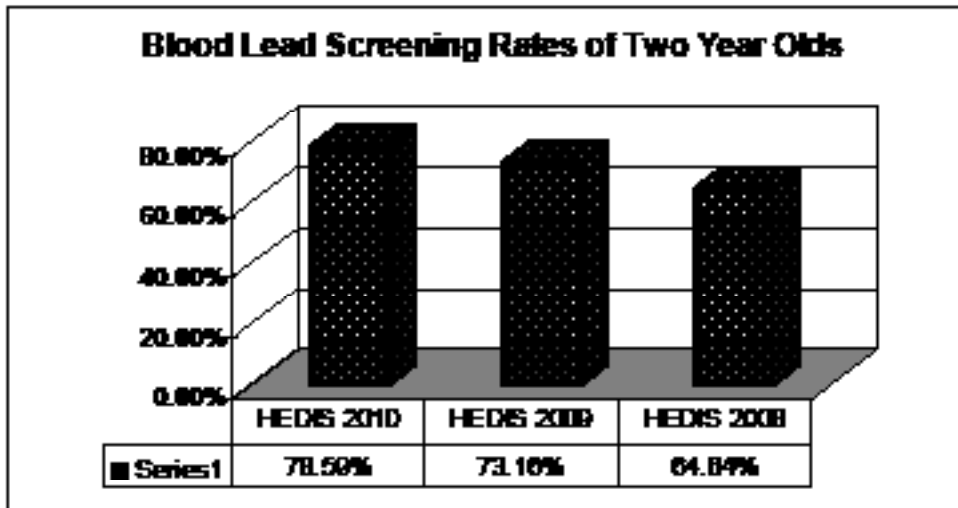
Small children ingest lead dust and lead fragments as part of the normal hand-to-mouth developmental process. They are doing this as their central nervous system is rapidly growing<sup>2</sup>.

### ACTION TAKEN:

- A GLHP nurse participates in the Michigan Childhood Lead Poisoning Prevention Program (CLPPP). CLPPP's purpose is to educate families, pregnant women, health care providers and child health advocates in Michigan communities on prevention of blood lead poisoning.
- GLHP nurses examine primary care practitioner (PCP) blood lead screening (BLS) rates of two year olds to identify those PCPs whose rates are lower than the national Medicaid 50th percentile and conduct in-office educational visits on BLS and use of filter paper kits for in-office sampling.
- GLHP runs articles in its monthly and quarterly provider newsletters on BLS and in-office filter paper kits to obtain test samples.
- GLHP identifies unscreened children who are turning two years old and calls parents/guardians to educate on blood lead poisoning, its effects and screening, and to make appointments for screening and arrange free transportation.
- GLHP also places recorded messages to parents/guardians of all children who are nine and 18 months to educate parents/guardians on BLS, free tests and free transportation.
- GLHP includes quarterly articles on BLS in its member newsletter.
- GLHP includes educational information on its member health pages concerning BLS.
- GLHP offers physician and member incentives for BLS.

**OUTCOME:** GLHP interventions were designed to address known barriers which include:

- Clinicians assert that there is no clinical research demonstrating that all children need to be screened for BLS.
- Parents do not understand the long term effects of blood lead poisoning on their children.
- Transportation is a problem for the poor.
- Poor children may have greater access to toys manufactured in countries with less requirements concerning lead content.
- Going to a lab after leaving a doctor's office for a venous blood draw is difficult for many parents due to transportation issues and time away from hourly paid jobs.



Using HEDIS<sup>®3</sup>, GLHP measured its BLS rate for two-year-old children continuously enrolled in the health plan for the measurement year, allowing for one 30-day enrollment break in the year. HEDIS 2008 (measurement year 2007) served as the baseline year. Over three years, GLHP improved its BLS rate nearly 14 percentage points. GLHP's performance goal is 80%.

<sup>1</sup> Michigan Department of Community Health, Childhood Lead Poisoning Prevention, A Call to Action, July 2003; [http://www.michigan.gov/documents/ChildLeadPoisoning2\\_71150\\_7.pdf](http://www.michigan.gov/documents/ChildLeadPoisoning2_71150_7.pdf)

<sup>2</sup> 2006 Annual Report on Blood Lead Levels in Adults and Children in Michigan, Kenneth D. Rosenman, M.D., Professor of Medicine and Amy S. Sims, B.S., ABLES Program Coordinator Michigan State University; Michigan Department of Labor and Economic Growth; Douglas J. Kalinowski, Director Michigan Occupational Safety and Health Administration; and Michigan Department of Community Health Brenda Fink, A.C.S.W., Division Director, Mary A. Scoblic, R.N., M.N., Child Health Unit Manager, Sharon Hudson, R.N., M.S.N., C.N.M., Program Coordinator. November 2007. [http://oem.msu.edu/userfiles/file/Annual%20Reports/Lead/06Lead\\_all.pdf](http://oem.msu.edu/userfiles/file/Annual%20Reports/Lead/06Lead_all.pdf)

<sup>3</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.

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## Keystone Mercy Health Plan, a member of the AmeriHealth Mercy Family of Companies Lose to Win Type II Diabetes and Obesity Education Program

**DESCRIPTION:** In Philadelphia, there is a rapidly growing epidemic of diabetes, obesity and other diseases that stem from poor eating habits and lack of physical activity. According to the Keystone Mercy Health Plan Population Analysis, diabetes ranked as the fifth most common cause for inpatient admissions and is one of the top six highest-volume diseases in terms of hospital readmissions. The Lose to Win Program was developed in cooperation with the local YMCA to reverse this trend and identify and educate high risk urban families by combining health screenings, nutrition and weight management, preventive diabetes/obesity disease management, and monitored exercise.

**ACTION TAKEN:** Lose to Win was a 12-week program launched in September 2009 in cooperation with the YMCA's Activate America Program. Prior to the start of the program, Keystone Mercy's nurse case managers administered a telephonic health survey of those members who expressed interest in the program to determine their ability to safely participate in a fitness program and gauge the member's understanding of diabetes management. A joint "kick off" event provided Keystone Mercy members with an opportunity to register and complete baseline health assessments. YMCA wellness directors contacted participants and scheduled a one-on-one session with a wellness coach, which included a fitness assessment and a personal action plan. Keystone Mercy's nurse case managers contacted participants to develop care plans to improve their blood glucose, blood pressure, and weight. This unique, team approach succeeded in helping patients comply with their treatment regimens. To keep members engaged, the program included special activities such as nutritionist-guided supermarket tours, cooking demonstrations, nutrition workshops and dance classes. The program culminated with a celebration for the 115 participants who completed the program. Each member received a one-year membership to the YMCA and those participants demonstrating the most improvement in measured parameters received additional awards.

**OUTCOME:** Keystone Mercy contacted over 500 members and enrolled 137 members into the program, each of whom were assigned to the closest YMCA site based on their location. A total of 115 participants completed the 12-week program and the average weight loss was 10 to 15 pounds. Several members lost more than 50 pounds, and many reduced their need for their diabetes and cardiovascular medications. On average, participants improved their BMI by 3.8 percent and their HDL by 5.5 percent. In a post-program survey, participants reported an increased knowledge surrounding nutrition and healthy food alternatives. In addition, most reported an increase in regular exercise, physical activity and an overall commitment to a healthier lifestyle. The ability of Keystone Mercy's care manager to build a relationship with the participant and maintain communication throughout the program was vital to increasing medical home collaboration and decreasing inpatient visits.

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## Passport Health Plan

### Mommy & Me Program

**DESCRIPTION:** The March of Dimes PeriStats 2006 report ranks Kentucky in the top 10 states for preterm deliveries. Between 1996 and 2006, the rate of preterm deliveries increased nearly 29% in the United States. In 2006, there were approximately 542,893 preterm deliveries in the United States or 12.8%. Low Birthweight\* (LBW) births accounted for 9.4% of the Plan's live births in 2009. Very Low Birthweight\*\* (VLBW) births accounted for 1.5% of the Plan's live births in 2009.

\* Low Birthweight: 1,501 grams to 2,500 grams

\*\*Very Low Birthweight: less than or equal to 1,500 grams

**ACTION TAKEN:** The Plan identifies pregnant members through provider referrals, member self-referrals and referrals from local health departments. The Plan mails educational material to emphasize the importance of early prenatal care, introduce the Mommy & Me program, and informs members how to reach a program representative. Members also receive a comprehensive, easy-to-read guidebook called *Mommy & Me Basics: A Guide to a Healthy Pregnancy, Delivery and Baby Care*. Upon referral, members are contacted by phone to identify high-risk factors that could lead to pregnancy complications or poor birth outcomes. Members are



referred to community agencies that can assist them during their pregnancy such as WIC, transportation, infant resources, financial assistance and housing. *The Mommy & Me* staff continue to follow-up with members through the postpartum period. In addition, the *Mommy & Me* staff is notified by providers if a member has missed an appointment for prenatal care. The staff works with the member to address reasons for missed appointments and assists with future appointments to ensure they receive the recommended care.

**OUTCOME:** In 2009, 92.15% of the plan's pregnant women received their first prenatal visit in the first trimester or within 42 days of enrollment as compared to 85.27% in 2000. In 1999, 68.51% of the Plan's female members received 81% of the recommended number of prenatal visits as compared to 85.22% in 2008. In 1999, 57.94% of female members received postpartum visits between 21 and 56 days after delivery and the rate increased to 76.21% in 2008.

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## Midwest Health Plan

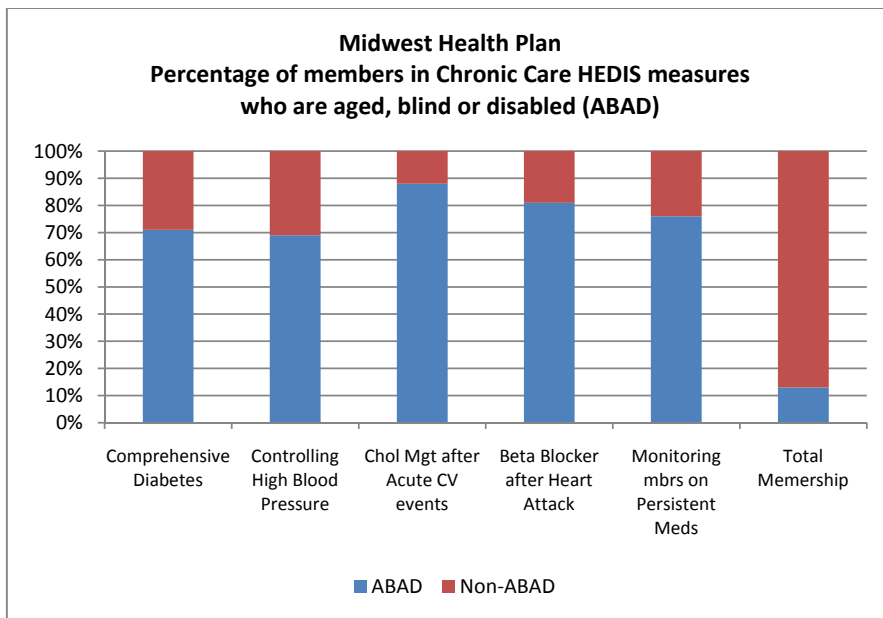
### Navigating for Care – Aged, Blind and Disabled

**DESCRIPTION:** According to the Centers for Health Care Strategy, Aged, Blind and Disabled (ABAD) beneficiaries make up 27% of Medicaid enrollees yet they account for 70% of total Medicaid spending. At Midwest Health Plan, 13.5% of its membership is ABAD, yet the population accounts for a disproportionate amount of inpatient admissions (38% of total admissions and 53% of non-delivery OB admissions). ABAD members also account for a disproportionate percentage of chronic care HEDIS measures. In order to help ensure its ABAD members were getting appropriate care, Midwest initiated “Navigating for Care – for the Aged, Blind and Disabled” project in 2008.

**ACTION TAKEN:** Midwest Quality Improvement nurses called ABAD members who had not had an office visit to encourage the establishment of a relationship with their PCP and ensure appropriate evaluation of their medical conditions is made. The nurse assisted in scheduling appointments, arranging transportation as needed and answering questions regarding the member’s condition and care. Midwest also offered members a Target gift card for visiting their doctor. Midwest also implemented an Opportunities Report available on our secure provider portal. The Report identifies members overdue for services and identifies historical diagnosis information to ensure appropriate evaluation occurs at each office visit. Midwest recognizes that ABAD patients are often more time consuming to care for and has adjusted capitation payments for ABAD patients reflect the increased severity. The Plan also offers an ABAD bonus tied to percentage of ABAD patients seen in order to provide additional incentive for PCPs to outreach to members and establish a relationship.

**OUTCOME:** Midwest saw improvements in many chronic conditions measures, including diabetic measures, annual monitoring for persistent medications, LDL-C for CV conditions, Controlling High Blood Pressure and Appropriate Medications for Patients with Asthma. A Summary of results is provided below.

Measure	2008	2009	2010
<b>Diabetes (71% ABAD )</b>			
<b>HbA1c testing</b>	75%	80%	82%
<b>HbA1c Control (lower rate is better)</b>	46%	61%	26%
<b>LDL-C Screening</b>	72%	81%	79%
<b>Blood pressure control</b>	53%	50%	60%
<b>Controlling High Blood Pressure (69% ABAD)</b>	50%	56%	68%
<b>Cholesterol Mgt after Acute CV Events (88% ABAD)</b>			
<b>LDL-C screening</b>	83%	86%	84%
<b>LDL-C control</b>	34%	40%	40%
<b>Monitoring for Persistent Medications (76% ABAD)</b>	79%	80%	82%
<b>Appropriate Medications for Asthma-total (58% ABAD)</b>	81%	83%	90%



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## Missouri Care, an Aetna Company

### Notice of Action Database (NOA database)

**DESCRIPTION:** A database was needed to significantly enhance the plan's ability to oversee, manage and report on its utilization management decisions to external regulatory bodies.

**ACTION TAKEN:** Missouri Care's Notice Of Action (NOA) database is an integrated, single, multi-user database to support the tracking, trending and reporting of all medical and behavioral health medical director review referrals based on state contract and NCQA requirements. All deny determinations require the UM staff to complete defined data fields in the database to support the auto-generation of the NOA as well as accurately identify the NCQA status of the request, i.e., pre-service, concurrent, or post-service). The NOA auto-generation process is performed at least once a day. This upload process archives cases with an "approved" status and kicks off the auto-generation of the NOA. Built in edits trigger "Error Messages" to the staff that information required on the NOA may be missing. Once the error is fixed, the process resumes and the NOA for both provider and member, as is necessary, is generated and sent as well as securely archived.

**OUTCOMES:** Missouri Care’s integrated, single, multi-user database for medical and BH medical director reviews supports the following activities:

- racks, reports and trends medical director review turn around times; the volume of medical director reviews by approved and denied statuses; and identifies cases as pre-service, concurrent, or post-services as is required by NCQA requirement.
- Establishes a tickler file for staff to monitor medical director review time frames.
- Reports all Administrative denials.
- Automates archiving of medical and behavioral health NOA letters in a single data folder
- Secures archiving of the NOA and retrieval of copies when needed.
- Supports auto-generating multiple denials for the same member, same episode of care when required.
- Allows the “team” to cover and manage other team members’ medical director referrals when necessary.

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## Nurse Response™- A Centene Corporation Specialty Company

### Nurse Response™ Treatment Adherence Support Program

**DESCRIPTION:** Nurse Response™, a subsidiary of NurseWise® and Centene Corporation, provides quality Telehealth services to managed care providers, academic institutions, physician groups, hospitals and employer groups.

Nurse Response™ developed an outbound call program which targeted persons with serious and persistent mental illness (SPMI) and who were prescribed psychotropic medications. Nurse Response™ developed a program designed to assist participants in self-managing their acute and chronic symptoms in an effort to increase adherence to their medications while obtaining medical services.

There was also a pre- and post-program measurement of self-reported quality of life.

**ACTION TAKEN:** The program was a six-month or longer program incorporating case management, disease management and motivation enhancement principles. Participants were identified using mined pharmacy claims data, and needed to have an active health plan membership, adult age-status, and an active prescription for an antipsychotic medication.

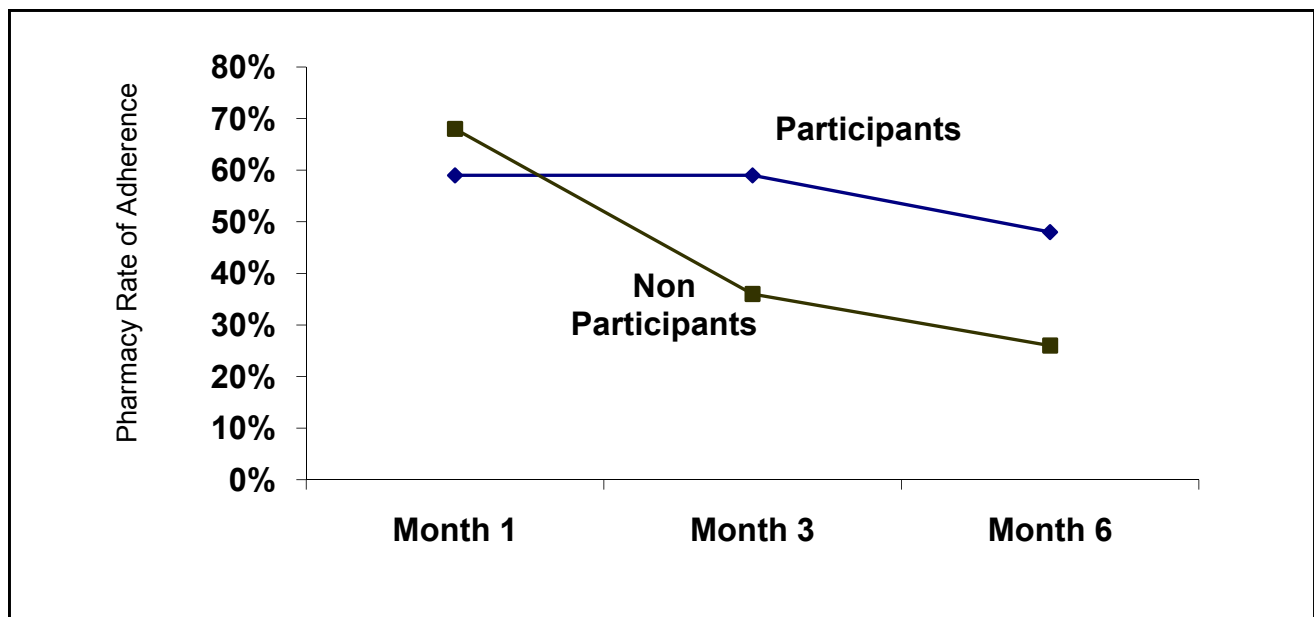
Several techniques were used to modify behavior, including motivational interviewing, assertiveness training, cognitive restructuring, self-monitoring, problem solving, and other behavioral interventions.

All members who chose to participate received a welcome / screening call and multiple subsequent follow-up calls from a nurse over a six-month period. Nurses used motivational enhancement and therapeutic communication to support participants. Follow-up mailings were made to emphasize themes of the calls. Educational materials consisted of coaching leaflets on communicating with physicians, stress management and drug-specific materials.

A proprietary assessment tool was used to classify participants according to risk of non-adherence. Members considered high risk received the full series of follow up calls, while low risk members received a follow up call at six months.

A key aspect to the program involved written communication to the attending physician and case manager about the nature of each call, adherence status, techniques used and materials sent.

**OUTCOMES:** The program demonstrated improved adherence to long-term medication, decreased emergency department utilization and self-reported improvements in quality of life. Working directly with patients and serving as an extension of the provider's practice contributed to the improved adherence.



Pharmacy rates were used to compare medication adherence outcomes. The Pharmacy rate for participants showed a more consistent adherence to medication, while the non-participant pharmacy rate showed a steeper decline.

In addition, participating members averaged 1.1 visits to the emergency department, compared to 5.03 visits for those not enrolled in the program.

The self reported quality of life score improved from initial intervention to conclusion.

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## Centene Corporation – Nurtur® Disease Management Specialty Company

### Nurtur® Asthma Program

**DESCRIPTION:** Nurtur® is a work-life, health and wellness company dedicated to helping people transform their lives and well-being through best-in-class life and health coaching.

Nurtur enrolled participants from Managed Health Services – Indiana (a Centene health plan) in their disease management program to improve respiratory disease outcomes for members with asthma and COPD (chronic obstructive pulmonary disease).

A study was conducted from January 2007 to September 2009 to determine if the program improved the outcomes of asthma patients and the cost structure of the asthma treatments.

**ACTION TAKEN:** This study was based on analysis of the medical and pharmacy claims of children (n=3,986) and adults (n=1,238) comprising 11,026 participant years and 2,940 participant years for children and adults with asthma, respectively. The control group was generated by matching each disease management participant with a matched non-participant determined by a propensity score to minimize selection bias. The propensity score was calculated using a logistic regression model with participation as the dependent variable and candidate program, presence of co-morbidities, age and gender as the independent variables. Logistic regression is a statistical tool that is used extensively in the medical and social sciences to predict the probability of an occurrence of an event.

**OUTCOME:** The program proved effective in improving multiple aspects of asthma and COPD treatment and utilization.

For children participants, ER visits were lower by 17.3% versus non-participants and inpatient admissions were 28.6% lower, both indicating better utilization. Visits to a primary physician were higher by 11.1% and vaccination rates were higher than non-participants by 22.5%, indicating improved preventive care. Results are statistically significant.

For adult participants, ER visits were lower by 9.4% versus non participants, while visits to a primary physician were higher by 16.4% and vaccination rates were higher by 51.3%. These figures indicate better utilization of MHS-Indiana's services due to the Nurtur® program, as well as proactive efforts by participants to engage in preventive care. Results are statistically significant.

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## UnitedHealthcare Community & State (Tennessee) Pediatric Obesity Program

**DESCRIPTION:** UnitedHealthcare Community & State (Tennessee) has developed a comprehensive weight management program for children ages five to 18. This program is comprised of mailed educational materials, coaching calls to high-risk members and unique local intervention options.

It is the goal of this program to provide members with opportunities to increase physical activity and education/awareness on healthy food choices and lifestyles. We include parental or caregiver involvement in each step of the process, and we strive to meet the unique needs of our membership. We consider factors such as transportation to fitness programs and the costs associated with purchasing healthier foods.

**ACTION TAKEN:** We have created customized educational pieces that include a Health Tracking Tool for goal-setting and condition monitoring, a fun child-friendly activity book for use at community outreach events, and healthy eating and fitness tips for children and parents. We have also partnered with existing community organizations to provide our members with access to fitness and nutrition education programs.

For instance, we offer services through the YMCA to our members in the Middle Tennessee region. The YMCA has designed a program called, "Stepping Up," which partners fitness and nutrition while including a parent component. This program is offered in after-school programs across the region and through a mobile unit to reach children in rural areas. We also offer memberships to all area YMCA facilities. Here the children can participate in any of the numerous youth friendly group classes offered.

In our West Tennessee region, we have partnered with the Church Health Center in Memphis to offer a weight management intervention. This facility offers state of the art exercise equipment, healthy cooking classes, and several group educational and fitness classes.

We are currently working with the Boys & Girls Clubs to create a similar intervention for members in our East Tennessee region.

**OUTCOME:** We currently have a total of 4,243 children currently participating in our weight management program. A group of 49 children who have been closely monitored since August 2009 have currently lost a combined total of 319 pounds. We have also been able to isolate several individual success stories. Please see one example of these personal successes below.

In July of 2009, a grandmother called to enroll her teenage grandson in our YMCA program. The 5'6", 303-pound member was reluctant at first. However, he began to enjoy his workouts after about two weeks. He is now exercising at least three times per week and has lost 24.5 pounds. The member reports a new found energy and says that he is now excited about his prom since he started losing the weight.

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## Horizon NJ Health

### Pharmacy Multi-Lingual Program

**DESCRIPTION:** Horizon NJ Health has developed a program that provides participating pharmacies with the necessary tools to encourage plan members to request their prescription labels in their preferred language. Pharmacy providers are given an overview of the program, a contact person and all the essential materials needed that will allow their patients to identify whether the pharmacy they frequent is capable of offering this valuable service. In addition, the program provides patients with a simple method for alerting their pharmacist that they wish to take advantage of this special service.

**ACTION TAKEN:** Pharmacy providers serving a mostly Hispanic patient population were specifically targeted for this program. These pharmacies are visited personally by Horizon NJ Health staff who provide bi-lingual materials and tools that are specifically designed to provide Horizon NJ Health patients with the medication directions written in their preferred language.

Overcoming any language barriers is essential to members' understanding of compliance. After a medication is filled in the alternate language, a patient "take-away" piece is also provided. This "take-away" piece describes each component of the medication label clearly and further reinforces the importance for understanding how the individual must take the medication being prescribed.

**OUTCOME:** Horizon NJ Health has instituted this program with over 100 network pharmacy providers and provided them with all the essential materials necessary to allow them to make this necessary and important service available to the population they serve. Thus far, the response has been overwhelmingly positive and, to date, more than 76% of the pharmacy providers interviewed report they have seen a significant increase in the requests for medication-labeled directions in an alternative language.

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## Centene Corporation

### Physician Summit Awards

**DESCRIPTION:** Centene and the Centene Foundation for Quality Healthcare sponsor a program to recognize physicians, providers and obstetricians for providing outstanding service and high quality care. The annual program acknowledges physicians who provide quality care and demonstrate clinical excellence for Centene's health plan members. There are two categories of awards: primary care and obstetrics.

**ACTION TAKEN:** For primary care providers, criteria for the award include follow-up after emergency room visits, routine preventive and well care services for both adults and children, and establishing a medical home for new enrollees. Providers must have a minimum panel size to be considered.

For obstetricians, criteria include risk-adjusted cesarean delivery rate, notification of pregnancy success and use of 17P, a weekly injection to prevent premature birth in women with a history of previous spontaneous preterm delivery. Criteria are applied to doctors who meet minimum delivery criteria and who provide obstetric care to our health plans members.

Data are compiled on the clinical metrics from claims and quality data. Medical directors, quality managers, and member and provider relations departments provide subjective feedback on physician performance.

**OUTCOME:** For 2010, eight obstetricians across our health plans were selected, and 16 primary care providers were selected to receive an award. The award consists of an engraved crystal award, a Centene national press release, catered luncheon for physician office staff, and local press release.

The effort to acknowledge strong clinical performance via the Summit Awards is meant to recognize quality and safety, in alignment with the statement from Dr. Daniel O'Keefe, Executive Vice-President, Society for Maternal-Fetal Medicine: "The Society of Maternal Fetal Medicine supports activities that help elevate the level of quality and safety in obstetric care for the Medicaid patient."

Feedback from the health plans shows the awards are very well received and appreciated by the providers and office staff.

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## Select Health of South Carolina

### Reducing the Risk of Recurring Pre-term Births with 17-P

**DESCRIPTION:** Select Health, with a membership that is mainly comprised of children, has a special concern for the health of babies and children in South Carolina. Therefore, with spontaneous preterm births increasing in the state, Select Health elected to develop programs that would reduce the number of preterm births for pregnant members with prior history of spontaneous preterm birth. In the quest to develop this program, Select Health assembled a Maternal Fetal Subcommittee of plan participating Maternal Fetal Specialists to evaluate the available research and develop guidelines in the use of 17 Alpha-Hydroxyprogesterone Caproate (17-P).

**ACTION TAKEN:** Based on the analysis of available research and input from the plan's Maternal Fetal Medicine network, the plan concluded that the data are strong in support of using 17-P to reduce risk of recurring preterm births for this subpopulation of at-risk members. Select Health was the first plan in South Carolina to offer 17-P, which has been proven to reduce certain preterm births. The program for "Reducing the Risk of Recurring Preterm Births with 17-P" offers the following:

- Development of benefit coverage guidelines for 17-P.
- Increase OB-GYN physician awareness of the benefits of utilizing 17-P.
- Earlier identification of high-risk pregnant members who have had a previous preterm newborn.
- Increase member awareness of the importance of early and consistent prenatal and postpartum care.
- Continue to collaborate with the Medical University of South Carolina's department of Maternal Fetal Medicine to enhance Select Health's 17-P program and utilization.
- Site visits to OB-GYN physician offices to encourage the appropriate utilization and review of the guidelines for the use of 17-P.
- Authorize in-home 17-P for members on bed rest or those who live a long distance from their provider's office.

**OUTCOME:** Benefits for the utilization of 17-P include up to a 73% reduction in recurring preterm births if used according to protocol in eligible pregnant members. Additionally, significantly lower rates of necrotizing enterocolitis, intraventricular hemorrhage and the need for supplemental oxygen are reported in infants born to mothers who received 17-P.

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## UnitedHealthcare Community & State (Pennsylvania) SECA Program

**DESCRIPTION:** A Member-targeted outreach to persons with a recent history of Significant Episodes of Cluster Activity (SECA) defined as two or more acute inpatient readmissions or four or more ER visits over the previous six months. Program is designed to identify and rapidly assist Members with significant clinical and/or behavioral health issues who may not be captured in traditional Disease Management programs.

**ACTION TAKEN:** Members meeting the SECA criteria are identified in near real-time. Care Teams composed of Inpatient and Complex Case Managers and a Social Worker collaborate to identify issues and barriers affecting Members' health.

The Care Team then deploys a variety of resources including, in-home physician visits, in-home lab draws, and total care coordination with PCP/Medical Home. Referrals are promptly made with behavioral health providers or other specialists. Members remain part of the SECA program for a minimum of one year following identification. Care Teams monitor and discuss Member compliance with treatment programs.

**OUTCOME:** SECA's member-centric approach has proven effective because it starts with a global assessment of all aspects affecting a Member's needs: clinical, behavioral and demographic and only then, drills down to clearly identify disease markers. On average, SECA Members enrolled six months or more have shown a 60% reduction in ER visits and Acute Readmissions.<sup>1</sup> The same continuously enrolled population has also shown a 22% reduction in overall annual medical costs.<sup>2</sup>

<sup>1</sup> Targeted Population vs. Control Group Jul-08 through June 2009

<sup>2</sup> Impact Pro © Claims Analysis 2009

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## Centene Corporation

# Start Smart for Your Baby® 17P Program Impact on Reducing Premature Birth

**DESCRIPTION:** The Start Smart for Your Baby® 17P Program identifies women who qualify for 17 alpha-hydroxyprogesterone caproate (17P) injections. 17P is a naturally occurring metabolite of the hormone progesterone, and is endorsed by the American College of Obstetricians and Gynecologists for use during certain high-risk pregnancies to reduce the rate of recurrent preterm delivery and neonatal intensive care (NICU) admissions.

Members are identified as potential candidates for 17P based on a Notification of Pregnancy form completed by the member, OB staff or physician, case manager in collaboration with vendors or claims history showing a prior preterm delivery.

**ACTION TAKEN:** An early identification process was established using a variety of data sources, along with an educational program aimed at physicians, their office staff and plan members in order to increase 17P utilization in appropriate candidates. Once the candidate meets the qualifications for the program and the physician prescribes 17P, arrangements are made to administer the injections either in the physician office or through home health by the case management team. Case management also includes: weekly or biweekly member contact, communication with the OB, educational materials, locating providers for home health or DME, referrals for transportation and post-partum welcome home assessments.

**OUTCOME:** A 2009 review was conducted of birth outcomes of 596 members treated with 17P versus a control group of 60 women not treated with 17P. Deliveries with a gestational age of less than 37 weeks decreased from 51.7% in the control group to 39.9% in the 17P group when 17P was initiated by 28 weeks gestation. Low birth weight deliveries (defined as birth weight less than 2500 grams) decreased significantly from 48.3% in the control group to 33.3% in the 17P group. And NICU or special care nursery admission rates decreased significantly from 45.0% in the control group to 29.2% in the 17P group.

Offering 17P as a benefit has a positive effect on reducing the rate of recurrent preterm delivery and rate of NICU and special care nursery admission in a managed Medicaid population.

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## Centene Corporation

### Start Smart for Your Baby® Notification of Pregnancy Process

**DESCRIPTION:** Start Smart for your Baby® is the Centene program that incorporates the concepts of case management, care coordination and disease management in an effort to provide pregnant and soon to be pregnant Centene members healthier babies. This program is able to best use its resources and expertise to improve pregnancy outcomes if we have Notification of Pregnancy (NOP) that documents the member's pregnancy.

#### **ACTION TAKEN:**

Identifying pregnant members enables us to help them gain access to prenatal medical care, give them education on their healthcare needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and the OB case management program as needed. Start Smart also works to educate doctors and their offices about the importance of completing a Notification of Pregnancy.



The goal of obtaining more Notifications of Pregnancy is being achieved by educating and encouraging physicians and plan members as well as offering incentives for submission of the information. Once submitted, members receive a mailing that provides pregnancy-related educational materials as well as an incentive booklet to track prenatal appointments, which can be turned in for gift items.

Based on the proprietary risk score from each Notification of Pregnancy, members are contacted for placement into case management when necessary. Case management includes regular member contact, communication with the OB, educational materials, referrals for transportation, and post-partum follow-up.

**OUTCOME:** Deliveries with birth weight less than 1,500 grams (very low birth weight) decreased significantly from 2.0% in the non-NOP group with no NOP to 1.7% in the NOP group. Deliveries with gestational age less than 32 weeks (premature deliveries) decreased significantly from 3.2% in the non-NOP group to 2.7% in the NOP group. Deliveries categorized as stillborn / expired decreased significantly from 1.0% in the non-NOP group to 0.6% in the NOP group. The number of NICU days per 1000 births decreased from 576 in 2007, to 493 in 2008, to 418 in 2009.

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## Centene Corporation

### Synagis® Success

**DESCRIPTION:** Respiratory syncytial virus (RSV) is a very common virus that most children contract at some point before their second birthday. Most children experience mild, cold-like symptoms (runny nose, fever, coughing). However, some high-risk children can suffer severe RSV-related illness such as pneumonia or bronchiolitis which can lead to death if not addressed. High-risk children include premature infants and children less than two years old with congenital heart or chronic lung disease, or with weakened immune systems.

**ACTION TAKEN:** Synagis® is a medication approved for the prevention of RSV disease in children younger than 24 months who are at high risk for serious RSV disease. It is an expensive treatment and was being overprescribed for cases not requiring it. The American Academy of Pediatrics (AAP) recently released new recommendations for the use of Synagis which Centene adopted.

**OUTCOME:** Early adoption of the new AAP guidelines for the 2009-2010 RSV season led to better utilization along with significant cost savings for our Medicaid plans. The changes due to the adoption of the AAP guidelines include:

Number of Synagis Requests Received Compared to Previous Season	Number of Received Requests Not Meeting AAP Criteria	Average Reduction in Number of Doses	Average Reduction in Dose Size	Savings Due to AAP Guideline Adoption
20% fewer	40% superfluous requests	1.4 fewer doses per member	13mg lower per dose	\$7.8 million for the 2009-2010 season

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## Superior HealthPlan Network – STAR Health, Centene Corporation

### Texas Health Passport and Its Impact on Psychotropic Medication Utilization in Texas Foster Care Children

**DESCRIPTION:** Health Passport (Passport) is a leading-edge, patient-centric electronic community health record for Foster Care children in the State of Texas. Passport is used by more than 7,000 provider users, 4,000 state employees, 2,000 medical consentors, and 100 local health plan staff. Passport can collect patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, immunization data, and other appropriate documentation. Providers can directly input additional or updated patient data and documentation into the Passport. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers and our case managers.

**ACTION TAKEN:** Overuse of psychotropic medications is a nationally recognized issue for Foster Care children. In 2005, the Texas Department of State Health Services released a practice parameter entitled, “Psychotropic Medication Utilization Parameters for Foster Children.” Based on these parameters, the health plan implemented the Psychotropic Medication Utilization Review (PMUR) process, which integrates the Health Passport.

The Health Passport aids in reducing the overuse of psychotropic medications in the Foster Care population through accessibility of information, and a review process based on established parameters. With this integration of Health Information Technology and the PMUR process, psychotropic medication prescribing patterns have improved significantly. This best practice involving the use of Health Passport and the PMUR process is utilized for Foster Care Children who are prescribed psychotropic medications.

**OUTCOME:** The effect of the best practice initiative on the target population has been significant. To date, there has been a 15% reduction in the overall prescribing of psychotropic medications, to a greater extent, specifically, a 21% reduction in the number of children prescribed a psychotropic medication for 60 or more days, and almost an 80% drop in children receiving five or more meds for 60 days or greater. Impressive outcomes in the decreases in the prescribing of non-stimulant medications, as well as overall polypharmacy, which has dropped 54% respectively without increase in psychiatric hospitalizations, have been demonstrated.

This positive impact has created a sense of significant accomplishment and a drive to continue serving this vulnerable population.

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## UnitedHealthcare Community & State - National Medical Management: Healthy First Steps Text4babies Program

**DESCRIPTION:** Each year in the United States, more than 500,000 babies are born prematurely, and an estimated 28,000 children die before their first birthday, according to the Center for Disease Control's National Center for Health Statistics. We have partnered with National Healthy Mothers, Healthy Babies Coalition (HMHB) on an innovative educational program called Text4baby. This new initiative is supported through a Voxiva collaboration to deliver free educational text messaging to pregnant women based upon their delivery dates and the baby's date of birth. Newborn messaging is also available up to one year of age.

**ACTION TAKEN:** We have engaged all 18 AmeriChoice states to approve participation. To date, we have all but four states approved to engage our members to participate in this program. Members in program approved states will receive the text4baby tri-fold describing the program and how to participate. We have also initiated an internal and external campaign through articles, posters and presentations.

**OUTCOME:** The program is designed to promote healthy births and reduce infant mortality among underserved populations. To assess the outcomes of this project, we have targeted a number of metrics to measure the effectiveness of the program.

The following are the categories with the metrics:

- HEDIS type measures
  - Timeliness: frequency of prenatal visits and postpartum checkups
- Utilization: # NICU/1000
- Behavioral Change:
  - Eating better, stop smoking, stop using drugs, etc.

### Survey Questions

We have also included the following questions to survey attitudes relative to the program:

- 1) Did you participate in the T4B program?
 

<input type="checkbox"/> YES ( <i>if yes go to the next question</i> )	<input type="checkbox"/> NO ( <i>End</i> )
--	--
- 2) Was the program information helpful?
 

<input type="checkbox"/> YES ( <i>if yes go to the next question</i> )	<input type="checkbox"/> NO ( <i>End</i> )
--	--
- 3) What messages were the most helpful?
 

<input type="checkbox"/> YES ( <i>if yes go to the next question</i> )	<input type="checkbox"/> NO ( <i>End</i> )
--	--

  - Community-based resources (mental health, WIC, crisis hotlines, immunizations (flu), domestic violence, access to healthcare)
  - Symptom management (nausea, UTI, yeast, STD, HIV Testing, placenta previa, heartburn, preterm labor, constipation, pre-eclampsia, placenta abruption, breasts, preterm labor)
  - Health information (nutrition, food safety, prenatal care, emotional support, substance abuse, smoking, breast feeding, exercise)

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## Centene Corporation

### Thumbs Up Johnnie Health Initiatives for Children



**DESCRIPTION:** Centene has partnered with an author of children books to create innovative health education programs for children. This initiative features “Thumbs Up Johnnie,” a children’s character, as an ambassador, created by author Michelle Bain to educate and inform children about health issues.

**ACTION TAKEN:** The “Thumbs Up Johnnie” books use relevant characters, stickers, coloring pages and games to teach healthy eating habits for audiences four to nine years of age. There is also a pre- and post-test in each book to determine the impact that the content of the book has on the reader. Centene has developed two programs:

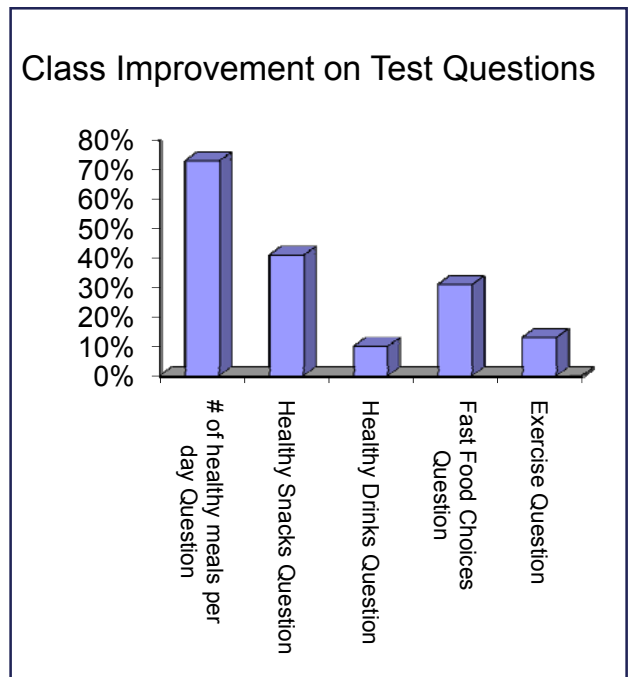
- *Preventive Obesity: The Adventures through Fitropolis* which educates children about healthy eating, balanced meals and exercise to prevent obesity. An accompanying book for the parent/guardian, with a review of the Fitropolis content, teaches the audience how to initiate healthy meals and planning with the help of their child. A third component of this initiative is a healthy kids cookbook patterned around the food pyramid and balanced meals.
- *Asthma: the Adventures from Puffletown* which educates children about how to manage their asthma.

Centene has partnered with the U.S. Government MyPyramid. government program to promote healthy eating habits. Centene has also partnered with the Girl Scouts of Eastern Missouri to create a “Thumbs Up Johnnie” fitness awareness program that results in the Girl Scout earning a badge.

Reading events formulated around the content of *The Adventures through Fitropolis* are conducted at adopted schools in our various health plans in several states. The “Thumbs Up Johnnie” mascot makes an appearance, and teachers are encouraged to administer the pre- and post-tests in their classrooms. To date more than 5,000 students have attended the reading events.

**OUTCOME:** Outcomes from the reading events show improvement between the pre-test and the post-test. The average improvement in class performance shows that learning is occurring as a result of the book. Five questions are administered in the pre-test and post-test:

- How many healthy meals a day is it best to eat? (Numbers 1-5 are shown)
- Circle three foods that would be the most healthy snacks (pictures of choices are shown)
- Circle three of the healthiest drinks (pictures of choices are shown)
- When you eat at a fast food restaurant, is it better to eat: (picture of choices are shown)
- Circle three things you can use to exercise (pictures of choices are shown)



The chart shows the average class improvement in correct answer improves for all questions, ranging from a 10% improvement on the healthy drinks question to 73% improvement on the number of meals per day question.

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## Select Health of South Carolina Type YOU Campaign

**DESCRIPTION:** During the fall of 2009, Select Health of South Carolina’s Culturally and Linguistically Appropriate Services Committee (CLAS Committee), with guidance from the Medical Affairs Department, launched the Type YOU campaign, a culturally competent diabetes initiative that involves a pilot group of 38 African-American women in lower South Carolina’s tri-county area. The group was chosen after internal health and demographic data showed that African-American women over the age of 30 in the Tri-County area disproportionately suffered from diabetes.

**ACTION TAKEN:** Select Health’s health plan members were introduced to the Type YOU campaign during the inaugural stop of the Health Ministry Empowerment Tour — a three-day lifestyle outreach event designed specifically for minority women. Each pilot group member was sent a customized invitation with a cover letter that explained the Type YOU program and encouraged them to take part in diabetes education workshops being offered at the Empowerment Tour.



After the Empowerment Tour was held, Select Health continued outreach to the pilot group members through the following interventions:

1. Enhancement of the cultural competency and health literacy of quarterly diabetes member mailings.
2. Creation of additional collateral material with diabetes eye exam and LDL test information.
3. Creation of talking points for the case management team working with the pilot group to enhance the cultural proficiency of member communications related to eye exams, LDL testing, and overall diabetes care.
4. Coordination of an in-service training for the case management team related to cultural barriers and themes influencing diabetes care among adult African-American women.

**OUTCOME:** The pilot program is still underway. The goal is to demonstrate significant improvement in diabetes care measurements among the pilot group.

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## Select Health of South Carolina Well-Child Outreach Initiatives

**DESCRIPTION:** The program is a comprehensive preventive health program available to members under the age of 21. This program provides outreach and education about regular health screenings, treatment and follow-up care for identified problems. Select Health follows the recommended schedule approved by the American Academy of Pediatrics and the American Academy of Family Physicians.

**ACTION TAKEN:** Select Health engages in outreach activities designed to encourage parents to take advantage of the preventive care benefits that are available for their child. Prior to their ideal screening dates, parents receive a “now-due” notice as well as a phone call reminding them that their child is due for their well-child visit. In 2009, the plan implemented an automated



reminder messaging program for provider offices. Through the plan’s member focus groups, it was identified that recommendations provided by a member’s personal physician are more influential in their decision to seek health screening appointments. Therefore, providers are given the opportunity to record the “now-due” reminder message in their own voice. This personalizes the message, and the member and/or caregiver feels as if their physician is speaking directly to them. The plan continues to promote the use of NaviNet for notifying providers of their members who have missed Early Periodic Screening Diagnosis and Treatment (EPSDT) screenings.

Members are rewarded for attending their EPSDT screening with a gift card incentive. In 2009, the plan implemented the use of an Integrated Voice Response (IVR) system. This is a fast-and-easy way for members to take advantage of the incentive, while confirming correct addresses and contact information.

**OUTCOME:** The plan has continued to improve EPSDT screening rates each year. For 2010, well-child visits in the first 15 months of life increased by 3.3%, for children in the third, fourth, fifth and sixth years of life, rates progressed by 2.7%, and adolescent well-child visits have gone up by 8.2%. Overall, we have enhanced members’ awareness about the importance of early periodic screenings and care to prevent childhood illnesses. The utilization of NaviNet provides health-related information to providers that can be used to improve adherence to care guidelines and prompt the provision of recommended clinical services to members. In addition, the use of the IVR system has allowed us to service high call volumes, reduce cost and improve the member experience by simplifying the process to claim their incentives.

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## UnitedHealthcare Community & State (Wisconsin)

### Wisconsin Wrap Around Intensive Case Management Program

**DESCRIPTION:** Wisconsin Wrap Around is a member-centric, intensive care management model that engages Plan care managers, community-based care managers and relevant providers as part of a ‘team’ for coordinating care across systems and services. The Wrap Around model targets members with complex medical, behavioral, social and spiritual needs. The team shares information, develops a plan and communicates that plan to the member and all team providers. The goal of Wrap Around is to reduce avoidable hospitalizations and ED visits, reduce medical errors that often result from poor care coordination and minimize the duplication of services.

**ACTION TAKEN:** Wrap Around is a resource intense management program. There are primary and secondary criteria for member selection for Wrap Around:

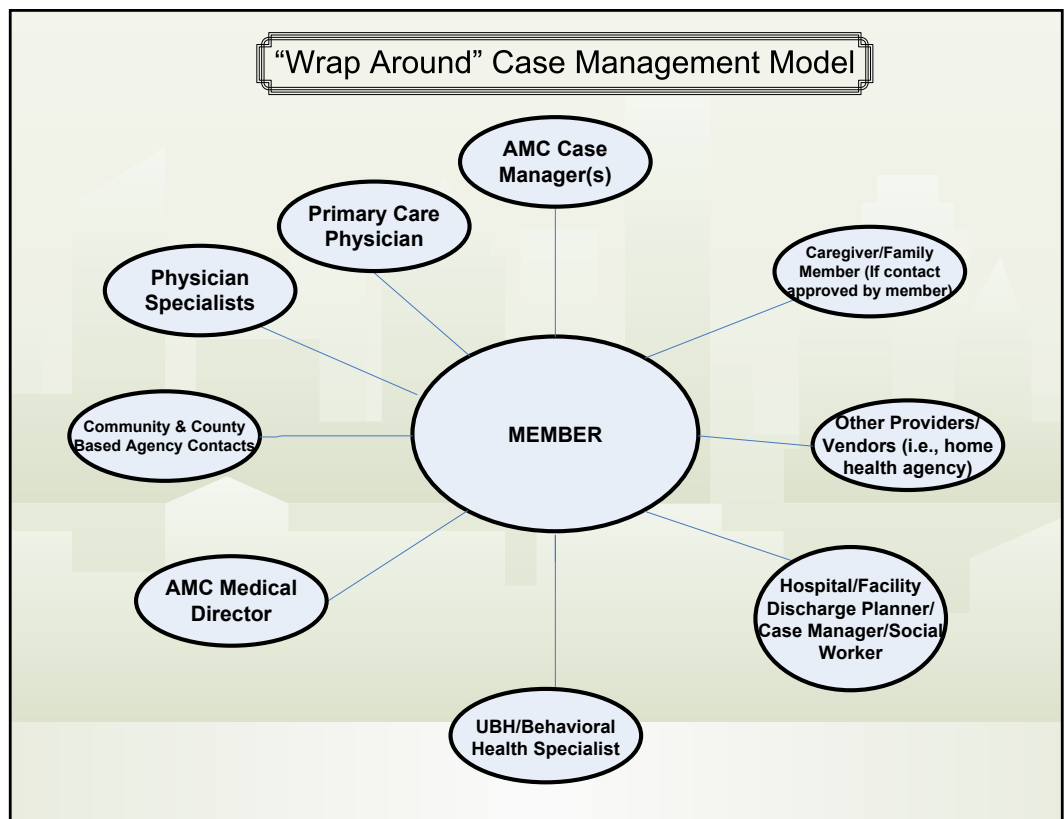
Primary criteria include three or more inpatient stays and/or six or more ED visits in a six-month period. Secondary criteria include admissions and ED visits associated with Ambulatory Care Sensitive Conditions (ACs) and overall medical costs.

Care managers compile information on Wrap Around enrollees including utilization history, current providers, member interview findings, member goals and perceptions of health status, member strengths and assets. The compiled information forms the basis of a holistic medical, psychosocial and problem list.

The plan’s Medical Director and care manager identify Wrap Around Team invitees based on the problem list.

These are typically ED physicians and hospitalists, primary care providers, specialists, community-based care managers and social workers, home health providers and behavioral health care managers. Once identified, these Wrap Around ‘team’ members participate in a conference call facilitated by the plan Medical Director. A care plan is developed as a result of the ‘team’ teleconference. The care plan, which typically involves a member contract, is disseminated to all team members and implemented.

Members continue to be followed by care managers. Several outcomes are measured including claims, cost, ED utilization and inpatient stays.



**OUTCOME:** Primary outcomes are post-Wrap Around ED and hospitalization rates as compared to pre-Wrap Around rates. There has been a 31% reduction in ED visits and 73% reduction in inpatient stays. In addition, the plan assessed per-member-per-month costs and claims.

**Table 1** below describes pre- and post-Wrap Around outcomes for currently enrolled members. No definitive conclusions can be drawn at the present time due to small numbers. However, preliminary outcomes appear promising for reducing utilization and cost. (See Table 1)

**Table 1. Outcomes Pre and Post Wrap Around Care Plan**

	Claims PMPM	Cost PMPM	ED visits PMPM	Inpatient PMPM
Pre Wrap Around Care Plan	76.6	\$7,986	3.2	1.1
Post Wrap Around Care Plan	63.3	\$3,476	1.4	0.3

Anecdotally, community providers and Wrap Around participants have responded favorably. The collaborative formation of a care plan, support from the HMO care managers, plan Medical Director involvement and sharing of information to support care coordination have empowered both providers and members.

Providers react positively because we solicit their opinions and suggestions and provide them support in the management of complex and challenging patients.

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## Passport Health Plan

### Women's Cancer Screening Program

**DESCRIPTION:** Passport Health Plan recognizes and promotes early detection for both breast and cervical cancer. However, in Kentucky the number of breast and cervical cancer diagnoses and deaths are higher than in the United States as a whole. According to the Centers for Disease Control and Prevention's most recent 2006 statistics, the number of breast cancer diagnoses each year in the United States is 119.3 per 100,000 and 121.8 per 100,000 in Kentucky. The number of breast cancer deaths each year in the United States is 23.4 per 100,000 and 23.8 per 100,000 in Kentucky. The number of cervical cancer diagnoses each year in the United States is 8 per 100,000 and 8.7 per 100,000 in Kentucky. The number of cervical cancer deaths each year in the United States is 2.4 per 100,000 and 2.2 per 100,000 in Kentucky.

**ACTION TAKEN:** The Plan developed a Women's Cancer Screening Program which includes a multi-disciplinary team to develop, implement and evaluate interventions aimed at improving women's overall health. As a member intervention, the staff conducts outreach calls to members who have not received the recommended screenings and assists them with scheduling appointments. Additionally, the Plan initiated automated outbound calls to contact members identified as due for breast and cervical cancer screenings.

The Plan also distributes bi-annual multilingual postcards to members identified as needing a screening and collaborates with facilities to host screening days dedicated to the female members. The Plan developed and distributed *Yearbook for Women*, an educational and entertaining magazine dedicated to women's health. Breast and cervical cancer screens are also a part of the Plan's Provider Recognition Program. Providers are encouraged to increase their screening rates. Providers receive semi-annual "Screens Due" reports for their panel that identifies members due for breast or cervical cancer screenings. In addition, the Plan has dedicated a provider relations representative to work with primary care providers to provide ongoing education regarding screenings and the Provider Recognition Program.

**OUTCOME:** In 1997, the Plan's breast cancer screening rate was 38.8% and the cervical cancer screening rate was 43.1%. Since 1997, the Plan has improved both measures. In 2009, the breast cancer screening rate increased to 54.76% and the cervical cancer screening rate increased to 70.8%.

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## PART II: Managed Care Industry Statistical Data

The following pages offer the most current statistical data released from the Centers of Medicare & Medicaid Services (CMS) on June 30, 2009.

### CMS Statistics: National Summary of Medicaid Managed Care Programs & Enrollment Managed Care Trends

*As of June 30, 2009*

YEAR	TOTAL MEDICAID POPULATION	MANAGED CARE POPULATION	OTHER POPULATION	% MANAGED CARE ENROLLMENT
2009	50,471,859	36,202,281	14,269,578	71.73%
2008	47,142,791	33,427,582	13,715,209	70.91%
2007	45,962,271	29,463,098	16,499,173	64.10%
2006	45,652,642	29,830,406	15,822,236	65.34%
2005	45,392,325	28,575,585	16,816,740	62.95%
2004	44,355,955	26,913,570	17,442,385	60.68%
2003	42,740,719	25,262,873	17,477,846	59.11%
2002	40,147,539	23,117,668	17,029,871	57.58%
2001	36,562,567	20,773,813	15,788,754	56.82%
2000	33,690,364	18,786,137	14,904,227	55.76%
1999	31,940,188	17,756,603	14,183,585	55.59%
1998	30,896,635	16,573,996	14,322,639	53.64%

These figures represent point-in-time enrollment as of June 30th for each reporting year.

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides **unduplicated** national figures for the Total Medicaid population and Other population. The statistics also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

## Medicaid Managed Care Enrollment - As of June 30, 2009

ROW NO.	NAME OF STATE	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	PERCENT IN MANAGED CARE
1	ALABAMA	812,220	540,093	66.50%
2	ALASKA	101,702	0	0.00%
3	ARIZONA	1,223,271	1,096,365	89.63%
4	ARKANSAS	645,389	511,014	79.18%
5	CALIFORNIA	6,955,761	3,632,547	52.22%
6	COLORADO	467,556	444,819	95.14%
7	CONNECTICUT	455,878	342,784	75.19%
8	DELAWARE	170,562	126,089	73.93%
9	DISTRICT OF COLUMBIA	153,779	150,406	65.97%
10	FLORIDA	2,426,010	1,600,550	92.00%
11	GEORGIA	1,385,721	1,274,823	92.00%
12	HAWAII	235,203	228,174	97.01%
13	IDAHO	198,000	166,524	84.10%
14	ILLINOIS	2,320,700	1,278,200	55.08%
15	INDIANA	961,986	711,636	73.98%
16	IOWA	397,823	329,897	82.93%
17	KANSAS	297,290	257,464	86.60%
18	KENTUCKY	768,777	638,083	83.00%
19	LOUISIANA	1,006,842	692,048	68.73%
20	MAINE	280,148	178,353	63.66%
21	MARYLAND	787,366	620,024	78.75%
22	MASSACHUSETTS	1,227,109	731,123	59.58%
23	MICHIGAN	1,629,959	1,447,373	88.80%
24	MINNESOTA	675,149	426,009	63.10%
25	MISSISSIPPI	673,630	512,796	76.12%
26	MISSOURI	895,077	883,423	98.70%
27	MONTANA	84,785	56,434	66.56%
28	NEBRASKA	214,699	179,512	83.61%
29	NEVADA	213,440	178,711	83.73%
30	NEW HAMPSHIRE	124,498	96,553	77.55%
31	NEW JERSEY	968,598	725,614	74.91%
32	NEW MEXICO	464,852	344,977	74.21%
33	NEW YORK	4,422,121	2,926,950	66.19%
34	NORTH CAROLINA	1,442,396	1,012,474	70.19%
35	NORTH DAKOTA	60,111	40,605	67.55%
36	OHIO	1,951,511	1,374,520	70.43%
37	OKLAHOMA	625,546	553,385	88.46%
38	OREGON	474,835	418,096	88.05%
39	PENNSYLVANIA	1,920,134	1,576,523	82.10%
40	PUERTO RICO	1,013,486	977,648	96.46%
41	RHODE ISLAND	177,981	110,584	62.13%
42	SOUTH CAROLINA	763,225	763,225	100.00%
43	SOUTH DAKOTA	107,196	85,476	79.74%
44	TENNESSEE	1,230,750	1,230,750	100.00%
45	TEXAS	3,343,241	2,161,210	64.64%
46	UTAH	238,358	204,793	85.92%
47	VERMONT	156,503	137,385	87.78%
48	VIRGIN ISLANDS	7,728	0	0.00%
49	VIRGINIA	814,820	520,773	63.91%
50	WASHINGTON	1,103,291	949,263	86.04%
51	WEST VIRGINIA	325,653	149,694	45.97%
52	WISCONSIN	1,004,704	606,509	60.37%
53	WYOMING	64,489	0	0.00%
<b>TOTALS</b>		<b>50,471,859</b>	<b>36,202,281</b>	<b>71.73%</b>

The unduplicated Medicaid enrollment figures include individuals in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards. The unduplicated managed care enrollment figures includes enrollees receiving comprehensive and limited benefits.

## Dual Eligible Enrollment - As of June 30, 2009

STATE	MEDICAID DUAL ELIGIBLES
Alabama	185,738
Alaska	12,501
Arizona	137,195
Arkansas	107,520
California	981,725
Colorado	68,718
Connecticut	83,246
Delaware	25,437
District of Columbia	19,462
Florida	544,958
Georgia	234,817
Hawaii	28,476
Idaho	25,000
Illinois	516,032
Indiana	128,779
Iowa	72,528
Kansas	64,358
Kentucky	152,054
Louisiana	162,278
Maine	84,539
Maryland	94,159
Massachusetts	233,181
Michigan	228,609
Minnesota	116,451
Mississippi	147,884
Missouri	160,535
Montana	18,904
Nebraska	32,875
Nevada	32,322
New Hampshire	24,891
New Jersey	184,158
New Mexico	60,067
New York	643,204
North Carolina	279,230
North Dakota	13,385
Ohio	267,085
Oklahoma	98,219
Oregon	82,148
Pennsylvania	367,192
Puerto Rico	217,652
Rhode Island	34,461
South Carolina	128,711
South Dakota	17,914
Tennessee	257,156
Texas	559,954
Utah	23,136
Vermont	32,384
Virginia	154,209
Washington	136,149
West Virginia	69,065
Wisconsin	160,867
Wyoming	9,050
<b>National Total</b>	<b>8,520,568</b>

This table provides an unduplicated number of Medicaid dual eligibles receiving full or partial Medicaid benefits.

## Number of Managed Care Entity Enrollees by State - As of June 30, 2009

STATE	HIO	COMMERCIAL		MEDICAID-ONLY		PCCM	PIHP	PAHP	PACE	OTHER
		MCO	MCO	MCO	MCO					
Alabama	0	0	0	443,327	540,093	0	0	0	0	0
Alaska	0	0	0	0	0	0	0	0	0	0
Arizona	0	0	1,096,365	0	104,101	0	0	0	0	0
Arkansas	0	0	0	411,351	0	451,863	21	0	0	0
California	601,662	2,996,873	7,507	0	157	447,661	2,311	0	0	0
Colorado	0	0	44,247	22,426	463,464	0	1,421	0	0	0
Connecticut	0	83,069	259,547	168	0	0	0	0	0	0
Delaware	0	0	117,602	0	0	0	0	0	8,487	0
DC	0	0	96,639	0	3,593	50,174	0	0	0	0
Florida	0	684,903	249,331	455,877	700,431	341,100	329	9,392	0	0
Georgia	0	0	838,344	108,619	0	1,274,823	0	0	0	0
Hawaii	0	160,120	68,037	0	0	0	17	0	0	0
Idaho	0	0	0	166,524	0	130,338	0	0	0	0
Illinois	0	133,200	44,700	1,100,300	0	0	0	0	0	0
Indiana	0	455,565	191,413	64,189	0	0	0	469	0	0
Iowa	0	0	0	170,659	329,897	0	55	0	0	0
Kansas	0	0	141,000	24,050	243,352	243,352	227	0	0	0
Kentucky	0	0	159,005	304,973	0	638,083	0	0	0	0
Louisiana	0	0	0	729,219	0	0	119	0	0	0
Maine	0	0	0	178,353	0	0	0	0	0	0
Maryland	0	0	589,540	0	0	30,346	138	0	0	0
Massachusetts	0	147,546	288,628	284,404	304,821	0	2,178	0	0	0
Michigan	0	0	1,088,815	0	1,447,373	295,794	387	0	0	0
Minnesota	0	375,046	50,963	0	0	0	0	0	0	0
Mississippi	0	0	0	0	0	512,796	0	0	0	0
Missouri	0	0	401,314	0	0	481,926	183	0	0	0
Montana	0	0	0	371	0	368	24	0	0	0
Nebraska	0	36,119	0	38,623	0	0	0	179,512	0	0
Nevada	0	59,381	46,921	0	0	178,711	0	0	0	0
New Hampshire	0	0	0	0	0	96,553	0	0	0	0
New Jersey	0	268,734	456,880	0	0	0	31	0	0	0
New Mexico	0	275,942	69,035	0	312,498	0	376	0	0	0
New York	0	862,624	2,013,976	16,639	24,353	0	3,210	6,148	0	0
North Carolina	0	0	0	998,909	72,734	0	50	0	0	0
North Dakota	0	0	0	29,339	0	2,427	25	0	0	0
Ohio	0	0	1,373,828	0	0	0	692	0	0	0
Oklahoma	0	0	0	412,473	0	553,385	49	0	0	0
Oregon	0	35,501	303,046	12,207	399,545	410,448	555	0	0	0
Pennsylvania	0	965,188	0	262,583	1,442,729	457,520	1,637	0	0	0
Puerto Rico	0	959,059	0	0	505,302	0	0	0	0	0
Rhode Island	0	46,216	74,027	0	0	41,717	164	0	0	0
South Carolina	0	0	341,782	90,136	0	763,367	407	0	0	0
South Dakota	0	0	0	85,476	0	0	0	0	0	0
Tennessee	0	0	1,159,089	0	143,322	0	309	1,909,526	0	0
Texas	0	210,066	1,218,036	732,219	306,513	54,794	889	0	0	0
Utah	0	0	0	58,484	273,016	176,036	0	0	0	0
Vermont	0	0	137,385	0	0	0	76	0	0	0
Virgin Islands	0	0	0	0	0	0	0	0	0	0
Virginia	0	312,878	153,794	54,101	0	520,773	315	0	0	0
Washington	0	581,587	0	4,495	949,263	8,386	319	0	0	0
West Virginia	0	149,694	0	14,747	0	0	0	0	0	0
Wisconsin	0	484,771	95,785	0	27,216	0	577	0	0	0
Wyoming	0	0	0	0	0	0	0	0	0	0
<b>TOTALS</b>	<b>601,662</b>	<b>10,284,082</b>	<b>13,176,581</b>	<b>7,275,241</b>	<b>8,593,773</b>	<b>8,162,741</b>	<b>17,091</b>	<b>2,113,534</b>		

This table provides duplicated figures that include enrollees receiving comprehensive and limited benefits. Total number of enrollees includes those who were enrolled in more than one managed care plan. Figures also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

## CMS Statistics

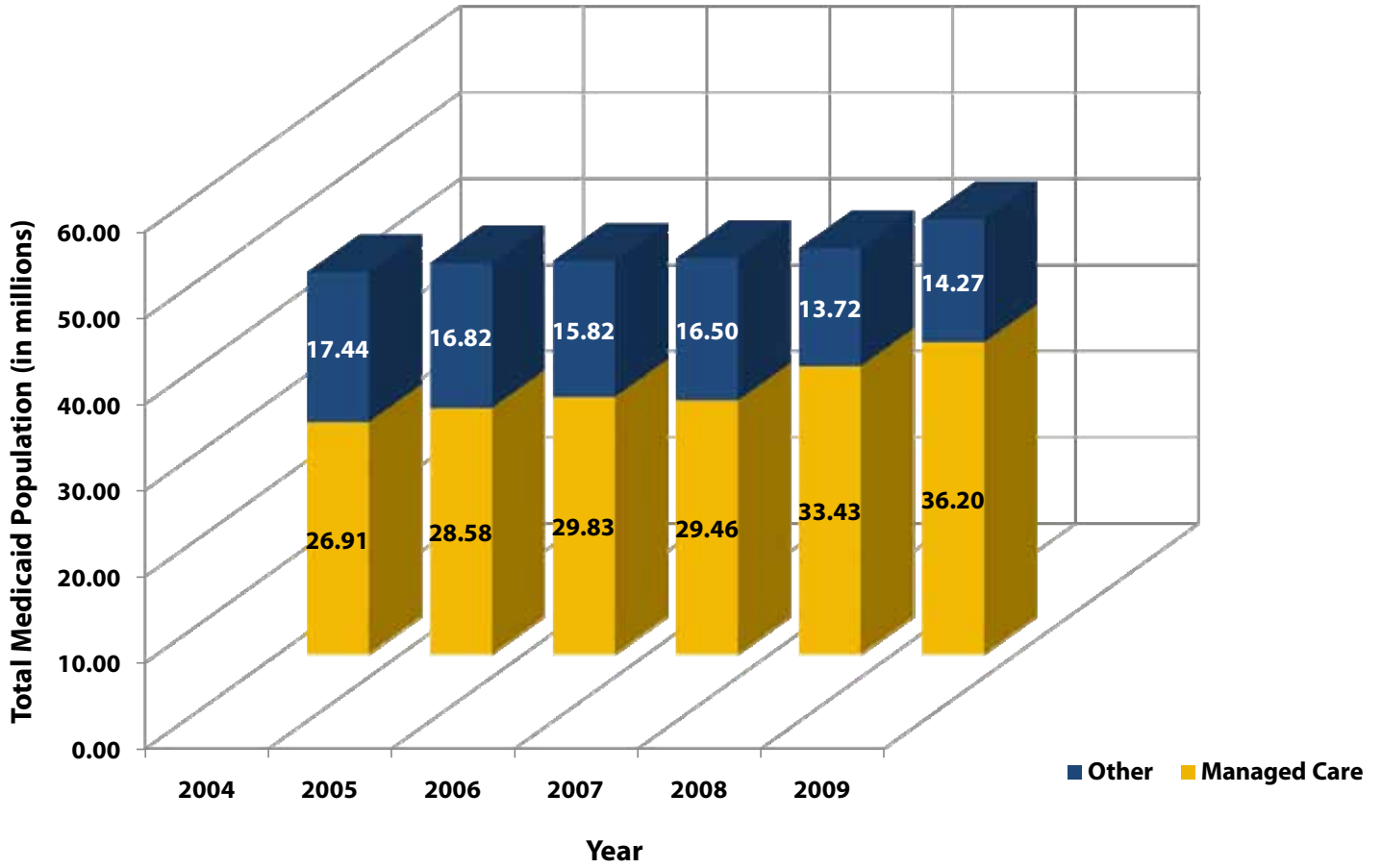
**National Breakout of Managed Care Entities and Enrollment***As of June 30, 2009*

MANAGED CARE ENTITY TYPE	# OF PLANS	# OF ENROLLEES
Health Insuring Organization	4	601,662
Commercial Managed Care Organization	159	10,284,082
Medicaid-only Managed Care Organization	159	13,176,581
Primary Care Case Management	36	7,275,241
Prepaid Inpatient Health Plan	152	8,593,773
Prepaid Ambulatory Health Plan	61	8,162,741
Program of ALL-inclusive Care for the Elderly	67	17,091
Other	9	2,113,534
<b>TOTAL</b>	<b>647</b>	<b>50,224,705</b>

This table provides **duplicated** figures by plan type. The total number of enrollees include 14,002,424 individuals who were individuals who were enrolled in more than one managed care plan. It also includes individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards

## Total Annual Medicaid Population Distribution by Year Managed Care vs. Other

*As of June 30, 2009*



## Number of Managed Care Entities by State - As of June 30, 2009

STATE	HIO	COMMERCIAL	MEDICAID-ONLY	PCCM	PIHP	PAHP	PACE	OTHER
		MCO	MCO					
Alaska	0	0	0	0	0	0	0	0
Arizona	0	0	29	0	1	0	0	0
Arkansas	0	0	0	1	0	1	1	0
California	4	23	2	0	1	13	5	0
Colorado	0	0	2	1	6	0	3	0
Connecticut	0	1	2	1	0	0	0	0
Delaware	0	0	2	0	0	0	0	1
DC	0	0	3	0	1	1	0	0
Florida	0	22	5	1	26	10	2	3
Georgia	0	0	3	1	0	1	0	0
Hawaii	0	4	1	0	0	0	1	0
Idaho	0	0	0	1	0	2	0	0
Illinois	0	1	2	1	0	0	0	0
Indiana	0	4	1	2	0	0	0	1
Iowa	0	0	0	1	1	0	1	0
Kansas	0	0	2	1	1	1	2	0
Kentucky	0	0	1	1	0	1	0	0
Louisiana	0	0	0	1	0	0	1	0
Maine	0	0	0	1	0	0	0	0
Maryland	0	0	7	0	0	5	1	0
Massachusetts	0	2	2	1	1	0	6	0
Michigan	0	0	14	0	18	1	4	0
Minnesota	0	6	3	0	0	0	0	0
Mississippi	0	0	0	0	0	1	0	0
Missouri	0	0	6	0	0	1	1	0
Montana	0	0	0	1	0	1	1	0
Nebraska	0	1	0	1	0	0	0	1
Nevada	0	1	1	0	0	1	0	0
New Hampshire	0	0	0	0	0	1	0	0
New Jersey	0	2	3	0	0	0	2	0
New Mexico	0	5	1	0	1	0	1	0
New York	0	21	13	4	17	0	5	1
North Carolina	0	0	0	2	1	0	2	0
North Dakota	0	0	0	1	0	1	1	0
Ohio	0	0	7	0	0	0	2	0
Oklahoma	0	0	0	2	0	1	1	0
Oregon	0	2	13	1	9	8	1	0
Pennsylvania	0	11	0	1	38	2	10	0
Puerto Rico	0	10	0	0	2	0	0	0
Rhode Island	0	2	1	0	0	1	1	0
South Carolina	0	0	6	1	0	3	2	0
South Dakota	0	0	0	1	0	0	0	0
Tennessee	0	0	6	0	2	0	1	2
Texas	0	6	13	1	1	1	2	0
Utah	0	0	0	1	11	1	0	0
Vermont	0	0	1	0	0	0	1	0
Virgin Islands	0	0	0	0	0	0	0	0
Virginia	0	3	2	1	0	1	4	0
Washington	0	8	0	1	1	1	1	0
West Virginia	0	3	0	1	0	0	0	0
Wisconsin	0	21	5	0	11	0	1	0
Wyoming	0	0	0	0	0	0	0	0
<b>TOTALS</b>	<b>4</b>	<b>159</b>	<b>159</b>	<b>36</b>	<b>152</b>	<b>61</b>	<b>67</b>	<b>9</b>

## Regional Break-Out of Medicaid Managed Care Enrollment

### *As of June 30, 2009*

US REGION	MEDICAID ENROLLMENT	MANAGED CARE ENROLLMENT	% REGION BENEFICIARIES ENROLLED IN MANAGED CARE	% NATIONAL MANAGED CARE ENROLLMENT
I - Boston	2,422,117	1,596,782	65.93%	4.41%
II - New York	6,411,933	4,630,212	72.21%	12.79%
III - Philadelphia	4,172,314	3,143,509	75.34%	8.68%
IV - Atlanta	9,502,729	7,572,794	79.69%	20.92%
V - Chicago	8,544,009	5,844,247	68.40%	16.14%
VI - Dallas	6,085,870	4,262,634	70.04%	11.77%
VII - Kansas City	1,804,889	1,650,296	91.43%	4.56%
VIII - Denver	1,022,495	832,127	81.38%	2.30%
IX - San Francisco	8,627,675	5,135,797	59.53%	14.19%
X - Seattle	1,877,828	1,533,883	81.68%	4.24%
<b>TOTALS</b>	<b>50,471,859</b>	<b>36,202,281</b>	<b>71.73%</b>	<b>100.00%</b>

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides **unduplicated** Medicaid enrollment figures by region. The enrollment figures include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

## States with Comprehensive Health Care Reform Demonstrations

### *As of June 30, 2009*

US STATE	MEDICAID ENROLLMENT	EXPANSION ENROLLMENT	MANAGED CARE ENROLLMENT	% ENROLLED IN MANAGED CARE
Arizona	1,223,271	183,789	1,096,365	89.63%
Arkansas	645,389	3,376	511,014	79.18%
Delaware	170,562	24,550	126,089	73.93%
Florida	2,426,010	225,749	1,600,550	65.97%
Hawaii	235,203	26,277	228,174	97.01%
Indiana	961,986	44,828	711,636	73.98%
Kentucky	768,777	0	638,083	83.00%
Maryland	787,366	30,346	620,024	78.75%
Massachusetts	1,227,109	115,929	731,123	59.58%
Minnesota	675,149	68,557	426,009	63.10%
New York	4,422,121	383,247	2,926,950	66.19%
Oklahoma	625,546	0	553,385	88.46%
Oregon	474,835	25,374	418,096	88.05%
Rhode Island	177,981	20,428	110,584	62.13%
Tennessee	1,230,750	30,667	1,230,750	100.00%
Utah	238,358	24,022	204,793	85.92%
Vermont	156,503	41,967	137,385	87.78%
<b>TOTALS</b>	<b>16,446,916</b>	<b>1,249,106</b>	<b>12,271,010</b>	<b>74.61%</b>

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits. This table also provides **unduplicated** Medicaid enrollment figures by region. The enrollment figures include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

## Medicaid Managed Care Enrollment

### As of June 30, 2009

RANK	STATES	WAIVER TYPE	MANAGED CARE ENROLLMENT
<b>STATES 1-10</b>			
1	California	1915(b), 1932(a), 1915(a), PACE	3,632,547
2	New York	1115(a), 1915(a), PACE	2,926,950
3	Texas	1915(b), 1932(a), 1915(a), 1915(b)/(c), PACE	2,161,210
4	Florida	1915(b), 1115(a), 1915(b)/(c), 1915(a)/(c), PACE	1,600,550
5	Pennsylvania	1915(b), 1915(a), 1902(a)(70), PACE	1,576,523
6	Michigan	1915(b), PACE	1,447,373
7	Ohio	1932(a), PACE	1,374,520
8	Illinois	1932(a), 1915(a)	1,278,200
9	Georgia	1932(a), 1902(a)(70)	1,274,823
10	Tennessee	1115(a), PACE	1,230,750
<b>Subtotal</b>			<b>18,503,446</b>
<b>National Managed Care Grand Total</b>			<b>36,202,143</b>
<b>Percentage</b>			<b>51.11%</b>

#### STATES 11-20

11	Arizona	1115(a)	1,096,365
12	North Carolina	1915(b)/(c), 1932(a), PACE	1,012,474
13	Puerto Rico	1915(a)	977,648
14	Washington	1915(b), 1932(a), PACE	949,263
15	Missouri	1915(b), 1902(a)(70), PACE	883,423
16	South Carolina	1915(b), 1932(a), 1902(a)(70), PACE	763,225
17	Massachusetts	1115(a), PACE	731,123
18	New Jersey	1915(b), 1932(a), PACE	725,614
19	Indiana	1915(b), 1115(a)	711,636
20	Louisiana	1932(a), PACE	692,048

<b>Subtotal</b>	<b>8,542,819</b>
<b>National Managed Care Grand Total</b>	<b>36,202,143</b>
<b>Percentage</b>	<b>23.60%</b>

The **unduplicated** managed care enrollment figures include enrollees receiving comprehensive benefits and limited benefits.

CMS Statistics  
**Managed Care Entity Types - As of June 30, 2009**

STATE	HIO	MCO	PCCM	PIHP	PAHP	PACE	OTHER
Arizona		93,768					
Arkansas					45,645	19	
California	113,960	82,215			14,886	2,068	
Colorado		2,788	4,786	53,278		1,356	
District of Columbia		251		17	11,048		
Florida		21,668		16,776	95	319	294
Georgia					129,559		
Hawaii		25,313				13	
Idaho			15,822		1,030		
Iowa				32,222		3	
Kansas				33,252	33,252	225	
Kentucky		12,557			88,914		
Louisiana						97	
Maryland						129	
Massachusetts		153				2,047	
Michigan						370	
Minnesota		49,553					
Missouri						152	
Mississippi					69,166		
Nebraska							19,557
Nevada					38,060		
New Jersey		20,271				28	
New Mexico		31,345				355	
New York		5,291	1,019	20,917		2,626	
North Carolina			46,957	13,241		28	
North Dakota						20	
Ohio						579	
Oklahoma					98,219	46	
Oregon		30,569	905	52,344	48,956	555	
Pennsylvania		2,581	626	188,192	50,955	1,540	
Puerto Rico		216,417		33,498			
Rhode Island						153	
South Carolina			8,337		128,711	395	
Tennessee		187,246		11,056		309	193,121
Texas		86,354		1,017		826	
Utah			4,621	20,789	14,534		
Vermont		14,832				72	
Virginia					106,372	296	
Washington		519		97,637		304	
Wisconsin		9,958		36,316		499	
<b>TOTALS</b>	<b>113,960</b>	<b>893,649</b>	<b>83,073</b>	<b>610,552</b>	<b>879,402</b>	<b>15,429</b>	<b>212,972</b>

\*This table provides duplicated figures that include enrollees receiving comprehensive and limited benefits. Total number of enrollees includes those who were enrolled in more than one managed care plan. Figures also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards..

## CMS Statistics

**Number of Prepaid Inpatient Health Plans (PIHPs) and Enrollment by State***As of June 30, 2009**\*MH denotes Mental Health*

State	# of Medical-only PIHPs	Medical-only Enrollees	# of MH PIHPs	MH PIHP Enrollees	# of MH & SUD PIHPs	MH & SUD Enrollees	# of SUD PIHPs	SUD Enrollees	Long-Term Care PIHPs	Long-Term Care Enrollees
Alabama	2	540,093								
Arizona					1	104,101				
California			1	157						
Colorado	1	15,157	5	448,307						
DC	1	3,593								
Florida	6	115,980	5	569,329					15	15,122
Iowa					1	329,897				
Kansas							1	243,352		
Massachusetts					1	304,821				
Michigan			18	1,447,373						
New Mexico			1	312,498						
New York									17	24,353
North Carolina					1	72,734				
Oregon			9	399,545						
Pennsylvania	4	203			34	1,442,526				
Puerto Rico					2	505,302				
Tennessee	1	71,661			1	71,661				
Texas					1	306,513				
Utah	2	71,454	9	201,562						
Washington			1	949,263						
Wisconsin					2	905			9	26,311
<b>TOTALS</b>	<b>17</b>	<b>818,141</b>	<b>49</b>	<b>4,328,034</b>	<b>44</b>	<b>3,138,460</b>	<b>1</b>	<b>243,352</b>	<b>41</b>	<b>65,786</b>

## CMS Statistics

## Number of Prepaid Ambulatory Health Plans (PAHPs) and Enrollment by State

*As of June 30, 2009*

State	Medical-only	Medical-only Enrollees	MH	MH Enrollees	Substance Use Disorders	Substance Use Disorder Enrollees	Dental	Dental Enrollees	Transportation	Transportation Enrollees	Disease Mgmt.	Disease Mgmt. Enrollees
AR									1	451,863		
CA							13	447,661				
DC									1	50,174		
FL	2	71,107					2	182,199	1	70,965	5	16,829
GA									1	1,274,823		
ID	1	1,030					1	129,308				
KS			1	243,352								
KY									1	638,083		
MD	5	30,346										
MI							1	295,794				
MS									1	512,796		
MO									1	481,926		
MT											1	368
NV									1	178,711		
NH											1	96,553
ND											1	2,427
OK									1	553,385		
OR					1	15,615	7	394,833				
PA									1	406,732	1	50,788
RI							1	41,717				
SC	1	142							2	763,225		
TX											1	54,794
UT									1	176,036		
VA									1	520,773		
WA											1	8,386
<b>Total</b>	<b>9</b>	<b>102,625</b>	<b>1</b>	<b>243,352</b>	<b>1</b>	<b>15,615</b>	<b>25</b>	<b>1,491,512</b>	<b>14</b>	<b>6,079,492</b>	<b>11</b>	<b>230,145</b>

## State Medicaid Directors

As of March 24, 2010

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### AMERICAN SAMOA

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*The above information was provided courtesy of the  
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As of October 1, 2010

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## Index

### The 2010 Best Practices *(listed alphabetically by health plan)*

#### AMERIHEALTH MERCY – 1 Submission

“Healthy You, Healthy Me” Childhood Obesity Program.....	3.2
--	-----

#### CENTENE – 10 Submissions

Connections Plus®.....	15
Generic Drug Fill Rates.....	26
Nurse Response™ Treatment Adherence Support Program.....	42
Nurtur® Asthma Program.....	44
Physician Summit Awards.....	47
Start Smart for Your Baby® 17P Program Impact on Reducing Premature Birth.....	50
Start Smart for Your Baby® Notification of Pregnancy Process.....	51
Synagis® Success.....	52
Texas Health Passport and Its Impact on Psychotropic Medication Utilization in Texas Foster Children <i>(with Superior HealthPlan Network)</i> .....	53
Thumbs Up Johnnie Health Initiatives for Children.....	55

#### CHOC HEALTH ALLIANCE SCHALLER ANDERSON/AETNA – 1 Submission

HEDIS Enhanced Capitation Program.....	34
--	----

#### HEALTH PARTNERS OF PHILADELPHIA, INC. – 2 Submissions

Biggest Winner Nutrition Program.....	9
Chopper Check Dental Screening for Children.....	13

#### HORIZON NJ HEALTH – 7 Submissions

Acute Case Management.....	7
Asthma Management Improvement Through Drug Utilization Review (DUR).....	8
Dancing for Your Health.....	17
Diabetes “One-on-One” Pilot Program.....	19
Health Literacy.....	30
Hospital ER Focused Dental Initiative.....	35
Pharmacy Multi-Lingual Program.....	46

#### KEYSTONE MERCY – 4 Submissions

CommunityBabyShowerProgram.....	14
Embedding a Care Manager in the Physician Office.....	23
Gift for Life: Aggressive Mammography Outreach and Event Scheduling.....	28
Lose to Win Type II Diabetes and Obesity Education Program.....	38

#### MIDWEST HEALTH PLAN – 3 Submissions

Childhood Obesity- Improving the monitoring of BMI.....	11
Don’t Gamble with Your Numbers: Improving Control of Hypertension and Hyperlipidemia.....	20
Navigating for Care – Aged, Blind and Disabled.....	40

**MISSOURI CARE – 3 Submissions**

Clinical Documentation Standard CHATME .....	12
Cultural Competency Program.....	16
Notice of Action Database (NOA Database).....	41

**PASSPORT HEALTH PLAN – 5 Submissions**

Diabetes Disease Management Program.....	18
Early Periodic Screening Diagnosis and Treatment (EPSDT) Program.....	22
Glorious Women Assembly.....	27
Mommy & Me Program .....	39
Women’s Cancer Screening Program.....	60

**SELECT HEALTH OF SOUTH CAROLINA, INC. – 5 Submissions**

Healthy Moms and Babies.....	31
Heart Failure Program.....	33
Reducing the Risk of Recurring Preterm Births with 17-P.....	48
Type YOU campaign .....	56
Well-Child Outreach Initiatives.....	57

**UNITEDHEALTHCARE COMMUNITY & STATE – 8 Submissions**

ER Diversion Program ( <i>Unison Health Plan of the Capital Area</i> ).....	24
Fluoride Varnish Program ( <i>New York</i> ).....	25
Gold Star Program ( <i>Pennsylvania</i> ).....	29
Improving Blood Lead Screening in Two-Year Olds ( <i>Great Lakes Health Plan</i> ).....	36
Pediatric Obesity Program ( <i>Tennessee</i> ).....	45
SECA Program ( <i>Pennsylvania</i> ).....	49
Text4babies Program ( <i>National Medical Management: Healthy First Steps</i> ).....	54
Wrap Around Program ( <i>Wisconsin</i> ).....	58











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