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

FIDE SNP and MLTSS

External Quality Review

Annual Technical Report

Review Period: January 1, 2021–December 31 2021

(2021-2022 Review 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.

The Medicare Dual Eligible Subset – Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) program, administered by the New Jersey (NJ) Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides comprehensive health services to beneficiaries who are eligible for Medicare Part A and B and who are also eligible for enrollment into Medicaid Managed Care (MMC) benefits. DMAHS is responsible for overseeing compliance of the FIDE SNPs in the State of New Jersey. The Centers for Medicare & Medicaid Services (CMS) requires that an independent, external review using established protocols be performed to ensure that FIDE SNPs meet quality and compliance standards in accordance with the Balanced Budget Act (BBA) of 1997.

The current review was undertaken by IPRO, the external quality review organization (EQRO) acting on behalf of DMAHS, to evaluate each FIDE SNP's operations and to determine their compliance with the regulations in the BBA governing MMC programs, as set forth in section 1932 of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR), part 438 et seq. and with State contractual requirements.

Five FIDE SNPs, namely Aetna Assure Premier Plus (AAPP), Amerivantage Dual Coordination (AvDC), Horizon NJ TotalCare (HNJTC), UnitedHealthcare Dual Complete ONE (UHCDCO), and WellCare Liberty (WCL) participated in the FIDE SNP Program in 2021. The total FIDE SNP enrollment in AAPP, AvDC, HNJTC, UHCDCO and WCL as of 12/31/2021 was 61,554 which is an increase from 55,851 FIDE SNP members from 12/31/2020.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the three mandatory and two 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), DMAHS encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

It should be noted that validation of network adequacy and assistance with the quality rating of MCOs was 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 determined 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 –** 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, one Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Survey for NJ FamilyCare FIDE SNP enrollees was conducted to assess consumers' experiences with their health plan. The NJ FamilyCare FIDE SNP adult survey project consisted of 58 core questions and 11 supplemental questions.

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. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in the **Section V: Validation of Performance Measures** of this report.

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 FIDE SNP 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 FIDE SNP 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 **Section IX: MCO Strengths and Opportunities for Improvement, and EQR Recommendations** of this report.

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted in 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 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. It was determined that New Jersey FIDE SNP MCOs could submit their Chronic Condition Improvement Projects (CCIPs), approved by CMS, to meet the mandatory Performance Improvement Projects requirement. All MCOs were required to provide data at the New Jersey specific FIDE SNP level for these projects. IPRO deemed CMS acceptance of these projects for compliance with Performance Improvement Project validation. In addition to the CCIP projects submitted by the FIDE SNP MCOs, PIPs related to Access and Availability of Primary Care Services were also submitted and validated. AAPP initiated a FIDE SNP product in 2021. AAPP submitted a proposal to evaluate Access and Availability of Primary Care Services during this review period.

Full validation results for the 2021 FIDE SNP PIPs are described in **Section III: Validation of Performance Improvement Projects** of this report.

The following FIDE SNP PIPs were conducted by the MCOs during the ATR review period.

1. Access to and Availability of PCP Services (Non-Clinical PIP) – (4 MCOs - AvDC, HNJTC, UHCDCO, and WCL)
    - April 2021 Project Update Submission – Project Status and Baseline Update
    - August 2021 Project Status Reports Submission - Baseline Report and project Year 1 Update
    - August 2021 Proposal (1 MCO - AAPP)

2. Diabetes Management (3 MCOs - AvDC, HNJTC and WCL)
    - April 2021 Project Update Submission – Project Status and Baseline Update
    - August 2021 Project Status Reports Submission - Baseline Report and project Year 1 Update

3. Management of Hypertension (1 MCO - UHCDCO)
    - April 2021 Project Update Submission – Project Status and Baseline Update

- August 2021 Project Status Reports Submission - Baseline Report and project Year 1 Update
- August 2021 Proposal (1 MCO – AAPP)

4. Management of Asthma (1 MCO - HNJTC)
    - August 2021 Final Report Submitted

Comprehensive Administrative Review (2021 Annual Assessment of MCO Operations)

The Annual Assessment of FIDE SNP/Managed Long-Term Services and Supports (MLTSS) Operations is designed to assist with validating, quantifying, and monitoring the quality of each FIDE SNP's structure, processes, and the outcomes of its operations. Effective January 1, 2016, the MLTSS population was included in the FIDE SNP product and Home and Community-Based Services (HCBS) were fully included in the FIDE SNP benefits (nursing facility [NF] was included effective January 2015); this audit period was January 2020–December 2020 for FIDE SNP/MLTSS. FIDE SNPs are subject to annual assessment of operations every three years. AvDC, HNJTC, UHCDCO and WCL were subject to a full annual assessment of operations review in the current review period (January 2020–December 2020).

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 January 1, 2020–December 31, 2020, AvDC, HNJTC, UHCDCO, and WCL scored above NJ's minimum threshold of 85%. In 2021, the average compliance score for three (3) standards (Quality Assessment and Performance Improvement, Programs for the Elderly and Disabled, and Utilization Management) showed increases ranging from 1 to 4 percentage points. In 2021, five (5) standards (Quality Assessment and Performance Improvement, Quality Management, Committee Structure, Programs for the Elderly and Disabled, and Management Information Systems) had an average score of 100%. Average compliance for four (4) standards (Access, Quality Management, Committee Structure, Provider Training and Performance,) remained the same from 2019 to 2021. Five (5) standards (Enrollee Rights and Responsibilities, Care Management and Continuity of Care, Credentialing and Recredentialing, Administration and Operations, and Management Information Systems) had decreases ranging from 1% to 3% in 2021. Findings from this review can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations** 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** below provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards. Of the 255 elements reviewed in 2019, and 220 elements reviewed in 2020 during the Annual Assessments, 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 (A), 2 - Credentialing and Re-Credentialing (CR), 3 - Administration and Operations (AO)	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	1 - 2019-2020 and 2021-2022 2- 2019-2020 and 2021-2022 3 - 2019-2020 and 2021-2022
Assurances of adequate capacity and services	438.207	1 – Access (A)	A4	1 - 2019-2020 and 2021-2022
Coordination and continuity of care	438.208	1 - Care Management and Continuity of Care (CM)	CM2, CM7 - CM11, CM14, CM26, CM29, CM34, CM38	1 – 2019-2020 and 2021-2022
Coverage and authorization of service	438.210	1 - Utilization Management (UM)	UM3, UM11, UM14, UM15, UM16, UM16o1 UM16o2	1– 2019-2020 and 2021-2022
Provider selection	438.214	1 - Credentialing and Re-Credentialing (CR) 2 - Care Management and Continuity of Care (CM)	CR2, CR3, CM27	1– 2019-2020 and 2021-2022 2 - 2019-2020 and 2021-2022
Confidentiality	438.224	1 - Provider Training and Performance (PT)	PT9	1 - 2019-2020 and 2021-2022
Grievance and appeal systems	438.228	1 - Utilization Management (UM) and Quality Management (QM)	UM16k,- UM16l, UM16m - UM16n, QM5	1– 2019-2020 and 2021-2022
Subcontractual relationships and delegation	438.230	1 - Administration and Operations (AO)	AO5, AO8– AO11	1– 2019-2020 and 2021-2022
Practice guidelines	438.236	1 – QAPI (Q), 2 - Quality Management QM), 3 - Programs for the Elderly and Disabled (ED)	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 (IS)	IS1–IS17	1– 2019-2020 and 2021-2022
Quality assessment and performance improvement (QAPI)	438.330	1 - Quality Assessment and Performance Improvement (QAPI) (Q)	Q1-Q3, Q5-Q9	1–2019-2020 and 2021-2022

*Within a three-year cycle, all four MCO's (AvDC, HNJTC, UHCDCO and WCL) had a full compliance review in 2019 and 2021.
DMAHS requires specific elements to be reviewed annually.

Validation of Performance Measure Reporting

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, 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 2021 Core Medicaid/MLTSS Annual Assessment of MCO Operations review which included the FIDE SNP population. Results of this review can be found in **Section V: Validation of Performance Measures** of this report.

MY 2020 FIDE SNP Performance Measures

For measurement year (MY) 2020 (Healthcare Effectiveness Data and Information Set [HEDIS®] MY 2020), MCOs reported the 13 FIDE SNP HEDIS measures required by CMS. As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to calculate the measures. Medication Reconciliation Post Discharge was retired for MY 2020. It is collected as a submeasure of Transitions of Care (TRC). In MY 2019, due to the COVID-19 pandemic, New Jersey did not require reporting of hybrid measures. Year over year comparisons in performance are therefore restricted to measures that were reported in MY 2019 and MY 2020. Results of this review can be found in **Section V: Validation of Performance Measures** of this report.

Strengths:

For the following measures, the weighted averages for NJ FIDE SNP were observed to be above the 75th percentile:

1. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
2. Pharmacotherapy Management of COPD Exacerbation (PCE) [Bronchodilator]
3. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Opportunities for improvement:

For the following measures, the weighted averages for NJ FIDE SNP were observed to be below the 50th percentile:

a. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Dementia + Tricyclic Antidepressants or Anticholinergic Agents, Chronic Renal Failure + Nonaspirin NSAIDs or Cox-3 Selective NSAIDs, and Total]
b. Antidepressant Medication Management (AMM) {Effective Acute Phase Treatment]
c. Transitions of Care (TRC) [Notification of Inpatient Admissions, and Receipt of Discharge Information]
d. Colorectal Cancer Screening (COL)
e. Pharmacotherapy Management of COPD Exacerbation (PCE) [Systemic Corticosteroid]
f. Controlling Blood Pressure (CBP)
g. Antidepressant Medication Management (AMM) {Effective Continuation Phase Treatment]
h. Follow-up After Hospitalization for Mental Illness (FUH) [30-Day Follow-Up, and 7-Day Follow-Up]
i. Transitions of Care (TRC) [Medication Reconciliation Post Discharge, and Patient Engagement After Inpatient Discharge]
j. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Falls + Tricyclic Antidepressants or Antipsychotics]

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 Assessments of Compliance with Medicaid Managed Care regulations. The ISCAs were conducted by their External Quality Review Organization (EQRO), IPRO.

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 above 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 FIDE SNP CAHPS Survey

IPRO subcontracted with a certified survey vendor to field the CAHPS survey for the FIDE SNP population. Surveys were fielded in spring 2021 for members enrolled in from July 1, 2020 through December 31, 2020. Four FIDE SNP MCO adult surveys were fielded. A total random sample of 7,020 cases was drawn from adult enrollees from the four NJ FamilyCare FIDE SNP plans (AvDC, HNJTC, UHCDCO and WCL); this consisted of a random sample of 1,755 enrollees from each plan.

During 2021, a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H survey for NJ FamilyCare FIDE SNP enrollees was conducted to assess consumers' experiences with their health plan. The NJ FamilyCare FIDE SNP adult survey project consisted of 58 core questions and 11 supplemental questions. Four FIDE SNPs namely Amerivantage Dual Coordination (AvDC), Horizon NJ TotalCare (HNJTC), UnitedHealthcare Dual Complete ONE (UHCDCO), and WellCare Liberty (WCL) participated in the FIDE SNP Program in 2021.

Results from the CAHPS 5.1H survey for NJ FamilyCare FIDE SNP enrollees provided a comprehensive tool for assessing consumers' experiences with their health plan. Complete interviews were obtained from 2,646 NJ FamilyCare FIDE SNP enrollees, and the NJ FamilyCare FIDE SNP response rate was 34.8%. For each of the four domains of member experience (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), a composite score was calculated. The composite scores give a summary assessment of how the plans performed across each domain. The overall composite scores for AvDC, HNJTC, UHCDCO and WCL were as follows: 91.4% for How Well Doctors Communicate; 89.2% for Customer Service; 81.7% for Getting Care Needed; and 81.7% for Getting Care Quickly. 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.

Encounter Data

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. Results of this review 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 focused study with the Core Medicaid and FIDE SNP MCOs and EDMU. The objective of the audit is to verify the accuracy of pharmacy encounter data submitted to DMAHS by all five NJ Medicaid and all four participating 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 has 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 have provided the adjudicated claim information and the EQRO is in the process of identifying 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 were to include a review of the corresponding claims on the Pharmacy Benefit Manager's (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 focused study has been completed, and IPRO provided DMAHS with a summary of findings report, August 2021. Results of this project can be found in **Section VII: Encounter Data Validation** of this report.

Conclusion and Recommendations

Section IX of this report provides a summary of strengths, opportunities for improvement, and EQR recommendations for AAPP, AvDC, HNJTC, UHCDCO, and WCL. These evaluations are based on the EQRO's review of MCO performance across all activities evaluated during the review period.

II. New Jersey FIDE SNP/MLTSS Program

FIDE SNP/MLTSS in New Jersey

The BBA of 1997 established that state agencies contracting with (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 MCOs. In accordance with the BBA of 1997 (Subpart E, 42 CFR Section 438.350), an EQRO sets forth the requirements for annual EQR of contracted MCOs. CFR 438.350 requires states to contract with an EQRO to perform an annual EQR of each MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; 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 CMS.

To meet these federal requirements, DMAHS has contracted with IPRO to conduct EQR activities on behalf of DMAHS for the FIDE SNP/MLTSS program. IPRO assesses FIDE SNP operations and performance on key activities and provides recommendations on how these activities can improve the timeliness, quality, and access to healthcare services for enrollees. This report is the result of IPRO's assessment and review of FIDE SNP activities for calendar year 2020.

The FIDE SNP program, administered by DMAHS, provides comprehensive health services to beneficiaries who are eligible for Medicare Part A and B or are enrolled in Medicare Part C and who are also eligible for Medicaid benefits. As of December 2021, there were approximately 61,554 individuals enrolled in AAPP, AvDC, HNJTC, UHCDCO and WCL (**Table 2**).

Table 2 shows percentages enrollment by Plan resulting an increase of 10.2% for the comparative year.

Table 2: 2020–2021 FIDE SNP Enrollment

FIDE SNP	Acronym	Enrollment as of December 2020	Enrollment as of December 2021	Enrollment Percentage Change (+/-)
Aetna Assure Premier Plus[1]	AAPP	NA	829	NA
Amerivantage Dual Coordination	AvDC	10,662	11,729	+10.0%
Horizon NJ TotalCare	HNJTC	14,778	15,974	+8.1%
UnitedHealthcare Dual Complete ONE	UHCDCO	24,905	26,980	+8.3%
WellCare Liberty	WCL	5,506	6,042	+9.7%
Total		**55,851**	**61,554**	**10.2%**

Source: DMAHS

[1] Aetna joined the FIDE SNP network on 1/1/2021.

Figure 1 is a graphic depiction of the size of each FIDE SNP's enrolled population in December 2020 and December 2021 in relation to the total.

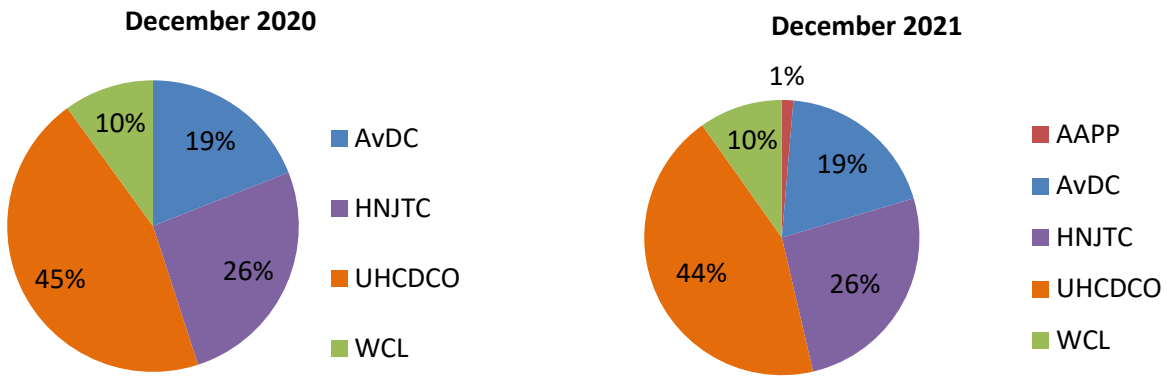

Figure 1: 2020 and 2021 Enrollment Percentages by FIDE SNP
Proportion of FIDE SNP enrollment in December 2020 and December 2021 for each FIDE SNP MCOs : blue: Amerivantage Dual Coordination (AvDC); purple: Horizon NJ TotalCare (HNJTC); orange: UnitedHealthcare Dual Complete ONE (UHCDCO); and green: WellCare Liberty (WCL); burgundy: Aetna Assure Premier Plus (AAPP) joined the Network on 1/1/2021.

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

Table 3: 2021 EQR Activities by MCO

	Annual Assessment of MCO Operations	PMs	FIDE SNP PIPs	Focused Quality Studies	CAHPS Surveys	ISCA Assessments
AAPP[1]	-	-	√	-	-	-
AvDC	√	√	√	√	√	√
HNJTC	√	√	√	√	√	√
UHCDCO	√	√	√	√	√	√
WCL	√	√	√	√	√	√

EQR: external quality review; MCO: managed care organization; PM: performance measure; PIP: performance improvement project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; ISCA: Information Systems Capabilities Assessment (conducted in 2020).

[1] Aetna Assure Premier Plus entered the FIDE SNP Network on 1/1/21, the MCO was not required to participate in the Annual Assessment review in 2021 or required to submitted HEDIS MY 2020 data.

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.

On June 24, 2021, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO reviewed requirements for the September 2021 PIP proposals for new Non-Clinical PIPS. The training (held via virtual platform due to COVID-19), focused on PIP Development, Implementation, and current PIP issues. The MCOs will continue to submit project updates in April and August progress reports each year.

Specific MCO PIP topics are displayed in **Table 4**.

Table 4: MCO PIP Topics

MCO	MCO PIP Title(s)[1]	State Topic
Aetna Assure Premier Plus (AAPP)	PIP 1: Improving Access and Availability to Primary Care for the FIDE SNP (Proposal)	**Access and Availability (Non-Clinical)**
	PIP 3: Promote the Effective Management of Hypertension to Improve Care and Health Outcomes (Proposal)	**Hypertension (HTN) PIP**
Amerivantage Dual Coordination (AvDC)	PIP 1: Increasing Access for Members with High Emergency Room Utilization through the Promotion of Telehealth	**Access and Availability (Non-Clinical)**
	PIP 2: Enhancing Education for Providers and Diabetic Members with Uncontrolled Diabetes (FIDE SNP proposal)	**Diabetes Management**

MCO	MCO PIP Title(s)[1]	State Topic
Horizon NJ TotalCare (HNJTC)	PIP 1: Increasing PCP Access and Availability for Members with High Ed Utilization – Horizon NJ Total Care (FIDE SNP Membership)	**Access and Availability (Non-Clinical)**
	PIP 2: Diabetes Management	**Diabetes Management**
	PIP 4: Reducing Asthma -Related ER Visits, Recurring ER Visits, Hospital Admissions and Readmissions in the FIDE SNP Population	**Management of Asthma (Final)**
UnitedHealthcare Dual Complete ONE (UHCDCP)	PIP 1: Decrease Emergency Room Utilization (FIDE SNP)	**Access and Availability**
	PIP 3: Promoting Adherence to Rein Angiotensin (RAS) Antagonist Hypertensive Medication (FIDE SNP)	**Hypertension (HTN) PIP**
WellCare Liberty (WCL)	PIP 1: FIDE SNP Primary Care Physician Access and Availability	**Access and Availability**
	PIP 2: Promote Effective Management of Diabetes in the FIDE SNP Population	**Diabetes Management**

[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 the conduct of the PIPs, IPRO provides technical assistance to each MCO. The technical assistance includes feedback.

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 fully 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 Submission Reports and provided scoring and suggestions to the MCOs to enhance their studies. IPRO reviewed the 2021 August /September Clinical and Non-Clinical PIPs for the five MCOs, and two proposals for one MCO (one clinical and one non-clinical) providing feedback on how to enhance the studies. One MCO (HNJTC) submitted a Final PIP on Asthma.

Table 6: PIP State Topic #1: Access and Availability

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP Proposal	**AvDC YR 1**	**HNJTC YR 1**	**UHCDCP YR 1**	**WCL 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	0	PM	M	M	M
1b. Impacts the maximum proportion of members that is feasible	0	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	0	M	M	M	M
1d. Reflects high-volume or high risk-conditions	0	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	0	PM	M	M	M
Element 1 Overall Review Determination	**0**	**PM**	**M**	**M**	**M**
Element 1 Overall Score	**0**	**50**	**100**	**100**	**100**
Element 1 Weighted Score	**0.0**	**2.5**	**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	0	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	0	M	M	M	M
2c. Objectives align aim and goals with interventions	0	PM	M	M	M
Element 2 Overall Review Determination	**0**	**PM**	**M**	**M**	**M**
Element 2 Overall Score	**0**	**50**	**100**	**100**	**100**
Element 2 Weighted Score	**0.0**	**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)	0	PM	M	M	M
3b. Performance indicators are measured consistently over time	0	M	M	PM	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	0	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	0	PM	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	0	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.	0	N/A	N/A	N/A	PM
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	0	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	0	M	M	M	M

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP Proposal	**AvDC YR 1**	**HNJTC YR 1**	**UHCDCP YR 1**	**WCL MY 1**
Element 3 Overall Review Determination	**0**	**PM**	**PM**	**PM**	**PM**
Element 3 Overall Score	**0**	**50**	**50**	**50**	**50**
Element 3 Weighted Score	**0.0**	**7.5**	**7.5**	**7.5**	**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	0	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	0	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	0	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	0	M	M	PM	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	0	M	M	M	M
4f. Literature review	0	M	M	M	M
Element 4 Overall Review Determination	**0**	**M**	**M**	**PM**	**M**
Element 4 Overall Score	**0**	**100**	**100**	**50**	**100**
Element 4 Weighted Score	**0.0**	**15.0**	**15.0**	**7.5**	**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	0	M	M	M	M
5b. Actions that target member, provider and MCO	0	M	M	M	M
5c. New or enhanced, starting after baseline year	0	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)	0	PM	M	M	M
Element 5 Overall Review Determination	**0**	**PM**	**M**	**M**	**M**
Element 5 Overall Score	**0**	**50**	**100**	**100**	**100**
Element 5 Weighted Score	**0.0**	**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	0	PM	M	M	M
Element 6 Overall Review Determination	**0**	**PM**	**M**	**M**	**M**
Element 6 Overall Score	**0**	**50**	**100**	**100**	**100**
Element 6 Weighted Score	**0.0**	**2.5**	**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.					

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP Proposal	**AvDC YR 1**	**HNJTC YR 1**	**UHCDCP YR 1**	**WCL MY 1**
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	0	PM	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	0	PM	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	0	PM	M	M	M
7d. Lessons learned & follow-up activities planned as a result	0	PM	PM	M	M
Element 7 Overall Review Determination	**0**	**PM**	**M**	**M**	**M**
Element 7 Overall Score	**0**	**50**	**100**	**100**	**100**
Element 7 Weighted Score	**0.0**	**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	0	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	0	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**0**	**0**	**0**	**0**	**0**
Element 8 Weighted Score	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed	**N/A**	**N**	**N**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**0.0**	**47.5**	**72.5**	**65.0**	**72.5**
Validation Rating Percent	**0.0%**	**59.0%**	**90.6%**	**81.3%**	**90.6%**
Validation Status	**No**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**N/A**	**Moderate**	**High**	**Moderate**	**High**

Scoring will occur in Measurement Year 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 7: PIP State Topic #2: Diabetes Management

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP[1]	**AvDC YR 1**	**HNJTC YR 1**	**UHCDOC[1]**	**WCL YR 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	0	PM	M	0	M
1b. Impacts the maximum proportion of members that is feasible	0	M	M	0	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	0	M	M	0	M
1d. Reflects high-volume or high risk-conditions	0	M	M	0	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	0	M	M	0	M
Element 1 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 1 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 1 Weighted Score	**0.0**	**2.5**	**5.0**	**0.0**	**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	0	M	M	0	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	0	M	M	0	M
2c. Objectives align aim and goals with interventions	0	PM	M	0	M
Element 2 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 2 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 2 Weighted Score	**0.0**	**2.5**	**5.0**	**0.0**	**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)	0	PM	M	0	M
3b. Performance indicators are measured consistently over time	0	M	M	0	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	0	M	M	0	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	0	M	M	0	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	0	0	M	0	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.	0	N/A	M	0	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	0	PM	M	0	M
3h. Study design specifies data analysis procedures with a corresponding timeline	0	PM	M	0	M
Element 3 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP[1]	AvDC YR 1	HNJTC YR 1	UHCDOC[1]	WCL YR 1
Element 3 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 3 Weighted Score	**0.0**	**7.5**	**15.0**	**0.0**	**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	0	M	M	0	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	0	M	M	0	M
4c. Provider input at focus groups and/or Quality Meetings	0	M	M	0	M
4d. QI Process data ("5 Why's", fishbone diagram)	0	PM	M	0	PM
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	0	M	M	0	M
4f. Literature review	0	M	M	0	M
Element 4 Overall Review Determination	**0**	**PM**	**M**	**0**	**PM**
Element 4 Overall Score	**0**	**50**	**100**	**0**	**50**
Element 4 Weighted Score	**0.0**	**7.5**	**15.0**	**0.0**	**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	0	M	M	0	M
5b. Actions that target member, provider and MCO	0	M	M	0	M
5c. New or enhanced, starting after baseline year	0	M	M	0	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)	0	PM	PM	0	M
Element 5 Overall Review Determination	**0**	**PM**	**PM**	**0**	**M**
Element 5 Overall Score	**0**	**50**	**50**	**0**	**100**
Element 5 Weighted Score	**0.0**	**7.5**	**7.5**	**0.0**	**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	0	PM	M	0	M
Element 6 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 6 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 6 Weighted Score	**0.0**	**2.5**	**5.0**	**0.0**	**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.					

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2021 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP[1]	AvDC YR 1	HNJTC YR 1	UHCDOC[1]	WCL YR 1
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	0	M	M	0	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	0	PM	M	0	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	0	M	M	0	M
7d. Lessons learned & follow-up activities planned as a result	0	PM	M	0	M
Element 7 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 7 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 7 Weighted Score	**0.0**	**10.0**	**20.0**	**0.0**	**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	0	N/A	N/A	0	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	0	N/A	0	0	N/A
Element 8 Overall Review Determination	**0**	**N/A**	**0**	**0**	**N/A**
Element 8 Overall Score	**0**	**N/A**	**0**	**0**	**N/A**
Element 8 Weighted Score	**0.0**	**N/A**	**0.0**	**0.0**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed	N/A	N	N	N/A	N

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**0**	**80**
Actual Weighted Total Score	**0.0**	**40.0**	**72.5**	**0.0**	**72.50**
Validation Rating Percent	**0%**	**50.0%**	**90.6%**	**0%**	**90.6%**
Validation Status	**No**	**Yes**	**Yes**	**No**	**Yes**
Validation Rating	**N/A**	**Low**	**High**	**N/A**	**High**

Scoring will occur in Measurement Year 1 ([1]AAPP and UHCDOC do not have DM PIPs at this time)

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 8: PIP State Topic #3: Hypertension Management

Management of Hypertension	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP[1] Proposal	**AvDC**	**HNJTC**	**UHCDC O[1] YR 1**	**WCL**
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	0	0	PM	0
1b. Impacts the maximum proportion of members that is feasible	N/A	0	0	M	0
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	0	0	M	0
1d. Reflects high-volume or high risk-conditions	N/A	0	0	M	0
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	0	0	M	0
Element 1 Overall Review Determination	**N/A**	**0**	**0**	**PM**	**0**
Element 1 Overall Score	**N/A**	**0**	**0**	**50**	**0**
Element 1 Weighted Score	**N/A**	**0.0**	**0.0**	**2.5**	**0.0**
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	0	0	M	0
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	0	0	M	0
2c. Objectives align aim and goals with interventions	N/A	0	0	M	0
Element 2 Overall Review Determination	**N/A**	**0**	**0**	**M**	**0**
Element 2 Overall Score	**N/A**	**0**	**0**	**100**	**0**
Element 2 Weighted Score	**N/A**	**0.0**	**0.0**	**5.0**	**0.0**
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	0	0	M	0
3b. Performance indicators are measured consistently over time	N/A	0	0	M	0
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	0	0	M	0
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	0	0	M	0
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	0	0	M	0
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	0	0	N/A	0
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	0	0	M	0
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	0	0	PM	0
Element 3 Overall Review Determination	**N/A**	**0**	**0**	**PM**	**0**
Element 3 Overall Score	**N/A**	**0**	**0**	**50**	**0**

Management of Hypertension	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP[1] Proposal	**AvDC**	**HNJTC**	**UHCDCO[1] YR 1**	**WCL**
Element 3 Weighted Score	**N/A**	**0.0**	**0.0**	**7.5**	**0.0**
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	N/A	0	0	M	0
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	0	0	M	0
4c. Provider input at focus groups and/or Quality Meetings	N/A	0	0	PM	0
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	0	0	M	0
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	0	0	M	0
4f. Literature review	N/A	0	0	M	0
Element 4 Overall Review Determination	**N/A**	**0**	**0**	**PM**	**0**
Element 4 Overall Score	**N/A**	**0**	**0**	**50**	**0**
Element 4 Weighted Score	**N/A**	**0.0**	**0.0**	**7.5**	**0.0**
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	0	0	M	0
5b. Actions that target member, provider and MCO	N/A	0	0	PM	0
5c. New or enhanced, starting after baseline year	N/A	0	0	PM	0
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	0	0	PM	0
Element 5 Overall Review Determination	**N/A**	**0**	**0**	**PM**	**0**
Element 5 Overall Score	**N/A**	**0**	**0**	**50**	**0**
Element 5 Weighted Score	**N/A**	**0.0**	**0.0**	**7.5**	**0.0**
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	N/A	0	0	M	0
Element 6 Overall Review Determination	**N/A**	**0**	**0**	**M**	**0**
Element 6 Overall Score	**N/A**	**0**	**0**	**100**	**0**
Element 6 Weighted Score	**N/A**	**0.0**	**0.0**	**5.0**	**0.0**
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	0	0	PM	0
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	0	0	M	0
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	0	0	M	0
7d. Lessons learned & follow-up activities planned as a result	N/A	0	0	PM	0

Management of Hypertension	IPRO 2021 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP[1] Proposal	**AvDC**	**HNJTC**	**UHCDCO[1] YR 1**	**WCL**
Element 7 Overall Review Determination	**N/A**	**0**	**0**	**PM**	**0**
Element 7 Overall Score	**N/A**	**0**	**0**	**50**	**0**
Element 7 Weighted Score	**N/A**	**0.0**	**0.0**	**10.0**	**0.0**
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	0	0	N/A	0
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	0	0	N/A	0
Element 8 Overall Review Determination	**N/A**	**0**	**0**	**N/A**	**0**
Element 8 Overall Score	**N/A**	**0**	**0**	**N/A**	**0**
Element 8 Weighted Score	**N/A**	**0.0**	**0.0**	**N/A**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed	**N/A**	**N/A**	**N/A**	**N**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**0**	**0**	**0**	**80**	**0**
Actual Weighted Total Score	**0.0**	**0.0**	**0.0**	**45.0**	**0.0**
Validation Rating Percent	**0%**	**0%**	**0%**	**56.3%**	**0%**
Validation Status	**No**	**No**	**No**	**Yes**	**No**
Validation Rating	**N/A**	**N/A**	**N/A**	**Low**	**N/A**

Scoring will occur in Measurement Year 1 ([1]AAPP (Proposal) and UHCDOC (Year 1) only two (2) MCOs that have a Hypertension Management PIP)
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)

Note: HNJTC completed the FIDE SNP Management of Asthma PIP using a long form that was replaced in 2018.

NEW JERSEY EXTERNAL QUALITY REVIEW - PERFORMANCE IMPROVEMENT PROJECT
REVIEW AND SCORING
Horizon NJ TotalCare (HNJTC)
REDUCING ASTHMA-RELATED ER VISITS, RECURRENT ER VISITS, HOSPITAL ADMISSIONS AND READMISSIONS IN THE FIDE SNP POPULATION
August 2021 Final Report Review

Table 9: PIP State Topic #3: Management of Asthma

	Horizon NJ TotalCare (HNJTC) – SUMMARY SCORING				
	Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
	Review Element 1 - Project Topic and Relevance	M	100	5%	5
	Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
	Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
	Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
	Review Element 6 - Data Collection Procedures	M	50	10%	10
	Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
	Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
	TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**80**
	Review Element 10 - Sustainability of Documented Improvement	M	100	20%	20
	TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**20**
	OVERALL PROJECT PERFORMANCE SCORE			***100%***	***100***
	Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

	COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT		
Score	**Range of Points**	**Level of Compliance**	**Action**
100	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

	COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT		
Score	**Range of Points**	**Level of Compliance**	**Action**
100	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

Table 10 presents FIDE SNP PIP scoring results for each MCO.

Table 10: MCO FIDE SNP PIP Validation Results – 2021

MCO Compliance Level	PIP 1 Access & Availability	PIP 2 Diabetes Management	PIP 3 HTN Management	PIP 4 Management of Asthma
AAPP[1]	N/A		N/A	
AvDC	59.0%	50.0%		
HNJTC[2]	90.6%	90.6%		100%
UHCDCO	81.0%		56.3%	
WCL	90.6%	90.6%		

[1]AAPP submitted two (2) proposal (Access & Availability and HTN Management).
[2] HNJTC was a year behind in their final report for the Management of Asthma PIP.
Cells shaded grey represent PIPs not undertaken by the MCO.

Strengths:

- AAPP – None
- AvDC – None
- HNJTC – Of the 3 PIPs scored, all 3 PIPs performed at or above the 85% threshold indicating high performance.
- UHCDCO – None
- WCL – Of the 2PIPs scored, both PIPs performed at or above the 85% threshold indicating high performance.

Opportunities for Improvement:

AAPP - There were opportunities for improvement in Methodology regarding details for sampling diagnoses, Barrier Analysis, and quarterly rate reporting for ITMs tables that have been altered. The MCO should ensure that the template format is correct to safeguard the accuracy of data reporting remains consistent year over year.

AvDC – 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.

HNJTC – There are opportunities for improvement in consistency regarding study design and methodologies for data collection

UHCDCO – There are opportunities of improvement regarding Robust Interventions, actions that target members, providers and the MCO. There are also opportunities for increased collaboration with providers in order to close any gaps identified in the data capture.

WCL – There are opportunities for improvement in Methodology, by specifying data that identifies a defined list of diagnoses to monitor over the life of the PIP.

For non-collaborative PIPs, interventions are presented below by PIP and by intervention type for each MCO in **Table 11**:

Table 11: Interventions by Type and MCO

State Topic: PCP Access & Availability					
	AAPP	AvDC	HNJTC	UHCDCO	WCL
Targeted Member Communication/Education		X	X		X
General Member Communication/Education					
Targeted Provider Communication/Education		X	X	X	X
General Provider Communication/Education					
Care Management based interventions			X		
State Topic: Diabetes Management					
	AAPP	AvDC	HNJTC	UHCDCO	WCL
Targeted Member Communication/Education		X	X		X
General Member Communication/Education					
Targeted Provider Communication/Education		X			X
General Provider Communication/Education					
Care Management based interventions			X		
State Topic: HTN Management					
	AAPP	AvDC	HNJTC	UHCDCO	WCL
Targeted Member Communication/Education	X			X	
General Member Communication/Education					
Targeted Provider Communication/Education					
General Provider Communication/Education					
Care Management based interventions					
State Topic: Asthma					
	AAPP	AvDC	HNJTC	UHCDCO	WCL
Targeted Member Communication/Education			X		
General Member Communication/Education					
Targeted Provider Communication/Education			X		
General Provider Communication/Education					
Care Management based interventions			X		
KEY: X = Intervention in process.					

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

Objectives

The Annual Assessment of FIDE SNP/MLTSS Operations is designed to assist with validating, quantifying, and monitoring the quality of each FIDE SNP's structure, processes, and the outcomes of its operations. Starting January 1, 2016, the MLTSS population was included in the FIDE SNP product, and HCBS was fully included in the FIDE SNP benefits (NF was included starting January 2015); FIDE SNPs are subject to an assessment of operations every three years. WCL was subject to a full annual assessment of operations review in 2017 for the audit period of January–December 2016.

Annual assessments of FIDE SNP MCO operations were not conducted in calendar year 2020. DMAHS elected not to conduct a FIDE SNP/MLTSS Annual Assessment review in calendar year 2020 as the MCOs participated in a full audit in 2018 and 2019. This meets the CMS requirement for conducting compliance reviews with the MCOs within a three year cycle. A full annual assessment review was conducted in calendar year 2021 for all four of the five FIDE SNP/MLTSS MCOs. (**Table 12**) (AAPP was not required to participate in an Annual Assessment as they just entered the FIDE SNP network on January 1, 2021. The first FIDE SNP/MLTSS Annual Assessment review for AAPP was held in March 2022.

During the 2021 FIDE SNP/MLTSS Annual Assessment review 220 elements were subject to review for all participating FIDE SNP plans. For the 2021 FIDE SNP/MLTSS Annual Assessment, certain MLTSS elements that were previously met in the 2020 Fall Core Medicaid Medicaid/MLTSS annual review were not reviewed again. Those elements were considered 'Not Applicable' for the current Assessment. A total of 2 elements (CS8 and UM19) were Not Applicable (N/A) for all the MCOs during this review. In 2021, elements UM4 and UM21 were removed from the Utilization Management category.

Table 12: 2020 Annual Assessment Type by FIDE SNP/MLTSS

FIDE SNP/ MLTSS	Assessment Type
AAPP	NA
AvDC	Full
HNJTC	Full
UHCDCO	Full
WCL	Full

Pursuant to the release of the updated EQRO Protocols by CMS in 2019, the State requested that IPRO conduct an ISCA review in conjunction with the MCOs' Annual Assessment. Activities and findings for this review are reported separately. Reviews of systems were conducted on the day following the interviews for the 2020 Annual Assessment. In 2021, IPRO conducted a Performance Measure Reporting review for each MCO the day following the Annual Assessment interviews.

IPRO's findings and results of the ISCA reviews can be found in the **Section V: Validation of Performance Measures** section of this report.

Technical Methods of Data Collection and Analysis

IPRO reviewed the FIDE SNP in accordance with the CMS protocol, "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans: A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al."

The review consisted of pre-offsite review of documentation provided by the FIDE SNP as evidence of compliance with the 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 FIDE SNP/MLTSS Operations Review Worksheet. This document closely follows the FIDE SNP/State contract and was developed to assess FIDE SNP compliance. Each element is numbered and organized by general topic (e.g., Access, QAPI, Care Management and Continuity of Care, Enrollee Rights and Responsibilities) and includes the contract reference. The worksheet was provided to the plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was calendar year 2020.

Following the document review, IPRO conducted interviews with key members of the FIDE SNP staff via WebEx. The interviews allowed IPRO to converse with FIDE SNP staff to clarify questions that arose from the desk review. The interview process also gave the FIDE SNP 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 the FIDE SNP understands the provisions of its contract.

IPRO reviewers conducted file reviews for the FIDE SNPs. Select files were examined for evidence of implementation of contractual requirements related to Care Management and Continuity of Care; Utilization Management; member and provider complaints, grievances, and appeals; and Credentialing and Recredentialing. File reviews utilized the eight-and-thirty file sampling methodology established by the NCQA. IPRO reviews an initial sample of eight files, and then reviews an additional sample of twenty-two files when any of the original eight fail the review, for a total of thirty records.

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 FIDE SNP 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 13.**

Table 13: 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 FIDE SNP/MLTSS 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 14** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards.

Table 14: 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 (A), 2 - Credentialing and Re-Credentialing (CR), 3 - Administration and Operations (AO)	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	1 - 2019-2020 and 2021-2022 2- 2019-2020 and 2021-2022 3 - 2019-2020 and 2021-2022
Assurances of adequate capacity and services	438.207	1 – Access (A)	A4	1 - 2019-2020 and 2021-2022
Coordination and continuity of care	438.208	1 - Care Management and Continuity of Care (CM)	CM2, CM7 - CM11, CM14, CM26, CM29, CM34, CM38	1 – 2019-2020 and 2021-2022
Coverage and authorization of service	438.210	1 - Utilization Management (UM)	UM3, UM11, UM14, UM15, UM16, UM16o1 UM16o2	1– 2019-2020 and 2021-2022
Provider selection	438.214	1 - Credentialing and Re-Credentialing (CR) 2 - Care Management and Continuity of Care (CM)	CR2, CR3, CM27	1– 2019-2020 and 2021-2022 2 - 2019-2020 and 2021-2022
Confidentiality	438.224	1 - Provider Training and Performance (PT)	PT9	1 - 2019-2020 and 2021-2022
Grievance and appeal systems	438.228	1 - Utilization Management (UM) and Quality Management (QM)	UM16k,- UM16l, UM16m - UM16n, QM5	1– 2019-2020 and 2021-2022
Subcontractual relationships and delegation	438.230	1 - Administration and Operations (AO)	AO5, AO8– AO11	1– 2019-2020 and 2021-2022
Practice guidelines	438.236	1 – QAPI (Q), 2 - Quality Management QM), 3 - Programs for the Elderly and Disabled (ED)	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 (IS)	IS1–IS17	1– 2019-2020 and 2021-2022
Quality assessment and performance improvement (QAPI)	438.330	1 - Quality Assessment and Performance Improvement (QAPI) (Q)	Q1-Q3, Q5-Q9	1–2019-2020 and 2021-2022

*Within a three-year cycle, all four MCO's (AvDC, HNJTC, UHCDCO and WCL) had a full compliance review in 2019 and 2021.
DMAHS requires specific elements to be reviewed annually.

Of the 220 elements reviewed during the 2021FIDE SNP/MLTSS Annual Assessments, 81 elements crosswalk to the eleven (11) CMS QAPI Standards. **Table 15** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI Standards identified by CMS.

Table 15: Subpart D and QAPI Standards - Scores by MCO

Subpart D and QAPI Standard	CFR Citation	AA Review Elements	# of Elements Reviewed	AvDC	HNJTC	UHCDCO	WCL
Availability of services	438.206	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	12	92%	92%	83%	92%
Assurances of adequate capacity and services	438.207	A4	1	100%	100%	100%	100%
Coordination and continuity of care	438.208	CM2, CM7 - CM11, CM14, CM26, CM29, CM34, CM38	11	100%	100%	91%	100%
Coverage and authorization of services	438.210	UM3, UM11, UM14, UM15, UM16, UM16o1 UM16o2	7	100%	71%	86%	100%
Provider selection	438.214	CR2, CR3, CM27	3	100%	100%	100%	100%
Confidentiality	438.224	PT9	1	100%	100%	100%	100%
Grievance and appeal systems	438.228	UM16k,- UM16l, UM16m - UM16n, QM5	9	100%	100%	100%	100%
Subcontractual relationships and delegation	438.230	AO5, AO8– AO11	5	100%	100%	100%	100%
Practice guidelines	438.236	Q4 QM1, QM3 ED3, ED10, ED23, ED29	7	100%	100%	100%	100%
Health information systems	438.242	IS1–IS17	17	100%	100%	100%	100%
Quality assessment and performance improvement program	438.330	Q1-Q3, Q5-Q9	8	100%	100%	100%	100%
Total Elements Reviewed			**81**				
Compliance Percentage				**99%**	**97%**	**96%**	**99%**

As noted in **Table 15**, all four (4) MCOs participated in the 2021 Compliance Review. A total of 220 elements were reviewed by each MCO for a total of 880 elements reviewed overall.

The four (4) participating FIDE SNP MCOs showed strong performance in the CMS Subpart D and QAPI Standards ranging from 96% to 99% compliance. Two of the four MCOs received 100% compliance for 10 of the 11 standard domains. All MCOs received 100% compliance in 8 of 11 standard domains.

One MCO (UHCDCO) was non-compliant in Availability of services. One MCO (HNJTC) was non-compliant in Coverage and authorization of services.

Table 16 displays a comparison of the overall compliance score for each of the four participating MCOs from 2019 and 2021. For the review period January 1, 2020 – December 31, 2021, AvDC, HNJTC, UHCDCO and WCL scored above NJ's minimum threshold of 85%. The 2021 compliance scores from the annual assessment

ranged from 94% to 98% (**Table 16**). WCL's compliance score decreased from 99% to 98% in 2021; HNJTC's compliance score increased from 95% to 98%; AvDC and UHCDCO's compliance scores remained unchanged at 98% and 94% respectively.(**Table 16**).

Annual assessment of FIDE SNP MCOs operations were not conducted in calendar year 2020. DMAHS elected not to conduct a FIDE SNP/MLTSS Annual Assessment review in calendar year 2020 as the MCOs participated in a full audit in 2018 and 2019. This meets the CMS requirement for conducting compliance reviews with the MCOs within a three year cycle.

In 2021, the average compliance score for three (3) standards (Quality Assessment and Performance Improvement, Programs for the Elderly and Disabled, and Utilization Management) showed increases ranging from 1 to 4 percentage points (**Table 17**). In 2021, five (5) standards (Quality Assessment and Performance Improvement, Quality Management, Committee Structure, Programs for the Elderly and Disabled, and Management Information Systems) had an average score of 100%. Average compliance for four (4) standards (Access, Quality Management, Committee Structure, Provider Training and Performance,) remained the same from 2019 to 2021. Five (5) standards (Enrollee Rights and Responsibilities, Care Management and Continuity of Care, Credentialing and Recredentialing, Administration and Operations and Management Information Systems) had decreases ranging from 1% to 3% in 2021. (**Table 17**). In 2021, Access had the lowest average compliance score at 83%.

Table 16: Comparison of 2019 and 2021 Compliance Scores by MCO

MCO	2019 Compliance %	2021 Compliance %	% Point Change from 2019 to 2021
AAPP	NA	NA	NA
AvDC	98%	98%	0%
HNJTC	95%	98%	+3%
UHCDCO	94%	94%	0%
WCL	99%	98%	-1%

Table 17: 2019 and 2021 Compliance Scores by Review Category

Review Category	MCO Average 2019[1]	MCO Average 2021[1]	Percentage Point Change
Access	83%	83%	0%
Quality Assessment and Performance Improvement	97%	100%	+3%
Quality Management	100%	100%	0%
Committee Structure	100%	100%	0%
Programs for the Elderly and Disabled	96%	100%	+4%
Provider Training and Performance	98%	98%	0%
Enrollee Rights and Responsibilities	100%	98%	-2%
Care Management and Continuity of Care	99%	97%	-2%
Credentialing and Recredentialing	100%	98%	-2%
Utilization Management	97%	98%	+1%
Administration and Operations	99%	96%	-3%
Management Information Systems	99%	100%	-1%
TOTAL	**97%[2]**	**97%**	**0%**

[1] FIDE SNP average is calculated as the average of the scores of the FIDE SNPs for each review category.
The State opted not to conduct Annual Assessments in 2020.
[2] Total is the average of compliance scores listed in **Table 16**.

Appendix: 2021 FIDE SNP-Specific Review Findings contains detailed information on each FIDE SNP's Annual Assessment.

FIDE SNP Strengths

Some of the most notable FIDE SNP strengths identified as a result of the 2021 Annual Assessment of FIDE SNP/MLTSS Operations are:

- The implementation and evaluation of a comprehensive Quality Management 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 four MCOs continue to perform at 100% compliance with regard to Committee Structure, Programs for the Elderly and Disabled, and Management Information Systems.

Recommendations

Recommendations represent areas of deficiency. 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 FIDE SNPs and that require follow-up for more than one reporting period.

The following are among the areas that IPRO recommended for improvement:

- The MCOs should provide an assessment of their FIDE SNP network.
- The MCOs should ensure that their member and provider complaint, grievance and appeals policy and procedures are well-defined and followed by employees who resolve complaints, grievances and appeals, and that timeframes are met as described in the policy and procedures.

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.

As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to calculate the measures.

HEDIS is a widely-used set of PMs developed and maintained by NCQA. FIDE SNPs 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. FIDE SNPs 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 FIDE SNP 's HEDIS rates based upon the HEDIS Final Audit Report (FAR) prepared by a NCQA-licensed audit organization for each FIDE SNP as required by NCQA. IPRO's review of the FAR helped determine whether each FIDE SNP appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable. In determining whether rates are reportable, licensed audit organizations evaluate the FIDE SNPs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, and all supplemental data sources used.

NCQA does not release national averages or percentiles for FIDE SNPs. As a proxy, IPRO compared the FIDE SNPs' reported HEDIS results to national Medicare 10th, 25th 50th and 75th percentiles from NCQA's Quality Compass® to identify opportunities for improvement and strengths. As the FIDE SNP population is not directly comparable to the general Medicare population, caution should be used when comparing the HEDIS results to the NCQA percentiles for Medicare.

Description of Data Obtained

The four participating FIDE MCOs with performance data for MY 2020 (AvDC, HNJTC, UHCDCO and WCL) 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 18).**

Table 18: MCO Compliance with Information System Standards – MY 2020

IS Standard	AvDC	HNJTC	UHCDCO	WCL
HEDIS Auditor				
1.0 Medical Services Data	Met	Met	Met	Met
2.0 Enrollment Data	Met	Met	Met	Met
3.0 Practitioner Data	Met	Met	Met	Met
4.0 Medical Record Review Processes	Met	Met	Met	Met
5.0 Supplemental Data	Met	Met	Met	Met
6.0 Data Preproduction Processing	Met	Met	Met	Met
7.0 Data Integration and Reporting	Met	Met	Met	Met

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 offer both a Medicaid and a Fully Integrated Dual Eligible Special Needs (FIDE SNP) product. The fifth MCO was scheduled to begin 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 below in **Table 19**:

Table 19: Information Systems Capabilities Assessment (ISCA) Results for 2020

MCO	AAPP	AvDC	HNJTC	UHCDCO	WCL
Standard[1]	Implications of Findings				
Completeness and accuracy of encounter data collected and submitted to the State.	NA	No implications	No implications	No implications	No implications
Validation and/or calculation of performance measures.	NA	No implications	No implications	No implications	No implications
Completeness and accuracy of tracking of grievances and appeals.	NA	No implications	No implications	No implications	No implications
Utility of the information system to conduct MCO quality assessment and improvement initiatives.	NA	No implications	No implications	No implications	No implications
Ability of the information system to conduct MCO quality assessment and improvements initiatives.	NA	No implications	No implications	No implications	No implications
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees.	NA	No implications	No implications	No implications	No implications
Ability of the information system to generate complete, accurate, and timely T-MSIS data.	NA	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Utility of the information system for review of provider network adequacy.	NA	No implications	No implications	No implications	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).	NA	No implications	No implications	No implications	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 Medicaid MCOs in New Jersey report audit HEDIS rates to the State. IPRO reviews the final audit reports and the reported rates. FIDE SNP is a Medicaid product. In addition, the MCOs produce 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 final day of 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.

Vendors: 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:

AAPP
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.

AvDC
The MCO 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.

HNJTC
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.

UHCDCO
No issues were noted.

WCL
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 FIDE SNP Performance Measures

IPRO validated the processes used to calculate the 13 HEDIS MY 2020 PMs required by CMS for SNP reporting by the four FIDE SNPs (AvDC, HNJTC, UHCDCO, and WCL). All four FIDE SNP MCOs reported the required measures for MY 2020.

1. Colorectal Cancer Screening (COL)
2. Care for Older Adults (COA)
3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
4. Pharmacotherapy Management of COPD Exacerbation (PCE)
5. Controlling Blood Pressure (CBP)
6. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
7. Osteoporosis Management in Women Who Had a Fracture (OMW)
8. Antidepressant Medication Management (AMM)
9. Follow-Up After Hospitalization for Mental Illness (FUH)
10. Transitions of Care (TRC)
11. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
12. Use of High-Risk Medications in the Elderly (DAE)
13. Plan All-Cause Readmissions (PCR)

Table 21 presents the individual FIDE SNP rates for each of the above 13 measures. There are no national benchmarks for the FIDE SNP population. Results for the NJ FIDE SNP average are compared to the National Medicare benchmarks. When interpreting these results, it should be kept in mind that the FIDE SNP population, which is a more vulnerable population, may differ considerably from the Medicare population.

Conclusions and Comparative Findings

Due to the COVID-19 pandemic and the challenges of obtaining medical record information to evaluate hybrid performance measures, CMS did not require the hybrid performance measures to be reported for MY 2019. In MY 2020, MCOs were required to submit a full set of SNP measures. No year-over-year comparisons are available for Colorectal Cancer Screening (COL), Care for Older Adults (COA), Controlling High Blood Pressure (CBP), and Transitions of Care (TRC). Medication Reconciliation Post Discharge was retired for MY 2020. It is collected as a submeasure of Transitions of Care (TRC). Changes to the specifications for Use of High-Risk Medications in the Elderly (DAE) do not support year-over-year comparisons.

Of the seven measures for which year-over-year comparisons were valid, six remained constant from MY 2019 to MY 2020 (<5 percentage point change). Significant increases (≥5 percentage point change) in performance from MY 2019 are noted below:

1. Improvements in performance from MY 2019:
    - Follow-Up After Hospitalization for Mental Illness (FUH) [30-Day Follow-Up, 7-Day Follow-Up]

There are no national benchmarks for the FIDE SNP population. Results for the NJ FIDE SNP Average are compared to the National Medicare benchmarks. In interpreting these results, it should be borne in mind that the SNP population, which is a more vulnerable population, may differ considerably from the Medicare population.

Plan All-Cause Readmissions (PCR) is a risk adjusted measures. Calculation of a weighted average for this measure is not appropriate.

1. Rates below the 10th percentile:
    a. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Dementia + Tricyclic Antidepressants or Anticholinergic Agents, Chronic Renal Failure + Nonaspirin NSAIDs or Cox-3 Selective NSAIDs, and Total]
2. Rates between the 10th percentile and the 25th percentile:
    a. Antidepressant Medication Management (AMM) {Effective Acute Phase Treatment]
    b. Transitions of Care (TRC) [Notification of Inpatient Admissions, and Receipt of Discharge Information]
3. Rates between the 25th percentile and 50th percentile:
    a. Colorectal Cancer Screening (COL)
    b. Pharmacotherapy Management of COPD Exacerbation (PCE) [Systemic Corticosteroid]
    c. Controlling Blood Pressure (CBP)
    d. Antidepressant Medication Management (AMM) {Effective Continuation Phase Treatment]
    e. Follow-up After Hospitalization for Mental Illness (FUH) [30-Day Follow-Up, and 7-Day Follow-Up]
    f. Transitions of Care (TRC) [Medication Reconciliation Post Discharge, and Patient Engagement After Inpatient Discharge]
    g. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Falls + Tricyclic Antidepressants or Antipsychotics]
4. Rates above the 75th percentile:
    a. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
    b. Pharmacotherapy Management of COPD Exacerbation (PCE) [Bronchodilator]
    c. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

The HEDIS rates are color coded to correspond to National percentiles (**Table 20**).

Table 20: Color Key for HEDIS Performance Measures

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 data presented in this section includes: Effectiveness of Care, and Utilization and Risk Adjusted Utilization. **Table 21** displays the HEDIS performance measures for MY 2020 for all MCOs and the New Jersey FIDE SNP Average. The FIDE SNP average is the weighted average of all MCO data.

Table 21: HEDIS MY 2020 FIDE SNP HEDIS Performance Measures

HEDIS MY 2020 FIDE SNP Measures	AvDC[1]	HNJTC	UHCDCO	WCL	Health Plan Average[2]	MY 2020 New Jersey FIDE SNP Average[3]
Colorectal Cancer Screening (COL) - Hybrid Measure[4,5]	59.14%	51.34%	70.80%	67.88%	62.29%	64.02%
Care for Older Adults (COA) - Hybrid Measure[5,6]						
Advance Care Planning	35.77%	79.32%	62.04%	39.17%	54.08%	58.77%
Medication Review	99.76%	77.62%	88.32%	90.02%	88.93%	88.19%
Functional Status Assessment	60.58%	79.81%	76.16%	53.53%	67.52%	71.82%
Pain Screening	94.65%	90.75%	90.02%	90.75%	91.54%	91.12%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.88%	32.84%	38.33%	45.71%	36.94%	36.14%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Systemic Corticosteroid	62.56%	77.42%	73.02%	68.18%	70.29%	71.80%
Bronchodilator	90.52%	91.61%	88.28%	86.36%	89.19%	89.73%
Controlling High Blood Pressure (CBP) - Hybrid Measure[4]	42.62%	51.34%	70.56%	61.80%	56.58%	60.15%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	100.00%	87.18%	NA	90.84%	92.00%
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	NA	31.71%	NA	CNC	29.49%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	77.08%	72.81%	72.30%	77.14%	74.83%	73.63%
Effective Continuation Phase Treatment	64.93%	59.52%	56.74%	61.90%	60.77%	59.21%
Follow-up After Hospitalization for Mental Illness (FUH)						
30-Day Follow-up	42.73%	51.20%	44.22%	40.79%	44.74%	45.17%
7-Day Follow-up	21.14%	31.10%	24.62%	17.11%	23.49%	24.61%
Transitions of Care (TRC) [5]						
Notification of Inpatient Admission	0.00%	4.14%	4.38%	10.95%	4.87%	4.03%
Medication Reconciliation Post-Discharge	42.09%	64.72%	40.15%	62.77%	52.43%	49.29%
Patient Engagement After Inpatient Discharge	74.21%	86.37%	75.74%	78.83%	78.79%	78.66%
Receipt of Discharge Information	0.49%	4.38%	1.22%	4.14%	2.56%	2.21%
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)[7]						
Falls + Tricyclic	36.06%	39.61%	37.74%	56.04%	42.36%	39.11%

HEDIS MY 2020 FIDE SNP Measures	AvDC[1]	HNJTC	UHCDCO	WCL	Health Plan Average[2]	MY 2020 New Jersey FIDE SNP Average[3]
Antidepressants or Antipsychotics						
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	52.70%	52.67%	57.98%	62.50%	56.46%	56.48%
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	18.72%	15.46%	20.91%	25.00%	20.02%	19.64%
Total	43.32%	41.01%	46.40%	56.95%	46.92%	45.82%
Use of High-Risk Medications in the Elderly (DAE)[7,8]	24.15%	19.91%	29.24%	32.62%	26.48%	26.72%
Plan All-Cause Readmissions (PCR) [7,9,10]						
18-64 Year Olds, Observed-to-Expected Ratio	1.8302	1.1701	1.1865	1.2686		
65+ Year Olds, Observed-to-Expected Ratio	1.3766	1.3544	1.3242	1.2071		

Note: Submission of Hybrid measures was not required for MY2019.

[1] Administrative measures for Amerigroup are calculated by combining the IDSS files with SubIDs 8854 and 13380. For the PCR measure, SubID 8854 is used as this is a risk adjusted measure

[2] Health Plan Average, uses only MCOs who had an eligible population greater than or equal to 30

[3] New Jersey Medicaid average, is weighted average of all MCO data

[4] Amerigroup reported this measure administratively

[5] Measure not reported in MY2019

[6] The data source of Amerigroup for this measure is from IDSS file with SubID 8854.

[7] This measure is inverted, meaning that lower rates indicate better performance

[8] Due to the changes to this measure comparison to prior year is not appropriate

[9] PCR is a risk adjusted measure. Calculation of MCO and Statewide averages is not appropriate

[10] This measure uses count of index stays as the denominator and an observed-to-expected ratio (observed readmission/average adjusted probability)

Designation NA: Plan had less than 30 members in the denominator

Designation NR: Not reportable, Biased Rate

Designation NQ: Not required

Designation CNC: An unweighted or weighted average can only be calculated if 2 or more MCOs have a rate

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

Objectives

IPRO subcontracted with a certified survey vendor to field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (5.1H) for the FIDE SNP population. Surveys were fielded in spring 2020 for members enrolled in from July 1, 2020 through December 31, 2020. Four FIDE SNP adult surveys were fielded.

Technical Methods of Data Collection and Analysis

The CAHPS survey drew, as potential respondents, FIDE SNP adult enrollees over the age of 18 years who were covered by NJ FamilyCare; enrollees had to be continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Respondents were surveyed in English and Spanish. The surveys were administered over a 10-week period from March 26, 2021 through June 10, 2021, using a standardized survey procedure and questionnaire. A total random sample of 7,020 cases was drawn from adult enrollees from the four NJ FamilyCare FIDE SNP MCOs (AvDC, HNJTC, UHCDCO and WCL); this consisted of a random sample of 1,755 enrollees from each MCO.

Results from the CAHPS 5.1H survey for NJ FamilyCare FIDE SNP enrollees provided a comprehensive tool for assessing consumers' experiences with their health plan. The instrument selected for the survey was the HEDIS-CAHPS 5.1H FIDE SNP Survey for use in assessing the performance of health plans. The survey instrument used for the NJ FamilyCare FIDE SNP survey project consisted of 58 core questions and 11 supplemental questions.

The CAHPS rates are color coded to correspond to the National percentiles as shown in **Table 22**.

Table 22: 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 National Medicaid 50th percentile
Green	Between 50th and 75th percentile
Blue	Between the 75th and national Medicaid 90th percentile
Purple	Above the national Medicaid 90th percentile

Description of Data Obtained and Conclusion

Complete interviews were obtained from 2,646 NJ FamilyCare FIDE SNP enrollees, and the NJ FamilyCare FIDE SNP response rate was 34.8%. For each of four domains of member experience (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), a composite score was calculated. The composite scores give a summary assessment of how the MCOs performed across each domain. The overall composite scores for AvDC, HNJTC, UHCDCO and WCL were as follows:

- 91.4% for How Well Doctors Communicate;
- 89.2% for Customer Service;
- 81.7% for Getting Needed Care;
- 81.7% for Getting Care Quickly

The New Jersey FIDE SNP product is a joint Medicaid/Medicare program. The comparisons below in **Table 23** rank responses for the FIDE SNP membership against National Medicaid responses. Overall, New Jersey MCOs showed a high level of member satisfaction in the MY 2020 FIDE SNP CAHPS surveys. Weighted Statewide average rates ranked at or above the NCQA national 50th percentile for four (4) adult survey measures. Opportunities for improvement are evident for two (2) MCOs (AvDC and WCL) with rates below the 25th percentile for Getting Needed Care and Customer Service. HNJTC had one rate below the 25th percentile for How Well Doctors Communicate.

Table 23: CAHPS MY 2020 Performance – FIDE SNP Survey

FIDE SNP Adult Survey - CAHPS Measure	AvDC	HNJTC	UHCCDCO	WCL	Statewide Weighted Average
Getting Needed Care	79.6%	82.7%	83.2%	76.6%	81.8%
Getting Care Quickly	81.0%	82.8%	81.7%	79.9%	81.7%
How Well Doctors Communicate	92.4%	89.9%	92.0%	91.1%	91.4%
Customer Service	87.6%	89.8%	89.9%	86.6%	89.2%
Rating of All Health Care[1]	79.7%	75.7%	78.4%	71.5%	77.3%
Rating of Personal Doctor[1]	87.5%	81.7%	86.5%	87.9%	85.6%
Rating of Specialist Seen Most Often[1]	83.4%	87.4%	87.0%	78.2%	85.6%
Rating of Health Plan[1]	81.8%	84.4%	87.2%	84.2%	85.2%

[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.

VII. 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 monitored 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 has 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 Pharmacy Benefit Managers (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 focused study has been completed, and IPRO provided DMAHS with a summary of findings report, August 2021, including identification of challenges and recommendations.

Conclusions and Comparative Findings

Below is the summary of findings section of the report issues 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 Data Warehouse (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.

VIII. 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 QI made by the EQRO during the previous year's EQR." **Tables 24–27** display the participating FIDE SNP MCOs' responses to the recommendations for QI made by IRPO during the previous EQR, as well as IPRO's assessment of these responses.

AvDC - Response to Previous EQR Recommendations

Table 24 display's AvDC's progress related to the *State of New Jersey DMAHS, Amerivantage Dual Coordination Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of AvDC's response.

Table 24: AvDC - Response to Previous EQR Recommendations

Recommendation for AvDC	AvDC Response/Actions Taken	IPRO Assessment of MCO Response[1]
The plan should consider implementation of quality improvement activities in the clinical areas in which the plan performed below the NCQA 25th percentile for Medicare.	Amerigroup in partnership with our pharmacy and Behavioral Health teams are continually monitoring the measures that fell below the benchmarks. Statin Therapy for Patients With diabetes ("SPD") measure is a continued focus of the Quality team and provider education is ongoing along with member outreach to impact adherence for statins. Monthly reporting to all providers on adherence, monthly engagement and patient deep dives included. Follow-Up After Hospitalization for Mental Illness ("FUH") and Follow-Up After Emergency Department for Mental Illness visits (FUM) also fell below the benchmarks. Our Behavioral Health team is increasing reporting to decrease lag time in order for their care management team to outreach members within the specified time frames. CDC-Eye measure just missed the benchmark but we have increased education to all providers as well as have implemented diabetic retinal clinic days in the market to impact members with provider partners to increase awareness with our call center and nurse educators.	Addressed
AvDC's recommendations are to focus on the Barrier Analysis and ensure that the interventions and (Intervention Tracking Measures) ITM's are in alignment with the Aim and Goals of the project. In addition, a new barrier arose in 2020, COVID-19 which has had a large impact on health care systems. The MCO should consider the overall impact of COVID-19 has had on	Member engagement in all areas has decreased with members being unwilling to venture to the physician's offices. Telephonic visit education has increased to bring the provider to the members. However preventative care has not be as successful, with members being reluctant to participate in clinic days and high no show rates. Member education on the importance of the preventative care has been of the utmost importance with a strong focus on reaching the members to also ensure that basic needs have been met. In conjunction of our care management team, MLTSS team and our quality team members have been called with care gaps to explain the importance of closing the care and timely care. Mitigation of barriers being the utmost priority. Our FIDE and Medicaid Care Management teams collaborated on outreach NJ SNP members regarding COVID vaccines. Dedicated staff were assigned to assigning cases to our Health Educators for outreach. The results of our outreach attempts were captured and monitored. Our Care Management policies and procedures are reviewed regularly to ensure ongoing COVID related requirements are updated and to reflect action taken to ensure compliance. Our Care Managers, health educators, Social Worker and Non-Clinical support staff all have	Addressed

Recommendation for AvDC	AvDC Response/Actions Taken	IPRO Assessment of MCO Response[1]
their projects.	information on COVID prevention as well as know where to obtain information regarding where to members can get a COVID vaccine administered. Amerigroup DSNP FIDE has a COVID 19 Pulse page where we maintain the most up to date COVID 19 information for all associates to access	

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

HNJTC - Response to Previous EQR Recommendations

Table 25 display's HNJTC's progress related to the *State of New Jersey DMAHS, Horizon New Jersey TotalCare Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of HNJTC's response.

Table 25: HNJTC - Response to Previous EQR Recommendations

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
The plan should consider implementation of quality improvement activities in the clinical areas in which the plan performed below the NCQA 25th percentile for Medicare.	In response to HEDIS 2020 (MY 2019), Horizon has implemented multiple quality improvement activities. In an effort to identify opportunities for improvement, Horizon conducts a comprehensive review of several components. These components include HEDIS measure review, population analysis, and a review of social determinants of health impacting our members. In addition, interdepartmental workgroups collaborate with specialized departments (i.e. Pharmacy, Care Management/Disease Management, Member Services, etc.) to gain subject matter insight. Through this comprehensive process, a detailed, measure-specific intervention strategy is developed to address low performing measures. The strategy implementation is monitored, tracked, and reassessed for modification as needed throughout the year with the goal of meeting the needs of our membership and improving health outcomes. Horizon acknowledges and continues to monitor for the impact of COVID-19 and NCQA benchmarks. Clinical performance is monitored monthly and reviewed at HEDIS Workgroup and Quality Improvement Committee meetings. The 2021 Horizon FIDE-SNP intervention strategy incorporates the following new enhancements: Mammogram Van Events (with COVID-19 protocol); Member Engagement PPE packages with health promotion insert; New IVR Call Campaigns addressing preventive screenings and Flu vaccine; Magellan Rx contracted for medication management outreach for Statin Use in Person with Diabetes(SUPD); Hallmark member engagement postcards addressing Health Outcomes Survey topics (I.e. fall reduction, preventive care visits, prescription coverage ,vaccination, and accessing health care during pandemic) Established behavioral health quality team to address behavioral/mental	Addressed

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
	health and substance use performance. Launched resource website for providers, including HEDIS documents and education videos.	
HNJTC's recommendations focus on the data, adjust interventions reflective of the data ensuring the interventions and ITM's are in alignment with the Aim and Goals of the project. In addition, a new barrier arose in 2020, COVID-19 which has had a large impact on health care systems. The MCO should consider the overall impact of COVID-19 has had on their projects.	The Quality Management team has been working very closely with the FIDE-SNP Case Management team and the Network team as it relates to interventions and performance measurement impacts from COVID-19 in the clinical and non-clinical Performance Improvement Projects (PIPs). Ongoing monthly monitoring and communications will continue to take place to review COVID-19 impacts and how it may be affecting the targeted populations. Any findings will be documented in the PIP submissions.	Addressed

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

UHCDCO - Response to Previous EQR Recommendations

Table 26 display's UHCDCO's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Dual Complete ONE Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of UHCDCO's response.

Table 26: UHCDCO - Response to Previous EQR Recommendations

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
The plan should consider implementation of quality improvement activities in the clinical areas in which the plan performed below the NCQA 25th percentile for Medicare	UHCCP will review the MY2020 FIDESNP HEDIS submission against the 2021 Medicare Quality Compass when released on October 29th to identify low performing clinical areas.	IPRO will review the MCO's Quality Improvement Activities related to the October 29th Quality Compass data upon receipt from the MCO.

<table>
<tr><th>Recommendation for UHCDCO</th><th>UHCDCO Response/Actions Taken</th><th>IPRO Assessment of MCO Response[1]</th></tr>
<tr><td>Recommendations for UHCDCO include review all aspects of the PIPs Aim and Goals, Interventions and ITM's focusing on how the data might assist with the education proposed in the PIPs. Solid data can assist in fortifying educational information by supporting the need for increase access and availability to PCP office care and services, and noting the decrease of Emergency Room visits. For members adding some data that supports improvement via increase adherence may help members understand the importance of complying with prescribed care regimes. In addition, a new barrier arose in 2020, COVID-19 which has had a large impact on health care systems. The MCO should consider summarizing the overall impact of COVID-19 has had on their projects.</td><td>Plan response for Data collection:
1. The following data was provided in the DSNP PIP:
Table 1.4 Practices Selected for Project – Adult DNSP ED Utilization Rates in 2019

<table>
<tr><th>Tin #</th><th>Practice</th><th>Number of Assigned DSNP Members in 2019</th><th>Number of all ER Visits by adult DSNP members</th><th>ER visits per 1000 assigned DSNP members</th><th>National Percentile (lower is better)</th></tr>
<tr><td>222747589</td><td>Newark Community Health Centers</td><td>336</td><td>283</td><td>842</td><td>75%</td></tr>
<tr><td>221914573</td><td>Rhomur Medical Services</td><td>99</td><td>86</td><td>869</td><td>75%</td></tr>
<tr><td>222475890</td><td>Forest Hills Family Health Associates</td><td>254</td><td>141</td><td>555</td><td>25%</td></tr>
</table>

Table 1.5 Practices Selected for Project – Adult DSNP Members PCP Utilization Rates in 2019

<table>
<tr><th>Tin #</th><th>Practice</th><th>Number of members enrolled for at least 11 months in 2019</th><th>Number of members enrolled for at least 11 months in 2019 with ambulatory/preventive Visits</th><th>Percentage of enrolled members with ambulatory/preventive visits</th><th>National percentile (higher is better)</th></tr>
<tr><td>222747589</td><td>Newark Community Health Centers</td><td>182</td><td>145</td><td>80%</td><td>33.3%</td></tr>
<tr><td>221914573</td><td>Rhomur Medical Services</td><td>73</td><td>68</td><td>93%</td><td>>95%</td></tr>
<tr><td>222475890</td><td>Forest Hills Family Health Associates</td><td>176</td><td>161</td><td>91%</td><td>>95%</td></tr>
</table>

This data set does not show as strong a correlation between ED visits and PCP visits, due to small sample size. Forest Hills Family Health Associates still show low ED utilization rates and high PCP rates.
In addition, in response to the auditor's comments, the plan analyzed 2020 data from the Provider Profiles (2019 data was not immediately available). The plan analyzed primary care providers with over 20 assigned members, and we analyzed the relationship between percentage of members with preventive care visits and ED utilization rate for the year (visits per member per year).

The data was loaded into an Excel spreadsheet, and the following graph was generated. The trendline shows an inverse linear relationship between percentage of members with PCP visits during the year, and rate</td><td></td></tr>
</table>

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
	of ED visits. Per the auditor's suggestion above, the plan will work to incorporate this data into member education, in order to help members understand the importance of complying with prescribed care regimes. 2020 ED VSITS (Per member, per year) COVID 19 Effects on PIPs. Information is specific to each PIP. ER Utilization PIP: Due to COVID-19, multiple Jewish Renaissance Medical Center sites in Essex County were closed. We chose a different practice with a large member panel, Rhomur Medical Services, to replace Jewish Renaissance Medical Center in this project. Change in ED utilization patterns. The most common Medicaid ED diagnoses for January were COVID-19 or Exposure to COVID-19. Only 10% of all Medicaid visits were for the diagnoses that we previously identified as most common avoidable ED diagnoses. Newark Community Health Centers: COVID-19 impact on the practice: the practice reported that as the result of COVID-19, the number of daily walk-in patients significantly declined in 2020 as compared to 2019. They also reported that they saw fewer patients daily in 2020 as compared to 2019. Rhomur Medical services: COVID-19 impact: the practice adjusted to the COVID-19 pandemic by starting to offer telehealth services to the patients. One of the providers is always on call, and they provide telehealth instead of just triage in urgent after-hours situations. Forest Hills Family Health Associates: Due to the COVID-19 pandemic, they created a model of care where all sick visits are seen via telehealth. There is always at least one dedicated provider doing telehealth all day, two on busier days like Mondays. Follow up visits and well visits are done in person at the office. Gaps in Care MLTSS PIP: Telephonic quarterly assessment instead of onsite No results in 2020 for some of the interventions No NJ Choice – had to approximate performance indicator due to COVID. Rates of flu vaccinations decreased in MY2, possibly due to COVID HHA agencies had difficulty finding staff for cases, and some members refused services due to COVID. CCIP: The only reference we made about COVID was for the increased performance indicator: It is also possible that members were more careful to take care of their chronic conditions to avoid risk of complication from COVID-19. Adolescent PIP: The health plan faced a barrier related to the COVID-19 pandemic. Targeted provider offices temporarily closed. Once they did reopen, there was a reduction of staff at all three of the targeted practices. This affected	

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
	our member outreach intervention, which relies on timely submission of appointment schedule lists for outreach. There were numerous instances that the monthly schedule was not received timely. This resulted in outreach that was not attempted because by the time the schedule was received, members already completed their well visit. In response to the COVID-19 pandemic, many provider offices began to offer telehealth visits for members who could not (or preferred not) to present to the provider office in person for the well child exam. Two of our three participating provider offices implemented telehealth visits in response to patient needs because of the pandemic. Telehealth visits are a creative alternative to in person visits, however, there is not a way to assure that adolescents receiving care through telehealth visits are receiving confidential care (without their caregiver present). This could potentially lead to erroneous risk and depression assessment responses. This was discussed in collaborative meetings and it was agreed upon in July 2020 that the collaborative would add sole telehealth visits as an exclusion criterion in the methodology section. Early Intervention PIP: The number of PIP eligible members declined in the sustainability year. This can be directly related to the COVID-19 pandemic. During the pandemic many families were not able to (or chose not to) get medical care in a timely and consistent manner. Therefore, the number of members who received lead testing dropped. This resulted in a smaller number of children who were identified as meeting PIP eligibility. The number of parents/guardians who agreed to referral has declined. The outreach process and language has not changed. It is not clear if this decline is related to the pandemic. There was a limitation related to the COVID-19 pandemic which temporarily halted services at the SPOE and which also caused a significant decrease in members getting lead testing in 2020 and 2021.	

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

WCL - Response to Previous EQR Recommendations

Table 27 display's WCL's progress related to the *State of New Jersey DMAHS, WellCare Liberty Annual External Quality Review Technical Report FINAL REPORT: April 2021,* as well as IPRO's assessment of WCL's response.

Table 27: WCL - Response to Previous EQR Recommendations

Recommendation for WCL	WCL Response/Actions Taken	IPRO Assessment of MCO Response[1]
The plan should consider implementation of quality improvement activities in the clinical areas in which the plan performed below the NCQA 25th percentile for Medicare.	WellCare submit on an annual basis, a quality work plan as per contract and State/IPRO request where clinical performance fell below the NCQA 25th 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 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. In addition, due to the NJ Lead crisis within its water system, the Plan implemented an initiative for lead text message to assist with alerting parent/guardian and education on the importance of testing. Targeted in person Pediatrics Providers visits which will focus on improving, Lead screening, Well Child visits and Child and Adolescent immunizations administration. To improve quality scores, WellCare also utilizes the Quality Incentive Programs for both members and providers.	Addressed
WCL's recommendation are to detail the specifics of the data capture, discuss in subsequent submissions how the data is supporting each project and enhance with additional interventions as the project	Wellcare utilizes a suite of member and provider reports to identify areas of opportunity and develop targeted interventions to improve our scores. Reporting available at the plan, provider, and member level are generated and analyzed on a monthly basis. The quality department holds weekly internal meetings to review all ongoing projects, evaluate effectiveness, identify possible barriers, and collaborate with market partners to create/implement future improvement activities. Additionally, WellCare holds interdisciplinary quarterly quality summits with department leadership across the organization to monitor current interventions and identify new opportunities. Plan continues to conduct virtual/telephonic educations, but recently opportunities have allowed for educational interactions with providers	Addressed

Recommendation for WCL	WCL Response/Actions Taken	IPRO Assessment of MCO Response[1]
progress. In addition, a new barrier arose in 2020, COVID-19 which has had a large impact on health care systems. The MCO should consider including summary of the overall impact of COVID-19 has had on their projects.	and office staff to be in person as offices are beginning to open up. The plan also continued to gain EMR access and has introduced providers the ability to upload medical records via SES- a secure email portal. Care gaps continue to be distributed to providers in a variety of avenues via in person, email, fax and mail to outreach members in an effort to close care gaps.	

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

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

Tables 28–32 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 2021 EQR activities as they relate to **quality**, **timeliness**, and **access**.

AAPP - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 28: AAPP - Strengths and Opportunities for Improvement, and EQR Recommendations

Aetna Assure Premium Plus - Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
PIPs	None	There were opportunities for improvement in Methodology regarding details for sampling diagnoses, Barrier Analysis, and quarterly rate reporting for ITMs tables that have been altered. The MCO should ensure that the template format is correct to safeguard the accuracy of data reporting remains consistent year over year.
Compliance with Medicaid and CHIP Managed Care Regulations	NA	NA
Performance Measures	NA	NA
Quality of Care Surveys – Member (CAHPS 2021)	NA	NA
Recommendations		
PIPs	The MCO should ensure that the template format is correct to safeguard the accuracy of data reporting remains consistent year over year. The MCO should review and clarify data definitions for accurate and consistency.	
Compliance with Medicaid and CHIP Managed Care Regulations	NA	
Performance Measures	NA	
Quality of Care Surveys – Member (CAHPS 2021)	NA	

NA – AAPP entered the FIDE SNP market on 1/1/2021.

AvDC - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 29: AvDC - Strengths and Opportunities for Improvement, and EQR Recommendations

AvDC - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	None	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.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, 10 standards received 100% compliance.	Opportunities for improvements were found in Access and Administration and Operations during the 2021 FIDE SNP/MLTSS compliance review.
Performance Measures	AvDC reported three (3) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 15 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS 2021)	Three (3) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	Five (5) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	The MCO should update the alignment of barriers, interventions, and ITMs clearly and consistently across PIP tables from the proposal throughout the life of the PIP. This information should include formatting conventions (to better facilitate interpretation of the reported information and appropriately evaluate the PIP progress).	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4c. The plan should continue to address access deficiencies in specialty providers in Atlantic County for oral surgeons and in Cape May County for oral surgeons and psychiatrists. 2. A4f. The plan should continue to address deficiencies in MLTSS social day providers in Salem and Warren Counties. 3. A7. The plan should continue to address appointment availability for adult PCPs, OB/GYNs, and behavioral health providers, as well as deficiencies in after-hours compliance. **Administration and Operations** 1. AO19. The plan should be able to provide all relevant job descriptions noted in the contract language.	
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO 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 FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	

HNJTC - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 30: HNJTC - Strengths and Opportunities for Improvement, and EQR Recommendations

HNJTC - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	Of the 3 PIPs scored, all 3 PIPs performed at or above the 85% threshold indicating high performance.	There are opportunities for improvement in consistency regarding study design and methodologies for data collection
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.	Opportunities for improvements were found in Access and Utilization Management during the 2021 FIDE SNP/MLTSS compliance review.
Performance Measures	HNJTC reported eight (8) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 11 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS 2021)	Four (4) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	Four (4) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	The MCO should review the PIPs Barrier Analysis, Interventions, and Intervention Tracking measures to ensure alignment between each table inclusive of start and end dates of interventions thereby ensuring the duration of intervention's importance for evaluating the strength of association of a given intervention on the performance indicators for a given measurement period.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4e. The plan should continue to address hospital deficiencies Warren County. 2. A4f. 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 MCO should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers. 3. A7. The plan should address urgent care appointment availability with medical specialists. 4. A7. The plan should continue to address deficiencies in after-hour access for PCPs, specifically with regard to call-back times (15-minute call-back time for emergent care and call back within 45 minutes). 5. A7. The plan should address dental provider availability for routine, urgent and emergency appointments. **Utilization Management** 1. UM16o.1. The plan should ensure that FIDE SNP UM notification letters are sent timely and documented in the files. 2. UM16o.2. The plan should ensure that MLTSS UM provider and member letters are sent timely and documented in the files.	
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO 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 FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	

UHCDCO - Strengths and Opportunities for Improvement, and EQR Recommendations

Table 31: UHCDCO - Strengths and Opportunities for Improvement, and EQR Recommendations

UHCDCO - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	None	There are opportunities of improvement regarding Robust Interventions, actions that target members, providers and the MCO. There are also opportunities for increased collaboration with providers in order to close any gaps identified in the data capture.
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.	Opportunities for improvements were found in Access, Enrollee Rights and Responsibilities, Care Management and Continuity of Care (FIDE SNP only), Credentialing and Recredentialing, Utilization Management, and Administration and Operations during the 2021 FIDE SNP/MLTSS compliance review.
Performance Measures	UHCDCO reported three (3) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 16 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS 2021)	Five (5) of the eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	Three (3) of the eight (8) composite FIDE SNP Adult CAHPS measures were below the 50th percentile.
Recommendations		
PIPs	The MCO might consider collaboration with the Provider groups to increase support of the PIP and potentially enhance outcomes.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4b. The plan should continue to monitor the pediatric PCP network in Morris County. 2. A4c. The plan should continue to monitor the specialty providers network in Atlantic, Burlington, Camden, Cumberland, Gloucester, and Salem Counties. Per-case agreements should be established to ensure access to acute care hospitals where appropriate. 3. A4e. The plan should continue to monitor the hospital network in Salem and Cumberland Counties. Per-case agreements should be established to ensure access to acute care hospitals where appropriate. 4. A4f. The plan should continue to monitor the MLTSS provider network in all counties, with the exception of Camden County. Per-case agreements should be established to ensure access to acute care hospitals where appropriate. 5. A7. The plan should continue to address appointment availability for OB/Gyns and behavioral health providers. **Enrollee Rights and Responsibilities** 1. ER4. The plan should develop a "population report" to identify the major population's representative of the plan's membership. **Care Management and Continuity of Care (FIDE SNP only)** 1. CM2. The plan should provide sample inpatient and discharge plans of care, noting how the inpatient CM facilitates coordination and continuity of care throughout the hospital stay and discharge. **Credentialing and Recredentialing**	

UHCDCO - Strengths, Opportunities for Improvement, and EQR Recommendations	
	1. CR8. The MCO should ensure PCP performance indicators are included in the FIDE SNP recredentialing files. **Utilization Management** 1. UM12. The plan should consider including a turnaround time (TAT) column on the blended census report to monitor timely concurrent and extended stay determinations. 2. UM16o.2. The plan should ensure timely UM determinations and timely member/provider written notifications. **Administration and Operations** 1. AO1. The plan should evaluate relevant policies and procedures annually and ensure that contract requirements related to timely notifications and approvals are included. 2. AO20. The plan should evaluate relevant policies and procedures annually and ensure that contract requirements related to timely notifications regarding significant changes are included.
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO 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 FIDE SNP Adult CAHPS scores that perform below the 50th percentile.

WCL Strengths and Opportunities for Improvement, and EQR Recommendations

Table 32: WCL - Strengths and Opportunities for Improvement, and EQR Recommendations

WCL - Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	Of the 2PIPs scored, both PIPs performed at or above the 85% threshold indicating high performance.	There are opportunities for improvement in Methodology, by specifying data that identifies a defined list of diagnoses to monitor over the life of the PIP.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2021, 10 standards received 100% compliance.	Opportunities for improvements were found in Access and Provider Training and Performance during the 2021 FIDE SNP/MLTSS compliance review.
Performance Measures	WCL reported two (2) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 15 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS 2021)	Two (2) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	Six (6) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	The MCO should define the specific data monitored with clarifications or adjustments for a well-developed PIP that ultimately demonstrates the intended impact on performance outcomes.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4e. The plan should continue to monitor the hospital network for Bergen and Mercer Counties. Per-case agreements should be established to ensure access to acute care hospitals where appropriate.	

WCL - Strengths, Opportunities for Improvement, and EQR Recommendations	
	2. A4f. The plan should continue to recruit for assisted living providers in Camden and Cumberland Counties. 3. A7. The plan should address after-hours availability with primary care providers. **Provider Training and Performance** 1. PT4. The plan should ensure the correct consent forms are attached to each claim before it is processed. 2. PT4. The plan should ensure participating providers comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 CFR 441.
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO 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 FIDE SNP Adult CAHPS scores that perform below the 50th percentile.

X. Appendix A

Appendix A: 2021 FIDE-SNP–Specific Review Findings

Appendix Table of Contents

Aetna Assure Premier Plus (AAPP)

AAPP: 2020 Annual Assessment of FIDE SNP/MLTSS Operations

AAPP joined the FIDE SNP network on January 1, 2021. AAPP was not required to participate in the 2021 FIDE SNP/MLTSS Annual Assessment of MCO Operations. The first FIDE SNP/MLTSS Annual Assessment review for AAPP was held in March 2022.

AAPP MY 2020 Performance Measure Validation – FIDE SNP Measures

AAPP was not required to submit HEDIS MY 2020 data.

AAPP: Performance Improvement Projects

AAPP PIP Topic 1: Improving Access and Availability to Primary Care for the FIDE SNP Population-Proposal

MCO Name: Aetna Assure Premier Plus (AAPP)
AAPP PIP Topic 1: Improving Access and Availability to Primary Care for the FIDE SNP Population Proposal

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	N/A					

criteria)						
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	N/A				
5b. Actions that target member, provider and MCO	N/A	N/A				
5c. New or enhanced, starting after baseline year	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				
Element 5 Overall Review Determination	**N/A**	**N/A**				
Element 5 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**	

Element 5 Weighted Score	**N/A**	**N/A**	**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, able 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	N/A					
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings	
Maximum Possible Weighted Score	**55**	**80**	**80**	**100**	**100**	
Actual Weighted Total Score	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	
Overall Rating	**0%**	**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 22, 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 not applicable (N/A).
Element 2 Overall Review Determination was not applicable (N/A).
Element 3 Overall Review Determination was N/A. Although not scored, a concern was identified in regard to Methodology, 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. The MCO has identified 10 PCP address serving adults in the FIDE SNP population with the highest ER utilization with a Low-Acuity Nonemergent (LANE) diagnosis in Q1 2021. The MCO has noted for the numerators of Indicators #3 and #4, the use of code sets to accompany claims with revenue codes for identifying ER visits with LANE diagnosis. The MCO also notes the use of ICD-10 diagnosis codes that exhibit a LANE diagnosis to identify the targeted ER visit. The MCO should provide an explanation of what each of these codes are, definitions as well as descriptions of how they provide context for the numerator definition. The MCO should clarify if the intent is to stratify the 10 targeted PCP addresses along with an aggregate percentage in the Results Table, which would include a baseline for each of the 10 targeted providers.
Element 4 Overall Review Determination was the MCO is partially complaint in regard to Barrier Analysis, a concern was identified in the previous submission regarding the Barrier Analysis 4d, QI process. The PIP Template, Barrier Analysis Table 1a and Quarterly Reporting of Rates for Intervention Tacking Measures (ITMs), Table 1b has been altered. The PIP Template is designed to track changes and progress throughout the life of the PIP thereby providing a comprehensive review year over year of adjustments toward obtaining the stated goals of the PIP. The MCO should return Tables 1a and 1b of the PIP to the original format noting the changes on the Change Table on page 2.
Element 5 Overall Review Determination was not applicable (N/A).
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 in not evaluated at the proposal phase.
Element 9 Overall Review Determination was N/A. Health Disparities was not discussed in the proposal.
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, barrier analysis (Table 1a) and quarterly rate reporting ITMs (Table 1b). 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.

AAPP PIP Topic 3: Promote the Effective Management of Hypertension to Improve Care and Health Outcomes

MCO Name: Aetna Assure Premier Plus (AAPP)

AAPP PIP Topic 3: Promote the Effective Management of Hypertension to Improve Care and Health Outcomes

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= Not Applicable)	N/A				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**55**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**0%**	**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 22, 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. Barrier #2 intervention has two parts, #2a and #2b, however in the description of the tracking measures, there is only one ITM #2a & b where #2a & b appear to be combined. The description of #2a states, "for those members diagnosed with hypertension and not current BP reading documented in the care plan, reach out to physician for most recent measurement." Whereas, #2b states, "For those members with no current reading, reach out to member and encourage getting their blood pressure checked. CM can facilitate a PCP follow-up appointment or source to obtain readings." The MCO should clarify both statements and update ITMs #2a and #2b accordingly. Additionally, ITMs #1ai, #1aii, #1b, ITM #2 notation is #2a & b, and ITM 3 notations are #3a, #3b, and #3c. The MCO

should review for consistent numbering conventions and might consider the most common such as 3a, 3b, 3c etc. for the interventions and ITMs.
Element 5 Overall Review Determination was N/A. Although not scored, a concern was identified with Robust Intervention Table 1b, Quarterly Reporting of Rates of Intervention Tracking Measures (ITMs), 5a, informed by barrier analysis. As noted above, in Element 4 the MCO has different numbering for the ITMs (for example 1ai and 1b, 2a/b, 3a, 3b, 3c). Additionally, Intervention 2a and 2b use the same numerator/denominator. Although #2a and #2b are similar the numerators are different as #2a is an outreach to the provider, while #2b is an outreach to the member. The MCO should review the numbering conventions as well as separate the 2a/b ITM to effectively track and trend this intervention.
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 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.

Amerivantage Dual Coordination (AvDC)

AvDC: 2021 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Subject To Review[1]	Met[2]	Not Met	N/A	% Met[3]
Access	19	19	16	3	0	84%
Quality Assessment and Performance Improvement	9	9	9	0	0	100%
Quality Management	14	14	14	0	0	100%
Committee Structure	9	9	8	0	1	100%
Programs for the Elderly and Disabled	43	43	43	0	0	100%
Provider Training and Performance	11	11	11	0	0	100%
Enrollee Rights and Responsibilities	10	10	10	0	0	100%
Care Management and Continuity of Care	9	9	9	0	0	100%
Credentialing and Recredentialing	10	10	10	0	0	100%
Utilization Management	44	44	41	0	3	100%
Administration and Operations	20	20	19	1	0	95%
Management Information Systems	22	22	22	0	0	100%
TOTAL	**220**	**220**	**212**	**4**	**4**	**98%**

1 The MCO was subject to a full review in this review period. All elements were subject to review.
2 Elements that were Met in this review period among those that were subject to review.
3 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.

AvDC Performance Measure Validation – FIDE SNP Measures

AvDC reported the CMS required FIDE SNP measures. A status of R indicates that the plan reported this measure and no material bias was found. A status of NA indicates that the plan reported the measure but that there were fewer than 30 members in the denominator. A status of NR indicates that the plan did not report the measure.

Findings

- AvDC reported the required measures for HEDIS MY 2020.

HEDIS 2021 (MY 2020) Performance Measures	Rate[1]	Status
Colorectal Cancer Screening (COL) - Hybrid Measure[2,3]	59.14%	R
Care for Older Adults (COA) - Hybrid Measure[3,4]		
Advance Care Planning	35.77%	R
Medication Review	99.76%	R
Functional Status Assessment	60.58%	R
Pain Screening	94.65%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.88%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	62.56%	R
Bronchodilator	90.52%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure[2]	42.62%	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	77.08%	R
Effective Continuation Phase Treatment	64.93%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-up	42.73%	R
7-Day Follow-up	21.14%	R
Transitions of Care (TRC) – Hybrid Measure[3]		
Notification of Inpatient Admission	0.00%	R
Medication Reconciliation Post-Discharge	42.09%	R
Patient Engagement After Inpatient Discharge	74.21%	R
Receipt of Discharge Information	0.49%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)[5]		
Falls + Tricyclic Antidepressants or Antipsychotics	36.06%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	52.70%	R
Chronic Renal Failure + Non Aspirin NSAIDs or Cox-2 Selective NSAIDs	18.72%	R
Total	43.32%	R
Use of High-Risk Medications in the Elderly (DAE)[5,6]	24.15%	R
Plan All-Cause Readmissions (PCR)[5,7,8]		
18-64 Year Olds, Observed-to-Expected Ratio	1.8302	R
65+ Year Olds, Observed-to-Expected Ratio	1.3766	R

Note: Submission of Hybrid measures was not required for MY2019.

[1] Administrative measures for Amerigroup are calculated by combining the IDSS files with SubIDs 8854 and 13380. For the PCR measure, SubID 8854 is used as this is a risk adjusted measure

[2] Amerigroup reported this measure administratively

[3] Measure not reported in MY2019

[4] The data source of Amerigroup for this measure is from IDSS file with SubID 8854.

[5] This measure is inverted, meaning that lower rates indicate better performance

[6] Due to the changes to this measure comparison to prior year is not appropriate

[7] PCR is a risk adjusted measure. Calculation of MCO and Statewide averages is not appropriate
[8] This measure uses count of index stays as the denominator and an observed-to-expected ratio (observed readmission/average adjusted probability)
Designation R: Reportable rate.

AvDC Performance Improvement Projects

AvDC PIP *Topic* 1: Increasing Access for Members with High Emergency Room Utilization through the Promotion of Telehealth

MCO Name: Amerivantage Dual Coordination (AvDC)
AvDC PIP Topic 1: Increasing Access for Members with Emergency Room High Utilization through the Promotion of Telehealth

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	PM				
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	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	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	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	N/A	M				
5b. Actions that target member, provider and MCO	N/A	M				
5c. New or enhanced, starting after baseline year	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				
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	PM				

Element 6 Overall Review Determination	**N/A**	**PM**				
Element 6 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**2.5**	**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	PM				
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	PM				
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	PM				
7d. Lessons learned & follow-up activities planned as a result	N/A	PM				
Element 7 Overall Review Determination	**N/A**	**PM**				
Element 7 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 7 Weighted Score	**N/A**	**10.0**	**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**	**47.5**	**0.0**	**0.0**	**0.0**	
Overall Rating	**N/A**	**59%**	**0%**	**0%**	**0%**	

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

IPRO Reviews: Donna Reinholdt (dreinholdt@ipro.org); Cynthia Steffe (CSteffe@ipro.org)
Date (report submission) reviewed: November 22, 2021
Reporting Period: Year 1 Findings
IPRO Comments:
Element 1 Overall Review Determination was that the MCO was partially compliant in regard to 1a and 1e supported with MCO data, a concern was identified 1a. Attestation signed and Project Identifies completed. On page 3, the attestations are signed however are dated 12/15/2020 as in the original proposal. The MCO should ensure that the PIP is reviewed for signatures and accurate dates prior to submission. The MCO also identifies in 2019 that Telehealth services were extremely low accounting for only 82 percent of encounters with DSNP members and the providers selected have low Telehealth utilization in 2019 and 2020. The MCO further discusses on page 5, although overall increases in telehealth utilization occurred in 2020, the selected providers did not see a significant increase in utilization of telephonic encounters and/or telehealth. Three of the providers surveyed didn't offer telehealth services at all. Seven of

the providers didn't offer evening and/or weekend access. However, on page 6 the MCO exhibits a zero (0) for Indicator #2 stating "In baseline year 2019, telemedicine was not used frequently and the MCO saw no increase in telemedicine encounters hence the zero-baseline rate in Indicator 2". It is clear that the data was analyzed and determined that the selected providers did not see a significant increase in Telehealth utilization, there was data to develop a baseline from. The MCO should review the information and update the Baseline for the use of Telehealth in the Goals Table pg.6.
Element 2 Overall Review Determination was partially compliant in regard to the Aim 2a, Aim specifies Performance Indicators for improvement with corresponding goals and 2c, Objectives align aim and goals with interventions, a concern was identified with the overall Aim and related aspects of the PIP. As noted in the previous proposal submission, the MCO's stated Aim, Objectives, and Goals were insufficiently clear in terms of how access and availability for the targeted provider groups is being studied. Although the MCO has adjusted the Aim Statement, "By 12/31/2023, the MCO aims to improve access to care for patients with high emergency utilization, defined as 6 or more visits in the last 13 months or 1 or more visits in the last 6 months, by increasing telemedicine availability from 55% to 90% for providers included in the PIP.", the MCO has not documented the change on the Change Table on page 2 as required as well as the statement continues to be unclear. For example, there are 2 definitions (6 or more visits in the last 13 months or 1 or more visits in the last 6 months) however this update does not align with Barrier Analysis, Interventions, or the results/outcomes. Additionally, there is a concern regarding the Table of Rates for Baseline, Benchmark, Y1 Short-term goal, Y2 Long-term goal on page 6 representing Indicators #1, #2, #3. As a rate table all the data displayed should be exhibited in rates and not numbers. For example, Indicator #1 exhibits consistent rates in terms of percentages, whereas Indicators #2 and #3 are exhibiting numeric data for Baseline and Benchmark rates, while Y1 ST goals and Y2 LT goals have both numeric and percent rates. The MCO should be consistent in how the data is presented, rates should be presented in percentages. The MCO should review Aim Statement, Objectives, and Goals to consistently align the PIP sections accordingly.
Element 3 Overall Review Determination was partially Complaint in regard to Methodology, for the proposed PIs across all three provider groups, the descriptions and specifications were insufficient. The eligible population was not sufficiently specific in terms of the inclusion and exclusion criteria for the calculated the rates as intended. Numerator and denominator criteria for each should be further described, specific to eligible members with each provider group panel and the nature of the visit under study. For the Methodology Section's Data Collection and Analysis Procedures subsection, descriptions of processes and procedures are insufficient, including for proposed sampling processes (used for determining the identified provider groups' panels) as well as for Data Collection more generally (e.g. for the Text message communications component: because PCP visitation and inpatient hospitalization are insufficiently defined, it is ambiguous if collected data is on all primary care inpatient admissions, a subset of primary care inpatient admissions, or other; for this, the MCO should also clarify how often these data will be collected in the MCO's QM documentation tool). 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 that the MCO was compliant.
Element 5 Overall Review Determination was partially compliant in regard to Robust Interventions 5c new or enhanced, starting after the baseline and 5d, a concern has been identified with interventions and associated aspects, including how Intervention Tracking Measures (ITMs) were described in Table 1a. As noted in the above comments for Element 3, aspects of measurements used in the PIP exhibit inadequate specificity and clarity which extends to the ITMs. In ITM #1a, the denominator is described as "# of members assigned to the targeted PCP with high ER utilization"; but the specific criteria for "high ER utilization" remains unclear in terms of the primary care concerns that may be seen in the office or via Telehealth; and understanding how to apply to "high ER Utilization" as defined "6 or more visits in the last 13 months or 1 or more visits in the last 6 months"; the MCO should clarify accordingly. Additionally, the MCO should also discuss and integrate the claims data to determine if there are certain chronic or disease specific ER visits that may be prevented by either an office visit or via Telehealth. The MCO should consider improving robustness of intervention through this PIP with inclusion of education activities (for example high ER utilization of certain chronic diseases), which could better capture key aspects of access and availability of the services provided by the targeted PCPs. This approach could potentially add value to the providers understanding of why members use the ER in lieu of an office visit and/or Telehealth. As the MCO modifies the PIP, the MCO should also confirm consistency and clarity with descriptions and specifications across the interventions and corresponding ITMs ensuring the linkage from the Aim, Objective, Goals, Barrier Analysis, Intervention and ITMs.
Element 6 Overall Review Determination was partially compliant regarding the Results Table, 6a. The Results Table does not contain Baseline data, nor does it document the rates anticipated for the Long-Term Goals of the PIP. The

Results Table is designed to monitor and compare progress of the PIP year over year throughout the life of the PIP and should be updated with current data as appropriate at each submission. The MCO should populate the Baseline data, include a full description of each indicator in column 1, Performance Indicator (PI) as well as the Final Long-Term Goals for each PI.

Element 7 Overall Review Determination was Partially compliant regarding the Discussion and validity of reported improvement. The MCO notes in the discussion of results information was not available due to claims lag although also notes that 43 providers were outreached and educated as they have been identified as having a lower than average telehealth claims or no claims at all. There are multiple inconsistencies in the discussion of results adding to the lack of specificity required for clear understanding of where opportunities for improvement exist. The MCO should review the Discussion of Results and clarify the consistent "due to claims lag" for the insufficient data and corresponding evaluations of progress toward the Goals of the PIP.

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 47.5 points, which results in a rating of 59.0% (which is at least or above 85% [≥ 85% being the threshold for meeting compliance]). Concerns were identified with aspects of the Aim, Methodology, and Interventions. The MCO should review each concern as noted above, address the above concerns with clarifications or adjustments for a well-developed PIP that is ultimately able to demonstrate the intended impact on performance outcomes. Additionally, the MCO should review the Plan name to ensure the PIP exhibits the correct Plan name according to the contract for each submission. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

MCO Name: Amerivantage Dual Coordination (AvDC)

PIP Topic 2: Enhancing Education for Providers and Diabetic Members with Uncontrolled Diabetes

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	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	N/A	N/A				

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	PM				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	PM				
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	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	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	PM				
Element 6 Overall Review Determination	**N/A**	**PM**				
Element 6 Overall Score	**N/A**	**50**	**0**	**0**	**0**	
Element 6 Weighted Score	**N/A**	**2.5**	**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.,	N/A	M				

interventions)					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	PM			
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	PM			
Element 7 Overall Review Determination	**N/A**	**PM**			
Element 7 Overall Score	**N/A**	**50**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**10.0**	**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**	**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**	**40.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**50.0%**	**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 22, 2021
Reporting Period: Year 1
IPRO Comments:

Element 1 Overall Review Determination was partially compliant in regard to Attestation signed and Project Identifiers Completed 1a, a concern was identified with the Change Table on page 2 number 4 the Change Table was not updated to reflect changes noted in the Year 1 update. For example, on pages 10-11, the Barrier Analysis Table 1a, Barrier #3, has been updated to ITM 3a and ITM 3b. The MCO should review all previous and subsequent updates to ensure that all changes to the PIP, additions, terminations, adjustments and edits etc. are updated on the Change Table. The Change Table is an important mode of tracking changes and progression of the PIP over time to ensure a comprehensive and accurate evaluation year over year. Additionally, on page 3, Attestation does not have the correct date for this submission. The date reads 9/25/2020 from the proposal submission. The MCO should review all sections of the PIP prior to each submission thereby ensuring the accuracy of the PIP for each submission.

Element 2 Overall Review Determination was partially compliant in regard to the Aim, Objective, and Goals 2c, a concern was identified in regard to aspects of the Aim. The MCO should expand further on the objective statement as this statement summarizes the members, providers and MCO that will be used to achieve each target of the PIP. For example, how will the education be provided and what is the timeframes for education to the members and providers along with other specifics lending greater definition to the objective statement. Additionally, the MCO should review

the standard symbols for greater than (>), less than (<), or equal to (≤) for accuracy of reporting throughout the life of the PIP.
Element 3 Overall Review Determination was partially compliant in regard to Methodology 3a Performance Indicators (PIs) are clearly defined and measurable. A concern was identified with PIs #1 and #2 numerators, as they are the same although the indicators for PIs #1 and #2 are different. PI #1 is specific for members ages 18-75 that had an A1C less than 9 in the calendar year, which corresponds to the numerator for the indicator whereas, PI #2, for members ages 18-75 who have had testing for their A1C in the calendar year. Although the difference is a slight on if the numerators remain the same you will only see PI #1 data for both, however if the numerator for PI #2 updated to reflect the indicator definition you should receive all the eligible members that were tested within the calendar with no parameter on the A1C value. The MCO should review the PIs for clarity and adjust accordingly. Additionally, on page 9, Data Collection and Analysis Procedures, the Data Collection description is insufficient as to data collection timeframes (monthly, quarterly, semi-annual and/or annually) by the specific person(s) or department that is responsible for data collection. The process should include description and credentials of the MCO staff and the process steps for each practice or workflow. The analysis should be detailed noting who is analyzing the data and be presented in a clear and concise manner exhibiting the alignment with timelines and reporting schedules.
Element 4 Overall Review Determination was partially compliant in regard to Barrier Analysis Table 1a, a concern continues regarding (Barrier Analysis, Interventions and Monitoring), Interventions #1a and #1b did not clearly align with respective ITMs. Although the Intervention #1 is labeled 1a and 1b with respective definitions, the Barrier Analysis Table 1a only reflects ITM 1a in the Description of Intervention Tracking Measures (ITMs). The MCO should review and adjust so as to align Barrier Analysis Table 1a and Quarterly Reporting Table 1b accordingly.
Element 5 Overall Review Determination was partially compliant in regard to Robust Interventions, a concern was identified with aspects of interventions 5d. For ITMs 1a and 1b have numerators and denominators exhibiting zeros and rates that exhibit 100% in Y1 Q1, and in Y1Q2 0%. Additionally, there is a dot with the statement, " 751 members contacted, and zero members requested assistance with transportation and/or scheduling a home lab vendor". This statement indicates that interventions #1 and #2 were contacted, which should be exhibited in the denominator of each intervention. The statement is unclear as it does not accurately identify the number of members contacted for intervention #1 and the number of members that declined assistance with transportation; for intervention #2 the number of members contacted for potential home lab vendor (denominator) along with the numerator exhibiting the number of members that opted not to have a home lab vendor visit. The MCO should review statistical writing conventions for accurate documentation of the data. Additionally, Interventions #3 and #4 also are noted as not using consistent decimal placement and rounding up as a standard practice.
Element 6 Overall Review Determination was partially compliant in regard to the Result Table #6, a concern was identified regarding the Long-Term Goals were not documented on the table. The Results Table is a comparison of year over year progress which leads next level actions and potential interventions for quality improvement opportunities that will move the project forward toward the goals of the PIP. Additionally, the MCO should review the writing conventions for consistent decimal placement and rounding styles. The MCO could consider adding a statement addressing a standard format for rounding and decimal placement in the Methodology Section of the PIP to ensure consistency in numeric/percent documentation.
Element 7 Overall Review Determination was partially compliant in regard to Discussion and Improvement of Validity of Reported Improvement, 7b data presented adhere to statistical techniques outlined int he MCO's data analysis plan and 7d lessons learned and follow up activities planned as a result. As noted in element # 5 above the MCO should review analytical data for accuracy, statistical writing conventions and consistency across all sections of the PIP including expansion of the discussion sections explaining the how and why the interventions are successful or clearly identifying any limitations. Of note, 7d Lessons Learned, was not completed. Although the lessons learned in Section 8, each submission should submission lessons learned which led to additional actions that move the project forward improving quality of care for the members.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the year 1 phase.
Element 9 Overall Review Determination was N/A. Although not scored, Healthcare disparities have not been addressed.
Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 40.0 points, which results in a rating of 50.0% (which is at below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has appropriately expanded the Descriptions of the Project Topic and Rational for the Topic Selection citing additional research of how Diabetes can impact the members negatively in multiple ways as well as the MCO's opportunity for improvement regarding this chronic disease process. The MCO could expand the objectives to

include how the MCO will validate the educational programs that are improving the percent of members in control of HbA1C. The MCO should update the alignment of barriers, interventions, and ITMs clearly and consistently across tables from the proposal throughout the life of the PIP, including with improved formatting conventions (to better facilitate interpretation of the reported information and appropriately evaluate the PIP progress). 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. Additionally, the MCO should review the Plan name to ensure the PIP exhibits the correct Plan name according to the contract for each submission. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

Horizon NJ TotalCare (HNJTC)

HNJTC: 2021 Annual Assessment of FIDE SNP/MLTSS Operation

Review Category	Total Elements	Subject To Review[1]	Met[2]	Not Met	N/A	% Met[3]
Access	19	19	16	3	0	84%
Quality Assessment and Performance Improvement	9	9	9	0	0	100%
Quality Management	14	14	14	0	0	100%
Committee Structure	9	9	8	0	1	100%
Programs for the Elderly and Disabled	43	43	43	0	0	100%
Provider Training and Performance	11	11	11	0	0	100%
Enrollee Rights and Responsibilities	10	10	10	0	0	100%
Care Management and Continuity of Care	9	9	9	0	0	100%
Credentialing and Recredentialing	10	10	10	0	0	100%
Utilization Management	44	44	39	2	3	95%
Administration and Operations	20	20	20	0	0	100%
Management Information Systems	22	22	21	0	1	100%
TOTAL	**220**	**220**	**210**	**5**	**5**	**98%**

1 The MCO was subject to a full review in this review period. All elements were subject to review.
2 Elements that were Met in this review period among those that were subject to review.
3 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.

HNJTC Performance Measure Validation – FIDE SNP Measures

HNJTC reported the CMS required FIDE SNP measures. A status of R indicates that the plan reported this measure and no material bias was found. A status of NA indicates that the plan reported the measure but that there were fewer than 30 members in the denominator. A status of NR indicates that the plan did not report the measure. A status of NQ indicates that the plan was not required to report the measure.

Findings

- HNJTC reported the required measures for HEDIS MY 2020.

HEDIS 2021 (MY 2020) Performance Measures	Rat	Status
Colorectal Cancer Screening (COL) - Hybrid Measure[1]	51.34%	R
Care for Older Adults (COA) - Hybrid Measure[1]		
Advance Care Planning	79.32%	R
Medication Review	77.62%	R
Functional Status Assessment	79.81%	R
Pain Screening	90.75%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	32.84%	R

HEDIS 2021 (MY 2020) Performance Measures	Rat	Status
(SPR)		
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	77.42%	R
Bronchodilator	91.61%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	51.34%	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	100.00%	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	72.81%	R
Effective Continuation Phase Treatment	59.52%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-up	51.20%	R
7-Day Follow-up	31.10%	R
Transitions of Care (TRC) – Hybrid Measure[1]		
Notification of Inpatient Admission	4.14%	R
Medication Reconciliation Post-Discharge	64.72%	R
Patient Engagement After Inpatient Discharge	86.37%	R
Receipt of Discharge Information	4.38%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)[2]		
Falls + Tricyclic Antidepressants or Antipsychotics	39.61%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	52.67%	R
Chronic Renal Failure + Non Aspirin NSAIDs or Cox-2 Selective NSAIDs	15.46%	R
Total	41.01%	R
Use of High-Risk Medications in the Elderly (DAE)[2,3]	19.91%	R
Plan All-Cause Readmissions (PCR)[2,4,5]		
18-64 Year Olds, Observed-to-Expected Ratio	1.1701	R
65+ Year Olds, Observed-to-Expected Ratio	1.3544	R

Note: Submission of Hybrid measures was not required for MY2019.

[1] Measure not reported in MY2019.

[2] This measure is inverted, meaning that lower rates indicate better performance.

[3] Due to the changes to this measure comparison to prior year is not appropriate.

[4] PCR is a risk adjusted measure. Calculation of MCO and Statewide averages is not appropriate.

[5] This measure uses count of index stays as the denominator and an observed-to-expected ratio (observed readmission/average adjusted probability).

Designation R: Reportable rate.

HNJTC Performance Improvement Projects

HNJTC PIP Topic 1: Increasing PCP Access and Availability for Members with High Ed Utilization – Horizon NJ Total Care (FIDE SNP Membership)

MCO Name: Horizon NJ TotalCare (HNJTC)

PIP Topic 1: Increasing PCP Access and Availability for Members with High Ed Utilization – Horizon NJ Total Care (FIDE SNP 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	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	N/A	M				

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	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	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	**N/A**	**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**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**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 22, 2021
Reporting Period: Year 1
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 partially complaint in regard to Methodology, data collection, a concern has been identified with aspects of the methodology. The PIP proposal study design requires specified data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. The MCO has updated the Appendix E regarding ICD10 diagnoses codes for a low acuity, non-emergent (LANE) diagnosis to represent not only the code numbers but aligning the with the corresponding language definitions for increased understanding of the code. However, the MCO should further review the claims data in comparison with Appendix E and EM codes to pare down specific diagnoses and tease out those diagnoses that are relevant and affect each practice county and provider that may be barriers or obstacles to provider networks and access to the PCPs office for care in lieu of the emergency room or urgent care.
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 that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was N/A. Healthcare disparities were not identified, evaluated, and addressed at the Year 1 phase.
Overall, the MCO is compliant with this PIP for the Sustainability reporting requirement; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5. points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO should address the above concerns with clarifications or adjustments for a well-developed PIP 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.

MCO Name: Horizon NJ TotalCare (HNJTC)

PIP Topic 2: Horizon NJ TotalCare (FIDE SNP) Diabetes 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				
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	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	N/A	M				

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	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	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						20% weight

(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				
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**	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**	**72.5**	**0.0**	**0.0**	**0.0**	
Overall Rating	**N/A**	**90.6%**	**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 22, 2021
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is complaint.
Element 2 Overall Review Determination was that the MCO is complaint.
Element 3 Overall Review Determination was that the MCO is complaint.
Element 4 Overall Review Determination was that the MCO is complaint.
Element 5 Overall Review Determination was partially compliant in regard to Robust Interventions, regarding 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 with the interventions, on Table 1a (Alignment of Barriers, Interventions, and Intervention Tracking Measures), no end dates are indicated for interventions (and duration of intervention is important for evaluating the strength of association of a given intervention on the performance indicators for a given

measurement period). Additionally, on Table 1b (Quarterly Reporting of Rates for Interventions Tracking Measures), the MCO noted Interventions 2a2, 4a2, 5a2 and 6a2 have a 90-day lag time for numerator data. Due to this lag time, numerator data is submitted after the 90-day time frame. However, the start date indicated on the Barrier Analysis is noted as 1/1/2021 which does not align with the N/A designation assigned the aforementioned ITMs in terms of lag time. On page 18, Data collection, it is stated data is collected on a quarterly basis for all intervention tracking measures and annually for all performance indicators. The MCO should clarify the N/A designation for the numerators of the aforementioned ITMs (numerator 0 pending claim review) as well as clarifying the claim lag timing for data collection.
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 in not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was N/A. Health disparities were not identified, evaluated, and addressed.
Overall, the MCO is compliant with this PIP for the Sustainability reporting requirement; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO should ensure the end dates are documented on the Barrier Analysis and that data is displayed appropriately. The MCO should address these concerns with clarifications or adjustments for a well-developed PIP that is ultimately demonstrates 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.

MCO Name: Horizon NJ TotalCare (HNJTC)

PIP Topic 4: REDUCING ASTHMA-RELATED ER VISITS, RECURRENT ER VISITS, HOSPITAL ADMISSIONS AND READMISSIONS IN THE FIDE SNP POPULATION

Horizon NJ TotalCare (HNJTC)
REDUCING ASTHMA-RELATED ER VISITS, RECURRENT ER VISITS, HOSPITAL ADMISSIONS AND READMISSIONS IN THE FIDE SNP POPULATION
August 2021 Final Report Review

	Horizon NJ TotalCare (HNJTC) – SUMMARY SCORING				
	Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
	Review Element 1 - Project Topic and Relevance	M	100	5%	5
	Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
	Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
	Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
	Review Element 6 - Data Collection Procedures	M	50	10%	10
	Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
	Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
	TOTAL DEMONSTRABLE IMPROVEMENT SCORE			**80%**	**80**
	Review Element 10 - Sustainability of Documented Improvement	M	100	20%	20
	TOTAL SUSTAINED IMPROVEMENT SCORE			**20%**	**20**
	OVERALL PROJECT PERFORMANCE SCORE			***100%***	***100***
	Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

	COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT		
Score	**Range of Points**	**Level of Compliance**	**Action**
100	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

	COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT		
Score	**Range of Points**	**Level of Compliance**	**Action**
100	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

REVIEW ELEMENT 1: PROJECT TOPIC AND TOPIC RELEVANCE									
Requirements	**PIP Report Section**	**M**	**PM**	**NM**	**NA**	**Date**	**Initials**	**Findings**	**References**
Demographic Information: The MCO submitted the Title of the Performance Improvement Project, the Study Period and Attestation.	**MCO and Project Identifiers**	**X**				**- 5/24/21 9/29/21**	**DMR/ CS**	The Plan provided appropriate demographic information for the PIP in this update, including the appropriate title, study period, and attestation. The name listed by the MCO is, "Horizon NJ Health (HNJH)"; the MCO should consistently provide the correct name of the organization in the report. **April 2019 Update:** Please identify if the plan is using Horizon NJ Health (HNJH) or Horizon NJ TotalCare (HNJTC) and ensure it is consistent throughout the PIP. **August 2019 Update**: The plan addressed to now state: Horizon Total Care (HNJTC) throughout the document. **April 2020 Update:** The plan did not provide information on the updates in the current version (Element 6 in Section 1). In future submissions the plan should provide summary of updates and date of update. **August 2020 Sustainability Update (1):** The plan provided updated descriptions of changes, as well as the date associated with each change, in the current version. Additionally, the signed attestation was updated. **April 2021 Sustainability Update** (2): The plan provided the Intervention update on this change that was noted in August 2020, Additionally, the signed attestation was updated. August 2021- No concerns noted	
Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**Project Topic:** Description; Topic Selection Rationale	**X**				**9/29/21**	**DMR/ CS**	The Plan reviewed multiple national sources of studies clearly defining the problem of potentially avoidable complications among those diagnosed with asthma. They also reviewed NJ and Horizon NJ Health data regarding the membership with asthma diagnoses. Chronic conditions with potentially avoidable complications are very prominent in the Horizon NJ Health (HNJH) Dual Special Needs Plan (DSNP). As of July 31, 2017, there were a total of 348 (8.37%) unique members with inpatient hospital admissions and 159 (3.82%) unique members with Emergency Room (ER) visits. Although hypertension presented as being the most prevalent chronic condition, asthma had the highest number of hospital admissions and ER visits. There were a total of 27.86% (56/201) of ER visits and hospital admissions combined and 17.86% (10/56) of those members had a recurrent visit to the hospital or ER. Additionally, HEDIS administrative rates for medication management for people with asthma (MMA) in the HNJH Medicaid population have traditionally shown a low compliance (pp7-9). It is noted that the reference to the HNJH HEDIS rate for MMA as of 7/17 seems extremely low at 3.98% (p9). The Plan should check the accuracy of this rate. **April 2018 Baseline Update:** There is no validation offered for the noted mid-2017 3.98% adherence rate for the HEDIS MMA measure [p12] as requested above. The rate for baseline year (BLY) 2017 is included in this update and reflects a denominator (D) of 4 members [p30] for the full year. This small D makes the 3.98% rate reported for Jan-Jul BLY2017 appears even more questionable. The Plan should provide validation for this rate. **August 2018 Y1 Update:** The issue of the D and the rate for the HEDIS MMA measure has been addressed (pp36-37). The FIDE SNP population was very small in 2017, resulting in only 4 members in the D. The BYL2017 annual rate for this cohort was 75%. Preliminary data for the first half of MY1 2018 indicates 85 members YTD in the D, with a rate of 85.88%. **August 2019 Update:** The plan continues to meet this Element. **April 2020 Update**: The issue relating to the small denominator for the MMA measure was resolved with a final year	• CMS Protocol pgs. 4 - 5 • CMS Worksheet Question 1.1

								denominator for MY1 (2018) of 88. In the discussion of the mid-year rate in 2018 (Aug 2018 update), the plan reported a rate of 85.88% for the initial 85 members in the denominator. However, the final rate for 2018 shows compliance for 9 members with a rate of 10.23%. No update was provided for MY2 (2019). As this is a HEDIS rate, data for 2019 will not be available until June 2020. The plan should review the calculation for MY1 for MMA. **August 2020 Sustainability Update (1):** The plan updated Table 5 in Section 6, showing the updated results of data analysis for the MMA performance indicator (and MY 2 rate was updated with utilization of HEDIS data which had become available, as discussed). The plan updated the goals accordingly. **April Sustainability Update (2):** No concerns noted. August 2021- No concerns noted	
Did the MCO's PIP address a broad spectrum of key aspects of enrollee care and services with potential to impact enrollee health, functional status and/or satisfaction?	**Project Topic:** Description; Topic Selection Rationale	**X**				**9/29/21**	**DMR/CS**	When not adequately treated, the chronic condition of asthma results in high cost, high volume and/or high-risk services and negatively affects quality of life, health, and functional status of those members. The focus of this PIP is on reducing adverse asthma outcomes/complications, including ER visits, recurrent ER visits, hospital admissions and readmissions as well as maintaining medication compliance. All of these efforts are directly related to improved health and functional status. **August 2019 Update:** The plan continues to meet this Element. **April 2020 Update:** No issues noted. **August 2020 Sustainability Update (1):** No issues noted. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	• CMS Protocol pgs. 4 - 5 • CMS Worksheet Question 1.2 - 1.5

REVIEW ELEMENT 2: STUDY QUESTION (AIM STATEMENT)									
Requirements	**PIP Report Section**	**M**	**PM**	**NM**	**NA**	**Date**	**Initials**	**Findings**	**References**
Was the study question(s) stated clearly in writing?	**Project Topic:** AIM Statement	**X**				**9/29/21**	**DMR/CS**	The AIM Statement is good, however it could be shorter and more concisely worded, as follows (p10): it contains a redundant reference to hospital readmissions; the "asthma-related" IP/ER events should be grouped together, with med adherence last; the medication adherence component includes the intervention or process methodology in addition to the AIM objective. That could be dropped so the statement reads simply "…and increasing asthma medication adherence". The objectives are well described with all short term (STG) and long term (LTG) goals included. FYI, the third bullet appears to have a typo, i.e., the word "hospital" should be deleted. **April 2018 Baseline Update:** The Aim Statement has been reworded as requested and is now clearly written, with objectives and goals. **August 2019 Update:** The plan continues to meet this Element. **April 2020 Update:** No issues noted	• CMS Protocol, pgs. 5 - 6 • CMS Worksheet Question 2.1

								August 2020 Sustainability Update (1): No issues noted. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	

REVIEW ELEMENT 3: STUDY VARIABLES (PERFORMANCE INDICATORS)									
Requirements	**PIP Report Section**	**M**	**PM**	**NM**	**NA**	**Date**	**Initials**	**Findings**	**References**
Did the study use objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes?	**Methodology:** Performance Indicators	**X**				**9/29/21**	**DMR/CS**	There are 5 performance indicators (PI) which are clearly defined and include denominators (D) and numerators (N) (pp12-13). The data sources are not listed per indicator, but they are explained with the Procedures. It would help if the PIs were numbered rather than lettered for ease of review and reference. Additionally, the lettering continues down the alphabet through the Outcome PI and the process measures (PM) descriptions. The PMs are referred to by numbers in subsequent narrative (p19) but here they are i) through q) (pp13-14). There are questions about PI#3 and 4 (c and d): For PI#3, the Plan should clarify why inpatient (IP) stays are included in the D and N definitions for the PI regarding ER visits; for PI#4, the Plan should clarify why ER visits are included in the D definition for the PI regarding IP admissions. Because the PIs and PMs are so similarly stated regarding admissions, readmissions, ERs and recurrent ERs, it is important to make sure all statements are accurate about the measures and the data sources or else it can become confusing to follow. There are 9 excellent PMs designed to evaluate the success of interventions and these also have D and N definitions (pp13-14). However, the following concerns are noted: PM#3(k) reads the same as PM#5(m) and PM#4(l) reads the same as PM#6(n), and it was unclear if the Plan meant to address recurrent ER visits and readmissions in 2 of these PMs. PM#7/8 (o/p) use the term "asthmatic", which is not a specific definition for identifying the D members. These PMs should read the same as PM#9 (q), which defines members as "with an asthma diagnosis". **April 2018 Baseline Update:** The 5 performance indicators (PI) are numbered and clearly described with denominator (D) and numerator (N) definitions [pp15-16]. As a comment, the repeat or recurrent Emergency Room Visit (ERV) and Hospital Admission (HA) PI Ds are based on the sub-cohort of members with an initial ERV or HA, not the full membership that is used as the D for the initial ERV or HA PIs. This is perfectly fine, but because of the way these PIs are described, it reads as if the D is the same for both (i.e., the entire membership), so the repeat visit rates seems quite high. For example: as reported [p29], 56.9% of members have at least 1 ERV, and 39.4% of members have >1 ERV. However, if the same D were used for both calculations, the repeat ERV member rate would be much lower. Both methodologies are correct for tracking improvement and the definitions of all the PI Ds and Ns are clearly stated; it is just the descriptions that are misleading as they both state "percent of members" as the cohort being measured. The 9 Process Measures (PM) are numbered and more clearly stated in general. However, as noted in the initial review, due to the similarity of the wording of the PIs and PMs it is important to make sure they consistently and accurately state the D and N definitions. A few issues around incomplete statements remain for PMs #1-#8 as follows: Only #1, #2 and #7 contain the term "asthma-related" in the description of the measure; only #7 contains the term "asthma-related" in both the description and the N definition. None except #7 contains the term "asthma-related" in the N definitions. The Plan should review the statements for all the PMs and make sure that they are stated consistent with the AIM and objectives. Both the PIs and the PMs have improved clarity and they are well-constructed and reflect good tracking measures for	• CMS Protocol pgs. 6 - 7 • CMS Worksheet Question 3.1 - 3.2

								performance improvement. However, it is noted that the Ds for PMs #1-#6 focus only on members who filled an asthma medication. In the reported BLY rates, there are only 4 members in the D for having persistent asthma and therefore eligible for dispensing of medication (per HEDIS) [p30]. Additionally, the Plan reports that administrative pharmacy data using HEDIS specifications will be used for the medication review interventions [p18]. The Plan is requested to address the expected size of the member cohort that will be included in these interventions and, as a result, in their PM tracking. **August 2018 Year 1 Update:** The descriptions, Ns and Ds for the process measures have been corrected to include "asthma-related" in all definitions (except PM#8 which still omits that criterion in its description) (pp17-18). As anticipated in the prior review, the D of members filling an asthma medication during MY1 2018 Q1 and Q2 was zero for PM#3, 5 and 6 and 2 for PM#4, indicating that the interventions associated with these PMs are not reaching any members to date. Although the plan does not address this issue in their discussion of these PMs (pp36-37), they do address the fact that PM#9 results (p35) indicate a very high rate of not filling medications, which has prompted exploration of additional interventions and PMs. This issue is addressed further under Element 7. **April 2020 Update:** There have been no changes to the Performance indicators for Process measures since the last review. Performance Indicator 5 (HEDIS MMA) will be discussed under Element 6 **August 2020 Sustainability Update (1):** There have been no changes to the methodology, including for description and utilization of performance indicators since the previous update. **April 2021 Sustainability Update (2):** There have been no changes to PIs since the last review. No issues noted.	
Did the indicators measure changes in health status, functional status, enrollee satisfaction or processes of care with strong associations with improved outcomes?	**Method-ology:** Performance Indicators	**X**				**9/29/21**	**DMR/CS**	Preventing potentially avoidable asthma complications such as admissions, readmissions and ER visits, as well as improving maintenance medication adherence is directly and strongly related to improved health outcomes and functional status. **August 2019 Update**: The plan continues to meet this Element. **August 2020 Sustainability Update (1):** There have been no changes to the indicators or their relevance to measuring change in health status **August 2020 Sustainability Update (1):** There have been no changes to the indicators or their relevance to measuring change in health status. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	• CMS Protocol pgs. 6 - 7 • CMS Worksheet Question 3.3

REVIEW ELEMENTS 4 and 5: IDENTIFIED STUDY POPULATION AND SAMPLING METHODS									
Requirements	**PIP Report Section**	**M**	**PM**	**NM**	**NA**	**Date**	**Initials**	**Findings**	**References**
Did the MCO clearly define all Medicaid enrollees to whom the study question and indicators	**Method-ology:** Baseline Study Population	**X**				**9/29/21**	**DMR/CS**	The at-risk population is Horizon NJ Health's DSNP members between the ages of 18-64 with the diagnosis of asthma, and 100% of these members who are enrolled for the entire measurement year comprise the eligible population for the PIP. The FIDE SNP MLTSS asthma	• CMS Protocol pgs. 8 - 9 CMS • CMS Worksheet

are relevant?								members are excluded due to separate interventions that would introduce a bias for evaluating intervention outcomes (p14). Data collection methodology includes all the Eligibles. **August 2019 Update:** The plan continues to meet this Element. **April 2020 Update:** There have been no changes to the identification of eligibles for the project **August 2020 Sustainability Update (1):** There have been no changes to the identification of eligibles for the PIP. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	Question 4.1 - 4.2
If a sample was used, did the identification of the sample include a statistical subset that represents the entire population?	**Method-ology:** Procedures - Sampling				**X**	**9/29/21**	**DMR/CS -**	There is no sampling used in this study. 100% of the eligible population is included in all data collection. HEDIS measure specifications are used for the medication adherence measurement. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	• CMS Protocol pgs. 9 - 10 • CMS Worksheet Question 5.1 and 5.3
If a sample was used, did the MCO employ valid sampling techniques that protected against bias? (*Specify the type of sampling or census used, e.g., random, convenience, etc.)*	**Method-ology:** Procedures - Sampling				**X**	**9/29/21**	**DMR/CS**	There is no sampling used in this study. 100% of the eligible population is included in all data collection. HEDIS measure specifications are used for the medication adherence measurement. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	• CMS Protocol, pgs. 9 -10 • CMS Worksheet Question 5.2
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will acceptable?	**Method-ology:** Procedures - Sampling				**X**	**9/29/21**	**DMR/CS**	There is no sampling used in this study. 100% of the eligible population is included in all data collection. HEDIS measure specifications are used for the medication adherence measurement. **April 2021 Sustainability Update (2):** No issues noted. August 2021- No concerns noted	• CMS Worksheet Question 5.1 • CMS Protocol pgs. 9 - 10

UnitedHealthcare Dual Complete One (UHCDCO)

UHCDCO: 2021 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Subject To Review[1]	Met[2]	Not Met	N/A	% Met[3]
Access	19	19	14	5	0	74%
Quality Assessment and Performance Improvement	9	9	9	0	0	100%
Quality Management	14	14	14	0	0	100%
Committee Structure	9	9	8	0	1	100%
Programs for the Elderly and Disabled	43	43	43	0	0	100%
Provider Training and Performance	11	11	11	0	0	100%
Enrollee Rights and Responsibilities	10	10	9	1	0	90%
Care Management and Continuity of Care	9	9	8	1	0	89%
Credentialing and Recredentialing	10	10	9	1	0	90%
Utilization Management	44	44	39	2	3	95%
Administration and Operations	20	20	18	2	0	90%
Management Information Systems	22	22	22	0	0	100%
TOTAL	**220**	**220**	**204**	**12**	**4**	**94%**

1 The MCO was subject to a full review in this review period. All elements were subject to review.
2 Elements that were Met in this review period among those that were subject to review.
3 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.

UHCDCO Performance Measure Validation – FIDE SNP Measures

UHCDCO reported the CMS required FIDE SNP measures. A status of R indicates that the plan reported this measure and no material bias was found. A status of NA indicates that the plan reported the measure but that there were fewer than 30 members in the denominator. A status of NR indicates that the plan did not report the measure.

Findings

- UHCDCO reported the required measures for HEDIS MY 2020.

HEDIS 2021 (MY 2020) Performance Measures	Rate[1]	Status
Colorectal Cancer Screening (COL) - Hybrid Measure[1]	70.80%	R
Care for Older Adults (COA) - Hybrid Measure[1]		
Advance Care Planning	62.04%	R
Medication Review	88.32%	R
Functional Status Assessment	76.16%	R
Pain Screening	90.02%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	38.33%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	73.02%	R
Bronchodilator	88.28%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	70.56%	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	87.18%	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	31.71%	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	72.30%	R

HEDIS 2021 (MY 2020) Performance Measures	Rate[1]	Status
Effective Continuation Phase Treatment	56.74%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-up	44.22%	R
7-Day Follow-up	24.62%	R
Transitions of Care (TRC) – Hybrid Measure[1]		
Notification of Inpatient Admission	4.38%	R
Medication Reconciliation Post-Discharge	40.15%	R
Patient Engagement After Inpatient Discharge	75.74%	R
Receipt of Discharge Information	1.22%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)[2]		
Falls + Tricyclic Antidepressants or Antipsychotics	37.74%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	57.98%	R
Chronic Renal Failure + Non Aspirin NSAIDs or Cox-2 Selective NSAIDs	20.91%	R
Total	46.40%	R
Use of High-Risk Medications in the Elderly (DAE)[2,3]	29.24%	R
Plan All-Cause Readmissions (PCR)[2,4,5]		
18-64 Year Olds, Observed-to-Expected Ratio	1.1865	R
65+ Year Olds, Observed-to-Expected Ratio	1.3242	R

Note: Submission of Hybrid measures was not required for MY2019.

[1] Measure not reported in MY2019.

[2] This measure is inverted, meaning that lower rates indicate better performance.

[3] Due to the changes to this measure comparison to prior year is not appropriate.

[4] PCR is a risk adjusted measure. Calculation of MCO and Statewide averages is not appropriate.

[5] This measure uses count of index stays as the denominator and an observed-to-expected ratio (observed readmission/average adjusted probability).

Designation R: Reportable rate.

UHCDCO Performance Improvement Projects

UHCDCO PIP Topic 1: Decrease Emergency Room Utilization (FIDE SNP) for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult DSNP Members.

MCO Name: UnitedHealthcare Dual Complete ONE (UHCDCO)
PIP Topic 1: Decrease Emergency Room Utilization (FIDE SNP) for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult DSNP 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	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	PM				
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	N/A	N/A				

representative sample, utilizing statistically sound 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	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	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,	N/A	M				

and the factors associated with success (e.g., interventions)					
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**	**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%**	**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 22, 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 in regard to Methodology, 3b Performance indicators are measured consistently over time. A concern was identified in regard to the MCO's ability to access data timely in order to measure progress monthly, quarterly, semi-annual, annually. The MCO reports a delay in the initiation of Intervention Tracking Measures (ITMs) 1a-1c, 2a-2c, 3a-3c due to the script approval process. However, the denominator for these ITMs are related to members for the 3 selected provider that had an Emergency Room visit for a non-urgent reason in the outreach quarter. The MCO might have populated the data as it pertains to the number of ER visits that transpired while awaiting script approval. The MCO should capture the data for adding a complete review of the 2021 as it pertains to the number of non-urgent ER visits that have transpired that will be helpful in the annual analysis.
Element 4 Overall Review Determination was partially compliant in regard to the Barrier Analysis, a concern was identified with the 4d, the QI Process. Frist, Barriers #1 and #2 have a start date noted for 1/1/2021, however it is acknowledged in the discussion and updates that these interventions did not actually begin until July of 2021. Barrier #3 does not have either a start or end date documented on Table 1a. The MCO should update Table 1a, Barrier Analysis to

ensure all dates start and end reflecting the appropriate timelines for implementation, changes and/or terminations and are reflected on the Change Table as well.

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 N/A. Sustainability is not evaluated at the Year 1 phase.

Element 9 Overall Review Determination was N/A. Healthcare disparities were not identified, evaluated, and addressed at the proposal phase.

Overall, the MCO is partially compliant with this PIP for the Year 1 reporting requirement; out of a maximum possible weighted score of 80.0 points, the MCO scored 65.0 points, which results in a rating of 81.0% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant adjustments to the PIP, although the MCO had some challenges with data capture for Y1 Q1 and Q2, the MCO has implemented all the interventions and should update all the data possible with the corresponding discussion points in the April 2022 update submission. The MCO should review and address the concerns noted above with clarifications and/or adjustments for a well-developed PIP that ultimately demonstrates the projected impact on the performance outcomes. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

MCO Name: UnitedHealthcare Dual Complete One (UHCDCO)
PIP Topic 3: Promoting Adherence to Renin Angiotensin (RAS) Antagonists Hypertensive Medications

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	N/A	N/A				

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	M				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	PM				
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	PM				
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**	**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	PM				
5c. New or enhanced, starting after baseline year	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				
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	PM				

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	PM			
Element 7 Overall Review Determination	**N/A**	**PM**			
Element 7 Overall Score	**N/A**	**50**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**10.0**	**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					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	**55**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**45.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**0%**	**56.3%**	**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 22, 2021
Reporting Period: Year 1
IPRO Comments:
Element 1 Overall Review Determination was partially compliant in regard to Project Phase for which this Report is being submitted, regarding the Timeline for the PIP. The MCO acknowledges several meetings related to the transition of a CCIP to the PIP process and has submitted the Proposal for the transition in September of 2020. The MCO states the Project Phase is, Project Year 2 and Project Year 3 Update as well as documented the rational for changing the PIP Timeline as noted on page 14. The MCO has restructured the Timeline to the "CCIP MAH" project which does not align with the timeline and reporting components of the PIP process. MCO asterisks the following statement below the MCO's updated Reporting Schedule and Forms on page 14, "*Project Status and Baseline Update, Baseline Report and Project Year 1 Update, Project Status Report Through March 2020 were not submitted, since the first submission to IPRO took place in September 2020. It was a combination of the Proposal and Project Year 1 and Project Year 2 Update. The project began as a National CCIP in January of 2019. "However, this was addressed in the Proposal Findings as well as the April update in 2021. The PIP Proposal submitted in September 2020, was a proposal which was to transition the existing CCIP to the PIP process or to submit a new PIP Proposal. As noted on page 6 there were discussions regarding this concern. Accordingly, the MCO states a meeting was held on July 30th, 2021 with National Quality Leadership and DSNP Leadership who made the decision to extend the CCIP MAH PIP until 2022. To that end, as the MCO transitions to the PIP process, the Proposal and PIP timeline will be recognized and the MCO will need to adjust the timeline.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was the MCO is partially compliant in regard to Methodology, 3h, Study design specifies data analysis procedures with a corresponding timeline. A concern was identified with the PIP exhibiting 1

Performance Indicator (PI) which is not sufficient in support of the Aim, Objective and Goal of the PIP. The MCO's Data Collection process, denotes the data is collected weekly and reported to the team and analyzed annually and updated to reflect Outreach data is reported by the pharmacy team quarterly as well as the PI data is reported to the STARS Team annually. The PI data, on Table 3.2.1 on page 11, Performance Indicator 1- Data Source: Pharmacy Claims and HEDIS®, Percent of the eligible* H3113-005 DSNP member population, 18 years or older, who adhere** to their prescribed RAS antagonist medication (ACE inhibitors, ARBs, or Direct Renin Inhibitors) 80% of the time (or more), and the Results Table notes the Rates for this PI, however there is no supporting data to validate that the Pharmacy Outreach Team and education provided for medication adherence is effective. The MCO should review the Barrier Analysis for additional data that can validate the PI.

Element 4 Overall Review Determination was the MCO is partially complaint in regard to 4c, Provider input at focus groups and/or Quality Meetings. A concern was identified that the MCO has terminated Interventions 1a and 3a, only leaving the PIP with 1 intervention which does not exhibit Provider group input or feedback regarding the PI data. Including provider groups, in collaboration with the MCO and Pharmacy Outreach Team may potentially bridge any gaps in provider-member relationships thereby increasing the rate of medication adherence as well as documented validation at each visit over time. The MCO should look to include the provider groups for input and feedback regarding process and/or potential interventions that may lend rise to increased adherence with medications.

Element 5 Overall Review Determination was that the MCO is partially compliant in regard to Robust Interventions, 5b. Actions that target member, provider and MCO. The MCO has 1 Intervention that is driven by Pharmacy Claims data. Although, this intervention has active outreach to the members to successfully contact and provide education to the members regarding importance of medication adherence. The MCO has not expanded the PIP to included targeted provider group panels that the members are assigned to. The MCO might consider collaboration with the Provider groups to increase support of the PIP and potentially enhance outcomes.

In regard to 5c, New or enhanced, starting after baseline year, the MCO documents the termination of Interventions 1a and 3a (9/30/2019 as part of the CCIP MAH PIP), noting for Intervention 1a, The Diabetes Health Navigator (DHN) was discontinued as of 9/30/2019, no gap closure metrics from this measure were available to be incorporated into MAH program (pg.22). Intervention 3a, also terminated 9/30/2021 as the primary intent of this intervention was to provide education to enrollees regarding their medications. Lastly, 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). Intervention 2a, does not align with the corresponding Year 2 phase of the PIP, nor does it align with the Results table 6.1 on page 24. The MCO has altered the PIP timeline to reflect "project year 2 and project year 3 update" for this August 2021 submission, although the proposal was received in September of 2020 (as noted above in Element 1 there are inconsistencies related to the PIP timelines), inclusive of an asterisk statement, "*Project Status and Baseline Update, Baseline Report and Project Year 1 Update, Project Status Report Through March 2020 were not submitted, since the first submission to IPRO took place in September 2020. It was a combination of the proposal and Project Year 1 and Project Year 2 Update. The project began as a National CCIP in January of 2019." The MCO should clarify the statements made in terms of the beginning of the PIP proposal.

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 of Validity of Reported Improvement, a concern was identified regarding (7a) Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions). The MCO cites 1 intervention consisting of Pharmacy data reflecting successful contacts and education of the importance of medication adherence. Table 6.1, Results notes that the Baseline for the project is 2018 and the Rate at that time was 85%. The MCO goes on to note 2019 data, prior to the PIP proposal and data for 2020 citing the Rate as 86% with the Final Long-Term Goal set at 88%. However, the concern noted in Element 1 above regarding the timeline which does not align with the PIP timeline, nor does it align with the Timeline inserted on page 14 or Table 1b, Quarterly Reporting of Intervention Tracking Measures. For example, in terms of the PIP expected Measurement Periods, the MCO would follow this outline: Baseline: January-December (Year) in this case as transition from the CCIP to the PIP process, 2018; MY 1, January-December 2021; MY 2, January-December 2022; Sustainability Year 2023 with the Final Report due in August of 2024. However, the MCO documents in the August update the following: Baseline (report) period January 1, 2018–December 31 2018; Year 1 measurement period January 1, 2019–December 31 2019; Year 2 measurement period January 1, 2020–December 31 2020; Year 3 measurement period January 1, 2021–December 31, 2021; Sustainability period January 1, 2022–December 31, 2022 and further states in the Reporting schedule; Proposal September 2020; Project Status and Baseline Update N/A*; Baseline Report and Project Year 1 Update N/A*; Project Status Report Through March 2020 N/A*; Project Year 1 and Project Year 2 Update

September 2020; Project Year 2 and Project Year 3 Update, August 2021. Additionally, Table 1b is not consistent with either timeline as it is documented Yr. 1 -2019; Yr. 2-2020; SY -2021. Although the MCO has had multiple discussion revolving around the timelines and expectation of the PIP process, it is unclear as to why there continues to be inconsistencies in the timeline thereby affecting the efficacy of the PIP. The MCO should align the timeline with the PIP proposal timeframe of September 2020 followed by the update and reporting timeframe as outlined in the PIP Template.

Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at the Year 1 phase.

Element 9 Overall Review Determination was N/A. Healthcare disparities were not identified, evaluated, and addressed.

Overall, the MCO is not compliant with this PIP for Year 1 reporting requirement; out of a maximum possible weighted score of 80.0 points, the MCO scored 45.0 points, which results in a rating of 56.3% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO should address the above concerns with clarifications or adjustments for a well-developed PIP that ultimately demonstrates the projected 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.

WellCare Liberty (WCL)

WCL: 2020 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Subject To Review[1]	Met[2]	Not Met	N/A	% Met[3]
Access	19	19	16	3	0	84%
Quality Assessment and Performance Improvement	9	9	9	0	0	100%
Quality Management	14	14	14	0	0	100%
Committee Structure	9	9	8	0	1	100%
Programs for the Elderly and Disabled	43	43	43	0	0	100%
Provider Training and Performance	11	11	10	1	0	91%
Enrollee Rights and Responsibilities	10	10	10	0	0	100%
Care Management and Continuity of Care	9	9	9	0	0	100%
Credentialing and Recredentialing	10	10	10	0	0	100%
Utilization Management	44	44	42	0	2	100%
Administration and Operations	20	20	20	0	0	100%
Management Information Systems	22	22	22	0	0	100%
TOTAL	**220**	**220**	**213**	**4**	**3**	**98%**

1 The MCO was subject to a full review in this review period. All elements were subject to review.
2 Elements that were Met in this review period among those that were subject to review.
3 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.

WCL Performance Measure Validation – FIDE SNP Measures

WCL reported the CMS required FIDE SNP measures. A status of R indicates that the plan reported this measure and no material bias was found. A status of NA indicates that the plan reported the measure but that there were fewer than 30 members in the denominator. A status of NR indicates that the plan did not report the measure. A status of NQ indicates that the plan was not required to report the measure.

Findings

- WCL reported the required measures for HEDIS MY 2020.

HEDIS 2021 (MY 2020) Performance Measures	Rate[1]	Status
Colorectal Cancer Screening (COL) - Hybrid Measure[1]	67.88%	R
Care for Older Adults (COA) - Hybrid Measure[1]		
Advance Care Planning	39.17%	R
Medication Review	90.02%	R
Functional Status Assessment	53.53%	R
Pain Screening	90.75%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	45.71%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	68.18%	R
Bronchodilator	86.36%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	61.80%	
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	77.14%	R
Effective Continuation Phase Treatment	61.90%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-up	40.79%	R
7-Day Follow-up	17.11%	R
Transitions of Care (TRC) – Hybrid Measure[1]		
Notification of Inpatient Admission	10.95%	R
Medication Reconciliation Post-Discharge	62.77%	R
Patient Engagement After Inpatient Discharge	78.83%	R
Receipt of Discharge Information	4.14%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)[2]		
Falls + Tricyclic Antidepressants or Antipsychotics	56.04%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	62.50%	R
Chronic Renal Failure + Non Aspirin NSAIDs or Cox-2 Selective NSAIDs	25.00%	R
Total	56.95%	R
Use of High-Risk Medications in the Elderly (DAE)[2,3]	32.62%	R
Plan All-Cause Readmissions (PCR)[2,4,5]		
18-64 Year Olds, Observed-to-Expected Ratio	1.2686	R
65+ Year Olds, Observed-to-Expected Ratio	1.2071	R

Note: Submission of Hybrid measures was not required for MY2019.

[1] Measure not reported in MY2019

[2] This measure is inverted, meaning that lower rates indicate better performance

[3] Due to the changes to this measure comparison to prior year is not appropriate

[4] PCR is a risk adjusted measure. Calculation of MCO and Statewide averages is not appropriate

[5] This measure uses count of index stays as the denominator and an observed-to-expected ratio (observed readmission/average adjusted probability)

Designation R: Reportable rate.

WCL Performance Improvement Projects

WCL PIP Topic 1: FIDE SNP Primary Care Physician Access and Availability

MCO Name: WellCare Liberty (WCL)

PIP Topic 1: FIDE-SNP 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	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	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	N/A	PM				

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	M				
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A					
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	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.,	N/A	M				

interventions)					
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**	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**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**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 22, 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 partially compliant in regard to Methodology, a concern was identified with Methodology bullet #2 for Sampling: it is unclear regarding the Baseline data, if the 9 identified providers that were reviewed are in fact represented in the Baseline data or as noted on page 25, the MCO cites 28 provider groups selected for the cohort. However, on pages 12-13, Bullet Number 2, Data Collection and Analysis Procedures, Sample size and Justification states "2% of our contracted PCPs are included in the cohort based on the selection criteria mentioned above." The MCO should clarify whether the 9-provider cohort or the 28-provider selected cohort is the participating provider in the PIP year over year and clarify any implications this may have on the Short and Long Term Goals set forth from the Baseline. For PI #4, the MCO chose an extensive list of potential diagnoses for trending with the provider cohort. However, the MCO should consider reviewing Appendix D-NYU ER Algorithm and comparing it to the MCO's ER utilization data to review and discuss any diagnoses that may exhibit a recurrent theme for a chronic illness which could be a potential additional opportunity 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 N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was N/A. Healthcare disparities were not identified, evaluated, and addressed at the proposal phase.
Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 91.6% (which is at least or above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made adjustments as appropriate and updated the Baseline information for Performance Indicator #3. The MCO should address the above concerns with clarifications or adjustments for a well-developed PIP that ultimately demonstrates the intended impact on performance outcomes. The MCO should be mindful of any Plan name change and confirm the Plan's name as it appears on the contract for each submission. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.

WCL PIP Topic 2: Promote Effective Management of Diabetes in the FIDE SNP Population

MCO Name: WellCare Liberty (WCL)

PIP Topic 2: Promote Effective Management of Diabetes in the FIDE SNP 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	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	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	N/A	M				

methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline						
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	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	N/A	M				

outlined in the MCO's data analysis plan					
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**	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**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**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 22, 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 complaint.
Element 4 Overall Review Determination was that the MCO is partially compliant in regard to the QI process 4d, a concern was identified with decimal placement and rounding inconsistencies. On Table 1b, page 18, Y1Q2 #2b, #3a and #3b exhibit various decimal placement (for example: #2b: N:261/D:443 =Rate 58.9% as compared to #3a N:176/D:471= Rate of 37%). The Results Table 6 on page 22 exhibits the same concern as well as additional rounding up to 1 or two decimal places. On the Results Table, Baseline Period 2017, Indicator #1 appears to have a miscalculation; N:654/D:844= Rate of 77.48815%, however the rate is displayed as 77.41%. The MCO should review all calculations with one mode of decimal placement and rounding conventions throughout the PIP in order to ensure accuracy of the data year over year.
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 N/A. Sustainability in not evaluated at the Year1 phase.
Element 9 Overall Review Determination was N/A. Healthcare disparities were not identified, evaluated, and addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 91.6% (which is at least or above 85% [≥ 85% being the threshold for meeting compliance]). The MCO should review decimal placement and rounding standard writing conventions, maintain one

style throughout the PIP in order to ensure consistent and accurate data capture year over year. The MCO has updated ITMs #3a, #3b and #3c clarifying denominators and has updated the Change Table accordingly. The MCO should be mindful of any Plan name changes and confirm the Plan's name as it appears on the contract for each submission. As changes are made, the MCO should consider the impact of COVID-19 on the PIP as the situation continues to evolve.