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New Jersey Department of Human Services
Division of Medical Assistance and Health Services
CORE MEDICAID and MLTSS
External Quality Review
Annual Technical Report
Review Period: January 1, 2021–December 31, 2021
(2021-2022 Reporting Cycle)

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I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO, Prepaid Inpatient Health Plan(PIHP), Prepaid Ambulatory Health Plan (PAHP), or Primary Care Case Management (PCCM) entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR Section § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the New Jersey (NJ) Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), contracted with IPRO, an EQRO, to conduct the 2021 EQR activities (reporting cycle 2021-2022) for five MCOs contracted to furnish Medicaid services in the state. During the period under review, January 1, 2021–December 31,2021, DMAHS's participating NJFamilyCare Managed Care MCOs included Aetna Better Health of New Jersey (ABHNJ), Amerigroup New Jersey, Inc. (AGNJ), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and WellCare Health Plans of New Jersey, Inc. (WCHP). As per DMAHS, enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and WCHP for Core Medicaid and Managed Long Term Services and Supports (MLTSS) was 2,017,540 as of 12/31/2021. This report presents aggregate and MCO-level results of these EQR activities for ABHNJ, AGNJ, HNJH, UHCCP and WCHP.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the three mandatory and five optional EQR activities that were conducted. External quality review (EQR) activities conducted during January 2021–December 2021 included annual assessment of MCO operations, performance measure (PM) validation, validation of performance improvement projects (PIPs), focused studies, which include Core Medicaid care management (CM) audits, and MLTSS CM audits, encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, calculation of additional performance measures, and implementation of additional PIPs.

It should be noted that validation of network adequacy and assistance with the quality rating of MCOs (Protocols 4 and 10) were to be conducted at the states' discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. Validation of Network Adequacy and assistance with Quality Rating System was not conducted by IPRO during this review period. The updated

protocols stated that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR Section § 438.358 Activities related to external quality review* (b)(1), these activities are:

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.
- ***CMS Optional Protocol 5:* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan –** This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.
- ***CMS Optional Protocol 6:* Administration or Validation of Quality of Care Surveys –** In 2021, two satisfaction surveys were conducted for adult and child Medicaid members. This activity measures satisfaction with care received, providers, and health plan operations.
- ***CMS Optional Protocol 7:* Calculation of Additional Performance Measures -** This activity specifies that the external quality review organization (EQRO) may calculate performance measures in addition to those specified by the state for inclusion in MCOs' QAPI programs.
- ***CMS Optional Protocol 8:* Implementation of Additional Performance Improvement Projects -** This activity validates that additional MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Optional Protocol 9:* Conducting Focus Studies of Health Care Quality -** This activity conducts clinical and non-clinical focus studies to assess quality of care at a point in time.

CMS defines *validation* in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The results of these EQR activities are presented in individual activity sections of this report. Each of the activity sections includes information on:

- data collection and analysis methodologies;
- comparative findings; and
- where applicable, the MCOs' performance strengths and opportunities for improvement.

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. A full ISCA was conducted with each NJ MCO in the prior reporting cycle. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in **Section V: Validation of Performance Measures** of this report in **Table 24**.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2020–2021 EQR activity findings to assess the performance of New Jersey Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

The following provides a high-level summary of these findings for the NJ FamilyCare Managed Care Program. The overall findings for MCOs were also compared and analyzed to develop overarching conclusions and recommendations for each MCO. These plan-level findings are discussed in each EQR activity section, as well as in the **MCO Strengths and Opportunities for Improvement, and EQR Recommendations** section.

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted from January 1, 2021 through December 31, 2021 demonstrated that DMAHS and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members.

Performance Improvement Projects

For January 2021–December 2021, this Annual Technical Report (ATR) includes IPRO's evaluation of the April 2021 PIP updates, August 2021 PIP report submissions, final PIP submissions, and the Fall 2021 PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. Full validation results for the Core Medicaid and MLTSS 2021 PIPs are described in **Section III: Validation of Performance Improvement Projects** of this report.

Core Medicaid :

The following four (4) PIPs were conducted by the MCOs during the ATR review period. Three are clinical and one is non-clinical. One clinical PIP was completed in August 2021 and proposals for an additional clinical PIP were submitted in September:

1. Developmental Screening – (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) (Final Report)
2. Adolescent Risk Behaviors and Depression – (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) (August Project Status Reports Submission – Project Year 2 and Sustainability Update)
3. Access to and Availability of PCP Services (Non-Clinical PIP) – (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) (August Project Status Reports Submission - Baseline Report and Project Year 1 Update)
   Note: ABHNJ is one year behind in the PIP reporting cycle.
4. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - (Clinical PIP Proposal) – (ABHNJ, AGNJ, HNJH, UHCCP and WCHP)

MLTSS:

Two MLTSS PIPs (2021) are currently being conducted by the MCOs, and are not completed:

1. One (1) MCO (AGNJ) is engaged in a MLTSS PIP topic relating to Falls Prevention (August Project Status Reports Submission – Project Year 2 and Sustainability Update)
2. All five (5) MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) are also engaged in a PIP for the topic regarding MLTSS Gaps in Care (August Project Status Reports Submission– Project Year 2 and Sustainability Update)

Comprehensive Administrative Review (2021 Annual Assessment of MCO Operations)

The external quality review organization assessed each MCO's operational systems to determine compliance with the Balanced Budget Act (BBA) regulations governing Medicaid managed care (MMC) programs, as detailed in the Code of Federal Regulations (CFR). The Annual Assessment of MCO Operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations.

In 2021, due to the continued impact of the 2019 novel coronavirus (COVID-19) pandemic, the Annual Assessment audits were conducted remotely. For the review period July 1, 2020–June 30, 2021, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. In 2021, the average compliance score for three standards (Efforts to Reduce Healthcare Disparities, Enrollee Rights and Responsibilities, and Credentialing and Recredentialing) showed increases ranging from 2 to 4 percentage points. In 2021, seven standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Committee Structure, Provider Training and Performance, Enrollee Rights and Responsibilities, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for eight standards (Quality Assessment and Performance Improvement, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Utilization Management, Administration and Operations, and Management Information Systems) remained the same from 2020 to 2021. One standard (Quality Management) decreased 9 percentage points from an average compliance score of 96% in 2020 to 87% in 2021. One standard (Access) decreased 8 percentage points from 77% in 2020 to 69% in 2021. In 2021, Access had the lowest average compliance score at 69%. Findings from this review can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations** section of this report.

During the audit, IPRO conducted a Performance Measure Reporting review for each MCO the day following the Annual Assessment interviews. Findings from this review can be found in **Section V: Validation of Performance Measures** of this report.

As part of the Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of each MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these eleven (11) standards be evaluated. **Table 1** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards. Of the 228 elements reviewed during the Annual Assessment, 81 crosswalk to the CMS QAPI Standards.

Table 1: Crosswalk of Standards Reviewed by EQRO to the Subpart D and QAPI Standard

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review*
Availability of services	438.206	1 - Access, 2 - Credentialing and Recredentialing, 3 - Administration and Operations	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	1 - 2019-2020 and 2021-2022 2 - 2020-2021 3 - 2019-2020 and 2021-2022
Assurances of adequate capacity and services	438.207	1 - Access	A4	1 - 2021-2022
Coordination and continuity of care	438.208	1 - Care Management and Continuity of Care	CM2, CM7 - CM11, CM14, CM26, CM29, CM34, CM38	1 - 2021-2022

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review*
Coverage and authorization of service	438.210	1 - Utilization Management	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	1 - 2019-2020 and 2021-2022
Provider selection	438.214	1 - Credentialing and Recredentialing 2 - Care Management and Continuity of Care	CR2, CR3, CM27	1 - 2019-2020 and 2021-2022 2 - 2021-2022
Confidentiality	438.224	1 - Provider Training and Performance	PT9	1 - 2019-2020 and 2021-2022
Grievance and appeal systems	438.228	1 - Utilization Management 2- Quality Management	UM16a – UM16d, UM16f-UM16i, QM5	1 - 2021-2022 2 - 2021-2022
Subcontractual relationships and delegation	438.230	1 - Administration and Operations	AO5, AO8–AO11	1 - 2019-2020 and 2021-2022
Practice guidelines	438.236	1 - Quality Assessment and Performance Improvement (QAPI) 2 - Quality Management, 3 - Programs for the Elderly and Disabled	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1 - 2019-2020 and 2021-2022 2 - 2019-2020 and 2021-2022 3 - 2019-2020 and 2021-2022
Health information systems	438.242	1 - Management Information Systems	IS1–IS17	1 - 2019-2020 and 2021-2022
Quality assessment and performance improvement (QAPI)	438.330	1 - Quality Assessment and Performance Improvement (QAPI)	Q1-Q3, Q5-Q9	1 - 2021-2022

The categories QAPI and Care Management and Continuity of Care are reviewed annually.
*Within a three-year cycle, four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a full compliance review in 2019-2020. One MCO (WCHP) had a partial compliance review in 2019-2020.
All 5 MCOs had a partial compliance review in 2020-2021.
Four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a partial compliance review in 2021-2022. One MCO (WCHP) had a full compliance review in 2021-2022.
DMAHS requires specific elements to be reviewed annually.

Validation of Performance Measure Reporting

The five MCOs in New Jersey report audited HEDIS rates to the State. IPRO reviews the final audit reports and the reported rates. In addition, the MCOs produce NJ specific, adult and child core set measures, and MLTSS specific measures. For these measures, IPRO reviews and validates source code, Member Level Data (MLD), and reported rates. In addition to these validation processes, IPRO undertook a detailed review of the reporting databases/warehouses used by the MCOs to report all performance measures. This review focused on the MCOs' definition of the populations required for each set of performance measures. The MCOs submitted documentation for review. Interviews were conducted with each MCO on the final day of their Annual Assessment of MCO Operations. Results of this review can be found in **Section V: Validation of Performance Measures** of this report.

MY 2020 New Jersey HEDIS Performance Measures

(NCQA National Medicaid Benchmarks are referenced in this section, unless stated otherwise.)

The NJ FamilyCare Managed Care Contract article 4.6.2.P requires NJ FamilyCare MCOs to report annually on Healthcare Effectiveness Data and Information Set (HEDIS®) PMs and ambulatory care utilization measures. As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to

calculate those measures. Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS Final Audit Report (FAR) prepared by a NCQA-licensed audit organization for each MCO as required by NCQA.

Notable HEDIS Measure Changes from MY 2019 to MY 2020

1. W30 replaces W15. A second age band for children between 15 and 30 months of age was added. Additionally, in MY 2020, the hybrid methodology was removed. Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) was combined with Adolescent Well Care Visits (AWC). The revised measure, Child and Adolescent Well Care Visits (WCV) also added an additional age-band for children aged seven to eleven years. Three age-bands are reported: 7-11 years; 12-17 years, and 18-21 years.
2. Three measures were removed: Adult BMI Assessment (ABA), Children's Access to Primary Care (CAP), and Medication Management for People with Asthma (MMA)
3. One new measure was added from the Electronic Clinical Data Systems measure set: Prenatal Immunization Status (PRS-E)

New Jersey Medicaid Weighted Average Year-Over-Year Performance for HEDIS Measures

Overall, most measures remained constant from MY 2019 to MY 2020 (<5 percentage point change). Significant improvement (≥ 5 percentage point change) in performance from MY 2019 to MY 2020 were noted for one or more rates of Statin Therapy for Patients with Cardiovascular Disease (SPC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and Asthma Medication Ratio (AMR). Significant declines (≥ 5 percentage point change) in performance from MY 2019 to MY 2020 were noted for one or more rates for Well Child Visits in the First 15 Months (6 or More Visits) (W15), Cervical Cancer Screening (CCS), Comprehensive Diabetes Care (CDC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing, and Annual Dental Visits (ADV).

MY 2020 New Jersey State-Specific Performance Measures and Core Set Measures

Measures reported for MY 2020 by the MCOs can be categorized as follows:
There are two required New Jersey Specific Performance Measures:

1. Preventive Dental Visit (NJD)
2. Multiple Lead Testing in Children through 26 months of age (MLT)

There are three Child Core Set Measures:

1. Developmental Screening (DEV-CH)
2. Contraceptive Care Postpartum Women ages 15-20 (CCP-CH)
3. Contraceptive Care All Women ages 15-20 (CCW-CH)

There are three Adult Core Set Measures:

1. Diabetes Short-Term Complications Admission Rate (PQI01-AD)
2. Contraceptive Care Postpartum Women ages 21-44 (CCP-AD)
3. Contraceptive Care All Women ages 21-44 (CCW-AD)

Significant declines were seen in year-over-year performance for the Preventive Dental measure. This was consistent with trends observed for Measurement Year 2020 for the HEDIS ADV measure. Developmental screening rates were comparable to the prior year. Changes in rates for the contraceptive measures for both populations were below one percentage point, with the exception of Most or Moderate Contraceptive Care at

60 days for Postpartum women in the 15-20 age group. That rate increased by 2.60 percentage points over the prior year. Admission rates for Diabetes Short-Term complications declined. Details of these results can be found in **Section V: Validation of Performance Measures** of this report.

2021 MLTSS Performance Measure Validation

IPRO worked closely with DMAHS Office of MLTSS Quality Monitoring and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications were updated in 2021 for the July 2021 through June 2022 measurement period. All MLTSS PMs are validated annually. IPRO reviews source code, member level files, and rates for each MCO. With the exception of PM #04, which is reported on a monthly basis, PMs are reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*). PM #20a was retired in 2021.In addition to annual validation of all PMs, IPRO monitored all ongoing reporting to the State on a quarterly basis. Results of this review can be found in **Section V: Validation of Performance Measures** of this report.

The following are the measures for validation, showing IPRO's alpha labeling and the New Jersey MLTSS Performance Measure number associated with the measure for 7/1/20-6/30/21:

- PM #04 - Timeliness of Nursing Facility Level of Care Assessment by MCO (Monthly)

The following measures are monitored quarterly and reviewed annually:

- PM #18 - Critical Incident Reporting
  18a - Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the State at the Total and Category level
  18b - Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the State within 2 business days at the Total and Category level
  18c - Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level
  18d - The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level
- PM #20 - MLTSS Members receiving MLTSS services
- PM #20a - New MLTSS members with MLTSS services within 120 days of enrollment
- PM #20b - Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
- PM #21 - MLTSS Members who Transitioned from NF to the Community
- PM #23 - MLTSS NF to HCBS Transitions who returned to NF within 90 days
- PM #26 - Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
- PM #27 - Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
- PM #28 - All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
- PM #29 - All Cause Readmissions of MLTSS NF members to hospital within 30 days: (HEDIS PCR)
- PM #30 - Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
- PM #31 - Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
- PM #33 - MLTSS services used by MLTSS HCBS members: PCA services only
- PM #34 - MLTSS services used by MLTSS HCBS members: Medical Day services only
- PM #36 - Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members: (HEDIS FUH)
- PM #38 - Follow-up after Mental Health Hospitalization for MLTSS NF members: (HEDIS FUH)

- PM #41 - MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
- PM #42 - Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
- PM #43 - Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members: (HEDIS FUA)
- PM #44 - Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
- PM #45 - Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
- PM #46 - MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services
- PM #47* - Post-hospital Institutional Care for MLTSS HCBS Members
- PM #48* - Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
- PM #49* - Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
- PM #50* - Follow-Up After Emergency Department Visit for HCBS MLTSS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
- PM #51* - Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
- PM #52 Care for Older Adults for HCBS MLTSS Members (HEDIS COA)
    i. 52a Advance care planning - HCBS
    ii. 52b Medication review - HCBS
    iii. 52c Functional status assessment - HCBS
    iv. 52d Pain assessment - HCBS

- PM 53 Care for Older Adults for NF MLTSS Members (HEDIS COA)
    i. 53a Advance care planning - NF
    ii. 53b Medication review - NF
    iii. 53c Functional status assessment – NF
    iv. 53d Pain assessment - NF

- PM #54 New MLTSS members receiving PCA, MDC and/or MLTSS services
  (This measure replaced PM #20a – the specifications were created, but this measure will be reviewed in the next reporting cycle.)

2020 and 2021 MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the plan of care (POC). This measure ensures MLTSS HCBS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: Adult Family Care, Assisted Living Services/Program, Chore Services, Community Residential Services, Home Delivered Meals, Medical Day Services, Medication Dispensing Device Monthly Monitoring, PCA/Home Based Supportive Care, PERS Monitoring, and Private Duty Nursing.

In 2021, the validation of PM #13 for measurement period from July 2019 to February 2020 continued. For the measurement period July 2019 to June 2020, Members were required to be enrolled in MLTSS HCBS with

the MCO between July 1, 2019 and February 29, 2020. The change of enrollment window from one year to eight months was to address the impact of COVID-19.

In addition, validation of PM #13 for measurement period July 2020 to June 2021 began. For both measurement periods (July 2019 to February 2020, and July 2020 to June 2021) samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. Validation of the files received from the MCOs for these two review periods is ongoing. Once all files pass validation, IPRO will conduct Primary Source Verification of the claims data received against the transactional systems to ensure that the claims files received are accurate. Results of this review can be found in **Section V: Validation of Performance Measures** of this report.

2021 Managed Long Term Services and Supports (MLTSS) Service Delivery Project

The purpose of the Managed Long-Term Services and Supports (MLTSS) Service Delivery Project is to evaluate compliance of the delivery of four specific MLTSS services, in accordance with the MLTSS members' Plan of Care (POCs) for members of Home and Community Based Services (HCBS) for NJ Medicaid Managed Care Organizations (MCOs). The four types of services include: Home Delivered Meals(HDM), Medical Day Care (MDC), Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). Evaluation of POC compliance with service delivery is based on type, scope, amount, frequency, and duration of service.

In addition to evaluating delivery of services in accordance with the POC, MCOs were evaluated against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS HCBS; PM #10: Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment; and PM #11: Plans of Care developed using "person-centered principles".

In 2021, the MLTSS Service Delivery project was based on the measurement period July 1, 2018 and December 31, 2018. A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. IPRO developed an algorithm, to minimize the number of unique cases required to ensure that there were 120 cases for each service type and to ensure that 120 new enrollees would be included for calculation of PM #8.

MCOs were required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. POCs that contained no information about the MLTSS services were excluded from the evaluation of the MLTSS services, but were included for scoring of PM #8, PM #10, and PM #11. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems. Results of this project can be found in **Section V: Validation of Performance Measure** in this report.

2020 Information Systems Capabilities Assessments

In 2016, CMS issued the Medicaid and CHIP Final Rule. In accordance with the 2016 Final Rule, CMS updated the External Quality Review (EQR) protocols, which were released in 2019. The updated protocols indicated that an Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR for Protocols 1 (Validation of Performance Improvement Projects), 2 (Validation of Performance Measures), 3 (Review of Compliance with Medicaid and CHIP Managed Care Regulations), and 4 (Validation of Network

Adequacy). The five Medicaid MCOs in New Jersey use HEDIS certified software and submit audited HEDIS results to the State of New Jersey. However, some measures, such as non-HEDIS Core set measures, measures associated with Managed Long Term Services and Supports (MLTSS), and New Jersey specific measures for Medicaid, are produced outside of the HEDIS audit. While CMS has clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA, DMAHS determined that all five MCOs should undergo an ISCA as part of the scheduled Annual Assessment of Compliance with Medicaid Managed Care regulations. The ISCAs were conducted by IPRO in 2020.

IPRO conducted a meeting with DMAHS and the MCOs on 8/31/2020 to review the agenda and process. Due to COVID-19 restrictions, the reviews occurred via WebEx. The assessment covered the following areas:

- Data Integration and Systems Architecture
- Claims/Encounter Data Systems and Processes
- Membership Data Systems and Processes
- Provider Data Systems and Processes
- Oversight of Contracted Vendors
- Supplemental Databases
- Grievance Systems

The Data Integration and Systems Architecture review consisted of a review of the structure of all systems and data warehouses supporting MCO operations and reporting. Claims, eligibility, provider, and grievance systems were directly reviewed. Discussion of oversight of contracted vendors focused on the MCO's ongoing oversight of vendors that process claims for services rendered to MCO members. The review of supplemental databases focused on data sources for services received by the MCO's membership, but not directly or indirectly paid for by the MCO. The structure of the review followed HEDIS audit processes for definitions of contracted vendors and supplemental data sources. No significant systems issues were identified for any of the five MCOs.

All five MCOs undergo a systems review annually as part of their HEDIS audit by an NCQA Licensed Organization. IPRO reviews these results annually. Details of this review can be found in **Section V: Validation of Performance Measures** in this report.

As noted under Performance Measure validation, in 2021 IPRO undertook a detailed review of MCO population definitions for reporting of HEDIS, non-HEDIS Core Set performance measures, and NJ Specific performance measures. This review occurred on the day following the 2021 Annual Assessment compliance reviews. Details of this analysis can be found in **Section V: Validation of Performance Measures** in this report.

Quality of Care Surveys

Member Satisfaction - 2021 CAHPS Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health Plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Aggregate reports were produced for the adult and child surveys. In addition, the certified vendor fielded one statewide Children's Health Insurance Program (CHIP) only survey. All of the members surveyed required continuous enrollment from July 1, 2020 through December 31, 2020, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey. Details on these surveys can be found in the **Section VI: Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey** of this report.

Focus Studies

2019 Maternal Mortality Focused Study

In 2019, at the request of DMAHS, IPRO developed a clinical focused study on maternal mortality. This study aimed to investigate pregnancy-associated deaths in the New Jersey Medicaid population and explore the predictors of maternal mortality. For the purposes of this study, pregnancy-associated death was defined as death of a woman within 1 year of the termination of a pregnancy (excluding those terminated by elective abortion). This study was a retrospective cohort study of Medicaid-enrolled women who died in 2017 and 2018 within one year of the termination of a pregnancy that occurred while the woman was enrolled in New Jersey Medicaid. Because of the anticipated small population of focus, statistical comparisons to the general maternal population were not conducted.

In 2021, IPRO completed the study and provided a final report to the State in August 2021. Study findings can be found in **Section VIII: Focus Studies of Health Care Quality** section in this report.

Encounter Data

Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the State Encounter Data Monitoring Unit (EDMU), and the EQRO. In 2017, DMAHS partnered with its EQRO, IPRO, to conduct an MCO system and encounter data process review to include a baseline evaluation of the submission and monitoring of encounter data. As of October 2017, IPRO has been attending the monthly EDMU calls with the MCOs. In 2021, IPRO continues to monitor encounter data submissions and patterns. Study findings can be found in **Section IX: Encounter Data Validation** of this report.

Pharmacy Claims vs. Encounter Data Validation

In 2021, the EQRO continued the pharmacy audit study with the Core Medicaid and FIDE SNP MCOs and EDMU. The objective of the audit was to verify the accuracy of pharmacy encounter data submitted to DMAHS by all five NJ Medicaid and all four FIDE SNP MCOs. The pharmacy encounter data submitted to DMAHS was reconciled to the corresponding source claim data from the originally adjudicated claims and differences were identified and investigated. Review period of the audit includes a nine-month survey period of April 1, 2018 to December 31, 2018. The EQRO selected a random sample of 1,000 Core Medicaid and 1,000 FIDE SNP pharmacy encounters for each month for each NJ Core Medicaid and FIDE SNP MCO. The MCOs provided the adjudicated claim information and the EQRO identified the discrepancies. The EQRO worked closely with the MCOs and EDMU to review the discrepant data elements. During February 2021, IPRO scheduled a 2-hour remote meeting with each MCO to discuss the discrepancies, and the discussions included a review of the corresponding claims on the PBM's source system. During the remote meetings, the MCOs and their PBMs provided an overview of the processes involved with the receipt, translation, and adjudication of pharmacy claims, the submission of pharmacy encounter data to DMAHS, and the reconciliation of the denied encounters. Each of the encounters that illustrated data discrepancies was reviewed during the remote meetings and the MCO, IPRO and DMAHS discussed in detail the discrepant data values and identified any follow-up items required. The study has been completed, and IPRO provided DMAHS with a summary of findings report in May 2021. Results of this project can be found in **Section IX: Encounter Data Validation** of this report.

Care Management Audits

2021 Core Medicaid Care Management Audits

IPRO undertook Core Medicaid Care Management (CM) Audits of ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. The purpose of the CM audits was to evaluate the effectiveness of the contractually required CM programs and CM services provided to all MCO members by these MCOs. The populations in the audits included members under the Division of Developmental Disabilities (DDD), the Division of Child Protection and Permanency (DCP&P) and the General Population (GP).

In 2020 and 2021, IPRO and OQA collaborated on revising the NJ EQRO MCO Care Management Audit tool to improve and refine the audit process.

The MY 2020 rates across all MCOs, populations, and categories ranged from 42% to 100%. Scores for Identification ranged from 84% to 93% for the General Population. Outreach ranged from 90% to 100% for all MCOs for all populations (GP, DDD and DCP&P). Scores for the Preventive Services Category ranged from 42% to 90% across all MCOs for all populations. Scores for Continuity of Care ranged from 64% to 97% across all MCOs for all populations. Scores for Coordination of Services ranged from 74% to 100% across all MCOs for all populations.

Four metrics (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for the GP, DDD, and DCP&P populations. For the GP population an additional metric, Identification, was also evaluated.

The Care Management and Continuity of Care standard is reviewed in conjunction with comprehensive file reviews. For the Core Medicaid population, up to 300 DDD, DCP&P and GP charts are reviewed for each MCO. The actual number of charts reviewed is dependent upon the population size that meets the sample criteria for audit. In addition to the Core Medicaid Care Management chart review audit, in 2021 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The Care Management assessment covered the period from January 1, 2020 to December 31, 2020. Interviews with the MCOs were held with key MCO staff via WebEx in April 2021. There are 30 contractual provisions in this category. Overall compliance scores for the five MCOs ranged from 80% to 90% in 2021. Results of this review can be found in **Section VII: Care Management Audits** of this report.

2021 MLTSS HCBS Care Management Audits

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audits was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. The review period for the annual HCBS audit is from July 1 through June 30.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS Performance Measures (#8 – Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contracts (Article 9) dated July 2020 and January 2021. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/2020 and 1/1/2021 (Group C) and existing MMC members enrolled in MLTSS between 7/1/2020 and 1/1/2021 (Group D), the 2021 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/2020) and continuously enrolled with the MCO in MLTSS through 6/30/2021. A minimum of 100 files were to be reviewed and abstracted across all three groups. An oversample was selected for the MCO to replace any excluded files. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample.

The New Jersey weighted average for the audit categories reviewed ranged from a low of 70.5% for Ongoing Care Management to a high of 97.6% for Gaps in Care/Critical Incidents.

Across all plans for the performance measures calculated during the audit, the total NJ weighted average for the 7/1/2020 to 6/30/2021 audit results ranged from 70.3% for PM #11(Plan of Care developed using "Person Centered Principles") to 98.7% for PM #16 (Member training on identifying/reporting critical incidents).

In addition to the MLTSS HCBS Care Management chart review audit, in 2020 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. The Care Management assessment covered the period from July 1, 2020 to June 30, 2021. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS. Interviews were held with key MCO staff via WebEx during August 2021.

There are 10 contractual provisions in this category. Overall compliance scores for the five MCOs ranged from 70% to 100% in 2021. Results of this review can be found in **Section VII: Care Management Audits** of this report.

2021 MLTSS Nursing Facility Care Management Audits

The purpose of the 2021 MLTSS Nursing Facility (NF) Care Management (CM) audits was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in an NF or Special Care Nursing Facility (SCNF) for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019 through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore,

IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. The results below relate to the review period from July 1, 2019 through February 29, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.

For the review period July 1, 2019, through February 29, 2020, four of the five MCOs scored at or above 86% for "MLTSS Plans of Care on file" and three of the five MCOs scored at or above 86%, "Members present at each onsite visit."

For the review period July 1, 2019, through February 29, 2020, three of the five MCOs scored at or above 86%, for "Members identified for transfer to HCBS." For Member and/or representative participated in the development of goals."

For the review period July 1, 2019, through February 29, 2020, three of the five MCOs scored at or above 86%, for Member and/or representative participated in the development of goals."

For the review period July 1, 2019, through February 29, 2020, two of the five MCOs scored at or above 86%, for New Jersey Choice Assessment completed during the review period."

Opportunities for improvement were identified for one (1) MCO with a score of 67.3% for "MLTSS Plans of Care on file"; two (2) MCOs scored between 63% and 83% for "Members present at each onsite visit"; two (2) MCOs scored between 55% and 83%, for "Members identified for transfer to HCBS"; two (2) MCOs scored between 63% and 83%, "Member and/or representative participated in the development of goals"; three (3) MCOs scored between 59.8% and 77.3%, for "New Jersey Choice Assessment completed during the review period". Results of this review can be found in **Section VII: Care Management Audits** of this report.

Impact of COVID-19

Comparison of NF Audit Results for Review Period and Expansion Period

Five audit elements were identified for comparison of care management activities during the review period, prior to suspension of certain in-person care management activities in March 2020, and during the expansion period from March 1, 2020 through December 31, 2020. These elements reflect activities that could be undertaken during the period when care management activities in the nursing facilities were restricted.

Acute Inpatient Events

In addition to reviewing selected care management elements for the expansion period, IPRO conducted an analysis of Acute Inpatient (IP) events for the period from July 1, 2019 through December 31, 2020. MCOs submitted files for all acute IP events for this period. For the first six months of the IP review period, random samples were selected by month. A total of 100 records were selected for each MCO. For the first six months of the review period, 5 cases per month were selected. For the period from January 1, 2020 through December 31, 2020, the remaining 70 cases were selected by date and diagnosis. For the first quarter, January 1, 2020 through March 31, 2020, 16 cases were selected for each MCO. For the remaining quarters, from April 1, 2020 through December 31, 2020, 18 cases were selected for each MCO. Selection of cases for the period of January 1, 2020 through December 31, 2020, was conducted in such a manner as to ensure that discharges with respiratory diagnoses or COVID-19 diagnoses were present in each quarter. COVID-19 diagnoses did not appear in the data until mid-March 2020. Results of this study can be found in **Section VII: Care Management Audits** of this report.

Conclusion and MCO Recommendations

Section XI of this report provides a summary of strengths, opportunities for improvement, and EQR recommendations for ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. These evaluations are based on the EQRO's review of MCO performance across all activities evaluated during the review period.

II. New Jersey Medicaid Managed Care Program

Managed Care in New Jersey

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. As per DMAHS, as of December 2021 there were approximately 2,017,540 individuals enrolled in Medicaid Managed Care (MMC) and the number increased from 1,837,833 in December 2020 (**Table 2**). Of the 2,017,540 individuals enrolled in MMC, 59,066 were receiving MLTSS services as of December 2021. More than 96% of managed care eligible beneficiaries receive services through the managed care program.

In 2011, NJ applied for a five-year Medicaid and CHIP Section 1115 research and demonstration waiver encompassing nearly all services and eligible populations served under a single authority. In October 2012, CMS approved NJ's request for the new Medicaid section 1115(a) demonstration, entitled "New Jersey Comprehensive Waiver." Under this demonstration, NJ will operate a statewide health reform effort that will expand existing managed care programs to include MLTSS and expand HCBS to some populations. Implementation of the MLTSS HCBS and NF services for new MLTSS members began in July 2014. The updated New Jersey Comprehensive 1115 Waiver was submitted to CMS in March 2017, approved in August 2017, and scheduled to expire June 2022.

New Jersey also expanded its Medicaid program under the Affordable Care Act effective January 1, 2014. This allows NJ to cover childless adults and parents up to 133% of the federal poverty level (FPL).

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in December 2020–December 2021. **Table 2** presents respective enrollment figures in December 2020 and December 2021.

Table 2: December 2020–December 2021 Medicaid MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2020	December 2021	December 2020	December 2021
Aetna Better Health of New Jersey	ABHNJ	106,834	124,882	4,734	5,265
Amerigroup New Jersey, Inc.	AGNJ	237,211	255,447	9,259	9,835
Horizon NJ Health	HNJH	1,019,574	1,129,000	20,957	21,677
UnitedHealthcare Community Plan	UHCCP	374,357	401,147	8,379	9,676
WellCare Health Plans of New Jersey, Inc.	WCHP	99,857	107,064	11,599	12,613
Total		**1,837,833**	**2,017,540**	**54,928**	**59,066**

[1]Managed Long Term Services and Supports (MLTSS) members are included in the December 2020–2021 Medicaid enrollment figures.
Source: DMAHS

Figure 1 shows each MCO's NJ FamilyCare Managed Care enrolled population for Medicaid including MLTSS-eligible enrollment for December 2020 and December 2021 in relation to the entire NJ MMC population.

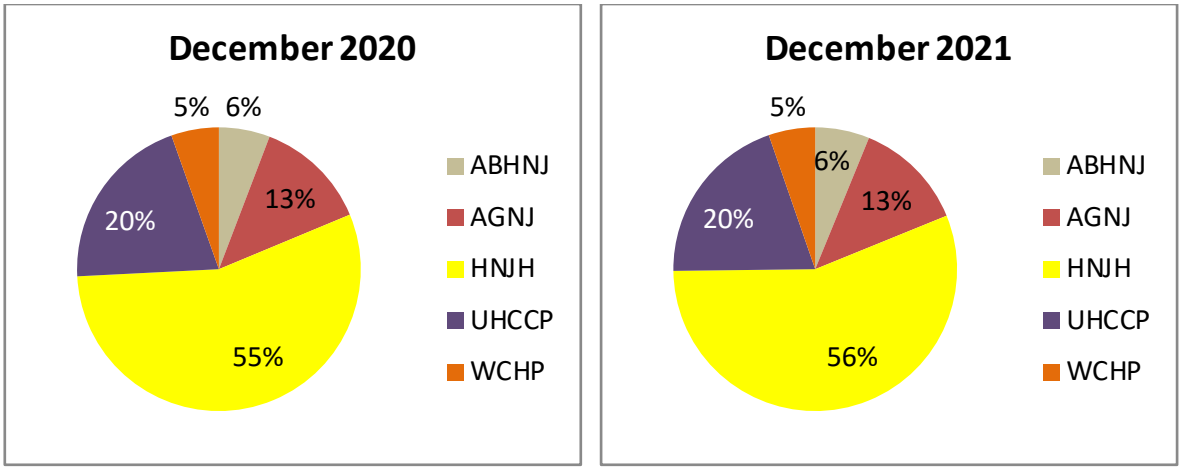

Figure 1: December 2020 – December 2021 Medicaid Managed Care Enrollment by MCO. Enrollment in MMC for each MCO reported as of December 2020 (left panel) and December 2021 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (grey); AGNJ: Amerigroup New Jersey, Inc. (red); HNJH: Horizon NJ Health (yellow); UHCCP: UnitedHealthcare Community Plan (purple); WCHP: WellCare Health Plans of New Jersey, Inc. (orange). Percentages may not add to 100% due to rounding.

Table 3 shows the activities discussed in this report and the MCOs included in each EQR activity.

Table 3: 2021 EQR Activities by MCO

		EQR Activity								
MCO	Annual Assessment of MCO Operations	PMs	Core Medicaid/ MLTSS PIPs	Focused Quality Studies	CAHPS Surveys	Core Medicaid CM Audits	MLTSS HCBS CM Audits	MLTSS NF CM Audits	ISCA Assessments[1]
ABHNJ	√	√	√	√	√	√	√	√	√
AGNJ	√	√	√	√	√	√	√	√	√
HNJH	√	√	√	√	√	√	√	√	√
UHCCP	√	√	√	√	√	√	√	√	√
WCHP	√	√	√	√	√	√	√	√	√

EQR: External Quality Review; MCO: Managed Care Organization; PM: Performance Measure; MLTSS: Managed Long Term Services and Supports; PIP: Performance Improvement Project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CM: Care Management; HCBS: Home and Community Based Services; NF: Nursing Facility; ISCA: Information Systems Capabilities Assessment [1] A full ISCA was conducted in 2020. HEDIS IS assessments are conducted every year including 2021. Additionally, a focused review of MCO population definitions was conducted in 2021.

New Jersey - 2021 State Initiatives

The information in this chapter is provided in its entirety by DMAHS and included verbatim herein.

This chapter provides information on initiatives that DMAHS is undertaking to improve quality of care and information technology. DMAHS has been active in the following State Initiatives: 1115 Renewal Proposal; Federal Medical Assistance Percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS); Electronic Visit Verification; Health Information Technology (HIT) and the Medicaid Enterprise System; Quality Improvement Program-New Jersey (QIP-NJ); Maternal/Child Health; and Medicaid Innovator Accelerator Program (IAP) Value Based Purchasing (VBP): Home and Community Based Services (HCBS). To implement our vision, New Jersey has focused on providing all of our members with quality care and services through

increased access and appropriate, timely utilization of health care services. The goals of our Quality Strategy, which include to improve timely, appropriate access to primary, preventative, and long term services and supports for adults and children; to improve the quality of care and services; to promote person-centered health care and social services and supports; and to assure member satisfaction with services and improve quality of life, guide the below initiatives in direction and scope.

1115 Renewal Proposal

In the fall of 2021, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) submitted an application to the federal Centers for Medicare and Medicaid Services (CMS) to renew the New Jersey FamilyCare Comprehensive Demonstration. This demonstration, authorized under Section 1115 of the Social Security Act, governs the operations of significant components of New Jersey's Medicaid program and Children's Health Insurance Program (CHIP). This demonstration is currently in its second five-year performance period, which is scheduled to expire on June 30, 2022.

This renewal is intended to modify and extend this demonstration for an additional five years. A copy of the 1115 Demonstration Renewal Draft Proposal and accompanying presentation was posted on the DMAHS website for public review and comment.

When developing the draft proposal, DMAHS focused on several overarching policy goals:

- **Maintaining momentum on existing demonstration elements:**
  - Continue improvements in quality of care and efficiency associated with managed care; improve access to critical services in the community through Managed Long Term Services and Supports (MLTSS) and other home and community based services programs; and create innovative service delivery models to address substance use disorders.
  - Update existing demonstration terms and conditions to address implementation challenges, and accurately capture how the delivery system has evolved in New Jersey over the past several years.
- **Expand our ability to better serve the whole person**:
  - Test new approaches to addressing the social determinants of health, with a particular emphasis on housing-related issues.
  - Encourage greater integration of behavioral and physical health, and continued availability of appropriate behavioral health services for all Medicaid beneficiaries.
- **Serve our communities the best way possible:**
  - Address known gaps and improve quality of care in maternal and child health.
  - Expand health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. LGBTQ identity).

Federal Medical Assistance Percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS)

Section 9817 of the American Rescue Plan temporarily increases the Federal Medical Assistance Percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS). This 10 percentage point increase is effective from April 1, 2021 until March 31, 2022. In order to qualify for this enhanced federal match, states are required to reinvest the additional federal dollars in enhancing, expanding or strengthening Medicaid HCBS. This funding source is an opportunity for states to make short and long-term investments in a critical part of their Medicaid system.

Per CMS guidance, New Jersey has submitted and received partial CMS approval for an initial spending plan, outlining our HCBS funding priorities. This plan must then be updated quarterly. New Jersey's proposed

investment plan seeks to strengthen existing robust HCBS offerings, while making new investments to maintain beneficiaries' access to high-quality community-based care, and addressing the ongoing effects of the COVID-19 public health emergency.

New Jersey's HCBS Spend Plan proposes funding rate increases for Personal Care Assistant (PCA) services, Assisted Living facilities, the Personal Preference Program (PPP), Support Coordinators, Applied Behavior Analysis (ABA) services, and the Jersey Assistance for Community Caregiving (JACC) program. Additionally, funds to support Traumatic Brain Injury (TBI) providers, Nursing facility transitions, "No Wrong Door" system enhancements, and Home Health Workforce development initiatives are included. Finally, new programs to improve Person Centered Planning in Managed Care, promote the interoperability of behavioral health data systems, develop housing for Medicaid members at risk of homelessness or institutionalization, and create a mobile intervention unit for youth with intensive Intellectual/Developmental Disabilities (I/DD) were proposed.

This spending plan lasts until March of 2024 and through the quarterly update process, New Jersey continues to work with CMS to receive approval of outstanding activities, implement already approved activities, and update budget assumptions.

Electronic Visit Verification

Section 12006(a) of the 21st Century Cures Act (Cures Act) mandates that states implement electronic visit verification (EVV) for Personal Care Services and Home Health Care Services (HHCS). In compliance with this mandate, DMAHS sought to procure a centralized web-based EVV system using the Open Vendor Model based on stakeholder feedback and preferences. This approach accommodates many healthcare providers who have already implemented their own "Cures Act-compliant" EVV systems that they would like to maintain while giving providers the option to use the State's EVV system.

In August 2020, DMAHS contracted with HHAeXchange (HHAX) to implement the EVV system which includes a data aggregation function. The system is undergoing an Outcomes Based Certification review to validate that the system delivers on the following outcomes:

- The State Medicaid Agency (SMA) has enhanced ability to prevent fraud, waste, and abuse through increased visibility into its Home and Community Based Services programs.
- The EVV solution is reliable, accessible, and minimally burdensome on providers, beneficiaries, and their caregivers.
- Appropriate safeguards of electronic protected health information and personally identifiable information are implemented and maintained.

The EVV system was implemented into production on December 14, 2020. Efforts in the areas of stakeholder collaboration, provider training and support are continuing to ensure successful adoption. With the guidance and support of CMS, a transition period ending on June 30, 2021 was utilized to monitor and ensure that applicable services are EVV compliant.

Collaboration and communication with stakeholders continues as the state prepares to implement EVV for Home Health Services by January 1, 2023 per the mandate in the 21st Century Cures Act.

Health Information Technology and the Medicaid Enterprise System

The Division of Medical Assistance & Health Services (DMAHS) continues to put health information technology (HIT) at the forefront, supporting initiatives that promote interoperability to reduce healthcare costs, improve care coordination and administrative efficiencies. The COVID-19 pandemic has cast a spotlight on the importance of interoperability and health information sharing during the public health emergency. While the pandemic has also exposed the gaps between disparate health systems, it has also presented several areas of opportunity to grow the health information technology infrastructure of the State Health Information Exchange (HIE) for better care coordination and improved patient health outcomes.

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid including the establishment of an overall Medicaid Enterprise System (MES) strategy encompassing IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E) and the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user experience, and understand and react to organizational change. DMAHS aims to implement projects utilizing agile methodology that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the systems will be developed to fully comply with the CMS Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards. This will help DMAHS achieve the dual goals of obtaining enhanced match funding, and the successful development and deployment of a modern information system. A more adaptable design will better position NJ's Medicaid Enterprise for the future, and provide the ability to more quickly address Medicaid program needs.

Medicaid Management Information System (MMIS)

DMAHS is continuing modernization activities to the MMIS. Transformation from the Replacement MMIS to MMIS Modernization referred to as the MMIS Modernization (MMIS-M) is a key component in the operation of DMAHS programs for providing comprehensive health coverage to over 2 million New Jersey residents. The COVID-19 public health emergency had been a major focus throughout Federal Fiscal Year (FFY) 2021. Although the pandemic required dedicated attention from MMIS resources to support an effective health system response, modernization initiatives continued with the project team strategizing to integrate modernizing the MMIS while making necessary enhancements to existing functions and capabilities required to support the Division's pandemic response.

New Jersey's modernization strategy is to implement business processes using the concept of modularity and agile methodology. In 2021, significant progress was realized surrounding efforts on Enterprise Architecture (EA), System Integration, Member and Provider Operational Data Store (ODS) and Provider Management Module. This requires an information technology strategy and migration approach to be laid out with an Enterprise Architecture that will support the incremental deployment of system modules. Several Proof of Concepts (POC) are being initiated which are required for adequate affirmation that the current legacy system will be capable of handling the modular approach. Through 2021, MMIS State and vendor teams continue to develop the system integration POCs which include: Data Synchronization, Security Integration, Portal Integration, Enterprise Service Bus integration, Synchronous Data Exchange and Asynchronous Data Exchange. In addition, the team completed tasks which support a Member ODS that will be the primary repository for cleansed/scrubbed member data for consumption of programs across the enterprise. A POC for the Master Client Index (MCI) is a core component in managing the Member ODS to match and link member records across all NJMMIS sources. Implementation of the MCI will also be leveraged for provider data to establish a Provider ODS. The Provider ODS is a key component of the Provider Management Module as it will use the

existing MCI process to determine unique provider identification using the National Provider Identifier as a common key. The Provider Module is intended to help realize efficiencies and benefits to business operations and improve the provider experience. The team made meaningful progress in 2021 to define and validate the business requirement for the Provider Module with key stakeholders to initiate the procurement process and planning for organizational change management and readiness.

In January 2021, DMAHS also added the Electronic Visit Verification Management System (EVVMS) that complies with Section 12006 of the 21st Century Cures Act. This was deployed with an Open Model providing a platform that enables Medicaid Payers, Managed Care Organizations (MCOs), and their contracted network of Health Care Providers to effectively and efficiently communicate the delivery of home healthcare services. The first phase of this project is geared towards enabling EVV for Personal Care Services (PCS).

In July 2021, DMAHS and its contracted Managed Care Organization (MCO) vendors deployed Provider Directory and Patient Access APIs in compliance with the Interoperability and Patient Access Final Rule (CMS-9115-F). While the MCOs implemented the systems required for MCO members, DMAHS deployed a solution that allows current and prospective members and the general public to find a list of participating providers in the Medicaid/NJFC Fee-for-Service (FFS) program.

In the long term, modernization efforts for the MMIS will provide a well-defined healthcare structure, enabling possibilities for business improvements and the flexibility to accommodate evolving business needs that are critically intertwined with health information technology (HIT) and health information exchange (HIE).

NJ FamilyCare Integrated Eligibility System

New Jersey continued leadership in the cloud-based eligibility system field through enhancements and improvements to the NJ FamilyCare Integrated Eligibility System (IES). Utilizing agile methodology and modularity in the development and implementation, the State is able to deliver services in a timely and cost-effective manner while reducing the overall risk associated with traditional software development. Using a cloud-based solution, New Jersey continued enhancing the online applications for Modified Adjusted Gross Income (MAGI), Aged, Blind and Disabled (ABD), and Presumptive Eligibility (PE) programs. The online application is used by citizens, county workers, assistors and health benefits coordinators. NJ FamilyCare allows clients to complete an application using any internet connected PC, laptop, tablet, or phone. NJ FamilyCare supports Windows, Apple IOS, and Android operating systems. NJ FamilyCare call center staff use the online application to complete telephonic applications. Along with the online application, New Jersey continued enhancing the online worker portal that enables county workers to complete eligibility determinations. The worker portal automates verification, MAGI and non-MAGI eligibility determination, and NJ FamilyCare program determination.

The NJ FamilyCare IES continues to utilize modular services that enhance the client and worker experience. The MAGI in the Cloud software service, designed and maintained by CMS and operated through New England States Consortium Systems Organization (NESCSO) is used to automate MAGI eligibility determination. This service allows all NJ MAGI eligibility and program determinations to be done consistently using one set of rules. NJ FamilyCare is configured to interface with the Federal Data Services Hub (FDSH) for verifications. Through the FDSH, the Social Security Administration (SSA), Verify Lawful Presence (VLP), and Equifax Income verifications have all been implemented. In November 2020, Get Covered New Jersey, the state's official health insurance marketplace, opened. Account Transfer (AT) functionality was set-up to electronically receive beneficiary accounts referred by the Marketplace.

In 2021, NJ FamilyCare IES rapidly made enhancements in order to accommodate urgently needed policy updates for the COVID-19 public health emergency, while at the same time expanding functionality to all

modules of the system. NJ FamilyCare launched an ABD Assistor Portal that allows approved and registered Medicaid ABD providers to more easily submit multiple ABD applications. Upgrades to Notices, Verify Lawful Presence (VLP) verifications, Medicaid Eligibility System (MES) automatic upload, and ABD to MAGI Case Transfer all helped to improve speed and accuracy of determinations. Currently, the State is implementing a pilot for electronic Renewals and Redeterminations and is in the design phase of the MES Modernization project which will move all core eligibility functions into NJ FamilyCare IES. These functionalities will only continue to improve eligibility determination processing time in order to provide for the healthcare needs of the most vulnerable beneficiaries in the State.

HITECH and the Promoting Interoperability Program

Since the implementation of the Medicaid Promoting Interoperability Program in 2011, DMAHS has administered over $221 million dollars in incentive payments to approximately 3500 eligible professionals and 62 hospitals participating in the program as of November 2021. Additionally, DMAHS continues to administer milestone based Promoting Interoperability Program for Substance Use Disorder (SUD) facilities in collaboration with the Department of Health and the Division of Mental Health and Addiction Services. As of December 2021, there are 77 actively engaged SUD facilities that have received a total of $1.43 million in milestone payments. Originally slated to end in March 2021, the program was approved for an extension until June 2023. New Jersey's SUD Promoting Interoperability Program is a novel strategy in the behavioral health information technology field, a number of States have requested information on this program and it had been requested to be presented in federal meetings including CMS and the Medicaid and CHIP Payment and Access Commission.

With the HITECH program in its sunset year in 2021, DMAHS has funded and accomplished a number of successful HIT use cases and initiatives. The program kept the eligible professionals engaged in the Medicaid Promoting Interoperability (previously Meaningful Use) program and assisted them with resources and tools in the final attestation years. Despite the pandemic disruptions and challenging Stage 3 Promoting Interoperability Program requirements, New Jersey received a total of 164 attestations from eligible professionals for final CY 2021 attestation. Expansion of the providers/facilities onboarding and connectivity to New Jersey's Health Information Network (NJHIN), the State HIE, continued through 2021. As of September 2021, NJHIN onboarded more than 18,000 providers across over 200 organizations, 71 hospitals and over 350 long term care facilities. In addition to Admission, Discharge and Transfer (ADT) notifications, NJHIN started a use case to serve as a conduit for transition of care to share clinical information among the members onboarded. The program ensured the successful completion of the technical development work and use case deployment for the HIE initiatives funded by HITECH. As of September 2021, NJHIN has successfully completed the development work for Practitioner Orders for Life-Sustaining Treatment (emPOLST) form using mobile technology with NJHIN, developed eConsent Management for behavioral health/substance use disorder providers and connecting perinatal risk assessment (PRA) registry with NJHIN. Through funding and oversight, the program has supported the Department of Health in the infrastructure enhancements of the public health registries such as New Jersey Immunization Information System, Child Lead, Birth/ Death registry and Emergency Medical Services (EMS) registry. DMAHS in partnership with the Division of Consumer Affairs (DCA) and Bamboo Health (formerly known as Appriss) is pursuing similar CMS certification for the continued operations funding of New Jersey Prescription Monitoring Program (NJPMP).

Quality Improvement Program– New Jersey (QIP-NJ)

To support continued population health improvement across NJ following the conclusion of the Delivery System Reform Incentive Payment (DSRIP) program, the Department of Health (DOH) implemented QIP-NJ on July 1, 2021. QIP-NJ was originally proposed to run for five years, from July 1, 2020, through June 30, 2025. However, due to the impacts of COVID-19, DOH delayed the implementation of QIP-NJ by one year to July 1, 2021. As a result of this delay, CMS approved a time-limited directed payment to support the financial stability

of acute care hospitals. The time-limited directed payment, known as the QIP-NJ "Bridge" payment, was approved by CMS on September 17, 2020, as a Section 438.6(c) Preprint and requires each of the state's Medicaid Managed Care Organizations (MMCOs) to issue a per diem add-on payment to hospital inpatient claims across several proposed classes of providers.

QIP-NJ, submitted by DOH and the Department of Human Services (DHS) via a Section 438.6(c) Preprint, was approved by CMS on May 20, 2021. DOH envisions QIP-NJ to be a multiyear program and is actively working with CMS to renew the program for future years. Please see the table below for information on QIP-NJ's measurement years (MYs). QIP-NJ is being administered by DOH, in partnership with DHS, as a Medicaid pay-for-performance initiative open to all acute care hospitals in the state. The primary purpose of QIP-NJ is to advance quality improvements in acute care hospitals for their Medicaid Managed Care (MMC) population in the domains of behavioral health (BH) and maternal health. Hospitals will earn QIP-NJ incentive payments through the achievement of performance targets on state-selected quality measures that demonstrate:

- Improvements in connections to BH services;
- Reductions in potentially preventable utilization for the BH population;
- Improvements in maternal care processes; and
- Reductions in maternal morbidity.

MY0 (Baseline)	**July 1, 2020 – December 31, 2020**
MY1	**July 1, 2021 – December 31, 2021**
MY2	**January 1, 2022 – December 31, 2022**
MY3	**January 1, 2023 – December 31, 2023**
MY4	**January 1, 2024 – December 31, 2024**
MY5	**January 1, 2025 – December 31, 2025**

In addition to the QIP-NJ BH and Maternal Health Performance-Based Section 438.6(c) Preprints, DOH also submitted a targeted MY1 Bridge Payment 438.6(c) Preprint, for the period of July 1, 2021, through December 31, 2021. DOH is directing this one-time payment arrangement to help ensure that hospitals with a high Relative Medicaid Percentage (RMP) have funding for continued response and recovery resulting from the COVID-19 pandemic, as well as to promote better access to care for Medicaid managed care members in light of the COVID-19 pandemic.

Maternal/Child Health

Aligning with the NurtureNJ campaign of First Lady Tammy Murphy, New Jersey (NJ) continues its work towards improving the state's maternal and infant health outcomes-with a focus on racial disparities. NJ's 2021 maternal health initiatives include:

- Starting in January 2021, NJ FamilyCare ended reimbursement of labor and delivery-related professional and facilities claims associated with Early Elective Deliveries. Early elective deliveries are medically unnecessary C-section and inductions prior to 39 weeks. For more information, please see N.J. P.L.2019, c.87.
- Starting in January 2021, reimbursement of prenatal care for the pregnant member covered by NJ FamilyCare became contingent on the completion of a Perinatal Risk Assessment (PRA). The PRA is a uniform screening tool that aids the obstetrical provider in identifying the member's medical and social needs, supports NJ's Medicaid MCOs in pregnancy risk stratification, and facilitates referrals for some Community Based resources. Completion of the PRA is now a reimbursable service. In 2021, NJ Medicaid participated in the PRA Revision Review committee convened by Family Health Initiatives to recommend updates to the PRA. For more information, please see N.J. P.L.2019, c.88.

- Starting in January 2021, perinatal doula care became a covered NJ FamilyCare benefit. Community doulas provide culturally competent, non-clinical, emotional, physical, and informational support throughout the perinatal period to the birthing individual. Doula care can be associated with positive birthing experiences and improved birth-related outcomes. NJ Medicaid is supporting the activities of the recently launched Doula Learning Collaborative. The Collaborative is funded by NJ's Department of Health to provide professional support for community doulas in the state, including those serving Medicaid members. The Collaborative will continue the stakeholder work NJ Medicaid initiated with community doulas around this benefit in 2019. For more information, please see NJ P.L.2019, c.85 and https://www.state.nj.us/humanservices/dmahs/info/doula.html.
- Starting in January 2021, NJ FamilyCare increased the reimbursement rate for certain certified nurse midwife services related to labor and delivery to 95% of the non-specialist physician rate. Midwifery care is associated with improved maternal and infant birth outcomes.
- Starting in April 2021, NJ FamilyCare clarified and strengthened its current coverage of breast pump equipment to reduce barriers to timely pump access and ensure a range of equipment is available to members. Improved health outcomes for both parent and infant are associated with breastfeeding and breastmilk feeding. For more information, please see NJ P.L.2019, c.343.
- NJ FamilyCare's perinatal episode of care is a three-year pilot to test a new alternative payment model for prenatal, labor, and postpartum services statewide. The pilot is supported by the recommendations of the Episode of Care Steering Committee. Participation in the voluntary pilot is available to NJ FamilyCare providers of obstetrical care. Participating providers are financially incentivized to take on comprehensive responsibility for the quality and cost of their patients' care, from the prenatal period to 60 days postpartum. Participating providers will also receive detailed personalized feedback on their performance. Launching in 2022, Performance Period 1 will run from April 1, 2022—June 30, 2023. For more information, please see NJ P.L.2019, c.86 and https://www.nj.gov/humanservices/dmahs/info/perinatalepisode.html.

NJ's 2021 child health initiatives include:

- The NJ Integrated Care for Kids (NJ InCK) Model will be available to pediatric members residing in Ocean and Monmouth counties. NJ Medicaid is supporting the NJ InCK Model implementation being led by Hackensack Meridian Health and others ("the NJ InCK Grantees"). The NJ InCK Grantees received funding through a cooperative agreement from the federal Center for Medicare and Medicaid Innovation to implement the InCK Model in NJ. This Model is a population-based intervention that identifies children with significant health complexity through preventive screening, and offers voluntary, family-centered and community-based care coordination for those children. NJ FamilyCare is now covering these NJ InCK-related services through a state payment model designed by the NJ InCK Grantees. This initiative was effective January 2022. For more information, please see https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model.

Medicaid Innovator Accelerator Program (IAP) Value Based Purchasing (VBP): Home and Community Based Services (HCBS)

The goal for this IAP opportunity was to support states as they design, develop, and implement Medicaid VBP models and/or enhance and expand existing state Medicaid payment reform. The one-on-one technical support program included peer-to-peer learning opportunities and tailored coaching focused on two key objectives:

- Building state knowledge and capacity to design a VBP strategy for HCBS; and
- Moving states toward implementation of a VBP strategy for HCBS.

New Jersey's goal for this IAP opportunity is to incentivize Managed Care Organizations (MCOs) to (1) better document the type, scope, frequency, amount and duration of HCBS in member services plans, and (2)

produce more timely, accurate, and valid claims reporting that corroborate the details for HCBS in the service plan. NJ aims to improve the delivery of services and member satisfaction/experience for community-dwelling individuals receiving HCBS.

A Scope of Work for a VBP initiative was created by the External Quality Review Organization (EQRO) in 2019 which incorporated MLTSS Performance measures from the HCBS Care Management Audit in addition to PM #13 – MLTSS/HCBS services delivered in accordance with the Plan of Care, including the type, scope, amount, frequency, and duration. Feedback on the Scope of Work was offered by the coaching team and incorporated into the EQRO'S Scope of Work for this initiative. The Technical Assistance (TA) for the VBP for HCBS ended in July 2019. Phase 1 of the VBP was initiated in 2020 and concluded in late 2021. Phase 2 began in late 2021 and remains ongoing.

VBP MLTSS Service Delivery

In late 2021, Phase 1 of the MLTSS Service Delivery Project concluded. Due to challenges encountered during Phase 1, the methodology was revised based upon the recommendation of the EQRO. The study now evaluates a 12 month measurement period rather than two six month measurement periods. Additionally DMAHS made the decision to not evaluate the January 1, 2019 to December 31, 2019 timespan due to the protracted amount of time it took to complete Phase 1.

Phase 2 of the 2021 VBP MLTSS Service Delivery is based on the measurement period of January 1, 2020 to December 1, 2020 and evaluates the delivery of heavily-utilized MLTSS services to members compared with services identified in the Plan of Care (POC), for HCBS members enrolled in the Medicaid Managed Care MLTSS program. The MLTSS utilized services assessed in this methodology are: Home Delivered Meals, Medical Day Care, Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). In addition to evaluating the delivery of services in accordance with the POC, MCOs are evaluated against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS; PM #10: Plans of Care aligned with members needs based on the results of the NJ Choice Assessment; and PM #11: Plans of Care developed using "Person-Centered Principles". A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. MCOs are required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation. IPRO is conducting an analysis of POCs in the CM records and comparing the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). Once all of the files pass validation, IPRO will proceed with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflect the claims in their transactional systems. The Primary Source Verification process will occur in 2022.

New Jersey Medicaid Quality Strategy

New Jersey's Medicaid Quality Strategy is currently in draft and is being reviewed by DMAHS leadership. New Jersey's Medicaid Quality Strategy will be submitted to CMS upon completion.

IPRO's Assessment of the New Jersey Medicaid Quality Strategy

IPRO will review the Quality Strategy once DMAHS leadership has finalized it.

Recommendations to New Jersey

IPRO will review the State's Quality Strategy in the next ATR.

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

In accordance with article 4.6.2.Q – PIPs of the NJ FamilyCare Managed Care Contract, MCOs are required to design, implement, and report results for each study topic area defined by DMAHS. IPRO conducted a comprehensive evaluation of each MCO's PIPs to determine compliance with the CMS protocol, "Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Reviews (EQR)." IPRO assessed each PIP for compliance with the relevant review categories for that PIP's submission.

Performance improvement projects (PIPs) are studies that MCOs conduct to evaluate and improve processes of care based on identified barriers. PIPs should follow rigorous methodology that will allow for the identification of interventions that have been proven to improve care. Ideally, PIPs are cyclical in that they test for change on a small scale, learn from each test, refine the change based on lessons learned, and implement the change on a broader scale. For example, spreading successes to the entire MCO's population. Periodic remeasurement should be undertaken to continually evaluate the effectiveness of the interventions implemented and to ensure that the gains have been sustained over time.

For January 2021-December 2021, this ATR includes IPRO's evaluation of the April 2021 and August 2021 PIP report submissions, final PIP submission, and Fall 2021 PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. The MCOs will continue to submit project updates in April and August progress reports each year.

In June 2021, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO reviewed requirements for the September 2021 PIP proposals for the new Core Medicaid PIPs. The training (held via virtual platform due to COVID-19) focused on PIP Development, Implementation, and current PIP issues.

Title 42 CFR § 438.356(a)(1) and *42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, the DMAHS contracted with IPRO to validate the PIPs that were underway in 2021 **(Table 4).** Unless indicated as non-clinical, those PIPs are clinical. PIPs that are at the final report stage or proposal are noted.

Table 4: Core Medicaid and MLTSS PIP Topics

MCO	MCO PIP Title(s)[1]	State Topic
Aetna Better Health of New Jersey (ABHNJ)	**PIP 1:** Improving Developmental Screening and Referral Rates to Early Intervention for Children – (Core Medicaid - Final)	**EPSDT- Developmental Screening and Early Intervention**
	PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors**
	PIP 3: Improving Access and Availability to Primary Care for the Medicaid Population (Non-Clinical – Core Medicaid - Proposal)	**Access and Availability (Non-Clinical)**
	PIP 4: Increasing Early and Periodic Screening Diagnostic and Treatment (EPSDT) Visits and Childhood Immunizations (Core Medicaid Proposal)	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Child Visits Childhood Immunization**

MCO	MCO PIP Title(s)[1]	State Topic
	PIP 5: Reduction in ER and IP Utilization Through Enhanced Chronic Disease Management (MLTSS)	**Gaps in Care for MLTSS Population**
	PIP 6: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population (MLTSS - Proposal)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**
Amerigroup New Jersey, Inc. (AGNJ)	**PIP 1**: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services for Members < 3 Years Old (Core Medicaid - Final)	**EPSDT- Developmental Screening and Early Intervention**
	PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors**
	PIP 3: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members (Non-Clinical – Core Medicaid)	**Access and Availability (Non-Clinical)**
	PIP 4: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months (Core Medicaid - Proposal)	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Child Visits** **Childhood Immunization**
	PIP 5: Decreasing Gaps in Care in Managed Long-Term Services and Supports (MLTSS)	**Gaps in Care for MLTSS Population**
	PIP 6: Prevention of Falls in the Managed Long-Term Services and Supports (MLTSS) Population	**Falls Prevention for the MLTSS Population**
	PIP 7: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population (MLTSS - Proposal)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**
Horizon NJ Health (HNJH)	**PIP 1:** Developmental Screening and Early Intervention in Young Children	**EPSDT- Developmental Screening and Early Intervention**
	PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors**
	PIP 3: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits – Core Medicaid Membership. (Non-Clinical – Core Medicaid)	**Access and Availability (Non-Clinical)**
	PIP 4: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population. (Core Medicaid – Proposal)	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Child Visits** **Childhood Immunization**
	PIP 5: Reducing Admissions, Readmissions and Gaps in Services for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting Population – (MLTSS)	**Gaps in Care for MLTSS Population**
	PIP 6: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Population (MLTSS - Proposal)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**

MCO	MCO PIP Title(s)[1]	State Topic
UnitedHealthcare Community Plan (UHCCP)	**PIP 1:** Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old) (Core Medicaid – Final)	**EPSDT- Developmental Screening and Early Intervention**
	PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors**
	PIP 3: Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members (Non-Clinical – Core Medicaid)	**Access and Availability**
	PIP 4: Improving Frequency of Well Visits in the First 30 months of Life and Compliance with Immunizations (Core Medicaid - Proposal)	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Child Visits Childhood Immunization**
	PIP 5: Improving Influenza and Pneumococcal Immunization Rates and timely PCA Service in the Managed Long-Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population – (MLTSS)	**Gaps in Care for MLTSS Population**
	PIP 6: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS - Proposal)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in t the MLTSS HCBS Population**
WellCare Health Plans of New Jersey, Inc. (WCHP)	**PIP 1:** Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age (Core Medicaid - Final)	**EPSDT- Developmental Screening and Early Intervention**
	PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors**
	PIP 3: Medicaid Primary Care Physician Access and Availability (Non-Clinical – Core Medicaid)	**Access and Availability**
	PIP 4: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations (Core Medicaid)	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Child Visits Childhood Immunization**
	PIP 5: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis (MLTSS)	**Gaps in Care for MLTSS Population**
	PIP 6: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**

[1] Includes performance improvement projects (PIPs) that started, are ongoing, and/or were completed in the review year.

Technical Methods of Data Collection and Analysis

IPRO's validation process begins at the PIP proposal phase and continues through the life of the PIP. During review of the PIPs, IPRO provides technical assistance, in the form of feedback, to each MCO.

IPRO assessed each PIP for compliance with the relevant review categories for that PIP's submission. The review categories are listed below. All elements from CMS Protocol 1 are included in the review.

Review Element 1: Topic and Rationale
Review Element 2: Aim
Review Element 3: Methodology:
- Study Population
- Study Indicator
- Sampling

Review Element 4: Barrier Analysis
Review Element 5: Robust Interventions:
- Improvement Strategies

Review Element 6: Results Table:
- Data Collection

Review Element 7: Discussion and Validity of Reported Improvement:
- Likelihood of real improvement

Review Element 8: Sustainability
Review Element 9: Healthcare Disparities (not included in scoring)

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. Specific to New Jersey, each PIP is then scored based on the MCO's compliance with elements 1–8 (listed above). The element is determined to be "met", "partial met" or "not met". Compliance levels are assigned based on the number of points (or percentage score) achieved. **Table 5** displays the compliance levels and their applicable score ranges.

Table 5: PIP Validation Scoring and Compliance Levels

IPRO Validation Level	CMS Rating	Scoring Range	Compliance Score Range Criteria
Met	High	≥ 85%	The MCO has demonstrated that it addressed the requirement.
Partial Met	Moderate	60%-84%	The MCO has demonstrated that it addressed the requirement, however not in its entirety.
Not Met (Non-compliant)	Low	Below 60%	The MCO has not addressed the requirement.
NA			Unable to evaluate performance at this time.

IPRO provided PIP report templates to each MCO for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Conclusions and Comparative Findings

IPRO reviewed the August 2021 Submission Reports and provided scoring and suggestions to the MCOs to enhance their studies. IPRO reviewed the 2021 September Proposals for the five (5) MCOs and provided feedback on how to enhance the studies. Current MCO specific PIP scoring reports along with IPRO findings can be found in **Appendix A**.

Table 6: PIP State Topic #1: Core Medicaid Developmental Screening and Early Intervention

New Jersey MCO PIP Scoring Report Developmental Screening and Early Intervention (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final Report	AGNJ Final Report	HNJH Final Report	UHCCP Final Report	WCHP Final Report
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	PM
1b. Impacts the maximum proportion of members that is feasible	PM	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**PM**	**M**	**M**	**M**	**PM**
Element 1 Overall Score	**50**	**100**	**100**	**100**	**50**
Element 1 Weighted Score	**2.5**	**5.0**	**5.0**	**5.0**	**2.5**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	PM	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	PM	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M

New Jersey MCO PIP Scoring Report Developmental Screening and Early Intervention (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final Report	AGNJ Final Report	HNJH Final Report	UHCCP Final Report	WCHP Final Report
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**PM**	**M**	**PM**	**M**	**M**
Element 3 Overall Score	**50**	**100**	**50**	**100**	**100**
Element 3 Weighted Score	**7.5**	**15.0**	**7.5**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	PM	M	M	M	PM
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**PM**	**M**	**M**	**M**	**PM**
Element 4 Overall Score	**50**	**100**	**100**	**100**	**50**
Element 4 Weighted Score	**7.5**	**15.0**	**15.0**	**15.0**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	PM	M	M	M
Element 5 Overall Review Determination	**PM**	**PM**	**M**	**M**	**M**
Element 5 Overall Score	**50**	**50**	**100**	**100**	**100**
Element 5 Weighted Score	**7.5**	**7.5**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**

New Jersey MCO PIP Scoring Report Developmental Screening and Early Intervention (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final Report	AGNJ Final Report	HNJH Final Report	UHCCP Final Report	WCHP Final Report
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	PM	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**10.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	M	M	M	M	M
Element 8 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 8 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 8 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**65**	**92.5**	**92.5**	**100.0**	**90.0**
Validation Rating Percent	**65.0%**	**92.5%**	**92.5%**	**100%**	**90%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**Moderate**	**High**	**High**	**High**	**High**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 7: PIP State Topic #2: Core Medicaid Adolescent Risk Behaviors and Depression

New Jersey MCO PIP Scoring Report Adolescent Risk Behaviors and Depression (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ SY	AGNJ SY	HNJH SY	UHCCP SY	WCHP SY
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	PM	M	M	M	M
Element 2 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**2.5**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M

New Jersey MCO PIP Scoring Report Adolescent Risk Behaviors and Depression (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ SY	AGNJ SY	HNJH SY	UHCCP SY	WCHP SY
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	PM
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	PM	M	M	PM
Element 5 Overall Review Determination	**PM**	**PM**	**M**	**M**	**PM**
Element 5 Overall Score	**50**	**50**	**100**	**100**	**50**
Element 5 Weighted Score	**7.5**	**7.5**	**15.0**	**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	PM	M	M	M	M
Element 6 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**2.5**	**5.0**	**5.0**	**5.0**	**5.0**

New Jersey MCO PIP Scoring Report Adolescent Risk Behaviors and Depression (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ SY	AGNJ SY	HNJH SY	UHCC P SY	WCHP SY
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	PM	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	PM	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**PM**	**PM**	**M**	**M**	**M**
Element 7 Overall Score	**50**	**50**	**100**	**100**	**100**
Element 7 Weighted Score	**10.0**	**10.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	PM	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	M	M	M	M	M
Element 8 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 8 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 8 Weighted Score	**10.0**	**20.0**	**20.0**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N**	**N**	**Y**	**Y**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**67.5**	**82.5**	**100.0**	**100.0**	**85.0**
Validation Rating Percent	**67.5%**	**82.5%**	**100%**	**100%**	**85.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**Moderate**	**Moderate**	**High**	**High**	**High**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 8: PIP State Topic #3: Core Medicaid Primary Care Providers Access and Availability

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ Proposal[1]	AGNJ MY 1	HNJH MY 1	UHCCP MY 1	WCHP MY 1
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	N/A	M	M	PM	M
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M	M
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M	M
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**PM**	**M**
Element 1 Overall Score	**N/A**	**100**	**100**	**50**	**100**
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**2.5**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	PM	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M
2c. Objectives align aim and goals with interventions	N/A	PM	M	M	M
Element 2 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**
Element 2 Overall Score	**N/A**	**50**	**100**	**100**	**100**
Element 2 Weighted Score	**N/A**	**2.5**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM	M	M	PM
3b. Performance Indicators are measured consistently over time	N/A	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	PM	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Proposal[1]	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	PM	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**	**M**	**PM**
Element 3 Overall Score	**N/A**	**50**	**50**	**100**	**50**
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**15.0**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	PM	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**
Element 4 Overall Score	**N/A**	**50**	**100**	**100**	**100**
Element 4 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M	M	M
5b. Actions that target member, provider and MCO	N/A	M	M	M	M
5c. New or enhanced, starting after baseline year	N/A	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	PM	M	PM
Element 5 Overall Review Determination	**N/A**	**M**	**PM**	**M**	**PM**
Element 5 Overall Score	**N/A**	**100**	**50**	**100**	**50**
Element 5 Weighted Score	**N/A**	**15.0**	**7.5**	**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M	M
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Proposal[1]	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N/A**	**N**	**N**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**N/A**	**62.5**	**65.0**	**77.5**	**65.0**
Validation Rating Percent	**N/A**	**78.1%**	**81.3%**	**96.9%**	**81.3%**
Validation Status	**No**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**N/A**	**Moderate**	**Moderate**	**High**	**Moderate**

[1]ABHNJ is at the proposal stage for this PIP and will be scored in MY 1.

Element 8 is not scored during measurement years 1 and 2.

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 9: PIP State Topic #4: Core Medicaid EPSDT Well Child Visits, Childhood Immunizations

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations[1] (Proposal) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	N/A	N/A	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	N/A	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	N/A	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	N/A	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	N/A	N/A	N/A	N/A
Element 1 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	N/A	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	N/A	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	N/A	N/A	N/A	N/A
Element 2 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	N/A	N/A	N/A	N/A
3b. Performance Indicators are measured consistently over time	N/A	N/A	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	N/A	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	N/A	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	N/A	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations[1] (Proposal) (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**WCHP**
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
Element 3 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	N/A	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	N/A	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	N/A	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	N/A	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	N/A	N/A	N/A	N/A
4f. Literature review	N/A	N/A	N/A	N/A	N/A
Element 4 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	N/A	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	N/A	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	N/A	N/A	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	N/A	N/A	N/A	N/A
Element 5 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	N/A	N/A	N/A	N/A
Element 6 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations[1] (Proposal) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	N/A	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **N/A = Not Applicable**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Validation Rating Percent	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Validation Status	**No**	**No**	**No**	**No**	**No**
Validation Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

[1]Scoring will occur in Measurement Year 1. In the current review period all MCOs are at the proposal stage.
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 10: PIP State Topic #5: MLTSS Gaps In Care

New Jersey MCO PIP Scoring Report MLTSS Gaps In Care (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ -SY	**AGNJ -SY**	**HNJH -SY**	**UHCCP-SY**	**WCHP -SY**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	PM	M

New Jersey MCO PIP Scoring Report MLTSS Gaps In Care (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ -SY	AGNJ -SY	HNJH -SY	UHCCP-SY	WCHP -SY
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**PM**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**50**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**7.5**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	PM	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**7.5**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	PM	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	PM	M	PM	M
Element 5 Overall Review Determination	**PM**	**PM**	**M**	**PM**	**M**
Element 5 Overall Score	**50**	**50**	**100**	**50**	**100**
Element 5 Weighted Score	**7.5**	**7.5**	**15.0**	**7.5**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item					

New Jersey MCO PIP Scoring Report MLTSS Gaps In Care (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ -SY	AGNJ -SY	HNJH -SY	UHCCP-SY	WCHP -SY
7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	PM	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	PM	PM	PM	M	PM
Element 7 Overall Review Determination	**PM**	**PM**	**PM**	**M**	**PM**
Element 7 Overall Score	**50**	**50**	**50**	**100**	**50**
Element 7 Weighted Score	**10.0**	**10.0**	**10.0**	**20.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	M	PM	M	M	M
Element 8 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 8 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 8 Weighted Score	**20.0**	**10.0**	**20.0**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	N	N	N	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**82.5**	**65..0**	**90.0**	**85.0**	**90.0**
Validation Rating Percent	**82.5%**	**65.0%**	**90.0 %**	**85.0%**	**90.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**Moderate**	**Moderate**	**High**	**Moderate**	**High**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 11: PIP State Topic #6: MLTSS Fall Prevention

New Jersey MCO PIP Scoring Report Falls Prevention[1] (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ	AGNJ -SY	HNJH	UHCCP	WCHP
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	M	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	M	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	N/A	N/A	N/A
Element 1 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**N/A**	**5.0**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	M	N/A	N/A	N/A
Element 2 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**N/A**	**5.0**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	N/A	N/A	N/A
3b. Performance indicators are measured consistently over time	N/A	M	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report Falls Prevention[1] (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ	AGNJ -SY	HNJH	UHCCP	WCHP
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	N/A	N/A	N/A
Element 3 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**N/A**	**15.0**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	N/A	N/A	N/A
4f. Literature review	N/A	M	N/A	N/A	N/A
Element 4 Overall Review Determination	**N/A**	**PM**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**N/A**	**50**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**N/A**	**7.5**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	M	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	N/A	M	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	N/A	N/A
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**N/A**	**50**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**N/A**	**N/A**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	N/A	N/A	N/A
Element 6 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 6 Weighted Score	**N/A**	**5.0**	**N/A**	**N/A**	**N/A**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item					

New Jersey MCO PIP Scoring Report Falls Prevention[1] (SY = Sustainability Year) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ	AGNJ -SY	HNJH	UHCCP	WCHP
7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	PM	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	M	N/A	N/A	N/A
Element 7 Overall Review Determination	**N/A**	**PM**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**N/A**	**50**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**N/A**	**10.0**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	M	0	0	0
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	M	0	0	0
Element 8 Overall Review Determination	**N/A**	**M**	**0**	**0**	**0**
Element 8 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**20.0**	**0.0**	**0**	**0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N/A**	**N**	**N/A**	**N/A**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**75.0**	**N/A**	**N/A**	**N/A**
Validation Rating Percent	**N/A**	**75.0%**	**N/A**	**N/A**	**N/A**
Validation Status	**No**	**YES**	**No**	**No**	**No**
Validation Rating	**N/A**	**Moderate**	**N/A**	**N/A**	**N/A**

[1]AGNJ is the only MCO that has this PIP in progress. All other MCOs completed this project in a prior review cycle.
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 12: PIP State Topic #7: MLTSS Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population[1] (Proposal) (Clinical)	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	N/A	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	N/A	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	N/A	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	N/A	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	N/A	N/A	N/A	N/A
Element 1 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	N/A	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	N/A	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	N/A	N/A	N/A	N/A
Element 2 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	N/A	N/A	N/A	N/A
3b. Performance indicators are measured consistently over time	N/A	N/A	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	N/A	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	N/A	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	N/A	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population[1] (Proposal) (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**WCHP**
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
Element 3 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	N/A	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	N/A	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	N/A	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	N/A	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	N/A	N/A	N/A	N/A
4f. Literature review	N/A	N/A	N/A	N/A	N/A
Element 4 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	N/A	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	N/A	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	N/A	N/A	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	N/A	N/A	N/A	N/A
Element 5 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	N/A	N/A	N/A	N/A
Element 6 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population[1] (Proposal) (Clinical)	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**WCHP**
Element 6 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Validation Rating Percent	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Validation Status	**No**	**No**	**No**	**No**	**No**
Validation Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

[1]Scoring will occur in Measurement Year 1. In the current review period all MCOs are at the proposal stage.
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 13 presents comparative performance for all MCOs across all PIP topics. PIP topics #4 and #7 are at the proposal stage for all MCOs and will be scored in Measurement Year (MY) 1. PIP topic #3 is at the proposal stage for ABHNJ and will be scored in MY 1. PIP Topic #6 was completed in a prior review cycle for all MCOs except AGNJ.

Table 13: 2021 PIP Validation Results

MCO Compliance Level	PIP 1[1]	PIP 2[1]	PIP 3[1,3]	PIP 4[1]	PIP 5[2]	PIP 6[2]	PIP 7[2]
	Early Intervention & developmental Screening	Adolescent Risk and Behaviors	Access and Availability (Non-Clinical)	EPSDT – Well Child Visits & Childhood Immunizations (Proposal)	Gaps in Care for MLTSS Population	Falls Prevention for the MLTSS Population (1 MCO)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population (Proposal)
ABHNJ	65.0%	67.5%	N/A	N/A	82.5%	N/A	N/A
AGNJ	92.5%	82.5%	78.1%	N/A	65.0%	75.0%	N/A
HNJH	92.5%	100%	81.3%	N/A	90.0%	N/A	N/A
UHCCP	100%	100%	96.9%	N/A	85.0%	N/A	N/A
WCHP	90.0%	85.0%	81.3%	N/A	90.0%	N/A	N/A

[1] PIPs 1, 2, 3, and 4 are Core Medicaid PIPs
[2] PIPs 5, 6 and 7 are MLTSS PIPs
[3] ABHNJ is at the proposal stage for this PIP and will be scored in MY 1, Note: ABHNJ is one year behind in the PIP reporting cycle due to a revision in their aim statement and performance indicators.

Strengths

AGNJ - Of the 5 PIPs scored, 1 PIP performed above the 85% threshold indicating high performance.
HNJH – Of the 4 PIPs scored, 3 PIPs performed above the 85% threshold indicating high performance.
UHCCP – Of the 4 PIPs scored, all 4 PIPs performed at or above the 85% threshold indicating high performance.
WCHP – Of the 4 PIPs scored, 3 PIPs performed at or above 85% threshold indicating high performance.

Opportunities for Improvement

ABHNJ – Overall, ABHNJ was partially compliant in presentation of data and analysis of results. There are opportunities for improvement in establishing robust interventions. The MCO has opportunities for improvement in the consistent design and implementation of their PIPs throughout the life cycle of the PIPs.

AGNJ – Overall, AGNJ was partially compliant in presentation of data and analysis of results. There are opportunities for improvement in establishing robust interventions. Opportunities for improvement are also present in terms of in-depth barrier analyses identifying subpopulations throughout the life of the PIP.

HNJN – Overall, HNJH was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions. There are opportunities for improvement in consistency regarding study design and methodologies for data collection.

UHCCP – Overall, UHCCP was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions.

WCHP – Overall, WCHP was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions. There are also opportunities for improvement in the consistent presentation of Intervention Tracking Measures (ITMs) throughout the life cycle of the PIPs.

Core Medicaid - Adolescent Risk Behaviors and Depression Collaborative

All five MCOs participated in the Adolescent Risk Behaviors and Depression Collaborative. For this PIP, common performance indicators were used by all five MCOs. **Table 14** below shows the comparative performance for each MCO.

Table 14: MCO PIP Results – Core Medicaid - Adolescent Risk Behaviors and Depression Collaborative – (2018 - 2021)

Indicators and Reporting Year	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Indicator 1: Tobacco Use					
2018 (Baseline)	63.63%	66.00%	99.05%	39.05%	89.38%
2019 Measurement Year 1 (MY 1)	63.00%	65.00%	99.05%	81.37%	89.52%
2020 Measurement Year 2 (MY 2)	63.00%	67.00%	98.10%	93.33%	98.06%
2021 Sustainability Year 3 (SY 3)	73.08%	N/A	N/A	N/A	N/A
Indicator 2: Alcohol Use					
2018 (Baseline)	55.55%	64.00%	88.57%	31.43%	89.38%
2019 Measurement Year 1 (MY 1)	63.00%	63.00%	98.10%	72.55%	82.86%
2020 Measurement Year 2 (MY 2)	70.00%	67.00%	98.10%	82.86%	97.09%
2021 Sustainability Year 3 (SY 3)	69.23%	N/A	N/A	N/A	N/A
Indicator 3: Drug Use					
2018 (Baseline)	54.54%	56.00%	87.62%	25.71%	89.38%
2019 Measurement Year 1 (MY 1)	61.00%	63.00%	98.10%	66.67%	82.86%
2020 Measurement Year 2 (MY 2)	73.00%	67.00%	98.10%	83.81%	95.15%
2021 Sustainability Year 3 (SY 3)	65.38%	N/A	N/A	N/A	N/A
Indicator 4: Sexual Behavior					
2018 (Baseline)	51.51%	64.00%	67.62%	25.71%	80.53%
2019 Measurement Year 1 (MY 1)	54.00%	63.00%	94.29%	69.61%	85.71%
2020 Measurement Year 2 (MY 2)	63.00%	54.00%	92.38%	82.86%	98.06%
2021 Sustainability Year 3 (SY 3)	53.85%	N/A	N/A	N/A	N/A
Indicator 5: Depression					
2018 (Baseline)	54.54%	75.00%	33.33%	45.71%	76.99%
2019 Measurement Year 1 (MY 1)	78.00%	95.00%	68.57%	82.35%	80.95%
2020 Measurement Year 2 (MY 2)	82.00%	100%	90.48%	91.43%	93.20%
2021 Sustainability Year 3 (SY 3)	76.92%	N/A	N/A	N/A	N/A

NA: No data was available at the time of review for 4 of the 5 MCOs. This project requires medical record retrieval which was complicated by the COVID-19 pandemic.

PIP Strengths:

In 2021, the MCOs continued participation in a Collaborative PIP titled "Adolescent Risk Behaviors and Depression Collaborative". This would be the Sustainability Year in which each MCO exhibited continued efforts to reach the Aim, Objectives, and Goals of the PIP. In the Collaborative meetings, each MCO would share their experiences, ideas, and strategies for outreaching members and providers during the COVID-19

pandemic when restrictions continued regarding home visits, offices reopening and having structured hours of operations, the continuation of Telehealth use, and the need for changes in policies and procedures. In this regard, the Collaborative was able to discuss new questions, ideas, and suggestions of keeping providers up to date regarding Gaps in Care, when possible, and partner to assist the member in keeping up with care concerns or questions throughout the pandemic. Overall, the MCOs experienced growth and learning in their projects throughout 2021.

In 2021, the MCO's participating in the Adolescent Risk Behaviors and Depression Collaborative experienced new ways of outreaching members and providers through the use of Telehealth and virtual meetings. This was noted by the MCOs as an important communication tool in continuing to assist members with their needs. The use of Telehealth can also help providers identify members in need of outreach due to office closures and office reopening times restructured to provide a safe visit to the office, thereby catching up on screenings that may not have been done during the beginning of the COVID-19 Pandemic.

Opportunities for Improvement:
In Sustainability Year 2021, 3 of the 5 MCOs overall experienced the following opportunities:

- Opportunity for improvement in establishing robust interventions.
- Opportunity for improvement regarding the QI process to identify all barriers relative to achieving the goals of the PIP.
- Opportunity for improvement in discussing the extent to which the PIP is successful.

Interventions

All five MCOs engaged in a Core Medicaid collaborative PIP relating to Adolescent Risk Behaviors and Depression. **Table 15** below provides a listing of interventions that each MCO implemented for this project.

Table 15: PIP Interventions Summary 2020–2021 for Adolescent Risk Behaviors and Depression

PIP	Interventions
ABHNJ Adolescent Risk Behaviors and Depression	**Intervention #1c**: Eliza/Health Crowd (Robo Outreach vendor) Adolescent Well Child outreach. Monitor successful outreach to intervention group members as evidence by outreach. **Intervention: #1g**: Complete personalized person to person outreach campaigns while in the provider setting to encourage adherence with AWC care for select provider, provider group and FQHC
	Intervention #1h: Implement state approved AWC incentive program and track adherence based on select provider, provider group and FQHC
	Intervention # 1I: All members will receive an EPSDT mailer encouraging timely well child visits
	Intervention #2a: Develop and train the select provider, provider group, and FQHC on the intent of the performance Improvement project, outline pertinent data representative of adolescent screening rates, provide goals, and discuss the medical record review criteria and MCO support
AGNJ Adolescent Risk Behaviors and Depression	**Intervention #1:** Educate provider quarterly on the importance of one on one time with the adolescent during the members AWC utilizing the University of Michigan's Adolescent Health Initiative
	Intervention #2: Distribute examples of high-risk behavior screening tools quarterly to the engaged providers during educational visits
	Intervention #4: Distribute scorecards to providers via fax annually to review the results of the medical record review which assessed risk behavior screenings
	Intervention #5: Educate the providers on the 5 risk behaviors and resources that are available when they screen positive for any of the screenings
HNJH Adolescent	**Intervention #1a**: This is a two-fold intervention involving a member mailing and provider gap list. It will include a mailing to parents of children ages 12-17 that are due for a well visit. The mailing will

PIP	Interventions
Risk Behaviors and Depression	address the importance of an annual visit, information relating to the four risk factors, the importance of routine screening, and emphasizing child-provider confidentiality to parent/guardians and adolescents assigned to the participating provider practices in Camden and Middlesex counties. Additionally, Providers will receive a gap list for those who were sent the letter and are due for a well-visit. **Intervention #1b:** This is a two-fold intervention involving a member mailing and provider gap list. It will include a mailing to adolescents ages 18-21 that are due for a well visit. The mailing will address the importance of an annual visit, information relating to the four risk factors, and the importance of routine screening assigned to the participating provider practices in Camden and Middlesex counties. Additionally, Providers will receive a gap list for those who were sent the letter and are due for a well-visit.
	Intervention #2a: Initial collaborative meeting with providers and staff at participating practices in Camden and Middlesex counties to discuss practice-related barriers along with an action plan to lessen or alleviate identified barriers. The providers will receive a handbook with information related to the risk behaviors during the initial touchpoint meeting This handbook will include: 1. Suggested screening tools 2. Acceptable billing codes 3. Clinical guidelines 4. Resources for positive screening outcomes Following the initial meeting, quarterly "touchpoint" meetings with practice providers and staff will take place and will focus on progress, newly encountered issues with revisions or additions to action plan. Providers will be audited (with audit tool) on random medical records to measure compliance based on the educational materials provided during the touchpoint visit. **Intervention #2b (Cooper and SP only):** Provide practice with list of acceptable billing codes to utilize when performing screening of adolescent risk behaviors and depression during adolescent well-care visits. *Please note: this intervention does not apply to Princeton Medical Center (PMC) because they do not utilize Current Procedural Terminology (CPT) Codes **Intervention #2c** (Cooper only): Provide practice with list of patients that had a CPT code for a depression screening so the staff can check for positive screenings and documentation of appropriate clinical responses for positive screenings.
	Intervention #3a: Provide participating groups with standardized depression screening tools to utilize and include in screening process. Educate the providers on the American Psychological Association (APA) recommendations for depression and the use of screening tools. Work with groups on a one-on-one basis to implement the use of the standardized tools into the daily workflow. Following the initial meeting, quarterly "touchpoint" meetings with practice providers and staff will take place and will focus on progress, newly encountered issues with revisions or additions to action plan. Providers will be audited (with audit tool) on random medical records to measure compliance based on the educational materials provided during the touchpoint visit.
UHCCP - Adolescent Risk Behaviors and Depression	**Intervention #1c:** Monthly telephonic outreach to all adult members 18 and over or member parent/guardians of adolescents under 18 yrs. in the target member population who are scheduled for an AWC at each of the target practices to educate about the importance of adolescent health screenings and confidentiality during the screening process.
	Intervention #2a (NEW): Quarterly practice visits by quality team to provide staff support and education, reinforce screening recommendations, review coding and reimbursements for adolescent screenings, conduct sample audit, and provide up to date referral resources. In addition, educational handouts that outline the importance of adolescent health screenings and confidentiality during the screening process will be given to the provider to distribute to members presenting to the office for AWC.
	All Providers (A, B, C)

PIP	Interventions
WCHP - Adolescent Risk Behaviors and Depression	**Intervention #1**: Tracking improvement of medical record documentation: #1. Conduct interim medical record review and in-person provider visits in the 3rd and 4th quarters of each measurement year to review the results of the interim medical record review. Up to a maximum of 5 randomly selected medical records will be audited in the 3rd and 4th quarter each measurement year to monitor provider documentation improvement regarding screenings and clinical response management.
	Intervention #2: Targeted providers will document in the medical records when youth-centric educational materials on risk behaviors and depression are distributed to adolescent members/families.
	Intervention# 3: Targeted practice sites will be monitored for provider practice changes as a result of feedback based on medical record review at a quarterly visit by the QI Specialist. The QI Specialist will interview providers of the targeted practices and complete a Provider Site Survey to identify barriers and interventions for improvement based on the results of the medical record review.

PIP scoring summaries, including aim, interventions, results, and validation findings are reported in **Tables 6 - 12** for each MCO.

For the non-collaborative PIPs, interventions are presented below by PIP and by intervention type for each MCO in **Table 16**:

Table 16: Interventions by Type and MCO

Interventions by Type and MCO					
State Topic: Developmental Screening					
	ABHNJ	AGNJ	HNJH	UHC	WCHP
Targeted Member Communication/Education	X	X	X	X	X
General Member Communication/Education			X		
Targeted Provider Communication/Education	X	X	X	X	X
General Provider Communication/Education			X		
Care Management based interventions		X	X	X	X
State Topic: PCP Access & Availability					
	ABHNJ	AGNJ	HNJH	UHC	WCHP
Targeted Member Communication/Education	X	X	X	X	X
General Member Communication/Education					
Targeted Provider Communication/Education	X	X	X		X
General Provider Communication/Education					
Care Management based interventions					
State Topic: EPSDT- Child Immunizations-Well Child Visits (Proposal)					
	ABHNJ	AGNJ	HNJH	UHC	WCHP
Targeted Member Communication/Education	X	X	X	X	X
General Member Communication/Education					
Targeted Provider Communication/Education	X	X	X		X
General Provider Communication/Education			x		
Care Management based interventions			X	X	
State Topic: MLTSS Follow-up after Hospitalization (FUH) (Proposal)					
	ABHNJ	AGNJ	HNJH	UHC	WCHP
Targeted Member Communication/Education			X	X	X

Interventions by Type and MCO					
General Member Communication/Education					
Targeted Provider Communication/Education		X	X		X
General Provider Communication/Education					
Care Management based interventions	X			X	
State Topic: MLTSS Gaps In Care					
	ABHNJ	AGNJ	HNJH	UHC	WCHP
Targeted Member Communication/Education	X	X	X	X	X
General Member Communication/Education					
Targeted Provider Communication/Education		X	X		X
General Provider Communication/Education					
Care Management based interventions		X	X	X	X
State Topic: MLTSS Falls Prevention					
	ABHNJ	AGNJ	HNJH	UHC	WCHP
Targeted Member Communication/Education		X			
General Member Communication/Education					
Targeted Provider Communication/Education		X			
General Provider Communication/Education					
Care Management based interventions		X			

AGNJ is the only MCO that has this PIP in progress. All other MCOs completed this project in a prior review cycle

KEY: X = Intervention in process.

IV. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

IPRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing MMC programs, as detailed in the CFR. To meet these federal requirements, the New Jersey (NJ) Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has contracted with IPRO, an EQRO, to conduct the Review of Compliance with Medicaid and CHIP Managed Care Regulations. The Annual Assessment of MCO Operations determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations in accordance with the requirements of CFR 438.360(a)(1).The Annual Assessment of MCO Operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations. All 5 MCOs participated in a 2021 compliance review; ABHNJ, AGNJ, HNJH, UHCCP and WCHP.

Due to the continued impact of the COVID-19 pandemic, all audits were conducted virtually (offsite). Staff interview questions were not provided prior to the offsite interview. The interview process was a structured process which focused on IPRO's current findings based on the documentation provided prior to the offsite interview. The Plan was provided with an opportunity to clarify responses and to provide requested documentation after the virtual interviews.

Effective 2019, the State moved to a new annual assessment audit cycle: 2 consecutive years of partial audits followed by 1 year of full audit. If the MCO scores less than 85% in the first partial audit, the MCO will have a full audit the following year. In 2021, partial reviews were conducted for ABHNJ, AGNJ, HNJH, and UHCCP, and a full review for WCHP. The reviews evaluated each health plan on 14 standards based on contractual requirements. The Care Management and Continuity of Care standard is reviewed in conjunction with comprehensive file reviews. For the Core Medicaid population, 300 charts are reviewed for each MCO.

The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2021 is outlined in **Table 17.**

Table 17: 2021 Annual Assessment Type by MCO

MCO	Assessment Type
ABHNJ	Partial
AGNJ	Partial
HNJH	Partial
UHCCP	Partial
WCHP	Full

IPRO's findings and results of the Performance Measure Reporting review can be found in **Section V: Validation of Performance Measures** in this report.

Technical Methods of Data Collection and Analysis

IPRO reviewed each MCO in accordance with the 2019 CMS Protocol, "EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."

The review consisted of pre-offsite review of documentation provided by the Plan as evidence of compliance with the 14 standards under review; review of randomly selected files; interviews with key staff; and post-audit evaluation of documentation and audit activities. To assist in submission of appropriate documentation,

IPRO developed the Annual Assessment of MCO Operations Review Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and organized by general topics (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract reference. The submission guide was provided to the Plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was July 1, 2020 to June 30, 2021.

Following the document review, IPRO conducted an interview via WebEx with key members of the MCO's staff. The interview allowed IPRO to converse with MCO staff to clarify questions that arose from the desk review. The interview process also gave the MCO an opportunity to demonstrate how written documentation is implemented and operationalized. In addition, IPRO was able to verify whether documented policies and procedures were actually carried out, providing supportive evidence that each MCO understands the provisions of the Contract.

Description of Data Obtained

IPRO reviewers conducted offsite file reviews for all MCOs. Select files were examined for evidence of implementation of contractual requirements related to credentialing, recredentialing, and utilization management, as well as member and provider grievances and appeals. Separate file sets were selected to review Core Medicaid and MLTSS requirements. File reviews utilized the eight and thirty file sampling methodology established by the NCQA.

During the annual assessment, IPRO considered three key factors (as appropriate) to determine full compliance with each requirement. The factors included:

- ***Policies and Procedures*:** Policies are pre-decisions made by appropriate leadership for the purpose of giving information and direction. Policies establish the basic philosophy, climate, and values upon which the MCO bases all its decisions and operations. Procedures are the prescribed means of accomplishing the policies. Effectively drawn procedures provide an MCO with the guidelines and, where appropriate, the specific action sequences to ensure uniformity, compliance, and control of all policy-related activities. Examples of policies and procedures reviewed by IPRO include grievances, enrollee rights, and credentialing.
- ***Communications:*** These include all mechanisms used to disseminate general information or policy and procedure updates for enrollees, staff, providers, and the community. IPRO reviewed examples of communications that included the MCO's member newsletters, the Provider Manual, website, Notice of Action (NOA) letters, and the Employee Handbook.
- ***Implementation:*** IPRO evaluated documents for evidence that the MCO's policies and procedures have been implemented. IPRO reviewed documents including committee meeting minutes, organizational charts, job descriptions, program descriptions, flow charts, tracking reports, and file reviews as applicable.

As a result of the completed process, each reviewed element received a compliance score of Met, Not Met, or Not Applicable. Elements that IPRO designated Not Met also received specific recommendations to help the MCO understand the actions needed to promote compliance in the future. Even high performing organizations can continue to grow and improve. As part of the assessment, IPRO also identified opportunities for improvement (quality improvement suggestions) that had no bearing on overall MCO compliance but could be considered as part of a broader effort towards continuous quality improvement (CQI).

The standard designations and assigned points used are shown in **Table 18.**

Table 18: New Jersey Medicaid Managed Care Compliance Monitoring Standard Designation

Rating	Rating Methodology	Review Type
Total Elements	Total number of elements within this standard.	Full, Partial
Met Prior Year	This element was met in the previous year.	Full, Partial
Subject to Review	This element was subject to review in the current review year.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review year and was met.	Full, Partial
Total Met	In a full review, this element was met among the elements subject to review in the current review year. In a partial review, this element was subject to review and met, or deemed met.	Full, Partial
Not Met	Not all of the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review year, and remains deficient in this review year.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review year, but was met in the current review year.	Full, Partial
Deficiency Status: New	This element was met in the previous review year, but was not met in the current review year.	Full, Partial

Conclusions and Comparative Findings

As part of the Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of the MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these eleven (11) standards be evaluated. **Table 19** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards.

Table 19: Crosswalk of Standards Reviewed by EQRO to the Subpart D and QAPI Standards

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review*
Availability of services	438.206	1 - Access, 2 - Credentialing and Recredentialing, 3 - Administration and Operations	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	1 - 2019-2020 and 2021-2022 2 - 2020-2021 3 - 2019-2020 and 2021-2022
Assurances of adequate capacity and services	438.207	1 - Access	A4	1 - 2021-2022
Coordination and continuity of care	438.208	1 - Care Management and Continuity of Care	CM2, CM7 - CM11, CM14, CM26, CM29, CM34, CM38	1 - 2021-2022
Coverage and authorization of service	438.210	1 - Utilization Management	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	1 - 2019-2020 and 2021-2022
Provider selection	438.214	1 - Credentialing and Recredentialing 2 - Care Management and Continuity of Care	CR2, CR3, CM27	1 - 2019-2020 and 2021-2022 2 - 2021-2022
Confidentiality	438.224	1 - Provider Training and Performance	PT9	1 - 2019-2020 and 2021-2022

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review*
Grievance and appeal systems	438.228	1 - Utilization Management 2- Quality Management	UM16a – UM16d, UM16f-UM16i, QM5	1 - 2021-2022 2 - 2021-2022
Subcontractual relationships and delegation	438.230	1 - Administration and Operations	AO5, AO8–AO11	1 - 2019-2020 and 2021-2022
Practice guidelines	438.236	1 - Quality Assessment and Performance Improvement (QAPI) 2 - Quality Management, 3 - Programs for the Elderly and Disabled	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1 - 2019-2020 and 2021-2022 2 - 2019-2020 and 2021-2022 3 - 2019-2020 and 2021-2022
Health information systems	438.242	1 - Management Information Systems	IS1–IS17	1 - 2019-2020 and 2021-2022
Quality assessment and performance improvement (QAPI)	438.330	1 - Quality Assessment and Performance Improvement (QAPI)	Q1-Q3, Q5-Q9	1 - 2021-2022

The categories QAPI and Care Management and Continuity of Care are reviewed annually.

*Within a three-year cycle, four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a full compliance review in 2019-2020. One MCO (WCHP) had a partial compliance review in 2019-2020.

All 5 MCOs had a partial compliance review in 2020-2021.

Four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a partial compliance review in 2021-2022. One MCO (WCHP) had a full compliance review in 2021-2022.

DMAHS requires specific elements to be reviewed annually.

Of the 228 elements reviewed during the 2021 Core Medicaid and MLTSS Annual Assessments, 81 elements crosswalk to the eleven (11) CMS QAPI Standards. **Table 20** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI Standards identified by CMS.

Table 20: Subpart D and QAPI Standards - Scores by MCO

Subpart D and QAPI Standard	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Availability of services	438.206	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	12	42%	58%	75%	75%	83%
Assurances of adequate capacity and services	438.207	A4	1	0%	100%	100%	100%	100%
Coordination and continuity of care	438.208	CM2, CM7 - CM11, CM14, CM26, CM29, CM34, CM38	11	64%	55%	73%	73%	82%

Subpart D and QAPI Standard	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Coverage and authorization of services	438.210	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	7	71%	100%	100%	100%	100%
Provider selection	438.214	CR2, CR3, CM27	3	100%	100%	100%	100%	100%
Confidentiality	438.224	PT9	1	100%	100%	100%	100%	100%
Grievance and appeal systems	438.228	UM16a – UM16d, UM16f-UM16i, QM5	9	78%	100%	100%	100%	89%
Subcontractual relationships and delegation	438.230	AO5, AO8–AO11	5	100%	100%	100%	100%	100%
Practice guidelines	438.236	Q4 QM1, QM3 ED3, ED10, ED23, ED29	7	100%	100%	100%	100%	100%
Health information systems	438.242	IS1–IS17	17	100%	100%	100%	100%	100%
Quality assessment and performance improvement program	438.330	Q1-Q3, Q5-Q9	8	100%	100%	100%	100%	100%
Total Elements Reviewed			**81**					
Compliance Percentage				**80%**	**88%**	**93%**	**93%**	**94%**

As presented in **Table 20**, all five (5) MCOs participated in the 2021 Compliance Review. A total of 228 elements were reviewed by each MCO for a total of 1,140 elements reviewed overall.

Four (4) of the five (5) New Jersey MCOs showed strong performance in the CMS Subpart D and QAPI Standards. Three of the five MCOs received 100% compliance for 9 of the 11 standard domains. All five (5) MCOs were non-compliant in Availability of services, and Coordination and Continuity of Care. **Table 21** displays a comparison of the overall compliance score for each of the five MCOs from 2020 to 2021. For the review period July 1, 2020–June 30, 2021, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2021 compliance scores from the annual assessment ranged from 91% to 97% (**Table 21**). ABHNJ's compliance score decreased from 97% to 91% in 2021; AGNJ's compliance score decreased from 97% to 96%; HNJH's compliance score decreased from 98% to 96%, UHCCP's compliance score increased from 93% to 94%; WCHP's compliance score remained at 97% (**Table 21**).

In 2021, the average compliance score for three standards (Efforts to Reduce Healthcare Disparities, Enrollee Rights and Responsibilities, and Credentialing and Recredentialing) showed increases ranging from 2 to 4 percentage points (**Table 22**). In 2021, seven standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Committee Structure, Provider Training and Performance, Enrollee Rights and Responsibilities, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for eight standards (Quality Assessment and Performance Improvement, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Utilization Management, Administration and Operations, and Management

Information Systems) remained the same from 2020 to 2021. One standard (Quality Management) decreased 9 percentage points from an average compliance score of 96% in 2020 to 87% in 2021 (**Table 22**). One standard (Access) decreased 8 percentage points from 77% in 2020 to 69% in 2021. In 2021, Access had the lowest average compliance score at 69% (**Table 22**).

Table 21: Comparison of 2020 and 2021 Compliance Scores by MCO

MCO	2020 Compliance %	2021 Compliance %	% Point Change from 2020 to 2021
ABHNJ	97%	91%	-6
AGNJ	97%	96%	-1
HNJH	98%	96%	-2
UHCCP	93%	94%	+1
WCHP	97%	97%	0

Table 22: 2020 and 2021 Compliance Scores by Review Category

Review Category	MCO Average 2020[2]	MCO Average 2021[2]	Percentage Point Change
Care Management and Continuity of Care – Core Medicaid[1]	NA	85%	NA
Care Management and Continuity of Care – MLTSS[1]	NA	94%	NA
Access	77%	69%	-8
Quality Assessment and Performance Improvement	100%	100%	0
Quality Management	96%	87%	-9
Efforts to Reduce Healthcare Disparities	96%	100%	+4
Committee Structure	100%	100%	0
Programs for the Elderly and Disabled	98%	98%	0
Provider Training and Performance	100%	100%	0
Satisfaction	96%	96%	0
Enrollee Rights and Responsibilities	98%	100%	+2
Credentialing and Recredentialing	96%	98%	+2
Utilization Management	97%	97%	0
Administration and Operations	100%	100%	0
Management Information Systems	100%	100%	0
TOTAL[3]	**97%**	**95%**	**-2**

[1] Care Management and Continuity of Care were reviewed and scored independently during the 2020 Core Medicaid and MLTSS HCBS Care Management audits. In 2021, the CM scores were included in the Annual Assessment reports.
[2]MCO Average is the average of the compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP).
[3]Total is the average of compliance scores listed in **Table 22**.

Individual MCO 2021 Annual Assessment scores by element can be found in **Appendix A**.

Figure 2 depicts compliance scores since 2019. Compliance scores for five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) have remained at or above 90% for all three years.

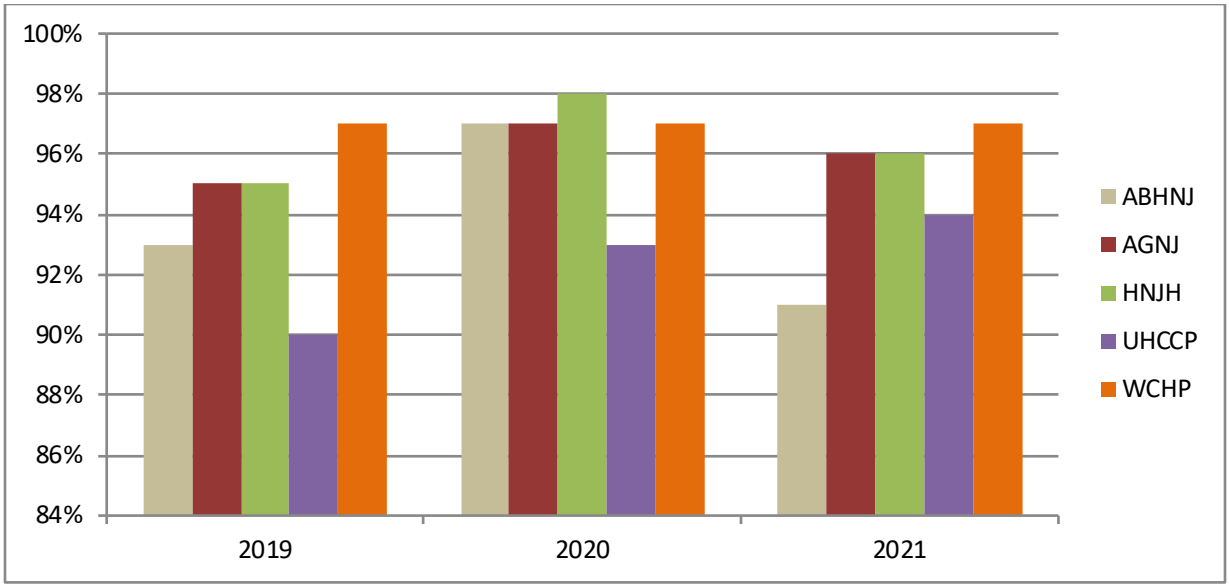

Figure 2: MCO Compliance Scores by Year (2019–2021).
Compliance scores for Aetna Better Health of New Jersey (ABHNJ, grey); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, green), UnitedHealthcare Community Plan (UHCCP, purple); and WellCare Health Plans of New Jersey, Inc. (WCHP, orange) are shown for 2019–2021.

MCO Strengths

The MCO's strengths are the valuable resources, capabilities, and distinguishing characteristics that it has developed or acquired over time. A few of the individual MCO strengths identified as a result of the 2021 annual assessment of MCO operations are listed below:

- The implementation and evaluation of a comprehensive Quality Assessment and Performance Improvement (QAPI) program that meets all of the compliance standards.
- The QAPI program delineates an identifiable committee structure responsible for performing quality improvement activities and demonstrates ongoing initiatives.
- All five MCOs continue to perform well with regard to Committee Structure, Provider Training and Performance, Enrollee Rights and Responsibilities, Administration and Operations, and Management Information Systems.

Opportunities for Improvement

Recommendations represent opportunities for improvement identified by IPRO during the course of the review. The MCO's opportunities for improvement focus on those resources or capabilities of an organization that are deficient and are viewed as shortcomings in its ability or performance. Because some recommendations are smaller in scope and impact, for the purposes of this report, IPRO has focused on areas that are the most common across MCOs and that require follow-up for more than one reporting period.

The following are the most common areas that IPRO recommended for improvement:

- Continue efforts in provider recruitment and improving access to hospitals, dental services, and primary care providers (PCPs) in all counties, including access to and coverage of out-of-network services as necessary;
- Continue to expand the MLTSS network to include at least two providers in every county;
- Continuing to focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers;

- Implement planned interventions in a timely manner to have an effective impact on the outcome of the PIPs;
- Continue to strengthen analytic support and address deficiencies in implementation of the PIPs;
- Develop a comprehensive approach to ensure applicable performance measure documentation is submitted correctly and timely;
- Ensure timely resolution of member and provider grievances and appeals.

V. Validation of Performance Measures

Objectives

The NJ FamilyCare Managed Care Contract article 4.6.2.P requires NJ FamilyCare MCOs to report annually on HEDIS PMs and ambulatory care utilization measures. As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to calculate those measures.

HEDIS is a widely-used set of PMs developed and maintained by NCQA. MCOs annually report HEDIS data to NCQA. HEDIS allows consumers and payers to compare health plan performance on key domains of care to other Plans and to national or regional benchmarks. HEDIS results can also be used to trend year-to-year performance. The MCOs are required by NCQA to undergo an audit of their results to ensure that the methods used to calculate HEDIS and the resultant rates are compliant with NCQA specifications.

Technical Methods of Data Collection and Analysis

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS FAR prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable **(Table 23).** In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used, and medical record review procedures relevant to the calculation of the hybrid measures.

Description of Data Obtained

The five MCOs with performance data for MY 2020 (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) reported HEDIS MY 2020 data. The MCOs' independent auditors determined that the rates reported by the MCOs were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified by the MCOs' independent auditors.

IPRO reviewed each of the New Jersey MCOs' HEDIS MY 2020 FARs to determine compliance with ISCA standards. The FARs revealed that all MCOs met all standards for successful reporting **(Table 23).**

Table 23: MCO Compliance with Information System Standards – MY2020

IS Standard	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
HEDIS Auditor					
1.0 Medical Services Data	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met
2.0 Enrollment Data	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met
3.0 Practitioner Data	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met
4.0 Medical Record Review Processes	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met
5.0 Supplemental Data	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met
6.0 Data Preproduction Processing	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met
7.0 Data Integration and Reporting	Fully Met	Fully Met	Fully Met	Fully Met	Fully Met

MCO: Managed Care Organization; IS: information system; HEDIS: Healthcare Effectiveness Data and Information Set.

Information Systems Capabilities Assessments (ISCA)

In 2020, IPRO worked with DMAHS to customize the ISCA worksheet of the protocols. Four of the five Medicaid MCOs in NJ offered both a Medicaid and a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) product. The fifth Plan began offering the FIDE SNP product in January 2021. In addition to customizing the worksheet for the Medicaid products, it was also modified to include questions relating to the FIDE SNP product. The worksheet was provided to all MCOs on 7/15/2020. All MCOs returned the completed worksheet and requested documentation on 8/12/2020. IPRO conducted a meeting with DMAHS and the MCOs on 8/31/2020 to review the agenda and process. Due to COVID-19 restrictions, the reviews occurred via WebEx.

The assessment covered the following areas:

- Data Integration and Systems Architecture
- Claims/Encounter Data Systems and Processes
- Membership Data Systems and Processes
- Provider Data Systems and Processes
- Oversight of Contracted Vendors
- Supplemental Databases
- Grievance Systems

The Data Integration and Systems Architecture review consisted of a review of the structure of all systems and data warehouses supporting MCO operations and reporting. Claims, eligibility, provider, and grievance systems were directly reviewed. Discussion of oversight of contracted vendors focused on the MCO's ongoing oversight of vendors that process claims for services rendered to MCO members. The review of supplemental databases focused on data sources for services received by the MCO's membership, but not directly or indirectly paid for by the MCO. The structure of the review followed HEDIS audit processes for definitions of contracted vendors and supplemental data sources. No significant systems issues were identified for any of the five MCOs.

All five MCOs undergo a systems review annually as part of their HEDIS audit by an NCQA Licensed Organization. IPRO reviews these results annually.

In 2021, IPRO undertook a detailed review of MCO population definitions for reporting of HEDIS, non-HEDIS Core Set performance measures, and NJ Specific performance measures. This review occurred on the day following the 2021 Annual Assessment compliance reviews.

IPRO's ISCA 2020 review findings and results by MCO are in **Table 24**:

Table 24: Information Systems Capabilities Assessment (ISCA) Results for 2020

MCO	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Standard[1]	Implications of Findings				
Completeness and accuracy of encounter data collected and submitted to the State.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Validation and/or calculation of performance measures.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Completeness and accuracy of tracking of grievances and appeals.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the information system to conduct MCO quality assessment and improvement initiatives.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to conduct MCO quality assessment and improvements initiatives.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to generate complete, accurate, and timely T-MSIS data.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the information system for review of provider network adequacy.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the MCO's information system for linking to other information sources for quality related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications

[1]Managed Care Organization (MCO). Encompasses managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities described in 42 C.F.R. § 438.310(c)(2).

Validation of Performance Measure Reporting Review

The five MCOs in New Jersey report audit HEDIS rates to the State. IPRO reviews the final audits reports and the reported rates. In addition, the MCOs produce NJ specific, adult and child core set measures, and MLTSS specific measures. For these measures, IPRO reviews and validates source code, MLD and reported rates. In addition to these validation processes, IPRO undertook a detailed review of the reporting databases/warehouses used by the MCOs to report all performance measures. This review focused on the MCOs' definition of the populations required for each set of performance measures. The MCOs submitted documentation for review. Interviews were conducted with each MCO on the day after their Annual Assessment of MCO Operations.

The purpose of the individual MCO review was to determine how the populations below are represented in the reporting databases/warehouses. In some instances, they may be excluded by the MCO. In some, they may be included and identified for inclusion or exclusion from specific measures.

The session reviewed databases/warehouses used to report the following:

1. Medicaid HEDIS
2. Medicaid Core Set
3. Medicaid NJ Specific

4. MLTSS HEDIS
5. MLTSS non-HEDIS Claims-Based Performance Measures

For 1 through 3 the following populations were reviewed:

- Non-Dual Core Medicaid
- FIDE SNP
- Non-FIDE SNP Duals with Medicare enrollment with your organization
- Non-FIDE Duals with Medicare enrollment with another organization or FFS
- Core Medicaid with Commercial TPL

For 4 and 5 the following populations were reviewed:

- Core Medicaid MLTSS (Non-FIDE SNP MLTSS)
- FIDE SNP MLTSS

During the review, IPRO asked to see sample members as represented in databases/warehouses. The focus was on eligible populations, not on claims. No direct review of claims in the databases/warehouses was required. With regard to the HEDIS warehouse, IPRO did not review the protocols for loading claims, supplemental data and/or medical record data into the warehouse for reporting.

All MCOs used certified HEDIS software to produce HEDIS measures. The vendor was not required to attend the session. However, it was necessary for the plan representative responsible for loading the HEDIS warehouse and producing the HEDIS measures to have thorough knowledge of how eligibility data are loaded into the warehouse. This includes knowledge of which population subsets are loaded into the warehouse and how subsets of members are identified for inclusion or exclusion from measures as needed.

Following are the results of the Validation of Performance Measure Reporting Review by MCO:

ABHNJ
No issues were noted in the population definitions used to produce Medicaid HEDIS, Medicaid Core Set, and New Jersey specific measures. However, the MCO included all Medicaid members in behavioral health measures where any behavioral health benefit was required. MCOs were requested to include only FIDE SNP members, DDD members, and MLTSS members in the behavioral health measures.

In reporting MLTSS HEDIS and claims-based measures, the MCO excluded members with Medicare dual eligibility with another organization or with fee-for-service Medicare. For MLTSS reporting, all MLTSS members should have been reported.

AGNJ
No issues were noted in the population definitions used to produce Medicaid HEDIS, Medicaid Core Set measures, New Jersey specific measures, MLTSS HEDIS Measures, or MLTSS claims-based measures. The plan does not include FIDE SNP members in Medicaid HEDIS reporting. This is in compliance with their accreditation structure for the Medicaid product and the FIDE SNP product.

HNJH
No issues were noted in the population definitions used to produce Medicaid HEDIS, Medicaid Core Set, and New Jersey specific measures. However, the MCO included all Medicaid members in behavioral health measures where any behavioral health benefit was required. MCOs were requested to include only FIDE SNP members, DDD members, and MLTSS members in the behavioral health measures.

For the Breast Cancer Screening (BCS) measure, Medicare dual eligible members were excluded from the Medicaid HEDIS reporting. This occurred because the Medicare BCS measure requires Socioeconomic Status (SES) stratifications. In setting up these stratifications for Medicare reporting, these members were excluded from the Medicaid report. No other HEDIS measures were impacted.

In reporting MLTSS HEDIS and claims-based measures, the MCO excluded members with Medicare dual eligibility with another organization or with fee-for-service Medicare. For MLTSS reporting, all MLTSS members should have been reported.

UHCCP
No issues were noted in the population definitions used to produce Medicaid HEDIS, Medicaid Core Set measures, New Jersey specific measures, MLTSS HEDIS Measures, or MLTSS claims-based measures.

WCHP
No issues were noted in the population definitions used to produce Medicaid HEDIS, Medicaid Core Set, New Jersey specific measures, MLTSS HEDIS measures, or MLTSS claims-based measures. However, the MCO included all Medicaid members in behavioral health measures where any behavioral health benefit was required. MCOs were requested to include only FIDE SNP members, DDD members, and MLTSS members in the behavioral health measures.

HEDIS MY 2020 Performance Measures

IPRO validated the processes used to calculate the HEDIS PMs and ambulatory care utilization measures by the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP). All of the five MCOs demonstrated the ability to accurately calculate and report the HEDIS measures to NCQA and to the State.

There are 33 required HEDIS Performance Measures on the New Jersey Medicaid Grid. Of these, three (3) measures require a behavioral health benefit with the MCO. Follow-up After Hospitalization for Mental Illness (FUH) requires an inpatient and outpatient mental health benefit. Follow-up After Emergency Department Visit for Mental Illness (FUM) requires any mental health benefit. Follow-up after Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (FUA) requires any chemical dependency benefit. Only DDD, MLTSS and FIDE SNP members have a full behavioral health benefit with the MCOs. For other Medicaid members, MCOs are responsible only for facility claims. The MCOs were instructed to exclude members who did not have a full behavioral health benefit with the MCO from measures requiring any behavioral health benefit. Three plans, Aetna, Horizon, and Wellcare did not apply this exclusion. The FUH measure was not impacted because that measure requires inpatient and outpatient benefits. Therefore, only members with a full behavioral health benefit would be included. However, FUM and FUA included all Medicaid members for these MCOs. These measures require any mental health (FUM) benefit or any chemical dependency (FUA) benefit.

Conclusions and Comparative Findings

All of the five MCOs included their non-FIDE Dual Eligible members in the HEDIS submission, where the MCO was also the MCO for the Medicare product, which followed the NCQA HEDIS MY2020 guidance. However, Horizon excluded these members from reporting for Breast Cancer Screening (BCS) due to the manner in which Medicare members were coded to facilitate the new Medicare demographic breakouts for the BCS measure.

Of the four MCOs with FIDE SNP products, Amerigroup did not include their FIDE SNP members in the HEDIS submission. Amerigroup's accreditation structure does not allow for inclusion of the FIDE SNP population in Medicaid HEDIS reporting.

Horizon, UnitedHealthcare, and WellCare included FIDE SNP in their Medicaid reporting. However, Dual Eligibles, including FIDE SNP members, were excluded from Breast Cancer Screening (BCS) for Horizon. This was due to the manner in which Medicare members were coded to facilitate the new Medicare demographic breakouts for the BCS measure.

Overall, most measures remained constant from MY 2019 to MY 2020 (<5 percentage point change). Significant increases and decreases (≥5 percentage point change) in performance from MY 2019 are noted below. Due to the impact of the Covid-19 pandemic, caution should be exercised in interpreting year-over-year performance for the MCOs.

Improvements in performance from MY 2019 to MY 2020:

- Statin Therapy for Patients with Cardiovascular Disease (SPC)
  - Statin Adherence 80% – 40-75 Years (Female) improved by 7.45 percentage points
  - Statin Adherence 80% – Total improved by 5.97 percentage points
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
  - Counseling for Physical Activity – 3-11 Years improved by 7.04 percentage points
- Follow-Up After Hospitalization for Mental Illness (FUH)
  - 30 Day Follow-Up – 18-64 Years improved by 8.54 percentage points
  - 7 Day Follow-Up – 18-64 Years improved by 5.46 percentage points
  - 30 Day Follow-Up– Total improved by 10.48 percentage points
  - 7 Day Follow-Up – Total improved by 5.83 percentage points
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
  - 30 Day Follow-Up – 18 and Older increased by 11.31 percentage points
  - 7 Day Follow-Up – 18 and Older increased by 7.81 percentage points
  - 30 Day Follow-Up – Total increased by 11.11 percentage points
  - 7 Day Follow-Up – Total increased by 7.67 percentage points
- Asthma Medication Ratio (AMR)
  - 5-11 Years increased by 5.20 percentage points

Decreases in performance from MY 2019 to MY 2020:

- Well Child Visits in the First 15 Months (6 or More Visits) (W15) decreased by 12.01 percentage points
- Cervical Cancer Screening decreased by 5.05 percentage points
- Comprehensive Diabetes Care
  - HbA1c Testing decreased by 8.19 percentage points
  - Eye Exam decreased by 9.08 percentage points
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
  - BMI percentile - 12-17 Years decreased by 5.29 percentage points
  - Counseling for Physical Activity - 12-17 Years decreased by 5.55 percentage points
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing
  - 1-11 Years decreased by 7.13 percentage points
  - 12-17 Years decreased by 8.12 percentage points
  - Total decreased by 7.57 percentage points
- Annual Dental Visits (ADV)
  - 2-3 Years decreased by 16.46 percentage points

- 4-6 Years decreased by 17.07 percentage points
- 7-10 Years decreased by 16.16 percentage points
- 11-14 Years decreased by 15.72 percentage points
- 15-18 Years decreased by 14.45 percentage points
- 19-20 Years decreased by 11.88 percentage points
- Total decreased by 16.02 percentage points

IPRO aggregated the MCO rates for the 33 measures included in the New Jersey Medicaid HEDIS grid and calculated weighted statewide averages to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e). HEDIS rates produced by the MCOs were also reported to the NCQA. Complete Audit Review Tables (ARTs) for each MCO are provided in **Appendix A.**

For this report, the MCOs' reported rates are compared to the NCQA HEDIS MY 2020 Quality Compass national percentiles for Medicaid health maintenance organizations (HMOs) for all measures where the NCQA HEDIS MY 2020 Quality Compass national percentiles are available. The HEDIS rates are color coded to correspond to national percentiles (**Table 25**).

Table 25: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2020 Quality Compass National Percentiles
Red	Below 10th Percentile
Orange	Between 10th and 25th Percentile
Yellow	Between 25th and 50th Percentile
Green	Between 50th and 75th Percentile
Blue	Above 75th Percentile
Purple	No percentiles released by NCQA

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; MY: measurement year.

HEDIS data presented in this section includes: Effectiveness of Care, Overuse/Appropriateness, Access/ Availability of Care, Utilization and Risk Adjusted Utilization, and Electronic Clinical Data System measures. **Table 26** displays the HEDIS performance measures for MY 2020 for all MCOs and the New Jersey Medicaid Average. The Medicaid average is the weighted average of all MCO data.

Table 26: HEDIS MY 2020 Performance Measures

HEDIS MY 2020 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[8]
Childhood Immunization (CIS)						
Combination 2	66.42%	62.77%	71.29%	56.93%	60.10%	65.94%
Combination 3	60.58%	57.66%	62.53%	53.28%	54.01%	59.18%
Combination 9	35.52%	31.14%	40.88%	33.33%	29.93%	37.07%
Lead Screening in Children (LSC)	71.53%	80.05%	71.34%	72.08%	76.30%	72.89%
Well-Child Visits in the First 30 Months of Life (W30)[5]						
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)	60.14%	48.15%	53.88%	43.64%	50.61%	50.72%
Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)	75.51%	77.91%	75.03%	72.87%	76.33%	74.89%

HEDIS MY 2020 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[8]
Child and Adolescent Well-Care Visits (WCV)[6]						
3 - 11 years	61.86%	67.61%	63.42%	63.81%	66.45%	64.10%
12 - 17 years	51.48%	59.61%	56.93%	57.28%	59.10%	57.24%
18 - 21 years	32.06%	40.70%	38.55%	38.55%	37.21%	38.55%
Total Rate	54.27%	61.45%	57.75%	58.23%	59.35%	58.27%
Breast Cancer Screening (BCS)	43.96%	52.75%	55.52%	59.27%	61.09%	56.53%
Cervical Cancer Screening (CCS)	45.26%	56.70%	59.11%	61.80%	52.61%	58.61%
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	75.67%	80.54%	77.86%	84.18%	85.19%	80.36%
HbA1c Poor Control (>9.0%)[1]	45.74%	40.63%	39.42%	37.96%	39.26%	39.29%
HbA1c Control (<8.0%)	46.72%	53.28%	52.31%	53.77%	53.83%	52.74%
Eye Exam	44.53%	46.96%	50.61%	57.42%	57.04%	52.51%
Blood Pressure Controlled <140/90 mm Hg	46.47%	53.53%	58.64%	58.39%	56.05%	57.55%
Controlling High Blood Pressure (CBP)	48.91%	52.07%	54.74%	59.85%	53.77%	55.81%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	65.28%	87.14%	82.74%	83.33%	83.24%
Statin Therapy for Patients with Cardiovascular Disease (SPC)						
21-75 years (Male) - Received Statin Therapy	84.75%	79.96%	81.33%	80.71%	85.42%	81.32%
40-75 years (Female) - Received Statin Therapy	61.40%	74.84%	74.87%	75.66%	80.12%	75.43%
Total - Received Statin Therapy	77.14%	77.85%	78.55%	78.21%	82.59%	78.62%
21-75 years (Male) - Statin Adherence 80%	76.00%	71.35%	77.95%	80.25%	76.59%	78.01%
40-75 years (Female) - Statin Adherence 80%	80.00%	73.95%	76.74%	79.87%	79.63%	78.08%
Total - Statin Adherence 80%	77.04%	72.38%	77.45%	80.07%	78.16%	78.04%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	88.32%	89.29%	79.49%	83.21%	85.89%	82.98%
Postpartum Care	72.51%	78.59%	70.89%	75.91%	67.15%	73.44%
Immunizations For Adolescents (IMA)						
Meningococcal	84.67%	91.48%	92.94%	89.54%	83.21%	91.48%
Tdap/Td	87.10%	94.40%	94.65%	93.19%	89.54%	93.96%
HPV	27.01%	33.09%	32.85%	32.60%	31.14%	32.65%
Combination 1	82.97%	90.02%	91.24%	87.83%	81.75%	89.81%
Combination 2	25.06%	31.14%	31.14%	31.39%	28.47%	31.02%
Appropriate Testing for Pharyngitis (CWP)						
3-17 Years	80.61%	86.49%	72.57%	84.96%	73.73%	78.33%
18-64 Years	42.69%	50.34%	45.19%	53.55%	28.56%	47.19%
65+ Years	NA	20.59%	26.69%	26.29%	10.43%	24.01%
Total	65.78%	76.08%	63.69%	76.19%	54.83%	68.64%
Appropriate Treatment for Upper Respiratory Infection (URI)						
3 Months-17 Years	92.98%	92.83%	91.64%	91.03%	91.00%	91.63%
18-64 Years	66.40%	63.11%	60.91%	60.53%	56.90%	61.00%
65+ Years	60.27%	55.56%	63.47%	49.93%	47.31%	54.24%
Total	86.43%	86.72%	84.32%	83.04%	79.88%	84.13%
Chlamydia Screening (CHL)						
16-20 Years	58.65%	62.63%	54.83%	59.49%	61.57%	57.28%
21-24 Years	66.15%	63.17%	64.88%	65.05%	62.51%	64.67%
Total	63.23%	62.88%	59.38%	61.88%	62.08%	60.66%
Weight Assessment and Counseling for Nutrition and Physical Activity						

HEDIS MY 2020 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[8]
for Children/Adolescents (WCC)						
BMI percentile - 3-11 Years	86.19%	91.34%	87.17%	76.83%	87.68%	85.13%
BMI percentile - 12-17 Years	88.11%	84.08%	80.60%	75.66%	83.06%	79.99%
BMI percentile - Total	86.86%	88.56%	84.72%	76.40%	85.97%	83.21%
Counseling for Nutrition - 3-11 Years	82.09%	84.25%	80.97%	71.04%	83.89%	79.05%
Counseling for Nutrition - 12-17 Years	83.22%	79.62%	74.63%	63.82%	79.03%	72.78%
Counseling for Nutrition - Total	82.48%	82.48%	78.61%	68.37%	82.09%	76.73%
Counseling for Physical Activity - 3-11 Years	77.61%	80.31%	75.66%	66.80%	79.62%	74.25%
Counseling for Physical Activity - 12-17 Years	81.82%	78.98%	69.40%	63.16%	78.23%	69.47%
Counseling for Physical Activity - Total	79.08%	79.81%	73.33%	65.45%	79.10%	72.50%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	45.37%	33.33%	35.18%	38.95%	34.23%	36.13%
Continuation and Maintenance Phase	NA	42.86%	39.44%	41.64%	NA	40.60%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing						
1-11 Years	22.45%	24.52%	15.90%	26.24%	29.55%	19.29%
12-17 Years	32.00%	34.07%	26.33%	40.75%	45.33%	31.19%
Total	28.23%	30.59%	22.32%	36.09%	39.50%	26.81%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	57.09%	56.98%	60.68%	62.44%	58.09%	60.59%
Effective Continuation Phase Treatment	40.78%	41.01%	46.71%	45.66%	44.07%	45.68%
Follow-Up After Hospitalization for Mental Illness (FUH)[7]						
6-17 years - 30-Day Follow-Up	NA	NA	36.59%	NA	NA	42.86%
6-17 years - 7-Day Follow-Up	NA	NA	19.51%	NA	NA	18.57%
18-64 years - 30-Day Follow-Up	41.84%	63.04%	52.75%	46.87%	42.17%	48.57%
18-64 years - 7-Day Follow-Up	30.50%	39.13%	30.72%	27.79%	21.69%	29.22%
65+ years - 30-Day Follow-Up	NA	NA	43.59%	47.54%	NA	44.00%
65+ years - 7-Day Follow-Up	NA	NA	12.82%	26.23%	NA	20.00%
Total - 30-Day Follow-Up	41.61%	56.36%	50.35%	47.43%	42.57%	47.75%
Total - 7-Day Follow-Up	28.86%	32.73%	28.00%	27.52%	21.78%	27.61%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[7]						
6-17 years - 30-Day Follow-Up	NA	NA	77.14%	71.49%	NA	75.56%
6-17 years - 7-Day Follow-Up	NA	NA	67.83%	62.61%	NA	66.35%
18-64 years - 30-Day Follow-Up	71.29%	79.52%	63.53%	59.71%	66.67%	62.92%
18-64 years - 7-Day Follow-Up	61.39%	71.08%	54.41%	51.10%	56.06%	53.91%
65+ years - 30-Day Follow-Up	NA	NA	47.22%	56.45%	NA	56.41%
65+ years - 7-Day Follow-Up	NA	NA	38.89%	43.55%	NA	44.45%
Total - 30-Day Follow-Up	70.94%	79.41%	68.33%	63.82%	66.67%	67.26%
Total - 7-Day Follow-Up	60.68%	70.59%	59.14%	55.01%	55.13%	58.14%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)[7]						
13-17 years - 30-Day Follow-Up	NA	NA	9.24%	11.90%	NA	10.07%
13-17 years - 7-Day Follow-Up	NA	NA	7.07%	8.33%	NA	7.46%
18 and older - 30-Day Follow-Up	26.73%	NA	24.26%	16.89%	7.89%	22.40%
18 and older - 7-Day Follow-Up	20.79%	NA	16.84%	11.78%	3.95%	15.58%
Total - 30-Day Follow-Up	26.73%	NA	23.91%	16.72%	7.89%	22.09%
Total - 7-Day Follow-Up	20.79%	NA	16.61%	11.67%	3.95%	15.38%
Diabetes Screening for People With	76.17%	83.73%	76.06%	84.40%	75.47%	78.73%

HEDIS MY 2020 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[8]
Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	56.02%	67.47%	68.65%	71.64%	71.47%	69.16%
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20-44 Years	64.89%	73.48%	79.09%	78.98%	67.44%	77.13%
45-64 Years	74.56%	80.48%	87.15%	86.95%	83.57%	85.67%
65+ Years	79.90%	80.27%	92.17%	91.64%	92.70%	91.10%
Total	68.60%	76.06%	82.67%	83.63%	77.32%	81.25%
Asthma Medication Ratio (AMR)						
5-11 Years	56.76%	74.21%	75.89%	75.79%	68.85%	75.45%
12-18 Years	63.27%	63.61%	64.44%	68.78%	62.75%	65.31%
19-50 Years	56.00%	53.28%	58.50%	58.40%	44.65%	57.64%
51-64 Years	55.07%	53.48%	58.61%	60.97%	49.30%	58.26%
Total	57.14%	59.44%	63.04%	64.60%	50.93%	62.70%
Annual Dental Visit (ADV)						
2-3 Years	35.54%	29.36%	35.59%	39.65%	31.55%	35.50%
4-6 Years	50.09%	52.27%	54.09%	59.23%	47.31%	54.74%
7-10 Years	54.59%	58.23%	58.32%	63.41%	51.80%	59.28%
11-14 Years	51.06%	54.83%	56.93%	61.23%	48.59%	57.38%
15-18 Years	41.17%	45.92%	50.83%	53.37%	41.80%	50.39%
19-20 Years	32.74%	32.11%	38.14%	39.77%	28.50%	37.25%
Total	46.20%	48.65%	52.07%	56.18%	44.00%	52.24%
Use of Opioids at High Dosage (HDO)[1]	10.55%	13.50%	13.15%	9.58%	7.43%	12.01%
Use of Opioids From Multiple Providers (UOP)[1]						
Multiple Prescribers	16.48%	14.47%	17.98%	11.40%	9.39%	15.78%
Multiple Pharmacies	5.17%	1.31%	1.89%	1.29%	1.49%	1.76%
Multiple Prescribers and Multiple Pharmacies	2.42%	0.37%	0.98%	0.63%	0.74%	0.88%
Risk of Continued opioid Use (COU)[1]						
18-64 years - >=15 Days covered	5.81%	3.68%	7.52%	6.94%	10.97%	7.10%
18-64 years - >=31 Days covered	3.90%	2.58%	4.72%	4.25%	5.48%	4.42%
65+ years - >=15 Days covered	11.90%	6.67%	19.62%	16.56%	17.87%	17.40%
65+ years - >=31 Days covered	11.90%	6.67%	11.16%	8.45%	8.59%	9.36%
Total - >=15 Days covered	5.96%	3.72%	7.86%	7.99%	11.96%	7.63%
Total - >=31 Days covered	4.09%	2.63%	4.90%	4.71%	5.93%	4.67%
Plan All-Cause Readmissions (PCR) [2]						
Index Stays per Year - 18-44	10.11%	10.96%	11.87%	11.15%	11.17%	11.54%
Index Stays per Year - 45-54	10.78%	11.46%	13.09%	11.04%	14.76%	12.51%
Index Stays per Year - 55-64	11.05%	12.36%	13.92%	12.64%	10.44%	13.21%
Index Stays per Year - Total	10.54%	11.49%	12.80%	11.59%	11.73%	12.29%
Observed-to-Expected Ratio	1.01	1.11	1.28	1.14	1.13	
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)[3]						
Total - Total Member Months	292.75	303.65	366.47	399.08	458.31	366.67
Dual Eligibles - Total Member Months	646.16	137.09	984.53	786.96	1,074.21	854.88
Disabled - Total Member Months	503.88	507.64	594.23	551.84	800.48	584.10
Other Low Income - Total Member Months	279.06	292.97	333.72	346.34	366.31	329.65
Ambulatory Care - Emergency Room Visits per Thousand Member						

HEDIS MY 2020 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[8]
Months (AMB)[3]						
Total - Total Member Months	36.44	29.53	41.75	35.46	39.73	38.42
Dual Eligibles - Total Member Months	12.71	9.63	60.76	50.74	50.83	52.11
Disabled - Total Member Months	59.77	61.38	72.18	63.73	69.43	68.43
Other Low Income - Total Member Months	35.54	27.8	38.92	31.42	35.61	35.53
ELECTRONIC CLINICAL DATA SYSTEMS						
Prenatal Immunization Status (PRS-E)[4]						
Influenza	20.94%	16.45%	20.94%	24.59%	20.16%	20.69%
Tdap	35.37%	30.57%	31.98%	28.78%	29.65%	31.30%
Combination	15.50%	10.79%	13.59%	14.93%	13.26%	13.42%

[1]Higher rates for HbA1c Poor Control, COU, HDO, and UOP indicate poorer performance.
[2] PCR's rate is based on observed count of 30-day readmission/count of index stays, and the ratio is observed-to-expected ratio with risk adjustment. For PCR, a lower ratio is indicative of better performance.
[3] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance.
[4] PRS-E is a new measure this year.
[5] W30 replaces W15. A second age band for children between 15 and 30 months of age was added. Additionally, in MY 2020, the hybrid methodology was removed.
[6] WCV replaced W34 and AWC. A third age band for children between 7 - 11 years of age was added. Additionally, in MY 2020, the hybrid methodology was removed.
[7] FUH and FUM are mental health measures. FUA is a chemical dependency measure. FUH requires full mental health benefits (inpatient and outpatient). FUM and FUA only require partial mental health or chemical dependency benefits. In the NJ Medicaid population, only DDD, MLTSS, and FIDE SNP members have full behavioral benefits from the MCO. Two plans (AGNJ and UHCCP) restricted these three measures to the DDD, MLTSS and FIDE SNP populations. The other three plans included the full population in the FUM and the FUA measures.
[8] New Jersey Medicaid average is weighted average of all MCO data.
Designation NA: For non-ambulatory measures, indicates that the MCO had a denominator less than 30. For ambulatory measures, indicates that the MCO had 0 member months in the denominator.
MCO: Managed Care Organization; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year

MY 2020 New Jersey State-Specific Performance Measures

The MCOs were required to report two (2) New Jersey-specific measures for their Medicaid population. The MCOs were required to provide member-level files for review and validation.

The required measures are:

- Preventive Dental Visit – The MCOs were required to report the rates for the total population, and for three subpopulations: Dual Eligible, Disabled, and Other Low Income.
- Multiple Lead Testing in Children through 26 months of age

As the Preventive Dental Visit measure is not a HEDIS measure, the MCOs were required to submit the source code used to calculate the measure along with the rate submission. Prior to accepting the submission, IPRO validated that the submitted source code correctly calculated the rates for this measure. MCOs were given the opportunity to respond to any issues found in the source code, and resubmit the rates if necessary.

The Multiple Lead Testing in Children through 26 months of age measure was new for MY 2020.

Conclusions and Comparative Findings

1. For MY 2020 Amerigroup, Horizon, United, and WellCare included FIDE SNP dual members in the Preventive Dental visit measure. Aetna did not have any enrollment in a FIDE SNP Product.
2. Breakouts for eligibility groups reported by Aetna and Horizon did not match the Member Level Files submitted for the Preventive Dental Visit measure. The member level file capitation codes were validated and the rates reported were corrected to reflect the accurate eligibility designations in the member level file.
3. Overall performance for all five MCOs declined for the Preventive Dental measure. This was consistent with trends seen for the HEDIS dental measure during the COVID-19 pandemic.

Table 27 shows state-specific performance measures for MY 2020 for all MCOs and the New Jersey Medicaid average.

Table 27: MY 2020 NJ State-Specific Performance Measures

MY 2020 NJ-Specific Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Preventive Dental Visit						
Total - 2-3 Years	34.33%	28.94%	34.44%	38.88%	31.12%	34.57%
Total - 4-6 Years	47.54%	49.93%	51.23%	56.71%	44.39%	52.04%
Total - 7-10 Years	50.64%	54.71%	54.83%	60.22%	47.59%	55.83%
Total - 11-14 Years	46.76%	50.12%	51.60%	56.81%	44.19%	52.41%
Total - 15-18 Years	35.43%	39.62%	43.67%	47.33%	35.99%	43.69%
Total - 19-21 Years	24.32%	26.91%	30.82%	33.38%	21.33%	30.32%
Total - 22-34 Years	19.36%	22.65%	27.87%	29.63%	17.24%	26.63%
Total - 35-64 Years	21.04%	23.14%	26.75%	28.43%	20.45%	26.23%
Total - 65+ Years	23.01%	21.58%	20.16%	20.41%	17.04%	20.39%
Total - Total	28.93%	34.03%	36.90%	39.28%	27.14%	36.47%
Dual Eligibles - 2-3 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 4-6 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 7-10 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 11-14 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 15-18 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 19-21 Years	NA	NA	33.86%	34.25%	NA	32.60%
Dual Eligibles - 22-34 Years	15.90%	19.67%	29.57%	30.77%	24.44%	28.73%
Dual Eligibles - 35-64 Years	23.53%	23.28%	29.62%	30.31%	20.60%	28.93%
Dual Eligibles - 65+ Years	24.39%	22.72%	20.75%	20.91%	18.56%	21.11%
Dual Eligibles - Total	23.78%	22.78%	24.27%	24.18%	19.10%	23.92%
Disabled - 2-3 Years	37.84%	25.58%	28.78%	35.93%	23.68%	30.63%
Disabled - 4-6 Years	29.21%	36.44%	43.26%	47.11%	34.67%	43.01%
Disabled - 7-10 Years	41.79%	41.29%	47.06%	48.02%	29.80%	46.25%
Disabled - 11-14 Years	38.79%	37.03%	41.97%	43.82%	25.88%	41.54%
Disabled - 15-18 Years	24.53%	29.67%	35.47%	38.70%	24.86%	35.24%
Disabled - 19-21 Years	17.58%	22.58%	28.62%	27.91%	17.59%	27.12%
Disabled - 22-34 Years	19.88%	20.14%	26.22%	25.98%	18.48%	24.85%
Disabled - 35-64 Years	21.14%	18.98%	21.93%	22.43%	19.71%	21.58%
Disabled - 65+ Years	15.72%	13.29%	15.85%	14.71%	13.89%	15.09%
Disabled - Total	21.82%	22.14%	26.89%	27.72%	18.81%	26.01%
Other Low Income - 2-3 Years	34.29%	28.98%	34.53%	38.94%	31.23%	34.64%
Other Low Income - 4-6 Years	47.99%	50.25%	51.48%	57.05%	44.62%	52.32%
Other Low Income - 7-10 Years	50.94%	55.15%	55.20%	60.79%	48.24%	56.26%
Other Low Income - 11-14 Years	47.00%	50.63%	52.10%	57.47%	44.99%	52.94%
Other Low Income - 15-18 Years	35.80%	40.08%	44.10%	47.81%	36.57%	44.13%
Other Low Income - 19-21 Years	24.64%	27.24%	30.97%	33.85%	21.54%	30.55%

MY 2020 NJ-Specific Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Other Low Income - 22-34 Years	19.44%	22.91%	27.93%	29.93%	17.05%	26.69%
Other Low Income - 35-64 Years	20.81%	23.77%	27.16%	28.97%	20.57%	26.57%
Other Low Income - 65+ Years	15.79%	21.05%	22.70%	25.33%	14.52%	22.43%
Other Low Income - Total	30.04%	36.17%	39.21%	43.26%	29.03%	39.04%
Multiple Lead Testing in Children through 26 Months of Age (MLT)[2]						
Screening between 9 Months and 18 Months	63.29%	67.72%	57.79%	65.53%	69.68%	61.50%
Screening at 18 Months through 26 Months	35.16%	42.68%	37.46%	40.85%	44.97%	39.10%
Screening between 9 Months and 18 Months AND Screening at 18 Months through 26 Months	25.74%	32.96%	24.33%	29.86%	33.05%	27.09%

[1] New Jersey Medicaid average, is weighted average of all MCO data.
[2] MY 2020 is the first year NJ is reporting the Multiple Lead Testing in Children through 26 Months of Age (MLT) measure.

Designation NA: Plan had less than 30 members in the denominator.
Designation CNC: An unweighted average can only be calculated if 2 or more MCOs have a rate.

MY 2020 New Jersey Core Set Performance Measures

DMAHS requested the MCOs to submit six Core Set Measures in MY 2020: Developmental Screening in The First Three Years of Life (DEV-CH), Diabetes Short-Term Complications Admission Rate (PQI01-AD), Contraceptive Care Postpartum Women ages 15-20 (CCP-CH), Contraceptive Care All Women ages 15-20 (CCW-CH), Contraceptive Care Postpartum Women ages 21-44 (CCP-AD), and Contraceptive Care All Women Ages 21-44 (CCW-AD).

Conclusions and Comparative Findings

1. Aetna saw no significant changes in their Core Set measure reporting for MY 2020.
2. For MY 2020 Amerigroup saw a decline of 10.13 percentage points for the youngest age group in Developmental Screening. The Diabetes Short-Term Complications Admission Rate increased by 9.18 points for the 65 years and older age group.
3. Horizon saw a decline in the admission rates for both age groups and for the overall population for the Diabetes Short-Term Complications Admission Rate measure. There was a 12.64 point decline for the 18-64 year-old age group, a 22.17 point decline for the 65 years and older age group, and overall decline of 13.04 points.
4. United saw an increase of 5.06 points for the admission rate for the 65 years and older age group for the Diabetes Short-Term Complications Admission Rate measure.
5. Wellcare saw increases of 5.94 percentage points for the 2 year-old population in Development Screening and an increase of 5.39 percentage points for the 3 year-old population. The Diabetes Short-Term Complications Admission Rate declined by 7.44 points for the 18-64 years age group. There was a decline of 18.48 percentage points for post-partum women in the 15-20 age group for the Most or Moderately Effective Contraception – 60 days in the Contraceptive Care – Post-Partum Women measure.

Table 28 shows the New Jersey Core Set Measures for MY 2020 for all MCOs and the New Jersey Medicaid average.

Table 28: MY 2020 NJ Core Set Measures

MY 2020 NJ Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Developmental Screening in The First Three Years of Life						
1 year old	34.13%	30.86%	38.52%	32.25%	34.45%	35.62%
2 year old	48.30%	55.48%	48.38%	41.19%	43.74%	47.40%
3 year-old	45.00%	49.34%	44.41%	36.82%	40.02%	43.00%
Total - 1-3 year	42.78%	46.42%	44.12%	37.06%	39.98%	42.46%
Diabetes Short-Term Complications Admission (PQI01) - Admissions per 100,000 Member Months[2,3]						
18-64	9.07	11.08	18.21	12.16	15.41	15.35
65 Years and Older	0.00	14.95	12.34	13.65	11.20	12.80
Total	8.73	11.40	17.97	12.36	14.86	15.16
Contraceptive Care - Postpartum Women						
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 3 days	1.47%	1.38%	2.36%	2.46%	0.00%	2.08%
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 60 days	26.47%	27.65%	32.90%	34.98%	13.33%	31.23%
Postpartum Women Ages 15-20 - LARC - 3 days	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Postpartum Women Ages 15-20 - LARC - 60 days	2.94%	3.23%	4.83%	2.96%	3.33%	4.15%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 3 days	5.74%	5.59%	9.51%	8.82%	5.91%	8.23%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 60 days	30.27%	32.24%	33.42%	36.16%	26.92%	33.24%
Postpartum Women Ages 21-44 - LARC - 3 days	0.16%	0.11%	0.18%	0.06%	0.14%	0.14%
Postpartum Women Ages 21-44 - LARC - 60 days	3.53%	3.86%	4.20%	4.80%	3.43%	4.17%
Contraceptive Care – All Women						
All Women Ages 15-20 - Provision of most or moderately effective contraception	15.64%	14.46%	17.15%	14.28%	13.41%	15.99%
All Women Ages 15-20 - Provision of LARC	0.85%	0.75%	0.87%	0.76%	0.72%	0.83%
All Women Ages 21-44 - Provision of most or moderately effective contraception	23.99%	25.58%	25.04%	24.26%	21.23%	24.74%
All Women Ages 21-44 - Provision of LARC	2.27%	2.65%	2.40%	2.71%	2.07%	2.48%

[1] New Jersey Medicaid average is weighted average of all MCO data.

[2] The year over year change for PQI-O1 represents a change in utilization per 100,000 member months and is not a Percentage Point Change.

[3] PQI01 is an inverse measure - higher rates indicate poorer performance.

2020 MLTSS Performance Measures

Specifications were updated in 2021 for the July 2021 through June 2022 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member level files, and rates for each MCO. With the exception of PM #04 which is reported on a monthly basis, PMs are reported on a

quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*). PM 20a was retired in 2021.

- PM #04 - Timeliness of Nursing Facility Level of Care Assessment by MCO (Monthly)

The following measures are monitored quarterly and reviewed annually:

- PM #18 - Critical Incident Reporting
  18a - Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the State at the Total and Category level
  18b - Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the State within 2 business days at the Total and Category level
  18c - Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level
  18d - The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level
- PM #20 - MLTSS Members receiving MLTSS services
- PM #20a - New MLTSS members with MLTSS services within 120 days of enrollment
- PM #20b - Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
- PM #21 - MLTSS Members who Transitioned from NF to the Community
- PM #23 - MLTSS NF to HCBS Transitions who returned to NF within 90 days
- PM #26 - Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
- PM #27 - Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
- PM #28 - All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
- PM #29 - All Cause Readmissions of MLTSS NF members to hospital within 30 days: (HEDIS PCR)
- PM #30 - Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
- PM #31 - Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
- PM #33 - MLTSS services used by MLTSS HCBS members: PCA services only
- PM #34 - MLTSS services used by MLTSS HCBS members: Medical Day services only
- PM #36 - Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members: (HEDIS FUH)
- PM #38 - Follow-up after Mental Health Hospitalization for MLTSS NF members: (HEDIS FUH)
- PM #41 - MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
- PM #42 - Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
- PM #43 - Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members: (HEDIS FUA)
- PM #44 - Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
- PM #45 - Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
- PM #46 - MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services
- PM #47* - Post-hospital Institutional Care for MLTSS HCBS Members
- PM #48* - Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
- PM #49* - Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)

- PM #50* - Follow-Up After Emergency Department Visit for HCBS MLTSS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
- PM #51* - Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
- PM #52 Care for Older Adults for HCBS MLTSS Members (HEDIS COA)
    v. 52a Advance care planning - HCBS
    vi. 52b Medication review - HCBS
    vii. 52c Functional status assessment - HCBS
    viii. 52d Pain assessment - HCBS

- PM 53 Care for Older Adults for NF MLTSS Members (HEDIS COA)
    v. 53a Advance care planning - NF
    vi. 53b Medication review - NF
    vii. 53c Functional status assessment – NF
    viii. 53d Pain assessment - NF

- PM #54 New MLTSS members receiving PCA, MDC and/or MLTSS services
  (This measure replaced PM #20a – the specifications were created, but this measure will be reviewed in the next reporting cycle.)

Conclusions and Comparative Findings

Validation Results of MLTSS Performance Measures

IPRO conducted annual validation of all MLTSS PMs, which included review of source code (where applicable), claims data files, and documentation of methodologies. IPRO met with each MCO to review their submissions and to request modifications to submissions as necessary. Following validation, data were submitted to the NJ Office of MLTSS Quality Monitoring team for submission to CMS.

In addition, throughout the year, IPRO monitored all ongoing reporting to the State on a quarterly basis. In 2021, IPRO produced an annual report which detailed the annual validation process and results, as well as the results of the monitoring activities. This report also provided annual rates for the July 2019- June 2020 measurement period.

The following results are for the July 2019 through June 2020 measurement period:

- PM #4: Timeliness of NF Level of Care Assessment by MCO
  MCO rates range from 44.3% to 100% from July 2019 to February 2020. Afterwards, the MCO rates all dropped to 0% due to the suspension of in-person care management activities due to COVID impact statewide.
- PM #18: Critical Incident Reporting
    - [Rate A – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the State at the Total and Category level] MCO rates range from 97.8% to 100%, and the statewide rates remained steady between 99.6% and 100%.
    - [Rate B – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the State within 2 business days at the Total and Category level] MCO rates range from 38.0% and 99.7%, and the statewide rates remained steady between 61.0% and 97.9%. Most of the rates are above 80%, except AGNJ and UHCCP reported rates of 39.3% and 38.0% respectively for the quarter of April 2020 to June 2020 and lowered the statewide rate.

- [Rate C – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level] MCO rates range from 97.6% to 100%, and the statewide rates remained steady between 98.2% and 99.1%.
- [Rate D – The average number of days from the date of occurrence for Critical Incidents in the Numerator of Rate C to the date the MCO became aware of the CI at the Total and Category level] The average days range from 7.6 day to 27.3 days for the MCOs to be aware of the CI. At the statewide level, it took averagely from 10.6 days to 16.2 days throughout the measurement year.

- PM #20: MLTSS Members Receiving MLTSS Services
  The quarterly MCO rates vary from 58.8% to 81.9%. Rates for all MCOs remain around 80%, except UHCCP and WCHP while their rates hover between 60% and 70%. The statewide rates stayed stable around 73%.
- PM #21: MLTSS Members Transitioned from NF to Community
  The quarterly MCO rates remain low, from 0.3% to 1.7%, and the statewide rates vary from 0.9% to 1.1%.
- PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days
  The MCO rates vary from 0% to 36.4%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates range from 3.7% to 11.2%.
- PM #26: Acute Inpatient Utilization by MLTSS HCBS Members
  The quarterly MCO rates vary from 13.4 to 49.5 utilization per 1000 member months, and the statewide rates range from 29.3 to 34.8 utilization per 1000 member months.
- PM #27: Acute Inpatient Utilization by MLTSS NF Members
  The quarterly rates vary from 14.7 to 55.2 utilization per 1000 member months, and the statewide rates range from 24.1 to 37.6 utilization per 1000 member months.
- PM #28: All-Cause Readmissions of MLTSS HCBS Members to Hospital Within 30 Days
  The quarterly rates ranges from 11.4% to 25.7%, and the statewide rates vary from 16.2% to 22.3%.
- PM #29: All-Cause Readmissions of MLTSS NF Members to Hospital Within 30 Days
  The quarterly rates ranges from 4.0% to 32.1%, and the statewide rates vary from 15.0% to 18.0%.
- PM #30: Emergency Department Utilization by MLTSS HCBS Members
  The quarterly rates vary from 20.6 to 104.6 utilization per 1000 member months, and the statewide rates stay relatively stable, from 36.9 to 76.1 utilization per 1000 member months. All MCOs had significant lower rate for quarter of April 2020 to June 2020, which drove the lowest statewide rate of 36.9 utilization per 1000 member months.
- PM #31: Emergency Department Utilization by MLTSS NF Members: the quarterly rates vary from 3.3 to 41.0 utilization per 1000 member months, and the statewide rates stay relatively stable, from 23.6 to 27.5 utilization per 1000 member months.
- PMs #33, #34, and #41: MLTSS PCA and Medical Day Services Used only by MLTSS HCBS Members:
  - [PM #33 PCA used only] the quarterly rates ranges from 7.1% to 20.4%, and the statewide rates stayed stable between 13.6% to 15.7%.
  - [PM #34 Medical Day used only] the quarterly rates ranges from 1.3% to 17.9%, and the statewide rates stayed stable between 6.1% to 6.5%.
  - [PM #41 PCA and Medical Day used only] the quarterly rates ranges from 2.1% to 15.6%, and the statewide rates stayed stable between 6.4% to 7.3%.
- PM #36: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members
  The quarterly rates ranges from 0% to 83.3%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates range from 19.4% to 33.3%.
- PM #38: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members: the quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are less than 10. The statewide rates range from 0% to 10.5%.

- PMs #42: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS HCBS Members
  The quarterly rates ranges from 0% to 42.9%. However, most of the reported quarterly denominators are less than 10. The statewide rates vary from 7.9% to 16.7%.
- PMs #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS NF Members
  The quarterly rates ranges from 0% to 37.5%. However, most of the reported quarterly denominators are less than 10. The statewide rates vary from 0% to 37.5%, while all of the denominators are less than 30.
- PMs #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members
  The quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates are relatively stable, varying between 54.9% to 66.7%.
- PMs #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members
  The quarterly rates ranges from 0% to 75.0%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates are relatively stable, varying between 31.6% to 38.1%.

2020 and 2021MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the plan of care (POC). This measure ensures MLTSS HCBS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: Adult Family Care, Assisted Living Services/Program, Chore Services, Community Residential Services, Home Delivered Meals, Medical Day Services, Medication Dispensing Device Monthly Monitoring, PCA/Home Based Supportive Care, PERS Monitoring, and Private Duty Nursing.

In 2021, the validation of PM #13 for measurement period from July 2019 to February 2020 continued. For the measurement period July 2019 to June 2020, Members were required to be enrolled in MLTSS HCBS with the MCO between July 1, 2019 and February 29, 2020. The change of enrollment window from one year to eight months was to address the impact of COVID-19.

In addition, validation of PM #13 for measurement period July 2020 to June 2021 began. For both measurement periods (July 2019 to February 2020, and July 2020 to June 2021) samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. Validation of the files received from the MCs for these two review periods is ongoing. Once all files pass validation, IPRO will conduct Primary Source Verification of the claims data received against the transactional systems to ensure that the claims files received are accurate.

2021 MLTSS Service Delivery Project

MLTSS Service Delivery evaluates compliance of the delivery of four specific MLTSS services, in accordance with the MLTSS members' Plan of Care (POCs) for Home and Community Based Services (HCBS) members for NJ Medicaid and FIDE SNP MCOs. The four services are: Home Delivered Meals (HDM), Medical Day Care (MDC), Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). Evaluation of POC compliance with service delivery is based on type, scope, amount, frequency, and duration of service. In addition to evaluating delivery of services in accordance with the POC, the project also includes evaluation of the MCOs against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS HCBS; PM #10: Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment; and PM #11: Plans of Care developed using "person-centered principles".

In 2021, the MLTSS Service Delivery project was based on the measurement period July 1, 2018 and December 31, 2018. A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. IPRO developed an algorithm, to minimize the number of unique cases required to ensure that there were 120 cases for each service type and to ensure that 120 new enrollees would be included for calculation of PM #8.

MCOs were required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. POCs that contained no information about the MLTSS services were excluded from the evaluation of the MLTSS services, but were included for scoring of PM #8, PM #10, and PM #11. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems.

Evaluation Methodology

- MLTSS Service Delivery Service data from the POCs were used to construct a timeline of expected services for each recurring service in the POC. The timeline of expected services was structured on a weekly or monthly basis, and reflected the amount (in units) of service the member was expected to receive for each week/month in the measurement period, according to the POC. PERS services were evaluated on a monthly basis.

  MLTSS Services are often provided on a weekly schedule that is customized for the member's needs. For instance, a member may require 16 units of Personal Care Assistant (PCA) service per day on weekdays, but only 8 units per day on weekends. Due to the lack of day-to-day homogeneity in service schedules, it was inappropriate to use partial weeks in this analysis. The cutoff date on a partial week could arbitrarily misrepresent the expected service delivery. Therefore, the timeline of expected services used POC data for full weeks only. Weeks of the service span were divided into weeks starting on Sunday and ending on Saturday, and any incomplete weeks were dropped from the timeline of expected services. Similarly, for monthly services, timelines were constructed using full months only; partial months at the start/end of the service span were dropped from the timeline. If there were any blackout periods or planned service discontinuations documented, they were removed from the timeline of expected services at the service level.

  IPRO used claims data to construct a companion timeline of delivered services. Start dates and end dates in the timeline of delivered services were set to match the corresponding start and end dates of the timeline of expected services. For each service, the timelines were compared to assess the percent of service delivery for each week/month. The percent of service delivery could never exceed 100% for any given week/month. Where claims indicated that more than 100% of the expected service units were delivered, the percent was capped at 100%. This was done so that in aggregating services over a span of weeks, claims in excess of expected services in one week would not offset deficiencies in delivery of expected services in another week.

  Evaluation of MLTSS Service Delivery is the average of service delivery versus planned amount for all members within the review period for each service.

- PM #8

IPRO requested initial enrollment date into MLTSS for the samples selected. PM #8 requires that the member be newly enrolled in MLTSS during the review period. The MLTSS Service Delivery samples were augmented to include sufficient cases from each MCO to ensure a sample of 120 cases for each MCO for PM #8.

- PM #10 and PM #11
  In addition to the POCs submitted for the MLTSS Service Delivery samples, IPRO requested copies of the New Jersey Choice Assessment for each member in the sample. This information was used to evaluate MCO compliance with PM #10. Compliance with PM #11 was determined based on a review of the POCs submitted for MLTSS Service Delivery.

Rates for PM #8, PM #10, and PM #11 are calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Compliance with PM #8 is calculated using 45 calendar days to establish an initial plan of care for new enrollees. In order to be compliant with PM #11 in the current review period, documentation needed to show that the member and/or authorized representative were involved in goal setting, and in agreement with established goals. In addition, the member's expressed needs and preferences, informal and formal supports, and options should have been addressed within the care plan.

Conclusions and Comparative Findings

As shown in **Table 29**, a total of 1,178 cases were sampled from the authorizations across all MCOs. For each MCO, an algorithm was used to minimize the number of unique cases required to ensure that there were 120 cases for each service type and PM #8. Sample sizes varied by MCO.

Table 29: MLTSS Service Delivery Sample Summary

MCO	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	Total
Unique Cases Sampled	307	227	236	196	212	1,178

Table 30 presents service rates by MCO and for the overall sample. UHCCP's rates are Not Reportable (NR). Issues were identified in the final data files submitted by UHCCP relating to the Medicaid ID numbers. This resulted in biased rates for UHCCP.

The overall percentages of service delivery versus expected services ranges from 66% of Medical Day, to 87% of PERS. For most of the MCOs, Medical Day has the lowest rate, while PERS shows the highest delivery rate. Among the MCOs, HNJH has the best performance with highest rate for each of the services.

Table 30: Rate of Service Delivery Versus Planned Amount

MCO	Home Delivered Meals	Medical Day	PCA	PERS
ABHNJ	82%	65%	79%	80%
AGNJ	79%	60%	77%	90%
HNJH	85%	74%	90%	94%
UHCCP	NR**	NR**	NR**	NR**
WCHP	62%	68%	77%	82%
Statewide*	78%	66%	81%	87%

*Statewide rates exclude UHCCP data. The Statewide rate is the weighted average of the MCO rates, as Table 30 illustrates.
**Designation NR: Not Reportable.

Table 31 presents a summary based on file review of the MCO's performance for the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #10 (Plans of Care are aligned with member needs based on the results of the NJ Choice Assessment), and #11 (Plans of Care developed using "person-centered principles").

Table 31: Results of Performance Measures

Performance Measure	MCO	Denominator	Numerator	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[1]	ABHNJ	108	58	54%
	AGNJ	127	102	80%
	HNJH	124	99	80%
	UHCCP	NR**	NR**	NR**
	WCHP	125	91	73%
	Total*	484	350	72%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[2]	ABHNJ	102	63	62%
	AGNJ	125	62	50%
	HNJH	121	118	98%
	UHCCP	NR**	NR**	NR**
	WCHP	122	117	96%
	Total*	470	360	77%
#11. Plans of Care developed using "person-centered principles"[3]	ABHNJ	120	76	63%
	AGNJ	126	66	52%
	HNJH	123	119	97%
	UHCCP	NR**	NR**	NR**
	WCHP	122	120	98%
	Total*	491	381	78%

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[2]Members are excluded from this measure if they do not have a completed NJCA or a completed POC.
[3]In the current review period, documentation should have demonstrated that the member and/or authorized representative were involved in goal setting and in agreement with the established goals. The member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
*Total rates exclude UHCCP data.
**Designation NR: Not Reportable.

The overall performance rates for PM #8, PM #10, PM #11, and each service of the MLTSS Service Delivery evaluation ranged from 66% for Medical Day to 87% for PERS. Only the PERS rate exceeded the CMS HCBS PM threshold of 86%, showing ample room for the MCOs to improve their service delivery.

VI. Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey

Objectives

Results from the HEDIS-CAHPS 2021 5.1H Surveys for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following two survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare MCOs: Center for the Study of Services (CSS) and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2020 through December 31, 2020, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult and child surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

Technical Methods of Data Collection and Analysis

The survey drew, as potential respondents, adult enrollees over the age of 18 years, and children under the age of 18 years who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2021 using a mixed-mode protocol that consisted of two waves of survey mailings and a phone follow-up to all members who had not responded to the mailings. All five health plans utilized a mail and telephone protocol. Additionally, ABHNJ, HNJH and UHCCP offered the option to complete the survey via the internet during the field.

Description of Data Obtained and Conclusion

For the adult survey, a total random sample of 8,100 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,350 ABHNJ enrollees, 1,755 AGNJ enrollees, 1,755 HNJH enrollees, 1,890 UHCCP enrollees, and 1,350 WCHP enrollees. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,491 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 18.7%, which was an increase from the previous year's response rate of 17.6%. Composite results of the adult NJ FamilyCare overall weighted responses for the five MCOs were: 93.2% for how well doctors communicate; 88.4% for customer service; 81.6% for getting needed care; and 76.6% for getting care quickly.

For the child survey, a total random sample of 10,527 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 2,772 ABHNJ enrollees, 2,145 AGNJ enrollees, 1,980 HNJH enrollees, 1,980 UHCCP enrollees, and 1,650 WCHP enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 2,226 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 21.5%, which was a significant increase from the previous year's response rate of 16.4%. Composite results of the Child NJ FamilyCare overall weighted responses for the five MCOs were: 91.3% for how well doctors communicate; 84.6% for customer service; 81.2% for getting needed care; and 76.1% for getting care quickly.

For the CHIP survey, a total random sample of 2,145 parent/caretakers of CHIP child enrollees was drawn. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 626 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 29.5%, which was a decrease from last year's response rate of 31.2%. Composite results of the CHIP NJ

FamilyCare overall statewide responses were: 93.0% for how well doctors communicate; 82.6% for getting needed care; 81.5% for customer service; and 74.2% for getting care quickly.

The CAHPS rates are color coded to correspond to the national percentiles as shown in **Table 32**.

Table 32: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2020 Quality Compass National Percentiles
Orange	Below the National Medicaid 25th percentile
Yellow	Between the 25th and 50th percentile
Green	Between 50th and 75th percentile
Blue	Between the 75th and 90th percentile
Purple	Above the National Medicaid 90th percentile

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; MY: measurement year.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all MCOs, IPRO compared the NJ FamilyCare overall Statewide weighted averages for adults and children (**Table 33 and Table 34**) to the national Medicaid benchmarks presented in the MY 2020 *Quality Compass*. Measures performing at or above the 75th percentile and below the 90th percentile were considered strengths; measures performing at the 50th percentile and below the 75th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement.

Table 33: CAHPS MY 2020 Performance – Medicaid Adult Survey

Adult Survey - CAHPS Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	Statewide Weighted Average
Getting Needed Care	81.3%	85.3%	81.1%	82.6%	75.6%	81.6%
Getting Care Quickly	78.7%	78.2%	76.4%	77.6%	71.4%	76.6%
How Well Doctors Communicate	92.1%	96.3%	92.9%	92.6%	92.7%	93.2%
Customer Service	85.3%	90.8%	90.0%	83.6%	88.9%	88.4%
Rating of All Health Care[1]	73.2%	81.1%	78.3%	77.0%	78.7%	78.1%
Rating of Personal Doctor[1]	81.9%	86.1%	83.8%	83.6%	81.0%	83.7%
Rating of Specialist Seen Most Often[1]	82.3%	82.6%	80.7%	84.4%	71.6%	81.1%
Rating of Health Plan[1]	67.2%	74.4%	81.1%	81.0%	78.8%	79.3%

[1] For rating of health care, personal doctor, specialist seen most often and health plan, Medicaid rates are based on survey scores of 8, 9 and 10.

Color key for how rate compares to the NCQA HEDIS 2021 Quality Compass national percentiles: orange shading – below the National Medicaid 25th percentile; yellow shading – between the 25th and 50th National Medicaid 50th percentile; green shading is between 50th and 75th percentile; blue shading – between the 75th and national Medicaid 90th percentile; purple shading – above the national Medicaid 90th percentile.

Table 34: CAHPS MY 2020 Performance – Medicaid Child Survey

Child Survey - CAHPS Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	Statewide Weighted Average
Getting Needed Care	84.0%	82.9%	79.1%	84.9%	79.5%	81.2%
Getting Care Quickly	82.5%	76.6%	74.9%	78.9%	69.6%	76.1%
How Well Doctors Communicate	93.1%	92.4%	91.1%	90.9%	90.7%	91.3%
Customer Service	86.4%	90.4%	80.9%	88.2%	87.7%	84.6%
Rating of All Health Care	88.0%	88.0%	84.8%	85.6%	88.6%	85.7%
Rating of Personal Doctor[1]	88.5%	91.2%	88.8%	90.0%	90.3%	89.4%
Rating of Specialist Seen Most Often[1]	84.8%	82.7%	95.1%	84.3%	78.7%	90.1%
Rating of Health Plan[1]	79.9%	80.9%	89.6%	83.1%	84.1%	86.4%

[1] For rating of health care, personal doctor, specialist seen most often and health plan, Medicaid rates are based on survey scores of 8, 9 and 10.

Color key for how rate compares to the NCQA HEDIS 2021 Quality Compass national percentiles: orange shading – below the National Medicaid 25th percentile; yellow shading – between the 25th and 50th National Medicaid 50th percentile; green shading is between 50th and 75th National Medicaid percentile; blue shading – between the 75th and national Medicaid 90th percentile; purple shading – above the national Medicaid 90th percentile.

Weighted Statewide average rates ranked at or above the NCQA national 50th percentile for 4 of the 8 adult measures, and for one (1) of the child survey measures. Opportunities for improvement are evident for the three adult measures (Getting Care Quickly, Customer Service and Rating of Specialist Seen Most Often). Opportunities for improvement are evident for the five (5) Child measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Rating of All Health Care).

For the Adult survey measures, AGNJ had five (5) measures above the national 50th percentile, (**Table 33**). HNJH had 5 measures above the national 50th percentile, including 1 measure above the national Medicaid 90th percentile. UHCCP and WCHP each had with one (1) measure above the national 50th percentile. All MCOs had one (1) Adult rate at or below the national 25th percentile: Getting Care Quickly.

For the Child survey measures, as presented in **Table 34**, HNJH had one (1) measure above the national 90th percentile, and one (1) measure between the national 50th and 75th percentile. AGNJ had two (2) measures at or above the national 50th percentile, followed by UHCCP and WCHP with one (1) measure above the national 50th percentile. All MCOs had one (1) Child rate at or below the national 25th percentile: Getting Care Quickly.

VII. Care Management Audits

2021 Core Medicaid Care Management Audits

2021 Core Medicaid Care Management Audits

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).
Annually, DMAHS evaluates MCO performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

In 2020 and 2021, IPRO, and OQA collaborated on revising the NJ EQRO MCO Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions were limited to exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether Enrollees met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

In the 2019 audit period, the General Population was not reviewed.

The MY 2020 rates across all MCOs, populations, and categories ranged from 42% to 100%. Scores for Identification ranged from 84% to 93% for the General Population. Outreach ranged from 90% to 100% for all MCOs for all populations (GP, DDD and DCP&P). Scores for the Preventive Services Category ranged from 42% to 90% across all MCOs for all populations. Scores for Continuity of Care ranged from 64% to 97% across all MCOs for all populations. Scores for Coordination of Services ranged from 74% to 100% across all MCOs for all populations.

One metric (Identification) was only evaluated for the General population. This metric is not relevant for the DDD and DCP&P populations because Care Management is required for those populations. Four metrics (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for all three populations (GP, DDD and DCP&P) within the five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 65 scores.

Assessment Methodology

The audit addressed MCO Contract requirements for Care Management services including MCO Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Summary of Core Medicaid Care Management Audit Performance

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 35, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Table 35: Core Medicaid Care Management Summary of Performance

Determination by Category	MCO				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
	MY 2020	MY 2020	MY 2020	MY 2020	MY 2020
GP	n = 100	n = 100	n = 100	n = 100	n = 100
Identification[1]	84%	93%	88%	88%	89%
Outreach	91%	100%	91%	90%	97%
Preventive Service	86%	60%	84%	49%	90%
Continuity of Care	69%	64%	71%	74%	96%
Coordination of Services	81%	92%	79%	98%	100%
DDD	n =54	n =39	n =92	n =2	n =34
Outreach	100%	99%	98%	100%	97%
Preventive Service	42%	60%	75%	64%	46%
Continuity of Care	80%	91%	84%	71%	91%
Coordination of Services	74%	96%	100%	100%	98%
DCP&P	n =84	n =73	n =100	n =25	n =21
Outreach	98%	98%	94%	96%	100%
Preventive Service	56%	77%	86%	83%	76%
Continuity of Care	92%	97%	90%	97%	96%
Coordination of Services	87%	100%	100%	100%	100%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

ABHNJ's 2020 audit results ranged from 42% to 100% across all populations for the five audit categories.

Overall, ABHNJ scored above 85% in the following review elements (**Table 35**):

- Outreach (General Population) (91%)
- Preventive Services (General Population) (86%)
- Outreach (DDD Population) (100%)
- Outreach (DCP&P Population) (98%)
- Continuity of Care (DCP&P Population) (92%)
- Coordination of Services (DCP&P Population) (87%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 35**):

- Identification (General Population) (84%)
- Continuity of Care (General Population) (69%)
- Coordination of Services (General Population) (81%)
- Preventive Services (DDD Population) (42%)
- Continuity of Care (DDD Population) (80%)
- Coordination of Services (DDD Population) (74%)
- Preventive Services (DCP&P Population) (56%)

AGNJ's 2020 audit results ranged from 60% to 100% across all populations for the five audit categories.

Overall, AGNJ scored above 85% in the following review elements (**Table 35**):

- Identification (General Population) (93%)
- Outreach (General Population) (100%)
- Coordination of Services (General Population) (92%)
- Outreach (DDD Population) (99%)
- Continuity of Care (DDD Population) (91%)
- Coordination of Services (DDD Population) (96%)
- Outreach (DCP&P Population) (98%)
- Continuity of Care (DCP&P Population) (97%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 35**):

- Preventive Services (General Population) (60%)
- Continuity of Care (General Population) (64%)
- Preventive Services (DDD Population) (60%)
- Preventive Services (DCP&P Population) (77%)

HNJH's 2020 audit results ranged from 71% to 100% across all populations for the five audit categories.

Overall, HNJH scored 85%or above in the following review elements (**Table 35**):

- Identification (General Population) (88%)
- Outreach (General Population) (91%)
- Outreach (DDD Population) (98%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (94%)
- Preventive Services (DCP&P Population) (86%)
- Continuity of Care (DCP&P Population) (90%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 35**):

- Preventive Services (General Population) (84%)
- Continuity of Care (General Population) (71%)
- Coordination of Services (General Population) (79%)
- Preventive Services (DDD Population) (75%)
- Continuity of Care (DDD Population) (84%)

UHCCP's 2020 audit results ranged from 49% to 100% across all populations for the five audit categories.

Overall, UHCCP scored above 85% in the following review elements (**Table 35**):

- Identification (General Population) (88%)
- Outreach (General Population) (90%)
- Coordination of Services (General Population) (98%)
- Outreach (DDD Population) (100%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (96%)
- Continuity of Care (DCP&P Population) (97%)

Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 35**):

- Preventive Services (General Population) (49%)
- Continuity of Care (General Population) (74%)
- Preventive Services (DDD Population) (64%)
- Continuity of Care (DDD Population) (71%)
- Preventive Services (DCP&P Population) (83%)

WCHP's 2020 audit results ranged from 46% to 100% across all populations for the five audit categories.

Overall, WCHP scored above 85% in the following review elements (**Table 35**):

- Identification (General Population) (89%)
- Outreach (General Population) (97%)
- Preventive Services (General Population) (90%)
- Continuity of Care (General Population) (96%)
- Coordination of Services (General Population) (100%)
- Outreach (DDD Population) (97%)
- Continuity of Care (DDD Population) (91%)
- Coordination of Services (DDD Population) (98%)
- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (96%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 35**):

- Preventive Services (DDD Population) (46%)
- Preventive Services (DCP&P Population) (76%)

Core Medicaid Care Management and Continuity of Care Annual Assessment

Assessment Methodology

The Care Management and Continuity of Care review examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The 2021 Care Management assessment covered the period from January 1, 2020, to December 31, 2020. Due to COVID-19, interviews with key MCOs staff via WebEx were held on April 29, 2021 and April 30, 2021.

There are 30 contractual elements in the 2021 assessment. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the 2021 Core Medicaid CM Audit. Overall compliance scores for the five MCOs ranged from 80% to 90%. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2020 for three populations, General Population (GP), enrollees under the Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P). **Table 36** presents an overview of the results by MCO.

Table 36: Summary of Findings for 2021 Core Medicaid Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	30	25	5	**83%**
AGNJ	30	24	6	**80%**
HNJH	30	25	5	**83%**
UHCCP	30	26	4	**87%**
WCHP	30	27	3	**90%**

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

Table 37 presents the summary of findings for the Core Medicaid Care Management Continuity of Care elements reviewed in 2021. Complete findings and IPRO's recommendations for each MCO can be located in **Appendices B-F.**

Table 37: Summary of Findings for Core Medicaid Care Management and Continuity of Care

Element	ABHNJ Met	AGNJ Met	HNJH Met	UHCCP Met	WCHP Met
CM1	X	X	X	X	X
CM2	-	-	X	X	X
CM3	X	X	X	X	X
CM4	X	X	X	X	X
CM5	X	X	X	X	X
CM6	X	X	-	-	-
CM7	-	-	-	-	-
CM8	-	-	-	-	X
CM9	X	X	X	X	X
CM10	X	X	X	X	X
CM11	X	-	X	X	X
CM12	X	X	X	X	X
CM13	X	X	X	X	X
CM14	-	-	-	-	-
CM15	X	X	X	X	X
CM16	X	X	X	X	X
CM17	X	X	X	X	X
CM18a	X	X	X	X	X
CM18c	X	X	X	X	X
CM18d	X	X	X	X	X
CM19	-	-	-	X	X
CM20	X	X	X	X	X
CM21	X	X	X	X	X

Element	ABHNJ Met	AGNJ Met	HNJH Met	UHCCP Met	WCHP Met
CM22	X	X	X	X	X
CM23	X	X	X	X	X
CM24	X	X	X	X	X
CM25	X	X	X	X	X
CM26	X	X	X	X	X
CM27	X	X	X	X	X
CM37[1]	X	X	X	X	X
TOTAL	25	24	25	26	27
Compliance Percentage	83%	80%	83%	87%	90%

[1]This documentation element is reviewed in any year where there are elements subject to review.

Two of the five MCOs, met the compliance threshold of 85% or above. All MCOs were provided recommendations for elements that were Not Met. These recommendations can be found in **Appendices B-F**.

2021 MLTSS Nursing Facility Care Management Audits

2021 MLTSS Nursing Facility Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019, through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019, and ending February 29, 2020. An expansion review period from March 1, 2020, through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019, through December 31, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.
Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2019 and

January 2020. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

The review period for this audit is July 1, 2019, through February 29, 2020. The review period was truncated due to the COVID-19 pandemic. MCOs were unable to conduct in-person care management visits in the NF setting from mid-March 2020 through June 2020.

Pre-Audit Planning Activities

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, the NF audit to evaluate the period from July 2018 through June 2019 was suspended. In 2020 and 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. The audit tool was also revised to allow for collection of elements needed to report the following MLTSS PMs: #8, #9, #9a, #11, and #16.

Based on the extensive revisions to the NJ EQRO MLTSS NF Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior review period's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool.

Population Selection

Capitation and Plan codes were used to identify MLTSS NF enrollment. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases from each of the five MCOs, including an oversample of 10 cases to replace any excluded files as necessary.

In order to collect additional information for MLTSS members who transitioned between HCBS and NF/SCNF during the review period, the selected HCBS and NF/SCNF population was further identified as one of the four subgroups shown in **Table 38**.

Table 38: MLTSS NF/SCNF Population Subgroups

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between July 1, 2019, and February 29, 2020, with the MCO of record on February 29, 2020
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between July 1, 2019, and February 29, 2020, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between July 1, 2019, and December 31, 2019, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of February 29, 2020)
Group 4	Members residing in HCBS for at least one month between July 1, 2019 and November 30, 2019, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

The 2021 MLTSS NF Audit Results are presented below in **Table 39**.

Table 39: 2021 MLTSS NF Audit Results

Category	7/1/19 – 2/29/20 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Facility and MCO Plan of Care															
Member's care management record contained copies of any facility plans of care on file during the review period	89	100	89.0%	90	100	90.0%	87	100	87.0%	39	100	39.0%	55	100	55.0%
Documented review of the facility plan of care by the care manager	88	89	98.9%	90	90	100.0%	87	87	100.0%	37	39	94.9%	47	55	85.5%
MLTSS plan of care on file includes information from the facility plan of care	84	89	94.4%	79	90	87.8%	86	87	98.9%	34	39	87.2%	37	55	67.3%
MLTSS Initial Plan of Care and Ongoing Plans of Care															
The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	8	9	88.9%	1	6	16.7%	2	2	100.0%	0	2	0.0%	2	2	100.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	91	100	91.0%	88	100	88.0%	98	100	98.0%	58	100	58.0%	51	100	51.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	91	100	91.0%	88	100	88.0%	98	100	98.0%	58	100	58.0%	52	100	52.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	91	100	91.0%	88	100	88.0%	98	100	98.0%	58	100	58.0%	52	100	52.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	91	100	91.0%	88	100	88.0%	98	100	98.0%	58	100	58.0%	51	100	51.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record.	75	100	75.0%	88	100	88.0%	98	100	98.0%	58	100	58.0%	53	100	53.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	1	1	100.0%	0	0	CNC	12	12	100.0%	2	2	100.0%	3	3	100.0%
Transition Planning															
Member was identified for transfer to HCBS and was offered options, including transfer to the community	92	100	92.0%	94	100	94.0%	100	100	100.0%	83	100	83.0%	55	100	55.0%
Evidence of the Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	72	100	72.0%	13	100	13.0%	15	100	15.0%	9	100	9.0%	50	100	50.0%

Category	7/1/19 – 2/29/20 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	93	100	93.0%	93	100	93.0%	100	100	100.0%	83	100	83.0%	63	100	63.0%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	61	100	61.0%	69	100	69.0%	78	100	78.0%	42	100	42.0%	37	100	37.0%
Members requiring coordination of care had coordination of care by the Care Manager	98	100	98.0%	94	100	94.0%	100	100	100.0%	88	100	88.0%	65	100	65.0%
Care Manager explained and discussed any payment liability with the member	57	100	57.0%	83	100	83.0%	75	100	75.0%	70	100	70.0%	47	100	47.0%
Reassessment of the POC and Critical Incident Reporting															
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	64	66	97.0%	46	61	75.4%	62	64	96.9%	58	75	77.3%	55	92	59.8%
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	75	100	75.0%	81	100	81.0%	98	100	98.0%	58	100	58.0%	54	100	54.0%
Care Manager reviewed the Member's Rights and Responsibilities	86	100	86.0%	90	100	90.0%	96	100	96.0%	58	100	58.0%	60	100	60.0%
Care Manager educated the Member on how to file a grievance and/or an appeal	86	100	86.0%	91	100	91.0%	96	100	96.0%	58	100	58.0%	66	100	66.0%
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	89	100	89.0%	90	100	90.0%	96	100	96.0%	58	100	58.0%	62	100	62.0%
PASRR Communication for Transitions to/from NF/SCNF															
Member was admitted to a NF/SCNF prior to the review period*	97			100			99			100			100		
Member was admitted to an NF/SCNF during the review period*	3			0			1			0			0		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	3	3	100%	0	0	CNC	0	1	0.0%	0	0	CNC	0	0	CNC
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	3	3	100%	0	0	CNC	0	1	0.0%	0	0	CNC	0	0	CNC
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Members who had PASSR Level II forms indicating a need for Specialized Services Setting was coordinated appropriately with DDD/DMHAS	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Transitions from NF/SCNF to HCBS (Groups 2 and 4)															
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC

Category	7/1/19 – 2/29/20 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Care Manager conducted a face-to-face visit within 10 business days following a NF/SCNF discharge to the community	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Transitions from HCBS to NF/SCNF (Groups 3 and 4)															
Member had a person-centered transition plan on file	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a discussion with the Member occurred prior to the change in service/placement	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC

Only four members across all five MCOs met criteria for evaluation of PASRR elements. Excluding these elements, 21 individual elements were evaluated across all 5 MCOs. Three of the five MCOs scored at or above 86% for 15 or more elements: ABHNJ scored at or above 86% for 16 elements; AGNJ scored at or above 86% for 15 elements; and HNJH scored at or above 86% for 18 elements. UHCCP scored at or above 86% for only 4 elements; WCNJ scored at or above 86% for only 2 elements. Individual recommendations were provided to the MCOs with their final report.

Beginning in 2021, the NF audit included evaluating the NF Population on the MLTSS Performance Measures. Population-specific findings by MCO in **Table 40** present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents).

Groups 2, 3, and 4 relate to members who transitioned between NF and HCBS settings. No members were identified for these groups for this review period.

Table 40: Results of MLTSS NF Performance Measures – July 2019 – February 2020

Performance Measure	Group	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	88.9%	16.7%	100.0%	0.0%	100.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**88.9%**	**16.7%**	**100.0%**	**0.0%**	**100.0%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	75.0%	81.0%	98.0%	58.0%	54.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**75.0%**	**81.0%**	**98.0%**	**58.0%**	**54.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	100.0%	CNC	100.0%	100.0%	100.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**100.0%**	**CNC**	**100.0%**	**100.0%**	**100.0%**
#11. Plans of Care developed using "person-centered principles"[4]	Group 1	91.0%	88.0%	98.0%	58.0%	51.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CCN	CNC
	Total	**91.0%**	**88.0%**	**98.0%**	**58.0%**	**51.0%**
#16. Member training on identifying/reporting critical incidents	Group 1	89.0%	90.0%	96.0%	58.0%	62.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**89.0%**	**90.0%**	**96.0%**	**58.0%**	**62.0%**

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[2]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[3]Members who did not have a documented change in condition during the study period are excluded from this measure.
[4]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
CNC: Could not calculate; N/A: Not applicable

Of the five performance measures calculated for the MCOs, only three had denominators large enough to comment on performance. The three performance measures with sufficient denominator sizes across all MCOs are PM #9 POC Reviewed Annually within 30 days of Anniversary and as Necessary, PM # 11 POC Developed Using "Person Centered Principles", and PM #16 Member Training on Identifying/Reporting Critical Incidents. Three MCOs, scored at or above 86% for PM #11 and PM #16 (ABHNJ, AGNJ, and HNJH). One MCO

(HNJH) also scored at or above 86% for PM #9. The remaining two MCOs (UHCCP and WCHP) scored below 86% on all three measures.

IPRO provided each MCO with a comprehensive report listing strengths and opportunities for improvement at the element level. IPRO provided the MCOs with recommendations for each opportunity for improvement. These recommendations can be found in **Appendices B-F**.

COVID Impact Review

Comparison of NF Audit Results for Review Period and Expansion Period

Five audit elements were identified for comparison of care management activities during the review period, prior to suspension of certain in-person care management activities in March 2020, and during the expansion period from March 1, 2020 through December 31, 2020. These elements reflect activities that could be undertaken during the period when care management activities in the nursing facilities were restricted. **Table 41** show the results by MCO for both periods. For all elements in both periods, the denominator was 100 for each MCO.

Table 41: Comparison of Review Period and Expansion Period

Transition Planning	Review Period (July 1, 2019- February 29, 2020)					Expansion Period (March 1, 2020- December 31, 2020)				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Member was identified for transfer to HCBS and was offered options, including transfer to the community	92%	94%	100%	83%	55%	100%	100%	100%	99%	56%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	72%	13%	15%	9%	50%	77%	10%	17%	3%	46%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	93%	93%	100%	83%	63%	18%	100%	100%	99%	61%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	61%	69%	78%	42%	37%	55%	80%	85%	60%	45%

Transition Planning	Review Period (July 1, 2019-February 29, 2020)					Expansion Period (March 1, 2020-December 31, 2020)				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Reassessment of the POC and Critical Incident Reporting										
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	75%	81%	98%	58%	54%	92%	99%	98%	52%	53%

While there is variability across MCOs on some of the review element, only one element for one MCO showed a marked decline from the review period to the expansion period. For ABHNJ, the element "Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care" declined from 93% to 18%. All other rates were largely comparable for both periods.

Acute Inpatient Events

In addition to reviewing selected care management elements for the expansion period, IPRO conducted an analysis of Acute Inpatient (IP) events for the period from July 1, 2019 through December 31, 2020. MCOs submitted files for all acute IP events for this period. For the first six months of the IP review period, random samples were selected by month. A total of 100 records were selected for each MCO. For the first six months of the review period, 5 cases per month were selected. For the period from January 1, 2020 through December 31, 2020, the remaining 70 cases were selected by date and diagnosis. For the first quarter, January 1, 2020 through March 31, 2020, 16 cases were selected for each MCO. For the remaining quarters, from April 1, 2020 through December 31, 2020, 18 cases were selected for each MCO. Selection of cases for the period of January 1, 2020 through December 31, 2020, was conducted in such a manner as to ensure that discharges with respiratory diagnoses or COVID-19 diagnoses were present in each quarter. COVID-19 diagnoses did not appear in the data until mid-March 2020.

Results from this analysis can be found in **Appendix A**.

ABHNJ's MLTSS NF Audit Results

Overall, Aetna scored 86% or above in the following review elements (Table 39):

- Copies of any Facility Plans of Care on file (89.0%)
- Documented Review of the Facility Plan of Care (98.9%)
- MLTSS Plan of Care on file (94.4%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (88.9%)
- Care Managers used a person-centered approach (91.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (91.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (91.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (91.0%)
- Updated Plan of Care for a Significant Change (100.0%)
- Member was identified for transfer to HCBS and was offered options (92.0%)
- Member was present at each onsite visit (93.0%)
- Members requiring coordination of care had coordination of care (98.0%)
- NJCA was completed to assess the Member (97.0%)

- Care Manager reviewed the Member's Rights and Responsibilities (86.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (86.0%)
- Member and/or representative had training on how to report a critical incident (89.0%)
- Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF (100.0%) - Denominator = 3
- Communication of PASRR Level I to OCCO (100.0%) – Denominator = 3

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 39):

- Documentation of the Member's agreement/disagreement with the POC statements were documented (75.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (72.0%)
- Timely Onsite Review of Member Placement and Services (61.0%)
- Care Manager explained and discussed any payment liability (57.0%)
- Plan of Care was updated, reviewed, and signed by the member (75.0%)

Strengths for MLTSS Performance Measures that scored at or above 86% (Table 40):

- PM #11 POC Developed Using "Person Centered Principles" (91.0%)
- PM #16 Member Training on Identifying/Reporting Critical Incidents (89.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 40):

- PM #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (75.0%)

AGNJ's MLTSS NF Audit Results

Overall, Amerigroup scored 86% or above in the following review elements (Table 39):

- Copies of any Facility Plans of Care on file (90.0%)
- Documented Review of the Facility Plan of Care (100.0%)
- MLTSS Plan of Care on file (87.8%)
- Care Managers used a person-centered approach (88.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (88.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (88.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (88.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (88.0%)
- Member was identified for transfer to HCBS and was offered options (94.0%)
- Member was present at each onsite visit (93.0%)
- Members requiring coordination of care had coordination of care (94.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (90.0%)

- Care Manager educated the Member on how to file a grievance and/or an appeal (91.0%)
- Member and/or representative had training on how to report a critical incident (90.0%)

Amerigroup's Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 39):

- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (16.7%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (13.0%)
- Timely Onsite Review of Member Placement and Services (69.0%)
- Care Manager explained and discussed any payment liability (83.0%)
- NJCA was completed to assess the Member (75.4%)
- Plan of Care was updated, reviewed, and signed by the member (81.0%)

Strengths for MLTSS Performance Measures that scored at or above 86% (Table 40):

- PM #11 POC Developed Using "Person Centered Principles" (88.0%)
- PM #16 Member Training on Identifying/Reporting Critical Incidents (90.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 40):

- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (81.0%)

HNJH's MLTSS NF Audit Results

Overall, Horizon scored 86% or above in the following review elements (Table 39):

- Copies of any Facility Plans of Care on file (87.0%)
- Documented Review of the Facility Plan of Care (100.0%)
- MLTSS Plan of Care on file (98.9%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (100.0%)
- Care Managers used a person-centered approach (98.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (98.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (98.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (98.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (98.0%)

- Updated Plan of Care for a Significant Change (100.0%)
- Member was identified for transfer to HCBS and was offered options (100.0%)
- Member was present at each onsite visit (100.0%)
- Members requiring coordination of care had coordination of care (100.0%)
- NJCA was completed to assess the Member (96.9%)
- Plan of Care was updated, reviewed, and signed by the member (98.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (96.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (96.0%)
- Member and/or representative had training on how to report a critical incident (96.0%)

Horizon's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 39):

- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (15.0%)
- Timely Onsite Review of Member Placement and Services (78.0%)
- Care Manager explained and discussed any payment liability (75.0%)
- Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF (0.0%) – Denominator = 1
- Communication of PASRR Level I to OCCO (0.0%) – Denominator = 1

Strengths for MLTSS Performance Measures that scored at or above 86% (Table 40):

- PM #9 POC Reviewed Annually within 30 days of Anniversary and as Necessary (98.0%)
- PM #11 POC Developed Using "Person Centered Principles" (98.0%)
- PM #16 Member Training on Identifying/Reporting Critical Incidents (96.0%)

UHCCP's MLTSS NF Audit Results

Overall, UnitedHealthcare scored 86% or above in the following review elements (Table 39):

- Documented Review of the Facility Plan of Care (94.9%)
- MLTSS Plan of Care on file (87.2%)
- Updated Plan of Care for a Significant Change (100.0%)
- Members requiring coordination of care had coordination of care (88.0%)

UnitedHealthcare's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 39):

- Copies of any Facility Plans of Care on file (39.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (0.0%)
- Care Managers used a person-centered approach (58.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (58.0%)

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (58.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (58.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (58.0%)
- Member was identified for transfer to HCBS and was offered options (83.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (9.0%)
- Member was present at each onsite visit (83.0%)
- Timely Onsite Review of Member Placement and Services (42.0%)
- Care Manager explained and discussed any payment liability (70.0%)
- NJCA was completed to assess the Member (77.3%)
- Plan of Care was updated, reviewed, and signed by the member (58.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (58.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (58.0%)
- Member and/or representative had training on how to report a critical incident (58.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 40):

- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (58.0%)
- #11. Plans of Care developed using "person-centered principles (58.0%)
- #16. Member training on identifying/reporting critical incidents (58.0%)

WCHP's MLTSS NF Audit Results

Overall, WellCare scored 86% or above in the following review elements (Table 39):

- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (100.0%)
- MLTSS Plan of Care on file (87.2%)
- Updated Plan of Care for a Significant Change (100.0%)

WellCare's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 39):

- Copies of any Facility Plans of Care on file (55.0%)
- Documented Review of the Facility Plan of Care (85.5%)
- MLTSS Plan of Care on file (67.3%)
- Care Managers used a person-centered approach (51.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (52.0%)

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (52.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (51.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (53.0%)
- Member was identified for transfer to HCBS and was offered options (55.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (50.0%)
- Member was present at each onsite visit (63.0%)
- Timely Onsite Review of Member Placement and Services (37.0%)
- Members requiring coordination of care had coordination of care (65.0%)
- Care Manager explained and discussed any payment liability (47.0%)
- NJCA was completed to assess the Member (59.8%)
- Plan of Care was updated, reviewed, and signed by the member (54.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (60.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (66.0%)
- Member and/or representative had training on how to report a critical incident (62.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 40):

- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (54.0%)
- #11. Plans of Care developed using "person-centered principles (51.0%)
- #16. Member training on identifying/reporting critical incidents (62.0%)

2021 MLTSS HCBS Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2020 through 6/30/2021. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. Group C was defined as newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/2020 and 1/1/2021; Group D was defined as existing Medicaid Managed Care (MMC) members enrolled in MLTSS between 7/1/2020 and 1/1/2021; Group E was defined as current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/2020) and continuously enrolled with the MCO in MLTSS through 2/28/2021.

A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. Additionally, for each MCO a random selection of Traumatic Brain Injury members was included in the sample. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 HCBS MLTSS members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure.

MLTSS HCBS Results by Category

Table 42 presents a summary, based on file reviews of all five MCOs performance. The 2021 MLTSS HCBS Care Management audit tool, was comprised of six categories of review elements (Assessment, Outreach, Telephonic Monitoring (Formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing CM and Gaps in Care). The results of individual review elements under each topic were calculated and rolled-up to produce a compliance score for each category.

Individual MCO compliance rates across all three (3) subpopulations ranged from a low of 46.2% for WellCare in the Assessment category to a high of 100.0% for Horizon in the Gaps in Care/Critical Incidents category. In review of total scores, three (3) MCOs (Aetna, Amerigroup and Horizon) scored above 90% in the Assessment category, two (2) MCOs (Horizon and WellCare) scored above 93% in the Outreach category, three (3) MCOs (Amerigroup, Horizon and WellCare) scored above 88% in the Telephonic Monitoring (Formerly Face-to-Face) Visits category, three (3) MCOs (Amerigroup, Horizon and WellCare) scored above 86% in the Initial Plan of Care (Including Back-up Plans) category, zero (0) MCOs scored above 86% in the Ongoing Care Management category, and all five (5) MCOs (Aetna, Amerigroup, Horizon, WellCare, and UnitedHealthcare) scored 95% and above in the Gaps in Care/Critical Incidents category.

Table 42: 2021 MLTSS HCBS Results by Category

Determination by Category 7/1/2020 – 6/30/2021	AETNA				AMERIGROUP				HORIZON				UNITED				WELLCARE				NJ Weighted Average[1]
	Group				Group				Group				Group				Group				
	C	D	E	Total	C	D	E	Total	C	D	E	Total	C	D	E	Total	C	D	E	Total	
Assessment[2]		91.6%		91.6%		90.3%		90.3%		93.2%		93.2%		48.4%		48.4%		46.2%		46.2%	71.8%
Outreach[3]	92.3%	76.5%		81.8%	80.0%	77.9%		78.2%	88.9%	97.4%		93.2%	75.0%	70.8%		71.2%	100.0%	92.2%		93.4%	83.6%
Telephonic Monitoring (Formerly Face-to-Face) Visits	87.4%	93.4%	66.4%	84.3%	82.9%	89.7%	88.1%	88.7%	91.0%	91.3%	90.4%	90.9%	55.9%	59.7%	56.9%	58.6%	96.2%	94.3%	87.7%	92.8%	83.4%
Initial Plan of Care (Including Back-up Plans)	88.9%	88.7%	77.3%	85.2%	88.2%	90.5%	80.8%	87.3%	97.5%	96.3%	86.7%	93.8%	66.2%	74.5%	74.0%	73.8%	94.1%	91.9%	86.8%	90.7%	86.1%
Ongoing Care Management	72.4%	72.4%	53.9%	68.5%	78.8%	71.5%	71.0%	72.1%	84.1%	81.0%	75.0%	81.1%	60.9%	59.4%	46.2%	57.0%	62.2%	78.1%	64.8%	73.5%	70.5%
Gaps in Care/Critical Incidents	96.2%	100.0%	96.9%	98.2%	75.0%	97.9%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	81.3%	96.9%	94.4%	95.0%	96.0%	99.2%	98.1%	98.5%	97.6%

Group C - Members New to Managed Care and Newly Eligible to MLTSS.

Group D - Current Members Newly Enrolled to MLTSS.

Group E - Members Enrolled in the MCO and MLTSS prior to the review period.

[1]The weighted average is the sum of all numerators compliant charts divided by the sum of all charts in the denominator and include all three subpopulations.

[2]MLTSS Assessment is not performed for members in Group C and Group E because they are already enrolled in MLTSS.

[3]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.

Table 42 contains individual MCO's aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's audit results for the combined MLTSS sample ranged from 68.5% to 98.2% across all three (3) populations for the six (6) audit categories.

AGNJ's audit results for the combined MLTSS sample ranged from 72.1% to 96.4% across all three (3) populations for the six (6) audit categories.

HNJH's audit results for the combined MLTSS sample ranged from 81.1% to 100% across all three (3) populations for the six (6) audit categories.

UHCCP's audit results for the combined MLTSS sample ranged from 48.4% to 95.0% across all three (3) populations for the six (6) audit categories.

WCHP's audit results for the combined MLTSS sample ranged from 46.2% to 98.5% across all three (3) populations for the six (6) audit categories.

Strengths and Opportunities for Improvement

IPRO provided the MCOs with recommendations for all opportunities for improvement. Those recommendations can be found in **Appendices B-F**. Below, for each MCO are the strengths and opportunities for improvement identified by IPRO.

ABHNJ

ABHNJ scored at or above 86% in the following categories by population:

- Assessment (Group D)
- Outreach (Group C)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups C and D)
- Initial Plan of Care (Including Back-up Plans) (Groups C and D)
- Gaps in Care/Critical Incidents (Groups C, D, and E)

Opportunities for Improvement were noted in the following categories by population:

- Outreach (Group D)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups E)
- Initial Plan of Care (Including Back-up Plans) (Group E)
- Ongoing Care Management (Groups C, D, and E)

AGNJ

AGNJ scored at or above 86% in the following categories by population:

- Assessment (Group D)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups D and E)
- Initial Plan of Care (Including Back-up Plans) (Groups C and D)
- Gaps in Care/Critical Incidents (Groups D and E)

Opportunities for Improvement were noted in the following categories by population:

- Outreach (Groups C and D)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups C)
- Initial Plan of Care (Including Back-up Plans) (Group E)
- Ongoing Care Management (Groups C, D, and E)
- Gaps in Care/Critical Incidents (Group C)

HNJH

HNJH scored at or above 86% in the following categories by population:

- Assessment (Group D)
- Outreach (Groups C and D)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups C, D, and E)
- Initial Plan of Care (Including Back-up Plans) (Groups C, D, and E)
- Gaps in Care/Critical Incidents (Groups C, D, and E)

Opportunities for Improvement were noted in the following categories by population:

- Ongoing Care Management (Groups C, D, and E)

UHCCP

UHCCP scored at or above 86% in the following categories by population:

- Gaps in Care/Critical Incidents (Groups D and E)

Opportunities for Improvement were noted in the following categories by population:

- Assessment (Group D)
- Outreach (Groups C and D)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups C, D, and E)
- Initial Plan of Care (Including Back-up Plans) (Groups C, D, and E)
- Ongoing Care Management (Groups C, D, and E)
- Gaps in Care/Critical Incidents (Group C)

WCHP

WCHP scored at or above 86% in the following categories by population:

- Outreach (Groups C and D)
- Telephonic Monitoring (Formerly Face-to-Face) Visits (Groups C, D, and E)
- Initial Plan of Care (Including Back-up Plans) (Groups C, D, and E)
- Gaps in Care/Critical Incidents (Groups C, D, and E)

Opportunities for Improvement were noted in the following categories by population:

- Assessment (Group D)
- Ongoing Care Management (Groups C, D, and E)

Table 43 – 2021 Comparison of MLTSS HCBS Performance Measures

Performance Measure	Group[2]	AETNA	AMERIGROUP	HORIZON	UNITED	WELLCARE	NJ Weighted Average[1]
		7/1/2020 to 6/30/2021	7/1/2020 to 6/30/2021	7/1/2020 to 6/30/2021	7/1/2020 to 6/30/2021	7/1/2020 to 6/30/2021	7/1/2020 to 6/30/2021
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[3]	C	73.1%	80.0%	86.1%	50.0%	83.3%	78.3%
	D	76.5%	77.9%	97.4%	70.8%	92.2%	81.8%
	E						
	TOTAL	76.5%	79.6%	90.9%	74.5%	90.0%	82.3%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	C						
	D						
	E	91.9%	33.3%	93.0%	85.7%	88.6%	79.0%
	TOTAL	91.9%	33.3%	93.0%	85.7%	88.6%	79.0%
#9a. Member's Plan of Care is amended based on change of member condition[5]	C	60.0%	100.0%	100.0%	N/A	N/A	77.8%
	D	100.0%	100.0%	100.0%	100.0%	N/A	100.0%
	E	100.0%	N/A	N/A	N/A	0.0%	50.0%
	TOTAL	75.0%	100.0%	100.0%	100.0%	0.0%	87.0%
#11. Plans of Care developed using "person-centered principles"[6]	C	69.2%	50.0%	100.0%	0.0%	100.0%	77.2%
	D	92.2%	89.7%	94.7%	3.1%	100.0%	73.4%
	E	13.3%	78.1%	96.2%	33.3%	80.8%	59.6%
	TOTAL	64.5%	82.7%	97.0%	11.0%	95.1%	70.3%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	C	100.0%	100.0%	100.0%	71.4%	100.0%	96.8%
	D	100.0%	98.5%	100.0%	95.4%	100.0%	98.6%
	E	100.0%	100.0%	90.9%	73.1%	100.0%	92.7%
	TOTAL	100.0%	99.0%	97.5%	87.8%	100.0%	96.8%
#16. Member training on identifying/reporting critical incidents	C	100.0%	100.0%	100.0%	75.0%	100.0%	97.8%
	D	100.0%	97.1%	100.0%	96.9%	100.0%	98.6%
	E	100.0%	100.0%	100.0%	96.3%	100.0%	99.3%
	TOTAL	100.0%	98.2%	100.0%	95.0%	100.0%	98.7%

[1] The weighted average is the sum of all numerator compliant charts divided by the sum of all charts in the denominator.
[2]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in
the MCO and MLTSS prior to the review period.
[3] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[4]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[5]Members who did not have a documented change in condition during the study period are excluded from this measure.
[6]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
[7]Members in CARS are excluded from this measure.
CNC: Could not calculate; N/A: Not applicable

2021 MLTSS HCBS Performance Measures Findings

In review of this year's total scores that include all three (3) MLTSS subpopulations (July 1, 2020-June 30, 2021), individual MCO results ranged from 0.0% to 100.0% across all six (6) MLTSS Performance Measures **(Table 43)**. Two (2) MCOs (Horizon and WellCare) had a compliance rate of 90% and above for Performance Measure #8 (Initial Plan of care established within 45 days of enrollment into MLTSS HCBS). Two (2) MCOs (Aetna and Horizon) had a compliance rate above 91% for Performance Measure #9 (Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary). Three (3) MCOs (Amerigroup, Horizon and UnitedHealthcare) had a compliance rate of 100% for Performance Measure #9a (Member's Plan of Care is amended based on change of member's condition). Two (2) MCOs (Horizon and WellCare) had a compliance rate above 95% for Performance Measure #11 (Plans of Care developed using "person-centered principles"). Four (4) MCOs (Aetna, Amerigroup, Horizon and WellCare) had a compliance rate of 97% and above for Performance Measure #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan. All five (5) MCOs (Aetna, Amerigroup, Horizon, UnitedHealthcare and WellCare) had a compliance rate of 95% and above for Performance Measure #16 (Member training on identifying/reporting critical incidents).

MLTSS 2021 Care Management and Continuity of Care Annual Assessment

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by the five MCOs, as evidence of compliance of the standards under review; interviews with key MCO staff (held via WebEx on August 23, 2021 and August 24, 2021); and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

During the offsite review, the MCO had the opportunity to provide supplemental documentation as requested by IPRO.

The MLTSS Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements. The rating scale for *Met* and *Not Met* elements is presented in **Table 44** below:

Table 44: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Not Met	Not all the required parts within the element were met.	Full, Partial

There are 10 contractual provisions in the 2021 MLTSS Care Management category. **Table 45** presents the total compliance scores for the five MCO's which ranged from 70% to 100%.

Table 45: Compliance Scores by MCO for the 2021 MLTSS Care Management and Continuity of Care Annual Assessment Elements

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	10	10	10	**100%**
AGNJ	10	10	10	**100%**
HNJH	10	10	10	**100%**
UHCCP	10	7	3	**70%**
WCHP	10	10	10	**100%**

Table 46 presents the summary of findings for each element reviewed during the 2021 MLTSS Annual Assessment Care Management audit.

Table 46: Summary of Findings for MLTSS Care Management and Continuity of Care

Annual Assessment CM Element	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
CM18b	X	X	X	X	X
CM28	X	X	X	X	X
CM29	X	X	X	X	X
CM30	X	X	X	X	X
CM31	X	X	X	-	X
CM32	X	X	X	X	X
CM34	X	X	X	-	X
CM36	X	X	X	X	X
CM37	X	X	X	-	X
CM38	X	X	X	X	X
TOTAL	**10**	**10**	**10**	**7**	**10**
Compliance Percentage	**100%**	**100%**	**100%**	**70%**	**100%**

One (1) MCO (UHCCP) did not meet compliance for MLTSS Care Management elements. All MCOs were provided recommendations for elements that were Not Met. These recommendations can be found in **Appendices B-F**.

VIII. Focus Studies of Health Care Quality

2019 Maternal Mortality Focused Study

Objectives

In 2019, at the request of DMAHS, IPRO developed a clinical focused study on maternal mortality. This study aimed to investigate pregnancy-associated and pregnancy-related deaths in the New Jersey Medicaid population. For the purposes of this study, pregnancy-associated death was defined as death of a woman within 1 year of the termination of a pregnancy (excluding those terminated by elective abortion). This was a retrospective cohort study of Medicaid-enrolled women who died in 2017 and 2018 within one year of the termination of a pregnancy that occurred while the woman was enrolled in New Jersey Medicaid. Because of the small population of focus, statistical comparisons to the general maternal population were not conducted. The focused study was ongoing in 2020 and concluded in 2021.

Technical Methods of Data Collection and Analysis

IPRO developed a value set to identify all potential terminations of pregnancy using diagnosis codes and procedure codes. This value set was used to identify all women in the New Jersey Medicaid population who had a potential termination of pregnancy with dates of service from January 1, 2016 to December 31, 2018. Both MCO encounter data and State FFS data were used to identify these cases. A universe of unique Medicaid enrollees was created using the latest date of service for the potential pregnancy terminations. Based on this universe, the State provided IPRO with a file of all Medicaid enrollees who died between January 1, 2017 and December 31, 2018.

IPRO compared the dates of death to the most recent potential terminations of pregnancy to identify women where death occurred within 12 months. Forty-five (45) cases were identified for review.

IPRO identified the MCO of record at the time of termination of pregnancy and at the time of death. FFS status was also identified if the Medicaid enrollee was not enrolled in an MCO at either the date of termination or the date of death. IPRO requested medical records, care/case management records, and the findings from any investigation from each MCO of record. For FFS cases, IPRO identified providers using claims data and directly requested records from those providers.

Study questions included:

1. What is the total number of pregnancy-associated deaths in the New Jersey Medicaid population during the study period?
2. Of these pregnancy-associated deaths, how many were pregnancy-related?
3. Are there disparities in pregnancy-associated deaths in the New Jersey Medicaid population associated with member demographics or health-related variables such as:
    a. race/ethnicity;
    b. age at death;
    c. medical and behavioral risk factors such as hypertension (pre-pregnancy and gestational), diabetes (pre-pregnancy and gestational), obesity, and smoking;
    d. when prenatal care was initiated (i.e., 1st trimester, 2nd trimester, 3rd trimester, or no prenatal care) and the frequency of prenatal visits; and
    e. postpartum care on or between the 21st day and the 56th day after delivery of a live birth.

Description of Data Obtained

Data sources for this study included medical records, MCO care management records, MCO documentation such as investigations into unexpected deaths, administrative claims data, and eligibility data.

The initial Study population universe, based on claims data, consisted of 45 cases from four MCOs and FFS Providers. The four MCOs were Aetna Better Health of New Jersey (ABHNJ), Amerigroup New Jersey, Inc. (AGNJ), Horizon NJ Health (HNJH), and UnitedHealthcare Community Plan (UHCCP). One MCO, WellCare Health Plans of New Jersey, Inc. (WCHP) had no cases that met criteria for inclusion. IPRO reviewed detailed claims for the 45 cases prior to requesting medical and MCO records. One case was excluded based on a review of claims and eligibility. This case was an 83 year-old female. Two other cases were determined to be expected deaths, based on claims data. These cases remain part of the study as they met eligibility criteria for pregnancy associated death.

Conclusions and Comparative Findings

Maternal Death Outcomes

Approximately 60% of pregnancy-related deaths occur within 42 days of the termination of pregnancy. Maternal death outcomes evaluate the timing of the woman's death in relation to the termination of pregnancy. At the time of this study, women who qualified for Medicaid in New Jersey based on pregnancy status retained coverage for 60 days after the termination of the pregnancy. After 60 days, coverage was terminated if they no longer met Medicaid eligibility criteria.

Table 47 and **Table 48** describe the timing of the enrollees' death after the termination of pregnancy. The analysis reveals that for this Study population, 78.1% of women died more than 61 days after the termination of pregnancy.

Of the seven (7) women who died less than or equal to 60 days after the termination of pregnancy, none (0.0%) had documentation of any postpartum care. In 71.4% (5/7) of cases, the women had chronic medical conditions, with 60% (3/5) of those having more than three chronic medical conditions. Only 28.6% (2/7) of these cases had a pregnancy related condition, both of which were preeclampsia. Only 8.0% (2/25) of women who died greater than 61 days from the termination of pregnancy had documentation of any postpartum care.

Table 47: Timing of Death after Termination of Pregnancy

Timing of Death After Termination of Pregnancy	Count	Percent
N=32		
Less than or equal to 60 days	7	21.9%
Greater than or equal to 61 days	25	78.1%
Grand Total	**32**	**100.0%**

Table 48: Timing of Death after Termination of Pregnancy by Month

Timing of Death After Termination of Pregnancy by Month	Count	Percent
N=32		
Less than one month	4	12.5%
Between one to three months	5	15.6%
Between four to six months	9	28.1%
Between seven to nine months	7	21.9%
Between ten to twelve months	7	21.9%
Grand Total	**32**	**100.0%**

Table 49 shows the final determinations of pregnancy associated, pregnancy related, and expected deaths based on the review of claims, medical record review, and analysis of all Study variables. For 21.7% (9/32) of cases, the documentation received was insufficient to make a definitive determination of whether the death was pregnancy related.

Table 49: Study Outcomes

Study Outcomes	Yes	No	UTD	Numerator	Denominator	Percent	Denom without UTD	Percent without UTD
Enrollee's death was pregnancy associated	40	0	0	40	40	100.0%		
Enrollee's death was expected	6	32	2	6	40	15.0%	38	15.8%
Enrollee's death was pregnancy related	5	18	9	5	32	15.6%	23	21.7%

Table 50 describes each pregnancy related death for an examination and comparison of relevant Study variables.

Table 50: Pregnancy Related Death Case Variables

Pregnancy Related Death Case Variables	Case 1	Case 2	Case 3	Case 4	Case 5
Age	34	37	27	38	37
Race/Ethnicity	Unknown/Non-Hispanic	Black/African American	Black/African American	Other/Hispanic	Other/Non-Hispanic
Received Prenatal Care	√			√	
Received Postpartum Care					
Enrolled in Care Management		√			
Enrolled in OB Care Management		√			
Anchor Event	Delivery (Vaginal)	Delivery (Vaginal)	Delivery (Vaginal)	Delivery (C-Section)	Delivery (Vaginal)
Pregnancy Term at Delivery	Moderate Preterm (32 weeks to 34 weeks)	Late Preterm (34 weeks to 37 weeks)	Late Preterm (34 weeks to 37 weeks)	Full Term (≤39 weeks)	Early Term (37 weeks to 38 weeks)
Fetal Demise		√			√
Chronic Medical Conditions	√	√	√		
Pregnancy Related Conditions				√	√
Mental Health Conditions	√	√			
History of Depression	√	√	√		
History of Substance Use	√	√	√		
History of Nicotine Use	√	√	√		

The analysis revealed that 15.6% (5/32) of deaths were pregnancy related. Pregnancy associated but not pregnancy related deaths accounted for 56.3% (18/32) of the cases. Pregnancy related death status could not be determined for 28.1% (9/32) of the cases.

IPRO provided DMAHS with case summaries for the pregnancy related and pregnancy associated but not related deaths. The cases for which no determination could be made ranged in ages twenty-two to forty-one years old with a mean age of 28.1 years. These patients died between seven weeks and eleven months following the termination of pregnancy, with a mean of 25.6 weeks. Determinations for these cases could not be made because of lack of sufficient documentation relating to cause of death.

IX. Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the State Encounter Data Monitoring Unit (EDMU), and the EQRO. In 2017, DMAHS partnered with its EQRO, IPRO, to conduct an MCO system and encounter data process review to include a baseline evaluation of the submission and monitoring of encounter data. As of October 2017, IPRO has been attending the monthly EDMU calls with the MCOs. In 2021, IPRO continues to monitor encounter data submissions and patterns.

On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from Gainwell Technologies (formerly DXC Technology). IPRO loads the following data to IPRO's Statistical Analysis Software (SAS) data warehouse: member eligibility, demographic, TPL information, State-accepted institutional inpatient and outpatient, professional, pharmacy, dental, home health, transportation, and vision encounter data. Starting June 2020, IPRO also began receiving a monthly supplemental pharmacy file that includes additional data elements. During 2021, IPRO worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts.

Pharmacy Claims vs. Encounter Data Validation

At the request of DMAHS, IPRO undertook a detailed analysis of pharmacy encounter data. In 2021, IPRO completed the Pharmacy Encounter Data Study.

Objectives

In 2021, the EQRO continued the pharmacy audit study with the Core Medicaid and FIDE SNP MCOs and EDMU. The objective of the audit was to verify the accuracy of pharmacy encounter data submitted to DMAHS by all five NJ Medicaid MCOs and all four FIDE SNP MCOs. The pharmacy encounter data submitted to DMAHS was reconciled to the corresponding source claim data from the originally adjudicated claims and differences were identified and investigated. Review period of the audit includes a nine-month survey period of April 1, 2018 to December 31, 2018. The EQRO selected a random sample of 1,000 Core Medicaid and 1,000 FIDE SNP pharmacy encounters for each month for each NJ Medicaid and FIDE SNP MCO. The MCOs provided the adjudicated claim information and the EQRO identified discrepancies. The EQRO worked closely with the MCOs and EDMU to review the discrepant data elements. During February 2021, the EQRO scheduled the MCO teleconferences to review the discrepant records. During the remote meetings, the MCOs and their PBMs provided an overview of the processes involved with the receipt, translation, and adjudication of pharmacy claims, the submission of pharmacy encounter data to DMAHS, and the reconciliation of the denied encounters. Each of the encounters that illustrated data discrepancies was reviewed during the remote meetings and the MCO, IPRO, and DMAHS discussed in detail the discrepant data values and identified any follow-up items required. The study has been completed, and IPRO provided DMAHS with a summary of findings report in May 2021, including identification of challenges and recommendations.

Conclusions and Comparative Findings

Below is the summary of findings section of the report issued August 2021:
As a result of the pharmacy encounter data study, the discrepant data element reviews during and following the MCO remote meetings identified the following challenges and recommendations:

- For Aetna, issues were identified with the non-compound quantity dispensed values provided on the PBM file for the study. The non-compound quantity dispensed included in the NJMMIS encounter was 1/10th the value provided on the PBM file. The non-compound quantity dispensed included in the NJMMIS encounters matched the values reviewed on the PBM claims adjudication system.
    - IPRO recommends that for any future pharmacy encounter data requests to Aetna, it is highlighted to Aetna that they provide the quantity dispensed value on their PBM claims adjudication system.

- For Amerigroup, the current recipient ID (CID) provided on the PBM file did not match the CID on IPRO's DW. During the remote meeting, Amerigroup stated that the CID in the NJMMIS encounter was different than the CID on IPRO's DW. Following the remote meeting, EDMU advised that the CID on IPRO's DW was the member's CID as of the date of service. The member's CID changed subsequently, and Amerigroup submitted the new CID on the NCPDP file. IPRO requested Amerigroup to provide the encounter submission date and confirm whether member eligibility is verified prior to submitting the encounter. Amerigroup stated the encounter submission date and confirmed that Amerigroup verifies eligibility as part of their encounter data submission process.
    - IPRO recommends a follow-up discussion between IPRO and DMAHS to clarify the process of the population of the CID field on Gainwell extracts to IPRO in cases where the CID of member changes.
- For Horizon, differences in the non-compound ingredient cost provided on the Core Medicaid and FIDE SNP PBM files were identified. Horizon is contracted with two different PBMs for Core Medicaid and FIDE SNP. The Core Medicaid PBM provided the approved ingredient cost on the PBM file, but the FIDE SNP PBM provided the pharmacy-submitted ingredient cost.
    - IPRO recommends that for any future pharmacy encounter data requests to Horizon, it is highlighted to Horizon that the approved ingredient cost value, which is included on the NCPDP file, should be submitted.
- For all MCOs, issues were identified with the compound Unit of Measure (UOM) data element values included on IPRO's DW. As per the NCPDP file specifications, MCOs only report the first compound UOM in the NJMMIS encounter. However, IPRO receives UOMs for all compound ingredients.
    - IPRO recommends that DMAHS further research the discrepant records with Gainwell and identify whether any changes to IPRO's monthly pharmacy extract is necessary.
- During the initial IPRO/DMAHS analysis of data discrepancies it was discovered that the prescription number being sent to IPRO in the monthly NJMMIS feed of encounters data is being truncated when the NJMMIS data file is built. It was therefore decided that the data for prescription number could not be reconciled, and that data element was excluded from the reconciliation. An NJMMIS project to correct the loading of prescription number in the IPRO feed will be requested.
- During the remote meetings, MCOs identified processes in place of how they utilize the First Databank and/or the MediSpan files for confirmation of various data elements.
    - IPRO recommends that DMAHS further review the Core Medicaid and FIDE SNP MCO processes in place regarding the submitting of compound NDCs, UOMs and ingredient quantities on encounter data to ensure consistency across plans. To help accomplish this, DMAHS recommends exploring contract changes that mandate the use of a single drug data repository by all MCOs.
- During the remote meetings, it was identified that there were almost no occurrences of Medicare payments in all Core Medicaid samples. The DMAHS will follow-up with all MCOs to confirm that all Medicare payments are being reported for non-FIDE SNP dual members.

X. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement (QI) made by the EQRO during the previous year's EQR." **Tables 51–55** display the MCOs' responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

ABHNJ Response to Previous EQR Recommendations

Table 51 displays ABHNJ's progress related to the *State of New Jersey DMAHS, Aetna Better Health of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of ABHNJ's response.

Table 51: ABHNJ Response to Previous EQR Recommendations

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The Plan should continue to contract with hospitals to improve access to care in deficient counties.	ABHNJ continues to monitor our network ensuring adequate access to care. Currently, we have hospital deficiencies in 3 counties, Sussex, Salem, and Warren. We are in active negotiations with 2 hospital systems which will close these gaps. We are anticipating finalizing negotiation by QTR4 2021. Salem Medical Hospital, St. Luke's Hospital	Addressed
The Plan should continue to expand the MLTSS network to include at least two providers in every county.	ABHNJ continues to review our GEO data to identify gaps within our network. An action plan is developed based on these finding to assure prompt action plans to fill deficiencies. Currently, we have identified gaps in AMDCs in Cape May, Hunterdon, Sussex and Warren Counties, Social Day deficiencies within Hunterdon, Morris, Salem, Sussex, and Warren Counties.	Remains an opportunity for improvement – MLTSS network compliance is not related to GEOAccess data.
The Plan should continue to address deficiencies identified in their provider network for adult PCPs, OB/GYNs, and behavioral health providers who fail to meet the required accessibility standards, as well as improve after-hours availability for PCPs.	ABHNJ will continue to outreach providers who have failed access standards. We currently mail letters to failed providers, including correspondence on access standards and requirements. We include this information on our website as well as periodic newsletters. Post pandemic ABHNJ will continue with our in-office meetings to individually discuss specific areas where the provider/group has failed access and speak to requirements.	Addressed
The Plan should develop a comprehensive approach to ensure applicable PM documentation is submitted correctly and timely.	ABHNJ has assigned a Project Manager to track and monitor completeness and timeliness of report submission. A tracking system has been implemented detailing the requests, due dates, and responsible parties for completion. At each point of data or reporting completion, at least two staff members review the results for completeness and accuracy. This includes checking incoming data files for accuracy, data prepared for the HEDIS vendor, checks for completeness of data load to HEDIS vendor software, accuracy of	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	HEDIS rates calculated by the vendor software, and accuracy of NJ-specific rates and member level files prior to submission to IPRO. Aetna has worked with the HEDIS vendor to ensure language and diversity fields are populated automatically, eliminating the need for manual updates.	
The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.	ABHNJ submitted a 2020 HEDIS Workplan to the State for review which included a barrier analysis and interventions to address each measure that fell below the NCQA 50th percentile. An interdisciplinary HEDIS workgroup was developed to monitor rate improvement on an ongoing basis with quarterly updates to be included within the workplan. New interventions are identified within the workplan and include, but not limited to, IVR and SMS campaigns focused on gap closure for adult, adolescent and well-child visits, annual dental visits, well-woman measures, asthma, and diabetes. ABHNJ continues to work with targeted provider groups to improve member outcomes by Quality Management and Population Health Specialists by frequently meeting with providers, reviewing medical records, claims data, and member rosters to identify opportunities for improvement specific to each practice. These initiatives are supplemented with member and provider incentives and member outreach.	Addressed
The Plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should ensure they have enough members for the population of their PIPs in order to gather meaningful data.	ABHNJ hired a new clinical lead to oversee the development, implementation, and oversight of Performance Improvement Projects. The clinical lead will meet with the Director of Quality Management at least monthly to review the monitoring plan and PIP results will be report to the Quality Management Committee on a quarterly basis. The clinical lead will also meet with the identified key PIP stakeholders monthly to review implementation and progress of PIP interventions. Attendance and meeting minutes will be maintained to ensure appropriate follow-up. In addition, the clinical lead will conduct and present a quarterly analysis to key PIP stakeholders to discuss potential barriers and the need for new or modified interventions. PIP stakeholders will attend IPRO's annual PIP Training. New PIP stakeholders will be trained by the Director of Quality Management and clinical lead on PIP requirements between annual IPRO trainings.	Addressed
For the 2020 Core Medicaid CM Audit, recommendations include the following: Recommendations for the Preventive Services Category for the DDD Population include:	The ABHNJ care managers contact the PCP for confirmation of EPSDT exams and immunization records. The ICM staff are now registered and utilizes the New Jersey Immunization information system. All members regardless of age are assigned a dental home. A new monthly report measures dental preventive utilization in the DDD population. We also measure utilization of all dental services for this population quarterly. A dental directory identifying dentists who treat DDD members is available on the member and provider side of the Aetna Better Health of New Jersey website. Care managers contact Liberty dental for claims information on the members to identify gaps and follow-up with the members/Caregiver	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• Aetna should ensure EPSDT exams and immunizations are confirmed by a reliable source, such as the PCP, and NJ immunization registry. • Aetna should ensure that dental needs are addressed for all members, particularly members 21 years of age and older. • Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.	to provide education and follow-up. Concentration will be on the members ages 21 and over. The Care managers provide dental education and follow-up on all DDD members ages 1 to 21 years of age annually and as needed.	
For the 2020 Core Medicaid CM Audit, recommendations include the following: Recommendations for the Continuity of Care Category for the DDD Population include: • Aetna should ensure all members receive a Comprehensive Needs Assessment within 45 days of enrollment. • Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA.	The Care Managers at ABHNJ provides Comprehensive Needs assessments within 45 days of enrollment, by aggressively outreaching the member to ensure enrollment. The engagement Hub has increased the CMA staff to ensure timely initial outreach and our dynamo system has flags to ensure timely outreach ABHNJ has initial a plan that all Care plans are developed and implemented within 24 hours with all required components within 24 hours of a completed CNA by the Care Managers.	Addressed
For the 2020 Core Medicaid CM Audit, recommendations	The ABHNJ Care managers continue to focus on age-appropriate immunizations for all the DCP&P children in Care management. The Care managers contacts the PCP, DCP&P nurse, or case manager for passports and updates. The ICM staff is now registered and utilizes	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
include the following: Recommendations for the in Preventive Services Category for the DCP&P Population include: • Aetna should continue to focus on age-appropriate immunizations for the child population enrolled in care management. • Aetna should ensure immunizations are confirmed by a reliable source, such as the PCP, NJ immunization registry, DCP&P nurse. • Aetna should ensure that dental needs are addressed for all members. Care Managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. • Aetna should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.	the New Jersey Immunization information System to Confirm immunizations, identify gaps, education the member/caregiver and ensure follow-up. All members regardless of age are assigned a dental home. A new monthly report measures dental preventive utilization in children. Children who do not see a dentist for preventive services are contacted by text messaging and letter. Dental providers are notified monthly of children who have not seen a dentist for a preventive service. A dental directory identifying dentists who treat children is available on the member and provider side of the Aetna Better Health of New Jersey website Care managers contact Liberty dental for claims information on the members to identify gaps and follow-up with the member/Caregiver to provide education and follow-up. The Care managers will ensure all members are tested for lead between the ages of 9 months and 72 months. The Care managers can offer incentives and home testing to our members. ABHNJ care managers communicate with the PCP, Public health nurses, Clinics and State Data base to confirm and to identify the need for follow-up and education. The high lead members are Case managed by a dedicated lead nurse.	
For the 2020 Core Medicaid CM Audit, recommendations include the following: Recommendations for the Continuity of Care Category for	The Care Managers at ABHNJ provides Comprehensive Needs assessments within 45 days of enrollment, by aggressively outreaching the member to ensure enrollment. The engagement Hub has increased the CMA staff to ensure timely initial outreach and our dynamo system has flags to ensure timely outreach ABHNJ has initial a plan that all Care plans are developed and implemented within 24 hours with all required components within 24 hours of a completed CNA by the Care Managers.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
the DCP&P Population include: • Aetna should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment. • Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.		
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Assessment category include: • Group D: Aetna should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA). Aetna should confirm the NJCA and PCA assessments are consistent or in agreement, to certify appropriate services are authorized and	Aetna uses the NJ Screen for Community Services in accordance with Article 5.4.E and completed NJCA dependent on the outcome of the SCS. Care Management Audit contains metric stating, "Group D (conversions): The Contractor shall utilize the NJ Screen for Community Services screening tool prior to conducting a NJ Choice Assessment to identify the individual's care needs will likely meet the clinical eligibility criteria for MLTSS." NJCA and PCA assessments should be congruent with the members assessed needs and time provided for said needs. Care Management audits have a metric stating "NJCA and PCA align and identify needs". Due to PHE, this item is scored N/A at the present time. Care Managers receive training on PCA tool during MLTSS Care Management Training class with the plan trainer as well as Aetna Learning and Performance team. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff is counseled per ABH policy.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
provided to the member.		
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Face-to-Face Visits category include: • Group C: Aetna should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Aetna should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Aetna should ensure that a cost neutrality analysis is completed during the review period.	Interim Plan of Care is included on the LTSS workflows and indicates requirement for signature by member or member's representative. This is also included on our Care Management audits. The metric states "Upon completion of the NJ Choice Assessment, an assessor certified by the State to perform Options Counseling, shall provide Options Counseling to the Member and complete the Interim Plan of Care form, including obtaining the Member's signature". Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Care Manager audit includes metric "When a Member expresses interest in pursuing the participant direction option, the Care Manager shall complete the Participant Direction Application Package and sent to DMAHS within 10 BD". Aetna is also arranging an alternate data tracking system through the QuickBase program for more efficient tracking and follow up. This is also listed on the LTSS workflow for care managers to follow the steps as indicated for timeliness. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Cost Neutrality Analysis is listed on the LTSS workflow indicating the circumstances when member would need a CEA completed as per 9.3.2. The CEA is not completed during interval visits unless the member has potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment or significant change assessment. This metric is noted on the Care Management audit "The MCO shall be responsible for conducting a cost effectiveness analysis to determine the most cost-effective placement where the Member's health and welfare needs can be adequately met. The MCO shall complete a cost effectiveness analysis for all MLTSS Members currently in, or with potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment, annual reassessment or significant change assessment." Care Managers receive training on CEA during MLTSS Care Management Training class with the plan trainer as well as Aetna Learning and Performance team. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	Addressed
• Group D: Aetna should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to	Care Manager audit includes metric "When a Member expresses interest in pursuing the participant direction option, the Care Manager shall complete the Participant Direction Application Package and sent to DMAHS within 10 BD". Aetna is also arranging an alternate data tracking system through the QuickBase program for more efficient tracking and follow up. This is also listed on the LTSS workflow for care managers to follow the steps as indicated for timeliness. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
self-direct. Aetna should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.	with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Cost Neutrality Analysis is listed on the LTSS workflow indicating the circumstances when member would need a CEA completed as per 9.3.2. The CEA is not completed during interval visits unless the member has potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment or significant change assessment. This metric is noted on the Care Management audit "The MCO shall be responsible for conducting a cost effectiveness analysis to determine the most cost-effective placement where the Member's health and welfare needs can be adequately met. The MCO shall complete a cost effectiveness analysis for all MLTSS Members currently in, or with potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment, annual reassessment or significant change assessment." The completed CEA must indicate the percentage. Care Managers receive training on CEA during MLTSS Care Management Training class with the plan trainer as well as Aetna Learning and Performance team. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	
• Group E: Aetna should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Aetna should ensure that a cost neutrality analysis is completed during the review period and the annual cost threshold should be documented as a numeric percentage.	Interim Plan of Care is included on the LTSS workflows and indicates requirement for signature by member or member's representative. This is also included on our Care Management audits. The metric states "Upon completion of the NJ Choice Assessment, an assessor certified by the State to perform Options Counseling, shall provide Options Counseling to the Member and complete the Interim Plan of Care form, including obtaining the Member's signature". Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Cost Neutrality Analysis is listed on the LTSS workflow indicating the circumstances when member would need a CEA completed as per 9.3.2. The CEA is not completed during interval visits unless the member has potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment or significant change assessment. This metric is noted on the Care Management audit "The MCO shall be responsible for conducting a cost effectiveness analysis to determine the most cost-effective placement where the Member's health and welfare needs can be adequately met. The MCO shall complete a cost effectiveness analysis for all MLTSS Members currently in, or with potential for placement in an HCBS setting at the time of the NJ Choice assessment system completion for enrollment, annual reassessment or significant change assessment." The completed CEA must indicate the percentage. Care Managers receive training on CEA during MLTSS Care Management Training class with the plan trainer as well as Aetna Learning and Performance team. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Initial Plan of Care (Including Back-up Plans) category include: • Group C: Aetna should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. Aetna should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. Members should be offered options and provided a choice of MLTSS service delivery including PACE during Options Counseling. Aetna should confirm the State mandated Back-up Plan is completed, signed,	When members enroll in ABH MLTSS, support team completes outreach and schedules the visit on behalf of the care manager. This visit is scheduled as early as possible, but no later than 45 days of enrollment. Care managers are not permitted to reschedule these initial visits without Supervisor approval to ensure that initial visits are completed timely. Aetna monitors timeliness of visits via our Dashboard and maintains close monitoring of visits approaching their 45-day mark. Care Plan letters that are unable to be completed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Plan of Cares that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Care managers are trained on person centered principles during Aetna Learning and Performance as well as MLTSS CM Class. This item is captured on our Care Management audit stating "Individual (person-centered) plan of care developed in collaboration with the Member, Member's family, significant other and/or the Member's authorized representative.". ABH continues to develop improvements to our LTSS job aide to provide further guidance to our care managers to improve their person-centered principles. Aetna has updated our visit documentation templates for care manager progress notes as of 5/13/21 to include prompts for: Name/relationship of individuals present during the visit; list new (care plan) goals added, list changes made to existing (care plan) goals, list barriers to achieving (care plan) goals. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Members are offered options via the Interim Plan of Care Document. During the PHE, the Interim Plan of Care was waived; the care managers continued to offer options counseling. As of 8/10/21, a PDF version of the Interim Plan of Care was added to the workflow for the care managers to complete for internal monitoring to ensure options are adequately counseled. Training on PACE is provided annually to all care managers; training was provided 6/14/21 via presentation with PACE contacts. Aetna continues to review this metric and means of improving. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. The State mandate Back-up Plan and instructions are provided on the LTSS job aide. The CM are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of concept and documentation requirements. Our Care Management audit tool captures the metric "Back-Up Plans will be completed using the State	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
and dated by the member/member representative. Aetna should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member and the member/member representative confirmed their understanding. Member's Rights and Responsibilities should be signed and dated by the member/member representative.	mandated form for Members enrolled in the MLTSS Program. The Back-Up Plan should be signed and dated by the Member (or Authorized Representative).". Back-up Plans unable to be signed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Back-up Plans that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Aetna LTSS job aid provides details for care managers regarding the requirement to provide member with a hard copy of his/her Rights and Responsibilities on an annual basis. The Care Management Audit tool provides metric "At least annually the Contractor shall ensure that a Member's Care Manager explains the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and report a critical incident. The Contractor shall provide a hard copy of the rights and responsibilities to the Member. The Member must sign and date a statement on an annual basis, indicating that the Member has received the Member's rights and responsibilities in writing, that these rights and responsibilities have been explained to the Member and that the Member understands them. This form shall be maintained in the Member's electronic Care Management.". Care Managers are trained on Rights and Responsibilities during MLTSS Care Management Training class with the plan trainer to ensure their understanding. Rights and Responsibilities that are unable to be signed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Rights and Responsibilities that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Initial Plan of Care (Including Back-up Plans) category include: • Group D: Aetna should ensure that the Initial Plan of Care is completed and signed within 45	When members enroll in ABH MLTSS, support team completes outreach and schedules the visit on behalf of the care manager. This visit is scheduled as early as possible, but no later than 45 days of enrollment. Care managers are not permitted to reschedule these initial visits without Supervisor approval to ensure that initial visits are completed timely. Aetna monitors timeliness of visits via our Dashboard and maintains close monitoring of visits approaching their 45-day mark. Care Plan letters that are unable to be completed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Plan of Cares that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
days of enrollment in the MLTSS program. Aetna should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. Members should be offered options and provided a choice of MLTSS service delivery including PACE during Options Counseling. Aetna should confirm the State mandated Back-up Plan is completed and signed and dated by the member/member representative.	with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Care managers are trained on person centered principles during Aetna Learning and Performance as well as MLTSS CM Class. This item is captured on our Care Management audit stating "Individual (person-centered) plan of care developed in collaboration with the Member, Member's family, significant other and/or the Member's authorized representative.". ABH continues to develop improvements to our LTSS job aide to provide further guidance to our care managers to improve their person-centered principles. Aetna has updated our visit documentation templates for care manager progress notes as of 5/13/21 to include prompts for: Name/relationship of individuals present during the visit; list new (care plan) goals added, list changes made to existing (care plan) goals, list barriers to achieving (care plan) goals. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Members are offered options via the Interim Plan of Care Document. During the PHE, the Interim Plan of Care was waived; the care managers continued to offer options counseling. As of 8/10/21, a PDF version of the Interim Plan of Care was added to the workflow for the care managers to complete for internal monitoring to ensure options are adequately counseled. Training on PACE is provided annually to all care managers; training was provided 6/14/21 via presentation with PACE contacts. Aetna continues to review this metric and means of improving. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. The State mandated Back-up Plan and instructions for completion are listed on the LTSS job aide for completion during each visit for the HCBS member. The Care Managers are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of concept and documentation requirements. Our Care Management audit tool captures the metric "Back-Up Plans will be completed using the State mandated form for Members enrolled in the MLTSS Program. The Back-Up Plan should be signed and dated by the Member (or Authorized Representative).". Back-up Plans unable to be signed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Back-up Plans that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	
For the 2020 MLTSS HCBS CM audit, recommendations	When members enroll in ABH MLTSS, support team completes outreach and schedules the visit on behalf of the care manager. This visit is scheduled as early as possible, but no later than 45 days of enrollment. Care managers are not permitted to reschedule these	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
include the following: Recommendations for the Ongoing Care Management category include: • Group C: Aetna should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS Services during the review period and that the Face-to-Face visits are completed within the appropriate timeframes. Aetna should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Aetna should ensure that members' Back-up Plans are reviewed, signed, and dated at least quarterly for members residing in the Community. Aetna should ensure that Face-to-Face visits from the member's Care Manager are completed within 10 business days of	initial visits without Supervisor approval to ensure that initial visits are completed timely. Aetna monitors timeliness of visits via our Dashboard and maintains close monitoring of visits approaching their 45-day mark. Aetna Support team completes Initial Outreach upon enrollment using a template designed by leadership to include resident type, address, current services in place, services needed. Following an initial MLTSS visit, the care managers use the Care Management system (Dynamo) to set reminders for timely visits, as per the member's placement. Leadership monitors the timeliness of visits via the Dashboard and supports care managers in maintaining timeliness of visits. Each LTSS visit workflow begins with a review of member's place and MLTSS services through the member file review. Aetna leadership developed an additional workflow 2/25/20 to assist care managers in documenting significant change in conditions. Aetna care management system (Dynamo) also provides care managers with an option to document when a care plan has been revised and/ or reviewed. The CM are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of POC concept and documentation requirements. Care Managers are required to capture member/ member repetitive signature to indicate the member's agreement or disagreement with the Plan of Care. Care Plan letters that are unable to be completed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Plan of Cares that are not signed and returned by member are reviewed at the following visit and a signature is obtained. A copy of the care plan letter is mailed to the member for their records as well. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. The State mandated Back-up Plan and instructions for completion are listed on the LTSS job aide for completion during each visit for the HCBS member. The Care Managers are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of concept and documentation requirements. Our Care Management audit tool captures the metric "CM to review Back-up Plan with the Member at least quarterly. Copies of the Back-Up Plan are given to the Member when developed and when there are changes". Back-up Plans unable to be signed by members during a face-to-face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Back-up Plans that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Aetna has implemented new processes to ensure Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Daily, Aetna leadership obtains a report listing any member with a claim for an inpatient stay. The Care Managers receive a daily email notating	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
discharge from an institutional facility to a HCBS setting. The MCO should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.	their members listed and multiple reminders, including to complete post discharge assessments. Aetna has identified area for improvement and has added the language "Face-to-Face visits from the member's Care Manager are required within 10 calendar days of discharge from an institutional facility to a HCBS setting" to the daily emails as of 8/26/21. Aetna leadership team also monitors for successful completion of post discharge assessments within the 10-day period as required. Care Management Audit tool also measures "The Care Manager shall conduct an on-site review within 10 business days following a discharge to an HCBS setting to ensure that appropriate services are in place and that the Member agrees with the service plan as authorized". Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Ongoing Care Management category include: • Group D: Aetna should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS Services during the review period and that the Face-to-Face visits are completed within the appropriate timeframes. Aetna should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member	When members enroll in ABH MLTSS, support team completes outreach and schedules the visit on behalf of the care manager. This visit is scheduled as early as possible, but no later than 45 days of enrollment. Care managers are not permitted to reschedule these initial visits without Supervisor approval to ensure that initial visits are completed timely. Aetna monitors timeliness of visits via our Dashboard and maintains close monitoring of visits approaching their 45-day mark. Aetna Support team completes Initial Outreach upon enrollment using a template designed by leadership to include resident type, address, current services in place, services needed. Following an initial MLTSS visit, the care managers use the Care Management system (Dynamo) to set reminders for timely visits, as per the member's placement. Leadership monitors the timeliness of visits via the Dashboard and supports care managers in maintaining timeliness of visits. Each LTSS visit workflow begins with a review of member's place and MLTSS services through the member file review. Aetna leadership developed an additional workflow 2/25/20 to assist care managers in documenting significant change in conditions. Aetna care management system (Dynamo) also provides care managers with an option to document when a care plan has been revised and/ or reviewed. The CM are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of POC concept and documentation requirements. Care Managers are required to capture member/ member repetitive signature to indicate the member's agreement or disagreement with the Plan of Care. Care Plan letters that are unable to be completed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Plan of Cares that are not signed and returned by member are reviewed at the following visit and a signature is obtained. A copy of the care plan letter is mailed to the member for their records as well. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. The Aetna Plan of Care document provides notification to members of the written notice of action and the members right to file an appeal	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
signs and is provided with a copy of the Plan of Care at each visit. Aetna should ensure that the Care Managers counsel the members on the written notice of action and explain their right to file an appeal when the member disagrees with their Assessment and or Services Authorizations. Aetna should ensure that members' Back-up Plans are reviewed, signed, and dated at least quarterly for members residing in the Community. Aetna should ensure that Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Aetna should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.	when the member disagrees with their Assessment and or Services Authorizations. This information is provided the member in writing and verbally when the Care Management reviews the Plan of Care; the member is also asked to initial on the POC to indicate these instructions were received and explained. This information is also provided in the Member Handbook, which members receive at initial enrollment and reviewed by the Care Manager on an annual basis. Care Management audit contains metric "The Contractor shall counsel Member for Member grievance and appeals and clearly explain the timeframes and process to the Member and/or authorized representative, including the continuation of benefits during the appeal process.". Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. The State mandated Back-up Plan and instructions for completion are listed on the LTSS job aide for completion during each visit for the HCBS member. The Care Managers are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of concept and documentation requirements. Our Care Management audit tool captures the metric "CM to review Back-up Plan with the Member at least quarterly. Copies of the Back-Up Plan are given to the Member when developed and when there are changes". Back-up Plans unable to be signed by members during a face-to-face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Back-up Plans that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Aetna has implemented new processes to ensure Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Daily, Aetna leadership obtains a report listing any member with a claim for an inpatient stay. The Care Managers receive a daily email notating their members listed and multiple reminders, including to complete post discharge assessments. Aetna has identified area for improvement and has added the language "Face-to-Face visits from the member's Care Manager are required within 10 calendar days of discharge from an institutional facility to a HCBS setting" to the daily emails as of 8/26/21. Aetna leadership team also monitors for successful completion of post discharge assessments within the 10-day period as required. Care Management Audit tool also measures "The Care Manager shall conduct an on-site review within 10 business days following a discharge to an HCBS setting to ensure that appropriate services are in place and that the Member agrees with the service plan as authorized". Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Ongoing Care Management category include: • Group E: Aetna should ensure that Care Managers document their actions to resolve any issues that impede members' access to care. Aetna should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period and the Face-to-Face visits are completed within the appropriate timeframes. Aetna should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Aetna should ensure that members' Back-up Plans are reviewed, signed, and dated at	Aetna case managers are required to document all actions taken to resolve any issues that impede member's access to care in the Care Management system (Dynamo). Each care manager undergoes file audits five times per month, during which time the Supervisors ensure all documentation is accurate and complete. Additional audits or review of documentation may be completed when a member issue is known to the MLTSS Supervisor, MLTSS State Liaison. The MLTSS Trainer also periodically reviews care management charts and counsels care managers on documentation recommendations for best practice and completeness. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. When members enroll in ABH MLTSS, support team completes outreach and schedules the visit on behalf of the care manager. This visit is scheduled as early as possible, but no later than 45 days of enrollment. Care managers are not permitted to reschedule these initial visits without Supervisor approval to ensure that initial visits are completed timely. Aetna monitors timeliness of visits via our Dashboard and maintains close monitoring of visits approaching their 45-day mark. Aetna Support team completes Initial Outreach upon enrollment using a template designed by leadership to include resident type, address, current services in place, services needed. Following an initial MLTSS visit, the care managers use the Care Management system (Dynamo) to set reminders for timely visits, as per the member's placement. Leadership monitors the timeliness of visits via the Dashboard and supports care managers in maintaining timeliness of visits. Each LTSS visit workflow begins with a review of member's place and MLTSS services through the member file review. Aetna leadership developed an additional workflow 2/25/20 to assist care managers in documenting significant change in conditions. Aetna care management system (Dynamo) also provides care managers with an option to document when a care plan has been revised and/ or reviewed. The CM are trained during MLTSS Care Management Training class with the plan trainer to ensure understanding of POC concept and documentation requirements. Care Managers are required to capture member/ member repetitive signature to indicate the member's agreement or disagreement with the Plan of Care. Care Plan letters that are unable to be completed by members during an initial face to face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Plan of Cares that are not signed and returned by member are reviewed at the following visit and a signature is obtained. A copy of the care plan letter is mailed to the member for their records as well. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. The State mandated Back-up Plan and instructions for completion are listed on the LTSS job aide for completion during each visit for the HCBS member. The Care Managers are trained during MLTSS Care Management Training class with the plan trainer to ensure	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
least quarterly for members residing in the Community. Aetna should ensure that the MLTSS Care Manager conducts a Face-to-Face visit within 24 hours for urgent/emergent situations that can't be handed telephonically. Aetna should ensure that the Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Aetna should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.	understanding of concept and documentation requirements. Our Care Management audit tool captures the metric "CM to review Back-up Plan with the Member at least quarterly. Copies of the Back-Up Plan are given to the Member when developed and when there are changes". Back-up Plans unable to be signed by members during a face-to-face visit are mailed to members/ member representative with a self-addressed stamped envelope for return to Aetna. Back-up Plans that are not signed and returned by member are reviewed at the following visit and a signature is obtained. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Aetna has updated the MLTSS Significant Change in Condition workflow (8/27/21) to reflect the contractual requirements of 9.6.5.E to ensure that the MLTSS Care Manager conducts a Face-to-Face visit within 24 hours for urgent/emergent situations that can't be handed telephonically. Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy. Aetna has implemented new processes to ensure Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Daily, Aetna leadership obtains a report listing any member with a claim for an inpatient stay. The Care Managers receive a daily email notating their members listed and multiple reminders, including to complete post discharge assessments. Aetna has identified area for improvement and has added the language "Face-to-Face visits from the member's Care Manager are required within 10 calendar days of discharge from an institutional facility to a HCBS setting" to the daily emails as of 8/26/21. Aetna leadership team also monitors for successful completion of post discharge assessments within the 10-day period as required. Care Management Audit tool also measures "The Care Manager shall conduct an on-site review within 10 business days following a discharge to an HCBS setting to ensure that appropriate services are in place and that the Member agrees with the service plan as authorized". Care managers that do not demonstrate sufficient proficiency or are identified as performing poorly with this metric engage in retraining with the plan trainer. If improvement is not noted, staff as counseled per ABH policy.	

[1]A**ddressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2022.

AGNJ Response to Previous EQR Recommendations

Table 52 displays AGNJ's progress related to the *State of New Jersey DMAHS, Amerigroup New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of AGNJ's response.

Table 52: AGNJ Response to Previous EQR Recommendations

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The Plan should continue to recruit adult PCPs, pediatric PCPs, and contract with hospitals to improve access to care in the deficient counties.	On a quarterly basis, Amerigroup monitors the standards for the number and geographic distribution of providers by analyzing provider ratio reports and GeoAccess reports to identify any geographic areas or specialties where standards are not met and take appropriate action to resolve access to care deficiencies. Since 2012, Hunterdon Medical Center (HMC) has refused to contract with another Medicaid MCO despite numerous attempts made by Amerigroup to do so. The most recent outreach was in September 2020 and will continue on an annual basis. HMC is the only hospital in this county and employs most of the physicians. Because of the Hospital's position, the physicians affiliated with the hospital-affiliated IPA will also not contract with Amerigroup. AGP NJ was previously granted a waiver for the facility and network requirements in Hunterdon county, which expired in July 2013. Amerigroup has filled several network waiver requests (October 2017; September and November 2020) and has not received a response. Amerigroup has attempted to cure deficiencies within Warren County in and around the area of highest need -- Phillipsburg 08865 -- but these efforts have uncovered that the St. Luke's hospital system owns the vast majority of area PCP practices. Despite numerous outreach attempts, the St. Luke's Hospital-Warren Campus has not committed to a full contract. The most recent outreach was in December 2020. Due to Amerigroup's continuing inability to obtain meaningful engagement from St. Luke's Hospital-Warren Campus to secure a hospital agreement and the resulting impact this has had on our ability to recruit Pediatric PCPs in the greater Phillipsburg area, a waiver from the current facility and primary care network requirements in N.J.A.C. 11:24:6.3(a)1 for Warren County was requested in September 2020. To date, Amerigroup has not received a response to the waiver request While Amerigroup will continue to make best efforts to cure these deficiencies, the single case agreement (SCA) process will be utilized should any members require services and required transportation will be coordinated through ModivCare (formerly Logisticare). Amerigroup monitors single case agreement requests and there were not any requests for out-of-network PCP care for members in either County in 2020.	Addressed
The Plan should continue to expand the MLTSS network to include at least two providers in social adult day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.	Amerigroup has been unable to identify Providers in Salem County that provide this service. Amerigroup is willing to contract with any provider interested in joining the network and will continue with recruitment efforts in this County. Amerigroup currently has a contract with Caring Inc. in adjacent Cumberland County and transportation, if required, will be arranged at no cost to the member. Single Case Agreements (SCAs) can also be utilized if member requires services at a nonparticipating provider.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The Plan should continue to focus on improving after-hours availability statewide.	To ensure compliance with State regulations, Amerigroup conducts an annual After-Hours audit. Overall compliance for random sample was 75% for the 2020 After Hours survey, administered August 10-25, 2020. For resurveyed providers, this was 64%. Amerigroup continues to apply the same strategy of requiring corrective action plans from all noncompliant providers, providing educational meetings, and sampling corrective action plans to confirm compliance prior to the following year's survey as all non-compliant providers are surveyed again the following year. Amerigroup continues to target efforts on improving compliance with providers that have answering machines, rather than answering services, to ensure that members have access to reach the on-call provider directly after hours by conducting meetings to educate and reinforce all access standards while still requiring formal CAPs.	Addressed
The Plan should continue to focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers.	To ensure compliance State regulations, Amerigroup conducts an annual Appointment Availability audit. The 2020 survey was administered August 19-25, 2020. Overall compliance for random sampling was 91%, which represents a slight drop of 4% over 2019. Overall compliance for PCP's was 94%, 98% for Pediatrics, and 88% for high volume OB/GYN's, 84% for high impact oncologists, and 85% for other specialists. Behavioral Health was 84% for prescribers and 89% for non-prescribers. The reason for the marked decline between 2019 and 2020 was due to in part to Urgent specialty and sick care adherence. Amerigroup attributes the compliance decline due to the pandemic as the survey was conducted in August of 2020 when many offices were impacted by office closures, staffing issues, etc., as well as many were also transitioning over to a telemedicine option. Amerigroup continues efforts on improving compliance with the 24-hour urgent care appointment access requirement through education meetings with providers. Amerigroup has found that Specialists and Behavioral Health providers are the most challenged with this requirement. For Specialists, many feel that their specialty does not provide urgent care services. Additionally, there is limited availability of urgent appointments within 24 hours of request for Specialists. For Behavioral Health, due to the nature of this specialty having longer appointments of 45-60 minutes each, availability of open appointments within 24 hours of request is difficult to meet. Over the next year Amerigroup will review the current calling scripts in an effort to achieve overall increased compliance.	Addressed
The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell	Amerigroup continues to monitor its clinical performance against the NCQA 50th percentile on a monthly basis through benchmark reporting and maintains a HEDIS interventions work plan which is monitored, updated throughout the year and is sent to the State for review. Amerigroup also continues to evaluate the HEDIS work plan on a monthly basis to modify any interventions that re ineffective in meeting and/or exceeding the NCQA 50th percentile. Clinical performance is evaluated annually and reported through the QM Program Evaluation.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
below the NCQA 50th percentile.		
The Plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should review Interventions and Intervention Tracking Measures (ITMs), and ensure data is being collected appropriately. The Plan should also follow appropriate timelines throughout the PIPs.	In addition to continuing 1) PIP-specific workgroups to ensure ongoing engagement of key departments with circulation of meeting minutes and follow-up action items, 2) a dedicated nurse resource for the PIPs, 3) maintaining a PIP monitoring work plan to track intervention and data/reporting needs to ensure accountability for intervention oversight and data deliverables and, 4) a dedicated staff lead within the operational team to work with the QM PIP lead and a dedicated physician specializing in internal medicine to support activities, Amerigroup implemented the following: The QM department began utilizing a team of data analysts in order to expand data collection, analysis and monitoring to ensure a more comprehensive review. Additionally, the data analyst team began regular attendance at the PIP workgroups. A quarterly deep-dive analysis of applicable measures will be conducted by the PIP specific workgroup. In addition, a quarterly data review meeting between QM PIP Lead and Data Analyst team will be held to assess current PIP data reported and evaluate if additional analytic reporting options should be developed to further support PIP intervention measurement and tracking. Amerigroup will continue to monitor its process related to PIP activity for opportunities for improvement and work with all involved operational areas and reporting department to ensure accurate data collection, review and analysis, and timely interventions.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Assessment category include: • Group D: Amerigroup should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA).	Please note: Effective March 2020, Care Managers paused completion of the NJCA as per State guidance in response to the COVID-19 pandemic. Amerigroup has adjusted clinical documentation guidelines and desktop processes to ensure completion of the Screen for Community Services (SCS) to screen for appropriateness of MLTSS enrollment by an NJCA certified clinician. Once AGP resumes completion of NJ Choice Assessments, internal auditing will review SCS completion prior to NCJA completion. In addition, NJCA reporting and monitoring has been developed/modified to ensure completion of screening for all NJ Choice Assessments coded for MLTSS enrollment to flag any cases for noncompliance. Upon resumption of NJCAs, Amerigroup will run this report weekly to monitor compliance trends.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Member	Amerigroup's initial outreach process targets new member outreach to be completed within 5 business days of enrollment. The task is assigned to a medical management specialist (MMS) supporting the field Care Management team to introduce the program, schedule a visit for the purpose of a care plan and gather any pertinent information on behalf of the Care Manager. The Medical Management specialist includes all outreach attempts in the member's record, whether successful or unsuccessful and allows the care manager	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Outreach category include: • Group D: Amerigroup should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care for the member.	visibility into the initial outreach process. The Medical Management Specialist will review any providers on file, claims reporting, etc. in an effort to contact the member and move forward with scheduling the visit. The MMS also provides a first layer of support for members such as finding a PCP or specialist, sharing the primary Care Manager contact information, etc. Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, with a status on all initial outreaches for members new to MLTSS. A risk summary report is compiled by the Compliance Team and shared with the management team to identify cases at risk for noncompliance. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis. Additionally, this requirement is captured in the MLTSS Care Management Desktop Processes and Policy and Procedures for staff review.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Face-to-Face Visits category include: • Group C: Amerigroup should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Amerigroup should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.	Please note: Effective March 2020, Care Managers ceased completion of the Interim Plan of Care as per State guidance in response to the COVID-19 pandemic. Amerigroup transitioned to a new medical management platform, Healthy Innovations Platform (HIP) in January 2020. This platform contains functionality to capture member signature directly on the Care Manager's laptop, within the clinical assessments. The Interim Plan of Care includes this signature functionality. Amerigroup revised the cost neutrality tool to capture percentage thresholds at the time of completion in May 2020. The tool was shared with staff and reviewed on 6/12/2020 during a Care Management WebEx. Training recordings are housed on the MLTSS internal SharePoint library for staff to reference. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis.	Addressed
Recommendations for the Face-to-Face Visits category include: • Group D: Amerigroup should ensure the Interim Plan of Care is completed and	Please note: Effective March 2020, Care Managers ceased completion of the Interim Plan of Care as per State guidance in response to the COVID-19 pandemic. Amerigroup transitioned to a new medical management platform, Healthy Innovations Platform (HIP) in January 2020. This platform contains functionality to capture member signature directly on the Care Manager's laptop, within the clinical assessments. The Interim Plan of Care includes this signature functionality. Amerigroup utilizes a desktop processes to standardize the process for tracking and monitoring Personal Preference Program	

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
signed by the member or member's representative. Amerigroup should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Amerigroup should ensure a cost neutrality analysis is completed during the review period and the annual cost threshold should be documented as a numeric percentage.	(PPP) application packet submission. When a PPP request is received or the Care Manager identifies member's interest in the PPP program during an outreach, the care manager tasks the Medical Management specialist for completion of the PPP application with the member. The care manager is able to track the progress of the PPP application process in the HIP system and submits it for processing upon completion. In addition, Management staff utilizes the clinical documentation platform to filter monitoring views in the system to see overdue tasks for PPP application follow-up. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis. Amerigroup revised the cost neutrality tool to capture percentage thresholds at the time of completion in May 2020. The tool was shared with staff and reviewed on 6/12/2020 during a Care Management WebEx. Training recordings are housed on the MLTSS internal SharePoint library for staff to reference. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis.	
Recommendations for the Face-to-Face Visits category include: • Group E: Amerigroup should ensure that the Care Manager documents when the NJCA is completed during the Face-to-Face visit. Amerigroup should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Amerigroup should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Amerigroup	Please note: Effective March 2020, Care Managers ceased completion of the NJCA as per State guidance in response to the COVID-19 pandemic. Amerigroup transitioned to a new medical management platform, Healthy Innovations Platform (HIP) in January 2020. This platform contains functionality to capture member signature directly on the Care Manager's laptop, within the clinical assessments. The Interim Plan of Care includes this signature functionality. Amerigroup utilizes a desktop processes to standardize the process for tracking and monitoring PPP application packet submission. When a PPP request is received or the care manager identifies member's interest in the PPP program during an outreach, the care manager tasks the Medical Management specialist for completion of the PPP application with the member. The care manager is able to track the progress of the PPP application process in the HIP system and submits it for processing upon completion. In addition, Management staff utilizes the clinical documentation platform to filter monitoring views in the system to see overdue tasks for PPP application follow-up. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis. Amerigroup revised the cost neutrality tool to capture percentage thresholds at the time of completion in May 2020. The tool was shared with staff and reviewed on 6/12/2020 during a Care Management WebEx. Training recordings are housed on the MLTSS internal SharePoint library for staff to reference. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
should ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold is documented as a numeric percentage.		
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Initial Plan of Care (Including Back-up Plans) category include: • Group C: Amerigroup should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program.	The AGP clinical system, Healthy Innovations Platform (HIP) assigns due dates to visits on Care Manager caseloads using configured timeframes based on contractual requirements. Newly enrolled member visits, including POC completion, have been configured with a due date within 30 days of MLTSS enrollment to allow for a 2-week buffer (contract requirement is 45 days). Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, with a status on all POC completion for members new to MLTSS. A risk summary report is compiled by the Compliance Team and shared with the management team to identify cases at risk for noncompliance. Ongoing internal auditing addresses compliance to this element allowing Management to provide re-education, as needed, on an individual and department level basis. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review.	Addressed
Recommendations for the Initial Plan of Care (Including Back-up Plans) category include: • Group D: Amerigroup should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. Amerigroup should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of	The AGP clinical system, Healthy Innovations Platform (HIP) assigns due dates to visits on Care Manager caseloads using configured timeframes based on contractual requirements. Newly enrolled member visits, including Plan of Care completion, have been configured with a due date within 30 days of MLTSS enrollment to allow for a 2-week buffer (contractually 45 days). Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, with a status on all POC completion for members new to MLTSS. A risk summary report is compiled by the Compliance Team and shared with the management team to identify cases at risk for noncompliance. HIP also contains functionality to capture member signature directly on the Care Manager's laptop, within the clinical assessments. The MLTSS Plan of Care includes this signature functionality. Amerigroup has adjusted clinical documentation guidelines and desktop processes to ensure the member's plan of care includes evidence of a member-centric approach, that risks are assessed and captured, and that back-up plans are initiated. This includes documentation of member being present and contributing to the development of goals, is offered options and continues to express needs or preferences, and that these needs or preferences were acknowledged and addressed in the clinical assessments and documentation. Ongoing internal auditing addresses compliance to these elements allowing Management to provide re-education, as needed, on an individual and department level basis. Additionally, this requirement is captured in the MLTSS Care	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. Amerigroup should confirm the State mandated Back-up Plan is completed, signed and dated by the member/member representative. Amerigroup should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and member.	Management Desk Top Processes and Policy and Procedures for staff review.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Ongoing Care Management category include: • Group C: Amerigroup should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period and that the Face-to-Face visits are completed within the appropriate timeframes.	The AGP clinical system, Healthy Innovations Platform (HIP) assigns due dates to visits on Care Manager caseloads using configured timeframes based on contractual requirements. Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, with a status on all POC completion for members new to MLTSS. A risk summary report is compiled by the Compliance Team and shared with the management team to identify cases at risk for noncompliance. Ongoing internal auditing addresses compliance to these elements allowing Management to provide re-education, as needed, on an individual and department level basis. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Recommendations for the Ongoing Care Management category include: • Group D: Amerigroup should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period and the face to face visits are completed within the appropriate timeframes.	The AGP clinical system, Healthy Innovations Platform (HIP) assigns due dates to visits on Care Manager caseloads using configured timeframes based on contractual requirements. Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, with a status on all POC completion for members new to MLTSS. A risk summary report is compiled by the Compliance Team and shared with the management team to identify cases at risk for noncompliance. Ongoing internal auditing addresses compliance to these elements allowing Management to provide re-education, as needed, on an individual and department level basis. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review.	Addressed
Recommendations for the Ongoing Care Management category include: • Group E: Amerigroup should ensure members receive timely Face-to-Face visits, to review member placement and MLTSS services during the review period and the Face-to-Face visits are completed within the appropriate timeframes. Amerigroup should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. Amerigroup should ensure that Plans of	The AGP clinical system, Healthy Innovations Platform (HIP) assigns due dates to face to face visits on Care Manager caseloads using configured timeframes based on contractual requirements. Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, with a status on all face-to-face visit completion for members new to MLTSS. A risk summary report is compiled by the Compliance Team and shared with the management team to identify cases at risk for noncompliance. Amerigroup has adjusted clinical documentation guidelines and desktop processes to ensure that back-up plans are initiated and reviewed on a quarterly basis. Ongoing internal auditing addresses compliance to these elements allowing Management to provide re-education, as needed, on an individual and department level basis. Amerigroup has developed a modified auditing tool that will be used by MLTSS Management staff, clinical compliance teams and process improvement staff to audit Care Management charts. Identified changes in condition will be audited for appropriate documentation that a member's plan of care was amended, reviewed and signed by member and/or authorized representative. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Care are reviewed and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.		

[1]A**ddressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2022.

HNJH Response to Previous EQR Recommendations

Table 53 displays HNJH's progress related to the *State of New Jersey DMAHS, Horizon New Jersey Health Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of ABHNJ's response.

Table 53: HNJH Response to Previous EQR Recommendations

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
The Plan should continue to negotiate a contract with dental providers to improve access to care in the deficient counties.	HNJH continues to collaborate with Skygen, our dental vendor, to recruit new providers throughout the State. In 2020, 150 dental providers were added to the network and 92 dental providers have been added this year as of 8/6/2021. In Atlantic County, there was a deficiency with access at 88.8%. HNJH contracted with Dental Care of South Jersey at a new location in Mays Landing, NJ and the office will be open by 9/1/2021. This will close the gap in Atlantic County. Dental Care of South Jersey will also open offices in Egg Harbor and Atlantic City in Q4 of 2021 to further strengthen our access to care in Atlantic County.	Addressed
The Plan should continue to expand the MLTSS network to include at least two providers in every county for adult social day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.	The plan continues to recruit providers for social adult daycare. The goal is to include at least two providers in every county, and HNJH continues to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers. Progress has been made with Cedar Knolls being added as a participating provider in Morris County as of 4/1/2021. Additionally, an application was received from Social Affairs in Passaic County. As of 8/18/2021, the Provider Contracting team is preparing the provider's file for credentialing to close network gaps. We also continue to call the Office of Aging departments in each county for their list of centers, and we outreach to adult medical daycare centers and encourage them to consider diversifying their business by adding social adult daycare as a service.	Addressed
The Plan should ensure that Core Medicaid provider grievance resolution letters are sent to	To ensure that all provider grievances are resolved and issued with timely resolution letters, a daily report is distributed to the Grievance and Appeal teams showing all open cases and their respective aging. Workflows were updated in 2020 and reinforced with all team members. The supervisors hold daily inventory meetings with the staff, and issues needing management support are escalated appropriately	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
the provider in a timely manner.	to ensure that cases are closed timely. Lastly, HNJH's pre-closure quality review process ensures that resolution letters are completed timely and attached to each case prior to closure. End-to-end oversight of this process is provided by the Appeals and Grievances Management team to ensure that resolution letters are completed in a timely manner.	
The Plan should ensure that MLTSS member appeal resolution letters are sent to members in a timely manner.	During 2020 Annual Assessment, one file failed for an untimely appeal resolution letter. The untimely case was reviewed to identify the root cause. It was determined that the appeals analyst miscalculated the resolution due date. As a result, Horizon implemented a date/time calculator to ensure accurate assessment of timeliness of appeal resolution letters. The appeals team was educated on how to use the calculator and how to document the use of the calculator in the case file. The appeals leadership team continues to monitor the appeal inventory report daily to ensure appeal requests are processed timely.	Addressed
The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.	Horizon clinical performance was impacted by COVID-19 in 2020. In addition to diligently working on achieving NCQA 50th percentile performance, the quality and clinical teams have provided members with support, resources and alternative health services (such as telehealth) to overcome the challenges of the pandemic. Horizon continues to monitor for the NCQA benchmarks and impact of COVID-19. Clinical performance is monitored monthly and reviewed at the HEDIS Work Group and Quality Improvement Committee meetings. In 2021, the HNJH has made the following enhancements to address areas where clinical performance fell below the NCQA 50th percentile: - A new rewards program was established for Prenatal and Postpartum Care - Enhanced member engagement through the GEMS program for Prenatal Care - A new rewards program was established for Diabetes management - A new disease management IVR campaign was established for Diabetes and Hypertension - HNJH promoted the HPV vaccine to adolescent members with a wellness visit mailer - A behavioral health quality team was established to address behavioral/mental health and substance use performance - A website was launched for providers to provide Quality material resources, including HEDIS documents and educational videos	Addressed
The Plan should ensure that the MLTSS Gaps in Care PIP implements interventions on a timely basis in order to have an effective impact on the overall outcome at the end of the review period.	All active interventions specific to the MLTSS Gaps in Care PIP are in progress and on target. While some interventions involving face-to-face visits have been changed to telephonic/remote outreach due to the COVID-19 pandemic, they remain on schedule. There were two interventions in the PIP that were terminated (4a and 6a). Explanations around their terminations are detailed in the April and August 2021 PIP updates.	Addressed
For the 2020 Core Medicaid CM Audit,	In Q1, 2020, The CM team revised call scripts and processes around age appropriate immunizations, EPSDT exam, blood lead level (BLL)	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
recommendations for the DDD & DCP&P Populations include the following: Recommendations for the Preventive Services Category for the DDD Population include: • Horizon should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, and NJ immunization registry, should be consistently documented. Care managers should ensure members 18 years of age and older receive appropriate vaccines. • Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. • Horizon should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence	expectations and communication. HNJH added alerts to our medical management system to flag such members who are lacking EPSDT exam, Dental Exam, BLL or age appropriate immunizations. HNJH also added a Preventive Health Survey to our medical management system, which will be used to ensure that documentation is in a single location where we have validated status of these measures, and only accepting information from trusted sources, such as PCP, Child Health Unit Nurse, or NJIIS. With regard to lead testing, all parents/guardians of members between the ages of 9-72 months of age are targeted in various interventions to educate them on the importance of lead testing and remind them that their child is due for a lead test. Additionally, reminders are mailed on a monthly basis to parents/guardians of members aging into the 9 month, 18 month and 27 month populations to ensure they are aware of the need to get a test done. Providers are targeted in various interventions to ensure appropriate lead testing in each of the age bands between 9-72 months of age.	

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
For the 2020 Core Medicaid CM Audit, recommendations for the DDD & DCP&P Populations include the following: Recommendations for the Continuity of Care Category for the DDD Population include: • Horizon should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment. • Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.	In Q1 2021, HNJH developed a Care Management Coordination survey within the medical management system to document when Comprehensive Needs Assessments (CNA) and Care Plans are completed and updated for the DDD and DCP&P populations. Workflows were enhanced to reinforce coordination expectations with CMO, PerformCare, Support Coordinators, etc., and HNJH updated its aggressive outreach workflow, which is also specific to DDD and DCP&P populations. Additional enhancements to this workflow are planned for Q3, 2021. Monitoring of continuity of care has improved with this enhanced tracking and the addition of staff to help support the outreach efforts. The enhanced tracking mechanism not only records when the CNA is completed timely, but also tracks the Care Plan to ensure it is implemented within 30 days of CNA completion. Care managers are trained to continually assess and update the Care Plan to accurately reflect the member's needs.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for Member Outreach category include: • Group D: Horizon should ensure that the Care Manager outreaches to the	The MLTSS Initial Outreach Operational Workflow is regularly reviewed, updated and redistributed to Care Management staff (most recently 6/8/20, 12/1/20, 4/1/21, and 6/1/21). The Weekly MLTSS Tableau Dashboard Report and the Monthly MLTSS HCBS Compliance Report are utilized by MLTSS regional managers and Care Management (CM) supervisors to monitor and trend compliance with initial outreach timeliness. Some modifications were made to the Bi-Weekly MLTSS Tableau Dashboard Monitoring throughout the State of Emergency/COVID-19 Pandemic to assist the MLTSS CM supervisors in monitoring revised workflows, such as outreach requirements and annual IPOCs. Additionally, MLTSS staff reviewed/validated the specifications of the MLTSS HCBS Compliance Report and as of April 2021, the team has a monthly tracking summary of the CMs	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care for the member.	performance compliance for ongoing monitoring, including timely outreaches. Operational expectations for care management performance continues to be discussed during monthly MLTSS Care Management Supervisors meetings.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Face-to-Face Visits category include: • Group E: Horizon should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit. Horizon should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage. Horizon should ensure that members at or above 85% of the ACTs should have a pre-call meeting and IDT meeting within the appropriate timeframes.	The MLTSS Face to Face visit Operational Workflow outlines detailed instructions on how the Care Managers are to document in each Member's electronic medical management record indicating when the NJCA is completed at the Face to Face, where the visit takes place and who was present. During the State of Emergency this Workflow continues to be regularly reviewed, updated and redistributed to Care Management staff (most recently 8/3/20, 9/15/20, 12/1/20, 2/1/21, 5/1/21, and 7/1/21). Operational expectations for performance are also discussed at monthly MLTSS Care Management Supervisors. The updated CEA Operational Workflow was reviewed, updated and redistributed on 2/13/20 and 2/1/21, and will be reissued on 9/1/21 as well. Since the Cost Neutrality summary in Care Radius was enhanced in January 2019 to reflect each member's CEA as a numeric percentage, there has been continuous improvement in this area. The HNJH IDT-RN continues to run Monthly CEA Reports from the medical management system of MLTSS member Cost Neutrality amounts and Level of Care categories in order to identify cases that require investigation by the MLTSS Regional Managers to determine if the case is appropriate for a Cost Effectiveness IDT. These reports assist in identifying erroneous IDT recommendations due to system related or data entry errors. CEA completion reports are run on a monthly basis by the IDT-RN and reviewed by CM Regional Managers for necessary follow-up action by MLTSS Care Managers to ensure that members at or above 85% of the ACTs have Precall and IDT meetings within appropriate timeframes. Additionally, Quarterly IDT Reports are prepared and presented at the HNJH MLTSS Subcommittee meetings (most recently 12/2/20 & 6/17/21) to review IDT operations and compliance outcomes.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Ongoing Care Management category include:	The Face to Face Workflow was reviewed, updated and redistributed to staff regularly throughout the pandemic (most recently 8/3/20, 9/15/20, 12/1/20, 2/1/21, 5/1/21, and 7/1/21). As instructed by the State in March 2020, due to COVID-19 safety precautions, in-home assessments and face to face visits have been on hold. It does remain that HNJH MLTSS Regional Managers and CM Supervisors utilize the MLTSS Tableau Dashboard to monitor CM staff performance in conducting timely contacts with members.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
• Group E: Horizon should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period. Horizon should also ensure that the Face-to-Face visits are completed within the appropriate timeframes. Horizon should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Horizon should ensure that the Care Managers counsel the members on the written notice of action and explains their right to file an appeal when the member disagrees with their Assessment and/or service authorizations. Horizon should ensure that Face-to-Face visits from the member's Care Manager are completed within 10	A new Pandemic/COVID-19 Care Management Workflow was created in March 2020 and has been continually updated and redistributed (most recently: 7/1/21, 5/1/21, 3/1/21, 1/1/21, 12/1/20, 10/1/20, 8/12/20, 7/6/20, and 6/8/20). This Workflow ensures standard communication to all MLTSS Care Managers about the expectation that they continue to follow all contractual requirements for MLTSS members during this time of telephonic outreach. The HNJH Notice of Action Policy and the HNJH Member and Provider UM Appeals Policy were approved in February 2021, and were distributed to MLTSS CM staff in April 2021 as an ongoing reminder of company expectations with regard to supporting member's due process for denials. As part of MLTSS Options Counseling, MLTSS Member Rights and Responsibilities (R&R) are reviewed, (as evidenced by a R&R Sign Off Statement) including ongoing education on how a member can file an Appeal whenever he or she disagrees with an Assessment and/or Authorization of placement/services (including the amount and/or frequency of a service). The Monthly Unsigned Documents Report, used to identify unsigned SPOCS, Back Up Plans, Risk Agreements and other documents, was completely revamped by April 2021 to include improvements so the report can go to the MLTSS CM team for review, and is run in alignment with the revised Pandemic workflow for operational consistencies. MLTSS CM Supervisors continue to perform periodic Care Manager chart audits to monitor compliance with timely Face-to-Face visits and SPOC completion/documentation, as warranted. These audits also include the review of documentation of any changes to the member's initial POC and whether appropriate updates were made to the SPOC, as warranted, and review of documentation of the Care Manager counseling the member on Rights and Responsibilities, including Notice of Action processes, as warranted. Evidence of Denial/Appeals letters triggering to members, when appropriate, is also a component of the MLTSS CM Sup chart audit. The NF Transition Operational Workflow was reviewed and redistributed on 7/1/21. Additionally, the NF Care Management Workgroup continues to meet (most recently on 2/18/21 and scheduled again for Fall 2021) to discuss operations specific to working with the NF resident population and providers, COVID impacts, NF Transition activities and post discharge follow-up expectations. The Post-Facility Follow-Up Workflow and the 30-Day Pledge Workflow are due to be updated and redistributed on 10/1/21. Ongoing monitoring of timely follow-up continues to be conducted by MLTSS CM Regional Managers/CM Supervisors using Post Facility Discharge Reports alerting staff of member discharge dates. MLTSS CM Supervisors receive daily alerts via email, regarding facility admission/discharge dates, so that timely and appropriate follow-up by Care Management staff is made on a case-by-case basis. Lastly, on 7/12/21, updated MLTSS Provider Alert Forms (for both Community-Based providers and Facility Providers) were fax-blasted to providers along with an explanatory cover letter reminding them to	

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
business days of discharge from an institutional facility to a HCBS setting. Horizon should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.	communicate key member updates with MLTSS Care Managers for improved care coordination efforts.	

[1]A**ddressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2022.

UHCCP Response to Previous EQR Recommendations

Table 54 displays UHCCP's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Community Plan of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of UHCCP's response.

Table 54: UHCCP Response to Previous EQR Recommendations

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
The Plan should continue to recruit adult PCP, pediatric specialists and contract with hospitals to improve access to care in the deficient counties, as well as monitor adequate access to adult PCP urgent care and after-hours access. Where no specialists are available in these counties, the MCO should delineate how specialty care for children in these counties is provided.	The Plan currently meets the requirement for PCP network adequacy. We have also outreached to pediatric specialists for possible recruitment and have provided a summary of our outreach efforts to possible physicians in each of the quarterly Network Deficiency reports at the Provider Advisory Committee (PAC) meetings. If no other providers to contract with exist in the area, we have provided evidence of that research in the Network Deficiency reports. The following language has been added to the 2021 version of the NM-106 Network Access policy "Where there are no providers available in counties with deficiencies, UHCCP can assist the provider or member with obtaining prior authorization so that a single case agreement and/or transportation can be coordinated for the member if needed". We also continue to negotiate with a hospital system that would fulfill any deficiencies for Cumberland and Atlantic counties. For PCPs who are non-compliant with urgent care and after-hours access, we will continue to educate their practices of this expectation through applicable mail, phone, and email methods, and monitor their progress after first, second, and third attempts.	Addressed
The Plan should work with the obstetric network to ensure adequate access to	As of Q2 2021, the Plan began reporting the results of the second and third outreach attempts to providers who failed the first access & availability phone survey conducted by third party vendor, Dial America. With a full report of 2019 access & availability results	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
prenatal care. Providers not meeting the standard should be requested to submit a corrective action plan (CAP) and should be re-evaluated.	including first, second, and third follow-up outreach phone surveys, the improvement of Ob/Gyn access & availability after these follow-up surveys and continued education improved, and the Ob/Gyn specialist category met the 90% threshold across all measures. We will continue to request that providers not meeting the standard submit a corrective action plan (CAP) or explanation for not being able to meet it.	
The Plan should ensure adequate access to emergency appointments for dental providers, as well as after-hours access.	The dental emergency and after-hours access requirements are not measures that are required for our Commercial or Medicare insurance plans that they are also contracted with, therefore, adoption to adhere to this requirement for NJFamilyCare/Medicaid and Dual Complete ONE plans only will require additional educational outreach. The Plan will continue to educate dental providers on this requirement through applicable mail, phone, and email methods. Reports on appointment access and availability are reviewed at the quarterly Dental Advisory Committee (DAC) meetings.	Addressed
The Plan should ensure adequate access to behavioral health providers for urgent and routine care appointments.	As of Q2 2021, the Plan began reporting the results of the second and third outreach attempts to providers who failed the first access & availability phone survey conducted by third party vendor, Dial America. With a full report of 2019 access & availability results including first, second, and third follow-up outreach phone surveys, the improvement of behavioral health access & availability after these follow-up surveys and continued education improved, and the behavioral health category met the 90% threshold for routine care appointments at 100%. The requirement for urgent care appointments after second and third follow-up attempts resulted in 89%, 1 percent under our target threshold. The Plan will continue to educate the behavioral health network on the requirement for urgent and routine care appointments. We will continue to request that providers not meeting the standard submit a corrective action plan (CAP) or explanation for not being able to meet it.	Addressed
The Plan should continue to expand the MLTSS network to include at least two providers in every county for and assisted living in Hudson County. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.	The Plan analyzes the MLTSS network deficiencies on a quarterly basis. Although there are deficiencies noted in counties with less than the requirement of two for a MLTSS provider type, not all deficiencies are true. The reasons we have provided in the quarterly Network Deficiency reports at the Provider Advisory Committee (PAC) meetings include: 1) there are no other provider options available to contract with in that area/county and the State of New Jersey is aware, 2) a MLTSS provider serves the entire state of New Jersey even though they are located in one area, 3) there are no other known providers to reach out to for contracting to our knowledge, or 4) the reason why an available provider was unable to be contracted. We continue to outreach to known MLTSS providers for contracting. We document the reason why the provider who may be able to fill the gap in access is unable to join the network (failed recredentialing, unable to reach, etc.) and present those findings in the quarterly Network Deficiency reports. We also document which county and specialty types are not able to be remediated, what the reasons are for not being able to	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	remediate, and which provider types and counties have been outreached to - in the quarterly Network Deficiency reports.	
The MCO should develop reporting around aspiration pneumonia, injuries, fractures, contusions, decubiti and seizure management for the broader Medicaid population.	UHCCP has been actively working to develop reporting that allows for reporting by Aspiration Pneumonia, Fractures/Injuries/Contusions, Decubiti, and Seizure Management for multiple populations. Discussions with the CMO began in May, and meetings with reporting analysts started in June and are continuing. A demonstration of Q1 2021 data was held 7/15/2021, and Quality Analysts were involved in testing, with the goal of implementation in August 2021. Further modifications were made to the report including correction of duplication errors. An updated version was created; reports for Q1 and Q2 were produced and are being analyzed. Quality Analysts will monitor reporting, analyze findings, and initiate further action as needed. Reporting is planned for the September PAC and QMC meetings. Additionally, a draft SOP is being reviewed, with completion anticipated in September 2021.	Addressed
The Plan should ensure MLTSS member grievance resolution letters are sent to members in a timely manner.	As of Q1 2021 additional staff training was conducted with the resolving analysts which covered appropriate and timely issue routing to the MLTSS Quality of Care team, letter content and Quality of Care/Quality of Service differentiation review. As of February 1, 2021, the Appeals & Grievance Operations Team also assumed responsibility for sending all resolution letters for MLTSS Quality of Care cases. This will ensure timely completion and enhanced visibility of letter completion utilizing reporting.	Addressed
The Plan should ensure review of quality metrics, including a review of complaints/quality issues, at the time of recredentialing, and that this is documented in the Core Medicaid PCP recredentialing files.	UHCCP has created and implemented, 1st quarter of 2021, a Recredentialing Checklist that ensures that the review of the quality metrics, including a review of complaints/quality issues during the providers recredentialing cycles is documented and added to the recredentialing files.	Addressed
The Plan should ensure dental policies are reviewed annually and/or during the review period.	All Dental Policies are reviewed, edited, and updated annually at our Quarterly Dental Advisory Committee meetings. During the 2020 Annual Audit, an outdated copy of a policy was uploaded in error. It was discovered during the actual audit and the Dental team was able to produce the corrected version before the end of the audit.	Addressed
The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell	UHCCP submitted the final UHCCP Performance Measures less than 50th Percentile workplan on August 20, 2020. It included a barrier analysis and listed specific interventions aimed at improving compliance for 13 measures. Multiple business segments were involved in the development of the action plans including Community Outreach, Pharmacy Services, Behavioral Health, Member Engagement and Provider Relations. Interventions were started in Q3 2020 and continued with modifications as needed due to COVID-19. In a YOY rate comparison between HEDIS MY2019 and HEDIS MY2020, the rates of most of the measures improved, and for the remaining measures, the	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
below the NCQA 50th percentile.	rate differences were negligible considering the ongoing public health emergency. UHCCP will continue to focus on efforts to close gaps in care with our members and provide each individual with opportunities to improve their health status.	
The Plan should ensure the MLTSS Gaps in Care PIP addresses revised timeframes and reporting schedules to ensure targeted improvements can be evaluated appropriately, in terms of performance over time.	The MLTSS timelines reflected the previous timelines but were corrected as below in the April 2021 submission. The corrected timeline was accepted by IPRO and will continue as the corrected timeline for all future submissions. The timelines for the PCA services are now in sync with the Flu and Pneumonia timelines which are July 1 through June 30 of each year. It is no longer a calendar year. The following are the MLTSS PIP Timeline Updates that were corrected also: Section B Updates: Baseline and timeline were corrected. Updated baseline year is July 1, 2018 – June 30, 2019. MY1 is July 1, 2019-June 30, 2020. MY2 is July 1, 2020 – June 30, 2021. SY is July 1, 2021-June 30, 2022. Original baseline year was July 1, 2017 – June 30, 2018. Baseline calculation of performance indicator was updated for the new baseline time period. The following elements in section B were updated to correspond to the updated timeline: Aim statement (had errors listing incorrect MY1 as CY 2019 and incorrect SY as CY 2021) Goals table (had errors listing old baseline) Timeline table (had incorrect baseline year listed as CY 2018) Results table (had incorrect baseline year (CY2018) and incorrect sustainability year (July 1, 2020 – June 30, 2021). Improving Influenza and Pneumococcal Immunization Rates and Timely Personal Care Assistant (PCA) Service in the Managed Long-Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population PIP continues to be the Aim of the PIP. The data team produces monthly reports of the PIP intervention tracking measures that are loaded to a shared drive. Training was provided in 4th quarter 2020 and again in 1st quarter 2021 to the Care Managers regarding the documentation of the measures to ensure that tracking is accurate. These reports are analyzed monthly by the Quality Nurse Analyst and discussed with the Quality Manager as needed. The Quality team communicates with the Care Management team manager. Monthly reports are provided for the MLTSS Care Managers' Manager for feedback/coaching and counseling regarding the reports. Future meetings are planned to discuss any changes needed to improve the rates of the PIP. Issues determined drive the type of additional training that would be needed to ensure an improvement in this PIP.	Addressed
For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P Populations include the following:	UnitedHealthcare (UHC) monitors immunization data by accessing the New Jersey Immunization Information System (NJIIS) on a monthly cadence and this data is distributed and made accessible to the care managers for follow up. In addition, Case Managers also attempt to obtain immunization data (including lead screening) from member's PCP/Specialist. UHC Case Managers will document in the appropriate documentation platform (Community Care and ICUE) applications. The	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Recommendations for the Preventive Services Category for the DDD Population include: • UnitedHealthcare should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, and NJ immunization registry, should be consistently documented. • Care managers should ensure members 18 years of age and older receive appropriate vaccines. • Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. • UnitedHealthcare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.	CM team utilizes the Community Care application to assess quality measures to include preventative care (such as EPSDT) and age-appropriate immunizations. Community Care application is used to identify any gaps in care, then addressed as indicated as well as documented. Policies and Procedures are up to date and in place for Clients of Division of Developmentally Disable (PCM1-P2A). UHC monitors status of dental services by pulling a monthly report of dental claims. In addition coordinating with the child's dental provider, and continued collaboration with the UHC dental department to ensure all members have a dental home. UnitedHealthcare Community Plan dental population ages 1-21 is automatically assign to a dental home. Policies and Procedures are up to date and in place for Dental Special Needs (DE:100). UnitedHealthcare monitors blood lead levels for children between 9-72 months of age by using bi-monthly HEDIS data reports. The data is stratified into the following age groups (9-18 Months, 18-26 Months, & 27-72 Months). The rates and member level detail for the custom lead measure are reported twice a month within a prospective HEDIS® data report to the Quality Director/Managers. The health plan analyzes the bi-monthly rates to determine necessary member and provider programs. The member level detail is used to determine the specific non-compliant members to be included in each program by the Quality Director/Managers. UHC has an established Lead Case Management Program (LCMP) that enrolls children with blood levels of >5 ug/dl. Supporting policy Lead Case Management (PCM3-SNU-P17)	
For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P Populations	UHC Case Management department completes aggressive outreaches to new enrollees that are received from the monthly enrollee file. If outreach is unsuccessful an unable to reach letter is sent to address on record. Case Management Policy- PCM3-SNU-P38 Aggressive Outreach, is in place for the CM aggressive outreach policy. When the member is	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
include the following: Recommendations for the Continuity of Care Category for the DDD Population include: • UnitedHealthcare should ensure all members receive a Comprehensive Needs Assessment within 45 days of enrollment. • Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.	contacted, the case manager explains services available to them, and then completes a Comprehensive Needs Assessment within the time frame in the NJ Case Management Workbook (45 days after enrollment). UHC adheres to the timeliness outlines in the Case Management Workbook in the NJ State Medicaid Contract. UHC has reporting in place to monitor compliance and this report is reviewed for timeliness (NJ State Mandated Executive Summary). UHC also conducts internal audits monthly, the tool includes timeliness of assessments. UHC adheres to the Clients of Division of Developmentally Disabilities policy (PCM1-P2A). A Plan of Care (POC) is developed for each member following the completion of the Comprehensive Needs Assessment. The development of the POC is initiated by the case manager. The POC may consist of long- and short-term goals and is developed with the collaboration of the member (member centric). This POC will be updated at least yearly (also evaluated/updated at each successful outreach and change of condition). The POC is shared with members PCP within 30 days of assessment unless POC sharing is declined by member/caregiver who must be documented accordingly. Supporting policy is Division of Developmentally Disability (PCM1-P2A). Compliance is monitored with the Mandated Executive Summary (timeliness of POC) in addition to internal audits conducted on staff addressing POC compliance in the tool.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Assessment category include: • Group D: UnitedHealthcare should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA).	SCS to be completed prior to NJ Choice. This was added to a new job aid; staff have been trained; unable to do fully d/t COVID. New LCAT job aid created to complete SCS first.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations	During 2020, no Face to Face (F2F) activities were conducted due to the Covid PHE guidelines. Telephonic POC were completed by care managers. Report created in Fall 2020 to monitor 5 business day	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
include the following: Recommendations for the Member Outreach category include: • Group C: UnitedHealthcare should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care.	requirement. All managers conduct quarterly audits of their staff, of which the 5-day welcome call is addressed. All welcome calls are monitored and reviewed on monthly reporting. Any staff showing non-compliance is addressed via individual coaching and remediation plan by the manager.	
Recommendations for the Member Outreach category include: • Group D: UnitedHealthcare should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care.	During 2020, no F2F activities were conducted due to the Covid PHE guidelines. Telephonic POC were completed by care managers. Report created in Fall 2020 to monitor 5 business day requirement. All managers conduct quarterly audits of their staff, of which the 5-day welcome call is addressed. All welcome calls are monitored and reviewed on monthly reporting. Any staff showing non-compliance is addressed via individual coaching and remediation plan by the manager.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Face-to-face Visits category include: • Group C: UnitedHealthcare should ensure that the Interim Plan of Care is completed and signed by the member or member's	The 10 business day requirement was removed from the Jan 2020 Contract (was 9.8.2.b in the July 2019 contract); Page 545/848 of Jan 2020 Contract 31.c.1 states we will obtain approval within 30 business days. (This is in Service Descriptions section of the contract). The Interim Plan of Care is completed in conjunction with the NJ Choice Assessment and the member signature is a required field. A step-by-step job aid on how to complete the Interim Plan was developed and staffed care management staff was trained on this new job aid in June 2020. Auditing activities will begin upon resumption of face to face visits. Based on auditing results, the CM will be coached by respective Manager to ensure that CEA is completed with documented numeric percentage. If discrepancies continue after initial coaching, a written warning will be issued to the CM and documented in the employee records. The Annual Cost Threshold is documented as a required field within the care manager management documentation template, New Jersey LTSS On-Site F2F Visit Assessment, which is completed during the review	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
representative. UnitedHealthcare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. UnitedHealthcare should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.	period. The MLTSS care manager staff was trained July 2020 on the revise CEA tool and LTSS On-Site F2F visit Assessment.	
Recommendations for the Face-to-face Visits category include: • Group D: UnitedHealthcare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. UnitedHealthcare should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.	The 10-business day requirement was removed from the Jan 2020 Contract (was 9.8.2.b in the July 2019 contract); Page 545/848 of Jan 2020 Contract 31.c.1 states we will obtain approval within 30 business days. (This is in Service Descriptions section of the contract). The care manager (CM) process is for participant direction is upon completion of the initial participant direction request, the CM will complete an HCBS Authorization assignment to authorize PPP services. The CM will create a reminder assignment to follow-up to confirm a determination was received. If the determine wasn't received, the CM will follow-up with the UM team to determine a timeframe and will create another reminder assignment in 15 more days to confirm a determination was received. The Interim Plan of Care is completed in conjunction with the NJ Choice Assessment and the member signature is a required field. A step-by-step job aid on how to complete the Interim Plan was developed and staffed care management staff was trained on this new job aid in June 2020. The Annual Cost Threshold is documented as a required field within the care manager management documentation template, New Jersey LTSS On-Site F2F Visit Assessment, which is completed during the review period. The MLTSS care manager staff was trained July 2020 on the revise CEA tool and LTSS On-Site F2F visit Assessment.	Addressed
Recommendations for the Face-to-face Visits category include:	The 10-business day requirement was removed from the Jan 2020 Contract (was 9.8.2.b in the July 2019 contract); Page 545/848 of Jan 2020 Contract 31.c.1 states we will obtain approval within 30 business days. (This is in Service Descriptions section of the contract). The care manager (CM) process is for participant direction is upon completion of	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
• Group E: UnitedHealthcare should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit. UnitedHealthcare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. UnitedHealthcare should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.	the initial participant direction request, the CM will complete an HCBS Authorization assignment to authorize PPP services. The CM will create a reminder assignment to follow-up to confirm a determination was received. If the determine wasn't received, the CM will follow-up with the UM team to determine a timeframe and will create another reminder assignment in 15 more days to confirm a determination was received. The process of documenting when a NJCA is completed during a face-to-face visit was reviewed during an End-to-End Case management Process for both Home and Community and Nursing Facility members, training occurred fall of 2020. An additional refresher training will occur prior the resumption of NJ Choice Assessments in November 2021. The Annual Cost Threshold is documented as a required field within the care manager management documentation template, New Jersey LTSS On-Site F2F Visit Assessment, which is completed during the review period. The MLTSS care manager staff was trained July 2020 on the revise CEA tool and LTSS On-Site F2F visit Assessment.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Initial Plan of Care (Including Back-up Plans) category include: • Group C: UnitedHealthcare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. UnitedHealthcare should ensure that the Plan of Care reflects a member-centric approach,	UHC developed and operationalized a daily report, Initial Plan of Care Report, which identifies all newly enrolled MLTSS members and the status of the Initial Plan of Care completion. The managers were trained on how to utilize the report to monitor their assigned staff. A manager monitoring process was developed to review the progression of the Initial Plan of Care on a daily and weekly basis, providing oversight and direction. The care managers are trained on how to develop a member-centered approach building a member's plan care with the member, and member representative, who are present during the development of the member's plan of care. The Plan of Care document which is reviewed with the member ensures that members Rights and Responsibilities are explained during each Plan of Care visit as this question is embedded within the Plan of Care document. Member-centered plan of care development is monitored and reviewed on weekly and monthly reporting by the managers. All managers conduct quarterly audits of their staff to view compliance and track trends. Individual coaching and remediation plan for identified process improvement activity will be facilitated by clinical managers for impacted care managers. The Plan of Care report was reviewed for accuracy in Q4 2020. Date of implementation: 1/1/2021. The report has been reviewed with MLTSS managers 1/4/2021. The report includes POC completion dates.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. UnitedHealthcare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member. UnitedHealthcare should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member, and the member/member representative confirmed their understanding. Member's Rights and Responsibilities should be signed and dated by the member/member representative.	Care managers are trained on how to identify risks, and when a member's risk is identified a Risk Management Agreements is created and signed by both the care manager and member or member representative.	
Recommendations for the Initial Plan of	UHC developed and operationalized a daily report, Initial Plan of Care Report, which identifies all newly enrolled MLTSS members and the	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Care (Including Back-up Plans) category include: • Group D: UnitedHealthcare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. UnitedHealthcare should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. UnitedHealthcare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member.	status of the Initial Plan of Care completion. The managers were trained on how to utilize the report to monitor their assigned staff. A manager monitoring process was developed to review the progression of the Initial Plan of Care on a daily and weekly basis, providing oversight and direction. The care managers are trained on how to develop a member-centered approach building a member's plan care with the member, and member representative, who are present during the development of the member's plan of care. The Plan of Care document which is reviewed with the member ensures that members Rights and Responsibilities are explained during each Plan of Care visit as this question is embedded within the Plan of Care document. Member-centered plan of care development is monitored and reviewed on weekly and monthly reporting by the managers. All managers conduct quarterly audits of their staff to view compliance and track trends. Individual coaching and remediation plan for identified process improvement activity will be facilitated by clinical managers for impacted care managers. The Plan of Care report was reviewed for accuracy in Q4 2020. Date of implementation: 1/1/2021. The report has been reviewed with MLTSS managers 1/4/2021. The report includes POC completion dates. Care managers are trained on how to identify risks, and when a member's risk is identified a Risk Management Agreements is created and signed by both the care manager and member or member representative.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Ongoing Care	United managers utilize the Touchpoint and Annual Adherent report to identify the progress of the face-to-face visits within the appropriate timeframe based on the member's placement status. The Plan of Care document includes the status of the Backup Plan to ensure that care managers review the document with the member at least once on a quarterly basis	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Management category include: • Group C: UnitedHealthcare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the face-to-face visits are completed within the appropriate timeframes. UnitedHealthcare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. MCO Response:		
Recommendations for the Ongoing Care Management category include: • Group D: UnitedHealthcare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes.	UHC monitors this during the CM manager audit process. Additionally, we have a touchpoint report to monitor timely touches at specified intervals based on member's placement status.	Addressed
Recommendations for the Ongoing Care	All managers conduct quarterly audits of their staff, of which the 10-day visit is addressed, and conduct staff-individual coaching and remediation plan development as dictated by monitoring results.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Management category include: • Group E: UnitedHealthcare should ensure that Care Managers document their actions to resolve any issues that impede members' access to care. UnitedHealthcare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and the Face-to-Face visits are completed within the appropriate timeframes. UnitedHealthcare should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. UnitedHealthcare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up		

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. UnitedHealthcare should ensure that a Face-to-Face visit from the member's Care Manager is completed within 10 business days of discharge from an institutional facility to a HCBS setting.		

[1]A**ddressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2022.

WCHP Response to Previous EQR Recommendations

Table 55 displays WCHP's progress related to the *State of New Jersey DMAHS, WellCare Health Plans of New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of WCHP's response.

Table 55: WCHP Response to Previous EQR Recommendations

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
The Plan should continue to recruit dental providers to improve access to care in the deficient counties.	We will continue to monitor GEO Access and Dental Vendor recruitment in Burlington County. 05/13/21 Bi-Weekly recruitment log of dental providers in Burlington count ▪ 05/27/21- Review Monthly Geo at JOC ▪ 6/24/21- Review Monthly Geo at JOC ▪ 07/22/21- Review Monthly Geo at JOC	Addressed
The Plan should continue to expand the MLTSS network to include at least two providers in every county for assisted living and social day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.	There are currently three ALR in Cumberland County- We currently have a contract with Spring Oak at Vineland PID 2434878 eff 4/27/21. WellCare continues to offer Single Case Agreements as needed. For ALCPCH- (true deficiency) one facility in the county- WellCare has a contract in place with Assisted Living Renaissance PID# 1289808. WellCare will use providers in bordering counties for additional coverage and will continue to offer Single Case Agreement as needed. Social Day Care Salem County: This is a true deficiency cross the state of New Jersey; WellCare will continue to make Single Case Agreement available to providers in surrounding counties. Private Duty Nursing (PDN) Salem County: WellCare continues to review provider availability in the county, which includes reviewing of competitor's directory, in addition to the NJMMIS directory with no success. WellCare will continue to use providers in Cumberland County and Gloucester County to address this deficiency and will provide Single Case Agreements as needed. Private Duty Nursing (PDN) Cape May County: WellCare continues to review provider availability in the county, which includes reviewing of competitors' directory in addition to the NJMMIS directory. We have identified one provider, Cape Regional Home Health Care, LLC dba Cape Regional Home Health Care, and are pursuing a contract. WellCare will continue to use providers in Atlantic County to address this deficiency and will provide Single Case Agreements as needed. All deficiencies are now reviewed by- weekly as they are a standing item on the team meeting agenda. Network gaps are also address as part of the overall Sprint Planning. Additionally, we review Dashboard monthly and meet with Network Integrity bi-weekly to address changes.	Addressed
The Plan should address areas where clinical performance was subpar in comparison to the NCQA	WellCare submit on an annual basis, a quality work plan as per contract and State/IPRO request where clinical performance fell below the NCQA 50th percentile. WellCare conducts quality focused provider education visits to providers/group practices. These visits focus on educating provider/office manager regarding coding and claims submission, review Care Gaps for their members. Provider Toolkits, which includes information on all HEDIS measures, best practices guidelines and medical record documentation	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.	guidelines, left behind as a resource. Provider Relations and Quality department coordinate efforts to close care gaps and educate providers on the importance of closing care gaps. This interdepartmental (POD) team approach reviews and identifies specific practices/providers with opportunities for improvement of their HEDIS rate. The POD team educates and assists the provider with care gap reports and missed opportunities. WellCare also provides a laminated coding sheet with the current codes for the billing staff to ensure claims are processed accurately and timely. This process includes reviewing a medical record to identify coding deficiencies then re-educating providers/practice manager. WellCare leadership and Quality staff monitor on a bi-monthly basis, the POD (Interdisciplinary) progress as well as practice/provider progress. WellCare Preventive Service Outreach (PSO) program to make outbound calls to non-compliant members notifying of their need for preventive services and assist with setting appointments. To improve quality scores, WellCare also utilizes the Quality Incentive Programs for both members and providers.	
The Plan should produce quarterly surveys for new enrollees, in person, by phone, or other means to adhere to Contract requirements.	WellCare performs monthly IVR outreaches to new members and results of survey questions are provided quarterly or upon request. WellCare is also currently working on creating a new member survey that will randomly reach out to members on a quarterly basis to further verify member understanding of their plans. The results of this outreach will be provided quarterly to adhere to Contract requirements.	Addressed
The Plan should ensure that Core Medicaid member appeal resolution letters are correct and sent to the members in a timely manner.	We will, moving forward, review ALL member appeals resolution letters not just unfavorable resolution letters, this review includes the letter, readability and appeals administrative determination form. NJ specific team trainings are being scheduled in order for the team to focus on solely on the market. This training will include when and/if an Appointment of Representation is needed, making outbound calls to clarify appeal requests, request medical records, outreaching to vendors, how to complete all NJ Medicaid letters, etc. Inventory reports are in the morning and evening before the team departs by the Supervisor and Team Senior.	Addressed
The Plan should ensure that MLTSS provider grievances resolution letters are sent to the providers in a timely manner.	The cited cases were noted and addressed during closing comments of the audit. Additionally, the market reviewed the process in place and added additional staff, to monitor email inquiries coming from the State. Based on findings, we have assigned multiple personnel to monitor state inquiries; Calendar reminder was added to ensure inquiries are reviewed and closed timely. We have also done trainings with other team members to address timely response to state inquiries. Additionally, the process to handle State inquires was reviewed and revised. Bi-weekly review of open cases will allow for timely response/resolution. Providers' resolution responses will be in line with time frames 100% of the time. Calendar alert to review open cases bi-weekly has been added.	Addressed
For the 2020 Core Medicaid CM Audit, recommendations for the DDD and	Vaccine administration and review of the EPSDT Schedule for Well Child Visits continue to be a part of all pediatric care plans for members in care management. LOB added to the QI Lead and Care Gaps report. QI and CM collaborate with outreach telephonically or written to ensure compliance of the vaccine schedule by monitor claims reports and HEDIS reviews. High	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
DCP&P Populations include the following: Recommendations for the Preventive Services Category for the DDD Population include: • WellCare should ensure members 18 years of age and above receive appropriate vaccines. Care managers should document all aggressive outreach attempts to obtain immunization for members 18 years of age and above. • Care Managers should address all dental needs for members 21 years of age and older. WellCare should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. • WellCare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.	volume pediatricians with low immunization compliance are identified by the QI Team and will have a Nurse Health Educator outreach to discuss barriers, lead clinical practice guidelines and offer CM assistance. In Q2 2020, WCHP developed a Lead Task Force (QI staff) to focus on providers' deficient with blood lead testing. QI staff are dedicated to, conduct quarterly outreach, educate providers regarding NJ Lead Screening requirements, and encourage in-office lead screening, review member panels with the providers to identify the status of each member with respect to lead screening. Qualitative Analysis: Barriers include, but are not limited, to the following: • Member Barriers Members' parent/guardian lack understanding of importance lead testing and prevalence of blood lead poisoning Members' parent/guardian do not go to labs outside a PCP office to obtain lead testing (childcare and time constraints) Members' parent/guardian fear of COVID prevented them from taking a child to the PCP office for a well visit or lab Members' parent/guardian do not want their child to experience the pain from a blood draw for lead (especially if they had immunizations administered during a well-child visit) • Provider Barriers PCP reluctance to conduct in-office blood lead testing in the office (venous/capillary) PCP limited office hours/staffing due to COVID to conduct in-office testing/or member follow-up related to scheduling well-child visits or lack of lead testing results • Plan Barriers PCP visits suspended in 2020 PCPs education through telephone/email/fax and virtual meetings due to COVID-19 may not be as effective as in person visits PCP limited office hours to conduct outreach and limited staff to discuss lead screening rates due to COVID Manual data collection Random selection of providers in AMRR limit's ability to include all providers on a Lead CAP in the audit • Recommendations for 2021: Continue focused lead screening outreach and monitoring by dedicated QI Staff assigned to particular provider offices; resume in-office visits when deemed appropriate by authority Continue to reinforce in-office blood lead testing to overcome member barriers going to outside lab Reinforce appropriate data collection and review results on a quarterly basis with Lead Task Force for improvement Continue interdisciplinary monthly provider lead cap meetings to discuss an improvement action plan for providers who are on a Lead CAP greater than two (2) consecutive 6-month periods Continue to escalate unresponsive providers to Network and Chief Medical Officer for follow-up Implement a process to review providers' medical records for lead screening documentation on a more frequent basis (outside of the AMRR process)	

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]

Continued collaboration with the QI Team to identify members that do not have an annual lead level screening. Any members that live in Hudson County, Passaic County and Newark with no annual lead screening claims and are not in care management are outreached quarterly for a lead verbal risk assessment, education and appointment assistance by the QI Team. For those newly enrolled members that do not live in Hudson County, Passaic County and Newark and are not in CM will have their assigned case worker outreached to discuss the care gap and offer appointment assistance by the care management team.

Continued collaboration with the QI Team to identify members that do not have an annual lead level screening. Any members that live in Hudson County, Passaic County and Newark with no annual lead screening claims and are not in care management are outreached quarterly for a lead verbal risk assessment, education and appointment assistance by the QI Team. For those newly enrolled members that do not live in Hudson County, Passaic County and Newark and are not in CM will have their assigned case worker outreached to discuss the care gap and offer appointment assistance by the care management team.

Lead Outreach (9-72 Months)	Members Outreached	Educated	Appt Made
Q1 2020	1136	320	1
Q2 2020	1046	583	42
Q3 2020	1019	291	27
Q4 2020	855	316	19
Q1 2021	**521**	127	0
Q2 2021	597	136	0

- Qualitative Analysis:

Barriers include, but are not limited, to the following:

- Member Barriers

Parents/Guardians lack the understanding of the importance of lead screening

Parents/Guardians not following through by taking their child to an outside lab for lead testing

Parents/Guardians fearful to taking the child to the doctor's office and/or lab due to COVID-19

Parents/Guardians unable to take multiple children to doctor's office/lab due to COVID-19 restrictions

- Provider Barriers

PCP reluctance to provide MedTox testing in the office

Provider limited office hours/staffing due to COVID-19

- Plan Barrier

Low telephonic Member contact rate due to inaccurate or missing telephone numbers on the enrollment file, resulting in the inability to educate parents and/or guardians on the importance of lead screening or assisting them in scheduling appointments with their child's PCPs

Providers educated through email/fax and virtual meetings due to COVID-19

Member outreach on hold 1Q 2020 due to COVID-19

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Recommendations for 2021: Continue quarterly telephone calls to non-compliant members in Newark, Hudson and Passaic counties to provide education and assist with scheduling appointments, and add text messaging to encourage lead screening Continue to identify alternative phone numbers for members unable to contact via third-party vendor Continue to educate providers regarding MedTox lead testing via virtual meetings/fax/email by QPAs; resume office visits after COVID-19 Continue to participate in all MCO collaborative to increase BLL screening rates in targeted counties. Resume Clinic Days in targeted pediatric offices with high-volume non-compliant members for lead screening after COVID-19 Dental education and review of the annual dental visit date continues to be an identified problem on all care plans. Members not only receive educational mailers annually regarding dental hygiene and check-ups, but verbal education is also given by the care manager and Liberty Dental. Liberty Dental Vendor began a text campaign targeting the DDD population to encourage utilization of their dental benefits. A call campaign began at the end of October 2020 for the DDD population to help members, parents and/or guardian schedule dental appointments and assist with transportation. Another call campaign began at the end of October 2020 for the DCP&P population to encourage the use of their dental benefits. Dental Workgroup was also created in the 4th quarter of 2020 to identify barriers and interventions with Liberty Dental to increase the dental utilization rates.	
For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P Populations include the following: Recommendations for the Continuity of Care Category for the DDD Population include: • WellCare should ensure all members receive a Comprehensive Needs Assessment. Care managers should develop and implement a care plan with all required	DDD and DCPP Monthly Score Card began in November 2020. As of February 2021, all CMs have consistently been receiving a score of 90 or above. The score card was created to monitor all newly enrolled members for the completion of the NJ CAN, care plan completion, immunization review and education and dental review and education. Timeliness is also monitored on this Score Card. The DDD/DCPP Supervisor will audit all newly enrolled cases at the end of the month. Passing score of 90 or better is required and if any of the audit criteria are not met the CM is required to complete in addition to immediate education. For continuity of care cases, 3 cases are randomly pulled and reviewed during the care managers' 1:1 session with the supervisor. In addition to that review, cases are audited by the Clinical Business Monitoring Team for quality review monthly.	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstance.		
For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P Populations include the following: Recommendations for the Preventive Services Category for the DCP&P Population include: • WellCare should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of immunizations from a reliable source, such as the PCP, NJ immunization registry, and DCP&P nurse if appropriate, should be consistently documented. • Care managers should provide dental education	DDD and DCPP Monthly Score Card began in November 2020. The score card was created to monitor all newly enrolled members for the completion of the NJ CAN, care plan completion, immunization review and education and dental review and education. Timeliness is also monitored on this Score Card. The DDD/DCPP Supervisor will audit all newly enrolled cases at the end of the month. Passing score of 90 of better is required and if any of the audit criteria are not met the CM is required to complete in addition to immediate education. For continuity of care cases, 3 cases are randomly pulled and reviewed during the care managers' 1:1 session with the supervisor. In addition to that review, cases are audited by the Clinical Business Monitoring Team for quality review monthly. Dental education, including the annual dental visit date continues to be an identified problem on all care plans. Members not only receive educational mailers regarding dental hygiene and check-ups, but verbal education is also given by the care manager and Liberty Dental. Dental Vendor, LIBERTY, began a text campaign targeting the DDD population to encourage utilization of their dental benefits. A call campaign began at the end of October 2020 for the DDD population to help members, parents and/or guardian schedule dental appointments and assist with transportation. Another call campaign began at the end of October 2020 for the DCP&P population to encourage the use of their dental benefits. Dental Workgroup was also created in the 4th quarter of 2020 to identify barriers and interventions with Liberty Dental to increase the dental utilization rates within this population. As of Q2 2021, CM Team receives a preventative dental report with the last known visits from claims. This information is documented in the member case file. All members without an annual visit receives an outreach from Liberty Dental and the Care Manager for appointment assistance.	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
and document the date of the member's annual dental visit for members from 1 to 21 years of age. WellCare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.		
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Assessment category include: • Group D: WellCare should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA). WellCare should ensure that the NJCA is submitted to OCCO within five business days of the completed assessment.	WellCare's Assessor Team were educated on conducting SCS assessment prior to state mandate go live date of January 1, 2020. Manager/Supervisor of Assessor Team tracks completion of SCS report weekly via Acute Net reports and compare both the SCS Tool Completion Report and the NJ Choice Tool Completion Report to monitor compliance. Prior to PHE, WellCare used a NJCA Completion/Submission Report which is tracked weekly to identify trends in untimely submission to allow MLTSS Managers/Supervisors discuss with individual care managers and assessors. Care Managers and Assessors were provided re-education regarding the requirement of completing NJCA within 72 hours to allow review/corrections and submission to OCCO within five business days. This report will continue to be used once face to face visits resume. Please note: The Plan inadvertently omitted a copy of the SCS assessment when the 2020 HCBS audit was performed. That will not be an issue moving forward.	Addressed
For the 2020 MLTSS HCBS CM audit, recommendations include the following:	WellCare should ensure that the Interim Plan of Care is completed and signed by the member or member's representative: 1. WellCare has a Review Team that confirms completion of all components of the NJCA and IPOC including signature of member/member representative before submission to OCCO. After review, a case note is entered into the	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Recommendations for the Face-to-Face Visits category include: • Group C: WellCare should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. WellCare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct.	member's electronic record documenting that the review is completed and NJCA was submitted. 2. NJCA Case Notes are monitored weekly by Director of Clinical Operations and Supervisor, Customer Service to ensure compliance via the Case Note Report. 3. The Review Team also monitors the rejection files whenever a NJCA is rejected by OCCO through the data exchange and any necessary corrections are made to the NJCA before resubmitting to OCCO. 4. Care Managers and Assessors were provided education reinforcing the importance of a completed and signed Interim Plan of Care. WellCare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct: 1. WellCare Care Coordination team (PPP liaison) developed an exception report to identify new members with completed PPP application which is reviewed weekly. 2. Additional NJ Choice assessment reporting will be monitored weekly to ensure any member requesting PPP through Options Counseling is confirmed. The report will capture the self-direction selection in the IPOC section of the NJ Choice Assessment compared to the PPP forms completed in AcuteNet.	
Recommendations for the Face-to-Face Visits category include: • Group E: WellCare should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit. WellCare should ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold is documented as a numeric percentage. WellCare should	Group E: WellCare should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit: 1. WellCare educated Care Managers and Assessors to document a case note in the member's electronic record that indicates the NJCA has been completed and the date it was completed. 2. MLTSS Managers and Supervisors will review that proper documentation has been completed during 1:1 case conference with the Care Managers. WellCare should ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold is documented as a numeric percentage. 1. Timeliness of annual Cost-Effective Analysis continues to be reviewed and tracked in WellCare's CM audits. 2. Timeliness of member annual Cost-Effective Analysis is reviewed and discussed during 1:1 case conference between MLTSS care managers and their Managers/Supervisors. Findings from these conferences are used to address individual MLTSS care manager performance. 3. Random record audits are performed by Manager/Supervisor (in addition to monthly Quality audits) to ensure that Cost Effective Analysis is documented, and annual cost threshold reflects a numeric percentage. 4. Care Managers were provided re-education to alert Manager/Supervisor if Cost effective Analysis is above 85%. 5. MLTSS Enrollment Report will be used to track Annual Cost-Effective Analysis to ensure compliance.	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
ensure members at or above 85% of the ACTs should have a pre-call meeting and IDT meeting within the appropriate timeframes.	WellCare should ensure members at or above 85% of the ACTs should have a pre-call meeting and IDT meeting within the appropriate timeframes 1. One MLTSS Manager (and a backup Manager) has been designated to take the lead on arranging, monitoring and tracking all MLTSS CEA Pre-IDTs and IDTs to discuss members with evaluations which exceed the documented ACT to ensure timeliness of both the Pre-IDT and IDT. 2. A designated MLTSS Manager (and back up Manager) notify the member's MLTSS Care Manager and Team Manager of any member that is on the CEA report which list all members whose ACT is 85% or above. Care Managers are also notified that required documents are needed and must be sent in a timely manner in order to help ensure that pre-call meetings and IDT meetings are requested and held within the appropriate timeframes. 3. MLTSS Care Managers were re-educated in December of 2019 regarding the following: --to notify their Manager upon completion of any member's CEA that exceeds the threshold--requirements of a pre-IDT and IDT meeting --the importance of documenting that a pre-call meeting and IDT meeting were requested and/or held within the appropriate timeframes. 4. MLTSS Managers to review the care manager's documentation after CEA Pre-IDT and IDT meetings are conducted to ensure compliance. 5. Care managers were educated to use specific verbiage to document pre-IDT and IDT meetings during the November 2020 team meetings.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Initial Plan of Care (Including Back-up Plans) category include: • Group C: WellCare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. WellCare should confirm the State mandated Back-up Plan is completed, signed and dated by the member/member representative.	WellCare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. WellCare should confirm the State mandated Back-up Plan is completed, signed and dated by the member/member representative: 1. MLTSS Managers and Supervisors conduct 1:1 case conference with care managers to ensure that documentation has been completed and that the backup plan was reviewed with the member during the initial face-to-face visit. 2. WellCare's standardized visit note template for initial and quarterly face-to-face visits include an area for the Care Manager to indicate whether the back-up plan has been reviewed and updated. 3. MLTSS Care Managers were re-educated regarding the frequency (at least quarterly) and completion of back-up plan. 4. A column for the Back-up plan completion date was placed on all new member scorecards and will be monitored and reviewed by MLTSS Managers/Supervisors. WellCare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member: 1. .MLTSS Care Managers were re-educated in July of 2020 regarding the following: -identifying when a risk agreement is needed after completion of a risk assessment -to notify their Manager/Supervisor upon completion of any member's risk assessment that needs a risk agreement -the Care Manager will follow-up with the Supervisor/Manager that the Risk Agreement is signed and completed and uploaded to the document center	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
WellCare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member. WellCare should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member, and the member/member representative confirmed their understanding. The member's Rights and Responsibilities should be signed and dated by the member/member representative.	2. MLTSS Managers and Supervisors conducted 1:1 case conferences with care managers to review and discuss members who have the potential need of a risk agreement and also that the Risk Agreement is completed, signed and dated by the CM and the member. 3. AcuteNet Risk Report run monthly to identify Risk Assessments completed that trigger the need for a Risk Agreement. Managers/Supervisors to review this report monthly and verify that a Risk Agreement is completed and included in the member's record. WellCare should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member and the member/member representative confirmed their understanding: 1. WellCare added a column for the Member Rights and Responsibilities (MRR) to the teams' monthly scorecard to assist MLTSS Managers/Supervisors and individual Care Managers in confirming that the initial MRR documentation and the MLTSS Managers/Supervisors will review and discuss the Annual MRR during 1:1 case conferences with care manager the following: -- member received his/her Rights and Responsibilities in writing -- Rights and Responsibilities were explained to the member and/or member representative -- member/member representative confirmed understanding -- Rights and Responsibilities form was signed and dated by the member and/or member representative. 2. Date of mailing of MRR to be verified by MLTSS Managers/Supervisors. Team scorecards are entered into a shared drive monthly for review by MLTSS Director. 3. Care Managers were educated in November 2020 team meetings regarding the use of proper verbiage when labeling the vendor mailing confirmation so that it will include what documents are being mailed to the member so it can be more easily identified.	
For the 2020 MLTSS HCBS CM audit, recommendations include the following: Recommendations for the Ongoing Care Management category include: • Group C: WellCare should ensure that members receive timely Face-to-Face visits to review member	1. WellCare continues to review member face-to-face visits for timeliness during CM audits. Audit findings will continue to be tracked and monitored for trends. 2. WellCare continues to review and discuss the timeliness of face-to-face visits during 1:1 case review conference between Manager/Supervisor and Care Manager. Findings from these conferences will continue to be used to address individual care manager performance. 3. WellCare continues to produce and monitor a weekly Visit Note Report that is distributed to MLTSS Care Management Managers for use in tracking care management activity by note type to help ensure member face-to-face visits are conducted timely (at least every 90 days for members in the community setting and at least every 180 days for members in CARS). 4. MLTSS care managers were provided re-education in February of 2020 reinforcing the following items: -After an initial visit, subsequent face-to-face visits need to be done at least every 90 days for HCBS members	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes.	- Care managers were instructed to start to plan visits at least 10 days ahead of both the 90 day and 180-day visit timeframe to help ensure compliance, to review member's placement and services, and to document in the member's electronic record if the member/member representative is not available during that timeframe or needs to reschedule a visit. 5. WellCare implemented a Visit Timeliness Report that is distributed to Managers/Supervisors and Care Managers for tracking due date of next face-to-face visit depending on date of previous visit and living arrangement of member - 90 days for HCBS members and 180 days for facility members.	
Recommendations for the Ongoing Care Management category include: • Group D: WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes. WellCare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis.	Group D: WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes. 1. WellCare continues to review member face-to-face visits for timeliness during WellCare's CM audits. Audit findings will continue to be tracked and monitored for trends. 2. WellCare continues to review and discuss the timeliness of face to face visits during 1:1 case review conferences between Manager/Supervisor and Care Manager. Findings from these conferences will continue to be used to address individual care manager performance. 3. WellCare Managers/ Supervisors continue to perform random record audits to ensure documentation reflects timeliness of ongoing face-to-face visit to review member placement and services that occurs at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial face-to-face visit. 4. WellCare continues to produce and monitor a weekly Visit Note Report that is distributed to MLTSS Care Management Managers for use in tracking care management activity by note type to help ensure member face-to-face visits are conducted timely (at least every 90 days for members in the community setting and at least every 180 days for members in CARS). 5. WellCare's Care Managers were provided re-education in February of 2020 reinforcing the following items: -After an initial visit, subsequent face-to-face visits need to be done at least every 90 days for HCBS members -Care managers were instructed to start to plan visits at least 10 days ahead of both the 90 day and 180 day visit timeframe to help ensure compliance, to review member's placement and services, and to document in the member's electronic record if the member/member representative is not available during that timeframe or needs to reschedule a visit. 6. WellCare implemented a Visit Timeliness Report that is distributed to Managers/Supervisors and Care Managers for tracking due date of next face-to-face visit depending on date of previous visit and living arrangement of member - 90 days for HCBS members and 180 days for facility members. WellCare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan reviewed with the member at least once on a quarterly basis. 1. MLTSS Managers and Supervisors conduct 1:1 case conferences with care managers to ensure that documentation has been completed and that the	

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	backup plan was reviewed with the member during the initial face-to-face visit. 2. WellCare's standardized visit note template for initial and quarterly face-to-face visits include an area for the Care Manager to indicate whether the back-up plan has been reviewed and updated. 3. MLTSS Care Managers were re-educated regarding the frequency (at least quarterly) and completion of back-up plan. 4. A column for the Back-up plan completion date was placed on all new member scorecards and will be monitored and reviewed by MLTSS Managers/Supervisors.	
Recommendations for the Ongoing Care Management category include: • Group E: WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes. WellCare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. WellCare should ensure that a Face-to-Face visit from the member's Care Manager is	WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes. 1. WellCare continues to review member face-to-face visits for timeliness during WellCare's CM audits. Audit findings will continue to be tracked and monitored for trends. 2. WellCare continues to review and discuss the timeliness of face to face visits during 1:1 case review conferences between Manager/Supervisor and Care Manager. Findings from these conferences will continue to be used to address individual care manager performance. 3. WellCare Managers/ Supervisors continue to perform random record audits to ensure documentation reflects timeliness of ongoing face-to-face visit to review member placement and services that occurs at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial face-to-face visit. 4. WellCare continues to produce and monitor a weekly Visit Note Report that is distributed to MLTSS Care Management Managers for use in tracking care management activity by note type to help ensure member face-to-face visits are conducted timely (at least every 90 days for members in the community setting and at least every 180 days for members in CARS). 5. WellCare's Care Managers were provided re-education in February of 2020 reinforcing the following items: -After an initial visit, subsequent face-to-face visits need to be done at least every 90 days for HCBS members -Care managers were instructed to start to plan visits at least 10 days ahead of both the 90 day and 180 day visit timeframe to help ensure compliance, to review member's placement and services, and to document in the member's electronic record if the member/member representative is not available during that timeframe or needs to reschedule a visit. 6. WellCare implemented a Visit Timeliness Report that is distributed to Managers/Supervisors and Care Managers for tracking due date of next face-to-face visit depending on date of previous visit and living arrangement of member - 90 days for HCBS members and 180 days for facility members. WellCare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. 1. MLTSS Managers and Supervisors conduct 1:1 case conferences with care managers to ensure that documentation has been completed and that the	

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
completed within 10 business days of discharge from an institutional facility to a HCBS setting.	backup plan was reviewed with the member during the initial face-to-face visit. 2. WellCare's standardized visit note template for initial and quarterly face-to-face visits include an area for the Care Manager to indicate whether the back-up plan has been reviewed and updated. 3. MLTSS Care Managers were re-educated regarding the frequency (at least quarterly) and completion of back-up plan. 4. A column for the Back-up plan completion date was placed on all new member scorecards and will be monitored and reviewed by MLTSS Managers/Supervisors. WellCare should ensure that a Face-to-Face visit from the member's Care Manager is completed within 10 business days of discharge from an institutional facility to a HCBS setting. 1. MLTSS Managers and Supervisors utilize WellCare's internal CM Audits to track and trend that a Face-to-Face visit is completed within 10 business days of discharge from an institutional facility to a HCBS setting and review with Care Manager to ensure compliance during 1:1 case conferences. 2. WellCare produces and monitors the Inpatient Census Report which is sent to the Care Managers bi-weekly by their Manager/Supervisor to track, monitor, and facilitate follow up with the member who has had an inpatient admission. 3. WellCare produces and monitors the Discharge Planning Report (DCP Report) which is sent to the Care Manager bi-weekly by their Manager/Supervisor to track and monitor any members who have been discharged from an inpatient facility. 4. WellCare Managers/Supervisors monitor and review Care Managers individual Discharge Spreadsheet monthly and also during 1:1 case conferences to discuss members who have been recently discharged from an institutional facility to HCBS setting to ensure that a visit was completed within 10 business days of discharge. 5. Care Mangers were re-educated during November 2020 team meetings regarding the importance of timeliness of Face to Face visit within 10 business days of discharge from an institutional facility.	

[1]A**ddressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2022.

XI. MCO Strengths and Opportunities for Improvement, and EQR Recommendations

Tables 56–60 highlight each MCO's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of MY 2021 EQR activities as they relate to **quality**, **timeliness**, and **access**.

ABHNJ - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 56: ABHNJ - Strengths and Opportunities for Improvement, and EQR Recommendations

ABHNJ - Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2021 PIPs	None	ABHNJ – Overall ABHNJ was partially compliant in presentation of data and analysis of results. There are opportunities for improvement in establishing robust interventions. The MCO has opportunities for improvement in the consistent design and implementation of their PIPs throughout the life cycle of the PIPs.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, six (6) standards received 100% compliance.	Five (5) standards, ranging from 0% to 78% did not meet compliance. Those measures were: Availability of services (42%) Assurances of adequate capacity and services (0%); Coordination and continuity of Care (64%); Coverage and authorization of services (71%) and Grievance and appeals systems (78%).
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	ABHNJ reported significant improvements (a more than five percentage point change is considered a significant change) in performance for 10 HEDIS measures.	ABHNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for 10 HEDIS measures. ABHNJ did not include dual eligible members with Medicare coverage through fee-for-service or another organization in HEDIS based MLTSS measures.
Quality of Care Surveys – Member (CAHPS 2021)	None	Eight (8) of eight (8) CAHPS measures for both Adult and Child surveys fell below the 50th percentile.
Core Medicaid - 2021 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, ABHNJ scored over the 85% threshold in 6 categories ranging from 86% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, ABHNJ scored below the 85% threshold in 7 categories ranging from 42% to 84%.
MLTSS – 2021 HCBS CM Review	Of the 6 categories at the sub-population level, ABHNJ scored at or above 86% for 9 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, ABHNJ scored below 86% for 6 of the 15 sub-populations scores.
MLTSS – 2021 NF CM Review	Of the 21 elements for which sufficient denominators were observed ABHNJ scored at or above 86% for 16 elements.	Of the 21 elements for which sufficient denominators were observed, ABHNJ had 5 review elements that scored below 86%.

ABHNJ - Strengths, Opportunities for Improvement, and EQR Recommendations	
Recommendations	
2021 PIPs	ABHNJ should address the PIP validation elements that were determined to be not met or partially met. See recommendations below under Quality Management QM11a and QM11b.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4. The MCO should ensure to provide the correct GeoAccess reports to show access compliance. 2. A4a- A4e. The MCO should ensure to provide the correct GeoAccess reports to show access compliance for Adult PCPs, Pediatric PCP, Specialty Providers, Dental Providers and Hospitals. 3. A4f. The MCO needs consistency in reporting to DMAHS and the EQRO regarding MLTSS Adult Social Day Care providers. 4. A7. The MCO should continue to focus on improving appointment availability for obstetricians/gynecologists (OB/GYN), specialty and behavioral health providers, and after-hours availability statewide. 5. A8. The MCO should ensure to provide the correct GeoAccess reports to show access compliance for all categories. **Quality Management** 1. QM11a. The MCO should review each section and ensure accuracy for the Core Medicaid Improving Developmental Screening and Referral Rates to Early Intervention for Children PIP and revise and update multiple sections in order to be able to have a positive impact on the early intervention Services. 2. QM11a. The MCO should ensure emerging barriers and systemic challenges regarding the Core Medicaid MCO Adolescent Risk Behaviors and Depression Collaborative PIP outcomes are comprehensively discussed, evaluated, and factored into continuous performance improvement as the PIP enters the sustainability phase. 3. QM11b. The MCO should review its approach with consideration to utilization of requisite data in accordance with the stated methodology, to ensure the efficacy of the MLTSS Reduction in ER and IP Utilization through Enhanced Chronic Disease Management PIP can be adequately evaluated. **Utilization Management** 1. UM16b: The MCO should ensure that Core Medicaid Provider grievance resolution letters are correct and sent to the members in a timely manner. 2. UM16e: The MCO should ensure that UM Core Medicaid provider and member notifications are done in a timely manner. 3. UM16g: The MCO should ensure that MLTSS provider grievances resolution letters are completed and included in files. 4. UM16i: The MCO should ensure that MLTSS provider appeals resolution letters are completed with a medical decision and in a final format before sending to provider.
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that all reporting include all appropriate MLTSS members to comply with EQRO PM Validation.
Quality of Care Surveys – Member (CAHPS 2021)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.

ABHNJ - Strengths, Opportunities for Improvement, and EQR Recommendations	
Core Medicaid - 2021 CM Review	ABHNJ should address the deficiencies noted in the following areas: • GP – Identification, Continuity of Care, Coordination of Services • DDD – Preventive Services, Continuity of Care, Coordination of Services • DCP&P – Preventive Services
MLTSS – 2021 HCBS CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B**.
MLTSS – 2021 NF CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B**.

AGNJ - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 57: AGNJ - Strengths and Opportunities for Improvement, and EQR Recommendations

AGNJ - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2021 PIPs	Out of five (5) PIPs scored, one (1) PIP performed above the 85% threshold indicating high performance for this PIP.	AGNJ – Overall AGNJ was partially compliant in presentation of data and analysis of results. There are opportunities for improvement in establishing robust interventions. Opportunities for improvement are also present in terms of in-depth barrier analyses identifying subpopulations throughout the life of the PIP.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 55% to 58% did not meet compliance. Those measures were: Availability of services (58%), and Coordination and continuity of Care (55%).
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	AGNJ reported significant improvements (a more than five percentage point change is considered a significant change) for six (6) HEDIS measures.	AGNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for 12 HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2021)	Five (5) of eight (8) Adult CAHPS measures were above the 50th percentile. Two (2) Child CAHPS measures were above the 50th percentile.	Three (3) of eight (8) Adult CAHPS measures fell below the 50th percentile. Six (6) of eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2021 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, AGNJ scored over the 85% threshold in nine (9) categories ranging from 91% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, AGNJ scored below the 85% threshold in four (4) categories ranging from 60% to 77%.
MLTSS – 2021 HCBS CM Review	Of the 6 categories at the sub-population level, AGNJ scored at or above 86% for 7 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, AGNJ scored below 86% for 8 of the 15 sub-populations scores.
MLTSS – 2021 NF CM Review	Of the 20 elements for which sufficient denominators were observed AGNJ scored at or above 86% for 14 elements.	Of the 20 elements for which sufficient denominators were observed, AGNJ had 6 review elements that scored below 86%.

AGNJ - Strengths, Opportunities for Improvement, and EQR Recommendations	
Recommendations	
2021 PIPs	AGNJ should address the PIP validation elements that were determined to be not met or partially met. See recommendations below under Quality Management QM11a and QM11b.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4a. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon County. 2. A4b. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for pediatric PCPs in Warren County. 3. A4e. The MCO should continue to address hospital deficiencies in Hunterdon and Warren Counties. 4. A4f. The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care. 5. A7. The MCO should continue to focus on improving after-hours availability statewide. **Quality Management** 1. QM11a. The Plan should focus on intervention details, monitoring and evaluating at close intervals to ensure that implementation delays and /or introduction of additional interventions are timely and well thought out. The MCO should be mindful of the objectives and goals as well as the impact to the members over the life of the PIP to monitor ongoing progress. 2. QM11b. The Plan should review each section of the PIP process to ensure that each section is updated according to new information, such as changes in process in Methodology, ensuring that changes are accurately documented for monitoring, analysis and a comprehensive evaluation is ongoing throughout the improvement process for understanding progress and impact to the membership.
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, AGNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
Quality of Care Surveys – Member (CAHPS 2021)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2021 CM Review	AGNJ should address the deficiencies noted in the following areas: • GP – Preventive Services, Continuity of Care • DDD – Preventive Services • DCP&P – Preventive Services
MLTSS – 2021 HCBS CM Review	AGNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.
MLTSS – 2021 NF CM Review	**1.** AGNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.

HNJH - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 58: HNJH - Strengths and Opportunities for Improvement, and EQR Recommendations

HNJH - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2021 PIPs	Three (3) PIPs performed above the 85% threshold indicating high performance.	HNJH - Overall HNJH was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions. There are opportunities for improvement in consistency regarding study design and methodologies for data collection.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 73% to 75% did not meet compliance. Those measures were: Availability of services (75%), and Coordination and continuity of Care (73%).
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	HNJH reported significant improvements (a more than five percentage point change is considered a significant change) in rates for 10 HEDIS measures.	HNJH reported significant declines (a more than five percentage point change is considered a significant change) in performance for six (6) HEDIS measures. HNJH did not include dual eligible members in the Breast Cancer Screening Measure (BCS). For all other HEDIS measures, dual eligible members were included where appropriate. HNJH did not include dual eligible members with Medicare coverage through fee-for-service or another organization in HEDIS based MLTSS measures.
Quality of Care Surveys – Member (CAHPS 2021)	Five (5) of eight (8) Adult CAHPS measures were above the 50th percentile. Two (2) Child CAHPS measures were above the 50th percentile.	Three (3) of eight (8) Adult CAHPS measures fell below the 50th percentile. Six (6) of eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2021 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, HNJH scored over the 85% threshold in eight (8) categories ranging from 86% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, HNJH scored below the 85% threshold in five (5) categories ranging from 71% to 84%.
MLTSS – 2021 HCBS CM Review	Of the 6 categories at the sub-population level, HNJH scored at or above 86% for 12 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, HNJH scored below 86% for 3 of the 15 sub-populations scores.
MLTSS – 2021 NF CM Review	Of the 21 elements for which sufficient denominators were observed HNJH scored at or above 86% for 18 elements.	Of the 21 elements for which sufficient denominators were observed, HNJH had 3 review elements that scored below 86%.
Recommendations		
2021 PIPs	HNJH should address the PIP validation elements that were determined to be not met or partially met. See recommendations below under Quality Management QM11b.	
2021 Compliance with Medicaid and	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4d. The MCO should continue to expand the Dental/Specialty Dental network in Atlantic	

HNJH - Strengths, Opportunities for Improvement, and EQR Recommendations	
CHIP Managed Care Regulations	County. The MCO should continue to negotiate contracts to meet deficient coverage areas for Dental/Specialty Dental providers. 2. A4f. The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care. 3. A7. The MCO should focus on improving appointment availability for dental providers, adult PCPs, specialists, and behavioral health providers, as well as improve after-hours availability. **Quality Management** 1. QM11b. The MCO should continue to review and revise their data for accuracy in the MLTSS PIP. The MCO should also continue to evaluate methodology, performance indicators, and timeframes to ensure positive outcomes. 2. QM18. The MCO should ensure FIDE SNP members are included in the Breast Cancer Screening Measure. 3. QM19. The MCO should ensure that all reporting include all appropriate MLTSS members to comply with EQRO Performance Measure validation. **Satisfaction** 1. S5. The MCO should ensure new member quarterly outreach is tracked to verify the enrollees understanding of the MCO's procedures and available services and made available to DMAHS per Contract requirements.
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	1. The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. See recommendations above under Quality Management QM18 and QM19.
Quality of Care Surveys – Member (CAHPS 2021)	The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2021 CM Review	HNJH should address the deficiencies noted in the following areas: • GP – Preventive Services, Continuity of Care, Coordination of Services • DDD – Preventive Services, Continuity of Care • DCP&P – No deficiencies were identified.
MLTSS – 2021 HCBS CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D**.
MLTSS – 2021 NF CM Review	1. HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D**.

UHCCP - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 59: UHCCP - Strengths and Opportunities for Improvement, and EQR Recommendations

UHCCP - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2021 PIPs	Four (4) PIPs performed above the 85% threshold indicating high performance.	Overall UHCCP was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 73% to 75% did not meet compliance. Those measures were: Availability of services (75%), and Coordination and continuity of Care (73%).
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	UHCCP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for five (5) HEDIS measures.	UHCCP reported significant declines (a more than five percentage point change is considered a significant change) in rates for eight (8) HEDIS measures. For MLTSS Performance Measure reporting, UHCCP was not timely in their submission of data and rates to IPRO for review.
Quality of Care Surveys – Member (CAHPS 2021)	Four (4) of eight (8) Adult CAHPS measures were above the 50th percentile. One (1) Child CAHPS measure was above the 50th percentile.	Four (4) of eight (8) Adult CAHPS measures fell below the 50th percentile. Seven (7) of eight (8) Child CAHPS measures fell below the 50th percentile.
MLTSS – 2021 HCBS CM Review	Of the 6 categories at the sub-population level, UHCCP scored at or above 86% for 2 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, UHCCP scored below 86% for 13 of the 15 sub-populations scores.
Core Medicaid - 2021 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, UHCCP scored over the 85% threshold in eight (8) categories ranging from 88% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, UHCCP scored below the 85% threshold in five (5) categories ranging from 49% to 83%.
MLTSS – 2021 NF CM Review	Of the 21 elements for which sufficient denominators were observed UHCCP scored at or above 86% for 4 elements.	Of the 21 elements for which sufficient denominators were observed, UHCCP had 17 review elements that scored below 86%.
Recommendations		
2021 PIPs	UHCCP should address the PIP validation elements that were determined to be not met or partially met. See recommendations below under Quality Management QM11b.	
2021 Compliance with Medicaid and CHIP Managed Care Regulations	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4e. The MCO should continue to address the hospital access deficiencies in Atlantic and Cumberland Counties. 2. A4f. The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care. 3. A7. The MCO should continue to focus on improving appointment availability for Adult PCPs, Pediatric providers, OB/GYN providers, high-volume Specialists, and Behavioral Health providers, as well as improve after-hours availability statewide. **Quality Management**	

UHCCP - Strengths, Opportunities for Improvement, and EQR Recommendations	
	1. QM11b. The MCO should implement planned interventions in a timely manner to have an effective impact on the outcome of the MLTSS PIP. **Programs for the Elderly and Disabled** 1. ED39 - ED42. The plan should ensure that reporting is finalized for the conditions: aspiration pneumonia, injuries, fractures, and contusions, decubiti, and seizure management. 2. ED44. The MCO should ensure that pre-onsite documentation not only describes processes, but that it also shows implementation of policies and procedures. **Credentialing and Recredentialing** 1. CR8. The MCO should ensure the review of quality metrics, including a review of complaints/quality issues, at the time of Recredentialing, and that this is documented in the Core Medicaid PCP Recredentialing files, including delegated PCP providers.
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	1. Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure accurate and timely submissions related to MLTSS Performance Measure clinical documentation.
Quality of Care Surveys – Member (CAHPS 2021)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2021 CM Review	UHCCP should address the deficiencies noted in the following areas: • GP – Preventive Services, Continuity of Care • DDD – Preventive Services, Continuity of Care • DCP&P- Preventive Services
MLTSS– 2021 HCBS CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E**.
MLTSS – 2021 NF CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E**.

WCHP - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 60: WCHP - Strengths and Opportunities for Improvement, and EQR Recommendations

WCHP - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2021 PIPs	Three (3) PIPs performed above the 85% threshold indicating high performance.	Overall WCHP was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions. There are also opportunities for improvement in the consistent presentation of Intervention Tracking Measures (ITMs) throughout the life cycle of the PIPs.
2021 Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, eight (8) standards received 100% compliance. One (1) standard received 89% compliance.	Two (2) standards, ranging from 82% to 83% did not meet compliance. Those measures were:

WCHP - Strengths, Opportunities for Improvement, and EQR Recommendations		
		Availability of services (83%), and Coordination and continuity of Care (82%). QAPI: Q2. On the 2020 QI Annual Evaluation of Patient Saftey Initiatives and Quality of Care report, the MCO should modify the 75% goal to close cases within 30 days to a goal of 100%. Quality Management: QM8. The MCO should look at the process for hospital discharges and review discharges that are listed as deceased, and further investigate if these were expected or unexpected.
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	WCHP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for five HEDIS measures.	WCHP reported significant declines (a more than five percentage point change is considered a significant change) in rates for 11 HEDIS measures. WCHP did not include dual eligible members with Medicare coverage through fee-for-service or another organization in HEDIS based MLTSS measures.
Quality of Care Surveys – Member (CAHPS 2021)	Three (3) of eight (8) Adult CAHPS measures were above the 50th percentile. One (1) Child CAHPS measure was above the 50th percentile.	Five (5) of eight (8) Adult CAHPS measures fell below the 50th percentile. Seven (7) of eight (8) Child CAHPS measures fell below the 50th percentile.
MLTSS – 2021 HCBS CM Review	Of the 6 categories at the sub-population level, WCHP scored at or above 86% for 11 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, WCHP scored below 86% for 4 of the 15 sub-populations scores.
Core Medicaid - 2021 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, WCHP scored over the 85% threshold in 11 categories ranging from 89% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, WCHP scored below the 85% threshold in two (2) categories ranging from 46% to 76%.
MLTSS – 2021 NF CM Review	Of the 21 elements for which sufficient denominators were observed WCHP scored at or above 86% for 2 elements.	Of the 21 elements for which sufficient denominators were observed, WCHP had 19 review elements that scored below 86%.
Recommendations		
2021 PIPs	WellCare should address the PIP validation elements that were determined to be not met or partially met.	
2021 Compliance with Medicaid and CHIP Managed Care Regulations	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4f. The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care. 2. A7. The MCO should continue to focus on improving after-hours availability for Adult PCP and Specialists (Oncology). **Utilization Management** 1. UM16h. The MCO should implement a process to ensure that all MLTSS Member Appeal letters are sent to the appropriate Member, and all determination letters should be sent out in timely manner.	

WCHP - Strengths, Opportunities for Improvement, and EQR Recommendations	
HEDIS MY 2020 Performance Measures and MLTSS Performance Measure Reporting	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that all reporting include all appropriate MLTSS members to comply with EQRO Performance Measure validation.
Quality of Care Surveys – Member (CAHPS 2021)	The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2021 CM Review	WCHP should address the deficiencies noted in the following areas: • GP - No opportunities were identified. • DDD – Preventive Services • DCP&P- Preventive Services
MLTSS – 2021 HCBS CM Review	WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.
MLTSS – 2021 NF CM Review	1. WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.

Appendix A: January 2021 – December 2021 NJ MCO-Specific Review Finding

Note: This is a separate document.

Appendix B: ABHNJ 2021 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix C: AGNJ 2021 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix D: HNJH 2021 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix E: UHCCP 2021 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix F: WCHP 2021 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix G: MCO MLTSS Nursing Facility/Special Care Nursing Facility COVID Impact Evaluation

Note: This is a separate document.

APPENDIX A: January 2021–December 2021 MCO-Specific Review Findings (2021 – 2022 Reporting Cycle)

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ABHNJ 2021 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	26	30	25	25	5	0	83%	3	1	2
Care Management and Continuity of Care - MLTSS*	10	9	10	10	10	0	0	100%	0	1	0
Access	14	11	10	1	5	9	0	36%	3	0	6
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[6]	20	17	11	7	16	4	0	80%	3	0	1
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	5	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	29	14	10	26	4	0	87%	0	0	4
Administration and Operations[7]	14	13	4	4	14	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	**0**	**0**	**0**
TOTAL	**198**	**190**	**85**	**68**	**181**	**17**	**0**	**91%**	**6**	**0**	**11**

[1] A total of 86 elements were reviewed in the previous review period; of these 86, 80 were *Met*, 5 were *Not Met.* One (1) element was N/*A* in Utilization Management. Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period. As a result, the sum of "Met Prior Year" and "Subject to Review" might exceed the total number of elements for some standards.

[3] Elements that were *Met* in this review period among those that were subject to review.

[4] Elements that were *Met* in this review period among those that were subject to review as well as elements that were *Met* in the previous review period and were not subject to review (i.e., were deemed *Met*). This total is used to calculate the compliance score for each standard as well as the overall compliance score.

[5] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.

[6] In 2021, QM11 was subdivided into QM11a (Core Medicaid PIPs) and QM11b (MLTSS PIPs).

[7] AO14 was added as a new element for Core Medicaid in 2021.

*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Correction Action Plans (CAPs) as applicable.

MCO Name: Aetna Better Health of New Jersey (ABHNJ)
PIP Topic 1: Improving Developmental Screening and Referral Rates to Early Intervention for Children

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings [1]	Year 1 Findings	Year 2 Findings	Sustainability Findings [2]	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M	M	
1b. Impacts the maximum proportion of members that is feasible	N/A	M	NM	NM	PM	
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	NM	M	M	
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	PM	M	M	M	
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**	**PM**	**PM**	
Element 1 Overall Score	**N/A**	**50.0**	**50.0**	**50.0**	**50**	
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**	**2.5**	**2.5**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	PM	PM	M	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M	
2c. Objectives align aim and goals with interventions	N/A	M	PM	M	M	
Element 2 Overall Review Determination	**N/A**	**M**	**PM**	**PM**	**M**	
Element 2 Overall Score	**N/A**	**100**	**50.0**	**50.0**	**100**	
Element 2 Weighted Score	**N/A**	**5.0**	**2.5**	**2.5**	**5.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM	PM	PM	PM	
3b. Performance indicators are measured consistently over time	N/A	M	M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M	M	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	PM	M	M	M	

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	PM	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	PM	PM	PM	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**	**PM**	**PM**	
Element 3 Overall Score	**N/A**	**50.0**	**50.0**	**50.0**	**50**	
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**7.5**	**7.5**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	PM	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	PM	
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	M	M	M	M	
4f. Literature review	N/A	PM	PM	M	M	
Element 4 Overall Review Determination	**N/A**	**PM**	**PM**	**M**	**PM**	
Element 4 Overall Score	**N/A**	**50.0**	**50.0**	**100**	**50**	
Element 4 Weighted Score	**N/A**	**7.5**	**7.5**	**15.0**	**7.5**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	PM	M	N/A	M	
5b. Actions that target member, provider and MCO	N/A	M	M	N/A	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	N/A	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	NM	N/A	PM	
Element 5 Overall Review Determination	**N/A**	**PM**	**PM**	**N/A**	**PM**	
Element 5 Overall Score	**N/A**	**50**	**50**	**N/A**	**50**	
Element 5 Weighted Score	**N/A**	**7.5**	**7.5**	**N/A**	**7.5**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight

6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	PM	M	M	
Element 6 Overall Review Determination	**N/A**	**PM**	**PM**	**M**	**M**	
Element 6 Overall Score	**N/A**	**50.0**	**50.0**	**100**	**100**	
Element 6 Weighted Score	**N/A**	**2.5**	**2.5**	**5.0**	**5.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	PM	PM	NM	PM	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M	
Element 7 Overall Review Determination	**N/A**	**PM**	**PM**	**PM**	**PM**	
Element 7 Overall Score	**N/A**	**50.0**	**50.0**	**50.0**	**50**	
Element 7 Weighted Score	**N/A**	**10.0**	**10.0**	**10.0**	**10.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	NM	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50.0**	**100**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**NA**	**M**	**Y**	**Y**	**Y**	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**100**	
Actual Weighted Total Score	**N/A**	**42.5**	**40.0**	**52.5**	**65**	
Overall Rating	**N/A**	**53.0%**	**50.0%**	**61.8%**	**65%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components.

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Final Report
IPRO Comments:

Element 1 Overall Review Determination was that the Managed Care Organization (MCO) is partially compliant in regard to subcomponent 1b. The MCO continues to struggle with the rational for scaling down provider /group/FQHC selections from the initial proposal of 34 providers to 3 providers (provider /group/FQHC) driving the necessary change in performance outcomes. Without a clear understanding for scaling down provider/group/FQHC selections and timeline it remains difficult to ensure clear and consistent measurement periods demonstrating the feasibility of maximizing the impact on its members. The MCO should summarize this concern and remedies in a clear, concise manner to align the many edits and adjustments to the PIP.
Element 2 Overall Review Determination was that the MCO was compliant.
Element 3 Overall Review Determination was that the MCO was partially compliant in regard to subcomponent part 3a, Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria). The MCO notes a deeper review of the data associated with outcomes measures 1-3, with the finding that most of the children seen for a well care visit (WCV) were being screened, and the majority of them utilized the 96110 code to identify the screening for developmental delays. However, review of the eligible members associated with the selected providers for claims received yielded only 25-40 percentage of the denominators. The MCO also notes that there were a number of interventions targeted to increase WCV visits, however, the impact of these interventions is unknown as the efficacy of these interventions were not tracked. The MCO has reviewed and made adjustments where practical. The MCO also noted they will continue to work with this population to determine if all well child visits are being accurately captured as well as promoting the use of evidenced based tools.
Element 4 Overall Review Determination was partially compliant in regard to Barrier Analysis, subcomponent 4d, QI process data. The MCO altered the Barrier Analysis, Interventions, and Monitoring Table 1a and Table 1b, Quarterly Reporting of Rates for Intervention Tracking Measures. The PIP Template is designed to track data over time accurately and requires that the template remain unchanged without approval of any modification. The MCO should restore the PIP Template to its original format for all futures submissions.
Element 5 Overall Review Determination was that the MCO was partially compliant in regard to Robust Interventions, subcomponent 5d, regarding corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports). Concerns were identified with alterations of the PIP Template as noted above. Additionally, terminations of the interventions should be identified and documented at the time of the termination in order to track and evaluate the effectiveness of the interventions. The MCO should ensure that all future submissions adhere to the appropriate format of the PIP Template. The MCO notes over the life of the PIP, MY1 and MY2 have had multiple challenges. Although many of the challenges have been subsequently reconciled, progress toward the goals and ultimate outcome measures, it remains unclear.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant in regard to Discussion and Validity of Reported Improvement 7c, changes in performance through the use of indicators, factors that influence comparability, and threats to internal/external validity. The MCO continues to struggle with the robustness of interventions and how results are reported as well as a full analysis that demonstrates the ability to impact quality improvement of the project. Although PI #1 exhibits a slow progression toward the goal, PIs #2 and #3 exhibit regression from MY 1 to Sustainability, noting that all three indicators did not meet the goals. The MCO should review the concerns raised with a deep dive approach to understand better the connections from methodology, barriers and the robustness of interventions.
Element 8 Overall Review Determination was that the MCO was compliant.
Element 9 Overall Review Determination was that the MCO provided information on a healthcare disparity by identifying and addressing geographical regions of Essex and Union counties. The MCO decided to focus its efforts on claims by providers for early intervention services in these two counties.
Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 65.0 points, which results in a rating of 65.0% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The PIP originally proposed 34 providers; however, this was found to be unmanageable. The MCO scaled down its activities accordingly and settled on three provider panels which targeted a provider/group/FQHC. The MCO has noted multiple changes throughout the PIP's inclusive baseline, timeline, barrier analysis and interventions. The MCO notes as well that PI indicators #4, #5, #6 exceeded the goals through the medical record review process. However, it did not sufficiently discuss the results in terms of sustainable outcomes and overall impact to the project. The MCO should fully review each section of the PIP to better facilitate the connectivity between the sections to optimize positive outcomes.

MCO Name: Aetna Better Health of New Jersey (ABHNJ)
PIP Topic 2: MCO Adolescent Risk Behaviors and Depression Collaborative

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	PM	PM	M		
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 1 Overall Score	**N/A**	**50**	**50**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**	**5.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	PM	PM	PM		
Element 2 Overall Review Determination	**N/A**	**PM**	**PM**	**PM**		
Element 2 Overall Score	**N/A**	**50**	**50**	**50**	**0**	
Element 2 Weighted Score	**N/A**	**2.5**	**2.5**	**2.5**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	PM	M	M		

3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50**	**50**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**15.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	NM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**N/A**	**50**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**7.5**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	M	PM		
Element 6 Overall Review Determination	**N/A**	**PM**	**M**	**PM**		
Element 6 Overall Score	**N/A**	**50**	**100**	**50**	**0**	
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**	**2.5**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight

7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	PM	PM		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**	**10.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	PM		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**	
Actual Weighted Total Score	**N/A**	**37.5**	**42.5**	**67.5**	**0.0**	
Overall Rating	**N/A**	**62.5%**	**65.4%**	**67.5%**	**0%**	
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)						

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 22, 2021
Report Period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is partially compliant in regard to subcomponent 2c.
2c. The MCO is partially compliant with the alignment of Objectives with Aim and Goals with interventions. The MCO has not established individual goals, objectives specific to each provider. As noted previously, the MCO should provide not only the aggregate of all three providers as well as include individual stratification of each provider exhibiting the alignment with the Objectives and Goals. The Baseline Rate and Benchmark Rate measurement periods should reflect the measurement period as noted on the header title on page 11.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was partially compliant regarding Section 5, Robust Interventions, Table 1a (Barrier Analysis, Interventions and Monitoring) and Table 1b (Quarterly Reporting Rates for Interventions Tracking

Measures) have been altered from their original form. The PIP Template is the monitoring and tracking form to comprehensively evaluate the MCO's progress toward achieving the goals of the PIP. The MCO should restore the Template to its original form for the Final Report due in August 2022. The MCO should note all changes in ITM's and Interventions respectively in Tables 1a and Table 1b, citing terminations, additions and /or edits to dates etc. as well as on the Change Table found on (pg. 3) should also exhibit dates of termination, addition or edits so as to track the measure efficiently.

Element 6 Overall Review Determination was that the MCO is partially compliant in regard to Section 6, Table 2, and Results. The MCO has made incorrect notation regarding the use of a zero in the denominator as yielding a zero (0) rate percentage. When there is a zero in the denominator the rate percentage is N/A. The MCO has multiple notations utilizing the zero (0%) percentage in Table 6-Results. There is also a miscalculation noted on page 44, Indicator # 5, Y-2 (2020). These notations should be reviewed and corrected prior to the Final Report submission in August 2022.

Element 7 Overall Review Determination was that the MCO is partially compliant in regard to Discussion and Validity of Reported Improvement, subcomponent 7a. The MCO was partially compliant with interpretation to which the PIP is successful, and the factors associated with success. The MCO's overall clarity and specificity regarding factors that support the upward trend of the interventions for risk behaviors are sufficiently detailed to fully understand how the interventions progressed to this point. In the sustainability period, detailing the steps taken toward achieving the goals of the PIP should be shown as supporting successes and discussing limitations to achievement.

Element 8 Overall Review Determination was that the MCO is partially compliant in regard to Sustainability 8a, there was ongoing, additional or modified interventions documented. The MCO has not clearly illustrated additional modifications to support the sustainability of the PIP. Table 1b, Quality Reporting Rate for Intervention Tracking Measures, exhibits 17 ITMs. Table 1b, exhibits 12 of the 17 ITMs have been terminated. This leaves only 5 ITMs to support the project. The ITM Tracking Table 1b shows sparse data throughout the 2020 MY to provide support for the ITMs that are left. In the Section 7, Discussion, the MCO provides Tables for Indicators #1, #2, #3, #4, and # 5, which illustrate progression toward the Goals for Sustainability. However, the connection between the ITMs and the positive movement toward the goals of PIP are not realized in the documentation. The MCO should review the PIP's Indicators and as well as the ITMs to clearly exhibit how the ITMs support the progression of the Risk Behaviors Indicators.

Element 9 Overall Review Determination was that a healthcare disparity is not addressed.

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 67.5 points, which results in a rating of 67.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO exhibits some progression towards the goals in regard to the Risk Behaviors however, the MCO should take note of the concerns identified above, review and detail information for the Final Report due August 2022. The MCO should continuously evaluate all aspects of the PIP recognizing successes and limitations and reconciling plans to move forward. As changes happen, the MCO should continue to monitor the changes made and the impact Covid -19 has on the PIP and its progress.

ABHNJ PIP 3: Improving Access and Availability to Primary Care for the Medicaid Population

MCO Name: Aetna Better Health of New Jersey (ABHNJ)

PIP Topic 3: Improving Access and Availability to Primary Care for the Medicaid Population

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					

1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					

4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	

Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N**				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@IPRO.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Proposal Resubmission
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was not applicable (N/A).
Element 2 Overall Review Determination was N/A. Although not scored, a concern was identified with the Aim, Objectives and Goals regarding 2a. The Aim statement on page 9 states "By 2024 the MCO aims to increase PCP visits for the targeted practices with high-volume emergency room utilization for non-emergent care per 1000 member months by 10%". The objectives (on pg. 9) state the MCO will collaborate with each targeted PCP practice to develop best practice. However, the Goals set forth related to Indicator #2 (Increase PCP utilization for targeted PCPs in the Medicaid Network) and Indicator #4 (Decrease ER Utilization for targeted PCPs in the Medicaid Network -LANE diagnosis), does not describe how the MCO will stratify the targeted PCP practices exhibiting their progress. It is unclear how the MCO will fulfill its objective if specific data for each of the targeted PCPs is not included along with the aggregate to exhibit the progression of improvement of the 10 Targeted PCPs month over month, quarter over quarter and year over year. The MCO should expand the data to include the specific rates for all of the targeted PCPs across the 4 Indicators as noted above. The MCO should also provide the Tables with grid lines to ensure the data aligns with the measurement period appropriately.
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Methodology regarding 3a and 3g. The Numerator definition in part states, " The numerator is the total number of distinct ER visits..." and further states "An ER visit is identified by pulling claims with revenue codes 0450,0451, 0456, 0459, 0981 or claims with service codes 99281-99285. The MCO should clarify the nature of each code by clearly labeling what the code means either the Numerator Definition or as an Appendix attached thereby clarifying the diagnosis that are being followed by the MCO. On page 13, #2, Data Collection and Analysis Procedures, the MCO chose to use sampling, as noted above in 2a, the MCO should expand the data for the ten (10) PCP practices/addresses to include the specific data of ER and PCP utilization for each address as well as the aggregate comparison with the entire network as stated in the Indicators #1, #2, #3, and #4.
Element 4 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Barrier Analysis regarding 4d. The MCO should update Table 1a: The MCO altered the Barrier Analysis, Interventions, and Monitoring Table 1a and Table 1b, Quarterly Reporting of Rates for Intervention Tracking Measures. The PIP Template is designed to track data over time accurately and requires that the template remain unchanged without approval of any modification. The MCO should restore the PIP Template to its original format for all futures submissions. Additionally, the instruction, "Note: Interventions that have been terminated during the project period should remain in the table", found under the section that describes the identified barriers identified and related interventions has been removed (page16).
Element 5 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the interventions. In Table 1b, The PIP Template Columns, Headings and content have been altered, no longer in alignment the PIP Template as designed. The MCO should review the IPRO PIP Template and re-establish the appropriate columns, headings and column content to its original format.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the proposal phase.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored healthcare disparities were not identified, evaluated or addressed.
For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed aim, methodology, barrier analysis, and interventions. The MCO should provide more definition to the provider practices such as stratification of the ten (10) PCP practices /addresses identify revenues codes in terms of diagnoses, those practices that treat chronic conditions and etc., as well as review of panels by counties for health care disparities and identify other potential barriers for accessing care and services. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

ABHNJ PIP 4: Increasing Early and Periodic Screening Diagnostic and Treatment (EPSDT) Visits and Childhood Immunizations

MCO Name: Aetna Better Health of New Jersey (ABHNJ)
PIP Topic 4: Increasing Early and Periodic Screening Diagnostic and Treatment (EPSDT) Visits and Childhood Immunizations

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					

2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					

Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			

Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A.
Element 3 Overall Review Determination was N/A.
Element 4 Overall Review Determination was N/A. Although not scored, concerns were identified with aspects of the Barrier Analysis, Interventions, and Monitoring, Table 1a. The MCO is using a numbering format that can be confusing. For example, in Barrier #1a, the MCO notes #1ai, #1aii and #1aiii. The MCO uses this numbering throughout Barriers 1-4. Although the MCO has chosen this numbering pattern, which is appropriate, the MCO might consider using 1a, 1b, 1c, 2a, 2b, 2c etc. for ease of reading and ensuring the specifics of each ITM are maintained, monitored and evaluated consistently throughout the life of the PIP on the Barrier Analysis Table 1a and Table 1 b, Quarterly Reporting of Rates for Intervention Tracking Measures.
Element 5 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of Robust Interventions, 5a, informed by Barrier analysis. Table 1b: quarterly Reporting of Rates for Intervention Tracking Measures (ITMs). Table 1b, Intervention #2a has a duplicate 2a noted in column 1, page 19. As noted above, the MCO should consider the numbering format for ease of monitoring, evaluation and consistency of ITMs over the life of the PIP.
Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have been identified. The MCO should elaborate on how the MCO evaluates and address members in these counties to decrease the disparity.
For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Barrier Analysis and Interventions. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

ABHNJ PIP 5: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management

MCO Name: Aetna Better Health of New Jersey (ABHNJ)
PIP Topic 5: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	PM	PM	M		
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 1 Overall Score	**N/A**	**50**	**50**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**2.5**	**3**	**5**	**0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	PM	M	M		

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**		
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**15**	**15**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15**	**15**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	NM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**0**	**50**	**0**	

Element 5 Weighted Score	**N/A**	**7.5**	**0**	**7.5**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	NM	PM	M		
Element 6 Overall Review Determination	**N/A**	**NM**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**0**	**50**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**2.5**	**5.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	PM	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	PM		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**		
Element 7 Overall Score	**N/A**	**0**	**50**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**10**	**10**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**0**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**0**	**20**	**0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	N/A	**N**	N	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**	
Actual Weighted Total Score	**N/A**	**37.5**	**50.0**	**82.5**	**0**	
Overall Rating	**N/A**	**62.5%**	**76.9%**	**82.5%**	**0%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

1 Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Findings Phase).

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org; Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 10, 2021
Report Period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination is that the Managed Care Organization (MCO) is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.
Element 4 Overall Review Determination is that the MCO is compliant.
Element 5 Overall Review Determination is that the MCO is partially compliant regarding Robust Interventions 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). A concern was identified regarding Table 1b quarterly data, MY 1 and MY 2, noting inconsistent decimal documentation and incorrect calculations. The MCO should be consistent in the statistical display of data to ensure its accuracy and confidence in the overall measurement results. For example, on page 25 Q1, ITM 1c2, demonstrates no rounding up for a rate of 66.666% documenting 66.66% and in Q3, 1c2, the rate of 96.666 was rounded up the 96.67%. There are also miscalculations, for example on page 27, Q1 ITM 1g, 39 divided by 69 equals 56.52% for a rate but the rate displayed is 52.17%. Additionally, it was noted that there are denominators containing a zero for which the rate would be N/A however, on page 29, ITM Q2-2c displays 0.00%. The MCO should review Table 1b, calculations throughout the PIP to ensure standard statistical documentation is presented throughout the PIP and calculations are accurate and terminations are clearly identified. The MCO has altered the PIP Template which is utilized for tracking and evaluating the progress of each PIP over the life of the PIP. The MCO should review the Template, re-establish the original formatting of the PIP and update the Templates for the August 2022 Final Report. Moving forward, the MCO should submit a request for adjustments to the PIP Template to IPRO in advance with the rationale for the adjustment.
Element 6 Overall Review Determination is that the MCO is compliant.
Element 7 Overall Review Determination is that the MCO is partially compliant in regard to Discussion and Validity Reported Improvement, 7d, lessons learned, and follow-up activities planned as a result. A concern was identified regarding insufficient discussion of the challenges and opportunities inclusive of potential activities that may impact the PIPs overall performance. For example, on page 42, the MCO discusses Barriers noting the inability to meet the 90-day visit requirement and the 10-day post follow up discharge visits which represented the most important barrier. However, the MCO does not go deep enough into why this is occurring, instead states that an additional tracking measure has been added, as well as details how the lack of these visits negatively impacts the members. The MCO should review MY1 and MY2 as well as following the interventions throughout the Sustainability Year to fully discuss the potential activities that could remedy this barrier.
Element 8 Overall Review Determination is that the MCO is compliant.
Element 9 Overall Review Determination is that the MCO did not address a healthcare disparity.
Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 82.5 points, which results in a rating 82.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant adjustments to improve the stability and quality of the PIP. The MCO has reviewed, updated, corrected and/or made adjustments throughout each section of the PIP to align the Aim, Objectives and Goals of the project ensuring accuracy of the data and monitoring for sustainability. The MCO's data displays the recalibration of Performance Indicators in which a downward trend has been noted during MY2 2020 during the pandemic, however in the first half of 2021, Sustainability displays forward progression toward the PI Goals. The MCO aptly notes having developed additional internal reports (page 42) will assist in supporting the data and increase the efficiency and accuracy. The MCO should address the concerns noted above and continue to monitor its progression, detailing the specifics of each section of edits, additions, data, utilization challenges and opportunities for the Final Report in August 2022. As changes continue to arise regarding Covid-19, the MCO should continue to monitor and detail the potential impact on the interventions of the PIP. As changes occur, the MCO should clearly document the impact of Covid-19 on the interventions inclusive of outcomes.

ABHNJ PIP 6: Improving Coordination of Care and Ambulatory Follow up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: Aetna Better Health of New Jersey (ABHNJ)
PIP Topic 6: Improving Coordination of Care and Ambulatory Follow up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	

Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**	
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 23, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not applicable (N/A) for a PIP proposal.
Element 1 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the topic/rationale, 1e. The MCO should further review the literature on the present guidelines that are in place and why the problem area is specifically an opportunity for the MCO to make improvements in. The MCO should provide rationale in terms of being specific to the MCO's members' needs, care and/or services with internal data to support

why and where there are opportunities for improvement. The MCO should also combine pages 1 and 2 to complete the cover sheet of the PIP Report. Additionally, the MCO has the Sustainability year and Final Report in the same year. This does not follow the Template timelines. The MCO should review the Timelines on page eleven (11) and clarifying the timelines which should be addressed in the next update in April on 2022 and August Report 2022.
Element 2 Overall Review Determination was N/A.
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of methodology regarding 3a, performance indicators (PIs), exclusion criteria for PI #1 and PI #2, cite "exclusions as per HEDIS tech spec volume 2" although under Validity and Reliability it states, "Numerator, denominator, and rates for this report are based on the 2020 HEDIS specifications attached. It should be noted that the rates did not come out of HEDIS certified software, and instead was based on code previously approved by IPRO for the State of NJ MLTSS PM #36. The only update to this State approved code was the removal of the provider specialty constraint, as provider specialties were not correctly accounted for in past years. “The MCO should clarify the exclusion criteria as the MCO states that the rates did not come from HEDIS certified software, however the MCO did not attach the 2020 HEDIS specifications as stated above. The MCO should also include the "Immediate Outreach Trigger List" presently drafted for understanding of triggers the MCO considers for immediate outreach. The MCO should review numerators for PIs #1 and #2, definitions states, “the percentage of MLTSS HCBS members...” although this is a member count and should be represented by a number. The rate represents the numerator number divided by the denominator number equals the percentage rate. Element 3g, Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. Under the Date Collection there are six (6) interventions regarding the collection of data that do not fully explain the collection process for each intervention. The MCO should document the processes for each intervention noting that each process is manually tracked. The MCO should explain how the manual tracking process is validated for compliance. Under Data Analysis, the MCO should expand the explanations of data analysis procedures for clarity of the analysis process and who may be responsible for each phase. The Timeline for the Final Report is noted as the same for the Sustainability update, which is incorrect. The Final Report should be due in August 2025.
Element 4 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Barrier Analysis, Interventions and Monitoring subcomponent 4d, QI process data. The MCO altered the Barrier Analysis, Interventions, and Monitoring Table 1a and Table 1b, Quarterly Reporting of Rates for Intervention Tracking Measures. The PIP Template is designed to track data over time accurately and requires that the template remain unchanged without approval of any modification. The MCO should restore the PIP Template to its original format for all futures submissions. Additionally, start and end dates for Intervention 3b are missing. The MCO also notes additional Intervention Tracking Measures on Table 1b that are not on Table 1a. The MCO should ensure alignment of both tables ensuring accuracy of monitoring and reporting.
Element 5 Overall Review Determination was N/A. Although not scored, a concern was identified with Robust Interventions, 5a, informed by the Barrier Analysis. As noted above Table 1b: Quarterly Reporting of Rates for Intervention Tracking Measures (ITMs) have been altered. For example, the headings for each quarter should include the year and Title Headings should reflect the format of the approved PIP Template. As noted above in Element 4 the PIP Template should be restored to its approved format. In Column 2, Description of Intervention Tracking Measures the numbering of the ITMs is confusing. For example, Intervention 1a is noted as ITM 1ai as is 1bi. This numbering continues throughout Table 1b. The MCO should consider 1a and 1b as sufficient identification of Intervention 1ai and 1bi, 2ai and 2bi, as well as 3a and 3b. Additionally, 3bi, 3bii, 3biii, and 3biv can be represented as 3b, 3c, 3d, 3e following the 3a, 3b sequencing. ITM 3bi is noted to have a description, however the numerator, denominator definitions do not appear to be present. Furthermore, Tables 1a and 1b are not in alignment. For example, Table 1b has ITMs 3bii, 3biii and 3biv are not noted in the Barrier Analysis Table 1a nor do they have start and end dates. The MCO should reformat Tables 1a and 1b for clarity and accuracy of monitoring and reporting, ensuring that the approved PIP Template is adhered to its format.
Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed. For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Aim, Methodology,

Barrier Analysis and Interventions. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

ABHNJ – HEDIS Audit Review Table MY 2020

Audit Review Table				
Aetna Better Health of New Jersey (Org ID: 236303, Sub ID: 12359, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)				
Measurement Year - 2020; Date & Timestamp - 06/02/2021 12:27 PM				
This submission is on the stage: PlanLock				
Measure/Data Element	**Benefit Offered**	**Rate**	**Audit Designation**	**Comment**
Effectiveness of Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		86.86%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		82.48%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.08%	R	Reported
Childhood Immunization Status (CIS)				
Childhood Immunization Status - DTaP		72.99%	R	Reported
Childhood Immunization Status - IPV		87.59%	R	Reported
Childhood Immunization Status - MMR		87.83%	R	Reported
Childhood Immunization Status - HiB		88.32%	R	Reported
Childhood Immunization Status - Hepatitis B		84.91%	R	Reported
Childhood Immunization Status - VZV		87.35%	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		70.32%	R	Reported
Childhood Immunization Status - Hepatitis A		75.91%	R	Reported
Childhood Immunization Status - Rotavirus		68.37%	R	Reported
Childhood Immunization Status - Influenza		51.82%	R	Reported
Childhood Immunization Status - Combo 2		66.42%	R	Reported
Childhood Immunization Status - Combo 3		60.58%	R	Reported
Childhood Immunization Status - Combo 4		57.42%	R	Reported
Childhood Immunization Status - Combo 5		50.36%	R	Reported
Childhood Immunization Status - Combo 6		41.85%	R	Reported
Childhood Immunization Status - Combo 7		48.18%	R	Reported
Childhood Immunization Status - Combo 8		40.15%	R	Reported
Childhood Immunization Status - Combo 9		35.52%	R	Reported
Childhood Immunization Status - Combo 10		34.31%	R	Reported
Immunizations for Adolescents (IMA)				

Immunizations for Adolescents - Meningococcal		84.67%	R	Reported
Immunizations for Adolescents - Tdap		87.1%	R	Reported
Immunizations for Adolescents - HPV		27.01%	R	Reported
Immunizations for Adolescents - Combination 1		82.97%	R	Reported
Immunizations for Adolescents - Combination 2		25.06%	R	Reported
Lead Screening in Children (LSC)				
Lead Screening in Children		71.53%	R	Reported
Breast Cancer Screening (BCS)				
Breast Cancer Screening		43.96%	R	Reported
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening		45.26%	R	Reported
Chlamydia Screening in Women (CHL)				
Chlamydia Screening in Women (16-20)		58.65%	R	Reported
Chlamydia Screening in Women (21-24)		66.15%	R	Reported
Chlamydia Screening in Women (Total)		63.23%	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y			
Appropriate Testing for Pharyngitis (3-17)		80.61%	R	Reported
Appropriate Testing for Pharyngitis (18-64)		42.69%	R	Reported
Appropriate Testing for Pharyngitis (65+)		23.53%	NA	Small Denominator
Appropriate Testing for Pharyngitis (Total)		65.78%	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		29.63%	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		88.66%	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		82.47%	R	Reported
Asthma Medication Ratio (AMR)	Y			
Asthma Medication Ratio (5-11)		56.76%	R	Reported
Asthma Medication Ratio (12-18)		63.27%	R	Reported
Asthma Medication Ratio (19-50)		56%	R	Reported
Asthma Medication Ratio (51-64)		55.07%	R	Reported
Asthma Medication Ratio (Total)		57.14%	R	Reported
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure		48.91%	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y			
Persistence of Beta-Blocker Treatment After a Heart Attack		79.31%	NA	Small Denominator
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		84.75%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		76%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		61.4%	R	Reported

Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		80%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		77.14%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		77.04%	R	Reported
Cardiac Rehabilitation (CRE)				
Cardiac Rehabilitation - Initiation (18-64)		1.8%	R	Reported
Cardiac Rehabilitation - Engagement1 (18-64)		3.6%	R	Reported
Cardiac Rehabilitation - Engagement2 (18-64)		3.6%	R	Reported
Cardiac Rehabilitation - Achievement (18-64)		2.7%	R	Reported
Cardiac Rehabilitation - Initiation (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Engagement1 (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Engagement2 (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Achievement (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Initiation (Total)		1.69%	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		3.39%	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		3.39%	R	Reported
Cardiac Rehabilitation - Achievement (Total)		2.54%	R	Reported
Comprehensive Diabetes Care (CDC)				
Comprehensive Diabetes Care - HbA1c Testing		75.67%	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		45.74%	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		46.72%	R	Reported
Comprehensive Diabetes Care - Eye Exams		44.53%	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		46.47%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)				
Kidney Health Evaluation for Patients With Diabetes (18-64)		29.4%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (65-74)		34.04%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (75-85)		32.18%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (Total)		29.81%	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y			
Statin Therapy for Patients With Diabetes - Received Statin Therapy		64.02%	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		65.46%	R	Reported
Antidepressant Medication Management (AMM)	Y			
Antidepressant Medication Management - Effective Acute Phase Treatment		57.09%	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		40.78%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		45.37%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		40.91%	NA	Small Denominator

Follow-up After Hospitalization for Mental Illness (FUH)	Y			
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)		50%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)		0%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)		41.84%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)		30.5%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (65+)		0%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)		0%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		41.61%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		28.86%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)		64.29%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)		57.14%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)		71.29%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)		61.39%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)		100%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)		50%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		70.94%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		60.68%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)		53.19%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)		23.4%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		53.19%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		23.4%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y			

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		26.73%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		20.79%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		26.73%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		20.79%	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y			
Pharmacotherapy for Opioid Use Disorder (16-64)		28.07%	R	Reported
Pharmacotherapy for Opioid Use Disorder (65+)			NA	Small Denominator
Pharmacotherapy for Opioid Use Disorder (Total)		28.07%	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	Y			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		76.17%	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia		60%	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		100%	NA	Small Denominator
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		56.02%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y			
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)		42.86%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)		28.57%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)		22.45%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)		53.33%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)		32%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)		32%	R	Reported

Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		49.19%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		30.65%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		28.23%	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.35%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)		92.98%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (18-64)		66.4%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (65+)		60.27%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (Total)		86.43%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)		58.86%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)		38.43%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)		59.09%	NA	Small Denominator
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		52.33%	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain		73.97%	R	Reported
Use of Opioids at High Dosage (HDO)	Y			
Use of Opioids at High Dosage		10.55%	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y			
Use of Opioids From Multiple Providers - Multiple Prescribers		16.48%	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		5.17%	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		2.42%	R	Reported
Risk of Continued Opioid Use (COU)	Y			
Risk of Continued Opioid Use - >=15 Days (18-64)		5.81%	R	Reported
Risk of Continued Opioid Use - >=31 Days (18-64)		3.9%	R	Reported
Risk of Continued Opioid Use - >=15 Days (65+)		11.9%	R	Reported
Risk of Continued Opioid Use - >=31 Days (65+)		11.9%	R	Reported
Risk of Continued Opioid Use - >=15 Days (Total)		5.96%	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		4.09%	R	Reported
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				

Adults' Access to Preventive/Ambulatory Health Services (20-44)		64.89%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (45-64)		74.56%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (65+)		79.9%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (Total)		68.6%	R	Reported
Annual Dental Visit (ADV)	Y			
Annual Dental Visit (2-3)		35.54%	R	Reported
Annual Dental Visit (4-6)		50.09%	R	Reported
Annual Dental Visit (7-10)		54.59%	R	Reported
Annual Dental Visit (11-14)		51.06%	R	Reported
Annual Dental Visit (15-18)		41.17%	R	Reported
Annual Dental Visit (19-20)		32.74%	R	Reported
Annual Dental Visit (Total)		46.2%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)		41.18%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)		4.41%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		60%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		11.11%	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)		58.33%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)		4.17%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)		49.09%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)		6.67%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		41.18%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		4.41%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		60%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		11.11%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		58.33%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		4.17%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		49.09%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		6.67%	R	Reported
Prenatal and Postpartum Care (PPC)				
Prenatal and Postpartum Care - Timeliness of Prenatal Care		88.32%	R	Reported
Prenatal and Postpartum Care - Postpartum Care		72.51%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)			NA	Small Denominator
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)		0%	NA	Small Denominator
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		0%	NA	Small Denominator
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 30 Months of Life (First 15 Months)		60.14%	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		75.51%	R	Reported

Child and Adolescent Well-Care Visits (WCV)				
Child and Adolescent Well-Care Visits (3-11)		61.86%	R	Reported
Child and Adolescent Well-Care Visits (12-17)		51.48%	R	Reported
Child and Adolescent Well-Care Visits (18-21)		32.06%	R	Reported
Child and Adolescent Well-Care Visits (Total)		54.27%	R	Reported
Frequency of Selected Procedures (FSP)			R	Reported
Ambulatory Care (AMBa)			R	Reported
Ambulatory Care (AMBb)			R	Reported
Ambulatory Care (AMBc)			R	Reported
Ambulatory Care (AMBd)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUb)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUc)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUd)			R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADb)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADc)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADd)	Y		R	Reported
Mental Health Utilization (MPTa)	Y		R	Reported
Mental Health Utilization (MPTb)	Y		R	Reported
Mental Health Utilization (MPTc)	Y		R	Reported
Mental Health Utilization (MPTd)	Y		R	Reported
Antibiotic Utilization (ABXa)	Y		R	Reported
Antibiotic Utilization (ABXb)	Y		R	Reported
Antibiotic Utilization (ABXc)	Y		R	Reported
Antibiotic Utilization (ABXd)	Y		R	Reported
Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)			R	Reported
Health Plan Descriptive Information				
Enrollment by Product Line (ENPa)			R	Reported
Enrollment by Product Line (ENPb)			R	Reported
Enrollment by Product Line (ENPc)			R	Reported
Enrollment by Product Line (ENPd)			R	Reported
Enrollment by State (EBS)			R	Reported
Language Diversity of Membership (LDM)			R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	Reported
Total Membership (TLM)			R	Reported
Electronic Clinical Data Systems				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening		43.96%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y			

Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		45.37%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		40.91%	NA	Small Denominator
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)				
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0%	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NA	Small Denominator
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)				
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0%	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)				
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NA	Small Denominator
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	Small Denominator
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	Small Denominator
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)				
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0%	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	Small Denominator
Adult Immunization Status (AIS-E)				
Adult Immunization Status - Influenza		8.75%	R	Reported
Adult Immunization Status - Td/Tdap		15.4%	R	Reported
Adult Immunization Status - Zoster		0.72%	R	Reported
Prenatal Immunization Status (PRS-E)				
Prenatal Immunization Status - Influenza		20.94%	R	Reported
Prenatal Immunization Status - Tdap		35.37%	R	Reported
Prenatal Immunization Status - Combination		15.5%	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)				
Prenatal Depression Screening and Follow-Up - Depression Screening		0%	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	Small Denominator
Postpartum Depression Screening and Follow-Up (PDS-E)				

Postpartum Depression Screening and Follow-Up - Depression Screening		0%	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	Small Denominator

AGNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

AGNJ 2021 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	25	30	24	24	6	0	80%	4	0	2
Care Management and Continuity of Care - MLTSS*	10	9	10	10	10	0	0	100%	0	1	0
Access	14	9	10	5	9	5	0	64%	5	0	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[6]	20	18	11	9	18	2	0	90%	2	0	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	5	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	30	14	14	30	0	0	100%	0	0	0
Administration and Operations[7]	14	13	4	4	14	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**198**	**190**	**85**	**78**	**191**	**7**	**0**	**96%**	**7**	**0**	**0**

[1] A total of 83 elements were reviewed in the previous review period; of these 83, 77 were *Met* and 6 were *Not Met.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period. As a result, the sum of "Met Prior Year" and "Subject to Review" might exceed the total number of elements for some standards.

[3] Elements that were *Met* in this review period among those that were subject to review.

[4] Elements that were *Met* in this review period among those that were subject to review as well as elements that were *Met* in the previous review period and were not subject to review (i.e., were deemed *Met*). This total is used to calculate the compliance score for each standard as well as the overall compliance score.

[5] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.

[6] In 2021,QM11 was subdivided into QM11a (Core Medicaid PIPs) and QM11b (MLTSS PIPs).

[7] AO14 was added as a new element for Core Medicaid in 2021.

*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Correction Action Plans (CAPs) as applicable.

AGNJ Performance Improvement Projects

AGNJ PIP 1: Increasing the utilization of Developmental Screening Tools and Awareness of Early Intervention Services for Members <3 years old

MCO Name: Amerigroup New Jersey, Inc. (AGNJ)
PIP Topic 1: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services for Members <3 years old

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings [1]	Year 1 Findings	Year 2 Findings	Sustainability Findings [2]	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M	M	
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M	M	
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M	M	
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M	M	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M	
2c. Objectives align aim and goals with interventions	N/A	M	M	M	M	
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM	M	M	M	
3b. Performance indicators are measured consistently over time	N/A	PM	M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M	M	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M	M	

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	PM	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**	
Element 3 Overall Score	**N/A**	**50.0**	**100**	**100**	**100**	
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**15.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	PM	PM	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	N/A	M	M	M	
4f. Literature review	N/A	M	M	M	M	
Element 4 Overall Review Determination	**N/A**	**PM**	**PM**	**M**	**M**	
Element 4 Overall Score	**N/A**	**50.0**	**50.0**	**100**	**100**	
Element 4 Weighted Score	**N/A**	**7.5**	**7.5**	**15.0**	**15.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	M	N/A	M	
5b. Actions that target member, provider and MCO	N/A	M	M	N/A	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	N/A	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	PM	N/A	PM	
Element 5 Overall Review Determination	**N/A**	**PM**	**PM**	**N/A**	**PM**	
Element 5 Overall Score	**N/A**	**50.0**	**50.0**	**N/A**	**50**	
Element 5 Weighted Score	**N/A**	**7.5**	**7.5**	**N/A**	**7.5**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M	M	
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**	

Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	PM	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	PM	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	PM	M	NM	M	
Element 7 Overall Review Determination	**N/A**	**PM**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**50.0**	**100**	**50.0**	**100**	
Element 7 Weighted Score	**N/A**	**10.0**	**20.0**	**10.0**	**20.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	PM	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50.0**	**100**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**M**	**Y**	**Y**	**Y**	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**80**	**80.0**	**85.0**	**100**	
Actual Weighted Total Score	**N/A**	**47.5**	**65.0**	**65.0**	**92.5**	
Overall Rating	**N/A**	**59.4%**	**81.3%**	**76.5%**	**92.5%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

[2] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Sustainability Phase).

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Final Report
IPRO Comments:

Element 1 Overall Review Determination was that the Managed Care Organization (MCO) is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO was partially compliant regarding Section 5 Table 1b., in regard to corresponding monthly or quarterly intervention tracking measures (aka process measures), and numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final

PIP Reports). The MCO was observed to have three calculation errors, noting when there is a zero in the denominator the rate should be N/A. However, there is another example of a rate cited as N/A, although the denominator exhibits number 3, the rate should reflect a zero. The MCO should review mathematical writing conventions in order to display the correct calculation.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that the MCO has identified a healthcare disparity by addressing racial and ethnic disparities in children with developmental delays.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 92.5 points, which results in a rating of 92.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO interpreted the performance indicator rates for each measurement period in descriptive terms of improvements and declines year-over-year. The MCO met its goals despite the discord with Ocean County, however the MCO continued to outreach. The MCO will bring this information to both the Quality and Provider Advisory Committees as well as exploring the possibility of including the projects findings in a Providers Newsletter. The MCO recognizes the opportunity in Ocean County and new intervention has been implemented to focus on Ocean County Providers with low developmental screening rates. As changes continue to happen, the MCO should monitor the Covid -19 impact on the members and processes that support them.

AGNJ PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: Amerigroup New Jersey, Inc. (AGNJ)
PIP Topic 2: MCO Adolescent Risk Behaviors and Depression Collaborative

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		

2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	PM	PM	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50**	**50**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**15.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**PM**	**M**	**M**		
Element 4 Overall Score	**N/A**	**50**	**100**	**100**	**0**	

Element 4 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	NM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**N/A**	**50**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**7.5**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	PM	M		
Element 6 Overall Review Determination	**N/A**	**M**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**100**	**50**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**2.5**	**5.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	PM	PM		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**	**10.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**	
Non-Scored Element: Element 9. Healthcare Disparities						

9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**37.5**	**45.0**	**82.5**	**0.0**
Overall Rating	**N/A**	**62.5%**	**69.2%**	**82.5%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc. (AGNJ)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 22, 2021
Reporting period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination was that the Managed Care Organization (MCO) is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO was partially compliant with regard to Robust Interventions, subcomponents 5d; a concern was identified with intervention tracking measures (ITMs) which lack correspondence to the updates for the interventions implemented. The MCO continues to be tracking interventions predominantly in terms of the provider count. As noted in previous submission, reporting generally on the count of provider training is insufficient. For example, the MCO could consider the efficacy of actions taken by providers during the Covid-19 pandemic such as a transition from Face-to- Face visits to a virtual approach in order to engage and maintain continuity of care with the members. The MCO should consider an expansion of the ITMs discussion for evaluating progress of the interventions. The MCO could also consider utilizing a post 2020 survey to the provider groups in regards to having the risk behavior screening tools in the EMR in terms of risk behavior screening effectiveness. The MCO should consider additional detail regarding successes and limitations to the sustainability of the PIP.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant with regard to subcomponent 7c. The MCO was partially compliant with its discussion of how its analysis identifies and factors threats to internal and external validity, in terms of changes and influences to PIs and their comparability. Under the subsection for Limitations on page 51, the MCO states that there were no factors that may pose a threat to the internal or external validity of the findings. However, this is contradictory to Table 2, noting that Provider 1 exhibits screening rates for 1 out of 5 risk behaviors while the other 2 providers have met their goals. This one non-compliant provider does pose a threat to the project. The MCO should re-engage the provider in order to ensure sustainable data is documented throughout the course of this measurement period.
Element 8 Overall Review Determination was that the MCO was compliant.
Element 9 Overall Review Determination was that the MCO did not address a healthcare disparity.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points the MCO scored 82.5 points, which results in a rating of 82.5%. (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has begun to implement new interventions to focus on additional areas of the PIP such as screening tools. The MCO continued to report and discuss engagements with providers, and some improvements were noted with regard to the documentation of continuous improvement processes. The MCO discussed impacts and implementation changes relating to COVID-19, although more details and analyses will be needed for a comprehensive evaluation of newly introduced factors that specifically influences how performance is indicated and meaningfully

measured in terms of sustainability. As changes happen, the MCO should continue to monitor the changes made and the impact Covid -19 has on the PIP and its progress.

AGNJ PIP 3: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

MCO Name: Amerigroup New Jersey, Inc. (AGNJ)
PIP Topic 3: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M				
1b. Impacts the maximum proportion of members that is feasible	N/A	M				
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M				
1d. Reflects high-volume or high risk-conditions	N/A	M				
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M				
Element 1 Overall Review Determination	**N/A**	**M**				
Element 1 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	PM				
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M				
2c. Objectives align aim and goals with interventions	N/A	PM				
Element 2 Overall Review Determination	**N/A**	**PM**				
Element 2 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**2.5**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM				
3b. Performance indicators are measured consistently over time	N/A	M				
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M				

3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M				
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M				
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M				
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M				
Element 3 Overall Review Determination	**N/A**	**PM**				
Element 3 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	PM				
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M				
4c. Provider input at focus groups and/or Quality Meetings	N/A	M				
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM				
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M				
4f. Literature review	N/A	M				
Element 4 Overall Review Determination	**N/A**	**PM**				
Element 4 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M				
5b. Actions that target member, provider and MCO	N/A	M				
5c. New or enhanced, starting after baseline year	N/A	M				
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M				
Element 5 Overall Review Determination	**N/A**	**M**				
Element 5 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**	

Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M				
Element 6 Overall Review Determination	**N/A**	**M**				
Element 6 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M				
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M				
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M				
7d. Lessons learned & follow-up activities planned as a result	N/A	M				
Element 7 Overall Review Determination	**N/A**	**M**				
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**	
Actual Weighted Total Score	**N/A**	**62.5**	**0.0**	**0.0**	**0.0**	
Overall Rating	**N/A**	**78.1%**	**0%**	**0%**	**0%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey (AGNJ)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021

Reporting Period: Year 1 Findings
IPRO Comments:
Element 1 Overall Review Determination was that the MCO was compliant.
Element 2 Overall Review Determination was partially compliant; a concern was identified with the overall Aim and related aspects of the PIP 2a and 2c.
2a. In the Aim Statement the MCO states "By the end of 2022, the MCO aims to increase access to PCPs by increasing member visits to an average of 2.55 visits per member for the three identified provider groups." However, the MCO does not specify what type of visits they are seeking to increase. The Objective(s) should specify how the MCO will implement the provider education, explain the methods proposed to utilize to increase availability of PCP appointments and align with the Aim and Goals of the PIP. The MCO has discussed Telehealth as a potential avenue that is not currently being fully optimized and may be an additional source for PCP visits as the Goals for these three identified provider groups have a focus on reducing average inpatient admissions, however Telehealth is not mentioned in the Objectives.
Element 3 Overall Review Determination was that the MCO is partially compliant with regard Methodology, a concern was identified 3a and 3g. The Performance Indicators across all three provider groups remain insufficient for specificity in regards to the type of PCP visits versus the type of inpatient admissions that have the potential to impact increasing the PCP visits as well decreasing the inpatient admissions. The eligible population remains insufficient in terms of inclusion or exclusion criteria for calculating the rates as intended. The numerator/denominator criteria should be further developed, specific to the eligible members for each provider group, as well as the nature of the visit (ex: well visit vs. sick visit) along with the inpatient admission diagnosis to better understand if the inpatient visit may have been avoided by and earlier PCP visit. The MCO does not identify any trends regarding increased inpatient stays for example Congestive Heart Failure (CHF) of a member that is being treated by one of the provider groups. The MCO should consider additional subcomponents regarding the diagnoses of this chronic disease which could have been treated in an office visit however was not. The MCO should improve descriptions and provide clarifications for the methodological collection of data, how it is refined, and utilized appropriately for reporting as part of the PIP.
Element 4 Overall Review Determination was partially compliant with regard to Barrier Analysis; a concern was identified in regards to 4a and 4d. Barrier Analysis 4a relates to susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics. The MCO has not fully determined what are the most prevalent diagnoses for each of the 3 selected provider groups regarding inpatient stays that may be potentially treatable in the PCP office or via Telehealth visit. Utilizing the QI data process, the "Why“ questions (Fishbone diagram) may assist in revealing additional barriers that may impact a members ability to obtain the care they need at the appropriate level of care. The Fishbone diagram exhibits insufficient information to answer these questions and hence may be missing a barrier that is an obstacle to obtaining care in the PCP office timely thereby avoiding an inpatient stay. The MCO should review the Fishbone diagram, ensuring all Barriers to access PCP visits are reviewed for inclusion in the PIP.
Element 5 Overall Review Determination was that the MCO was compliant.
Element 6 Overall Determination was that the MCO was complaint.
Element 7 Overall Review Determination was that the MCO was compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that no healthcare disparities were not identified, evaluated, or addressed.
Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 62.5.0 points, which results in a rating of 78.1% which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP that ultimately expresses the intended impact on performance outcomes. The MCO appropriately recognizes the delay in implementation and has made adjustments accordingly in updating the Objective, Goals, Methodology and several interventions have been added and/or updated moving PIP closer to the MCO's goals. As the MCO modifies the PIP, the MCO should also confirm consistency and clarity with descriptions and specifications across the interventions and corresponding ITMs. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

MCO Name: Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 4: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	**N/A**					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					

3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					

Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**	
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A. Although not scored, concerns were Identified regarding the Aim, Objectives and Goals, 2c, objectives align aim and goals with interventions. Study objectives are used to summarize the member, provider and MCO intervention sets that will be used to achieve each target goal. The MCO states the Objective is to, "Implement education for the providers and members to improve well child visits and immunizations rates from baseline to final measurement". The MCO has chosen 2019 as the baseline, the benchmark rate reflects a 2020 review of the data and short and long term goals for Indicators #1 and #3 are noted. However, the MCO asterisks Indicator #2 (page 7) stating the "Benchmark and goal rates will be updated when available", however does not include the baseline in the footnote. The MCO should provide the explanation for the delay in Indicator #2, as well as provide expected timeframes for data updates. For example, Indicator #2 data will be updated in the April 2022 submission. Additionally, the MCO should expand and define the education proposed, explain the process for implementation, measurements and timeframes of monitoring and reporting.
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified regarding Methodology, 3g, study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. Under Validity and Reliability, the MCO states, "Administrative claims data is securely stored in an internal database server after going through corporate review". This statement is insufficient to explain the process. The MCO should detail how the MCO validates the data and information, by whom and what processes are in place to ensure the data is reliable. This will include who is processing the data and explains the process. Under Data Analysis, the MCO should expand the explanation of who is analyzing the data, what the process or workflow is for data capture, and timeframe (monthly, quarterly, semi-annually and/or annually) specifics.
Element 4 Overall Review Determination was N/A. Although not scored, the MCO has chosen to use 2019 for a baseline capturing 2019 W15 data as well as review of the 15-30 months of life data. The MCO should discuss the progression of the data from baseline comparing to the revised Well Child Visit measure, noting any changes in the data to the Well Child Measure data updating as appropriate for 2021. The MCO should also review 2020 data for the COVID-19 impact in the April 2022 submission as well August updated data, edits or changes to the PIP.
Element 5 Overall Review Determination was N/A.
Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase. Although not scored, a concern was identified with the Results Table 2. The Baseline information is based on 2019 W15 measure. However, the W15 measure has been revised to Well Child visits in the first 30 months of Life (W30) in 2020. The MCO does not explain how they will reconcile Baseline data as well as short and long term goals as noted above in Element 2. The MCO should update the data for the next submission.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Aim, Objective and Goals and Methodology. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent

submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

AGNJ PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports

MCO Name: Amerigroup New Jersey, Inc. (AGNJ)
PIP Topic 5: Decreasing Gaps in Care in Managed Long Term Services and Supports

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	PM	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	PM	M	M		
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 1 Overall Score	**N/A**	**50**	**50**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**	**5.0**	**0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM	M	M		

3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**		
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	NM	PM		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**PM**	**PM**		
Element 4 Overall Score	**N/A**	**100**	**50**	**50**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**7.5**	**7.5**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	PM		

5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**N/A**	**50**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**7.5**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	NM	PM	M		
Element 6 Overall Review Determination	**N/A**	**NM**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**0**	**50**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**0**	**2.5**	**5.0**	**0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	PM	PM		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**10**	**10.0**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	PM		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65**	**100**	**100**
Actual Weighted Total Score	**N/A**	**37.5**	**42.5**	**65.0**	**0.0**
Overall Rating	**N/A**	**62.5%**	**65.4%**	**65.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 10, 2021
Reporting Period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination is that the Managed Care Organization (MCO) is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.

Element 4 Overall Review Determination is that the MCO is partially compliant 4d, QI Process data ("5 Why's", fishbone diagram). A concern was identified regarding using the QI process in support of the Barriers and Interventions monitored within the PIP. Utilizing the process of asking why not only leads to the identification of barriers but also opportunities for improvement at each level providing support and rational for interventions and ITMs to achieve the goals of the PIP. For example, intervention 2c, by asking the "why questions" for this intervention, the MCO may have come up with additional ways to assist the eligible population, thereby potentially achieving the goal of this intervention.

Element 5 Overall Review Determination is that the MCO was partially compliant regarding Element 5c and 5d. Robust Interventions, 5c, new or enhanced, starting after the Baseline. A concern was identified regarding the Change Table on pages 2-4. In the column labeled "Date of Change", which indicates the actual date of the change, month, day, and year and should align with the Barrier Analysis Table 1a and Quarterly Reporting Table 1b. The Change Table is designed to track all changes, edits, additions, terminations, and adjustments throughout the life of the PIP to provide a comprehensive evaluation of the project over time. The MCO has utilized August 2020 submission, Y2 Q1, SY Q1, etc. for identifying the date of change which is insufficient to evaluate the alignment with the corresponding sections of the PIP. The MCO has also used an asterisk form of noting additional information on Table 1b, however it may be more beneficial to use footnotes that provide a brief explanation as well as the detail in the Discussion Section. The MCO should use one method of documenting changes and/or footnotes to ensure accurate alignment of information throughout the PIP. 5d, The MCO is partially compliant regarding using corresponding monthly or quarterly intervention tracking measures (ITMs), with appropriately specified numerators and denominators. A concern was identified regarding Quarterly Reporting of Rates for Interventions Tracking Measures (Table 1b) exhibits insufficient data. The MCO repeatedly utilizes N/A over multiple quarters for MY1 and MY2 and asterisks referring to, data challenges which refers to Section 7; noting the rate reported collectively in subsequent quarter; making it difficult to determine progression throughout Table 1b. The MCO should ensure intervention start dates are timely and discuss in further detail why intervention start dates were delayed and/or limited data could be reported for ongoing interventions. Additionally, timelines on Table 1a continue to use span of time designations such as Start Date: August 2020-March 2021, on page 20. The Start Date should represent August 2020, End Date March 2021 along with the day the intervention began. If you are exhibiting a timeframe year over year this would be an update to the PIP each year.

Element 6 Overall Review Determination is that the MCO is compliant.

Element 7 Overall Review Determination was that the MCO is partially compliant regarding 7d. Lessons learned & follow-up activities planned as a result. A concern was identified regarding overall understanding of what was working, what did not work in terms of process improvement and why. The MCO should review all sections of the PIP and consider using the "Why Questions" framework to fully discuss actions that moved the project forward and the

limitations that held the project from obtaining the goals set. The MCO plans to continue with Intervention #7, monitoring HDM monthly and outreach to the members assessed for HDM needs.

Element 8 Overall Review Determination was that the MCO is partially compliant regarding Sustainability 8b, sustained improvement was demonstrated through repeated measurements over comparable time periods. The MCO notes that the Final Goal has not been met for PI #2, however is trending upward throughout MY 1 and MY 2. The ITMs, 2c, 4 a-d, 5 a-c, 6b-d, do not generally have sufficient data to evaluate progress over time, noting many N/As and/or numerator 0/dominator 0 =0%. The writing convention is noted as incorrect as when the denominator in zero the rate should be N/A. The MCO should review the ITMs describing in detail for the Final Report the explanations of variable data and actions taken to obtain data such as supplemental data, internal reporting data etc.
Element 9 Overall Review Determination is that the MCO did not address a healthcare disparity.

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 65.0 points, which results in a rating of 65% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO continues to experience significant concerns as noted above. The MCO should review each section for completeness of documentation, data where appropriate or can be obtained to update Table 1b, as noted above exhibits insufficient data for a comprehensive evaluation of progress toward the Aim, Objectives, and Goals of the PIP. For example, if claims data is available, that may not have been available (as noted by asterisk Table 1b), the MCO might consider a look back for data capture to analyze and evaluate the PIP processes. The MCO should clearly document situations that impacted interventions and any actions taken to utilize alternate sources to obtain the data that may have been a challenge in the implementation of the PIP. As changes occur, the MCO should clearly document the impact of Covid-19 on the interventions inclusive of outcomes.

AGNJ PIP 6: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population

MCO Name: Amerigroup New Jersey, Inc.(AGNJ)
PIP Topic 6: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	

Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**	
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**	

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 23, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Aim, 2c, objectives align aim and goals with interventions. Objectives are used to summarize the member, provider, and

MCO intervention sets that will be used to achieve each goal. The MCO should expand the Objective statement by describing how the MCO intends to achieve each goal, aligning the Aim, Objectives and Goals clearly.
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of Methodology, 3g, study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. Under Validity and Reliability (pg.9), the MCO states Administrative claims are securely stored in an internal database server after going through corporate review. It is unclear what the corporate review process entails. The MCO should detail how the data is validated and by whom, what process is utilized in the validation process and explain how the MCO ensures the data is reliable. The MCO should include the staff members and qualifications for performing these functions. Under the Data Analysis section (pg.9) the MCO should go further in explaining how Claims and HEDIS measurement datasets are evaluated and timeframes of analysis for monthly, quarterly, and annual monitoring and reporting.
Element 4 Overall Review Determination was N/A.
Element 5 Overall Review Determination was N/A.
Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have been assessed, however MCO states none found.
For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Aim, and Methodology. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

AGNJ PIP 7: Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) Population

MCO Name: Amerigroup New Jersey, Inc.
PIP Topic: Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) population

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	

Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	PM	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	PM	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**PM**	**M**	**M**		
Element 2 Overall Score	**N/A**	**50.0**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**2.5**	**5.0**	**5.0**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	PM	PM		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		

Element 4 Overall Review Determination	**N/A**	**M**	**PM**	**PM**		
Element 4 Overall Score	**N/A**	**100**	**50**	**50**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**7.5**	**7.5**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	PM	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**	**50**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**7.5**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	PM	M		
Element 6 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**50.0**	**50**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**2.5**	**2.5**	**5.0**	**0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	PM	PM		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50.0**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**	**10.0**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0**	
Non-Scored Element: Element 9. Healthcare Disparities						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**47.5**	**45.0**	**75.0**	**0**
Overall Rating	**N/A**	**79.2%**	**69.2%**	**75.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); and Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 10, 2021
Reporting Period: Sustainability
IPRO Comments:

Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

Element 3 Overall Review Determination was that the MCO is compliant.

Element 4 Overall Review Determination was that the MCO is partially compliant regarding subcomponent 4d, a concern was identified with the utilization of quality improvement process data. The Change Table page 2-3 in Section 1 does not fully demonstrate consistent tracking of the dates of changes, edits, additions and /or terminations made to Barrier Analysis, Methodology, Interventions and ITMs regarding month, day, and year of the change. Consistent tracking of these changes is needed for the comprehensive evaluation of the PIP components throughout the life of the PIP. The MCO should review and detail each change in alignment with the appropriate sections affected by the change. Additionally, the MCO should review the 5 Why's Fishbone diagram for inclusion in the PIP demonstrating and supporting your identification of barriers and interventions utilized to move the project toward the goals set.

Element 5 Overall Review Determination was partially compliant regarding 5d, a concern was identified regarding relating to analyses of barrier, appropriateness of activities targeting member, provider, and organization, and utilization of corresponding intervention tracking measures (ITMs). Although the MCO has modified its approach to Barriers #1 and #2 (and associated interventions and tracking) on page 24, the concern expressed in the last review related to understanding the number of staff educated and when the education was provided has not been identified to align with the ITMs in terms of understanding the impact of staff education has on decreasing the number of falls. When this is established, the relationship between the education and member falls interventions can be more effectively evaluated. The MCO should also consider providing a sample of education provided to staff and have a process for documenting the number of staff, method of presentation, and a validation tool such as survey in lieu of pre/post-test originally proposed. The MCO should continue to review, consider opportunities for improvements, with the use of supplemental data sources to better understand the effects over time.

Element 6 Overall Review Determination was that the MCO is compliant.

Element 7 Overall Review Determination was that the MCO is partially compliant regarding subcomponent 7a, a concern was identified with the Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions). The MCO acknowledges challenges in the modification providing education to facility staff via mailings, however it remains unclear how the association of education to staff and the number of falls can be evaluated regarding success or failure without understanding more specifics of the number of staff educated, how the education was presented, and potential for survey questions in lieu of pre/post-tests proposed for face-to-face. Additionally, the engagement of all the facilities included in the PIP, should be clearly documented in attempts to engage further with the education process.

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review was that a healthcare disparity is not addressed.

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 75.0 points, which results in a rating of 75.0% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO should review of all descriptions and specifications of modified and updated interventions and ITMs as well as ensure that alignment of the Change Table, Barrier Analysis, Interventions and ITMs, Results Table and analysis of each area are addressed in measurable terms consistently throughout the PIP. The MCO should clearly document successes and limitations as appropriate as well as potential use of the information gained through the PIP

process. As changes occur, the MCO should clearly document the impact of Covid-19 on the interventions inclusive of outcomes.

AGNJ – HEDIS Audit Review Table MY 2020

Audit Review Table				
Amerigroup New Jersey, Inc. (Org ID: 1791, Sub ID: 4308, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)				
Measurement Year - 2020; Date & Timestamp - 05/11/2021 5:58 PM				
This submission is on the stage: Import				
Measure/Data Element	**Benefit Offered**	**Rate**	**Audit Designation**	**Comment**
Effectiveness of Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		88.56%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		82.48%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.81%	R	Reported
Childhood Immunization Status (CIS)				
Childhood Immunization Status - DTaP		73.48%	R	Reported
Childhood Immunization Status - IPV		87.83%	R	Reported
Childhood Immunization Status - MMR		91.48%	R	Reported
Childhood Immunization Status - HiB		87.35%	R	Reported
Childhood Immunization Status - Hepatitis B		81.51%	R	Reported
Childhood Immunization Status - VZV		90.51%	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		70.32%	R	Reported
Childhood Immunization Status - Hepatitis A		82.97%	R	Reported
Childhood Immunization Status - Rotavirus		64.23%	R	Reported
Childhood Immunization Status - Influenza		49.39%	R	Reported
Childhood Immunization Status - Combo 2		62.77%	R	Reported
Childhood Immunization Status - Combo 3		57.66%	R	Reported
Childhood Immunization Status - Combo 4		54.26%	R	Reported
Childhood Immunization Status - Combo 5		47.45%	R	Reported
Childhood Immunization Status - Combo 6		36.5%	R	Reported
Childhood Immunization Status - Combo 7		45.5%	R	Reported
Childhood Immunization Status - Combo 8		34.31%	R	Reported
Childhood Immunization Status - Combo 9		31.14%	R	Reported
Childhood Immunization Status - Combo 10		29.68%	R	Reported
Immunizations for Adolescents (IMA)				
Immunizations for Adolescents - Meningococcal		91.48%	R	Reported
Immunizations for Adolescents - Tdap		94.4%	R	Reported
Immunizations for Adolescents - HPV		33.09%	R	Reported
Immunizations for Adolescents - Combination 1		90.02%	R	Reported

Immunizations for Adolescents - Combination 2		31.14%	R	Reported
Lead Screening in Children (LSC)				
Lead Screening in Children		80.05%	R	Reported
Breast Cancer Screening (BCS)				
Breast Cancer Screening		52.75%	R	Reported
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening		56.7%	R	Reported
Chlamydia Screening in Women (CHL)				
Chlamydia Screening in Women (16-20)		62.63%	R	Reported
Chlamydia Screening in Women (21-24)		63.17%	R	Reported
Chlamydia Screening in Women (Total)		62.88%	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y			
Appropriate Testing for Pharyngitis (3-17)		86.49%	R	Reported
Appropriate Testing for Pharyngitis (18-64)		50.34%	R	Reported
Appropriate Testing for Pharyngitis (65+)		20.59%	R	Reported
Appropriate Testing for Pharyngitis (Total)		76.08%	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		31.44%	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		67.16%	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		84.18%	R	Reported
Asthma Medication Ratio (AMR)	Y			
Asthma Medication Ratio (5-11)		74.21%	R	Reported
Asthma Medication Ratio (12-18)		63.61%	R	Reported
Asthma Medication Ratio (19-50)		53.28%	R	Reported
Asthma Medication Ratio (51-64)		53.48%	R	Reported
Asthma Medication Ratio (Total)		59.44%	R	Reported
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure		52.07%	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y			
Persistence of Beta-Blocker Treatment After a Heart Attack		65.28%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		79.96%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		71.35%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		74.84%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		73.95%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		77.85%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		72.38%	R	Reported

Cardiac Rehabilitation (CRE)				
Cardiac Rehabilitation - Initiation (18-64)		1.88%	R	Reported
Cardiac Rehabilitation - Engagement1 (18-64)		1.88%	R	Reported
Cardiac Rehabilitation - Engagement2 (18-64)		1.88%	R	Reported
Cardiac Rehabilitation - Achievement (18-64)		0%	R	Reported
Cardiac Rehabilitation - Initiation (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Engagement1 (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Engagement2 (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Achievement (65+)		0%	NA	Small Denominator
Cardiac Rehabilitation - Initiation (Total)		1.77%	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		1.77%	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		1.77%	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0%	R	Reported
Comprehensive Diabetes Care (CDC)				
Comprehensive Diabetes Care - HbA1c Testing		80.54%	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		40.63%	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		53.28%	R	Reported
Comprehensive Diabetes Care - Eye Exams		46.96%	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		53.53%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)				
Kidney Health Evaluation for Patients With Diabetes (18-64)		28.29%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (65-74)		28.21%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (75-85)		20.22%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (Total)		28.04%	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y			
Statin Therapy for Patients With Diabetes - Received Statin Therapy		66.75%	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		66.89%	R	Reported
Antidepressant Medication Management (AMM)	Y			
Antidepressant Medication Management - Effective Acute Phase Treatment		56.98%	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		41.01%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		33.33%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		42.86%	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y			
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)		25%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)		0%	NA	Small Denominator

Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)		63.04%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)		39.13%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (65+)		20%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)		0%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		56.36%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		32.73%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)		78.57%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)		64.29%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)		79.52%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)		71.08%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)		80%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)		80%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		79.41%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		70.59%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)		55.56%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)		0%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)		0%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)		0%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		50%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		0%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		15.38%	NA	Small Denominator

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		15.38%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		15.38%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		15.38%	NA	Small Denominator
Pharmacotherapy for Opioid Use Disorder (POD)	Y			
Pharmacotherapy for Opioid Use Disorder (16-64)		19.05%	R	Reported
Pharmacotherapy for Opioid Use Disorder (65+)		0%	NA	Small Denominator
Pharmacotherapy for Opioid Use Disorder (Total)		18.98%	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	Y			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		83.73%	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia		63.08%	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		53.85%	NA	Small Denominator
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		67.47%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y			
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)		37.98%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)		27.4%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)		24.52%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)		51.37%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)		36.26%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)		34.07%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		46.5%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		33.04%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		30.59%	R	Reported

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.05%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)		92.83%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (18-64)		63.11%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (65+)		55.56%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (Total)		86.72%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)		46.65%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)		33.48%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)		32.35%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		42.58%	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain		81.17%	R	Reported
Use of Opioids at High Dosage (HDO)	Y			
Use of Opioids at High Dosage		13.5%	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y			
Use of Opioids From Multiple Providers - Multiple Prescribers		14.47%	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.31%	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.37%	R	Reported
Risk of Continued Opioid Use (COU)	Y			
Risk of Continued Opioid Use - >=15 Days (18-64)		3.68%	R	Reported
Risk of Continued Opioid Use - >=31 Days (18-64)		2.58%	R	Reported
Risk of Continued Opioid Use - >=15 Days (65+)		6.67%	R	Reported
Risk of Continued Opioid Use - >=31 Days (65+)		6.67%	R	Reported
Risk of Continued Opioid Use - >=15 Days (Total)		3.72%	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		2.63%	R	Reported
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Adults' Access to Preventive/Ambulatory Health Services (20-44)		73.48%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (45-64)		80.48%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (65+)		80.27%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (Total)		76.06%	R	Reported

Annual Dental Visit (ADV)	Y			
Annual Dental Visit (2-3)		29.36%	R	Reported
Annual Dental Visit (4-6)		52.27%	R	Reported
Annual Dental Visit (7-10)		58.23%	R	Reported
Annual Dental Visit (11-14)		54.83%	R	Reported
Annual Dental Visit (15-18)		45.92%	R	Reported
Annual Dental Visit (19-20)		32.11%	R	Reported
Annual Dental Visit (Total)		48.65%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)		53.33%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)		10%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		47.62%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		14.29%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)		57.14%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)		9.52%	NA	Small Denominator

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)		50.75%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)		10.45%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		53.33%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		10%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		47.62%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		14.29%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		57.14%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		9.52%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		50.75%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		10.45%	R	Reported
Prenatal and Postpartum Care (PPC)				
Prenatal and Postpartum Care - Timeliness of Prenatal Care		89.29%	R	Reported
Prenatal and Postpartum Care - Postpartum Care		78.59%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)			NA	Small Denominator
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)			NA	Small Denominator
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)			NA	Small Denominator
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 30 Months of Life (First 15 Months)		48.15%	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		77.91%	R	Reported
Child and Adolescent Well-Care Visits (WCV)				
Child and Adolescent Well-Care Visits (3-11)		67.61%	R	Reported
Child and Adolescent Well-Care Visits (12-17)		59.61%	R	Reported
Child and Adolescent Well-Care Visits (18-21)		40.7%	R	Reported
Child and Adolescent Well-Care Visits (Total)		61.45%	R	Reported
Frequency of Selected Procedures (FSP)			R	Reported

Ambulatory Care (AMBa)			R	Reported
Ambulatory Care (AMBb)			R	Reported
Ambulatory Care (AMBc)			R	Reported
Ambulatory Care (AMBd)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUb)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUc)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUd)			R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADb)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADc)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADd)	Y		R	Reported
Mental Health Utilization (MPTa)	Y		R	Reported
Mental Health Utilization (MPTb)	Y		R	Reported
Mental Health Utilization (MPTc)	Y		R	Reported
Mental Health Utilization (MPTd)	Y		R	Reported
Antibiotic Utilization (ABXa)	Y		R	Reported
Antibiotic Utilization (ABXb)	Y		R	Reported
Antibiotic Utilization (ABXc)	Y		R	Reported
Antibiotic Utilization (ABXd)	Y		R	Reported
Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)			R	Reported
Health Plan Descriptive Information				
Enrollment by Product Line (ENPa)			R	Reported
Enrollment by Product Line (ENPb)			R	Reported
Enrollment by Product Line (ENPc)			R	Reported
Enrollment by Product Line (ENPd)			R	Reported
Enrollment by State (EBS)			R	Reported
Language Diversity of Membership (LDM)			R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	Reported
Total Membership (TLM)			R	Reported
Electronic Clinical Data Systems				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening			NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase			NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase			NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)				
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)			NR	Not Reported

Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)				
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)			NR	Not Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)				
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)				
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)			NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NR	Not Reported
Adult Immunization Status (AIS-E)				
Adult Immunization Status - Influenza			NR	Not Reported
Adult Immunization Status - Td/Tdap			NR	Not Reported
Adult Immunization Status - Zoster			NR	Not Reported
Prenatal Immunization Status (PRS-E)				
Prenatal Immunization Status - Influenza		16.45%	R	Reported
Prenatal Immunization Status - Tdap		30.57%	R	Reported
Prenatal Immunization Status - Combination		10.79%	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)				
Prenatal Depression Screening and Follow-Up - Depression Screening			NR	Not Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	Not Reported
Postpartum Depression Screening and Follow-Up (PDS-E)				
Postpartum Depression Screening and Follow-Up - Depression Screening			NR	Not Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	Not Reported

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2021 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	25	30	25	25	5	0	83%	3	2	2
Care Management and Continuity of Care - MLTSS*	10	10	10	10	10	0	0	100%	0	0	0
Access	14	12	10	7	11	3	0	79%	2	0	1
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[6]	20	19	11	8	17	3	0	85%	0	0	3
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	5	3	2	4	1	0	80%	0	0	1
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	28	14	13	29	0	1	100%	0	2	0
Administration and Operations[7]	14	13	4	4	14	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**198**	**192**	**85**	**77**	**190**	**7**	**1**	**96%**	**2**	**2**	**5**

[1] A total of 83 elements were reviewed in the previous review period; of these 83, 77 were *Met*, 6 were *Not Met;* 0 were *N/A.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period. As a result, the sum of "Met Prior Year" and "Subject to Review" might exceed the total number of elements for some standards.

[3] Elements that were *Met* in this review period among those that were subject to review.

[4] Elements that were *Met* in this review period among those that were subject to review as well as elements that were *Met* in the previous review period and were not subject to review (i.e., were deemed *Met*). This total is used to calculate the compliance score for each standard as well as the overall compliance score.

[5] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.

[6] QM11 was subdivided into QM11a (Core Medicaid Performance Improvement Projects) and QM11b (MLTSS PIPs).

[7] AO14 was added as a new element for Core Medicaid in 2021.

*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Correction Action Plans (CAPs) as applicable.

HNJH Performance Improvement Projects

HNJH PIP 1: Developmental Screening and Early Intervention in Young Children

MCO Name: Horizon NJ Health (HNJH)

PIP Topic: Developmental Screening and Early Intervention in Young Children

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings [1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M	M	
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M	M	
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M	M	
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M	M	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M	
2c. Objectives align aim and goals with interventions	N/A	M	M	M	M	
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M	M	
3b. Performance indicators are measured consistently over time	N/A	M	M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or	N/A	PM	PM	PM	PM	

processes of care with strong associations with improved outcomes						
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	M	M	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**	**PM**	**PM**	
Element 3 Overall Score	**N/A**	**50.0**	**50.0**	**50.0**	**50**	
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**7.5**	**7.5**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M	
4f. Literature review	N/A	M	M	M	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**15.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	M	N/A	M	
5b. Actions that target member, provider and MCO	N/A	M	M	N/A	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	N/A	M	

5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M	N/A	M	
Element 5 Overall Review Determination	**N/A**	**M**	**M**	**N/A**	**M**	
Element 5 Overall Score	**N/A**	**100**	**100**	**N/A**	**100**	
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**N/A**	**15.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M	M	
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**20.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**M**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80.0**	**85.0**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**72.5**	**77.5**	**92.5**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**91.2%**	**92.5%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components
[2]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Sustainability Phase).

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon New Jersey Health (HNJH)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Final Report
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.

Element 3 Overall Review Determination was that the MCO is partially compliant in regard to subcomponent 3c, Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes. The MCO was partially compliant in regard to performance indicators (PIs) for measuring changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes. The MCO has identified several areas of opportunity in regards to 3c. The MCO is utilizing mailing for ITM # 4, a brochure, on developmental milestones. These are mailed monthly throughout the measurement period. The MCO also mails reminders for appointments, regarding falling behind on visits (ITM#5). However, it is difficult to know if the mailings actually had any impact on a visit completed without additional validation metrics. ITM #11 was impacted due to staffing challenges, and outreach calls to infants discharged from the NICU were noted to be low as compared to the overall number of discharges. ITM # 15 A and B were developed and implemented late in the course of the PIP. The MCO expressed that if these ITMs had been brought forward sooner, the impact of the ITMs may have been more beneficial to the project and the members. One main limitation regarding the capture of developmental screenings noted was the CPT codes 96110 and 96111. These codes can also be used for single domain such as Autism, which is not considered global developmental screening thus may overestimate an accurate count of developmental screenings. Therefore the percentage represented in the PI data may over represent the true rate of those who had a developmental screening in multiple domains. The MCO should review all the data and opportunities contained within PIs and potentially build upon any success while focusing on opportunities for improvement.

Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is Compliant
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was the MCO identifies a healthcare disparity based on examination of counties that had the lowest claims for Early Intervention services.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 92.5 points, which results in a rating of 92.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]).

The MCO has submitted all the final report information outlining successes and limitations along with understanding the opportunities that lie ahead for the MCO to engage in. The MCO notably discusses a Disparity Analysis with the assistance and collaboration of the HNJH Health Care Disparities Workgroup who assists in identifying disparities and barriers to care. The MCO discussed in-depth the implications of COVID-19 and the emergency circumstances, including specifics of interrupted interventions and the subsequent resuming of PIP intervention activities, not limited to the effects on intervention outcomes. As changes happen, the MCO should continue to monitor to impact of Covid-19 on the membership populations and update as appropriate.

HNJH PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 2: MCO Adolescent Risk Behaviors and Depression Collaborative

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or	N/A	M	M	M		

processes of care with strong associations with improved outcomes						
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	N/A	M		
Element 5 Overall Review Determination	**N/A**	**M**	**N/A**	**M**		
Element 5 Overall Score	**N/A**	**100**	**N/A**	**100**	**0**	
Element 5 Weighted Score	**N/A**	**15.0**	**N/A**	**15.0**	**0.0**	

Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**Y**	**y**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**65.0**	**100.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**100.0%**	**100.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 22, 2021
Report Period: Project Year 2 and Sustainability Update
IPRO Comments:

Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination is the MCO was that healthcare disparities were addressed.

Overall, the MCO is compliant with this PIP for the Sustainability reporting requirement; out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO continues to monitor interventions in accordance with the methodology, and calculated ITMs which were presented at both the individual practice level as well as in the aggregate. The MCO continues to update ITM data in accordance to reporting instructions, and as appropriate for the associated interventions. The MCO has taken steady steps to monitor and document changes to the PIP, specifically the ITMs, updating documentation at each submission when changes occur. The MCO discussed in-depth the implications of COVID-19 and the emergency circumstances, including specifics of interrupted (and subsequent resuming of) PIP activities, not limited to the effects on intervention outcomes.

HNJH PIP 3: Increasing PCP Access and Availability for Members with Low Acuity, Non-Emergent ED visits

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 3: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits – Core Medicaid Membership

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M				
1b. Impacts the maximum proportion of members that is feasible	N/A	M				
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M				
1d. Reflects high-volume or high risk-conditions	N/A	M				
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M				
Element 1 Overall Review Determination	**N/A**	**M**				
Element 1 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight

2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M				
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M				
2c. Objectives align aim and goals with interventions	N/A	M				
Element 2 Overall Review Determination	**N/A**	**M**				
Element 2 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M				
3b. Performance indicators are measured consistently over time	N/A	M				
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M				
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	PM				
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M				
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A				
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M				
Element 3 Overall Review Determination	**N/A**	**PM**				
Element 3 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M				

4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M				
4c. Provider input at focus groups and/or Quality Meetings	N/A	M				
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M				
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M				
4f. Literature review	N/A	M				
Element 4 Overall Review Determination	**N/A**	**M**				
Element 4 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M				
5b. Actions that target member, provider and MCO	N/A	M				
5c. New or enhanced, starting after baseline year	N/A	M				
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM				
Element 5 Overall Review Determination	**N/A**	**PM**				
Element 5 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M				
Element 6 Overall Review Determination	**N/A**	**M**				
Element 6 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M				
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M				
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M				
7d. Lessons learned & follow-up activities planned as a result	N/A	M				

Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon NJ Health (HNJH)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Year 1
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is partially compliant; a concern has been identified with aspects of the methodology, regarding 3d and 3g. There is a sizeable population of members which the MCO will need to further define as the PIP progresses. The MCO should consider stratifying the LANE diagnoses to coordinate with selected provider groups that provide services to members that exhibit the "top LANE" diagnoses in their geographical area. By coordination of both the members with ER visits, LANE diagnoses and a geographical location may lead to an understand of an area that has health care disparities. The data is vast as is the eligible population and multiple geographical locations can have pockets of members with concerns about getting care and this could be another source.

Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant; a concern has been identified with a sizable eligible population and the tracking of the interventions. The MCO should consider how the population might be labeled in means of LANE diagnosis which would provide more definition regarding the impact of the intervention on the

members and the PIP. The MCO might also consider how interventions directly impact the 6 selected provider groups in creating additional time for urgent walk-in care or expanding hours, and how those interventions would have an impact on increasing access to PCP offices. Additionally, on Table 1b, Quarterly Reporting of Rates for Intervention Tracking, the MCO should Footnote all data that is not yet available or has a preliminary start date. On page 22, Intervention #1b, Y1Q3 does not have any data as well as the Barrier Analysis Start and End Dates display N/A which should be reviewed for Start and Stop dates.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that a healthcare disparity is not addressed.
Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 65.0 points, which results in a rating of 81.3% (which is below 85% [≥ 85% being the threshold for meeting compliance]). Concerns were identified with aspects of the methodology, barrier analysis, and interventions. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

HNJH PIP 4: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 4: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	

Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					

5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Aim, Objectives, and Goals, 2b, the Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark. Although not scored, the MCO has not provided Benchmark or Baseline data for the proposal. The MCO has stated, "The baseline year for this PIP will be 2021 with corresponding HEDIS data available for analysis in June of 2022. Additionally, the Benchmark data for 2019 is still in the process of being finalized and therefore was not entered below. "The MCO could have used the 2019 data for the Benchmark/Baseline as preliminary data and footnote as well as give and explanation regarding the preliminary data. The MCO should update the Table on pg. 10 to include the Performance Indicator rates for the Baseline, Benchmark, Short-Term, and Long-Terms goals.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A. Although not scored, a concern was identified with the Barrier Analysis, 4d, QI Process data. The MCO should include both Start and End dates as these dates are used to monitor the changes to the PIP over time. In this manner, the tracking of when there was a change is noted on the Change table and Tables 1a and 1b ensures all changes are realized and evaluated to ensure data accuracy and progress to the objectives stated in the proposal. The MCO should update the End dates for the next August 2022 report submission.

Element 5 Overall Review Determination was N/A.
Element 6 Overall Review Determination was N/A. Although not scored, a concern was identified with the Results Table 2, 6a, Table 2 shows Performance Indicator rates, numerators, and denominators, with corresponding goals. The MCO has noted the Baseline Year is 2021, however the MCO should footnote and provide the explanation of why there was a lack of data and update the information and data in the April 2022 submission.

Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Aim, Objectives and Goals and Results Table. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 5: Reducing admissions, readmissions and gaps in services for members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		

3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		

5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	N/A	M		
Element 5 Overall Review Determination	**N/A**	**M**	**N/A**	**M**		
Element 5 Overall Score	**N/A**	**100**	**0**	**100**	**0**	
Element 5 Weighted Score	**N/A**	**15.0**	**0.0**	**15.0**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	PM	PM		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	PM		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**		
Element 7 Overall Score	**N/A**	**0**	**50**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**10.0**	**10.0**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						

9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**55.0**	**90.0**	**0**
Overall Rating	**N/A**	**100%**	**84.6%**	**90.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon NJ Health (HNJH)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org): Cynthia Steffe (CSteffe@ipro.org
Date (report submission) reviewed: November 10, 2021
Report Period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination is that the MCO is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.
Element 4 Overall Review Determination is that the MCO is compliant.

Element 5 Overall Review Determination is that the MCO is compliant.
Element 6 Overall Review Determination is that the MCO is compliant.

Element 7 Overall Review Determination is the MCO is partially compliant regarding subcomponent 7a and 7d. The MCO was partially compliant with its interpretation to the extent to which the PIP was successful, and the factors associated with success. The MCO updated intervention descriptions in accordance with submission feedback, although Barrier Analysis, Table 1a does not exhibit end dates to show when a Barrier and its corresponding intervention ended or is ending. On page 53, the MCO notes at a meeting in September 2020, it was identified that while 100% of the identified MLTSS CHF members were successfully outreached to post hospitalization to schedule a practitioner follow-up appointment, less than half of these communications were being captured in Care Radius. The MLTSS training team devised a CHF training that was successfully implemented in six (6) sessions during December of 2020 and was completed by all care managers involved in MLTSS CHF member outreach. The MCO should provide the outcome of the training in the Final Report due in August 2022. The MCO provided a comprehensive table outlining newly identified potential barriers to Covid-19 and list potential impact to the PIP, however, has not expanded discussion on the MCO's use of Telehealth and potential miscalculations in the data regarding coding of visits or how the MCO plans to integrate Telehealth into the MCOs tracking systems. The MCO should ensure implications are discussed appropriately when drawing overall conclusions in terms of PIP success. The MCO did not address lessons learned in Section 8 although have some limited discussion regarding successes and limitations. The MCO should further discuss successes, limitations and plans of use for this information in the future.

Element 8 Overall Review Determination is that the MCO is compliant.

Element 9 Overall Review Determination is that the MCO did not address a healthcare disparity.
Overall, the MCO is compliant with this PIP for Sustainability; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has incorporated feedback appropriately and continues to monitor the progress of the

PIP despite the Covid-19 pandemic. The MCO has made progress and continues to refine processes to improve the quality of the project to benefit the members. The MCO should review the project, reviewing each section for alignment from the Change Table to Lessons Learned ensuring dates, footnotes, impact of Covid-19 are clear and concise and are fully supported by the data. As changes occur, the MCO should clearly document the impact of Covid-19 on the interventions inclusive of outcomes.

HNJH PIP 6: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 6: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					

3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight

6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 23, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A.

Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified regarding Methodology, 3a, Performance Indicators (PIs) are clearly defined and measurable (specifying numerator and denominator criteria). Under Performance Indicators (pgs.12-14) the exclusion criteria for each PI, bullet 2, states "Not continuously enrolled (more than 45 days). However, under number 2. Data Collection and Analysis Procedures (pg.15), it is stated that the eligible population targeted includes continuously enrolled (no more than a 45-day gap in coverage). The Barrier Analysis reflects this same language (continuously enrolled) for each of the Interventions and subsequent ITMs. The MCO should clarify the exclusions for the performance indicators and align the PIs.
Element 4 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Barrier Analysis, 4d, QI Process data. The MCO has provided the Start date for each intervention and subcomponents, however the End dates are labeled as TBD. The MCO should complete the Start and End dates on the proposal, noting any change can be updated on the Change Table on page 2 of the Template. The Proposal should reflect the MCOs proposed thoughts and processes with the understanding that changes occur throughout the life of the PIP with each change being identified and explained.
Element 5 Overall Review Determination was N/A.
Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare Disparities have been assessed, based on race/ethnicity and sex, and identified White males (14/52) and determined due to the low number not to proceed at this time.
For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Methodology and Barrier Analysis. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

HNJH – HEDIS Audit Review Table MY 2020

Audit Review Table				
Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health (Org ID: 6610, Sub ID: 7459, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)				
Measurement Year - 2020; Date & Timestamp - 06/09/2021 9:39 AM				
This submission is on the stage: PlanLock				
Measure/Data Element	**Benefit Offered**	**Rate**	**Audit Designation**	**Comment**
Effectiveness of Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		84.72%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		78.61%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		73.33%	R	Reported
Childhood Immunization Status (CIS)				
Childhood Immunization Status - DTaP		78.35%	R	Reported
Childhood Immunization Status - IPV		91%	R	Reported
Childhood Immunization Status - MMR		88.81%	R	Reported
Childhood Immunization Status - HiB		89.29%	R	Reported
Childhood Immunization Status - Hepatitis B		88.56%	R	Reported
Childhood Immunization Status - VZV		88.81%	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		72.26%	R	Reported
Childhood Immunization Status - Hepatitis A		80.54%	R	Reported
Childhood Immunization Status - Rotavirus		71.05%	R	Reported
Childhood Immunization Status - Influenza		59.37%	R	Reported
Childhood Immunization Status - Combo 2		71.29%	R	Reported
Childhood Immunization Status - Combo 3		62.53%	R	Reported
Childhood Immunization Status - Combo 4		58.88%	R	Reported
Childhood Immunization Status - Combo 5		52.55%	R	Reported
Childhood Immunization Status - Combo 6		45.99%	R	Reported
Childhood Immunization Status - Combo 7		50.12%	R	Reported
Childhood Immunization Status - Combo 8		44.28%	R	Reported
Childhood Immunization Status - Combo 9		40.88%	R	Reported
Childhood Immunization Status - Combo 10		39.42%	R	Reported
Immunizations for Adolescents (IMA)				
Immunizations for Adolescents - Meningococcal		92.94%	R	Reported
Immunizations for Adolescents - Tdap		94.65%	R	Reported
Immunizations for Adolescents - HPV		32.85%	R	Reported
Immunizations for Adolescents - Combination 1		91.24%	R	Reported
Immunizations for Adolescents - Combination 2		31.14%	R	Reported
Lead Screening in Children (LSC)				
Lead Screening in Children		71.34%	R	Reported

Breast Cancer Screening (BCS)				
Breast Cancer Screening		55.52%	R	Reported
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening		59.11%	R	Reported
Chlamydia Screening in Women (CHL)				
Chlamydia Screening in Women (16-20)		54.83%	R	Reported
Chlamydia Screening in Women (21-24)		64.88%	R	Reported
Chlamydia Screening in Women (Total)		59.38%	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y			
Appropriate Testing for Pharyngitis (3-17)		72.57%	R	Reported
Appropriate Testing for Pharyngitis (18-64)		45.19%	R	Reported
Appropriate Testing for Pharyngitis (65+)		26.69%	R	Reported
Appropriate Testing for Pharyngitis (Total)		63.69%	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		32.96%	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		71.8%	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		87.61%	R	Reported
Asthma Medication Ratio (AMR)	Y			
Asthma Medication Ratio (5-11)		75.89%	R	Reported
Asthma Medication Ratio (12-18)		64.44%	R	Reported
Asthma Medication Ratio (19-50)		58.5%	R	Reported
Asthma Medication Ratio (51-64)		58.61%	R	Reported
Asthma Medication Ratio (Total)		63.04%	R	Reported
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure		54.74%	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y			
Persistence of Beta-Blocker Treatment After a Heart Attack		87.14%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		81.33%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		77.95%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		74.87%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		76.74%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		78.55%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		77.45%	R	Reported
Cardiac Rehabilitation (CRE)				
Cardiac Rehabilitation - Initiation (18-64)		1.42%	R	Reported
Cardiac Rehabilitation - Engagement1 (18-64)		1.72%	R	Reported

Cardiac Rehabilitation - Engagement2 (18-64)		1.27%	R	Reported
Cardiac Rehabilitation - Achievement (18-64)		0.3%	R	Reported
Cardiac Rehabilitation - Initiation (65+)		0%	R	Reported
Cardiac Rehabilitation - Engagement1 (65+)		0%	R	Reported
Cardiac Rehabilitation - Engagement2 (65+)		0%	R	Reported
Cardiac Rehabilitation - Achievement (65+)		0%	R	Reported
Cardiac Rehabilitation - Initiation (Total)		1.38%	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		1.67%	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		1.24%	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0.29%	R	Reported
Comprehensive Diabetes Care (CDC)				
Comprehensive Diabetes Care - HbA1c Testing		77.86%	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		39.42%	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		52.31%	R	Reported
Comprehensive Diabetes Care - Eye Exams		50.61%	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		58.64%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)				
Kidney Health Evaluation for Patients With Diabetes (18-64)		10.54%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (65-74)		12.98%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (75-85)		10.39%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (Total)		10.63%	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y			
Statin Therapy for Patients With Diabetes - Received Statin Therapy		65.59%	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		70.61%	R	Reported
Antidepressant Medication Management (AMM)	Y			
Antidepressant Medication Management - Effective Acute Phase Treatment		60.68%	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		46.71%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		35.18%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		39.44%	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y			
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)		36.59%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)		19.51%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)		52.75%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)		30.72%	R	Reported

Follow-Up After Hospitalization For Mental Illness - 30 days (65+)		43.59%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)		12.82%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		50.35%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		28%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)		77.14%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)		67.83%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)		63.53%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)		54.41%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)		47.22%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)		38.89%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		68.33%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		59.14%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)		45.87%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)		28.44%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)		33.33%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)		11.11%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		44.09%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		25.98%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)		9.24%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)		7.07%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		24.26%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		16.84%	R	Reported

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		23.91%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		16.61%	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y			
Pharmacotherapy for Opioid Use Disorder (16-64)		29.69%	R	Reported
Pharmacotherapy for Opioid Use Disorder (65+)		43.18%	R	Reported
Pharmacotherapy for Opioid Use Disorder (Total)		29.88%	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	Y			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		76.06%	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia		62.36%	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		71.94%	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		68.65%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y			
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)		23.74%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)		23.51%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)		15.9%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)		42.17%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)		36.01%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)		26.33%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		35.09%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		31.21%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		22.32%	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				

Non-Recommended Cervical Cancer Screening in Adolescent Females		0.53%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)		91.64%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (18-64)		60.91%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (65+)		63.47%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (Total)		84.32%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)		49.62%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)		35.73%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)		50.99%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		44.58%	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain		78.45%	R	Reported
Use of Opioids at High Dosage (HDO)	Y			
Use of Opioids at High Dosage		13.15%	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y			
Use of Opioids From Multiple Providers - Multiple Prescribers		17.98%	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.89%	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.98%	R	Reported
Risk of Continued Opioid Use (COU)	Y			
Risk of Continued Opioid Use - >=15 Days (18-64)		7.52%	R	Reported
Risk of Continued Opioid Use - >=31 Days (18-64)		4.72%	R	Reported
Risk of Continued Opioid Use - >=15 Days (65+)		19.62%	R	Reported
Risk of Continued Opioid Use - >=31 Days (65+)		11.16%	R	Reported
Risk of Continued Opioid Use - >=15 Days (Total)		7.86%	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		4.9%	R	Reported
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Adults' Access to Preventive/Ambulatory Health Services (20-44)		79.09%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (45-64)		87.15%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (65+)		92.17%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (Total)		82.67%	R	Reported
Annual Dental Visit (ADV)	Y			
Annual Dental Visit (2-3)		35.59%	R	Reported

Annual Dental Visit (4-6)		54.09%	R	Reported
Annual Dental Visit (7-10)		58.32%	R	Reported
Annual Dental Visit (11-14)		56.93%	R	Reported
Annual Dental Visit (15-18)		50.83%	R	Reported
Annual Dental Visit (19-20)		38.14%	R	Reported
Annual Dental Visit (Total)		52.07%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)		100%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)		0%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)		0%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)		0%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)		33.33%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)		0%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)		39.14%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)		4.57%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		40%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		14.29%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)		37.95%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)		4.29%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)		38.34%	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)		7.33%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		39.32%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		4.56%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		40%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		14.29%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		37.7%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		4.26%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		38.32%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		7.3%	R	Reported
Prenatal and Postpartum Care (PPC)				
Prenatal and Postpartum Care - Timeliness of Prenatal Care		79.49%	R	Reported
Prenatal and Postpartum Care - Postpartum Care		70.89%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)		63.66%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)		67.45%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		65.93%	R	Reported
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 30 Months of Life (First 15 Months)		53.88%	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		75.03%	R	Reported
Child and Adolescent Well-Care Visits (WCV)				
Child and Adolescent Well-Care Visits (3-11)		63.42%	R	Reported
Child and Adolescent Well-Care Visits (12-17)		56.93%	R	Reported
Child and Adolescent Well-Care Visits (18-21)		38.55%	R	Reported
Child and Adolescent Well-Care Visits (Total)		57.75%	R	Reported
Frequency of Selected Procedures (FSP)			R	Reported
Ambulatory Care (AMBa)			R	Reported
Ambulatory Care (AMBb)			R	Reported

Ambulatory Care (AMBc)			R	Reported
Ambulatory Care (AMBd)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUb)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUc)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUd)			R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADb)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADc)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADd)	Y		R	Reported
Mental Health Utilization (MPTa)	Y		R	Reported
Mental Health Utilization (MPTb)	Y		R	Reported
Mental Health Utilization (MPTc)	Y		R	Reported
Mental Health Utilization (MPTd)	Y		R	Reported
Antibiotic Utilization (ABXa)	Y		R	Reported
Antibiotic Utilization (ABXb)	Y		R	Reported
Antibiotic Utilization (ABXc)	Y		R	Reported
Antibiotic Utilization (ABXd)	Y		R	Reported
Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)			R	Reported
Health Plan Descriptive Information				
Enrollment by Product Line (ENPa)			R	Reported
Enrollment by Product Line (ENPb)			R	Reported
Enrollment by Product Line (ENPc)			R	Reported
Enrollment by Product Line (ENPd)			R	Reported
Enrollment by State (EBS)			R	Reported
Language Diversity of Membership (LDM)			R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	Reported
Total Membership (TLM)			R	Reported
Electronic Clinical Data Systems				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening			NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase			NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase			NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)				
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)			NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NR	Not Reported

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)				
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)			NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)			NR	Not Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)				
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)				
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)			NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NR	Not Reported
Adult Immunization Status (AIS-E)				
Adult Immunization Status - Influenza			NR	Not Reported
Adult Immunization Status - Td/Tdap			NR	Not Reported
Adult Immunization Status - Zoster			NR	Not Reported
Prenatal Immunization Status (PRS-E)				
Prenatal Immunization Status - Influenza		20.94%	R	Reported
Prenatal Immunization Status - Tdap		31.98%	R	Reported
Prenatal Immunization Status - Combination		13.59%	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)				
Prenatal Depression Screening and Follow-Up - Depression Screening			NR	Not Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	Not Reported
Postpartum Depression Screening and Follow-Up (PDS-E)				
Postpartum Depression Screening and Follow-Up - Depression Screening			NR	Not Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	Not Reported

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2021 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	25	30	26	26	4	0	87%	2	3	2
Care Management and Continuity of Care - MLTSS*	10	9	10	7	7	3	0	70%	0	1	3
Access	14	10	10	7	11	3	0	79%	3	1	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[6]	20	18	11	9	18	2	0	90%	1	1	1
Efforts to Reduce Healthcare Disparities	5	4	5	5	5	0	0	100%	0	1	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	40	11	6	39	5	0	89%	4	0	1
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	5	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	7	4	4	8	0	0	100%	0	1	0
Credentialing and Recredentialing	10	8	4	3	9	1	0	90%	1	1	0
Utilization Management	30	29	14	12	28	0	2	100%	0	1	0
Administration and Operations[7]	14	13	4	4	14	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**198**	**182**	**86**	**73**	**185**	**11**	**2**	**94%**	**9**	**6**	**2**

[1] A total of 88 elements were reviewed in the previous review period; of these 88, 72 were *Met*, 14 were *Not Met;* 2 were *N/A.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period. As a result, the sum of "Met Prior Year" and "Subject to Review" might exceed the total number of elements for some standards.

[3] Elements that were *Met* in this review period among those that were subject to review.

[4] Elements that were *Met* in this review period among those that were subject to review as well as elements that were *Met* in the previous review period and were not subject to review (i.e., were deemed *Met*). This total is used to calculate the compliance score for each standard as well as the overall compliance score.

[5] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.

[6] QM11 was subdivided into QM11a (Core Medicaid Performance Improvement Projects) and QM11b (MLTSS PIPs).

[7] AO14 was added as a new element for Core Medicaid in 2021.

*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Correction Action Plans (CAPs) as applicable.

UHCCP Performance Improvement Projects

UHCCP PIP 1: Early Intervention for children in Lead Case Management (Age Birth to 2.99 Years Old)

MCO Name: UnitedHealthcare Community Plan (UHCCP)
PIP Topic 1: Early Intervention for children in Lead Case Management (Age Birth to 2.99 Years Old)

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M	M	
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M	M	
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M	M	
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M	M	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M	
2c. Objectives align aim and goals with interventions	N/A	PM	M	M	M	
Element 2 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**	
Element 2 Overall Score	**N/A**	**50.0**	**100**	**100**	**100**	
Element 2 Weighted Score	**N/A**	**2.5**	**5.0**	**5.0**	**5.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	PM	M	M	
3b. Performance indicators are measured consistently over time	N/A	M	M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M	M	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M	M	

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	**M**	**M**	**M**	**M**	
Element 3 Overall Review Determination	**N/A**	**M**	**PM**	**M**	**M**	
Element 3 Overall Score	**N/A**	**100**	**50.0**	**100**	**100**	
Element 3 Weighted Score	**N/A**	**15.0**	**7.5**	**15.0**	**15**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	N/A	N/A	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	N/A	N/A	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	N/A	N/A	M	
4f. Literature review	N/A	M	N/A	N/A	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**15**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	M	N/A	M	
5b. Actions that target member, provider and MCO	N/A	PM	M	N/A	M	
5c. New or enhanced, starting after baseline year	N/A	PM	M	N/A	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M	N/A	M	
Element 5 Overall Review Determination	**N/A**	**PM**	**M**	**N/A**	**M**	
Element 5 Overall Score	**N/A**	**50.0**	**100**	**N/A**	**100**	
Element 5 Weighted Score	**N/A**	**7.5**	**15.0**	**N/A**	**15**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M	M	

Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	M
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	PM	M	M	M
Element 7 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**
Element 7 Overall Score	**N/A**	**50.0**	**100**	**100**	**100**
Element 7 Weighted Score	**N/A**	**10.0**	**20.0**	**20.0**	**20**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**Y**	**Y**	**Y**	**y**

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**72.5**	**85.0**	**100**
Overall Rating	**N/A**	**75.0%**	**90.6%**	**100%**	**100%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

[2] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Sustainability Phase).

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Final Report
IPRO Comments:
Element 1 Overall Review Determination was that the Managed Care Organization (MCO) is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.

Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that the MCO identified, evaluated, and addressed geographic healthcare disparities.
Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Overall, the MCO has met the objective of the PIP. The lead Case Management Team has been successful in implementing an early identification and referral process for the target populations to their local county Early Intervention program in order to improve the percent of children that receive Early Intervention Testing from the baseline to the final measurement. The MCO credits the success of the PIP to multiple factors such as Team collaboration meeting, weekly, requesting and receiving feedback form key stakeholders, engaging and maintaining PCP relationships, and additional members of the team are bilingual which was very beneficial in maintaining relationships with the member population. It is clear to see the QI process was followed with consistent methodological prowess. The MCO also noted some limitations such as COVID-19 in 2020, noting there was population decline as well as testing. Increasing poverty and health care disparities may be another reason why members will decline referrals for assistance. The MCO has been reviewing limitations noted in the project and creating potential actions plan in order to maintain the successes achieved and diminish what obstacles may arise. As changes are made, the MCO should consider the impact of COVID-19 on the PIP interventions moving forward as the situation continues to evolve.

UHCCP PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: UnitedHealthcare Community Plan (UHCCP)
PIP Topic 2: MCO Adolescent Risk Behaviors and Depression Collaborative

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		

Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5**	**5**	**0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5**	**5**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	PM	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**		

Element 3 Overall Score	**N/A**	**50.0**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**15**	**15**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15**	**15**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	M		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**M**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**	**100**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**15**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight

6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**5**	**5**	**0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**20**	**20**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20**	**0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings

Maximum Possible Weighted Score	**N/A**	**60.0**	**65**	**100**	**100**
Actual Weighted Total Score	**N/A**	**45.0**	**65.0**	**100.0**	**0.0**
Overall Rating	**N/A**	**75.0%**	**100.0%**	**100.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 22, 2021
Report Period: Project Year 2 and Sustainability Update
IPRO Comments:
Element 1 Overall Review Determination was that the MCO was compliant.
Element 2 Overall Review Determination was that the MCO was compliant.
Element 3 Overall Review Determination was that the MCO was compliant.
Element 4 Overall Review Determination was that the MCO was compliant.
Element 5 Overall Review Determination was that the MCO was compliant.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO was compliant.
Element 8 Overall Review Determination was that the MCO was compliant.
Element 9 Overall Review Determination was that Healthcare Disparities were not addressed.
Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO conducted full audits with sampled records from each practice, aggregated the results and provided individual and aggregate analysis of both. Interpretations of comparative results factoring in limitations when sample sizes were small, inclusive of the baseline were used to identify opportunities and potential limitations. The MCO evaluated short and long term goals for each indicator for all practices noting that the cumulative performance indicator results exhibit all the long-term goals either met or exceeded their goals. Despite the Covid-19 pandemic, the MCO was able to successfully engage providers and staff in all three practices. All three providers continued with the project and made significant improvements as well as participated in quarterly and annual meetings. The MCO also experienced new areas of opportunities, regarding Covid-19 as some offices temporarily closed, some practices created hybrid tools to facilitate care of the members such as two-part visits. This was a creative way of utilizing Telehealth to have the member interview (part 1) and set up an appointment for the physical exam (part 2). The MCO noted the resulting appointments reviewed the Telehealth questions for risk behaviors along with the physical exam, hence included in the denominator. However, the coding for the process has not yet been refined and would need to be reviewed by medical record documentation for inclusion of the data. The MCO continues to demonstrate efforts of reinforcing the importance of risk screening and documentation throughout the measurement year. As changes continue to happen the MCO should monitor the Covid -19 impact on the members and processes that support them.

UHCCP PIP 3: Decrease Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members (Non-Clinical)

MCO Name: UnitedHealthcare Community Plan (UHCCP)
PIP Topic 3: Decrease Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care For Adult Medicaid Members (Non-clinical)

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	PM				
1b. Impacts the maximum proportion of members that is feasible	N/A	M				
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M				
1d. Reflects high-volume or high risk-conditions	N/A	M				
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M				
Element 1 Overall Review Determination	**N/A**	**PM**				
Element 1 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**2.5**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M				
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M				
2c. Objectives align aim and goals with interventions	N/A	M				
Element 2 Overall Review Determination	**N/A**	**M**				
Element 2 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight

3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M				
3b. Performance indicators are measured consistently over time	N/A	M				
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M				
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M				
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M				
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M				
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M				
Element 3 Overall Review Determination	**N/A**	**M**				
Element 3 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M				
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M				
4c. Provider input at focus groups and/or Quality Meetings	N/A	M				
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M				
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M				
4f. Literature review	N/A	M				
Element 4 Overall Review Determination	**N/A**	**M**				
Element 4 Overall Score	**N/A**	**100**	**0**	**0**	**0**	

Element 4 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M				
5b. Actions that target member, provider and MCO	N/A	M				
5c. New or enhanced, starting after baseline year	N/A	M				
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M				
Element 5 Overall Review Determination	**N/A**	**M**				
Element 5 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M				
Element 6 Overall Review Determination	**N/A**	**M**				
Element 6 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M				
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M				
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M				
7d. Lessons learned & follow-up activities planned as a result	N/A	M				
Element 7 Overall Review Determination	**N/A**	**M**				
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**	

Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**77.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**96.9%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Year 1
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is partially compliant with 1a; a concern was identified with an aspect of the Change Table pages 2-5. The MCO has noted many changes in multiple areas throughout the PIP. Although each change has appropriately enhanced the project status, it is difficult to understand the timing of the change. The change Table should exhibit the timeframe of the actual change noting the month, day, year the change occurred. The MCO should review the Table for accuracy and update as appropriate thereby ensuring alignment with the Barrier Analysis Table 1a and the Quarterly ITM Reporting Table 1b.
Element 2 Overall Review Determination was that the MCO was compliant.
Element 3 Overall Review Determination was that the MCO was compliant.
Element 4 Overall Review Determination was that the MCO was compliant.
Element 5 Overall Review Determination was that the MCO was compliant.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO was compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that no healthcare disparities were not identified, evaluated, or addressed.
Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 77.5 points, which results in a rating of 96.9% (which is above 85% [≥ 85% being the threshold for meeting compliance]).

The MCO has made significant changes over this first year, taking time to review every aspect of the PIP, using the QI process to make appropriate changes in each area when needed. In the discussion section the MCO outlines each step of progress and had identified limitations as well as areas for monitoring over time such as factors that may affect claims data. The MCO found in review, the claims pull for Q1 2021, exhibited a change in the ED Utilization patterns, noticing that ICD 10 code listed in the ED claims capture did not always correspond to the actual problem treated for that claim. The MCO will monitor over the next six months to understand the potential issue. The MCO has updated the Methodology appropriately to align with the Aim and Goals of the PIP. The MCO was successful in meeting with participating providers to discuss the potential of each practice to open time slot(s) during the day for urgent (low acuity diagnosis) as means of increasing PCP visits versus using the emergency room for low acuity care and found success in 2 of the 3 providers. The MCO additionally, created a short educational presentation regarding the importance of the project and building relationship with their members. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

UHCCP PIP 4: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 4: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight

3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and	N/A					

baseline PIP reports, with actual data reported in Interim and Final PIP Reports)						
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A.
Element 3 Overall Review Determination was N/A.
Element 4 Overall Review Determination was N/A. Although not scored, a concern was identified with the Barrier Analysis, 4d, QI Process data ("5 Why's", fishbone diagram). The MCO should consider a deeper dive into social determinants of health to understand the specifics of any barriers that the members may identify as a deterrent to preventive care appointments by using the "5 Whys" Fishbone diagram process. The MCO should also review Table 1b for the most current version of the PIP template for the numerator/ denominator and rate.

Element 5 Overall Review Determination was N/A.
Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase. Although not scored, a concern was identified in the Results Table 2, 6a, table shows Performance Indicator rates, numerators and denominators, with corresponding goals. On page 29, Indicator 2, Practice 2, the rounding convention of this calculation is not in alignment with the rest of the calculations that were rounded up. For example, Indicator 1, Practice 3, has rounded up the rate to 66.67% whereas Indicator 2, practice 2, was not rounded up to (89.10%). Although the MCO has rounding up to the hundredth place consistently, the use of rounding conventions should also be consistent. For example, the rate of 89.06% would then be rounded up to 89.10% (as the last number in the decimal is 5 or greater) and is consistent with rounding decimal to the hundredth place. The MCO should review this calculation and rounding conventions to ensure accurate monitoring and evaluation and document clearly to ensure that all staff follow the same rounding convention by footnoting and /or adding a statement in Methodology in regard to rounding conventions utilized throughout the PIP.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed. For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Barrier Analysis and Results. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. Lastly, the MCO should ensure that all reports submitted to EQRO should be finalized, and not contain tracked changes and/or author comments in the margins. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

UHCCP PIP 5: Improving Influenza and Pneumococcal Immunization Rates and Timely Personal Care Assistant (PCA) Service in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population

MCO Name: UnitedHealthcare Community Plan (UHCCP)
PIP Topic 5: Improving Influenza and Pneumococcal Immunization Rates and Timely Personal Care Assistant (PCA) Service in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population

New Jersey MCO PIP Scoring Report **PIP Components and Subcomponents**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	PM	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**PM**	**M**		
Element 1 Overall Score	**N/A**	**100**	**50**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**2.5**	**5.0**	**0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	PM	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	PM	M	M		
Element 2 Overall Review Determination	**N/A**	**PM**	**PM**	**M**		
Element 2 Overall Score	**N/A**	**50**	**50**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**2.5**	**2.5**	**5.0**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	PM	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	PM	PM		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**PM**	**PM**		
Element 3 Overall Score	**N/A**	**100**	**50**	**50**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**7.5**	**7.5**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50.0**	**0**	**50**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**0**	**7.5**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	M	M		
Element 6 Overall Review Determination	**N/A**	**PM**	**M**	**M**		

Element 6 Overall Score	**N/A**	**50**	**100**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**	**5.0**	**0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**0**	
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**47.5**	**52.5**	**85.0**	**0**
Overall Rating	**N/A**	**79.2%**	**80.8%**	**85.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 10, 2021
Reporting Period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination is that the MCO is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination was the MCO partially compliant regarding Methodology subcomponent 3g. The MCO was partially compliant regarding study design specifying data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. The MCO notes on page 16, the "NJ Choice Assessment may not reflect accurate data due to not only reliability of the member's recollection of receiving the vaccinations but also the framing of the question for the vaccination period. "The MCO also notes on page 33 Performance indicators for MY2 (July 2020-June2021) were calculated using an internal quarterly face-to-face (F2F)

and not the NJ Choice Assessment which was used in MY1 and the Baseline. As the NJ Choice Assessment was paused in March 2020, the MCO utilized this internal assessment as it asked that same questions regarding Flu and Pneumonia vaccines. Although the MCO was able to gather data in this manner regarding vaccination status of the members, several concerns came forward. First, the MCO acknowledges that the data acquired from NJ Choice Assessment, or the Internal Assessment may not be reliable due to the member's recollection and /or the period of the vaccination (year of). The second concern is regarding updating the sections of the PIP to reflect the change in Methodology, Barrier Analysis and Quarterly Reporting Table (1b) to reflect the change of NJ Choice to an Internal Assessment Form in which the questions regarding Flu and Pneumonia vaccination status would be asked. The MCO has noted the update by a change of language stating "Face-to-Face Quarterly Assessment" in place of NJ Choice Assessment on the Barrier Analysis Table 1a and Quarterly Reporting Table 1b, however it has not been updated in Methodology to reflect the update of assessment used to gather vaccination status. Thirdly, the MCO has not sufficiently addressed the threat of validity to the PIP regarding gathering data via questionnaire with some other form of validation. To add to this concern, a second concern was identified by the MCO noting that the documentation processes by the CM Staff was not following the process accurately and did not always document in the data capture system the results of the Internal Assessment, to pull the data for the vaccination questions and have accurate data of what was documented. The MCO, met with staff, reviewed the documentation requirements, and put in place monitoring of the documentation to ensure all documentation is updated in the data capture system. The MCO might consider a claims review to compare the data and provide an analysis of the data.
Element 4 Overall Review Determination is that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant regarding subcomponent 5d, concerns were identified with correspondence of interventions to intervention tracking measures (ITMs). Although the MCO has updated some of the ITM data that was not apparent for active interventions in Table 1b (both Parts A and B), Y1 Q4 2020 has numerator zero, denominator zero, and rate as zero. When there is a zero in the denominator the rate will be N/A. The MCO should reflect the corrections in both parts A and B.
Element 6 Overall Review Determination is that the MCO is compliant.
Element 7 Overall Review Determination is that the MCO is compliant.
Element 8 Overall Review Determination is that the MCO is compliant.

Element 9 Overall Review Determination is that this PIP does not address Healthcare Disparities.
Overall, the MCO is compliant with this PIP for Sustainability Year reporting requirement; out of a maximum possible weighted score of 100 points, the MCO scored 85.0 points, which results in a rating of 85.0% (which is below 85% [≥ 85% being the threshold for meeting compliance]). Overall, the PIP interventions continued to be active and applicable to barriers identified and have noted successful movement toward the goals from the baseline for interventions #1a and #1b. The MCO continuously analyzed and implemented modifications to enhance the efficacy of the PIP activities noting new barriers and challenges due to Covid-19. The transition of NJ Choice (as this process was paused due to Covid-19) to an Internal Assessment process, not as face-to-face was also modified to telephonic communications. The MCO educated staff to changes in processes and workflows, however as they continued to analyze the data, another concern was identified, noting documentation concerns in Part A and Part B. The MCO took steps to remedy documentation and flaws in processes and continues to monitor. The MCO should review documentation concerns as potential threat to the validity of the PIP, analyze and provide the impact on the PIP in terms of successes, limitations, and outcomes. As changes occur, the MCO should continue to note the impact of Covid-19 on the PIP Part A and Part B.

UHCCP PIP 6: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: UnitedHealthcare Community Plan (UHCCP)
PIP Topic 6: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound	N/A					

methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.						
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight

7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 23, 2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Aim, 2b, goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark. The MCO states the Objective is "Implement Behavioral Health Care Coordination Program to improve the rate of follow up visits within 30 days of discharge after mental health hospitalization for MLTSS HCBS members from baseline to final measurement. "However the MCO does not describe this program, the processes used to implement the program nor does it state who will implement the program and what the timeline will be. The MCO notes the "preliminary 2021 baseline rate is higher than our short term and long-term goals. If final 2021 rate is higher than our short- and long-term goals, the goals will be revised higher for April submission"; the 2020 Benchmark, Quality Compass, 50th percentile cites a rate of 59.38%. It is unclear why the MCO

would initially cite the short term and long goals below this benchmark. The MCO should clarify and align the Aim Statements with the Objectives and Goals for consistency and accuracy throughout the PIP. Indicator 1 states in part, "The percentage of discharges for MLTSS HCBS members who were hospitalized for treatment of selected mental health disorders, "however the MCO does not include what the selected mental health disorders are. The MCO should define the "selected mental health disorders" to ensure accuracy of monitoring and inclusion into the PIP. The MCO should remove the instructional comment below the Aim Statement.

Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified regarding Methodology, 3c, Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes. The MCO has proposed only 1 indicator noting the eligible population to be "All MLTSS HCBS members who were hospitalized for treatment of selected mental health disorders (as defined in HEDIS® FUH measure specifications). "As noted above, the selected mental health disorders are not identified and cannot be monitored or tracked accordingly. The MCO has chosen only 1 indicator, however it does not describe if the indicator will be monitored monthly, quarterly, bi-annually in the interim or the processes utilized monitoring progression throughout the MY. Additionally, the MCO should remove the instructions under 1, Performance Indicators (pg.9) prior to submission.

Element 4 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Barrier Analysis, Interventions, and Monitoring Table 1a, 4d, QI Process data ("5 Why's", fishbone diagram). The MCO should consider using the "5 Whys" process to assist in root cause of why members are non-compliant. For example, Barrier #4, speaks to specific Social Determinants of Health (SDOH) that may prevent members from completing their follow-up appointments, however this subject in not discussed in the initial research or rational for this topic. The MCO should consider what SDOH are concerns in the member population, what geographic areas are impacted with this population as well as other areas noted in SDOH.

Element 5 Overall Review Determination was N/A.

Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.

Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.

Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Aim, Objectives and Goals, Methodology and Barrier Analysis. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

UHCCP – HEDIS Audit Review Table MY 2020

Audit Review Table				
AmeriChoice of New Jersey, Inc. dba UnitedHealthcare Community Plan (NJ) (Org ID: 1995, Sub ID: 8004, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)				
Measurement Year - 2020; Date & Timestamp - 06/03/2021 2:34 AM				
This submission is on the stage: PlanLock				
Measure/Data Element	**Benefit Offered**	**Rate**	**Audit Designation**	**Comment**
Effectiveness of Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		76.4%	R	Reported

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		68.37%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		65.45%	R	Reported
Childhood Immunization Status (CIS)				
Childhood Immunization Status - DTaP		65.45%	R	Reported
Childhood Immunization Status - IPV		82.24%	R	Reported
Childhood Immunization Status - MMR		83.94%	R	Reported
Childhood Immunization Status - HiB		84.18%	R	Reported
Childhood Immunization Status - Hepatitis B		71.29%	R	Reported
Childhood Immunization Status - VZV		82.24%	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		64.72%	R	Reported
Childhood Immunization Status - Hepatitis A		72.26%	R	Reported
Childhood Immunization Status - Rotavirus		60.58%	R	Reported
Childhood Immunization Status - Influenza		52.55%	R	Reported
Childhood Immunization Status - Combo 2		56.93%	R	Reported
Childhood Immunization Status - Combo 3		53.28%	R	Reported
Childhood Immunization Status - Combo 4		49.15%	R	Reported
Childhood Immunization Status - Combo 5		44.53%	R	Reported
Childhood Immunization Status - Combo 6		37.47%	R	Reported
Childhood Immunization Status - Combo 7		41.61%	R	Reported
Childhood Immunization Status - Combo 8		36.01%	R	Reported
Childhood Immunization Status - Combo 9		33.33%	R	Reported
Childhood Immunization Status - Combo 10		32.12%	R	Reported
Immunizations for Adolescents (IMA)				
Immunizations for Adolescents - Meningococcal		89.54%	R	Reported
Immunizations for Adolescents - Tdap		93.19%	R	Reported
Immunizations for Adolescents - HPV		32.6%	R	Reported
Immunizations for Adolescents - Combination 1		87.83%	R	Reported
Immunizations for Adolescents - Combination 2		31.39%	R	Reported
Lead Screening in Children (LSC)				
Lead Screening in Children		72.08%	R	Reported
Breast Cancer Screening (BCS)				
Breast Cancer Screening		59.27%	R	Reported
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening		61.8%	R	Reported
Chlamydia Screening in Women (CHL)				
Chlamydia Screening in Women (16-20)		59.49%	R	Reported
Chlamydia Screening in Women (21-24)		65.05%	R	Reported
Chlamydia Screening in Women (Total)		61.88%	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y			
Appropriate Testing for Pharyngitis (3-17)		84.96%	R	Reported
Appropriate Testing for Pharyngitis (18-64)		53.55%	R	Reported
Appropriate Testing for Pharyngitis (65+)		26.29%	R	Reported
Appropriate Testing for Pharyngitis (Total)		76.19%	R	Reported

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		34.32%	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		65.42%	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		82.8%	R	Reported
Asthma Medication Ratio (AMR)	Y			
Asthma Medication Ratio (5-11)		75.79%	R	Reported
Asthma Medication Ratio (12-18)		68.78%	R	Reported
Asthma Medication Ratio (19-50)		58.4%	R	Reported
Asthma Medication Ratio (51-64)		60.97%	R	Reported
Asthma Medication Ratio (Total)		64.6%	R	Reported
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure		59.85%	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y			
Persistence of Beta-Blocker Treatment After a Heart Attack		82.74%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		80.71%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		80.25%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		75.66%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		79.87%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		78.21%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		80.07%	R	Reported
Cardiac Rehabilitation (CRE)				
Cardiac Rehabilitation - Initiation (18-64)		1.32%	R	Reported
Cardiac Rehabilitation - Engagement1 (18-64)		1.76%	R	Reported
Cardiac Rehabilitation - Engagement2 (18-64)		1.62%	R	Reported
Cardiac Rehabilitation - Achievement (18-64)		0.73%	R	Reported
Cardiac Rehabilitation - Initiation (65+)		0.83%	R	Reported
Cardiac Rehabilitation - Engagement1 (65+)		0.83%	R	Reported
Cardiac Rehabilitation - Engagement2 (65+)		0.83%	R	Reported
Cardiac Rehabilitation - Achievement (65+)		0.83%	R	Reported
Cardiac Rehabilitation - Initiation (Total)		1.25%	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		1.62%	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		1.5%	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0.75%	R	Reported
Comprehensive Diabetes Care (CDC)				
Comprehensive Diabetes Care - HbA1c Testing		84.18%	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		37.96%	R	Reported

Comprehensive Diabetes Care - HbA1c Control (<8%)		53.77%	R	Reported
Comprehensive Diabetes Care - Eye Exams		57.42%	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		58.39%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)				
Kidney Health Evaluation for Patients With Diabetes (18-64)		29.2%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (65-74)		34.4%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (75-85)		29.67%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (Total)		30.23%	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y			
Statin Therapy for Patients With Diabetes - Received Statin Therapy		68.41%	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		75.08%	R	Reported
Antidepressant Medication Management (AMM)	Y			
Antidepressant Medication Management - Effective Acute Phase Treatment		62.44%	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		45.66%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		38.95%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		41.64%	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y			
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)		57.89%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)		26.32%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)		46.87%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)		27.79%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (65+)		47.54%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)		26.23%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		47.43%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		27.52%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)		71.49%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)		62.61%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)		59.71%	R	Reported

Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)		51.1%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)		56.45%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)		43.55%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		63.82%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		55.01%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)		37.93%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)		20.69%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)		18.75%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)		9.38%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		32.77%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		17.65%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)		11.9%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)		8.33%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		16.89%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		11.78%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		16.72%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		11.67%	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y			
Pharmacotherapy for Opioid Use Disorder (16-64)		21.86%	R	Reported
Pharmacotherapy for Opioid Use Disorder (65+)		36.21%	R	Reported
Pharmacotherapy for Opioid Use Disorder (Total)		22.57%	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	Y			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		84.4%	R	Reported

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia		70.56%	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		78.57%	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		71.64%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y			
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)		40.59%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)		27.23%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)		26.24%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)		58.55%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)		42.15%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)		40.75%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		52.78%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		37.36%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		36.09%	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.23%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)		91.03%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (18-64)		60.53%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (65+)		49.93%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (Total)		83.04%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)		51.63%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)		36.62%	R	Reported

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)		36.13%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		45.59%	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain		80.53%	R	Reported
Use of Opioids at High Dosage (HDO)	Y			
Use of Opioids at High Dosage		9.58%	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y			
Use of Opioids From Multiple Providers - Multiple Prescribers		11.4%	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.29%	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.63%	R	Reported
Risk of Continued Opioid Use (COU)	Y			
Risk of Continued Opioid Use - >=15 Days (18-64)		6.94%	R	Reported
Risk of Continued Opioid Use - >=31 Days (18-64)		4.25%	R	Reported
Risk of Continued Opioid Use - >=15 Days (65+)		16.56%	R	Reported
Risk of Continued Opioid Use - >=31 Days (65+)		8.45%	R	Reported
Risk of Continued Opioid Use - >=15 Days (Total)		7.99%	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		4.71%	R	Reported
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Adults' Access to Preventive/Ambulatory Health Services (20-44)		78.98%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (45-64)		86.95%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (65+)		91.64%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (Total)		83.63%	R	Reported
Annual Dental Visit (ADV)	Y			
Annual Dental Visit (2-3)		39.65%	R	Reported
Annual Dental Visit (4-6)		59.23%	R	Reported
Annual Dental Visit (7-10)		63.41%	R	Reported
Annual Dental Visit (11-14)		61.23%	R	Reported
Annual Dental Visit (15-18)		53.37%	R	Reported
Annual Dental Visit (19-20)		39.77%	R	Reported
Annual Dental Visit (Total)		56.18%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)		50%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)		0%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)		50%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)		0%	NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)		41.74%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)		5.73%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		51.24%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		13.64%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)		45.6%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)		7.82%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)		44.37%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)		8.03%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		41.74%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		5.73%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		51.24%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		13.64%	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		45.63%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		7.77%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		44.38%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		8.01%	R	Reported
Prenatal and Postpartum Care (PPC)				
Prenatal and Postpartum Care - Timeliness of Prenatal Care		83.21%	R	Reported
Prenatal and Postpartum Care - Postpartum Care		75.91%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)		67.92%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)		70.13%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		69.44%	R	Reported
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 30 Months of Life (First 15 Months)		43.64%	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		72.87%	R	Reported
Child and Adolescent Well-Care Visits (WCV)				
Child and Adolescent Well-Care Visits (3-11)		63.81%	R	Reported
Child and Adolescent Well-Care Visits (12-17)		57.28%	R	Reported
Child and Adolescent Well-Care Visits (18-21)		38.55%	R	Reported
Child and Adolescent Well-Care Visits (Total)		58.23%	R	Reported
Frequency of Selected Procedures (FSP)			R	Reported
Ambulatory Care (AMBa)			R	Reported
Ambulatory Care (AMBb)			R	Reported
Ambulatory Care (AMBc)			R	Reported
Ambulatory Care (AMBd)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUb)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUc)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUd)			R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADb)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADc)	Y		R	Reported

Identification of Alcohol and other Drug Services (IADd)	Y		R	Reported
Mental Health Utilization (MPTa)	Y		R	Reported
Mental Health Utilization (MPTb)	Y		R	Reported
Mental Health Utilization (MPTc)	Y		R	Reported
Mental Health Utilization (MPTd)	Y		R	Reported
Antibiotic Utilization (ABXa)	Y		R	Reported
Antibiotic Utilization (ABXb)	Y		R	Reported
Antibiotic Utilization (ABXc)	Y		R	Reported
Antibiotic Utilization (ABXd)	Y		R	Reported
Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)			R	Reported
Health Plan Descriptive Information				
Enrollment by Product Line (ENPa)			R	Reported
Enrollment by Product Line (ENPb)			R	Reported
Enrollment by Product Line (ENPc)			R	Reported
Enrollment by Product Line (ENPd)			R	Reported
Enrollment by State (EBS)			R	Reported
Language Diversity of Membership (LDM)			R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	Reported
Total Membership (TLM)			R	Reported
Electronic Clinical Data Systems				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening		59.11%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		38.91%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		41.44%	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)				
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0%	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NA	Small Denominator
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)				
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0%	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)				

Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NA	Small Denominator
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	Small Denominator
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	Small Denominator
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)				
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0%	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	Small Denominator
Adult Immunization Status (AIS-E)				
Adult Immunization Status - Influenza		14.65%	R	Reported
Adult Immunization Status - Td/Tdap		22.28%	R	Reported
Adult Immunization Status - Zoster		0.95%	R	Reported
Prenatal Immunization Status (PRS-E)				
Prenatal Immunization Status - Influenza		24.59%	R	Reported
Prenatal Immunization Status - Tdap		28.78%	R	Reported
Prenatal Immunization Status - Combination		14.93%	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)				
Prenatal Depression Screening and Follow-Up - Depression Screening		0%	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	Small Denominator
Postpartum Depression Screening and Follow-Up (PDS-E)				
Postpartum Depression Screening and Follow-Up - Depression Screening		0%	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	Small Denominator

WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

WCHP 2021 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	27	30	27	27	3	0	90%	2	1	1
Care Management and Continuity of Care - MLTSS*	10	10	10	10	10	0	0	100%	0	0	0
Access	14	12	14	12	12	2	0	86%	1	1	1
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[5]	20	19	20	18	18	2	0	90%	0	0	2
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	44	44	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	11	11	11	0	0	100%	0	0	0
Satisfaction	5	4	5	5	5	0	0	100%	0	1	0
Enrollee Rights and Responsibilities	8	8	8	8	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	10	10	10	0	0	100%	0	0	0
Utilization Management	30	28	30	28	28	1	1	97%	0	2	1
Administration and Operations[6]	14	13	14	14	14	0	0	100%	0	0	0
Management Information Systems	18	18	18	18	18	0	0	100%	0	0	0
TOTAL	**198**	**191**	**198**	**192**	**192**	**5**	**1**	**97%**	**1**	**4**	**4**

1 A total of 83 elements were reviewed in the previous review period; of these 83, 78 were Met, 5 were Not Met. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

2 The MCO was subject to a full review in this review period. All elements were subject to review.

3 Elements that were Met in this review period.

4 The compliance score is calculated as the number of Met elements over the number of applicable elements. The denominator is number of total elements minus N/A elements. The numerator is the number of Met elements.

5 In 2021,QM11 was subdivided into QM11a (Core Medicaid PIPs) and QM11b (MLTSS PIPs).

6 AO14 was added as a new element for Core Medicaid in 2021.

*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Correction Action Plans (CAPs) as applicable.

WCHP Performance Improvement Projects

WCHP PIP 1: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 1: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M	PM	
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M	M	
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M	M	
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**	**PM**	
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**50**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**2.5**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M	M	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M	
2c. Objectives align aim and goals with interventions	N/A	M	M	M	M	
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	

Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M	M	
3b. Performance indicators are measured consistently over time	N/A	M	M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	PM	M	M	M	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	PM	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	M	N/A	N/A	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**	
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	**100**	
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**15.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	PM	

4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M	
4f. Literature review	N/A	M	M	M	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	**PM**	
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**50**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**7.5**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	M	N/A	M	
5b. Actions that target member, provider and MCO	N/A	M	M	N/A	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	N/A	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M	N/A	M	
Element 5 Overall Review Determination	**N/A**	**M**	**M**	**N/A**	**M**	
Element 5 Overall Score	**N/A**	**100**	**100**	**N/A**	**100**	
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**N/A**	**15.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M	M	
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**	
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**	
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	PM	M	

7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**100**	**100**	**50**	**100**	
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**10.0**	**20.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**M**	**Y**	**Y**	**y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**80.0**	**75.0**	**90.0**
Overall Rating	**N/A**	**90.6%**	**100%**	**88.2%**	**90.0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

[2] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Sustainability Phase).

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Final Report
IPRO Comments:

Element 1 Overall Review Determination was that the Managed Care Organization (MCO) is partially compliant regarding 1a. On page 2, the Change Table appeared to have inconsistent dates of changes noted on the Barrier Analyses, which did not align with the narrative's description and/or timing of Barrier Analyses. This concern was noted during the last submission although has not been updated. The MCO should ensure that these dates are consistent so changes can be easily tracked and reconciled in the narrative, which reinforces continuous process improvement in the PIP.

Element 2 Overall Review Determination was that the MCO is compliant.

Element 3 Overall Review Determination was that the MCO is compliant.

Element 4 Overall Review Determination was that the MCO is partially compliant regarding subcomponent 4d, QI Process Data. The MCO is partially compliant with subcomponent 4d in regard to the alignment of dates of changes in Methodology, Barrier Analysis and Terminations of Interventions documented consistently from the Change Table on page 2-3, to the Barrier Analysis, Interventions and Monitoring (Table 1a), to Table 1b: Quarterly Reporting and Rates for Intervention Tracking Measures. Table 1a does not appear to be in full alignment with the ITM start dates. While the Change Table documents dates of change for chronological order purposes, it is unclear if the date of change reflected on the Change Table is the date (MM/DD/YYYY) the change was implemented by the MCO and clearly aligns with the Barrier Analysis, Interventions and Monitoring as well Table 1b is updated in alignment with the implementation date of the change. The MCO should also review and update Table 1b for alignment with start dates and documenting the appropriate writing conventions. For example, ITM 2d-2h Y1Q4 2018, are documented as N/A although the start date is 11/1/2018 and should exhibit November and December 2018 data (even if there is zero in the denominator). There are additional ITMs that appear to express a gap in reporting throughout Table b. The MCO should review the data tables, update for accuracy in case of future use and consider using footnotes to explain any discrepancy or omission of data at the end of each table.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that MCO identified racial and ethnic disparities in blood lead levels in children less than 3 years of age.
Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Overall, the MCO clearly monitored and reported updates inclusive of intervention progress or limitations from the Baseline, inclusive of interpretation of progressive outcomes year over year, noting both successes and limitations along the way. As noted above the volume of referrals to the MCO's Care Management team was a material concern specifically noted in 2019 regarding sustainability. The MCO sought out the means to access additional data through the Progeny Vendor (the MCO's NICU Case Management vendor), which initially made possible the addition of 70 new pre-term members in 2019. However, although these eligible pre-term infants were successfully referred to Care Management, a data sharing challenge was identified with joint use of the MCO's in-house ID number with the vendor, which the MCO continues to pursue for potential use in the future. Although the MCO did not reach their final Goals, the MCO exhibited progressive movement forward noting the relationship between the MCO's Care Management and Quality Teams which continue to work together to seek out opportunities that will support and enhance projects through collaboration, integrating additional modalities such as the Progeny vendor accessing readily available data, as well as looking toward other avenues of referral sources to enhance, strengthen and move projects forward with data, consistent monitoring and follow up. The MCO discussed Covid -19 and the impact throughout MY 2020, inclusive of potential limitations and obstacles to achieving stated Goals. However, as Covid continues to be of concern there is not a clear outcome to the impact on this PIP. However, the MCO continues to take into account the safety of staff, members and their families with continuous communications to and from providers.

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 2: MCO Adolescent Risk Behaviors and Depression Collaborative

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		

3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	PM	PM		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	**M**		
Element 4 Overall Review Determination	**N/A**	**M**	**PM**	**PM**		
Element 4 Overall Score	**N/A**	**100**	**50**	**50**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**7.5**	**7.5**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis		M	N/A	M		
5b. Actions that target member, provider and MCO	N/A	M	N/A	M		
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**N/A**	**50**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**7.5**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight

7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**	
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**0**
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**52.5**	**57.5**	**85.0**	**0**
Overall Rating	**N/A**	**87.5%**	**88.5%**	**85.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 22, 2021
Report Period: Sustainability
IPRO Comments:

Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is partially compliant in regard to Barrier Analysis subcomponent 4d. The MCO was partially compliant with aligning and updates to the Barrier Analysis, Intervention and Monitoring Table 1a. The Barrier Analysis, Interventions, and Monitoring Table 1a, column Intervention Timeframe exhibits Start Dates however no end dates are documented. The MCO should update Table 1a reflecting the expected end dates.
Element 5 Overall Review Determination was that the MCO is partially compliant with the robustness of the interventions, 5d. Table 1b - Quarterly Reporting of Rates for Intervention Tracking Measures, exhibits multiple data points not provided throughout the Table. It is noted that one provider stands out in reviewing the data that is not participating at the same level as the other 2 providers exhibiting in Y2 Q4 and SY Q3, data has not been provided for the

MCO to review and tabulate on Table 1b. The MCO notes that two of the three providers are engaged with the process and contribute to the discussions and planning potential changes that enhance their practices. One provider is presently disengaged which creates a sizable reduction to the provider participation and potentially generalizes abstracted data as a result. The MCO should continue to re-engage this provider and continue to report progress and /or developments in the re-engaging this provider. It was also noted on page 48, Table 1b, ITM 3b - Y2Q3 and Y2Q4 of 2020 do not have any data, N/A or other designation for review. The MCO should review if there is data for the ITM and complete the table for the Final Report in August 2022.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is complaint.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that the MCO did not address a healthcare disparity.

Overall, the MCO is compliant with this PIP for the Sustainability reporting requirement; out of a maximum possible weighted score of 100.0 points, the MCO scored 85.0 points, which results in a rating of 85.0% (which is equal to 85% [≥ 85% being the threshold for meeting compliance]). Generally, the MCO clearly and comprehensively reported key updates, including baseline and intervention progress, as well as interpretation of results with disclosures of noteworthy limitations in year-over-year comparisons. The MCO identified areas of opportunity with regard to improving medical record documentation, use of standardization of forms, and collaborations with the providers as a means to continually modify and enhance PIP activities. The MCO has a tracking of the collaboration between the Providers and the MCO staff (pg. 81) that exhibit how the two engaged providers have made progress in enhancing their practices with the improvement projects. The MCO discussed the impact of COVID-19 on the PIP activity for the Y2 Q2-Y2Q4 of 2020 and notes that collaborative meetings are continuing to provide updates; in consideration to the evolving circumstances, the MCO notes active monitoring and evaluation of providers and facilitation of communications in tandem with ensuring safety of staff members, patients, and their families.

WCHP PIP 3: Medicaid Primary Care Physician Access and Availability

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 3: Medicaid Primary Care Physician Access and Availability

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M				
1b. Impacts the maximum proportion of members that is feasible	N/A	M				
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M				
1d. Reflects high-volume or high risk-conditions	N/A	M				
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M				
Element 1 Overall Review Determination	**N/A**	**M**				
Element 1 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M				

2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M				
2c. Objectives align aim and goals with interventions	N/A	M				
Element 2 Overall Review Determination	**N/A**	**M**				
Element 2 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM				
3b. Performance indicators are measured consistently over time	N/A	M				
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M				
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M				
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M				
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M				
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M				
Element 3 Overall Review Determination	**N/A**	**PM**				
Element 3 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M				
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M				
4c. Provider input at focus groups and/or Quality Meetings	N/A	M				
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M				
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M				
4f. Literature review	N/A	M				
Element 4 Overall Review Determination	**N/A**	**M**				
Element 4 Overall Score	**N/A**	**100**	**0**	**0**	**0**	

Element 4 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis		M				
5b. Actions that target member, provider and MCO	N/A	M				
5c. New or enhanced, starting after baseline year	N/A	M				
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM				
Element 5 Overall Review Determination	**N/A**	**PM**				
Element 5 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M				
Element 6 Overall Review Determination	**N/A**	**M**				
Element 6 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M				
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M				
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M				
7d. Lessons learned & follow-up activities planned as a result	N/A	M				
Element 7 Overall Review Determination	**N/A**	**M**				
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A				
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A				
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**0.0**	**0.0**	**0.0**	
Non-Scored Element: Element 9. Healthcare Disparities						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**				

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
Reporting Period: Year 1
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is partially compliant with regard to subcomponent 3a, Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria). PI # 3 specifies office-based visits and PI #4 specifies visits in the ER and Urgent Care. For both PIs, the denominator criterion remains listed as the same without clarification regarding the "Member months with the respected selected cohort". The MCO has revised the PIs from five descriptive items to three descriptive items, however, continues to need additional clarification regarding who the "respected selected cohort" represents. The MCO has identified 28 provider groups that will participate in the PIP project and have outreached each for education regarding educational information for non-emergent ER/Urgent Care visits that may be provided from the PCP office. The MCO should clarify if all 28 provider groups are inclusive in the denominator for PIs #3 and # 4.
Element 4 Overall Review Determination was that the MCO was compliant.
Element 5 Overall Review Determination was partially compliant regarding 5d, with corresponding monthly or quarterly intervention tracking measures.
In Table 1a (Alignment of Barriers, Interventions and Intervention Tracking Measures [ITMs]), For Intervention #3, there is insufficient specificity of data collection and distribution to the PCP providers to valid any true impact regarding utilization of primary care services. The MCO should note how often the Network will contact the provider to discuss services rendered outside of the primary care office as monthly, quarterly, bi-annually or annually for tracking progress made from each contact. For ITM #3, the MCO states on page 26 of the 2021 update ITM #3, "A tracking log has been created to ensure all providers are outreached as appropriate." However, it is unclear how the information in the log is communicated to the providers. On page 13, Data Analysis, It states "In the measurement year, administrative claims results will be pulled for the specific targeted providers/groups and selected population on a quarterly basis and annual basis". The MCO should clarify the specifics regarding distribution to the providers in the cohort and align with the Barrier Analysis to understand the impact of the intervention over the life of the PIP. The MCO should update the Change Table to reflect 1b as a new ITM with the date of inclusion to the PIP.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO was compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that the MCO did not address health disparities.
Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 65.0 points, which results in a rating of 81.3% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made enhancement to an identified concern regarding aspects of the proposed aim, methodology, and an intervention, noting the performance Indicator (PI) #3 has been updates from a zero to the Baseline Rate of 3503 visits per 1000 on the Table on page 7. Additionally, the MCO reviewed and revised PI # 3 and PI #4 to clarify denominator criterion specific to the number of provider groups, however the MCO should add additional clarity as noted above in Element 3a. In addition, it is noted that the Appendix D: NYU ER Algorithm for Diagnosis

inclusion was not available in the submission. The MCO should ensure that all references cited are attached for review. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

WCHP PIP Topic 4: Improving Early and Periodic Screening diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 4: Improving Early and Periodic Screening diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	**N/A**					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					
Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	

Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: December 3, 2021
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A.
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified with the aspects of Methodology, 3a, performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria). For Indicator #1, the MCO notes the data source as Xcelys (WellCare's claims data base) regarding the query for diagnoses, however, does not identify the written description for the ICD-10 codes trigger. The MCO should consider adding an appendix with the codes and descriptions of what the MCO is measuring in order to fully understand what triggers are utilized and measured. Under Data Collection and Analysis, "Is the entire population being targeted by the PIP interventions?", the MCO discusses the revision of W15 to W30, as well as for measurement years 1-3 and before

the final HEDIS reporting, the MCO will capture the potential population for each of the PIs from which a sample of each population will be drawn on the following method. However, under Sampling the MCO notes N/A which is confusing. The MCO should review this section and clearly document sample methodologies if the MCO intends to use a sample population. For example, under Data Collection page 13, Medical Record: a sampled members' medical records will be requested from 2 providers per year with electronic medical records a first consideration. Although, under Data Analysis it states, "In the MY, administrative claims results will be pulled for the specific targeted providers/ groups and selected population on an annual basis. The MCO should identify the targeted providers/groups and describe the sample methodology, sample size, and justification for the sample.

Element 4 Overall Review Determination was N/A. Although not scored, the MCO has chosen to use 2019 for a baseline capturing 2019 W15 data as well as W30 internal historical data. The MCO should discuss the progression of the data from baseline comparing to the revised Well Child Visit measure, noting any changes during the 2021 implementation phase of the PIP and updating and discussing as appropriate for April 2021 submission. The MCO should also review 2020 data for the COVID-19 impact in the April 2022 submission as well August updated data, edits or changes to the PIP.

Element 5 Overall Review Determination was N/A. Although not scored, a concern was identified regarding Robust Interventions, 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). The MCO is providing education to the members on several levels to encourage adherence to meeting the well child visits and immunization schedules for the W30 and CIS measures. However, the MCO does not define how the MCO will validate that the education was the reason for the increased adherence to well child visits/immunizations. The MCO should consider a mechanism to understand the impact of the mailing and validate what prompted any increase in adherence to well child visits /immunizations.

Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.

Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.

Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Methodology and Robust Interventions. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 5: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis

New Jersey MCO PIP Scoring Report PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A	M	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M	M		

3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M		
4f. Literature review	N/A	M	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A	M	NA	M		
5b. Actions that target member, provider and MCO	N/A	M	NA	M		

5c. New or enhanced, starting after baseline year	N/A	M	NA	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	NA	M		
Element 5 Overall Review Determination	**N/A**	**PM**	**NA**	**M**		
Element 5 Overall Score	**N/A**	**50**	**NA**	**100**	**0**	
Element 5 Weighted Score	**N/A**	**7.5**	**NA**	**15.0**	**0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	M	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**	
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	PM		
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**PM**		
Element 7 Overall Score	**N/A**	**0**	**100**	**50**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**20.0**	**10.0**	**0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**	

Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**52.5**	**65.0**	**90.0**	**0**
Overall Rating	**N/A**	**87.5%**	**100.0%**	**90.0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan).

[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Findings Phase).

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 10, 2021
Reporting Period: Sustainability
IPRO Comments:
Element 1 Overall Review Determination was that the Managed Care Organization (MCO) is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is complaint.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant in regard 7d. The MCO has monitored and updated each of the interventions separately however, there is little discussion regarding potential of Sustainability. The MCO should begin to pull the information together to review what has been working and what has not worked allowing the lessons of the project to come through. In this manner, the MCO can confirm what interventions may be sustainable to achieve and sustain the goals of the PIP. The MCO has aptly acknowledged data collection challenges over MY1 and MY2 due to the use of a manual process for tracking Care Management activities. The MCO has noted that this process is being transitioned into electronic media thereby enhancing the data collection process for the Care Management Activities. The MCO should discuss further the potential threat to the validity of the data, noting the use of the modified Interventions Tracking Grid to collect and report data by unique members. The MCO should detail the lessons learned in the Final Report, summarizing all aspects of the PIP and potential plan to improve the quality of care for the members moving forward.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that healthcare disparities are not identified, evaluated, and addressed.
Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is at or above 85% [≥ 85% being the threshold for meeting compliance]). Overall, the MCO continues to monitor the interventions, capturing data, despite the Covid 19 pandemic and adjusting course of the PIP when and where it's needed. The MCO continues to engage the members, with use of telephonic communications (in lieu of Face-to-Face meetings) in the interim. The MCO discussed in the last submission the impact of Covid-19 and provided the appropriate reasoning for continuing to use the existing cohort (1) of eligible members for the second year of implementation instead of adding a second as previously planned. For the sustainability year, the MCO is planning to adjust the methodology and expand its evaluation to the next cohort of eligible members. The MCO should review each section of the PIP, ensure dates and corresponding actions are documented with the rationale and analysis of how each intervention impacts and/or supports the performance outcomes and the overall

goals of the PIP. As changes continue to arise regarding Covid-19, the MCO should continue to monitor and detail the potential impact on the interventions of the PIP.

WCHP PIP 6: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 6: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Element 1. Topic/ Rationale Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)						5% weight
1a. Attestation signed & Project Identifiers Completed	N/A					
1b. Impacts the maximum proportion of members that is feasible	N/A					
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A					
1d. Reflects high-volume or high risk-conditions	N/A					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A					
Element 1 Overall Review Determination	**N/A**					
Element 1 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 2. Aim Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)						5% weight
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A					
2c. Objectives align aim and goals with interventions	N/A					
Element 2 Overall Review Determination	**N/A**					
Element 2 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)						15% weight
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A					
3b. Performance indicators are measured consistently over time	N/A					

3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A					
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
Element 3 Overall Review Determination	**N/A**					
Element 3 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.						15% weight
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:						
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A					
4c. Provider input at focus groups and/or Quality Meetings	N/A					
4d. QI Process data ("5 Why's", fishbone diagram)	N/A					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A					
4f. Literature review	N/A					
Element 4 Overall Review Determination	**N/A**					
Element 4 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.						15% weight
5a. Informed by barrier analysis	N/A					
5b. Actions that target member, provider and MCO	N/A					
5c. New or enhanced, starting after baseline year	N/A					
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A					

Element 5 Overall Review Determination	**N/A**					
Element 5 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.						5% weight
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A					
Element 6 Overall Review Determination	**N/A**					
Element 6 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.						20% weight
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A					
7d. Lessons learned & follow-up activities planned as a result	N/A					
Element 7 Overall Review Determination	**N/A**					
Element 7 Overall Score	**N/A**	**0**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**	
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.						20% weight
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A			
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**			
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**	
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**						
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**					

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0%**	**0%**	**0%**	**0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 23,2021
Reporting Period: Proposal Findings
IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.
Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A. Although not scored, a concern was identified with aspects of the Aim, Objectives and Goals, 2b, Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark. The MCO notes Performance Indicators (PIs) #1, #2, and #3 do not have a Benchmark for comparison, nor do indicators #2 and #3 have Baseline line data. Indicators #2 and #3 have asterisks for the footnote which states indicators 1 and 2 represents a 10% increase per measurement year, which is confusing. It is unclear how the MCO will measure a 10% increase without baseline data or a benchmark. The MCO should clarify the footnote and update the data for indicators #2 and #3 with baseline data for 2019 aligning the table (goals pg. 8) in order to monitor and trend year over year progress.
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified regarding Methodology, 3a, Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria). The MCO provides Performance Indicator #1 (pgs. 9-11) with a table of ICD-10 diagnosis codes used to identify the eligible population (Behavioral Health Value Set 2019). The MCO might consider providing a table with written diagnoses to correspond with the codes in order understand clearly what diagnoses are the most concerning that exhibit poor compliance with follow-up care. The MCO has provided a baseline for inpatient discharges (indicator 1) with a behavior health diagnosis which can provide the data identifying the top diagnoses for the MCO to focus initial efforts on. Additionally, PI #1, is presented in alignment with the goals table on pg. 8, however PI #2 on pg. 12 aligns with Indicator #3 on page 8. Indicator #2 is not present for description of numerator, denominator, eligible population and exclusions. The MCO should review and update the PIs aligning Aim, Objectives and Goals. Under Data Analysis, identification of eligible population is insufficient as a description of the data analysis process and the staff that are involved. The MCO should explain the data analysis process in detail inclusive of the staff performing the analysis, systems utilized and timeline for collection and reporting.

Element 4 Overall Review Determination was N/A.
Element 5 Overall Review Determination was N/A.
Element 6 Overall Review Determination was N/A. Although results are not evaluated at the proposal phase, the MCO should include the Baseline data noting the Baseline period is 2019 and/or an explanation of how the MCO arrived at a 10% long term goals without a baseline. The MCO might consider researching state information the PIs #2 and #3 regarding SDOH and use of Behavioral Health screening tools.
Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement is not evaluated at the proposal phase.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have been assessed, based on race/ethnicity and sex, and identified White males (14/52) and determined due to the low number not to proceed at this time.
For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the proposed Methodology and Barrier Analysis. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2022 submissions. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

WCHP – HEDIS Audit Review Table MY 2020

Audit Review Table				
WellCare Health Plans of New Jersey, Inc. (Org ID: 10793, Sub ID: 11953, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)				
Measurement Year - 2020; Date & Timestamp - 06/08/2021 7:00 PM				
This submission is on the stage: PlanLock				
Measure/Data Element	**Benefit Offered**	**Rate**	**Audit Designation**	**Comment**
Effectiveness of Care				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		85.97%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		82.09%	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.1%	R	Reported
Childhood Immunization Status (CIS)				
Childhood Immunization Status - DTaP		69.83%	R	Reported
Childhood Immunization Status - IPV		85.64%	R	Reported
Childhood Immunization Status - MMR		87.83%	R	Reported
Childhood Immunization Status - HiB		84.18%	R	Reported
Childhood Immunization Status - Hepatitis B		77.37%	R	Reported
Childhood Immunization Status - VZV		85.89%	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		65.94%	R	Reported
Childhood Immunization Status - Hepatitis A		75.67%	R	Reported
Childhood Immunization Status - Rotavirus		62.29%	R	Reported
Childhood Immunization Status - Influenza		48.42%	R	Reported
Childhood Immunization Status - Combo 2		60.1%	R	Reported
Childhood Immunization Status - Combo 3		54.01%	R	Reported
Childhood Immunization Status - Combo 4		50.61%	R	Reported
Childhood Immunization Status - Combo 5		44.28%	R	Reported
Childhood Immunization Status - Combo 6		36.01%	R	Reported
Childhood Immunization Status - Combo 7		42.34%	R	Reported
Childhood Immunization Status - Combo 8		34.79%	R	Reported
Childhood Immunization Status - Combo 9		29.93%	R	Reported
Childhood Immunization Status - Combo 10		29.2%	R	Reported
Immunizations for Adolescents (IMA)				
Immunizations for Adolescents - Meningococcal		83.21%	R	Reported
Immunizations for Adolescents - Tdap		89.54%	R	Reported
Immunizations for Adolescents - HPV		31.14%	R	Reported
Immunizations for Adolescents - Combination 1		81.75%	R	Reported
Immunizations for Adolescents - Combination 2		28.47%	R	Reported
Lead Screening in Children (LSC)				
Lead Screening in Children		76.3%	R	Reported

Breast Cancer Screening (BCS)				
Breast Cancer Screening		61.09%	R	Reported
Cervical Cancer Screening (CCS)				
Cervical Cancer Screening		52.61%	R	Reported
Chlamydia Screening in Women (CHL)				
Chlamydia Screening in Women (16-20)		61.57%	R	Reported
Chlamydia Screening in Women (21-24)		62.51%	R	Reported
Chlamydia Screening in Women (Total)		62.08%	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y			
Appropriate Testing for Pharyngitis (3-17)		73.73%	R	Reported
Appropriate Testing for Pharyngitis (18-64)		28.56%	R	Reported
Appropriate Testing for Pharyngitis (65+)		10.43%	R	Reported
Appropriate Testing for Pharyngitis (Total)		54.83%	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		43.55%	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y			
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		59.94%	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		87.82%	R	Reported
Asthma Medication Ratio (AMR)	Y			
Asthma Medication Ratio (5-11)		68.85%	R	Reported
Asthma Medication Ratio (12-18)		62.75%	R	Reported
Asthma Medication Ratio (19-50)		44.65%	R	Reported
Asthma Medication Ratio (51-64)		49.3%	R	Reported
Asthma Medication Ratio (Total)		50.93%	R	Reported
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure		53.77%	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y			
Persistence of Beta-Blocker Treatment After a Heart Attack		83.33%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y			
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		85.42%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		76.59%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		80.12%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		79.63%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		82.59%	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		78.16%	R	Reported
Cardiac Rehabilitation (CRE)				
Cardiac Rehabilitation - Initiation (18-64)		2.05%	R	Reported
Cardiac Rehabilitation - Engagement1 (18-64)		4.79%	R	Reported

Cardiac Rehabilitation - Engagement2 (18-64)		5.48%	R	Reported
Cardiac Rehabilitation - Achievement (18-64)		4.11%	R	Reported
Cardiac Rehabilitation - Initiation (65+)		0%	R	Reported
Cardiac Rehabilitation - Engagement1 (65+)		0%	R	Reported
Cardiac Rehabilitation - Engagement2 (65+)		0%	R	Reported
Cardiac Rehabilitation - Achievement (65+)		0%	R	Reported
Cardiac Rehabilitation - Initiation (Total)		1.69%	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		3.93%	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		4.49%	R	Reported
Cardiac Rehabilitation - Achievement (Total)		3.37%	R	Reported
Comprehensive Diabetes Care (CDC)				
Comprehensive Diabetes Care - HbA1c Testing		85.19%	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		39.26%	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		53.83%	R	Reported
Comprehensive Diabetes Care - Eye Exams		57.04%	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		56.05%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)				
Kidney Health Evaluation for Patients With Diabetes (18-64)		32.41%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (65-74)		35.09%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (75-85)		27.75%	R	Reported
Kidney Health Evaluation for Patients With Diabetes (Total)		32.45%	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y			
Statin Therapy for Patients With Diabetes - Received Statin Therapy		73.34%	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		71.99%	R	Reported
Antidepressant Medication Management (AMM)	Y			
Antidepressant Medication Management - Effective Acute Phase Treatment		58.09%	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		44.07%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		34.23%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		54.55%	NA	Small Denominator
Follow-up After Hospitalization for Mental Illness (FUH)	Y			
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)			NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)			NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)		42.17%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)		21.69%	R	Reported

Follow-Up After Hospitalization For Mental Illness - 30 days (65+)		44.44%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 7 days (65+)		22.22%	NA	Small Denominator
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		42.57%	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		21.78%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y			
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)		66.67%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)		56.06%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)		66.67%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)		50%	NA	Small Denominator
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		66.67%	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		55.13%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)			NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)		52%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)		40%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)		0%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)		0%	NA	Small Denominator
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		39.39%	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		30.3%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)			NA	Small Denominator
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		7.89%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		3.95%	R	Reported

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		7.89%	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		3.95%	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y			
Pharmacotherapy for Opioid Use Disorder (16-64)		29.37%	R	Reported
Pharmacotherapy for Opioid Use Disorder (65+)		35.71%	NA	Small Denominator
Pharmacotherapy for Opioid Use Disorder (Total)		29.53%	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	Y			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		75.47%	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)				
Diabetes Monitoring for People With Diabetes and Schizophrenia		79.92%	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		84.38%	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		71.47%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y			
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)		38.64%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)		29.55%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)		29.55%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)		62.67%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)		46.67%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)		45.33%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		53.78%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		40.34%	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		39.5%	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)				

Non-Recommended Cervical Cancer Screening in Adolescent Females		2.06%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y			
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)		91%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (18-64)		56.9%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (65+)		47.31%	R	Reported
Appropriate Treatment for Upper Respiratory Infection (Total)		79.88%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y			
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)		45.57%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)		33.62%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)		25.36%	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		39.87%	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)				
Use of Imaging Studies for Low Back Pain		79.64%	R	Reported
Use of Opioids at High Dosage (HDO)	Y			
Use of Opioids at High Dosage		7.43%	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y			
Use of Opioids From Multiple Providers - Multiple Prescribers		9.39%	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.49%	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.74%	R	Reported
Risk of Continued Opioid Use (COU)	Y			
Risk of Continued Opioid Use - >=15 Days (18-64)		10.97%	R	Reported
Risk of Continued Opioid Use - >=31 Days (18-64)		5.48%	R	Reported
Risk of Continued Opioid Use - >=15 Days (65+)		17.87%	R	Reported
Risk of Continued Opioid Use - >=31 Days (65+)		8.59%	R	Reported
Risk of Continued Opioid Use - >=15 Days (Total)		11.96%	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		5.93%	R	Reported
Access/Availability of Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Adults' Access to Preventive/Ambulatory Health Services (20-44)		67.44%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (45-64)		83.57%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (65+)		92.7%	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (Total)		77.32%	R	Reported
Annual Dental Visit (ADV)	Y			
Annual Dental Visit (2-3)		31.55%	R	Reported

Annual Dental Visit (4-6)		47.31%	R	Reported
Annual Dental Visit (7-10)		51.8%	R	Reported
Annual Dental Visit (11-14)		48.59%	R	Reported
Annual Dental Visit (15-18)		41.8%	R	Reported
Annual Dental Visit (19-20)		28.5%	R	Reported
Annual Dental Visit (Total)		44%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)			NA	Small Denominator
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)		44.19%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)		1.16%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		41.79%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		4.48%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)		46.38%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)		2.9%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)		41.67%	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)		2.94%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		44.19%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		1.16%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		41.79%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		4.48%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		46.38%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		2.9%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		41.67%	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		2.94%	R	Reported
Prenatal and Postpartum Care (PPC)				
Prenatal and Postpartum Care - Timeliness of Prenatal Care		85.89%	R	Reported
Prenatal and Postpartum Care - Postpartum Care		67.15%	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)			NA	Small Denominator
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)			NA	Small Denominator
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)			NA	Small Denominator
Utilization				
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 30 Months of Life (First 15 Months)		50.61%	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		76.33%	R	Reported
Child and Adolescent Well-Care Visits (WCV)				
Child and Adolescent Well-Care Visits (3-11)		66.45%	R	Reported
Child and Adolescent Well-Care Visits (12-17)		59.1%	R	Reported
Child and Adolescent Well-Care Visits (18-21)		37.21%	R	Reported
Child and Adolescent Well-Care Visits (Total)		59.35%	R	Reported
Frequency of Selected Procedures (FSP)			R	Reported
Ambulatory Care (AMBa)			R	Reported
Ambulatory Care (AMBb)			R	Reported

Ambulatory Care (AMBc)			R	Reported
Ambulatory Care (AMBd)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUb)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUc)			R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUd)			R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADb)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADc)	Y		R	Reported
Identification of Alcohol and other Drug Services (IADd)	Y		R	Reported
Mental Health Utilization (MPTa)	Y		R	Reported
Mental Health Utilization (MPTb)	Y		R	Reported
Mental Health Utilization (MPTc)	Y		R	Reported
Mental Health Utilization (MPTd)	Y		R	Reported
Antibiotic Utilization (ABXa)	Y		R	Reported
Antibiotic Utilization (ABXb)	Y		R	Reported
Antibiotic Utilization (ABXc)	Y		R	Reported
Antibiotic Utilization (ABXd)	Y		R	Reported
Risk Adjusted Utilization				
Plan All-Cause Readmissions (PCR)			R	Reported
Health Plan Descriptive Information				
Enrollment by Product Line (ENPa)			R	Reported
Enrollment by Product Line (ENPb)			R	Reported
Enrollment by Product Line (ENPc)			R	Reported
Enrollment by Product Line (ENPd)			R	Reported
Enrollment by State (EBS)			R	Reported
Language Diversity of Membership (LDM)			R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	Reported
Total Membership (TLM)			R	Reported
Electronic Clinical Data Systems				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening		60.98%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y			
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		34.23%	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		54.55%	NA	Small Denominator
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)				
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0%	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NA	Small Denominator

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)				
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)		0%	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0%	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)				
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NA	Small Denominator
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	Small Denominator
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	Small Denominator
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)				
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0%	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	Small Denominator
Adult Immunization Status (AIS-E)				
Adult Immunization Status - Influenza		14.43%	R	Reported
Adult Immunization Status - Td/Tdap		15.97%	R	Reported
Adult Immunization Status - Zoster		0.9%	R	Reported
Prenatal Immunization Status (PRS-E)				
Prenatal Immunization Status - Influenza		20.16%	R	Reported
Prenatal Immunization Status - Tdap		29.65%	R	Reported
Prenatal Immunization Status - Combination		13.26%	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)				
Prenatal Depression Screening and Follow-Up - Depression Screening		0%	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	Small Denominator
Postpartum Depression Screening and Follow-Up (PDS-E)				
Postpartum Depression Screening and Follow-Up - Depression Screening		0%	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	Small Denominator

Appendix B – ABHNJ 2021 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Chart Audit and Annual Assessment
Aetna Better Health of New Jersey
Contract Year 4

August 2021

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Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates MCO performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO Contract requirements for Care Management services including MCO Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the Tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit Tool, it was agreed upon by IPRO and DMAHS that for the General Population only, the results in the current review period will not be compared to the prior year's reported rates because there can be no direct comparison from the current Audit Tool to the previous Audit Tool.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the two populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 251 cases for Aetna Better Health of New Jersey (ABHNJ), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (87). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (54).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 49499. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/20	>= 3 months as of 12/31/2020	>= 3 months and < 18 years as of 12/31/2020
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2020 to 7/1/2020	Initial enrollment between 1/1/2020 and 12/31/2020	Initial enrollment between 1/1/2020 and 12/31/2020
Current Enrollment	Enrolled as of 12/31/2020	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2020 allowing no more than a one month gap.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an offsite review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site.

- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Aetna's 2020 audit results ranged from 42% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP	DDD	DDD	PPD	DCP&P	DCP&P	PPD
	2020 (n=100)	2020 (n=54)	2019 (n=27)		2020 (n=84)	2019 (n=71)	
Identification[1]	84%						
Outreach	91%	100%	100%	0.0	98%	99%	-1.0
Preventive Services	86%	42%	69%	-27.0	56%	76%	-20.0
Continuity of Care	69%	80%	76%	4.0	92%	72%	20.0
Coordination of Services	81%	74%	100%	-26.0	87%	99%	-12.0

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 27 Enrollees were new Enrollees, and 73 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification - GP Population

Identification	General Population		
	Numerator	Denominator	Percent
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	6	6	100.0%
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)	0	10	0.0%
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only)*	11	27	40.7%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	27	100.0%[1]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2019)*	17	73	23.3%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2019)	6	56	89.3%[1]
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2019 not already in Care Management)*	28	56	50.0%

[1] Percentage rate is indicative of an inverse percentage

**Not Included in aggregate score calculation*

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (39).

Table 4: Outreach – GP Population

Outreach	General Population		
	Numerator	Denominator	Percent
Initial outreach to complete a CNA was done	35	39	89.7%
The outreach for CNA was timely within 30 days of the identification of CM needs	32	35	91.4%
Outreach was successful (even if the Enrollee declines to complete the CNA)*	24	35	68.6%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	18	20	90.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	10	24	41.7%
The Enrollee declined Care Management*	13	35	37.1%

**Not Included in aggregate score calculation*

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (30). There were three (3) Enrollees under the age of 21 years old and twenty-seven (27) Enrollees over the age of 21.

Table 5: Preventive Services - GP Population

Preventive Services	General Population		
	Numerator	Denominator	Percent
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	2	3	66.7%
Aggressive outreach attempts were documented to confirm EPSDT status	1	1	100.0%
The Care Manager sent EPSDT reminders	0	1	0.0%
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	2	3	66.7%
Aggressive outreach attempts were documented to confirm immunization status	1	1	100.0%
Appropriate vaccines have been administered for Enrollees age 18 and above	24	27	88.9%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	3	3	100.0%
Dental needs are addressed for Enrollees age 21 and above	27	27	100.0%
A dental visit occurred during the review period for Enrollees age 1 to 21	1	2	50.0%
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	1	1	100.0%
Dental reminders were sent to Enrollees age 1 to 21	1	1	100.0%
Enrollees age 9 months to 26 months were tested twice for lead	0	2	0.0%
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	2	0.0%
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	2	2	100.0%
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	2	2	100.0%

Continuity of Care

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (30).

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population		
	Numerator	Denominator	Percent
A Comprehensive Needs Assessment was completed for the Enrollee	12	30	40.0%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)*	1	3	33.3%
A level of Care Management was determined for the Enrollee	12	12	100.0%
The Enrollee is in Community Based Care Management (CBCM)*	7	30	23.3%
A Care Plan was completed for the Enrollee that included all required components	26	26	100.0%
The Care Plan was developed within 30 days of CNA Completion	11	26	42.3%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	11	11	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]

**Not Included in aggregate score calculation*

[1] could not calculate

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (30).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population		
	Numerator	Denominator	Percent
When appropriate for the applicable Enrollees, Care Manager has contacted Case Manager s from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	11	30	36.7%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	28	28	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	27	27	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	13	13	100.0%

DDD Population Findings

A total of 54 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	54	54	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	54	54	100.0%	100.0%	0.0
Outreach was successful (even if the Enrollee declines to complete the CNA)*	42	54	77.8%	74.1%	3.7
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	44	45	97.8%	100.0%	-2.2
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	10	42	23.8%	20.0%	3.8
The Enrollee declined Care Management*	10	54	18.5%	14.8%	3.7

**Not Included in aggregate score calculation*

Preventive Services

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	12	33	36.4%	76.9%	-40.6
Aggressive outreach attempts were documented to confirm EPSDT status	16	21	76.2%	100.0%	-23.8
The Care Manager sent EPSDT reminders	2	21	9.5%	100.0%	-90.5
The Enrollee's immunizations are up to date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	3	22	13.6%	9.1%	4.5
Aggressive outreach attempts were documented to confirm immunization status	11	19	57.9%	100.0%	-42.1
Appropriate vaccines have been administered for Enrollees age 18 and above	15	32	46.9%	50.0%	-3.1
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	11	17	64.7%	100.0%	-35.3
Dental needs are addressed for Enrollees age 21 and above	14	21	66.7%	71.4%	-4.8
A dental visit occurred during the review period for Enrollees age 1 to 21	5	33	15.2%	38.5%	-23.3
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	17	28	60.7%	100.0%	-39.3
Dental reminders were sent to Enrollees age 1 to 21	10	28	35.7%	100.0%	-64.3
Enrollees age 9 months to 26 months were tested twice for lead	0	2	0.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	2	0.0%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	2	2	100.0%	CNC[1]	CNC
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	2	2	100.0%	CNC	CNC

[1] Could not calculate

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	28	54	51.9%	51.9%	0.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	22	28	78.6%	78.6%	0.0
A level of Care Management was determined for the Enrollee	27	28	96.4%	100.0%	-3.6
The Enrollee is in Community Based Care Management (CBCM)*	6	54	11.1%	14.8%	-3.7
A Care Plan was completed for the Enrollee that included all required components	54	54	100.0%		
The Care Plan was developed within 30 days of CNA Completion	28	54	51.9%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	2	2	100.0%	89.5%	10.5
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	CNC	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Manager s from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	30	54	55.6%	100.0%	-44.4
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	20	20	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	21	21	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	2	3	66.7%	100.0%	-33.3
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2020, the Care Manager documented evidence of follow up within 30 days of discharge	0	0	CNC[1]	CNC	CNC
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC	CNC	CNC

[1] Could not calculate

DCP&P Population Findings

A total of 87 files were reviewed for the DCP&P Population. Three (3) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	82	84	97.6%	98.6%	-1.0
The outreach for CNA was timely within 45 days of enrollment	81	82	98.8%	98.6%	0.2
Outreach was successful (even if the Enrollee declines to complete the CNA)*	69	82	84.1%	82.9%	1.3
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	66	66	100.0%	95.4%	4.6
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	17	69	24.6%	13.8%	10.8

**Not Included in aggregate score calculation*

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	59	84	70.2%	84.5%	-14.3
Aggressive outreach attempts were documented to confirm EPSDT status	21	25	84.0%	100.0%	-16.0
The Care Manager sent EPSDT reminders	5	25	20.0%	100.0%	-80.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	43	84	51.2%	56.3%	-5.1
Aggressive outreach attempts were documented to confirm immunization status	27	41	65.9%	100.0%	-34.1
Appropriate vaccines have been administered for Enrollees age 18 and above	0	0	CNC[1]	CNC	CNC
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	0	0	CNC	CNC	CNC
Dental needs are addressed for Enrollees age 21 and above	0	0	CNC	CNC	CNC
A dental visit occurred during the review period for Enrollees age 1 to 21	34	64	53.1%	54.4%	-1.3
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	21	30	70.0%	100.0%	-30.0
Dental reminders were sent to Enrollees age 1 to 21	8	30	26.7%	100.0%	-73.3
Enrollees age 9 months to 26 months were tested twice for lead	0	18	0.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	18	5.6%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	18	18	100.0%	95.0%	5.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	17	18	94.4%	95.0%	-0.6

[1] Could not calculate

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	58	84	69.0%	62.0%	7.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	43	58	74.1%	75.0%	-0.9
A level of Care Management was determined for the Enrollee	57	58	98.3%	100.0%	-1.7
A Care Plan was completed for the Enrollee that included all required components	56	56	100.0%		
The Care Plan was developed within 30 days of CNA Completion	54	56	96.4%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	1	1	100.0%	56.3%	43.8
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	100%	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	68	84	81.0%	98.6%	-17.6
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	26	26	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	20	20	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	3	4	75.0%	100.0%	-25.0

Discussion

Limitations

Audit results for the DDD Population should be considered cautiously due to the low sample size of 54 Enrollees.

Corrective Action Plan/Work Plan

Aetna was not required to submit a Work Plan or CAP for the CM Chart Audit findings due to the public health emergency. Aetna was required to develop CAPs for IPRO's review of the elements in the CM section of the Annual Assessments.

Conclusions and Recommendations

Overall, the MCO scored above 85% in the following review elements (**Table 2**):

- Outreach (General Population) (91%)
- Preventive Services (General Population) (86%)
- Outreach (DDD Population) (100%)
- Outreach (DCP&P Population) (98%)
- Continuity of Care (DCP&P Population) (92%)
- Coordination of Services (DCP&P Population) (87%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 2**):

- Identification (General Population) (84%)
- Continuity of Care (General Population) (69%)
- Coordination of Services (General Population) (81%)
- Preventive Services (DDD Population) (42%)
- Continuity of Care (DDD Population) (80%)
- Coordination of Services (DDD Population) (74%)
- Preventive Services (DCP&P Population) (56%)

Opportunities for improvement for the General Population

Identification

- Aetna should perform timely and aggressive outreach; to new Enrollees within 45 days of enrollment to ensure timely completion of the IHS.

Continuity of Care

- Aetna should ensure the CNA is completed within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources, (referrals, utilization reports, pharmacy data, risk scores, clinical judgment).
- Aetna should ensure timely Plan of Care development within 30 days from a completed CNA.

Coordination of Services

- Aetna should ensure Care Managers contact Case Managers from DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P, the family, PCPs, specialists and the local health department, when appropriate.

Opportunities for improvement for the DDD Population

Preventive Services

- For Enrollees under 21 years of age, Aetna should confirm from a reliable source that the EPSDT exam is up-to-date per the periodicity exam schedule. Care Managers should send mailers, reminders and provide education for appropriate and timely preventive services.
- Aetna should continue to focus on age-appropriate immunizations for Enrollees ages 0 to 18, and confirm immunizations status from a reliable source, such as the PCP or the NJ immunization registry.
- Aetna should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence.

- Aetna should ensure confirm immunization status for Enrollees 18 and above, and address dental needs for Enrollees 21 and above.

Continuity of Care

- Aetna should ensure a Comprehensive Needs Assessment is completed within 45 days for newly enrolled DDD Enrollees. Aetna's Care Manager should develop a Plan of Care within 30 days of a completed CNA.

Coordination of Services

- Aetna should ensure Care Managers contact Case Managers from DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P, the family, PCPs, specialists and the local health department when appropriate**.**
- Aetna should ensure DDD Enrollees receive timely and adequate discharge planning and follow up.

Opportunities for improvement for the DCP&P Population

Preventive Services

- For Enrollees under 21 years of age, Aetna should confirm from a reliable source that the EPSDT exam is up-to-date to per the periodicity exam schedule. Care Managers should send mailers, reminders and provide education for appropriate and timely preventive services.
- Aetna should continue to focus on age-appropriate immunizations for Enrollees ages 0 to 18, and utilize aggressive outreach to confirm immunizations status from a reliable source, such as the PCP or the NJ immunization registry.
- Aetna should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence.
- Aetna should ensure that dental needs are addressed for Enrollees ages 1 to 21 years of age. Care Managers should provide dental education and reminders, and document the date of the Enrollees' annual dental visit.

Care Management and Continuity of Care

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standard under review; offsite review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key ABHNJ staff via WebEx were held on April 29 2021; and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on February 11, 2021 and received documentation from the MCOs on February 26, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on March 1, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2020 to December 31, 2020.

During the offsite review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance in partial and full reviews.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all of the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle, but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle, but was not met in the current review cycle.	Full, Partial

The Care Management and Continuity of Care review category examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review category also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

There are 30 contractual provisions in this category. ABHNJ received an overall compliance score of 83% in 2021. In 2020, the MCO received a score of 87% for this category. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2021. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2020 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	X	X	-	X	-	-	-	X
CM3	X	X	X	-	-	-	-	-
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	X	X	X	-	-	-	-	-
CM7	-	X	-	X	-	X	-	-
CM8	-	X	-	X	-	X	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	-	X	X	-	-	-	X	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	-	X	-	-	-	X
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37[1]	X	X	X	-	-	-	-	-
TOTAL	26	30	25	5	0	3	1	2
Compliance Percentage			83%					

[1]This documentation element is reviewed in any year where there are elements subject to review.

Table 18: Findings for Deficient Care Management and Continuity of Care Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 66.70% for the DDD Population and 75% for DCP&P Population, who were hospitalized, and adequate discharge planning was performed.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA Tool that appears in the Care Management Workbook must be included in the MCOs' assessment Tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM file audit the Plan scored: • 33.3% for General Population within 30 days of a completed CNA, 78.6% for DDD and 74.1% for DCP&P Populations, who had a completed CNA within 45 days of enrollment.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care	In the 2021 CM file audit the Plan scored: • 42.30% for General Population and 51.90% for the DDD Population, receiving a completed Plan of Care including all required components within 30 days of CNA completion.

Element	Contract Language	Reviewer Comments
	Management goals, specific actionable objectives, and measureable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 66.70% for the General Populations, 13.60% for DDD and 51.20% for the DCP&P Populations, ages 0-18 yrs. immunizations are up-to-date and immunization status is confirmed by a reliable source. • 66.70% for the General Population, 36.40% for the DDD and 70.20% for the DCP&P Populations, up-to-date EPSDT exam per periodicity schedule ages under 21 years of age, and confirmed by a reliable source. • 50% for the General Population, 15.20% for DDD and 53.10% for DCP&P Population ages 1-21 years, for dental visits occurring during the audit period. • 66.7% for DDD the Population, ages 21 years and above for addressing dental needs. • 46.90% for the DDD Population, appropriate vaccines been administered for Enrollees 18 years and older. • 0% for the General Population, DDD and DCP&P Populations, ages 9 to 26 months tested twice for lead. 0% for General and DDD Populations, and 5.6% of the DCP&P. never tested for lead before 24 months of age.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM file audit the Plan scored: • 36.70% for the General Population, 55.60% for the DDD and 81.00% for the DCP&P Populations. Care Manager coordinated needed care/services actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.

Table 19: Findings for Resolved Deficiencies for Care Management and Continuity of Care Elements

Element	Contract Language
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.

Strengths

None

Recommendations

1. CM2: The Plan should ensure adequate discharge planning is executed for all appropriate hospitalized DDD and DCP&P Populations.
2. CM7: The Plan should ensure CNAs are completed within 45 days of enrollment for the General, DDD and DCP&P Populations.
3. CM8: The Plan should ensure the Plan of Care is completed including all required components within 30 days of CNA completion for the General and DDD Populations.
4. CM14: The Plan should ensure that Enrollees are educated on the importance of receiving Preventative Services, Immunizations, Dental Care and Lead Testing as applicable for the General, DDD and DCP&P Populations.
5. CM14: The Plan should certify that Preventative Services: Exams and Immunization are up-to-date and status is confirmed by a reliable source for the General, DDD and DCP&P Populations under 21 years of age.
6. CM19: The Plan should ensure Care Managers coordinate needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services for the General, DDD and DCP&P Populations.

Findings for Improvement

None

2021 Core Medicaid Care Management Document Submission Guide

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of, or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** The Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would	

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees,	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7*	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8*	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measureable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan:** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s)

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCOs must develop policies and	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18b	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18c	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19*	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5.I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5.L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description

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2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4.6.5.L Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Aetna Better Health New Jersey

Review Period July 1, 2020 – June 30, 2021

January 2022

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2020 through 6/30/2021. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2020. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 141 cases for Aetna Better Health New Jersey (ABHNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care members enrolled in MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care members enrolled in MLTSS prior to 7/1/2020 and continuously enrolled in MLTSS through 6/30/2021	• The member must have been initially enrolled in MLTSS HCBS prior to 7/1/2020. • The member must have remained enrolled in MLTSS HCBS through 6/30/2021 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. Additionally, for each MCO a random selection of Traumatic Brain Injury (5) members was included in the sample. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 HCBS MLTSS members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 141 cases selected for the MCO, 141 member files were reviewed and 139 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	26
Group D	Current Members Newly Enrolled to MLTSS	51
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	37
Ancillary Group	Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure	25
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	2

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 68.5% to 98.2% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 2020– June 2021			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		91.6%		91.6%
Outreach	92.3%	76.5%		81.8%
Telephonic Monitoring (Formerly Face-to-Face) Visits	87.4%	93.4%	66.4%	84.3%
Initial Plan of Care (Including Back-up Plans)	88.9%	88.7%	77.3%	85.2%
Ongoing Care Management	72.4%	72.4%	53.9%	68.5%
Gaps in Care/Critical Incidents	96.2%	100.0%	96.9%	98.2%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

TBI Population-specific findings are presented in **Table 3a,** which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Table 3a provides the aggregate scores only for TBI members.

Table 3a. Results by TBI Population

Determination by Category	July 2020– June 2021			
	Group C[1]	Group D	Group E[1,2]	Combined[3]
Case Count TBI Population	0	0	5	5
Assessment		NA		NA
Outreach	NA	NA		NA
Telephonic Monitoring (Formerly Face-to-Face) Visits	NA	NA	71.4%	71.4%
Initial Plan of Care (Including Back-up Plans)	NA	NA	84.0%	84.0%
Ongoing Care Management	NA	NA	75.0%	75.0%
Gaps in Care/Critical Incidents	NA	NA	100.0%	100.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 26 files were reviewed for new members enrolled in managed care and newly eligible for MLTSS (Group C). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 26 files were further reviewed for compliance in five (5) categories.

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	24	26	92.3%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	26	26	100.0%
Options Counseling was provided to the Member.	18	26	69.2%
Member was offered the participant direction option during options counseling.	26	26	100.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	5	7	71.4%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	22	26	84.6%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	19	26	73.1%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	26	26	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	18	19	94.7%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	3	5	60.0%

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.	26	26	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	18	26	69.2%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	18	18	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	18	18	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	17	18	94.4%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	16	17	94.1%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	21	26	80.8%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	23	26	88.5%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	13	13	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	7	26	26.9%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	3	3	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	3	3	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	14	18	77.8%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	4	4	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	6	7	85.7%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	3	5	60.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	24	26	92.3%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	26	26	100.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 51 files were reviewed for members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 51 files were further reviewed for compliance in all six (6) categories.

	July 2020 – June 2021		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	44	51	86.3%
Screening for Community Services Assessment was submitted to DoAs by the 10th of the following month.	43	44	97.7%

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	39	51	76.5%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	51	51	100.0%
Options Counseling was provided to the Member.	47	51	92.2%
Member was offered the participant direction option during options counseling.	48	51	94.1%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	3	7	42.9%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	48	51	94.1%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	39	51	76.5%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	51	51	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	10	30	33.3%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	3	4	75.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.	51	51	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	47	51	92.2%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	50	50	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	50	50	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	48	50	96.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	43	48	89.6%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	40	51	78.4%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	49	51	96.1%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	10	10	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	10	51	19.6%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	2	2	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	2	2	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	43	50	86.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	8	8	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	5	5	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	2	2	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	51	51	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	3	3	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	51	51	100.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 37 files were reviewed for the members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Outreach is not assessed for members in Group E. All 37 files were reviewed for compliance in four (4) categories.

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	30	30	100.0%
Options Counseling was provided to the Member.	4	30	13.3%
Member was offered the participant direction option during options counseling.	22	30	73.3%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	2	5	40.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	25	30	83.3%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the member's anniversary (from the date of the Initial Plan of Care).	34	37	91.9%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	30	30	100.0%
Member file had documentation to demonstrate contact with the members' HCBS providers at least annually to discuss the providers' reviews of the member's needs and status and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	30	30	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	1	1	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.	29	30	96.7%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	4	30	13.3%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	23	23	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	23	23	100.0%
Care Manager completed an Annual Risk Assessment for the member (not applicable for Members residing in CARS).	23	30	76.7%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.	5	30	16.7%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	20	23	87.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	23	30	76.7%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	8	8	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	4	30	13.3%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	1	0.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	1	1	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	17	23	73.9%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	7	7	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	3	5	60.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	1	1	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	28	30	93.3%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	4	4	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	30	30	100.0%

4. Performance Measures

The performance measures results summarize the MCO's performance in terms of the MLTSS measures. Of the total 25 cases selected for the MCO, 25 member files were reviewed and 25 were included in the file review.

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Performance Measure #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment) was not validated during the audit this year.

Population-specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's Plan of Care is reviewed annually within 30 days of Members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2020 and 2021 audit findings. Overall, The MCO's audit results ranged from 64.5% to 100% across all groups for six (6) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: ABHNJ

Performance Measure	Group[1]	July 2020 – June 2021		
		N	**D**	**Rate**
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	19	26	73.1%
	Group D	39	51	76.5%
	Group E			
	Ancillary Group C	5	7	71.4%
	Ancillary Group D	15	18	83.3%
	Total	78	102	76.5%

#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	34	37	91.9%
	Total	34	37	91.9%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	3	5	60.0%
	Group D	2	2	100.0%
	Group E	1	1	100.0%
	Total	6	8	75.0%
#11. Plans of Care developed using "person-centered principles"[5]	Group C	18	26	69.2%
	Group D	47	51	92.2%
	Group E	4	30	13.3%
	Total	69	107	64.5%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group C	18	18	100.0%
	Group D	50	50	100.0%
	Group E	23	23	100.0%
	Total	91	91	100.0%
#16. Member training on identifying/reporting critical incidents	Group C	26	26	100.0%
	Group D	51	51	100.0%
	Group E	30	30	100.0%
	Total	107	107	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period
[4]Members who did not have a documented change in condition during the study period are excluded from this measure
[5]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[6]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 91.6% in the Assessment category.

Group	7/20 to 6/21
Group C	
Group D	91.6%
Group E	
Combined	91.6%

Member Outreach

Across groups, the MCO had a combined score of 81.8% in the Member Outreach category.

Group	7/20 to 6/21
Group C	92.3%
Group D	76.5%
Group E[1]	
Combined	81.8%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

Opportunities for improvement for the elements of Member Outreach include the following:

- Group D: Aetna should ensure the Care Manager contacts the Member telephonically to conduct a Screening for the Community Services Assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.

Telephonic Monitoring (Formerly Face-to-Face) Visits

Across all three groups, the MCO had a combined score of 84.3% in the Telephonic Monitoring Visits category.

Group	7/20 to 6/21
Group C	87.4%
Group D	93.4%
Group E	66.4%
Combined	84.3%

Opportunities for improvement for elements of the Telephonic Monitoring (formerly Face-to-face) Visits category include the following:

- Group E: Aetna should ensure option counseling is provided to all MLTSS Members, the MLTSS Care Managers should discuss and offers Participant Direction as applicable during Options Counseling. Aetna should ensure that the Participant Direction Application packet is completed and submitted within thirty (30) business days of the Member's request to self-direct. Aetna should ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold should be documented as a numeric percentage.

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 85.2% in the Initial Plan of Care (Including Back-up Plans) category.

Group	7/20 to 6/21
Group C	88.9%
Group D	88.7%
Group E	77.3%
Combined	85.2%

Opportunities for improvement for elements of the Initial Plan of Care (Including Back-up Plans) category include the following:

- Group E: Aetna should ensure that the Plan of Care reflects a member-centric approach, and the Member/Member Representative is present and involved in the development and modification of agreed upon goals and is given the opportunity to express their needs or preferences, and their needs or preferences are acknowledged and addressed in the Plan of Care. The Plan should ensure the Care Manager completes an Annual Risk Assessments for MLTSS Members, and if a risk is identified a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member. Aetna should ensure Members receive their Rights and Responsibilities in writing during the review period, Rights and Responsibilities should be discussed, and the Care Manager should confirm the Member's understand their Rights and Responsibilities.

Ongoing Care Management

Across all three groups, the MCO had a combined score of 68.5% in the Ongoing Care Management category.

Group	7/20 to 6/21
Group C	72.4%
Group D	72.4%
Group E	53.9%
Combined	68.5%

Opportunities for improvement for elements of the Ongoing Care Management category include the following:

- Group C: Aetna should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for members in CARS. Aetna should ensure that the Member's Back-up Plan is reviewed at least quarterly for Member's residing in the Community. Aetna should ensure that the Care Manager completes a telephonic visit within 10 business days of the Member's discharge from an institutional facility to a HCBS setting. The Plan should ensure that Plans of Care are reviewed, and/or amended and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the member's needs or condition.

- Group D: Aetna should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for members in CARS.

- Group E: Aetna should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for members in CARS. Aetna should ensure when the Member's Initial Plan of Care requires revision, the Plan of Care is reviewed and/or revised, the Care Manager should confirm the Member's agreement, signature/verbally acknowledgement, and a copy of the Plan of Care should be provided to the Member. Aetna should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. Aetna should ensure that the Care Manager completes a telephonic visit within 10 business days of the Member's discharge from an institutional facility to a HCBS setting.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 98.2% in the Gaps in Care/Critical Incidents category.

Group	7/20 to 2/21
Group C	96.2%
Group D	100.0%
Group E	96.9%
Combined	98.2%

Performance Measures

Overall, the MCO scored below 86% in three (3) of the six (6) performance measures.

- #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (76.5%).
- #9: Member's Plan of Care is amended based on change of member condition (75.0%).
- #11: Plans of Care developed using "person-centered principles" (64.5%).

Opportunities for improvement for Performance Measures include the following:

- #8: Aetna should ensure that the Initial Plans of Care are developed within 45 days of enrollment into the MLTSS program.
- #9a: Aetna should ensure that the Member's Plan of Care is amended based on change of member condition, and the Plan of Care is reviewed, signed/verbally acknowledged, and dated by the Member/Member Representative.
- #11: Aetna should ensure that the Plan of Care reflects "Person-Centered Principles", and the Member/Member Representative is present and involved in the Plan of Care development.

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

Aetna Better Health of New Jersey
Managed Long Term Services and Supports (MLTSS)
2021 Annual Assessment Review of
Care Management

Review Period - July 1, 2020 to June 30, 2021

October 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standards under review; interviews with key ABHNJ staff (held via WebEx on August 23, 2021); and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on June 18, 2021 and received from the MCOs on July 2, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on July 6, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2020, to June 30, 2021. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

During the offsite review, the MCO had the opportunity to provide supplemental documentation as requested by IPRO.

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2021 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit were completed and sent to the MCOs on October 20, 2021.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. ABHNJ received an overall compliance score of 100% in 2021. In 2020, the MCO received a score of 90% for this category. **Table 1a** presents an overview of the results, **Table 1b** presents Contract language for resolved element(s).

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	-	X	X	-	-	-	X	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	9	10	10	0	0	0	1	0
Compliance Percentage	90%		100%					

Table 1b: Findings for Resolved MLTSS Care Management and Continuity of Care Elements

Element	Contract Language
CM36	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.

Strengths

None

Recommendations

None

Findings for Improvement

None

New Jersey Annual Assessment of MCO Operations

MLTSS HCBS CM
2021 Audit Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.64.1.1.F.1 9.3.3.B 9.3.3.C 9.6.6.E 4.1.1.E 9.6.6.F	**4.6.5.D.6** If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3.B The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: Notify providers of their role in providing continuity of care for their Members in transition; 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services;	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-effective manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1.D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health and long term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1.J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2.B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or	▪ Care Management job descriptions used in recruitment ▪ Organization Chart with CM names

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members; 2. Caseload management and casework practices; 3. Human services principles for determining eligibility for benefits and services; 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	▪ CM resumes
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A MLTSS Training The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements. 9.5.4.A A. The Contractor shall develop standards for Care Management Training which includes the following components: 1. Training curriculum including goals of training, competency standards, and frequency of retraining 2. Quality Assurance program to identify inter/intra-rater reliability and core standards 3. Continue Quality Assurance standards to ensure standards are being met	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Remediation training plan for employees who do not meet the standards 9.5.4.BCare Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.	
CM34	9.5.5.J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g. holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2.A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4.A	4.7.4 **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			related to compliance.
CM38	9.4.1.A.4 9.5.1.E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
Aetna Better Health New Jersey

Review Period: July 2019 – February 29, 2020
Expansion Period: March 1, 2020 – December 31, 2020
October 2021

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019 through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.

Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2019 and January 2020. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

The audit is comprised of two review periods: July 1, 2019 through February 29, 2020, and an expansion period from March 1, 2020 to December 31, 2020. The initial review period includes an assessment of all audit elements, and the expansion period focuses specific elements aimed to evaluate the MCOs COVID response for NF members. Only the review period from July 1, 2019 to February 29, 2020 has been considered in determining the final Audit scoring. Audit elements applicable to both review periods can be compared to evaluate MCO performance across review periods. Audit elements that are only applicable to the initial assessment period are not compared to any other review periods.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, the NF audit to evaluate the period from July 2018 through June 2019 was suspended. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and

presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit tool to evaluate the measures for the applicable population.

Based on the extensive revisions to the NJ EQRO MLTSS NF Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior review period's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Aetna Better Health New Jersey (ABHNJ), including an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on December 31, 2020,
  And
- The member must have been enrolled as an NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on December 31, 2020,
  And
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (December 31, 2020).

Members residing in a NF/SCNF less than six consecutive months at any time between July 1, 2019 and February 29, 2020 (starting July 1, 2019) were excluded.

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between July 1, 2019 and February 29, 2020 with the MCO of record on February 29, 2020
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between July 1, 2019 and February 29, 2020, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between July 1, 2019 and December 31, 2019, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of February 29, 2020)
Group 4	Members residing in HCBS for at least one month between July 1, 2019 and November 30, 2019, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for ABHNJ, 100 member files were reviewed and included in the audit results. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Care Management Outreaches, Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting, and PASRR Communication (see Tables 2a-f). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold both in the tables and Conclusion section of this report.

All rates for the Expansion Period from March 1, 2020 through December 31, 2020 are for informational purposes only and are not considered as part of the final audit score in the Conclusions section of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	89	100	89.0%
Documented Review of the Facility Plan of Care by the Care Manager	88	89	98.9%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	84	89	94.4%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	8	9	88.9%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	91	100	91.0%
Care Manager arranged Plan of Care services using both formal and informal supports	91	100	91.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	91	100	91.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	91	100	91.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	75	100	75.0%

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (July 1, 2019-February 29, 2020)		
	N	D	Rate
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	1	1	100.0%

Table 2c.

Transition Planning	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	92	100	92.0%	100	100	100.0%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	72	100	72.0%	77	100	77.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	93	100	93.0%	18	100	18.0%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	61	100	61.0%	55	100	55.0%
Members requiring coordination of care had coordination of care by the Care Manager	98	100	98.0%			
Care Manager explained and discussed any payment liability with the Member	57	100	57.0%			

CNC: Could not calculate

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions; significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	64	66	97.0%			
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	75	100	75.0%	92	100	92.0%
Care Manager reviewed the Member's Rights and Responsibilities	86	100	86.0%			
Care Manager educated the Member on how to file a grievance and/or an appeal	86	100	86.0%			
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	89	100	89.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period*	97		
Member was admitted to an NF/SCNF during the review period*	3		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	3	3	100%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	3	3	100%
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	CNC

*Element not scored

CNC: Could not calculate

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for ABHNJ, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold both in the tables and Conclusion section of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

Transitions from NF/SCNF to HCBS	Review Period (July 1, 2019-February 29, 2020) Groups 2, 4			Expansion Period (March 1, 2020-December 31, 2020) Groups 2, 4		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC			
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC			
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC			
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC			
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC			
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC			

CNC: Could not calculate

Reviews of this population are optional and not scored

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions from HCBS to NF/SCNF	Review Period (July 1, 2019- February 29, 2020) Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

Reviews of this population are optional and not scored

CNC: Could not calculate

The expansion of the Nursing Facility audit components included evaluating the NF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: ABHNJ

Performance Measure	Group	July 2019 – February 2020		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	8	9	88.9%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**8**	**9**	**88.9%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	75	100	75.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**75**	**100**	**75.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	1	1	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**1**	**1**	**100.0%**
#11. Plans of Care developed using "person-centered principles"[4]	Group 1	91	100	91.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**91**	**100**	**91.0%**
#16. Member training on identifying/reporting critical incidents	Group 1	89	100	89.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**89**	**100**	**89.0%**

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.

[2]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.

[3]Members who did not have a documented change in condition during the study period are excluded from this measure.

[4]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.

CNC: Could not calculate; N/A: Not applicable

Limitations

The annual NF CM audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. The 2020 NF CM review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (89.0%)
- Documented Review of the Facility Plan of Care (98.9%)
- MLTSS Plan of Care on file (94.4%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (88.9%)
- Care Managers used a person-centered approach (91.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (91.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (91.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (91.0%)
- Updated Plan of Care for a Significant Change (100.0%)
- Member was identified for transfer to HCBS and was offered options (92.0%)
- Member was present at each onsite visit (93.0%)
- Members requiring coordination of care had coordination of care (98.0%)
- NJCA was completed to assess the Member (97.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (86.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (86.0%)
- Member and/or representative had training on how to report a critical incident (89.0%)
- Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF (100.0%)
- Communication of PASRR Level I to OCCO (100.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Documentation of the Member's agreement/disagreement with the POC statements were documented (75.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (72.0%)
- Timely Onsite Review of Member Placement and Services (61.0%)
- Care Manager explained and discussed any payment liability (57.0%)
- Plan of Care was updated, reviewed, and signed by the member (75.0%)

Recommendations for audit elements include the following:

Aetna's MLTSS Care Managers should ensure the Member's Plan of Care is reviewed, revised if applicable, and confirm the agreement/disagreement statement is reviewed and signed by the Member/POA. The MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. Aetna should ensure the MLTSS Care Managers discuss payment liability, and review the Member's placement and services timely.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (75.0%)

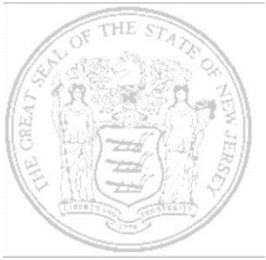
Recommendations for MLTSS Performance Measures include the following:

Aetna's MLTSS Care Managers should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix C – AGNJ 2021 Core Medicaid and MLTSS Care Management Audit Reports



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of Quality Assurance

MCO Care Management Chart Audit and Annual Assessment
Amerigroup New Jersey, Inc.
Contract Year 4

August 2021

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The purpose of the Care Management audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates MCO performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO Contract requirements for Care Managements services including MCO Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the Tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit Tool, it was agreed upon by IPRO and DMAHS that for the General Population only, the results in the current review period will not be compared to the prior year's reported rates because there can be no direct comparison from the current Audit Tool to the previous Audit Tool.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the two populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 289 cases for Amerigroup New Jersey, Inc. (Amerigroup), including a 10% oversample for the GP and a 40% oversample for the DCP&P population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. Random samples of 140 Enrollees for the DCP&P Population (including an oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (39).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 49499. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/20	>= 3 months as of 12/31/2020	>= 3 months and < 18 years as of 12/31/2020
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2020 to 7/1/2020	Initial enrollment between 1/1/2020 and 12/31/2020	Initial enrollment between 1/1/2020 and 12/31/2020
Current Enrollment	Enrolled as of 12/31/2020	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2020 allowing no more than a one month gap.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an offsite review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Amerigroup's 2020 audit results ranged from 60% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP	DDD	DDD	PPD	DCP&P	DCP&P	PPD
	2020 (n=100)	2020 (n=39)	2019 (n=41)		2020 (n=73)	2019 (n=89)	
Identification[1]	93%						
Outreach	100%	99%	98%	1%	98%	98%	0%
Preventive Services	60%	60%	80%	-20%	77%	84%	-7%
Continuity of Care	64%	91%	80%	11%	97%	84%	13%
Coordination of Services	92%	96%	100%	-4%	100%	99%	1%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 9 Enrollees were new Enrollees, and 91 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population		
	Numerator	Denominator	Percent
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	0	0	CNC[1]
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)	7	8	87.5%
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only)*	6	9	66.7%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	9	100.0%[2]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2019)*	10	91	11.0%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2019)	6	81	92.6%[2]
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2019 not already in Care Management)*	58	81	71.6%

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] Percentage rate is indicative of an inverse percentage

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (64).

Table 4: Outreach – GP Population

Outreach	General Population		
	Numerator	Denominator	Percent
Initial outreach to complete a CNA was done	64	64	100.0%
The outreach for CNA was timely within 30 days of the identification of CM needs	64	64	100.0%
Outreach was successful (even if the Enrollee declines to complete the CNA)*	25	64	39.1%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	46	50	92.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	10	25	40.0%
The Enrollee declined Care Management*	18	64	28.1%

**Not Included in aggregate score calculation*

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (19). There were three (3) Enrollees under the age of 21 years old and sixteen (16) Enrollees over the age of 21.

Table 5: Preventive Services – GP Population

Preventive Services	General Population		
	Numerator	Denominator	Percent
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	3	3	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status	0	0	CNC[1]
The Care Manager sent EPSDT reminders	0	0	CNC[1]
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	0	3	0.0%
Aggressive outreach attempts were documented to confirm immunization status	2	3	66.7%
Appropriate vaccines have been administered for Enrollees age 18 and above	10	16	62.5%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	2	6	33.3%
Dental needs are addressed for Enrollees age 21 and above	11	16	68.8%
A dental visit occurred during the review period for Enrollees age 1 to 21	2	2	100.0%
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	0	0	CNC[1]
Dental reminders were sent to Enrollees age 1 to 21	0	0	CNC[1]
Enrollees age 9 months to 26 months were tested twice for lead	1	3	33.3%
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	2	0.0%
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	2	2	100.0%
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	2	2	100.0%

[1] Could not calculate

Continuity of Care

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (19).

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population		
	Numerator	Denominator	Percent
Comprehensive Needs Assessment was completed for the Enrollee.	6	19	31.6%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources). (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)*	4	4	100%
A level of Care Management was determined for the Enrollee	4	6	66.7%
The Enrollee is in Community Based Care Management (CBCM)*	7	19	36.8%
A Care Plan was completed for the Enrollee that included all required components	6	6	100.0%
The Care Plan was developed within 30 days of CNA Completion	5	6	83.3%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	6	6	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	2	2	100.0%

*Not Included in aggregate score calculation

[1] Could not calculate

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (19).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population		
	Numerator	Denominator	Percent
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	14	19	73.7%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	17	17	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	15	15	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	13	13	100.0%

DDD Population Findings

A total of 39 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	39	39	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	38	39	97.4%	95.1%	2.3
Outreach was successful (even if the Enrollee declines to complete the CNA)*	36	39	92.3%	92.7%	-0.4
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	8	8	100.0%	100.0%	0.0
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	2	36	5.6%	2.6%	2.9
The Enrollee declined Care Management*	2	39	5.1%	2.4%	2.7

*Not Included in aggregate score calculation

Preventive Services

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	18	27	66.7%	85.2%	-18.5
Aggressive outreach attempts were documented to confirm EPSDT status	9	9	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	8	9	88.9%	100.0%	-11.1
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	10	17	58.8%	65.0%	-6.2
Aggressive outreach attempts were documented to confirm immunization status	1	7	14.3%	100.0%	-85.7
Appropriate vaccines have been administered for Enrollees age 18 and above	5	22	22.7%	57.1%	-34.4
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	10	17	58.8%	100.0%	-41.2
Dental needs are addressed for Enrollees age 21 and above	3	12	25.0%	100.0%	-75.0
A dental visit occurred during the review period for Enrollees age 1 to 21	13	27	48.1%	55.6%	-7.4
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	14	14	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	14	14	100.0%	100.0%	0.0
Enrollees age 9 months to 26 months were tested twice for lead	0	2	0.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	1	100.0%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	2	2	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	2	2	100.0%	100.0%	0.0

[1] Could not calculate

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	35	39	89.7%	90.2%	0.5
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	32	35	91.4%	73.0%	18.5
A level of Care Management was determined for the Enrollee	35	35	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management(CBCM)*	0	39	0.0%	7.3%	-7.3
A Care Plan was completed for the Enrollee that included all required components	33	36	91.7%		
The Care Plan was developed within 30 days of CNA Completion	31	36	86.1%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	1	3	33.3%	30.0%	3.3
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%	100.0%	0.0

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	38	39	97.4%	100.0%	-2.6
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	18	18	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	18	19	94.7%	100.0%	-5.3
For Enrollees who were hospitalized, adequate discharge planning was performed	1	2	50.0%	100.0%	-50.0
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2020, the Care Manager documented evidence of follow up within 30 days of discharge	1	1	100.0%	100.0%	0.0
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[1]	CNC	CNC

[1] Could not calculate

DCP&P Population Findings

A total of 140 files were reviewed for the DCP&P Population. Sixty-seven (67) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	73	73	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	70	73	95.9%	96.6%	-0.7
Outreach was successful (even if the Enrollee declines to complete the CNA)*	72	73	98.6%	89.9%	8.7
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	20	21	95.2%	92.9%	2.4
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	5	72	6.9%	1.3%	5.7

**Not Included in aggregate score calculation*

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	65	73	89.0%	92.1%	-3.1
Aggressive outreach attempts were documented to confirm EPSDT status	8	8	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	8	8	100.0%	100.0%	0.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	55	73	75.3%	77.5%	-2.2
Aggressive outreach attempts were documented to confirm immunization status	12	18	66.7%	100.0%	-33.3
Appropriate vaccines have been administered for Enrollees age 18 and above	0	0	CNC[1]	CNC	CNC
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	0	0	CNC	CNC	CNC
Dental needs are addressed for Enrollees age 21 and above	0	0	CNC	CNC	CNC
A dental visit occurred during the review period for Enrollees age 1 to 21	28	40	70.0%	78.0%	-8.0
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	12	12	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	12	12	100.0%	100.0%	0.0
Enrollees age 9 months to 26 months were tested twice for lead	3	21	14.3%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	4	14	28.6%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	18	18	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	18	18	100.0%	100.0%	0.0

[1] Could not calculate

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	72	73	98.6%	89.9%	8.7
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	64	72	88.9%	81.3%	7.6
A level of Care Management was determined for the Enrollee	72	72	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	73	73	100.0%		
The Care Plan was developed within 30 days of CNA Completion	71	73	97.3%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	3	3	100.0%	22.2%	77.8
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	CNC[1]	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	73	73	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	71	71	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	73	73	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	1	1	100.0%	75.0%	25.0

Discussion

Limitations

Audit results for the DDD Population should be considered cautiously due to the very low sample sizes (39 Enrollees).

Corrective Action Plan/Work Plan

Amerigroup was not required to submit a Work Plan or CAP for the CM Chart Audit findings due to the public health emergency. Amerigroup was required to develop CAPs for IPRO's review of the elements in the CM section of the Annual Assessments.

Conclusions and Recommendations

Overall, the MCO scored above 85% in the following review elements (**Table 2**):

- Identification (General Population) (93%)
- Outreach (General Population) (100%)
- Coordination of Services (General Population) (92%)
- Outreach (DDD Population) (99%)
- Continuity of Care (DDD Population) (91%)
- Coordination of Services (DDD Population) (96%)
- Outreach (DCP&P Population) (98%)
- Continuity of Care (DCP&P Population) (97%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 2**):

- Preventive Services (General Population) (60%)
- Continuity of Care (General Population) (64%)
- Preventive Services (DDD Population) (60%)
- Preventive Services (DCP&P Population) (77%)

Opportunities for improvement for the General Population

Preventive Services

- Amerigroup should continue to focus on age appropriate immunizations for Enrollees age 0 to 18. Aggressive outreach should be documented to obtain and confirm immunizations status from a reliable source, such as the PCP, NJ immunization registry.
- Amerigroup should ensure Enrollees age 18 and above receive appropriate vaccines. Aggressive outreach should be utilized to confirm vaccination status for Enrollees age 18 and above.
- Amerigroup should ensure address dental needs for Enrollees 21 and above.
- Amerigroup should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence.

Continuity of Care

- Amerigroup's Care Manager should develop a Plan of Care and document the Enrollee's level of care within 30 days of a completed CNA.

Opportunities for improvement for the DDD Population

Preventive Services

- For Enrollees under 21 years of age, Amerigroup should confirm from a reliable source that the EPSDT exam is up-to-date to per the periodicity exam schedule.
- Amerigroup should continue to focus on age appropriate immunizations for Enrollees age 0 to 18. Aggressive outreach should be documented to obtain and confirm immunizations status from a reliable source, such as the PCP, NJ immunization registry.
- Amerigroup should ensure Enrollees age 18 and above receive appropriate vaccines. Aggressive outreach should be utilized to confirm vaccination status for Enrollees age 18 and above. Amerigroup should address dental needs for Enrollees 21 and above.
- Amerigroup should ensure that dental needs and visits are addressed for Enrollees ages 1 to 21 years of age. Care Managers should provide dental education and reminders, and document the date of the Enrollees s annual dental visit.
- Amerigroup should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead to ensure Contract adherence.

Opportunities for improvement for the DCP&P Population

Preventive Services

- Amerigroup should continue to focus on age appropriate immunizations for Enrollees ages 0 to 18. Aggressive outreach should be documented to obtain and confirm immunizations status from a reliable source, such as the PCP, NJ immunization registry.
- Amerigroup should ensure that dental needs and visits are addressed for Enrollees age 1 to 21 years of age. Care Managers should provide dental education and reminders, and document the date of the Enrollees annual dental visit.
- Amerigroup should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence.

Care Management Annual Assessment

Care Management and Continuity of Care

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Amerigroup New Jersey, Inc. (AGNJ) as evidence of compliance of the standard under review; offsite review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key AGNJ staff via WebEx were held on April 29, 2021, and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on February 11, 2021 and received documentation from the MCOs on February 26, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on March 1, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2020 to December 31, 2020.

During the offsite review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance in partial and full reviews.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all of the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle, but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle, but was not met in the current review cycle.	Full, Partial

The Care Management and Continuity of Care review category examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review category also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

There are 30 Contractual provisions in this category. AGNJ received an overall compliance score of 80% in 2021. In 2020, the MCO received a score of 83% for this category. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2021. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2020 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s).

Table 17: Summary of Findings for Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	-	X	-	X	-	X	-	-
CM3	X	X	X	-	-	-	-	-
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	X	X	X	-	-	-	-	-
CM7	-	X	-	X	-	X	-	-
CM8	X	X	-	X	-	-	-	X
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	-	X	-	X	-	X	-	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	-	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	-	X	-	-	-	X
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37[1]	X	X	X	-	-	-	-	-
TOTAL	25	30	24	6	0	4	0	2
Compliance Percentage			80%					

[1]This documentation element is reviewed in any year where there are elements subject to review.

Table 18: Findings for Deficient Care Management and Continuity of Care Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 50% for the DDD Enrollees, who were hospitalized, and adequate discharge planning was performed.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM file audit the Plan scored: • 66.7% of the General Population Enrollees, who were assigned a level of care management.

Element	Contract Language	Reviewer Comments
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM file audit the Plan scored: • 83.3% for General Population Enrollees, who received a Plan of Care including all required components within 30 days of CNA completion.
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	In the 2021 CM file audit the Plan scored: • 33.3% for the DDD Enrollees, receiving a modified Plan of Care based on changes in the Enrollee's care needs or circumstances.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 58.8% for the DDD and 75.3% for the DCP&P Populations, age 0-18 years, immunizations are up-to-date and immunization status is confirmed by a reliable source. • 66.7% for the DDD Enrollees, up-to-date EPSDT exam per periodicity schedule under 21 years of age, and confirmed by a reliable source. • 48.1% for DDD and 70% for DCP&P Population age 1-21 years, for dental visits occurring during the audit period. • 68.8% for the General Population and 25% for the DDD Enrollees, age 21 years and above whose dental needs were addressed. • 62.5% of the General Population Enrollees and 22.7% of the DDD Enrollees, who received appropriate vaccines for Enrollees 18 years and older. • 33.3% for the General Population, .% of

Element	Contract Language	Reviewer Comments
		the DDD and 14.3% of the DCP&P. Population, ages 9 to 26 months tested twice for lead. 0% for General Population and 28.6% of the DCP&P never tested for lead before 24 months of age.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM file audit the Plan scored: • 73.7% for the General Population, the Plan outreached and forged ongoing partnerships and communication linkages with independent client advocates; Area Agencies on Aging/Aging and Disability Resource Connections (ADRCs); the Division of Aging Services (DoAS); Office of Community Choice Options (OCCO); County Welfare Agencies (CWAs); the Department of Community Affairs; the Division of Disability Services (DDS); County Offices on Disability; the State Health Insurance Assistance Program (SHIP), the Centers for Independent Living (CIL); Early Intervention Special Child Health Services; and both County and State Offices of Emergency.

Strengths

None

Recommendations

1. CM2: The Plan should ensure adequate discharge planning is executed for all appropriate hospitalized DDD Enrollees.
2. CM7: The Plan should ensure that the CNA is completed within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources. The Plan should ensure a level of Care Management assigned to applicable General Population Enrollees.
3. CM8: The Plan should ensure a Plan of Care including all required components is developed within 30 days of CNA completion for the General Population Enrollees.
4. CM11: The Plan should ensure the DDD Enrollees receive a modified Plan of Care based on changes in the Enrollee's care needs or circumstances.
5. CM14: The Plan should ensure that Enrollees are educated on the importance of receiving Preventative Services, Immunizations, Dental Care and Lead Testing as applicable for the General, DDD and DCP&P Populations.
6. CM14: The Plan should certify that Preventative Services: Exams and Immunization are up-to-date and status is confirmed by a reliable source for the DDD and DCP&P Populations under 21 years of age.
7. CM19: The Plan should ensure Care Managers forged ongoing partnerships and communication linkages with independent client advocates, for the General Population.

Findings for Improvement

None

2021 Core Medicaid Care Management Document Submission Guide

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of, or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** The Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would	

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees,	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7*	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8*	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measureable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan:** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s)

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCOs must develop policies and	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18b	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18c	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19*	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5.I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5.L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4.6.5.L Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Amerigroup New Jersey, Inc.

Review Period July 1, 2020 – June 30, 2021

January 2022

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2020 through 6/30/2021. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2020. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 145 cases for Amerigroup New Jersey, Inc. (AGNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care members enrolled in MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care members enrolled in MLTSS prior to 7/1/2020 and continuously enrolled in MLTSS through 6/30/2021	• The member must have been initially enrolled in MLTSS HCBS prior to 7/1/2020. • The member must have remained enrolled in MLTSS HCBS through 6/30/2021 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. Additionally, for each MCO a random selection of Traumatic Brain Injury (10) members was included in the sample. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 HCBS MLTSS members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 145 cases selected for the MCO, 145 member files were reviewed and 142 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	10
Group D	Current Members Newly Enrolled to MLTSS	68
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	39
Ancillary Group	Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure	25
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	3

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 72.1% to 96.4% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 2020– June 2021			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		90.3%		90.3%
Outreach	80.0%	77.9%		78.2%
Telephonic Monitoring (Formerly Face-to-Face) Visits	82.9%	89.7%	88.1%	88.7%
Initial Plan of Care (Including Back-up Plans)	88.2%	90.5%	80.8%	87.3%
Ongoing Care Management	78.8%	71.5%	71.0%	72.1%
Gaps in Care/Critical Incidents	75.0%	97.9%	100.0%	96.4%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

TBI Population-specific findings are presented in Table 3a, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Table 3a provides the aggregate scores only for TBI members.

Table 3a. Results by TBI Population

	July 2020 - June 2021			
Determination by Category	**Group C[1]**	**Group D**	**Group E[1,2]**	**Combined[3]**
Case Count TBI Population	0	2	8	10
Assessment		75.0%		75.0%
Outreach	NA	100.0%		100.0%
Telephonic Monitoring (Formerly Face-to-Face) Visits	NA	88.9%	90.9%	90.5%
Initial Plan of Care (Including Back-up Plans)	NA	95.0%	82.5%	85.0%
Ongoing Care Management	NA	83.3%	70.6%	73.9%
Gaps in Care/Critical Incidents	NA	100.0%	100.0%	100.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 10 files were reviewed for new members enrolled in managed care and newly eligible for MLTSS (Group C). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 10 files were further reviewed for compliance in five (5) categories.

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	8	10	80.0%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	10	10	100.0%
Options Counseling was provided to the Member.	5	10	50.0%
Member was offered the participant direction option during options counseling.	10	10	100.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	1	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	8	10	80.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	8	10	80.0%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	10	10	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	4	5	80.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	1	0.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.)	10	10	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	5	10	50.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	5	5	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	5	5	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	5	5	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS)	5	5	100.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	10	10	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	7	10	70.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	6	10	60.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	3	3	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	3	3	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	5	5	100.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	1	1	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	1	1	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	5	10	50.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	10	10	100.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 68 files were reviewed for members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 68 files were further reviewed for compliance in all six (6) categories.

	July 2020 – June 2021		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested	67	68	98.5%
Screening for Community Services Assessment was submitted to DoAs by the 10th of the following month.	54	66	81.8%

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	53	68	77.9%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	65	68	95.6%
Options Counseling was provided to the Member.	61	68	89.7%
Member was offered the participant direction option during options counseling.	67	68	98.5%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	19	29	65.5%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	58	68	85.3%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	53	68	77.9%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	67	68	98.5%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	28	64	43.8%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	12	13	92.3%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	67	68	98.5%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	61	68	89.7%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	66	67	98.5%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	66	66	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	66	67	98.5%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	65	66	98.5%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	67	68	98.5%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	53	68	77.9%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	6	8	75.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	28	68	41.2%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	14	14	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	14	14	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	59	66	89.4%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	1	0.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	8	18	44.4%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	6	6	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	67	68	98.5%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	4	4	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	66	68	97.1%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 39 files were reviewed for the members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Outreach is not assessed for members in Group E. All 39 files were reviewed for compliance in four (4) categories.

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	32	32	100.0%
Options Counseling was provided to the Member.	25	32	78.1%
Member was offered the participant direction option during options counseling.	31	32	96.9%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	0	6	0.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	30	32	93.8%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the member's anniversary (from the date of the Initial Plan of Care).	13	39	33.3%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	32	32	100.0%
Member file had documentation to demonstrate contact with the members' HCBS providers at least annually to discuss the providers' reviews of the member's needs and status and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	28	32	87.5%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	1	1	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	32	32	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	32	78.1%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	27	27	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	27	27	100.0%
Care Manager completed an Annual Risk Assessment for the member (not applicable for Members residing in CARS).	31	32	96.9%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.	3	32	9.4%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	31	31	100.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	32	32	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	19	32	59.4%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	0	N/A
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	24	27	88.9%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	5	9	55.6%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	0	N/A

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	32	32	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	32	32	100.0%

4. Performance Measures

The performance measures results summarize the MCO's performance in terms of the MLTSS measures. Of the total 25 cases selected for the MCO, 25 member files were reviewed and 25 were included in the file review.

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Performance Measure #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment) was not validated during the audit this year.

Population-specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's Plan of Care is reviewed annually within 30 days of Members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2020 and 2021 audit findings. Overall, The MCO's audit results ranged from 33.3% to 100% across all groups for six (6) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: AGNJ

Performance Measure	Group[1]	July 2020 – June 2021		
		N	**D**	**Rate**
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	8	10	80.0%
	Group D	53	68	77.9%
	Group E			
	Ancillary Group C	0	0	N/A
	Ancillary Group D	21	25	84.0%
	Total	82	103	79.6%

#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	13	39	33.3%
	Total	13	39	33.3%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	1	1	100.0%
	Group D	6	6	100.0%
	Group E	0	0	N/A
	Total	7	7	100.0%
#11. Plans of Care developed using "person-centered principles"[5]	Group C	5	10	50.0%
	Group D	61	68	89.7%
	Group E	25	32	78.1%
	Total	91	110	82.7%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group C	5	5	100.0%
	Group D	66	67	98.5%
	Group E	27	27	100.0%
	Total	98	99	99.0%
#16. Member training on identifying/reporting critical incidents	Group C	10	10	100.0%
	Group D	66	68	97.1%
	Group E	32	32	100.0%
	Total	108	110	98.2%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period
[4]Members who did not have a documented change in condition during the study period are excluded from this measure
[5]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[6]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 90.3% in the Assessment category.

Group	7/20 to 6/21
Group C	

Group	7/20 to 6/21
Group D	90.3%
Group E	
Combined	90.3%

Member Outreach

Across groups, the MCO had a combined score of 78.2% in the Member Outreach category.

Group	7/20 to 6/21
Group C	80.0%
Group D	77.9%
Group E[1]	
Combined	78.2%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

Opportunities for improvement for the elements of Member Outreach include the following:

- Group C: Amerigroup should ensure that the Care Manager contacts the member within five business days of MLTSS enrollment to schedule a telephonic visit to develop their Plan of Care.

- Group D: Amerigroup should ensure the Care Manager contacts the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.

Telephonic Monitoring (Formerly Face-to-Face) Visits

Across all three groups, the MCO had a combined score of 88.7% in the Telephonic Monitoring Visits category.

Group	7/20 to 6/21
Group C	82.9%
Group D	89.7%
Group E	88.1%
Combined	88.7%

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 87.3% in the Initial Plan of Care (Including Back-up Plans) category.

Group	7/20 to 6/21
Group C	88.2%
Group D	90.5%
Group E	80.8%
Combined	87.3%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 72.1% in the Ongoing Care Management category.

Group	7/20 to 6/21
Group C	78.8%
Group D	71.5%

Group E	71.0%
Combined	72.1%

Opportunities for improvement for elements of the Ongoing Care Management category include the following:

- Group C: Amerigroup should ensure approved/authorized MLTSS services are in place within forty-five (45) days of MLTSS enrollment, with the exemption of residential and vehicle modifications. Amerigroup should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for members in CARS.

- Group D: Amerigroup should ensure approved/authorized MLTSS services are in place within forty-five (45) calendar days of MLTSS enrollment, with the exemption of residential and vehicle modifications. Amerigroup should ensure that Care Managers document their actions to resolve any issues that impede Members' access to care. Amerigroup should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. Amerigroup should ensure that the MLTSS Care Manager conducts a telephonic visit within 24 hours for urgent/emergent situations. Amerigroup should ensure that the Care Manager completes a telephonic visit within 10 business days of the Member's discharge from an institutional facility to a HCBS setting.

- Group E: Amerigroup should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. Amerigroup should ensure that the Care Manager completes a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 96.4% in the Gaps in Care/Critical Incidents category.

Group	7/20 to 2/21
Group C	75.0%
Group D	97.9%
Group E	100.0%
Combined	96.4%

Performance Measures

Overall, the MCO scored below 86% in three (3) of the six (6) performance measures.

- #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (79.6%).
- #9: Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (33.3%).
- #11: Plans of Care developed using "person-centered principles" (82.7%).

- **Opportunities for improvement for Performance Measures include the following:**

- #8: Amerigroup should ensure that the Initial Plans of Care is developed within 45 days of enrollment into the MLTSS program.

- #9: Amerigroup should ensure that the Care Manager reviews the Member's Plan of Care within 30 days of the Member's MLTSS anniversary and as necessary.
- #11: Amerigroup should ensure that the Plan of Care reflects "Person-Centered Principles", and the Member/Member Representative is present and involved in the Plan of Care development.

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

Amerigroup New Jersey, Inc.
Managed Long Term Services and Supports (MLTSS)
2021 Annual Assessment Review of
Care Management

Review Period - July 1, 2020 to June 30, 2021

October 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by AGNJ as evidence of compliance of the standards under review; interviews with key AGNJ staff (held via WebEx on August 24, 2021); and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on June 18, 2021 and received from the MCOs on July 2, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on July 6, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2020, to June 30, 2021. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

During the offsite review, the MCO had the opportunity to provide supplemental documentation as requested by IPRO.

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met and therefore be considered full reviews every year.

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2021 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit were completed and sent to the MCOs on October 20, 2021.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. AGNJ received an overall compliance score of 100% in 2021. In 2020, the MCO received a score of 90% for this category. **Table 1a** presents an overview of the results, **Table 1b** presents Contract language for resolved element(s).

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	-	X	X	-	-	-	X	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	9	10	10	0	0	0	1	0
Compliance Percentage	90%		100%					

Table 1b: Findings for Resolved MLTSS Care Management and Continuity of Care Elements

Element	Contract Language	
CM18b	4.6.5.D.6 If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty-five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3.B The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: Notify providers of their role in providing continuity of care for their members in transition. 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services. 9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Strengths

None

Recommendations

None

Findings for Improvement

None

New Jersey Annual Assessment of MCO Operations

MLTSS HCBS CM
2021 Audit Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.64.1.1.F.1 9.3.3.B 9.3.3.C 9.6.6.E 4.1.1.E 9.6.6.F	**4.6.5.D.6** If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3.B The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: Notify providers of their role in providing continuity of care for their Members in transition; 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services;	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-effective manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1.D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health and long term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1.J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2.B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or	▪ Care Management job descriptions used in recruitment ▪ Organization Chart with CM names

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members; 2. Caseload management and casework practices; 3. Human services principles for determining eligibility for benefits and services; 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	▪ CM resumes
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A MLTSS Training The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements. 9.5.4.A A. The Contractor shall develop standards for Care Management Training which includes the following components: 1. Training curriculum including goals of training, competency standards, and frequency of retraining 2. Quality Assurance program to identify inter/intra-rater reliability and core standards 3. Continue Quality Assurance standards to ensure standards are being met	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Remediation training plan for employees who do not meet the standards 9.5.4.BCare Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.	
CM34	9.5.5.J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g. holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2.A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4.A	4.7.4 **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			related to compliance.
CM38	9.4.1.A.4 9.5.1.E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
Amerigroup New Jersey, Inc.

Review Period: July 2019 – February 29, 2020
Expansion Period: March 1, 2020 – December 31, 2020
October 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019 through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.

Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2019 and January 2020. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

The audit is comprised of two review periods: July 1, 2019 through February 29, 2020, and an expansion period from March 1, 2020 to December 31, 2020. The initial review period includes an assessment of all audit elements and the expansion period focuses specific elements aimed to evaluate the MCOs COVID-19 response for NF members. Only the review period from July 1, 2019 to February 29, 2020 has been considered in determining the final Audit scoring. Audit elements applicable to both review periods can be compared to evaluate MCO performance across review periods. Audit elements that are only applicable to the initial assessment period are not compared to any other review periods.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, the NF audit to evaluate the period from of July 2018 through June 2019 was suspended. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and

presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit tool to evaluate the measures for the applicable population.

Based on the extensive revisions to the NJ EQRO MLTSS NF Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior review period's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Amerigroup New Jersey, Inc. (AGNJ), including an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on December 31, 2020,
  And

- The member must have been enrolled as an NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on December 31, 2020,
  And
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (December 31, 2020).

Members residing in a NF/SCNF less than six consecutive months at any time between July 1, 2019 and February 29, 2020 (starting July 1, 2019) were excluded.

In order to collect additional information for MLTSS Members who transitioned between HCBS and a NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between July 1, 2019 and February 29, 2020 with the MCO of record on February 29, 2020
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between July 1, 2019 and February 29, 2020, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between July 1, 2019 and December 31, 2019, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of February 29, 2020)
Group 4	Members residing in HCBS for at least one month between July 1, 2019 and November 30, 2019, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for AGNJ, 100 member files were reviewed and included in the audit results. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Care Management Outreaches, Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting, and PASRR Communication (see Tables 2a-f). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold both in the tables and Conclusion section of this report. All rates for the Expansion Period from March 1, 2020 through December 31, 2020 are for informational purposes only and are not considered as part of the final audit score in the Conclusions section of this report.

Table 2a.

Facility and MCO Plan of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	90	100	90.0%
Documented Review of the Facility Plan of Care by the Care Manager	90	90	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	79	90	87.8%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	1	6	16.7%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	88	100	88.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	88	100	88.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	88	100	88.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	88	100	88.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record.	88	100	88.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	0	CNC

CNC: Could not calculate

Table 2c.

Transition Planning	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	94	100	94.0%	100	100	100.0%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	13	100	13.0%	10	100	10.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	93	100	93.0%	100	100	100.0%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	69	100	69.0%	80	100	80.0%
Members requiring coordination of care had coordination of care by the Care Manager	94	100	94.0%			
Care Manager explained and discussed any payment liability with the Member	83	100	83.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions; significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	46	61	75.4%			
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	81	100	81.0%	99	100	99.0%
Care Manager reviewed the Member's Rights and Responsibilities	90	100	90.0%			
Care Manager educated the Member on how to file a grievance and/or an appeal	91	100	91.0%			
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	90	100	90.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2019-February 29, 2020)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period*	100		
Member was admitted to an NF/SCNF during the review period*	0		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	0	0	CNC
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	CNC

*Element not scored

CNC: Could not calculate

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for AGNJ, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold both in the tables and Conclusion section of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

Transitions from NF/SCNF to HCBS	Review Period (July 1, 2019-February 29, 2020) Groups 2, 4			Expansion Period (March 1, 2020-December 31, 2020) Groups 2, 4		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC			
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC			
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC			
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC			
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC			
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC			

CNC: Could not calculate

Reviews of this population are optional and not scored

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions from HCBS to NF/SCNF	Review Period (July 1, 2019-February 29, 2020) Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

Reviews of this population are optional and not scored

The expansion of the Nursing Facility audit components included evaluating the NF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of

Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: AGNJ

Performance Measure	Group	July 2019 – February 2020		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	1	6	16.7%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**1**	**6**	**16.7%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	81	100	81.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**81**	**100**	**81.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0	0	CNC
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**0**	**0**	**CNC**
#11. Plans of Care developed using "person-centered principles" [4]	Group 1	88	100	88.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**88**	**100**	**88.0%**
#16. Member training on identifying/reporting critical incidents	Group 1	90	100	90.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**90**	**100**	**90.0%**

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[2]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[3]Members who did not have a documented change in condition during the study period are excluded from this measure.
[4]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
CNC: Could not calculate; N/A: Not applicable

Limitations

The annual NF CM audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. The 2020 NF CM review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (90.0%)
- Documented Review of the Facility Plan of Care (100.0%)
- MLTSS Plan of Care on file (87.8%)
- Care Managers used a person-centered approach (88.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (88.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (88.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (88.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (88.0%)
- Member was identified for transfer to HCBS and was offered options (94.0%)
- Member was present at each onsite visit (93.0%)
- Members requiring coordination of care had coordination of care (94.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (90.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (91.0%)
- Member and/or representative had training on how to report a critical incident (90.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (16.7%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (13.0%)
- Timely Onsite Review of Member Placement and Services (69.0%)
- Care Manager explained and discussed any payment liability (83.0%)
- NJCA was completed to assess the Member (75.4%)
- Plan of Care was updated, reviewed, and signed by the member (81.0%)

Recommendations for audit elements include the following:

Amerigroup should ensure the Plan of Care is signed and developed in collaboration with the Member and mailed within 45 days of MLTSS enrollment. Prior to March 1, 2020 Amerigroup's MLTSS Care Managers should have utilized the New Jersey Choice Assessment (NJCA) to assess Members. The Care Manager should ensure the Member's Plan of Care is reviewed, revised if applicable, and signed by the Member/POA. The Care Manager should confirm that there is documentation of the Member's participation in at least one Facility IDT meeting annually. Amerigroup should ensure the MLTSS Care Managers discusses payment liability, and reviews the Member's placement and services timely.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (16.7%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (81.0%)

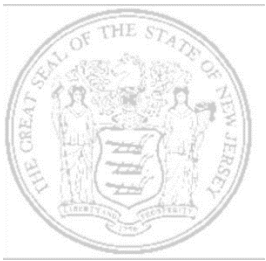
Recommendations for MLTSS Performance Measures include the following:

Amerigroup should ensure that the Member's Initial Plan of Care is developed within 45 days of enrollment into the MLTSS program. Amerigroup's MLTSS Care Managers should certify that the Member's Plan of Care is reviewed as needed, and annually within 30 days of the Member's MLTSS anniversary.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix D – HNJH 2021 Core Medicaid and MLTSS Care Management Audit Reports



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of Quality Assurance

MCO Care Management Chart Audit and Annual Assessment

Horizon NJ Health

Contract Year 4

August 2021

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The purpose of the Care Management audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates MCO performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO Contract requirements for Care Management services including MCO Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit Tool, it was agreed upon by IPRO and DMAHS that for the General Population only, the results in the current review period will not be compared to the prior year's reported rates because there can be no direct comparison from the current Audit Tool to the previous Audit Tool.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the two populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the

selection of 342 cases for Horizon NJ Health (HNJH), including a 10% oversample for the GP and a 40% oversample for the DCP&P population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. Random samples of 140 Enrollees for the DCP&P Population (including an oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (92).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 49499. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/20	>= 3 months as of 12/31/2020	>= 3 months and < 18 years as of 12/31/2020
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2020 to 7/1/2020	Initial enrollment between 1/1/2020 and 12/31/2020	Initial enrollment between 1/1/2020 and 12/31/2020
Current Enrollment	Enrolled as of 12/31/2020	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2020 allowing no more than a one month gap.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an offsite review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Horizon's 2020 audit results ranged from 71% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP	DDD	DDD	PPD	DCP&P	DCP&P	PPD
	2020 (n=100)	2020 (n=92)	2019 (n=68)		2020 (n=100)	2019 (n=100)	
Identification[1]	88%						
Outreach	91%	98%	99%	-1%	94%	99%	-5%
Preventive Services	84%	75%	77%	-2%	86%	91%	-5%
Continuity of Care	71%	84%	79%	5%	90%	90%	0%
Coordination of Services	79%	100%	99%	1%	100%	100%	0%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 11 Enrollees were new Enrollees, and 89 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification - GP Population

Identification	General Population		
	Numerator	Denominator	Percent
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	1	4	25.0%
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)	3	9	33.3%
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only)*	10	11	90.9%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	11	100.0%[1]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2019)*	15	89	16.9%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2019)	3	74	95.9%[1]

Identification	General Population		
	Numerator	Denominator	Percent
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2019 not already in Care Management)*	66	74	89.2%

**Not Included in aggregate score calculation*

[1] Percentage rate is indicative of an inverse percentage

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (76).

Table 4: Outreach - GP Population

Outreach	General Population		
	Numerator	Denominator	Percent
Initial outreach to complete a CNA was done	72	76	94.7%
The outreach for CNA was timely within 30 days of the identification of CM needs	62	72	86.1%
Outreach was successful (even if the Enrollee declines to complete the CNA)*	42	72	58.3%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	25	39	64.1%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	19	42	45.2%
The Enrollee declined Care Management*	26	72	36.1%

**Not Included in aggregate score calculation*

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (36). There were four (4) Enrollees under the age of 21 years old and thirty-two (32) Enrollees over the age of 21.

Table 5: Preventive Services - GP Population

Preventive Services	General Population		
	Numerator	Denominator	Percent
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	4	4	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status	0	0	CNC[1]
The Care Manager sent EPSDT reminders	0	0	CNC
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	4	4	100.0%
Aggressive outreach attempts were documented to confirm immunization status	0	0	CNC
Appropriate vaccines have been administered for Enrollees age 18 and above	25	32	78.1%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	7	7	100.0%
Dental needs are addressed for Enrollees age 21 and above	29	32	90.6%
A dental visit occurred during the review period for Enrollees age 1 to 21	1	4	25.0%
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	3	3	100.0%
Dental reminders were sent to Enrollees age 1 to 21	3	3	100.0%
Enrollees age 9 months to 26 months were tested twice for lead	2	3	66.7%
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	1	0.0%
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	1	1	100.0%
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	1	1	100.0%

[1] Could not calculate

Continuity of Care

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (36).

Table 6: Continuity of Care - GP Population

Continuity of Care	General Population		
	Numerator	Denominator	Percent
A Comprehensive Needs Assessment was completed for the Enrollee	15	36	41.7%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources) (applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.*	9	13	69.2%
A level of Care Management was determined for the Enrollee	15	15	100.0%
The Enrollee is in Community Based Care Management (CBCM)*	2	36	5.6%
A Care Plan was completed for the Enrollee that included all required components	16	16	100.0%
The Care Plan was developed within 30 days of CNA Completion	10	16	62.5%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	9	9	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	2	2	100.0%

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (36).

Table 7: Coordination of Services - GP Population

Coordination of Services	General Population		
	Numerator	Denominator	Percent
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	9	36	25.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	36	36	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	36	36	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	18	18	100.0%

DDD Population Findings

A total of 92 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach - DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	92	92	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	88	92	95.7%	98.5%	-2.9
Outreach was successful (even if the Enrollee declines to complete the CNA)*	60	92	65.2%	77.9%	-12.7
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	51	60	85.0%	100.0%	-15.0
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	2	60	3.3%	0.0%	3.3
The Enrollee declined Care Management*	0	92	0.0%	0.0%	0.0

**Not Included in aggregate score calculation*

Preventive Services

Table 9: Preventive Services -DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	38	56	67.9%	59.5%	8.3
Aggressive outreach attempts were documented to confirm EPSDT status	18	18	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	18	18	100.0%	100.0%	0.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	31	39	79.5%	79.2%	0.3
Aggressive outreach attempts were documented to confirm immunization status	8	8	100.0%	100.0%	0.0
Appropriate vaccines have been administered for Enrollees age 18 and above	24	53	45.3%	54.5%	-9.3
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	29	29	100.0%	100.0%	0.0
Dental needs are addressed for Enrollees age 21 and above	25	36	69.4%	96.2%	-26.7
A dental visit occurred during the review period for Enrollees age 1 to 21	31	56	55.4%	50.0%	5.4
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	25	25	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	25	25	100.0%	100.0%	0.0
Enrollees age 9 months to 26 months were tested twice for lead	1	1	100.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	0	CNC[1]		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	0	0	CNC	100.0%	CNC
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	0	0	CNC	100.0%	CNC

[1] Could not calculate

Continuity of Care

Table 10: Continuity of Care - DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	59	92	64.1%	77.9%	-13.8
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	23	59	39.0%	71.7%	-32.7
A level of Care Management was determined for the Enrollee	59	59	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management (CBCM)*	0	92	0.0%	8.8%	-8.8
A Care Plan was completed for the Enrollee that included all required components	59	59	100.0%		
The Care Plan was developed within 30 days of CNA Completion	58	59	98.3%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	2	2	100.0%	52.9%	47.1
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	100.0%	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 11: Coordination of Services - DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	92	92	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	61	61	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	62	62	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	8	8	100.0%	100.0%	0.0
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2020, the Care Manager documented evidence of follow up within 30 days of discharge	2	2	100.0%	75.0%	25.0
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[1]	0.0%	CNC

[1] Could not calculate

DCP&P Population Findings

A total of 131 files were reviewed for the DCP&P Population. Thirty-one (31) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach - DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	100	100	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	87	100	87.0%	98.0%	-11.0
Outreach was successful (even if the Enrollee declines to complete the CNA)*	98	100	98.0%	98.0%	0.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	56	57	98.2%	97.9%	0.3
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	98	0.0%	0.0%	0.0

**Not Included in aggregate score calculation*

Preventive Services

Table 13: Preventive Services - DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	98	100	98.0%	99.0%	-1.0
Aggressive outreach attempts were documented to confirm EPSDT status	2	2	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	2	2	100.0%	100.0%	0.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	86	100	86.0%	94.0%	-8.0
Aggressive outreach attempts were documented to confirm immunization status	14	14	100.0%	100.0%	0.0
Appropriate vaccines have been administered for Enrollees age 18 and above	0	0	CNC[1]	CNC	CNC
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	0	0	CNC	CNC	CNC
Dental needs are addressed for Enrollees age 21 and above	0	0	CNC	CNC	CNC
A dental visit occurred during the review period for Enrollees age 1 to 21	38	45	84.4%	94.7%	-10.3
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	7	7	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	7	7	100.0%	100.0%	0.0
Enrollees age 9 months to 26 months were tested twice for lead	1	20	5.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	3	9	33.3%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	19	19	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	19	19	100.0%	100.0%	0.0

[1] Could not calculate

Continuity of Care

Table 14: Continuity of Care - DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	100	100	100.0%	98.0%	2.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	62	100	62.0%	69.4%	-7.4
A level of Care Management was determined for the Enrollee	100	100	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	99	99	100.0%		
The Care Plan was developed within 30 days of CNA Completion	98	99	99.0%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	5	5	100.0%	97.5%	2.5
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%	100.0%	0.0

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	100	100	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	98	98	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	100	100	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	7	7	100.0%	100.0%	0.0

Discussion

Limitations

No limitations are noted

Corrective Action Plan/Work Plan

HNJH was not required to submit a Work Plan or CAP for the CM Chart Audit findings due to the public health emergency. HNJH was required to develop CAPs for IPRO's review of the elements in the CM section of the Annual Assessments.

Conclusions and Recommendations

Overall, the MCO scored 85%or above in the following review elements (**Table 2**):

- Identification (General Population) (88%)
- Outreach (General Population) (91%)
- Outreach (DDD Population) (98%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (94%)
- Preventive Services (DCP&P Population) (86%)
- Continuity of Care (DCP&P Population) (90%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 2**):

- Preventive Services (General Population) (84%)
- Continuity of Care (General Population) (71%)
- Coordination of Services (General Population) (79%)
- Preventive Services (DDD Population) (75%)
- Continuity of Care (DDD Population) (84%)

Opportunities for improvement for the General Population

Preventive Services

- HNJH should ensure Enrollees age 18 and above receive appropriate vaccines.
- HNJH should ensure that dental needs and visits are addressed for Enrollees age 1 to 21 years, and Care Managers should document the date of the Enrollees annual dental visit.
- HNJH should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence.

Continuity of Care

- HNJH should ensure the CNA is completed within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources, (referrals, utilization reports, pharmacy data, risk scores, clinical judgment).
- HNJH's should ensure timely Plan of Care development within 30 days of a completed CNA.

Coordination of Services

- HNJH should ensure Care Managers contact Case Managers from DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P, the family, PCPs, specialists and the local health department when appropriate.

Opportunities for improvement for the DDD Population

Preventive Services

- For Enrollees under 21 years of age, HNJH should confirm that the EPSDT exam is up-to-date, per the periodicity exam schedule, and confirmed by a reliable source.
- HNJH should continue to focus on age-appropriate immunizations for Enrollees ages 0 to 18, and confirm immunizations status from a reliable source, such as the PCP or the NJ immunization registry.
- HNJH should ensure Enrollees age 18 and above receive appropriate vaccines.
- HNJH should ensure dental needs are addressed for Enrollees 21 and above.
- HNJH should ensure that dental needs and visits are addressed for Enrollees age 1 to 21 years, and Care Managers should document the date of the Enrollees annual dental visit.

Continuity of Care

- HNJH should ensure a Comprehensive Needs Assessment is completed, and inclusive of all required elements within 45 days for newly enrolled DDD Enrollees**.**

Care Management and Continuity of Care

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Horizon New Jersey Health (HNJH) as evidence of compliance of the standard under review; offsite review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key HNJH staff via WebEx were held on April 29, 2021, and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on February 11, 2021 and received documentation from the MCOs on February 26, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on March 1, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2020 to December 31, 2020.

During the offsite review , the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance in partial and full reviews.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all of the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle, but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle, but was not met in the current review cycle.	Full, Partial

The Care Management and Continuity of Care review category examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review category also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

There are 30 Contractual provisions in this category. HNJH received an overall compliance score of 83% in 2021. In 2020, the MCO received a score of 83% for this category. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2021. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2020 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	-	X	X	-	-	-	X	-
CM3	X	X	X	-	-	-	-	-
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	X	X	-	X	-	-	-	X
CM7	-	X	-	X	-	X	-	-
CM8	-	X	X	X	-	X	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	-	X	X	-	-	-	X	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	-	X	-	-	-	X
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37[1]	X	X	X	-	-	-	-	-
TOTAL	**25**	**30**	**25**	**5**	**0**	**3**	**2**	**2**
Compliance Percentage			**83%**					

[1]This documentation element is reviewed in any year where there are elements subject to review.

Table 18: Findings for Deficient Care Management and Continuity of Care Elements

Element	Contract Language	Reviewer Comments
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	In the 2021 CM file audit the Plan scored: • 25% for the General Population Enrollees, who had an IHS is completed within 45 days of enrollment for new Enrollees and 33.3% when aggressive outreach was attempted and documented when initial outreach was unsuccessful.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	In the 2021 CM file audit the Plan scored: • 69.2% for General Population Enrollees, who had a Comprehensive Needs Assessment completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources. For the DDD Enrollees the Plan scored: • 64.1% for completed Comprehensive Needs Assessments including all the required elements and 39% for Comprehensive Needs Assessments completed within 45 days of enrollment. For the DCP&P Enrollees the Plan scored: • 62% for Comprehensive Needs Assessments completed within 45 days of enrollment.

Element	Contract Language	Reviewer Comments
	http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM File audit the Plan scored: • 62.5% for the General Population Enrollees, who's Plan of Care was developed within 30 days of CNA completion.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 79.5% for the DDD Enrollees, age 0-18 years, immunizations are up-to-date and immunization status is confirmed by a reliable source. • 67.9% for the DDD Enrollees, up-to-date EPSDT exam per periodicity schedule ages under 21 years of age, and confirmed by a reliable source. • 25% for the General Population Enrollees, 55.4%% for DDD and 84.4% for DCP&P Population age 1-21 years, for dental visits occurring during the audit period. • 69.4% for the DDD Enrollees, age 21 years and above whose dental needs were addressed. • 78.1% of the General Population Enrollees and 45.3% of the DDD Enrollees, who received appropriate vaccines for Enrollees 18 years and older. • 66.7% for the General Population, 5% of the DCP&P Population, ages 9 to 26 months tested twice for lead. 0% for General Population and 33.3% of the DCP&P. never tested for lead before 24 months of age.
CM19	**4.6.5.E** **Documentation**	In the 2021 CM file audit the Plan scored: • 25% for the General Population, the Plan outreached and forged ongoing partnerships

Element	Contract Language	Reviewer Comments
	The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	and communication linkages with independent client advocates; Area Agencies on Aging/Aging and Disability Resource Connections (ADRCs); the Division of Aging Services (DoAS); Office of Community Choice Options (OCCO); County Welfare Agencies (CWAs); the Department of Community Affairs; the Division of Disability Services (DDS); County Offices on Disability; the State Health Insurance Assistance Program (SHIP), the Centers for Independent Living (CIL); Early Intervention Special Child Health Services; and both County and State Offices of Emergency.

Table 19: Findings for Resolved Deficiencies for Care Management and Continuity of Care Elements

Element	Contract Language
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.

Strengths

None

Recommendations

1. CM6: The Plan should ensure the IHS is completed within 45 days of enrollment for new Enrollees and aggressive outreach was attempted and documented when initial outreach was unsuccessful.
2. CM7: The Plan should ensure that the CNA is completed within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources. The Plan should ensure a level of Care Management is assigned to applicable General Population Enrollees.

3. CM7: The Plan should ensure a CNA is completed with all required components within 45 days of enrollment for the DDD and DCP&P Enrollees.
4. CM8: The Plan should ensure a Plan of Care including all required components is developed within 30 days of CNA completion for the General Population Enrollees.
5. CM14: The Plan should ensure that Enrollees are educated on the importance of receiving Preventative Services, Immunizations, Vaccines, Dental Care and Lead Testing as applicable for the General, DDD and DCP&P Populations.
6. CM14: The Plan should certify that Preventative Services: Exams and Immunization are up-to-date and status is confirmed by a reliable source for the DDD and DCP&P Populations under 21 years of age.

7. CM19: The Plan should ensure Care Managers forged ongoing partnerships and communication linkages with independent client advocates, for the General Population.

Findings for Improvement

None

2021 Core Medicaid Care Management Document Submission Guide

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of, or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** The Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would	

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees,	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7*	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8*	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measureable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan:** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s)

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCOs must develop policies and	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18b	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18c	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19*	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5.I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5.L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4.6.5.L Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Horizon New Jersey Health

Review Period July 1, 2020 – June 30, 2021

January 2022

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2020 through 6/30/2021. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2020. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 145 cases for Horizon New Jersey Health (HNJH), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care, and Newly Eligible for MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care members enrolled in MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care members enrolled in MLTSS prior to 7/1/2020 and continuously enrolled in MLTSS through 6/30/2021	• The member must have been initially enrolled in MLTSS HCBS prior to 7/1/2020. • The member must have remained enrolled in MLTSS HCBS through 6/30/2021 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. Additionally, for each MCO a random selection of Traumatic Brain Injury (10) members was included in the sample. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 HCBS MLTSS members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 145 cases selected for the MCO, 145 member files were reviewed and 142 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	36
Group D	Current Members Newly Enrolled to MLTSS	38
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	43
Ancillary Group	Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure	25
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	3

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 81.1% to 100% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 2020 – June 2021			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		93.2%		93.2%
Outreach	88.9%	97.4%		93.2%
Telephonic Monitoring (Formerly Face-to-Face) Visits	91.0%	91.3%	90.4%	90.9%
Initial Plan of Care (Including Back-up Plans)	97.5%	96.3%	86.7%	93.8%
Ongoing Care Management	84.1%	81.0%	75.0%	81.1%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

TBI Population-specific findings are presented in **Table 3a,** which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Table 3a provides the aggregate scores only for TBI members.

Table 3a. Results by TBI Population

	July 2020 - June 2021			
Determination by Category	**Group C[1]**	**Group D**	**Group E[1,2]**	**Combined[3]**
Case Count TBI population	1	0	9	10
Assessment		NA		NA
Outreach	0.0%	NA		0.0%
Telephonic Monitoring (Formerly Face-to-Face) Visits	75.0%	NA	94.4%	92.5%
Initial Plan of Care (Including Back-up Plans)	100.0%	NA	85.1%	86.5%
Ongoing Care Management	100.0%	NA	78.6%	82.4%
Gaps in Care/Critical Incidents	100.0%	NA	100.0%	100.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 36 files were reviewed for new members enrolled in managed care and newly eligible for MLTSS (Group C). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 36 files were further reviewed for compliance in five (5) categories.

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	32	36	88.9%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	36	36	100.0%
Options Counseling was provided to the Member.	36	36	100.0%
Member was offered the participant direction option during options counseling.	35	36	97.2%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	7	11	63.6%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	27	36	75.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	31	36	86.1%

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	36	36	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	17	19	89.5%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	5	5	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	36	36	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	36	36	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	22	22	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	22	22	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	22	22	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	6	6	100.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	36	36	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	33	36	91.7%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	25	36	69.4%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	3	3	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	3	3	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	20	22	90.9%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	1	0.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	2	2	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	3	3	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	36	36	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	36	36	100.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 38 files were reviewed for members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 38 files were further reviewed for compliance in all six (6) categories.

	July 2020 – June 2021		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	36	38	94.7%
Screening for Community Services Assessment was submitted to DoAs by the 10th of the following month.	33	36	91.7%

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	37	38	97.4%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	38	38	100.0%
Options Counseling was provided to the Member.40	36	38	94.7%
Member was offered the participant direction option during options counseling.	30	38	78.9%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	7	8	87.5%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	35	38	92.1%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	NA

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	37	38	97.4%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	38	38	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	18	28	64.3%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	7	7	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	38	38	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	36	38	94.7%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	37	37	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	37	37	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	37	37	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	13	13	100.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	38	38	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	38	38	100.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	2	2	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	21	38	55.3%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	3	3	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	3	3	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	31	37	83.8%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	1	1	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	1	0.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	3	3	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	38	38	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	38	38	100.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 43 files were reviewed for the members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Outreach is not assessed for members in Group E. All 43 files were reviewed for compliance in four (4) categories.

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	26	26	100.0%
Options Counseling was provided to the Member.	25	26	96.2%
Member was offered the participant direction option during options counseling.	21	26	80.8%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	0	0	N/A
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	22	26	84.6%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the member's anniversary (from the date of the Initial Plan of Care).	40	43	93.0%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	25	26	96.2%

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member file had documentation to demonstrate contact with the members' HCBS providers at least annually to discuss the providers' reviews of the member's needs and status and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	26	26	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	26	96.2%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	26	96.2%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	20	22	90.9%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	20	20	100.0%
Care Manager completed an Annual Risk Assessment for the member (not applicable for Members residing in CARS.	22	26	84.6%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.	3	26	11.5%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	3	4	75.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	26	26	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	15	26	57.7%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	1	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	1	1	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	19	20	95.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A

Ongoing Care Management	July 2020 – June 2021 N	D	Rate
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	0	N/A

Gaps in Care/Critical Incidents	July 2020 – June 2021 N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	26	26	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	26	26	100.0%

4. Performance Measures

The performance measures results summarize the MCO's performance in terms of the MLTSS measures. Of the total 25 cases selected for the MCO, 25 member files were reviewed and 25 were included in the file review.

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Performance Measure #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment) was not validated during the audit this year.

Population-specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's Plan of Care is reviewed annually within 30 days of Members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2020 and 2021 audit findings. Overall, The MCO's audit results ranged from 90.9% to 100% across all groups for six (6) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: HNJH

Performance Measure	Group[1]	July 2020 – June 2021 N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	31	36	86.1%
	Group D	37	38	97.4%
	Group E			
	Ancillary Group C	8	9	88.9%
	Ancillary Group D	14	16	87.5%
	Total	90	99	90.9%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	40	43	93.0%
	Total	40	43	93.0%
	Group C	3	3	100.0%

#9a. Member's Plan of Care is amended based on change of member condition[4]	Group D	3	3	100.0%
	Group E	0	0	N/A
	Total	6	6	100.0%
#11. Plans of Care developed using "person-centered principles"[5]	Group C	36	36	100.0%
	Group D	36	38	94.7%
	Group E	25	26	96.2%
	Total	97	100	97.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group C	22	22	100.0%
	Group D	37	37	100.0%
	Group E	20	22	90.9%
	Total	79	81	97.5%
#16. Member training on identifying/reporting critical incidents	Group C	36	36	100.0%
	Group D	38	38	100.0%
	Group E	26	26	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period
[4]Members who did not have a documented change in condition during the study period are excluded from this measure
[5]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[6]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 93.2% in the Assessment category.

Group	7/20 to 6/21
Group C	
Group D	93.2%
Group E	
Combined	93.2%

Member Outreach

Across groups, the MCO had a combined score of 93.2% in the Member Outreach category.

Group	7/20 to 6/21
Group C	88.9%
Group D	97.4%
Group E[1]	
Combined	93.2%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

Telephonic Monitoring (Formerly Face-to-Face) Visits

Across all three groups, the MCO had a combined score of 90.9% in the Telephonic Monitoring Visits category.

Group	7/20 to 6/21
Group C	91.0%
Group D	91.3%
Group E	90.4%
Combined	90.9%

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 93.8% in the Initial Plan of Care (Including Back-up Plans) category.

Group	7/20 to 6/21
Group C	97.5%
Group D	96.3%
Group E	86.7%
Combined	93.8%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 81.1% in the Ongoing Care Management category.

Group	7/20 to 6/21
Group C	84.1%
Group D	81.0%
Group E	75.0%
Combined	81.1%

Opportunities for improvement for elements of the Ongoing Care Management category include the following:

- Group C: Horizon should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. Horizon should ensure that the MLTSS Care Manager conducts a telephonic visit within 24 hours for urgent/emergent situations.

- Group D: Horizon should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. Horizon should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Member's residing in the

Community. Horizon should ensure that the Care Manager completes a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.

- Group E: Horizon should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100% in the Gaps in Care/Critical Incidents category.

Group	7/20 to 2/21
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, the MCO scored above 86% for all the six (6) performance measures.

New Jersey Annual Assessment of MCO Operations

MLTSS HCBS CM
2021 Audit Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.64.1.1.F.1 9.3.3.B 9.3.3.C 9.6.6.E 4.1.1.E 9.6.6.F	**4.6.5.D.6** If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3.B The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: Notify providers of their role in providing continuity of care for their Members in transition; 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services;	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-effective manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1.D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health and long term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1.J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2.B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or	▪ Care Management job descriptions used in recruitment ▪ Organization Chart with CM names

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members; 2. Caseload management and casework practices; 3. Human services principles for determining eligibility for benefits and services; 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	▪ CM resumes
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A MLTSS Training The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements. 9.5.4.A A. The Contractor shall develop standards for Care Management Training which includes the following components: 1. Training curriculum including goals of training, competency standards, and frequency of retraining 2. Quality Assurance program to identify inter/intra-rater reliability and core standards 3. Continue Quality Assurance standards to ensure standards are being met	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Remediation training plan for employees who do not meet the standards 9.5.4.BCare Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.	
CM34	9.5.5.J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g. holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2.A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4.A	4.7.4 **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			related to compliance.
CM38	9.4.1.A.4 9.5.1.E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy

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

Horizon New Jersey Health
Managed Long Term Services and Supports (MLTSS)
2021 Annual Assessment Review of
Care Management

Review Period - July 1, 2020 to June 30, 2021

October 2021

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Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Horizon New Jersey Health (HNJH) as evidence of compliance of the standards under review; interviews with key HNJH staff (held via WebEx on August 24, 2021); and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on June 18,2021 and received from the MCOs on July 2, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on July 6, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2020, to June 30, 2021. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

During the offsite review, the MCO had the opportunity to provide supplemental documentation as requested by IPRO.

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2021 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit were completed and sent to the MCOs on October 20, 2021.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. HNJH received an overall compliance score of 100% in 2021. In 2020, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage			**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
Horizon New Jersey Health

Review Period: July 2019 – February 29, 2020
Expansion Period: March 1, 2020 – December 31, 2020
October 2021

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019 through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.

Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2019 and January 2020. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

The audit is comprised of two review periods: July 1, 2019 through February 29, 2020, and an expansion period from March 1, 2020 to December 31, 2020. The initial review period includes an assessment of all audit elements and the expansion period focuses specific elements aimed to evaluate the MCOs COVID-19 response for NF members. Only the review period from July 1, 2019 to February 29, 2020 has been considered in determining the final Audit scoring. Audit elements applicable to both review periods can be compared to evaluate MCO performance across review periods. Audit elements that are only applicable to the initial assessment period are not compared to any other review periods.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, the NF audit to evaluate the period from of July 2018 through June 2019 was suspended. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and

presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit tool to evaluate the measures for the applicable population.

Based on the extensive revisions to the NJ EQRO MLTSS NF Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior review period's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Horizon New Jersey Health (HNJH), including an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on December 31, 2020,
  And

- The member must have been enrolled as an NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on December 31, 2020,
  And
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (December 31, 2020).

Members residing in a NF/SCNF less than six consecutive months at any time between July 1, 2019 and February 29, 2020 (starting July 1, 2019) were excluded.

In order to collect additional information for MLTSS Members who transitioned between HCBS and a NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between July 1, 2019 and February 29, 2020 with the MCO of record on February 29, 2020
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between July 1, 2019 and February 29, 2020, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between July 1, 2019 and December 31, 2019, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of February 29, 2020)
Group 4	Members residing in HCBS for at least one month between July 1, 2019 and November 30, 2019, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for HNJH, 101 member files were reviewed and included in the audit results. One (1) case was excluded as it did not meet audit eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Tables 2a-e**, were calculated using the

sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Care Management Outreaches, Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting, and PASRR Communication (see Tables 2a-f). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold both in the tables and Conclusion section of this report. All rates for the Expansion Period from March 1, 2020 through December 31, 2020 are for informational purposes only and are not considered as part of the final audit score in the Conclusions section of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	87	100	87.0%
Documented Review of the Facility Plan of Care by the Care Manager	87	87	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	86	87	98.9%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	2	2	100.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	98	100	98.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	98	100	98.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	98	100	98.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	98	100	98.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record.	98	100	98.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	12	12	100.0%

Table 2c.

Transition Planning	Review Period (July 1, 2019- February 29, 2020)			Expansion Period (March 1, 2020- December 31, 2020)		
	N	D	Rate	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	100	100	100.0%	100	100	100.0%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	15	100	15.0%	17	100	17.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	100	100	100.0%	100	100	100.0%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	78	100	78.0%	85	100	85.0%
Members requiring coordination of care had coordination of care by the Care Manager	100	100	100.0%			
Care Manager explained and discussed any payment liability with the Member	75	100	75.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2019- February 29, 2020)			Expansion Period (March 1, 2020- December 31, 2020)		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions; significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	62	64	96.9%			
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	98	100	98.0%	98	100	98.0%
Care Manager reviewed the Member's Rights and Responsibilities	96	100	96.0%			
Care Manager educated the Member on how to file a grievance and/or an appeal	96	100	96.0%			
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	96	100	96.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period*	99		
Member was admitted to an NF/SCNF during the review period*	1		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	0	1	0.0%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	0	1	0.0%
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	CNC

*Element not scored

CNC: Could not calculate

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for HNJH, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold both in the tables and Conclusion section of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

Transitions from NF/SCNF to HCBS	Review Period (July 1, 2019-February 29, 2020) Groups 2, 4			Expansion Period (March 1, 2020-December 31, 2020) Groups 2, 4		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC			
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC			
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC			
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC			
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC			
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC			

CNC: Could not calculate

Reviews of this population are optional and not scored

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions from HCBS to NF/SCNF	Review Period (July 1, 2019-February 29, 2020) Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

Reviews of this population are optional and not scored

The expansion of the Nursing Facility audit components included evaluating the NF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is

amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: HNJH

Performance Measure	Group	July 2019 – February 2020		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	2	2	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**2**	**2**	**100.0%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	98	100	98.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**98**	**100**	**98.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	12	12	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**12**	**12**	**100.0%**
#11. Plans of Care developed using "person-centered principles" [4]	Group 1	98	100	98.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**98**	**100**	**98.0%**
#16. Member training on identifying/reporting critical incidents	Group 1	96	100	96.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**96**	**100**	**96.0%**

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[2]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[3]Members who did not have a documented change in condition during the study period are excluded from this measure.
[4]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
CNC: Could not calculate; N/A: Not applicable

Limitations

The annual NF CM audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. The 2020 NF CM review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (87.0%)
- Documented Review of the Facility Plan of Care (100.0%)
- MLTSS Plan of Care on file (98.9%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (100.0%)
- Care Managers used a person-centered approach (98.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (98.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (98.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (98.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (98.0%)
- Updated Plan of Care for a Significant Change (100.0%)
- Member was identified for transfer to HCBS and was offered options (100.0%)
- Member was present at each onsite visit (100.0%)
- Members requiring coordination of care had coordination of care (100.0%)
- NJCA was completed to assess the Member (96.9%)
- Plan of Care was updated, reviewed, and signed by the member (98.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (96.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (96.0%)
- Member and/or representative had training on how to report a critical incident (96.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (15.0%)
- Timely Onsite Review of Member Placement and Services (78.0%)
- Care Manager explained and discussed any payment liability (75.0%)
- Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF (0.0%)
- Communication of PASRR Level I to OCCO (0.0%)

Recommendations for audit elements include the following:

Horizon's MLTSS Care Managers should confirm that there is documentation of the Member's participation in at least one Facility IDT meeting annually. Horizon should ensure the MLTSS Care Managers discusses payment liability, and reviews Member's placement and services timely. Horizon should ensure there is sufficient communication of the PASRR Level I to OCCO, as applicable prior to a NF/SCNF transfer.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix E – UHCCP 2021 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Chart Audit and Annual Assessment
UnitedHealthcare Community Plan
Contract Year 4

August 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The purpose of the Care Management audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates MCO performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO Contract requirements for Care Management services including MCO Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit Tool, it was agreed upon by IPRO and DMAHS that for the General Population only, the results in the current review period will not be compared to the prior year's reported rates because there can be no direct comparison from the current Audit Tool to the previous Audit Tool.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the two populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 148 cases for UnitedHealthcare Community Plan (UHCCP), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (36). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (2).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 49499. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/20	>= 3 months as of 12/31/2020	>= 3 months and < 18 years as of 12/31/2020
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2020 to 7/1/2020	Initial enrollment between 1/1/2020 and 12/31/2020	Initial enrollment between 1/1/2020 and 12/31/2020
Current Enrollment	Enrolled as of 12/31/2020	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2020 allowing no more than a one month gap.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an offsite review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

United's 2020 audit results ranged from 49% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP	DDD	DDD	PPD	DCP&P	DCP&P	PPD
	2020 (n=100)	2020 (n=2)	2019 (n=53)		2020 (n=25)	2019 (n=100)	
Identification[1]	88%						
Outreach	90%	100%	100%	0%	96%	97%	-1%
Preventive Services	49%	64%	73%	-9%	83%	83%	0%
Continuity of Care	74%	71%	78%	-7%	97%	95%	2%
Coordination of Services	98%	100%	98%	2%	100%	100%	0%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 4 Enrollees were new Enrollees, and 96 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population		
	Numerator	Denominator	Percent
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	0	1	0.0%
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)	0	2	0.0%
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only)*	2	4	50.0%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	4	100.0%[1]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2019)*	30	96	31.3%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2019)	6	66	90.9%[1]
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2019 not already in Care Management)*	34	66	51.5%

[1] Percentage rate is indicative of an inverse percentage

**Not Included in aggregate score calculation*

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (36).

Table 4: Outreach – GP Population

Outreach	General Population		
	Numerator	Denominator	Percent
Initial outreach to complete a CNA was done	33	36	91.7%
The outreach for CNA was timely within 30 days of the identification of CM needs	29	33	87.9%
Outreach was successful (even if the Enrollee declines to complete the CNA)*	24	33	72.7%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	9	13	69.2%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	4	24	16.7%
The Enrollee declined Care Management*	4	33	12.1%

**Not Included in aggregate score calculation*

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (51). There were eight (8) Enrollees under the age of 21 years old and forty-three (43) Enrollees over the age of 21.

Table 5: Preventive Services – GP Population

Preventive Services	General Population		
	Numerator	Denominator	Percent
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	8	8	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status	0	0	CNC[1]
The Care Manager sent EPSDT reminders	0	0	CNC
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	2	8	25.0%
Aggressive outreach attempts were documented to confirm immunization status	2	6	33.3%
Appropriate vaccines have been administered for Enrollees age 18 and above	28	43	65.1%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	1	15	6.7%
Dental needs are addressed for Enrollees age 21 and above	23	43	53.5%
A dental visit occurred during the review period for Enrollees age 1 to 21	2	7	28.6%
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	3	5	60.0%
Dental reminders were sent to Enrollees age 1 to 21	3	5	60.0%
Enrollees age 9 months to 26 months were tested twice for lead	1	4	25.0%
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	2	0.0%
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	1	3	33.3%
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	1	3	33.3%

[1] Could not calculate

Continuity of Care

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (51).

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population		
	Numerator	Denominator	Percent
A Comprehensive Needs Assessment was completed for the Enrollee	32	51	62.7%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)*	14	17	82.4%
A level of Care Management was determined for the Enrollee	9	32	28.1%
The Enrollee is in Community Based Care Management (CBCM)*	25	51	49.0%
A Care Plan was completed for the Enrollee that included all required components	27	27	100.0%
The Care Plan was developed within 30 days of CNA Completion	24	27	88.9%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	24	27	88.9%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	22	22	100.0%

**Not Included in aggregate score calculation*

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (51).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population		
	Numerator	Denominator	Percent
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	50	51	98.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	46	46	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	45	45	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	38	40	95.0%

DDD Population Findings

A total of 2 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach - DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	2	2	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	2	2	100.0%	100.0%	0.0
Outreach was successful (even if the Enrollee declines to complete the CNA)*	1	2	50.0%	69.8%	-19.8
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	1	1	100.0%	97.4%	2.6
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	1	0.0%	5.4%	-5.4
The Enrollee declined Care Management*	0	2	0.0%	3.8%	-3.8

**Not Included in aggregate score calculation*

Preventive Services

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	1	2	50.0%	70.6%	-20.6
Aggressive outreach attempts were documented to confirm EPSDT status	1	1	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	1	1	100.0%	100.0%	0.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	0	0	CNC[1]	39.1%	CNC
Aggressive outreach attempts were documented to confirm immunization status	0	0	CNC	100.0%	CNC
Appropriate vaccines have been administered for Enrollees age 18 and above	0	2	0.0%	46.7%	-46.7
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	2	2	100.0%	100.0%	0.0
Dental needs are addressed for Enrollees age 21 and above	0	0	CNC	84.2%	CNC
A dental visit occurred during the review period for Enrollees age 1 to 21	0	2	0.0%	55.9%	-55.9
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	2	2	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	2	2	100.0%	93.3%	6.7
Enrollees age 9 months to 26 months were tested twice for lead	0	0	CNC		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	0	CNC		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	0	0	CNC	100.0%	CNC
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	0	0	CNC	100.0%	CNC

[1] Could not calculate

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	1	2	50.0%	66.0%	-16.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	1	1	100.0%	94.3%	5.7
A level of Care Management was determined for the Enrollee	1	1	100.0%	94.3%	5.7
The Enrollee is in Community Based Care Management (CBCM)*	0	2	0.0%	17.0%	-17.0
A Care Plan was completed for the Enrollee that included all required components	1	2	50.0%		
The Care Plan was developed within 30 days of CNA Completion	1	2	50.0%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	1	1	100.0%	78.3%	21.7
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	100.0%	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	2	2	100.0%	100.0%	0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	1	1	100.0%	100.0%	0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	1	1	100.0%	100.0%	0
For Enrollees who were hospitalized, adequate discharge planning was performed	0	0	CNC[1]	75.0%	CNC
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2020, the Care Manager documented evidence of follow up within 30 days of discharge	0	0	CNC	0.0%	CNC
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC	0.0%	CNC

[1] Could not calculate

DCP&P Population Findings

A total of 36 files were reviewed for the DCP&P Population. Eleven (11) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	25	25	100.0%	99.0%	1.0
The outreach for CNA was timely within 45 days of enrollment	23	25	92.0%	96.0%	-4.0
Outreach was successful (even if the Enrollee declines to complete the CNA)*	25	25	100.0%	99.0%	1.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	4	4	100.0%	97.9%	2.1
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	25	4.0%	0.0%	4.0

**Not Included in aggregate score calculation*

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	24	25	96.0%	95.0%	1.0
Aggressive outreach attempts were documented to confirm EPSDT status	1	1	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	1	1	100.0%	100.0%	0.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	23	25	92.0%	77.0%	15.0
Aggressive outreach attempts were documented to confirm immunization status	1	2	50.0%	100.0%	-50.0
Appropriate vaccines have been administered for Enrollees age 18 and above	0	0	CNC[1]	CNC	CNC
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	0	0	CNC	CNC	CNC
Dental needs are addressed for Enrollees age 21 and above	0	0	CNC	CNC	CNC
A dental visit occurred during the review period for Enrollees age 1 to 21	3	5	60.0%	78.9%	-18.9
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	2	2	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	2	2	100.0%	100.0%	0.0
Enrollees age 9 months to 26 months were tested twice for lead	0	5	0.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	3	0.0%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	5	5	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	5	5	100.0%	100.0%	0.0

[1] Could not calculate

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	25	25	100.0%	94.0%	6.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	23	25	92.0%	93.6%	-1.6
A level of Care Management was determined for the Enrollee	25	25	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	25	25	100.0%		
The Care Plan was developed within 30 days of CNA Completion	24	25	96.0%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	CNC[1]	92.2%	CNC
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%	100.0%	0.0

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	25	25	100.0%	99.0%	1.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	25	25	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	24	24	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	2	2	100.0%	100.0%	0.0

[1] Could not calculate

Discussion

Limitations

Audit results for the DDD and DCP&P Populations should be considered cautiously due to the very low sample sizes (2 Enrollees and 25 Enrollees, respectively).

Corrective Action Plan/Work Plan

UHCCP was not required to submit a Work Plan or CAP for the CM Chart Audit findings due to the public health emergency. UHCCP was required to develop CAPs for IPRO's review of the elements in the CM section of the Annual Assessments.

Conclusions and Recommendations

Overall, the MCO scored above 85% in the following review elements (**Table 2**):

- Identification (General Population) (88%)
- Outreach (General Population) (90%)
- Coordination of Services (General Population) (98%)
- Outreach (DDD Population) (100%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (96%)
- Continuity of Care (DCP&P Population) (97%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 2**):

- Preventive Services (General Population) (49%)
- Continuity of Care (General Population) (74%)
- Preventive Services (DDD Population) (64%)
- Continuity of Care (DDD Population) (71%)
- Preventive Services (DCP&P Population) (83%)

Opportunities for improvement for the General Population

Preventive Services

- UHCCP should continue to focus on age-appropriate immunizations for Enrollees ages 0 to 18, and utilize aggressive outreach to confirm and document immunizations status from a reliable source, such as the PCP or the NJ immunization registry.
- UHCCP should ensure Enrollees age 18 and above receive appropriate vaccines, and aggressive outreach should be utilized to confirm vaccination status as applicable.
- UHCCP should ensure that dental needs are addressed for Enrollees ages 1 to 21 and Enrollees 21 years and above. Care Managers should provide dental education and reminders, and document the date of the Enrollee's annual dental visit.
- UHCCP should ensure dental needs are addressed for Enrollees 21 and above.
- UHCCP should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence. Care Managers should provide Enrollees from 9 months to 72 months, lead education, screening reminders, and document all attempts made to obtain the Enrollee's lead status.

Continuity of Care

- UHCCP should ensure the CNA is completed within 30 days following an IHS score of 5 or greater, or Identification of potential Care Management needs through other sources, (referrals, utilization reports, pharmacy data, risk scores, clinical judgment).

- UHCCP's Care Manager should document the Enrollee's level of care upon completion of the CNA.

Opportunities for improvement for the DDD Population

Preventive Services

- For Enrollees under 21 years of age, UHCCP should confirm from a reliable source that the EPSDT exam is up-to-date to per the periodicity exam schedule.
- UHCCP should ensure Enrollees age 18 and above receive appropriate vaccines.
- UHCCP should ensure that dental needs and visits are addressed for Enrollees age 1 to 21 years, and Care Managers should document the date of the Enrollees annual dental visit.

Continuity of Care

- UHCCP should ensure a Comprehensive Needs Assessment with all required elements is completed within 45 days for newly enrolled DDD Enrollees. UHCCP's Care Manager's should develop a Plan of Care with all the required components within 30 days of a completed CNA.

Opportunities for improvement for the DCP&P Population

Preventive Services

- UHCCP should utilize and document aggressive outreach attempts to confirm immunization status for Enrollees 0 to 18 years of age.
- UHCCP should ensure that dental needs and visits are addressed for Enrollees age 1 to 21 years, and Care Managers should document the date of the Enrollees annual dental visit.
- UHCCP should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence**.**

Care Management and Continuity of Care

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by UnitedHealthcare Community Plan (UHCCP) as evidence of compliance of the standard under review; offsite review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key UHCCP staff via WebEx were held on April 30, 2021, and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on February 11, 2021 and received documentation from the MCOs on February 26, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on March 1, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2020 to December 31, 2020.

During the offsite review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance in partial and full reviews.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all of the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle, but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle, but was not met in the current review cycle.	Full, Partial

The Care Management and Continuity of Care review category examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review category also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

There are 30 Contractual provisions in this category. UHCCP received an overall compliance score of 87% in 2021. In 2020, the MCO received a score of 83% for this category. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2021. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2020 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	-	X	X	-	-	-	X	-
CM3	X	X	X	-	-	-	-	-
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	X	X	-	X	-	-	-	X
CM7	X	X	-	X	-	-	-	X
CM8	-	X	-	X	-	X	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	-	X	X	-	-	-	X	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	X	-	-	-	-	-
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	-	X	X	-	-	-	X	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37[1]	X	X	X	-	-	-	-	-
TOTAL	**25**	**30**	**26**	**4**	**0**	**2**	**3**	**2**
Compliance Percentage			**87%**					

[1]This documentation element is reviewed in any year where there are elements subject to review.

Table 18: Findings for Deficient Care Management and Continuity of Care Elements

Element	Contract Language	Reviewer Comments
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	In the 2021 CM file audit the Plan scored: • 0% for the General Population Enrollees, who had an IHS, is completed within 45 days of enrollment for new Enrollees and 0% when aggressive outreach was attempted and documented when initial outreach was unsuccessful.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be	In the 2021 CM file audit the Plan scored: • 82.4% for General Population Enrollees, who had a Comprehensive Needs Assessment completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources. The Plan assigned a Care Management level to 28.1% of the applicable General Population. The Plan attempted and documented aggressive outreach in 69.2% of the applicable General Population when initial outreach to complete a CNA was unsuccessful.

Element	Contract Language	Reviewer Comments
	included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	In the 2021 CM File audit the Plan scored: • 50% for the DDD Enrollees, who's Plan of Care was developed and included all the required components within 30 days of CNA completion.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 25% of the General Population, age 0-18 years, immunizations are up-to-date and immunization status is confirmed by a reliable source. Aggressive outreach to confirm immunization status was utilized in 33.3% of the applicable General and 50% of the DCP&P Populations. • 50% for the DDD Enrollees, up-to-date EPSDT exam per periodicity schedule under 21 years of age, and confirmed by a reliable source. • 28.6% for the General Population Enrollees, 0% for DDD and 60% for DCP&P Population age 1-21 years, for dental visits occurring during the audit period. Care Managers attempted to obtain dental status, reminders were sent, and dental needs were addressed for Enrollees age 1 to 21 in: 60% of the General Population. • 53.5% of the General Population, age 21

Element	Contract Language	Reviewer Comments
		years and above whose dental needs were addressed. • 65.1% of the General Population Enrollees and 0% of the DDD Enrollees, who received appropriate vaccines for Enrollees 18 years and older. Aggressive outreach to confirm immunization status was utilized in 6.7% of the applicable General Population. • 25% for the General Population, 0% of the DCP&P Population, ages 9 to 26 months tested twice for lead. 0% for General Population and 0% of the DCP&P never tested for lead before 24 months of age. Care Managers attempted to obtain lead status and sent lead reminders to 33.3% of General Population Enrollees.

Table 19: Findings for Resolved Deficiencies for Care Management and Continuity of Care Elements

Element	Contract Language
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include coordination of services for Enrollees with special needs.
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.
CM25	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.

Strengths

None

Recommendations

1. CM6: The Plan should ensure the IHS is completed within 45 days of enrollment for new General Population Enrollees and aggressive outreach was attempted and documented when initial outreach was unsuccessful.
2. CM7: The Plan should ensure that the CNA is completed within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources. The Plan should ensure a level of Care Management is assigned to applicable General Population Enrollees. Aggressive outreach should be utilized to complete the CNA if applicable.

3. CM7: The Plan should ensure a CNA is completed with all required components within 45 days of enrollment for the DDD and DCP&P Enrollees.
4. CM8: The Plan should ensure a Plan of Care including all required components is developed within 30 days of CNA completion for the DDD Enrollees.
5. CM14: The Plan should ensure that Enrollees are educated on the importance of receiving Preventative Services, Immunizations, Vaccines, Reminders, Dental Care and Lead Testing as applicable for the General, DDD and DCP&P Populations.
6. CM14: The Plan should certify that Preventative Services: Exams and Immunization are up-to-date and status is confirmed by a reliable source for the DDD Enrollees under 21 years of age.

Findings for Improvement

None

2021 Core Medicaid Care Management Document Submission Guide

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of, or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** The Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would	

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees,	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7*	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8*	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measureable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan:** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s)

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCOs must develop policies and	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18b	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18c	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19*	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5.I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5.L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4.6.5.L Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
UnitedHealthcare Community Plan of New Jersey

Review Period July 1, 2020 – June 30, 2021

January 2022

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management Activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2020 through 6/30/2021. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2020. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 145 cases for UnitedHealthcare Community Plan of New Jersey (UHCCP), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care members enrolled in MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care members enrolled in MLTSS prior to 7/1/2020 and continuously enrolled in MLTSS through 6/30/2021	• The member must have been initially enrolled in MLTSS HCBS prior to 7/1/2020. • The member must have remained enrolled in MLTSS HCBS through 6/30/2021 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. Additionally, for each MCO a random selection of Traumatic Brain Injury (9) members were included in the sample. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 HCBS MLTSS members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 145 cases selected for the MCO, 145 member files were reviewed and 140 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	8
Group D	Current Members Newly Enrolled to MLTSS	65
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	42
Ancillary Group	Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure	25
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	5

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 48.4% to 95.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 2020– June 2021			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		48.4%		48.4%
Outreach	75.0%	70.8%		71.2%
Telephonic Monitoring (Formerly Face-to-Face) Visits	55.9%	59.7%	56.9%	58.6%
Initial Plan of Care (Including Back-up Plans)	66.2%	74.5%	74.0%	73.8%
Ongoing Care Management	60.9%	59.4%	46.2%	57.0%
Gaps in Care/Critical Incidents	81.3%	96.9%	94.4%	95.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

TBI Population-specific findings are presented in Table 3a, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Table 3a provides the aggregate scores only for TBI members.

Table 3a. Results by TBI Population

	July 2020 - June 2021			
Determination by Category	**Group C[1]**	**Group D**	**Group E[1,2]**	**Combined[3]**
Case Count TBI Population	0	0	9	9
Assessment		NA		NA
Outreach	NA	NA		NA
Telephonic Monitoring (Formerly Face-to-Face) Visits	NA	NA	75.7%	75.7%
Initial Plan of Care (Including Back-up Plans)	NA	NA	81.2%	81.2%
Ongoing Care Management	NA	NA	84.6%	84.6%
Gaps in Care/Critical Incidents	NA	NA	94.4%	94.4%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 8 files were reviewed for new members enrolled in managed care and newly eligible for MLTSS (Group C). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 8 files were further reviewed for compliance in five (5) categories.

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	6	8	75.0%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	7	8	87.5%
Options Counseling was provided to the Member.	0	8	0.0%
Member was offered the participant direction option during options counseling.	4	8	50.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	2	2	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	6	8	75.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	4	8	50.0%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	8	8	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	6	6	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	6	8	75.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	0	8	0.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	5	7	71.4%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	5	5	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	5	7	71.4%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	3	0.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	6	8	75.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	7	8	87.5%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	3	8	37.5%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	0	N/A
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	3	5	60.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	1	2	50.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	0	N/A

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	7	8	87.5%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	6	8	75.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 65 files were reviewed for members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 65 files were further reviewed for compliance in all six (6) categories.

	July 2020 – June 2021		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	60	65	92.3%
Screening for Community Services Assessment was submitted to DoAs by the 10th of the following month.	0	59	0.0%

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	46	65	70.8%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	65	65	100.0%
Options Counseling was provided to the Member.	2	65	3.1%
Member was offered the participant direction option during options counseling.	30	65	46.2%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	3	3	100.0%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	57	65	87.7%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	46	65	70.8%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	65	65	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	34	48	70.8%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	1	0.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	61	65	93.8%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	2	65	3.1%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	62	65	95.4%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	62	62	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	57	65	87.7%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	41	0.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	63	65	96.9%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	63	65	96.9%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	18	65	27.7%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	1	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	1	1	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	31	62	50.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	5	7	71.4%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	1	1	100.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	63	65	96.9%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	63	65	96.9%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 42 files were reviewed for the members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Outreach is not assessed for members in Group E. All 42 files were reviewed for compliance in four (4) categories.

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	26	27	96.3%
Options Counseling was provided to the Member.	9	27	33.3%
Member was offered the participant direction option during options counseling.	3	27	11.1%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	1	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	23	27	85.2%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the member's anniversary (from the date of the Initial Plan of Care).	36	42	85.7%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	26	27	96.3%
Member file had documentation to demonstrate contact with the members' HCBS providers at least annually to discuss the providers' reviews of the member's needs and status and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	27	27	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	26	27	96.3%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	9	27	33.3%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	19	26	73.1%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	19	19	100.0%
Care Manager completed an Annual Risk Assessment for the member (not applicable for Members residing in CARS.	25	27	92.6%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.	1	27	3.7%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	13	0.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	26	27	96.3%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	11	27	40.7%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	0	N/A
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	8	19	42.1%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	5	6	83.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	0	N/A

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	25	27	92.6%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	26	27	96.3%

4. Performance Measures

The performance measures results summarize the MCO's performance in terms of the MLTSS measures. Of the total 25 cases selected for the MCO, 25 member files were reviewed and 25 were included in the file review.

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Performance Measure #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment) was not validated during the audit this year.

Population-specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's Plan of Care is reviewed annually within 30 days of Members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2020 and 2021 audit findings. Overall, The MCO's audit results ranged from 11.0% to 100% across all groups for six (6) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: UHCCP

Performance Measure	Group[1]	July 2020 – June 2021		
		N	**D**	**Rate**
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	4	8	50.0%
	Group D	46	65	70.8%
	Group E			
	Ancillary Group C	0	0	N/A
	Ancillary Group D	23	25	92.0%
	Total	73	98	74.5%

#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	36	42	85.7%
	Total	36	42	85.7%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	0	0	N/A
	Group D	1	1	100.0%
	Group E	0	0	N/A
	Total	1	1	100.0%
#11. Plans of Care developed using "person-centered principles"[5]	Group C	0	8	0.0%
	Group D	2	65	3.1%
	Group E	9	27	33.3%
	Total	11	100	11.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group C	5	7	71.4%
	Group D	62	65	95.4%
	Group E	19	26	73.1%
	Total	86	98	87.8%
#16. Member training on identifying/reporting critical incidents	Group C	6	8	75.0%
	Group D	63	65	96.9%
	Group E	26	27	96.3%
	Total	95	100	95.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period
[4]Members who did not have a documented change in condition during the study period are excluded from this measure
[5]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[6]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 48.4% in the Assessment category.

Group	7/20 to 6/21
Group C	
Group D	48.4%
Group E	

Group	7/20 to 6/21
Combined	48.8%

Opportunities for improvement for elements of the Assessment category include the following:

- Group D: UnitedHealthcare should ensure the Screening for Community Services Assessment is submitted timely, by the 10th of the month following completion of the Screening for Community Services Assessment.

Member Outreach

Across groups, the MCO had a combined score of 71.2% in the Member Outreach category.

Group	7/20 to 6/21
Group C	75.0%
Group D	70.8%
Group E[1]	
Combined	71.2%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

Opportunities for improvement for the elements of Member Outreach include the following:

- Group C: UnitedHealthcare should ensure that the Care Manager contacts the member within five (5) business days of MLTSS enrollment to schedule a telephonic visit to develop the Member's Plan of Care.

- Group D: UnitedHealthcare should ensure the Care Manager contacts the Member telephonically to conduct a Screening for Community Services Assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.

Telephonic Monitoring (Formerly Face-to-Face) Visits

Across all three groups, the MCO had a combined score of 58.6% in the Telephonic Monitoring Visits category.

Group	7/20 to 6/21
Group C	55.9%
Group D	59.7%
Group E	56.9%
Combined	58.6%

Opportunities for improvement for elements of the Telephonic Monitoring (formerly Face-to-face) Visits category include the following:

- Group C: UnitedHealthcare should ensure Options Counseling is provided to all MLTSS Members, and the MLTSS Care Manager should discuss and offer Participant Direction as applicable during Options Counseling. UnitedHealthcare should ensure that a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold should be documented as a numeric percentage.

- Group D: UnitedHealthcare should ensure Options Counseling is provided to all MLTSS Members, and the MLTSS Care Manager should discuss and offer Participant Direction as applicable during Options Counseling.

- Group E: UnitedHealthcare should ensure Options Counseling is provided to all MLTSS Members, and the MLTSS Care Manager should discuss and offer Participant Direction as applicable during Options Counseling.

UnitedHealthcare should ensure that a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold should be documented as a numeric percentage.

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 73.8% in the Initial Plan of Care (Including Back-up Plans) category.

Group	7/20 to 6/21
Group C	66.2%
Group D	74.5%
Group E	74.0%
Combined	73.8%

Opportunities for improvement for elements of the Initial Plan of Care (Including Back-up Plans) category include the following:

- Group C: UnitedHealthcare should ensure that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member representative, and a copy of the Plan of Care should be provided to the Member within 45 days of enrollment in the MLTSS program. UnitedHealthcare should ensure the Member's Initial Plan of Care (POC) contains goals that meet all the criteria (member specific, measurable, specified plan of action/intervention to be used to meet the goals, and include a timeframe to attain the desired outcomes. Member's POC goals should be reviewed during each visit and progress should be documented. UnitedHealthcare should ensure that the Plan of Care reflects a member-centric approach, and the Member/Member Representative should be present and involved in the development and modification of agreed upon goals. The Member should be given the opportunity to express their needs and preferences, and their needs and preferences should be acknowledged and addressed in the Plan of Care. UnitedHealthcare should confirm that the State mandated Back-up Plan is completed, signed/verbally acknowledged, and dated by the Member/Member Representative. UnitedHealthcare should ensure, Care Managers complete an Annual Risk Assessments for MLTSS Members, and if a risk is identified a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member. UnitedHealthcare should ensure Members receive their Rights and Responsibilities in writing during the review period, Rights and Responsibilities should be discussed, and the Care Manager should confirm the Members understand their Rights and Responsibilities.

- Group D: UnitedHealthcare should ensure that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member Representative, and a copy of the Plan of Care should be provided to the Member within 45 days of MLTSS enrollment. UnitedHealthcare should ensure the Care Manager assesses the Member for PCA as applicable within 45 days of MLTSS enrollment. UnitedHealthcare should ensure, that Members are re-assessed for PCA if they experience a change in condition or living arrangements. UnitedHealthcare should ensure that the Plan of Care reflects a member-centric approach, and the Member/Member Representative should be present and involved in the development and modification of agreed upon goals. The Member should be given the opportunity to express their needs and preferences, and their needs and preferences should be acknowledged and addressed in the Plan of Care. UnitedHealthcare should ensure that upon completion of a Risk Assessments for the Members, and a risk was identified, a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member.

- Group E: UnitedHealthcare should ensure that the Care Managers complete the annual Plan of Care review within 30 days of the Member's MLTSS anniversary. UnitedHealthcare should ensure that the Plan of Care

reflects a member-centric approach, and the Member/Member Representative should be present and involved in the development and modification of agreed upon goals. The Member should be given the opportunity to express their needs and preferences, and their needs and preferences should be acknowledged and addressed in the Plan of Care. UnitedHealthcare should confirm that the State mandated Back-up Plan is completed, signed/verbally acknowledged, and dated by the Member/Member Representative. UnitedHealthcare should ensure the Care Manager complete an Annual Risk Assessments for the MLTSS Members, and if a risk is identified a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member.

Ongoing Care Management

Across all three groups, the MCO had a combined score of 57.0% in the Ongoing Care Management category.

Group	7/20 to 6/21
Group C	60.9%
Group D	59.4%
Group E	46.2%
Combined	57.0%

Opportunities for improvement for elements of the Ongoing Care Management category include the following:

- Group C: UnitedHealthcare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. UnitedHealthcare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. UnitedHealthcare should ensure that the Care Managers complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.

- Group D: UnitedHealthcare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. UnitedHealthcare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. UnitedHealthcare should ensure that the Care Managers complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.
- Group E: UnitedHealthcare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. UnitedHealthcare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. UnitedHealthcare should ensure that the Care Managers complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 95.0% in the Gaps in Care/Critical Incidents category.

Group	7/20 to 2/21
Group C	81.3%
Group D	96.9%
Group E	94.4%
Combined	95.0%

Performance Measures

Overall, the MCO scored below 86% in three (3) of the six (6) performance measures.

- #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (74.5%).
- #9: Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (85.7%).
- #11: Plans of Care developed using "person-centered principles" (11.0%).

Opportunities for improvement for Performance Measures include the following:

- **#**8: UnitedHealthcare should ensure that the Initial Plans of Care are developed within 45 days of enrollment into the MLTSS program.
- #9: UnitedHealthcare should ensure that the Care Manager reviews the Member's Plan of Care within 30 days of the Member's MLTSS anniversary and as necessary.
- #11: UnitedHealthcare should ensure that the Plan of Care reflects "Person-Centered Principles", and the Member/Member Representative is present and involved in the Plan of Care development.

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

UnitedHealthcare Community Plan
Managed Long Term Services and Supports (MLTSS)
2021 Annual Assessment Review of
Care Management

Review Period - July 1, 2020 to June 30, 2021

October 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by UnitedHealthcare Community Plan (UHCCP) as evidence of compliance of the standards under review; interviews with key UHCCP staff (held via WebEx on August 24, 2021); and post-offsite evaluation of documentation and offsite activities.
To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on June 18, 2021 and received from the MCOs on July 2, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on July 6, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2020 to June 30, 2021. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

During the offsite review, the MCO had the opportunity to provide supplemental documentation as requested by IPRO.

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2021 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit were completed and sent to the MCOs in October 20, 2021.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. UHCCP received an overall compliance score of 70% in 2021. In 2020, the MCO received a score of 90% for this category. **Table 1a** presents an overview of the results, **Table 1b** presents Contract language for resolved element(s), and **Table 1c** presents Contract language and reviewer comments for deficient element(s).

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	-	X	X	-	-	-	X	-
CM31	X	X	-	X	-	-	-	X
CM32	X	X	X	-	-	-	-	-
CM34	X	X	-	X	-	-	-	X
CM36	X	X	X	-	-	-	-	-
CM37	X	X	-	X	-	-	-	X
CM38	X	X	X	-	-	-	-	-
TOTAL	**9**	**10**	**7**	**3**	**0**	**0**	**1**	**3**
Compliance Percentage	**90%**		**70%**					

Table 1b: Findings for Resolved MLTSS Care Management and Continuity of Care Elements

Element	Contract Language
CM30	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers, and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers, and Care Managers.

Table 1c: Findings for Deficient MLTSS Care Management and Continuity of Care Elements

Element	Contract Language	Reviewer Comments
CM31	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members. 2. Caseload management and casework practices. 3. Human services principles for determining eligibility for benefits and services. 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	During the Care Management interviews UHCCP discussed their training process implemented due to COVID, for Core Care Managers assigned to MLTSS members. The Plan provided a MLTSS training attendance roster, but the attendance roster did not identify Core Care Managers attending the MLTSS training. Senior MLTSS Management made reference that Core Medicaid benefits are the same for Core Medicaid and MLTSS Members.
CM34	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2. Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care	The Plan was not able to demonstrate or provide a report to track timely return calls within one business day.

Element	Contract Language	Reviewer Comments
	Manager. 6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g., holidays, weekends, and overnights).	
CM37	4.7.4 INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information	The Plan did not consistently submit appropriate documentation/documents, to support evidence for each applicable contract requirement. The Plan was unable to sufficiently explain MLTSS Care Management processes and MLTSS benefits.

Strengths

None

Recommendations

1. CM31: The Plan should provide a comprehensive and ongoing MLTSS training program for Core Care Managers assigned to MLTSS Members. Training attendance rosters should identify Core Care Managers and MLTSS Care Managers. MLTSS training should define and expand on the differences between Core Medicaid and MLTSS benefits.

2. CM34: The Plan should have a tracking process or report in place to ensure that Member calls are returned by the Care Manager within one business day.

3. CM37: The Plan should ensure submitted documentation/documents exhibits evidence for each applicable contract requirement. Appropriate MCO representation should be available to discuss, MLTSS processes and MLTSS benefits.

Findings for Improvement

None

New Jersey Annual Assessment of MCO Operations

MLTSS HCBS CM
2021 Audit Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.64.1.1.F.1 9.3.3.B 9.3.3.C 9.6.6.E 4.1.1.E 9.6.6.F	**4.6.5.D.6** If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3.B The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: Notify providers of their role in providing continuity of care for their Members in transition; 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services;	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-effective manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1.D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health and long term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1.J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2.B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or	▪ Care Management job descriptions used in recruitment ▪ Organization Chart with CM names

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members; 2. Caseload management and casework practices; 3. Human services principles for determining eligibility for benefits and services; 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	▪ CM resumes
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A MLTSS Training The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements. 9.5.4.A A. The Contractor shall develop standards for Care Management Training which includes the following components: 1. Training curriculum including goals of training, competency standards, and frequency of retraining 2. Quality Assurance program to identify inter/intra-rater reliability and core standards 3. Continue Quality Assurance standards to ensure standards are being met	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Remediation training plan for employees who do not meet the standards 9.5.4.BCare Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.	
CM34	9.5.5.J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g. holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2.A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4.A	4.7.4 **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			related to compliance.
CM38	9.4.1.A.4 9.5.1.E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
UnitedHealthcare Community Plan of New Jersey

Review Period: July 2019 – February 29, 2020
Expansion Period: March 1, 2020 – December 31, 2020
October 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019 through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.

Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2019 and January 2020. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

The audit is comprised of two review periods: July 1, 2019 through February 29, 2020, and an expansion period from March 1, 2020 to December 31, 2020. The initial review period includes an assessment of all audit elements and the expansion period focuses specific elements aimed to evaluate the MCOs COVID-19 response for NF members. Only the review period from July 1, 2019 to February 29, 2020 has been considered in determining the final Audit scoring. Audit elements applicable to both review periods can be compared to evaluate MCO performance across review periods. Audit elements that are only applicable to the initial assessment period are not compared to any other review periods.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, the NF audit to evaluate the period from of July 2018 through June 2019 was suspended. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and

presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit tool to evaluate the measures for the applicable population.

Based on the extensive revisions to the NJ EQRO MLTSS NF Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior review period's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for UnitedHealthcare Community Plan (UHCCP), including an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on December 31, 2020,
  And

- The member must have been enrolled as an NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on December 31, 2020,
  And
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (December 31, 2020).

Members residing in a NF/SCNF less than six consecutive months at any time between July 1, 2019 and February 29, 2020 (starting July 1, 2019) were excluded.

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between July 1, 2019 and February 29, 2020 with the MCO of record on February 29, 2020
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between July 1, 2019 and February 29, 2020, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between July 1, 2019 and December 31, 2019, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of February 29, 2020)
Group 4	Members residing in HCBS for at least one month between July 1, 2019 and November 30, 2019, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for UHCCP, 100 member files were reviewed and included in the audit results. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Tables 2a-f**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Care Management Outreaches, Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting, and PASRR Communication (see Tables 2a-f). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold both in the tables and Conclusion section for this report.

All rates for the Expansion Period from March 1, 2020 through December 31, 2020 are for informational purposes only and are not considered as part of the final audit score in the Conclusions section of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	39	100	39.0%
Documented Review of the Facility Plan of Care by the Care Manager	37	39	94.9%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	34	39	87.2%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	0	2	0.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	58	100	58.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	58	100	58.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	58	100	58.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	58	100	58.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	58	100	58.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	2	2	100.0%

Table 2c.

Transition Planning	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	83	100	83.0%	99	100	99.0%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	9	100	9.0%	3	100	3.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	83	100	83.0%	99	100	99.0%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	42	100	42.0%	60	100	60.0%
Members requiring coordination of care had coordination of care by the Care Manager	88	100	88.0%			
Care Manager explained and discussed any payment liability with the Member	70	100	70.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions; significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	58	75	77.3%			
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	58	100	58.0%	52	100	52.0%
Care Manager reviewed the Member's Rights and Responsibilities	58	100	58.0%			
Care Manager educated the Member on how to file a grievance and/or an appeal	58	100	58.0%			
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	58	100	58.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period*	100		
Member was admitted to an NF/SCNF during the review period*	0		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	0	0	CNC
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	CNC

*Element not scored

CNC: Could not calculate

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for UHCCP, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold both in the tables and Conclusion section for this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

Transitions from NF/SCNF to HCBS	Review Period (July 1, 2019-February 29, 2020) Groups 2, 4			Expansion Period (March 1, 2020-December 31, 2020) Groups 2, 4		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC			
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC			
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC			
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC			
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC			
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC			

CNC: Could not calculate

Reviews of this population are optional and not scored

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020."for consistency.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions from HCBS to NF/SCNF	Review Period (July 1, 2019- February 29, 2020) Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

Reviews of this population are optional and not scored

The expansion of the Nursing Facility audit components included evaluating the NF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: UHCCP

Performance Measure	Group	July 2019 – February 2020		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	0	2	0.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**0**	**2**	**0.0%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	58	100	58.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**58**	**100**	**58.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	2	2	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**2**	**2**	**100.0%**
#11. Plans of Care developed using "person-centered principles" [4]	Group 1	58	100	58.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**58**	**100**	**58.0%**
#16. Member training on identifying/reporting critical incidents	Group 1	58	100	58.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**58**	**100**	**58.0%**

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.

[2]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.

[3]Members who did not have a documented change in condition during the study period are excluded from this measure.

[4]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.

CNC: Could not calculate; N/A: Not applicable

Limitations

The annual NF CM audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. The 2020 NF CM review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Documented Review of the Facility Plan of Care (94.9%)
- MLTSS Plan of Care on file (87.2%)
- Updated Plan of Care for a Significant Change (100.0%)
- Members requiring coordination of care had coordination of care (88.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (39.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (0.0%)
- Care Managers used a person-centered approach (58.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (58.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (58.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (58.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (58.0%)
- Member was identified for transfer to HCBS and was offered options (83.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (9.0%)
- Member was present at each onsite visit (83.0%)
- Timely Onsite Review of Member Placement and Services (42.0%)
- Care Manager explained and discussed any payment liability (70.0%)
- NJCA was completed to assess the Member (77.3%)
- Plan of Care was updated, reviewed, and signed by the member (58.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (58.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (58.0%)
- Member and/or representative had training on how to report a critical incident (58.0%)

Recommendations for audit elements include the following:

UnitedHealthcare's Care Managers (CM) should outreach MLTSS Members timely, and the Plan of Care should be signed and developed in collaboration with the Member and mailed within 45 days of MLTSS enrollment. UHCCP should ensure the Member's Facility Plan of Care is reviewed and saved in the Member's electronic file. The MLTSS Care Manager should ensure the Member's Plan of Care is person-centered, addresses formal and informal supports, goals should be developed to address needs identified during the assessment, and the agreement/disagreement statement should be reviewed and signed by the Member/POA.

Prior to March 1, 2020 UHCCP's MLTSS Care Managers should have utilized the New Jersey Choice Assessment (NJCA) to assess Members. The Care Managers should ensure the Member's Plan of Care is reviewed, revised if applicable, and signed by the Member/POA. The Care Manager should confirm that there is documentation of the Member's participation in at least one Facility IDT meeting annually. UHCCP should ensure the MLTSS Care Managers discuss payment liability, and review the Member's placement and services timely. MLTSS Member's/POA's should be present during the onsite facility CM visits and Member's should be assessed for transfer to the Community, and should be provided options regarding alternative living arrangements.

Annually, UHCCP's MLTSS Care Managers should review and inform the MLTSS Members of their Rights and Responsibilities, how to file a Grievance and/or Appeal, and train MLTSS Members on identifying and reporting Critical Incidents.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (0.0%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (58.0%)
- #11. Plans of Care developed using "person-centered principles (58.0%)
- #16. Member training on identifying/reporting critical incidents (58.0%)

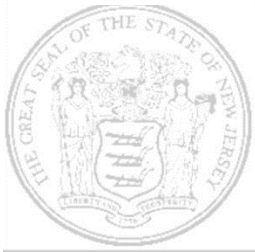
Recommendations for MLTSS Performance Measures include the following:

UnitedHealthcare should ensure that the Member's Initial Plan of Care is developed within 45 days of enrollment into the MLTSS program. MLTSS Care Manager's should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary. MLTSS Plans of Care should be developed utilizing person-centered principles. UnitedHealthcare should ensure MLTSS members receive annual training on how to identify and report Critical Incidents.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix F – WCHP 2021 Core Medicaid and MLTSS Care Management Audit Reports



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
WellCare Health Plans of New Jersey, Inc.
Contract Year 4

August 2021

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The purpose of the Care Management audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates MCO performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO Contract requirements for Care Management services including MCO Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit Tool, it was agreed upon by IPRO and DMAHS that for the General Population only, the results in the current review period will not be compared to the prior year's reported rates because there can be no direct comparison from the current Audit Tool to the previous Audit Tool.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the two populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 188 cases for WellCare Health Plans of New Jersey, Inc. (WCHP), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (44). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (34).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 49499. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/20	>= 3 months as of 12/31/2020	>= 3 months and < 18 years as of 12/31/2020
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2020 to 7/1/2020	Initial enrollment between 1/1/2020 and 12/31/2020	Initial enrollment between 1/1/2020 and 12/31/2020
Current Enrollment	Enrolled as of 12/31/2020	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2020 allowing no more than a one month gap.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2020 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2020, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an offsite review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

WellCare's 2020 audit results ranged from 46% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP	DDD	DDD	PPD	DCP&P	DCP&P	PPD
	2020 (n=100)	2020 (n=34)	2019 (n=43)		2020 (n=21)	2019 (n=21)	
Identification[1]	89%						
Outreach	97%	97%	99%	-2%	100%	93%	7%
Preventive Services	90%	46%	73%	-27%	76%	75%	1%
Continuity of Care	96%	91%	74%	17%	96%	81%	15%
Coordination of Services	100%	98%	99%	-1%	100%	100%	0%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 14 Enrollees were new Enrollees, and 86 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population		
	Numerator	Denominator	Percent
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	3	6	50.0%
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)	0	2	0.0%
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only)*	10	14	71.4%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	1	14	92.9%[1]

Identification	General Population		
	Numerator	Denominator	Percent
Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2019)*	2	86	2.3%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2019)	6	84	92.9%[1]
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2019 not already in Care Management)*	67	84	79.8%

[1] Percentage rate is indicative of an inverse percentage

**Not Included in aggregate score calculation*

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (77).

Table 4: Outreach – GP Population

Outreach	General Population		
	Numerator	Denominator	Percent
Initial outreach to complete a CNA was done	76	77	98.7%
The outreach for CNA was timely within 30 days of the identification of CM needs	72	76	94.7%
Outreach was successful (even if the Enrollee declines to complete the CNA)*	50	76	65.8%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	31	32	96.9%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	15	50	30.0%
The Enrollee declined Care Management*	16	76	21.1%

**Not Included in aggregate score calculation*

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (34). There were no Enrollees under the age of 21 years old and thirty-four (34) Enrollees over the age of 21.

Table 5: Preventive Services – GP Population

Preventive Services	General Population		
	Numerator	Denominator	Percent
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	0	0	CNC[1]
Aggressive outreach attempts were documented to confirm EPSDT status	0	0	CNC
The Care Manager sent EPSDT reminders	0	0	CNC
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	0	0	CNC
Aggressive outreach attempts were documented to confirm immunization status	0	0	CNC
Appropriate vaccines have been administered for Enrollees age 18 and above	32	34	94.1%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	0	2	0.0%
Dental needs are addressed for Enrollees age 21 and above	31	34	91.2%
A dental visit occurred during the review period for Enrollees age 1 to 21	0	0	CNC
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	0	0	CNC
Dental reminders were sent to Enrollees age 1 to 21	0	0	CNC
Enrollees age 9 months to 26 months were tested twice for lead	0	0	CNC
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	0	CNC

Preventive Services	General Population		
	Numerator	Denominator	Percent
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	0	0	CNC
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	0	0	CNC

[1] Could not calculate

Continuity of Care

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (34).

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population		
	Numerator	Denominator	Percent
A Comprehensive Needs Assessment was completed for the Enrollee	30	34	88.2%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)*	27	29	93.1%
A level of Care Management was determined for the Enrollee	30	30	100.0%
The Enrollee is in Community Based Care Management (CBCM)*	22	34	64.7%
A Care Plan was completed for the Enrollee that included all required components	32	32	100.0%
The Care Plan was developed within 30 days of CNA Completion	30	32	93.8%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	29	30	96.7%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	23	23	100.0%

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (34).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population		
	Numerator	Denominator	Percent
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	34	34	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	31	31	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	33	33	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	19	19	100.0%

DDD Population Findings

A total of 34 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	33	34	97.1%	97.7%	-0.6
The outreach for CNA was timely within 45 days of enrollment	32	33	97.0%	100.0%	-3.0
Outreach was successful (even if the Enrollee declines to complete the CNA)*	23	33	69.7%	78.6%	-8.9
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	14	15	93.3%	100.0%	-6.7
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	2	23	8.7%	9.1%	-0.4
The Enrollee declined Care Management*	2	33	6.1%	7.0%	-0.9

**Not Included in aggregate score calculation*

Preventive Services

Table 9: Preventive Service – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	5	13	38.5%	89.5%	-51.0
Aggressive outreach attempts were documented to confirm EPSDT status	8	8	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	7	8	87.5%	100.0%	-12.5
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	2	7	28.6%	81.8%	-53.2
Aggressive outreach attempts were documented to confirm immunization status	5	5	100.0%	100.0%	0.0
Appropriate vaccines have been administered for Enrollees age 18 and above	3	27	11.1%	62.5%	-51.4
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	13	24	54.2%	75.0%	-20.8
Dental needs are addressed for Enrollees age 21 and above	3	21	14.3%	70.8%	-56.5
A dental visit occurred during the review period for Enrollees age 1 to 21	1	13	7.7%	31.6%	-23.9
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	11	12	91.7%	100.0%	-8.3
Dental reminders were sent to Enrollees age 1 to 21	11	12	91.7%	92.3%	-0.6
Enrollees age 9 months to 26 months were tested twice for lead	0	1	0.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	1	0.0%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	1	1	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	1	1	100.0%	100.0%	0.0

[1] Could not calculate

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	27	34	79.4%	62.8%	16.6
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	26	27	96.3%	100.0%	-3.7
A level of Care Management was determined for the Enrollee	27	27	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management (CBCM)*	1	34	2.9%	0.0%	2.9
A Care Plan was completed for the Enrollee that included all required components	29	33	87.9%		
The Care Plan was developed within 30 days of CNA Completion	29	33	87.9%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	2	0.0%	27.3%	-27.3
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	100.0%	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	34	34	100.0%	97.7%	2.3
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	27	27	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	29	31	93.5%	100.0%	-6.5
For Enrollees who were hospitalized, adequate discharge planning was performed	2	2	100.0%	100.0%	0.0
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2020, the Care Manager documented evidence of follow up within 30 days of discharge	1	1	100.0%	CNC[1]	CNC
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC	CNC	CNC

[1] Could not calculate

DCP&P Population Findings

A total of 44 files were reviewed for the DCP&P Population. Twenty-three (23) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Initial outreach to complete a CNA was done	21	21	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	21	21	100.0%	85.7%	14.3
Outreach was successful (even if the Enrollee declines to complete the CNA)*	21	21	100.0%	90.5%	9.5
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	12	14	85.7%	100.0%	-14.3
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	21	0.0%	0.0%	0.0

**Not Included in aggregate score calculation*

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
The Enrollee's EPSDT exam is up-to-date per periodicity exam schedule and status is confirmed by a reliable source	16	21	76.2%	81.0%	-4.8
Aggressive outreach attempts were documented to confirm EPSDT status	5	5	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	5	5	100.0%	100.0%	0.0
The Enrollee's immunizations are up-to-date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	14	21	66.7%	61.9%	4.8
Aggressive outreach attempts were documented to confirm immunization status	7	7	100.0%	100.0%	0.0
Appropriate vaccines have been administered for Enrollees age 18 and above	0	0	CNC[1]	CNC	CNC
Aggressive outreach attempts were documented to confirm immunization status for Enrollees age 18 and above	0	0	CNC	CNC	CNC
Dental needs are addressed for Enrollees age 21 and above	0	0	CNC	CNC	CNC
A dental visit occurred during the review period for Enrollees age 1 to 21	5	10	50.0%	50.0%	0.0
Care Manager made attempts to obtain dental status for Enrollees age 1 to 21	5	5	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees age 1 to 21	5	5	100.0%	100.0%	0.0
Enrollees age 9 months to 26 months were tested twice for lead	0	4	0.0%		
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	3	33.3%		
Care Manager made attempts to obtain lead status for Enrollees age 9 months to 72 months	4	4	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees age 9 months to 72 months	4	4	100.0%	100.0%	0.0

[1] Could not calculate

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	21	21	100.0%	85.7%	14.3
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)	17	21	81.0%	77.8%	3.2
A level of Care Management was determined for the Enrollee	21	21	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	21	21	100.0%		
The Care Plan was developed within 30 days of CNA Completion	21	21	100.0%		
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	5	5	100.0%	50.0%	50.0
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	CNC	CNC

**Not Included in aggregate score calculation*

[1] Could not calculate

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2020)	Percent (2019)	PPD
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	21	21	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	21	21	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	21	21	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	2	2	100.0%	CNC[1]	CNC

[1] Could not calculate

Discussion

Limitations

WellCare's audit results for the DDD and DCP&P Populations should be considered cautiously due to the very low sample sizes (34 Enrollees and 21 Enrollees, respectively).

Corrective Action Plan/Work Plan

WellCare was not required to submit a Work Plan or CAP for the CM Chart Audit findings due to the public health emergency. WellCare was required to develop CAPs for IPRO's review of the elements in the CM section of the Annual Assessments.

Conclusions and Recommendations

Overall, the MCO scored above 85% in the following review elements (**Table 2**):

- Identification (General Population) (89%)
- Outreach (General Population) (97%)
- Preventive Services (General Population) (90%)
- Continuity of Care (General Population) (96%)
- Coordination of Services (General Population) (100%)
- Outreach (DDD Population) (97%)
- Continuity of Care (DDD Population) (91%)
- Coordination of Services (DDD Population) (98%)
- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (96%)
- Coordination of Services (DCP&P Population) (100%)

Opportunities for improvement for review elements scored below 85% exist in the following elements (**Table 2**):

- Preventive Services (DDD Population) (46%)
- Preventive Services (DCP&P Population) (76%)

Opportunities for improvement for the DDD Population

Preventive Services

- For Enrollees under 21 years of age, WellCare should confirm from a reliable source that the EPSDT exam is up-to-date to per the periodicity exam schedule.
- WellCare should continue to focus on age-appropriate immunizations for Enrollees ages 0 to 18, and confirm immunizations status from a reliable source, such as the PCP or the NJ immunization registry.
- WellCare should ensure Enrollees age 18 and above receive appropriate vaccines and should utilize aggressive outreach to confirm vaccination status.
- WellCare should ensure dental needs are addressed for Enrollees ages 1-21 years of age including documentation of the annual visit.
- WellCare should ensure dental needs are addressed for Enrollees age 21 and older.
- WellCare should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence.

Opportunities for improvement for the DCP&P Population

Preventive Services

- For Enrollees under 21 years of age, WellCare should confirm from a reliable source that the EPSDT exam is up-to-date to per the periodicity exam schedule.
- WellCare should continue to focus on age-appropriate immunizations for Enrollees ages 0 to 18, and confirm immunizations status from a reliable source, such as the PCP or the NJ immunization registry.
- WellCare should ensure dental needs are addressed for Enrollees ages 1-21 years of age including documentation of the annual visit.
- WellCare should ensure Enrollees between the ages of 9 months and 26 months are tested twice for lead, and Enrollees never tested for lead before 24 months should have a lead test to ensure Contract adherence

Care Management and Continuity of Care

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by WellCare Health Plans of New Jersey, Inc. (WCHP) as evidence of compliance of the standard under review; offsite review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key WCHP staff via WebEx were held on April 30, 2021; and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on February 11, 2021 and received documentation from the MCOs on February 26, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on March 1, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2020 to December 31, 2020.

During the offsite review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance in partial and full reviews.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all of the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle, but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle, but was not met in the current review cycle.	Full, Partial

The Care Management and Continuity of Care review category examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review category also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

There are 30 Contractual provisions in this category. WCHP received an overall compliance score of 90% in 2021. In 2020, the MCO received a score of 90% for this category. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2021. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2020 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	X	X	X	-	-	-	-	-
CM3	X	X	X	-	-	-	-	-
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	X	X	-	X	-	-	-	X
CM7	-	X	-	X	-	X	-	-
CM8	X	X	X	-	-	-	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	-	X	X	-	-	-	X	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	X	-	-	-	-	-
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37[1]	X	X	X	-	-	-	-	-
TOTAL	27	30	27	3	0	2	1	1
Compliance Percentage			90%					

[1]This documentation element is reviewed in any year where there are elements subject to review.

Table 18: Findings for Deficient Care Management and Continuity of Care Elements

Element	Contract Language	Reviewer Comments
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	In the 2021 CM file audit the Plan scored: • 50% for the General Population Enrollees, who had an IHS, is completed within 45 days of enrollment for new Enrollees and 0% when aggressive outreach was attempted and documented when initial outreach was unsuccessful.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be	In the 2021 CM file audit the Plan scored: • 81% for DCP&P Enrollees, who had a Comprehensive Needs Assessment completed within 45 days of enrollment. • 79.4% of the DDD Enrollees received a Comprehensive Needs Assessment with all the required elements.

Element	Contract Language	Reviewer Comments
	included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
C14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	In the 2021 CM file audit the Plan scored: • 28.6% of the DDD and 66.7% of the DCP&P Enrollees, age 0-18 years, immunizations are up-to-date and immunization status is confirmed by a reliable source. • 38.5% for the DDD and 76.8% of the DCP&P Enrollees, up-to-date EPSDT exam per periodicity schedule ages under 21 years of age, and confirmed by a reliable source. • 7.7% for DDD and 50% for DCP&P Enrollees age 1-21 years, for dental visits occurring during the audit period. • 14.3% of the DDD Enrollees, age 21 years and above whose dental needs were addressed. • 11.1% of the DDD Enrollees, who received appropriate vaccines for Enrollees 18 years and older. Aggressive outreach to confirm immunization status was utilized in 0% of the applicable General Population Enrollees and 54.2% of the DDD Enrollees. • 0% of the DDD and 0% of the DCP&P Enrollees, ages 9 to 26 months tested twice for lead. 0% of the DDD and 33.3% of the DCP&P. never tested for lead before 24 months of age.

Table 19: Findings for Resolved Deficiencies for Care Management and Continuity of Care Elements

Element	Contract Language
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.

Strengths

None

Recommendations

1. CM6: The Plan should ensure the IHS is completed within 45 days of enrollment for new General Population Enrollees and aggressive outreach should be attempted and documented when initial outreach was unsuccessful.
2. CM7: The Plan should ensure a CNA is completed with all required components within 45 days of enrollment for the DDD and DCP&P Enrollees.
3. CM14: The Plan should ensure that Enrollees are educated on the importance of receiving Preventative Services, Immunizations, Vaccines, Reminders, Dental Care and Lead Testing as applicable for the General, DDD and DCP&P Populations.
4. CM14: The Plan should certify that Preventative Services: Exams and Immunization are up-to-date and status is confirmed by a reliable source for the DDD and DCP&P Enrollees under 21 years of age.

Findings for Improvement

None

2021 Core Medicaid Care Management Document Submission Guide

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all of the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of, or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** The Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would	

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees,	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7*	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCOs will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM8*	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measureable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan:** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s)

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCOs must develop policies and	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a Continuity of Care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as Preventive Services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18b	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18c	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19*	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5.I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5.L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4.6.5.L Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities

Care Management and Continuity of Care			
2020 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

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Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
WellCare Health Plan of New Jersey, Inc.

Review Period July 1, 2020 – June 30, 2021

January 2022

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2020 through 6/30/2021. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2020. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 145 cases for WellCare Health Plans of New Jersey, Inc. (WCHP), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care members enrolled in MLTSS between 7/1/2020 and 1/1/2021	• The member must have been initially enrolled in MLTSS HCBS between 7/1/2020 and 1/1/2021. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2021 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care members enrolled in MLTSS prior to 7/1/2020 and continuously enrolled in MLTSS through 6/30/2021	• The member must have been initially enrolled in MLTSS HCBS prior to 7/1/2020. • The member must have remained enrolled in MLTSS HCBS through 6/30/2021 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. Additionally, for each MCO a random selection of Traumatic Brain Injury (10) members was included in the sample. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 HCBS MLTSS members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.

- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 145 cases selected for the MCO, 145 member files were reviewed and 144 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	12
Group D	Current Members Newly Enrolled to MLTSS	64
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	44
Ancillary Group	Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within the required timeframe) to ensure a denominator of 100 was obtained for this measure	24
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	1

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 46.2% to 98.5% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 2020 – June 2021			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		46.2%		46.2%
Outreach	100.0%	92.2%		93.4%
Telephonic Monitoring (Formerly Face-to-Face) Visits	96.2%	94.3%	87.7%	92.8%
Initial Plan of Care (Including Back-up Plans)	94.1%	91.9%	86.8%	90.7%
Ongoing Care Management	62.2%	78.1%	64.8%	73.5%
Gaps in Care/Critical Incidents	96.0%	99.2%	98.1%	98.5%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

TBI Population-specific findings are presented in **Table 3a,** which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Table 3a provides the aggregate scores only for TBI members.

Table 3a. Results by TBI Population

	July 2020 - July 2021			
Determination by Category	**Group C[1]**	**Group D**	**Group E[1,2]**	**Combined[3]**
Case Count TBI Population	0	0	10	10
Assessment		NA		NA
Outreach	NA	NA		NA
Telephonic Monitoring (Formerly Face-to-Face) Visits	NA	NA	92.7%	92.7%
Initial Plan of Care (Including Back-up Plans)	NA	NA	91.0%	91.0%
Ongoing Care Management	NA	NA	77.3%	77.3%
Gaps in Care/Critical Incidents	NA	NA	100.0%	100.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 12 files were reviewed for new members enrolled in managed care and newly eligible for MLTSS (Group C). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 12 files were further reviewed for compliance in five (5) categories.

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	12	12	100.0%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	12	12	100.0%
Options Counseling was provided to the Member.	12	12	100.0%
Member was offered the participant direction option during options counseling.	12	12	100.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	2	4	50.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	12	12	100.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	10	12	83.3%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	11	12	91.7%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	7	9	77.8%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	12	12	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	12	12	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	10	10	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	9	10	90.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	10	10	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	2	2	100.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	12	12	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	10	12	83.3%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	2	12	16.7%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	1	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	1	1	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	8	10	80.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	0	N/A

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	11	12	91.7%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	12	12	100.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 64 files were reviewed for members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 64 files were further reviewed for compliance in all six (6) categories.

	July 2020 – June 2021		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	55	64	85.9%
Screening for Community Services Assessment was submitted to DoAs by the 10th of the following month.	0	55	0.0%

	July 2020 – June 2021		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	59	64	92.2%

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	64	64	100.0%
Options Counseling was provided to the Member.	64	64	100.0%
Member was offered the participant direction option during options counseling.	50	64	78.1%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	5	5	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	63	64	98.4%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	59	64	92.2%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	64	64	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	46	47	97.9%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	64	64	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	64	64	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	64	64	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	64	64	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	64	64	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	2	45	4.4%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	64	64	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	63	64	98.4%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	30	64	46.9%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	0	N/A
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	57	64	89.1%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	0	N/A

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	63	64	98.4%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	64	64	100.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 44 files were reviewed for the members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members

in Group E were not evaluated for elements in the Assessment category. Initial Outreach is not assessed for members in Group E. All 44 files were reviewed for compliance in four (4) categories.

	July 2020 – June 2021		
Telephonic Monitoring (Formerly Face-to-Face) Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	26	26	100.0%
Options Counseling was provided to the Member.	21	26	80.8%
Member was offered the participant direction option during options counseling.	20	26	76.9%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	2	50.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	25	26	96.2%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the member's anniversary (from the date of the Initial Plan of Care).	39	44	88.6%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	26	26	100.0%
Member file had documentation to demonstrate contact with the members' HCBS providers at least annually to discuss the providers' reviews of the member's needs and status and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	26	26	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	26	26	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	21	26	80.8%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	25	25	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	25	25	100.0%
Care Manager completed an Annual Risk Assessment for the member (not applicable for Members residing in CARS.	26	26	100.0%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.	2	26	7.7%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	1	4	25.0%

	July 2020 – June 2021		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	26	26	100.0%

	July 2020 – June 2021		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	11	26	42.3%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	1	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	1	1	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	22	25	88.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	0	1	0.0%

	July 2020 – June 2021		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	25	26	96.2%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	26	26	100.0%

4. Performance Measures

The performance measures results summarize the MCO's performance in terms of the MLTSS measures. Of the total 25 cases selected for the MCO, 25 member files were reviewed and 24 were included in the file review. One (1) file was excluded because of permanent NF placement.

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Performance Measure #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment) was not validated during the audit this year.

Population-specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's Plan of Care is reviewed annually within 30 days of Members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2020 and 2021 audit findings. Overall, The MCO's audit results ranged from 0.0% to 100% across all groups for six (6) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: WCHP

Performance Measure	Group[1]	July 2020 – June 2021		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	10	12	83.3%
	Group D	59	64	92.2%
	Group E			
	Ancillary Group C	3	3	100.0%
	Ancillary Group D	18	21	85.7%
	Total	90	100	90.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	39	44	88.6%
	Total	39	44	88.6%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	0	0	N/A
	Group D	0	0	N/A
	Group E	0	1	0.0%
	Total	0	1	0.0%
#11. Plans of Care developed using "person-centered principles"[5]	Group C	12	12	100.0%
	Group D	64	64	100.0%
	Group E	21	26	80.8%
	Total	97	102	95.1%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group C	10	10	100.0%
	Group D	64	64	100.0%
	Group E	25	25	100.0%
	Total	99	99	100.0%
#16. Member training on identifying/reporting critical incidents	Group C	12	12	100.0%
	Group D	64	64	100.0%
	Group E	26	26	100.0%
	Total	102	102	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period

[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care

[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period

[4]Members who did not have a documented change in condition during the study period are excluded from this measure
[5]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[6]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 46.2% in the Assessment category.

Group	7/20 to 6/21
Group C	
Group D	46.2%
Group E	
Combined	46.2%

Opportunities for improvement for elements of the New Jersey Choice Assessment category include the following:

- Group D: WellCare should ensure that a Screening Community Service Assessment (SCS) is utilized to identify potential MLTSS needs and should be submitted by the 10th of the month following completion of the SCS.

Member Outreach

Across groups, the MCO had a combined score of 93.4% in the Member Outreach category.

Group	7/20 to 6/21
Group C	100.0%
Group D	92.2%
Group E[1]	
Combined	93.4%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS

Telephonic Monitoring (Formerly Face-to-Face) Visits

Across all three groups, the MCO had a combined score of 92.8% in the Telephonic Monitoring Visits category.

Group	7/20 to 6/21
Group C	96.2%
Group D	94.3%
Group E	87.7%
Combined	92.8%

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 90.7% in the Initial Plan of Care (Including Back-up Plans) category.

Group	7/20 to 6/21
Group C	94.1%
Group D	91.9%
Group E	86.8%
Combined	90.7%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 73.5% in the Ongoing Care Management category.

Group	7/20 to 6/21
Group C	62.2%
Group D	78.1%
Group E	64.8%
Combined	73.5%

Opportunities for improvement for elements of the Ongoing Care Management category include the following:

- Group C: WellCare should ensure approved/authorized MLTSS services are in place within forty-five (45) calendar days of MLTSS enrollment, with the exemption of residential and vehicle modifications. WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Member's residing in the Community.

- Group D: WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS.

- Group E: WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 98.5% in the Gaps in Care/Critical Incidents category.

Group	7/20 to 2/21
Group C	96.0%
Group D	99.2%
Group E	98.1%
Combined	98.5%

Performance Measures

Overall, the MCO scored below 86% in one (1) of the six (6) performance measures.

- #9a: Member's Plan of Care is amended based on change of member condition (0.0%).

Opportunities for improvement for Performance Measures include the following:

- #9a: WellCare should ensure the member's Plan of Care is amended based on change of member needs or condition. The Plan of Care should be reviewed, signed, and dated by the member and/or authorized representative.

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

WellCare Health Plans of New Jersey, Inc.
Managed Long Term Services and Supports (MLTSS)
2021 Annual Assessment Review of
Care Management

Review Period - July 1, 2020 to June 30, 2021

October 2021

IPRO
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Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That the services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by WellCare Health Plans of New Jersey, Inc. (WCHP) as evidence of compliance of the standards under review; interviews with key WCHP staff (held via WebEx on August 23, 2021); and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on June 18, 2021 and received from the MCOs on July 2, 2021. The documentation review occurred at the IPRO office in New Jersey beginning on July 6, 2021. The offsite review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2020 to June 30, 2021. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

During the offsite review, the MCO had the opportunity to provide supplemental documentation as requested by IPRO.

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2021 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit were completed and sent to the MCOs in October 20, 2021.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. WCHP received an overall compliance score of 100% in 2021. In 2020, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage	**100%**		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

New Jersey Annual Assessment of MCO Operations

MLTSS HCBS CM
2021 Audit Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.64.1.1.F.1 9.3.3.B 9.3.3.C 9.6.6.E 4.1.1.E 9.6.6.F	**4.6.5.D.6** If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3.B The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: Notify providers of their role in providing continuity of care for their Members in transition; 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services;	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-effective manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1.D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health and long term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1.J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2.B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or	▪ Care Management job descriptions used in recruitment ▪ Organization Chart with CM names

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a Bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members; 2. Caseload management and casework practices; 3. Human services principles for determining eligibility for benefits and services; 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	▪ CM resumes
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A MLTSS Training The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements. 9.5.4.A A. The Contractor shall develop standards for Care Management Training which includes the following components: 1. Training curriculum including goals of training, competency standards, and frequency of retraining 2. Quality Assurance program to identify inter/intra-rater reliability and core standards 3. Continue Quality Assurance standards to ensure standards are being met	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Remediation training plan for employees who do not meet the standards 9.5.4.BCare Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.	
CM34	9.5.5.J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g. holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2.A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4.A	4.7.4 **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			related to compliance.
CM38	9.4.1.A.4 9.5.1.E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
WellCare Health Plans of New Jersey, Inc.

Review Period: July 2019 – February 29, 2020
Expansion Period: March 1, 2020 – December 31, 2020
October 2021

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1, 2019 through June 30, 2020. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. Additionally, in 2021, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit to evaluate the measures for the applicable population.

Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2019 and January 2020. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

The audit is comprised of two review periods: July 1, 2019 through February 29, 2020, and an expansion period from March 1, 2020 to December 31, 2020. The initial review period includes an assessment of all audit elements and the expansion period focuses specific elements aimed to evaluate the MCOs COVID-19 response for NF members. Only the review period from July 1, 2019 to February 29, 2020 has been considered in determining the final Audit scoring. Audit elements applicable to both review periods can be compared to evaluate MCO performance across review periods. Audit elements that are only applicable to the initial assessment period are not compared to any other review periods.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, the NF audit to evaluate the period from of July 2018 through June 2019 was suspended. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and

presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were added to the NF CM audit tool to evaluate the measures for the applicable population.

Based on the extensive revisions to the NJ EQRO MLTSS NF Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior review period's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for WellCare Health Plans of New Jersey, Inc. (WCHP), including an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on December 31, 2020,
  And

- The member must have been enrolled as an NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on December 31, 2020,
  And
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (December 31, 2020).

Members residing in a NF/SCNF less than six consecutive months at any time between July 1, 2019 and February 29, 2020 (starting July 1, 2019) were excluded.

In order to collect additional information for MLTSS Members who transitioned between HCBS and a NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between July 1, 2019 and February 29, 2020 with the MCO of record on February 29, 2020
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between July 1, 2019 and February 29, 2020, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between July 1, 2019 and December 31, 2019, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of February 29, 2020)
Group 4	Members residing in HCBS for at least one month between July 1, 2019 and November 30, 2019, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for WCHP, 104 member files were reviewed and included in the audit results. Four (4) cases were excluded as they did not meet eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Care Management Outreaches, Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting, and PASRR Communication (see Tables 2a-f). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold both in the tables and Conclusion section in this report.

All rates for the Expansion Period from March 1, 2020 through December 31, 2020 are for informational purposes only and are not considered as part of the final audit score in the Conclusions section of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	55	100	55.0%
Documented Review of the Facility Plan of Care by the Care Manager	47	55	85.5%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	37	55	67.3%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	2	2	100.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	51	100	51.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	52	100	52.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	52	100	52.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	51	100	51.0%

Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	53	100	53.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	3	3	100.0%

Table 2c.

Transition Planning	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	55	100	55.0%	56	100	56.0%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	50	100	50.0%	46	100	46.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	63	100	63.0%	61	100	61.0%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	37	100	37.0%	45	100	45.0%
Members requiring coordination of care had coordination of care by the Care Manager	65	100	65.0%			
Care Manager explained and discussed any payment liability with the Member	47	100	47.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2019-February 29, 2020)			Expansion Period (March 1, 2020-December 31, 2020)		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions; significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	55	92	59.8%			
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	54	100	54.0%	53	100	53.0%
Care Manager reviewed the Member's Rights and Responsibilities	60	100	60.0%			
Care Manager educated the Member on how to file a grievance and/or an appeal	66	100	66.0%			
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	62	100	62.0%			

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2019- February 29, 2020)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period*	100		
Member was admitted to an NF/SCNF during the review period*	0		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	0	0	CNC
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	0	0	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	CNC

*Element not scored

CNC: Could not calculate

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for WCHP, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold both in the tables and Conclusion section in this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

Transitions from NF/SCNF to HCBS	Review Period (July 1, 2019-February 29, 2020) Groups 2, 4			Expansion Period (March 1, 2020-December 31, 2020) Groups 2, 4		
	N	D	Rate	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC			
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC			
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC			
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC			
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC			
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC			

CNC: Could not calculate

Reviews of this population are optional and not scored

Table sections that are grey indicate that the element was not evaluated for the expansion period from March 1, 2020 to December 31, 2020.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions from HCBS to NF/SCNF	Review Period (July 1, 2019-February 29, 2020) Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

Reviews of this population are optional and not scored

There expansion of the Nursing Facility audit components included evaluating the NF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: WCHP

Performance Measure	Group	July 2019 – February 2020		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	2	2	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**2**	**2**	**100.0%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	54	100	54.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**54**	**100**	**54.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	3	3	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**3**	**3**	**100.0%**
#11. Plans of Care developed using "person-centered principles"[4]	Group 1	51	100	51.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**51**	**100**	**51.0%**
#16. Member training on identifying/reporting critical incidents	Group 1	62	100	62.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	**62**	**100**	**62.0%**

[1]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[2]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[3]Members who did not have a documented change in condition during the study period are excluded from this measure.
[4]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
CNC: Could not calculate; N/A: Not applicable

Limitations

The annual NF CM audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. The 2020 NF CM review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (100.0%)
- MLTSS Plan of Care on file (87.2%)
- Updated Plan of Care for a Significant Change (100.0%)

- Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):
  Copies of any Facility Plans of Care on file (55.0%)
- Documented Review of the Facility Plan of Care (85.5%)
- MLTSS Plan of Care on file (67.3%)
- Care Managers used a person-centered approach (51.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (52.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (52.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (51.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (53.0%)
- Member was identified for transfer to HCBS and was offered options (55.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (50.0%)
- Member was present at each onsite visit (63.0%)
- Timely Onsite Review of Member Placement and Services (37.0%)
- Members requiring coordination of care had coordination of care (65.0%)
- Care Manager explained and discussed any payment liability (47.0%)
- NJCA was completed to assess the Member (59.8%)
- Plan of Care was updated, reviewed, and signed by the member (54.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (60.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (66.0%)
- Member and/or representative had training on how to report a critical incident (62.0%)

Recommendations for audit elements include the following:

WellCare's Care Managers (CM) should outreach MLTSS Members timely and should coordinate care for MLTSS Members as appropriate. WCHP should ensure the Member's Facility Plan of Care and MLTSS Plans of Care are reviewed and saved in the Member's electronic file. The MLTSS Care Manager should ensure the Member's Plan of Care is person-centered, addresses formal and informal supports, goals should be developed to address needs identified during the assessment, and the agreement/disagreement statement should be reviewed and signed by the Member/POA.

Prior to March 1, 2020 WellCare's MLTSS Care Managers should have utilized the New Jersey Choice Assessment (NJCA) to assess Members. The Care Managers should ensure the Member's Plan of Care is reviewed, revised if applicable, and signed by the Member/POA. The Care Manager should confirm that there is documentation of the Member's participation in at least one facility IDT meeting annually. WellCare should ensure the MLTSS Care Managers discuss payment liability, and review the Member's placement and services timely. MLTSS Member's/POA's should be present during the onsite facility CM visits and Members should be assessed for transfer to the Community, and should be provided options regarding alternative living arrangements.

Annually, WellCare's MLTSS Care Managers should review and inform the MLTSS Members of their Rights and Responsibilities, how to file a Grievance and/or Appeal, and train MLTSS Members on identifying and reporting Critical Incidents.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (54.0%)
- #11. Plans of Care developed using "person-centered principles (51.0%)
- #16. Member training on identifying/reporting critical incidents (62.0%)

Recommendations for MLTSS Performance Measures include the following:

WellCare's MLTSS Care Manager's should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary. MLTSS Plans of Care should be developed utilizing person-centered principles. WellCare should ensure MLTSS Members receive annual training on how to identify and report Critical Incidents.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix G – MCO MLTSS Nursing Facility/Special Care Nursing Facility COVID Impact Evaluation

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State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility COVID Impact Evaluation

April 2022

Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Background

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit is to evaluate the effectiveness of the contractually required MLTSS CM program. Annually, IPRO conducts an audit of MLTSS NF Care Management files on behalf of DMAHS. The review period is typically from July 1 through June 30 for each audit cycle. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the 2021 review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. An expansion review period from March 1, 2020 through December 31, 2020, was added to assess the impact of COVID-19 on the MLTSS NF members. Plans were required to provide documentation noting all Care Management outreaches to the member and/or family/personal representative from July 1, 2019 through December 31, 2020. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Results of the NF Care management audit were provided to the MCOs and to DMAHS in a separate report.

Comparison of NF Audit Results for Review Period and Expansion Period

Five audit elements were identified for comparison of care management activities during the review period, prior to suspension of certain in-person care management activities in March 2020, and during the expansion period from March 1, 2020 through December 31, 2020. These elements reflect activities that could be undertaken during the period when care management activities in the nursing facilities were restricted. **Table 1** below, show the results by MCO for both periods. For all elements in both periods, the denominator was 100 for each MCO.

Table 1 Comparison of Review Period and Expansion Period

Transition Planning	Review Period (July 1, 2019- February 29, 2020)					Expansion Period (March 1, 2020- December 31, 2020)				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Member was identified for transfer to HCBS and was offered options, including transfer to the community	92%	94%	100%	83%	55%	100%	100%	100%	99%	56%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	72%	13%	15%	9%	50%	77%	10%	17%	3%	46%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	93%	93%	100%	83%	63%	18%	100%	100%	99%	61%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	61%	69%	78%	42%	37%	55%	80%	85%	60%	45%
Reassessment of the POC and Critical Incident Reporting										
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	75%	81%	98%	58%	54%	92%	99%	98%	52%	53%

While there is variability across MCOs on some of the review element, only one element for one MCO showed a marked decline from the review period to the expansion period. For ABHNJ, the element "Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care" declined from 93% to 18%. All other rates were largely comparable for both periods.

Acute Inpatient Events

In addition to reviewing selected care management elements for the expansion period, IPRO conducted an analysis of Acute Inpatient (IP) events for the period from July 1, 2019 through December 31, 2020. MCOs submitted files for all acute IP events for this period. For the first six months of the IP review period, random samples were selected by month. A total of 100 records were selected for each MCO. For the first six months of the review period, 5 cases per month were selected. For the period from January 1, 2020 through December 31, 2020, the remaining 70 cases were selected by date and diagnosis. For the first quarter, January 1, 2020 through March 31, 2020, 16 cases were selected for each MCO. For the remaining quarters, from April 1, 2020 through December 31, 2020, 18 cases were selected for each MCO. Selection of cases for the period of January 1, 2020 through December 31, 2020, was conducted in such a manner as to ensure that discharges with respiratory diagnoses or COVID-19 diagnoses were present in each quarter. COVID-19 diagnoses did not appear in the data until mid-March 2020.

Results from Requested Documentation to Evaluate COVID-19 Impact of NF Population

The distribution of inpatient events by quarter and MCO is shown in **Table 2**.

Table 2: Inpatient Events by Quarter

		Discharges by Quarter					
	Q3-2019	Q4-2019	Q1-2020	Q2-2020	Q3-2020	Q4-2020	Total
ABHNJ	15	15	16	18	18	18	100
AGNJ	15	15	16	18	18	18	100
HNJH	15	15	16	18	18	18	100
UHCCP	15	15	16	18	18	18	100
WCHP	15	15	16	18	18	18	100
Total	**75**	**75**	**80**	**90**	**90**	**90**	**500**

Table 3 shows discharge status by discharge diagnosis. Discharge was unknown for one case.

Table 3: Discharge Status by Diagnosis

	Discharge Status by Diagnosis							
	Back to NF	Community	Other Acute	Subacute	Expired	Other	Unknown*	Total
COVID-19	32	1	3	11	25	2	-	74
Other Respiratory	51	1	1	10	10	-	-	73
Sepsis	47	5	1	9	27	3	1	93
Other	190	7	7	34	18	4	-	260
Total	**320**	**14**	**12**	**64**	**80**	**9**	**1**	**500**

*For 1 case, the MCO was unable to determine the discharge status. This has no impact on the overall results.

Of the 14 cases discharged to the community, the care manager attempted to reach the member or family member in ten cases. Of these outreaches, 8 were successful. Six of the 14 members had a status change from NF to HCBS. Of these six, four had HCBS services put in place. No HCBS services were reported for the eight members whose status did not change from NF to HCBS.

Table 4 shows outreach attempts to the member and/or family/personal representative by MCO and whether outreach was successful. One MCO, AGNJ, attempted to reach members and/or family/personal representatives for more than 70% of the discharges. Two MCOs, HNJH and WCHP, attempted outreach for more than 50% of the discharges. The remaining two, ABHNJ and UHCCP, were below 20% for outreach attempts. Where outreach was attempted, the MCOs reported, successful outreach ranged from 70.7% to 100%. MCOs reported attempted contacts with facilities. However, these attempts are not reflected here as they may not have been associated with a specific member or discharge.

Table 4: Care Manager Outreach to Member and/or Family/Personal Representative Post Discharge

	Care Manager Outreach by MCO					
	Discharges	Outreach Attempted	Unknown*	% Outreach	Outreach Successful	Percent Successful
ABHNJ	100	7	-	7.0%	7	100.0%
AGNJ	100	72	1	72.7%	70	97.2%
HNJH	100	50	3	51.5%	40	80.0%
UHCCP	100	11	-	11.0%	10	90.9%
WCHP	100	58	-	58.0%	41	70.7%
Grand Total	**500**	**198**	**4**	**39.9%**	**168**	**84.8%**

*No information was provided regarding outreach attempts by two MCOs for a total of four cases. There is no impact on the overall results.

Table 5 shows the discharge status for each quarter.

Table 5: **Discharge Status by Quarter**

		Discharges by Quarter					
	Q3-2019	Q4-2019	Q1-2020	Q2-2020	Q3-2020	Q4-2020	Total
Back to NF	53	57	53	46	57	54	320
Community	4	1	1	-	4	4	14
Other Acute	1	4	1	1	3	2	12
Subacute	10	8	12	10	10	14	64
Expired	5	5	12	31	12	15	80
Other	2	-	1	1	4	1	9
Unknown	-	-	-	1	-	-	1
Total	**75**	**75**	**80**	**90**	**90**	**90**	**500**

Of the 80 deaths that occurred during the 18 month period under review for this sample, 39% occurred during the second quarter of 2020. Prior to 2020, there were five deaths for the randomly selected acute inpatient events (75 events per quarter) each quarter. Selection of cases in the last two quarters of 2019 was random. COVID-19 diagnosis codes were not used prior to the second quarter of 2020. Selection of records in first quarter of 2020 included at least one respiratory case per MCO. Selection of cases for last three of the four quarters in 2020 included at least 1 COVID-19 diagnosis. **Table 6** shows the diagnoses by quarter and the deaths by diagnosis for each quarter.

Table 6: **Deaths by Diagnosis per Quarter**

		Expired by Quarter and Diagnosis					
	Q3-2019	Q4-2019	Q1-2020	Q2-2020	Q3-2020	Q4-2020	Total
COVID-19 Cases	-	-	-	35	15	24	74
COVID-19 Expired	-	-	-	15	2	8	25
Other Respiratory Cases	10	7	18	11	16	11	73
Other Respiratory Expired	1	-	3	3	2	1	10
Sepsis Cases	11	23	17	17	14	11	93
Sepsis Expired	3	5	4	8	5	2	27
Other Cases	54	45	45	27	45	44	260
Other Expired	1	-	5	5	3	4	18
Total Cases	**75**	**75**	**80**	**90**	**90**	**90**	**500**
Total Expired	**5**	**5**	**12**	**31**	**12**	**15**	**80**

Table 7 shows length of time to notification of discharge by MCO by Quarter. No consistent pattern was observed across MCOs by quarter.

Table 7: Time from Discharge Date to MCO Notification

	Time from Discharge Date to MCO Notification						
	Length of Notification to MCO	Qtr 3 2019	Qtr 4 2019	Qtr 1 2020	Qtr 2 2020	Qtr 3 2020	Qtr 4 2020
ABHNJ Unknown 25	Minimum Number of Days	1	0	0	0	0	0
	Maximum Number of Days	68	40	105	59	62	153
	Average Number of Days	25.8	12.5	17.3	15.0	19.3	41.2
AGNJ Unknown 0	Minimum Number of Days	0	0	0	1	0	0
	Maximum Number of Days	17	10	5	11	71	27
	Average Number of Days	23.0	3.0	2.2	3.7	19.2	4.9
HNJH Unknown 11	Minimum Number of Days	0	0	0	0	0	0
	Maximum Number of Days	29	57	97	60	71	83
	Average Number of Days	7.8	12.9	27.7	8.1	16.3	15.8
UHCCP Unknown 4	Minimum Number of Days	0	0	0	0	0	0
	Maximum Number of Days	163	34	20	313	131	92
	Average Number of Days	31.8	9.5	4.8	21.6	23.8	19.2
WCHP Unknown 28	Minimum Number of Days	0	0	0	0	0	0
	Maximum Number of Days	101	57	31	103	64	31
	Average Number of Days	25.7	21.4	15.8	16.1	15.4	7.1

Conclusion

This report is intended to provide descriptive information for MLTSS NF members immediately prior to and during the 2020 COVID-19 pandemic. Review of care management activities for the period prior to the pandemic, and for the period from March 1, 2020 through December 31, 2020, do not show any patterns of change for any MCO. The inpatient acute events data show an increase in the number of deaths, particularly for the second quarter of 2020. However, the samples from April 2020 forward were selected to include at least one COVID-19 case per MCO.